STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055887	A. Building B. Wing	08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Bend Nursing Center	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)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. (continued on next page)

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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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide treatment in accordance with professional standards of care for forty (40) residents in a census of 86, when the licensed nurse (LN) did not have consistent practice in enteral tube (flexible tube inserted into the gastrointestinal tract to deliver liquid nutrition or medications directly to the stomach or small intestine) medication administration, and the facility provided two versions of the policy and procedure addressing the practice with the same revision date and modified text.These failures had the potential to expose the residents on enteral tubes to unsafe medication administration and the adverse side effects of the medications.During a concurrent observation and interview on 8/13/25 commencing at 4:27 p.m., a medication pass was conducted with LN 4. LN 4 prepared and administered seven medications for Resident 3. LN 4 combined and crushed together six medications: aspirin 81 mg (milligram unit of measurement, blood thinning medication), docusate sodium 100 mg (a stool softener medication), magnesium oxide 400 mg (a supplement medication), metoprolol tartrate 12.5 mg (a blood pressure medication), risperidone 1 mg (a medication used to treat psychiatric conditions), and famotidine 20mg (a medication used to tread high stomach acid). LN 4 stated that Resident 3 had an order that allowed medications to be crushed and combined together. LN 4 additionally prepared 5ml (milliliters, unit of measurement) of valproic acid 250mg/5ml (milligram/milliliter unit of concentration, a medication used for seizures or psychiatric conditions). LN 4 poured the valproic acid suspension into the measuring cup without shaking the medication prior to pouring. LN 4 entered Resident 3's room and administered 6 combined crushed medications diluted in water, followed by 5 ml of valproic acid without flushing in-between administrations through the PEG tube (percutaneous endoscopic gastrostomy tube, a tube inserted through a skin incision directly into the stomach) with 30 ml water flushes before and after administration. After administering the medications, LN 4 came out of the room and confirmed that she administered six combined and crushed medications, followed by valproic acid without flushing in-between. LN 4 also stated that she did not shake the valproic acid medication bottle prior to administration and showed the bottle with directions on the label to shake for 15 seconds prior to administration.During a review of Resident 3's Physician's Orders (PO), the PO indicated the following:1. Aspirin 81 Oral Tablet Chewable, give 1 tablet via PEG-Tube one time a day for Heart health. Start Date 10/10/2024;2. Docusate Sodium, oral tablet 100mg give via PEG-tube two times a day for bowel care. Start date- 05/12/2025;3. Magnesium Oxide, oral tablet 400mg, give 1 tablet via PEG-tube one time a day for supplement. Start date 10/10/2024;4. Metoprolol Tartrate tablet, give 12. 5mg via PEG-Tube two times a day for Sinus Tachycardia. Start date 11/17/2024;5. Risperidone, oral tablet 1mg, give 1 tablet via PEG-Tube two times a day for continuousyelling/screaming. Start date 01/24/2025;6. Famotidine Tablet 20mg, give 1 tablet via PEG-tube every 12 hours for GI PPx (gastrointestinal prophylaxis). Start date 10/10/2024;7. Valproic Acid oral solution 250 mg/5ml, give 5 ml via PEG tube two times a day for moodswings and irritability. *shake well for 15 sec*. Start date 05/19/2025; 8. ENTERAL: May Crush Medications And Give Via GTube Unless Contraindicated -D/C [discontinue] Date- 08/13/2025 1714. The order was active since 10/10/24.9. ENTERAL: Flush before and after administration of medication, 30 ml, and 10 ml in between administration of each medication. Active [since] 10/10/24.10 ENTERAL: May Crush Medications And Give all together Via G-Tube Unless Contraindicated. Active 08/13/2025.During an interview on 8/14/25 at 4:47 p.m. with LN 4, LN 4 confirmed that Resident 3's chart did not have a specific order to combine and crush medications together at the time of medication pass observation on 8/13/25, but the chart did have an order to flush between each medication. LN 4 further confirmed that right after the med pass observation on 8/13/25 at 5:14 p.m. she obtained a new PO, which indicated, ENTERAL: May Crush Medications And Give all together Via G-Tube Unless Contraindicated. Active 08/13/2025. LN 4 added that the facility had a policy that allowed staff to combine, crush, and administer enteral medications together. During an interview on 8/14/25 with LN 6, LN 6 stated that facility nurses don't combine and crush medications together for enteral tube administration, and stated, Each medication is administered separately. LN 6 indicated she was not aware of the orders that would allow the practice of combining and crushing medications together for enteral administration.During an interview on 8/15/25 at 11:14 a.m. with LN 7, LN 7 stated that she administered each enteral medication separately.During a review of the facility's policy and procedure (P&P) titled, Administering Medications Through an Enteral Tube, revised November 2018, provided by the Administrator (Admin) during the facility survey prior to 8/14/25 noon time, the P&P step 3

