

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055887	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/30/2026
NAME OF PROVIDER OR SUPPLIER  River Bend Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2215 Oakmont Way West Sacramento, CA 95691	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>Based on interview and record review, the facility failed to ensure that services were provided in accordance with professional standards for 1 of 6 sampled residents (Resident 1) when staff did not administer a prescribed antibiotic (a medication used to kill or stop the growth of bacteria) medication as ordered by the physician. This failure had the potential to result in inadequate infection treatment and worsening symptoms for Resident 1. Findings: Resident 1 was originally admitted to the facility in March 2026 with diagnoses that included non-traumatic intracerebral hemorrhage (bleeding inside the brain) and H. pylori gastritis (a stomach infection caused by Helicobacter pylori bacteria). A review of Resident 1's Hospital After Visit Summary (AVS), dated 3/17/26, the AVS indicated that the metronidazole (medication used to treat infections caused by bacteria or parasites) 500 mg (milligram, unit of measurement) every 6 hours was last given on 3/17/26 at 12:12 p.m. A review of Resident 1's Order Summary Report, with a start date of 3/17/26, indicated, Metronidazole Oral Tablet 500 mg. Give 1 tablet via PEG tube [a small tube that helps deliver food and medicine directly to the stomach when eating by mouth is not safe] every 6 hours for H. Pylori Gastritis. A review of Resident 1's Medication Administration Record (MAR) for March 2026, the MAR indicated that Resident 1 did not receive the prescribed metronidazole doses scheduled for 3/17/26 at 6 p.m. and 3/18/26 at 12 a.m. During a concurrent interview and record review on 3/30/26 at 3:45 p.m. with the Infection Preventionist (IP), the IP stated that the medication had not been given as indicated in Resident 1's Administration Notes dated 3/17/26 at 7:45 p.m. and 3/18/26 at 12:32 a.m. The Administration Notes indicated that the medication was pending pharmacy delivery. During a concurrent observation and interview on 3/30/26 at 4 p.m. with the Infection Preventionist (IP) Nurse in the medication room, the IP was observed checking the contents of the medication emergency kit (e-kit), which contained metronidazole. The IP stated the nurse should have utilized the medication e-kit to administer the scheduled antibiotic if it was available. The IP further stated that if antibiotics were not administered appropriately, bacteria could become resistant to the medication. During an interview on 3/30/26 at 4:22 p.m. with the Director of Nursing (DON), the DON stated that if an antibiotic was not administered, it could delay the healing process, and an acute situation might occur. The DON stated the nurse should have used the ordered medication from the e-kit. A review of the facility's policies and procedures titled Administering Medications (undated) indicated, Medications are administered in a safe and timely manner, and as prescribed. Medications are administered in accordance with prescribed orders, including any required time frame.</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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