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview, and record review, the facility failed to ensure necessary care and services were provided to meet the communication needs for three of 30 sampled residents (Resident 12, Resident 55, and Resident 60), when:1. Resident 12, non-English speaking resident, was not provided with any communication board or devices; and2. Resident 55 and Resident 60, non-verbal dependent residents, were not provided with any visual materials to express their needs. These failures had the potential to result in Resident 12, Resident 55 and Resident 60's inability to participate in daily tasks, make choices, or have their preferences and unmet needs heard. 1. During a review of Resident 12's admission Record (AR), dated 5/2025, the AR indicated Resident 12 had diagnosis of mild cognitive impairment. During a review of Resident 12's Physician's Order (PO) dated 5/28/25, the PO indicated Resident 12 had no mental capacity to make healthcare decisions. During a concurrent observation and interview on 8/13/25 at 10:35 a.m. inside Resident 12's room with Licensed Nurse 5 (LN 5), LN 5 confirmed Resident 12 did not speak English and there were no communication board or visuals available for use in her room. During a review of Resident 12's Communication Care Plan (CCP), dated 8/14/25, the CCP indicated, Communication: First Language Mandarin.Offer communication board for translation assist when desired.During an observation on 8/14/25 at 8:54 a.m. in Resident 12's room, Resident 12 was in bed, stared back and did not answer when spoken to in English. There were no visuals, picture boards, or symbols available at the bedside for Resident 12 to communicate her understanding or needs. During a concurrent observation and interview on 8/14/25 at 2:46 p.m. in Resident 12's room with the Infection Prevention (IP) Nurse, the IPN confirmed Resident 12 did not speak English and there were no communication board or devices available at the bedside. The IPN indicated that providing communication materials in her native language (Mandarin) meant advocating for her needs and would allow Resident 12 to get engaged and feel more connected. The IPN stated Resident 12 had the right to know what services and treatment she was getting while residing at the facility. 2. During a review of Resident 55's AR, dated 2/2025, the AR indicated Resident 55 had a traumatic brain injury (TBI, injury that occurs when an external force causes damage to the brain) and aphasia (a disorder that makes it difficult to speak). During review of Resident 55's PO, dated 2/21/25, the PO indicated Resident 55 had no mental capacity to make healthcare decisions.During a review of Resident 55's Activities of Daily Living (ADL) CP, revised 6/1/25, the ADL CP indicated, ADL functioning with self-care deficit.explain procedures before performing.During an observation on 8/13/25 at 8:54 a.m. in Resident 55's room, Resident 55 was in bed, eyes opened, unable to respond verbally but was able to move his right hand and made a thumbs-up when asked to acknowledge. There were no visual materials using pictures or symbols to outline daily routines and activities, boards with images, symbols, or words that Resident 55 could point to express needs, thoughts and emotions. During a concurrent observation and interview on 8/13/25 at 11:23 a.m., in Resident 55's room with LN 9, LN 9 confirmed Resident 55 was non-verbal and there were no communication board or visual pictures available for use. When asked what method LN 9 used to communicate with Resident 55 to explain procedures, services or treatment, LN 9 could not explain how she could communicate what nursing care or treatment Resident 55 was getting. During a concurrent observation and interview on 8/14/25 at 9:23 a.m. in Resident 55's room with the IPN, the IPN stated residents with speech, language, or communication difficulties should be provided with communication visuals or materials. The IPN added having available visuals or pictures could be effective for learning and retaining new skills, especially for tasks that are difficult to explain verbally. During a review of Resident 60's AR, dated 9/2014, the AR indicated Resident 60 had TBI and aphasia. During a review of Resident 60's PO, dated 4/30/20, the PO indicated Resident 60 had no mental capacity to make healthcare decisions.During a review of Resident 60's CCP, revised 6/25, the CCP indicated, Impaired communication related to TBI, as evidenced by (AEB) sometimes understood, sometimes understands, sometimes will speak in short sentences, usually non-verbal.have communication board at bedside and use PRN [PRN-as needed]. During an observation on 8/13/25 at 10:21 a.m. in Resident 60's room, Resident 60 was in bed, unable to answer verbally but smiled and blinked his eyes when asked to respond. There were no communication visuals available at the bedside. During a concurrent observation and interview on 8/13/25 at 11:23 a.m. in Resident 60's room with LN 9, LN 9 confirmed Resident 60 was non-verbal and there were no communication visuals available at the bedside. LN 9 stated communication board for non-verbal residents should be available so they could respond back by pointing at the pictures or visuals provided. LN 9 stated not understanding the needs of our non-verbal

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure necessary services to maintain good grooming, nail care and oral hygiene were provided to five of 30 sampled residents (Resident 12, Resident 22, Resident 27, Resident 60 and Resident 77) who were unable to carry out activities of daily living (ADLs), when:1. Resident 12's toenails were long, untrimmed, curled inward and discolored;2. Resident 22's left big toenail was long, jagged, untrimmed and curled outward; 3. Resident 27 toenails were long, jagged, untrimmed, discolored and curled inward;4. Resident 60's fingernails and toenails were long, jagged and untrimmed, his nostrils had yellowish-colored substance, his upper and lower eyelids and eyebrows had white-colored-crust-dried substance, his teeth were discolored, and his lips were cracked and dry, dry and scaly skin; and, 5. Resident 77's left second finger was discolored, jagged, untrimmed and curled inward, her eyebrows and the crevice of her nose had whitish-yellowish-flaky substances, and her cheeks had food residue markings. These failures resulted in Resident 12, Resident 22, Resident 27, Resident 60, and Resident 77's unkempt appearance and compromised well-being. 1. During a review of Resident 12's admission Record (AR), dated 5/2025, the AR indicated Resident 12 was admitted in mid-2025 with diagnoses of mild cognitive impairment and diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing).During a review of Resident 12's Physician's Order (PO), dated 5/28/25, the PO indicated Resident 12 had no mental capacity to make healthcare decisions. During an observation on 8/14/25 at 8:54 a.m., in Resident 12's room, Resident 12 was in bed, her toenails were long, jagged, untrimmed and had black substances underneath the nail beds.During a concurrent observation and interview on 8/14/25 at 2:46 p.m., in Resident 12's room with the Infection Prevention (IP) Nurse, the IPN confirmed the findings, and stated Resident 12's toenails had to be trimmed or should be referred to the podiatrist (medical specialists who help with problems that affect the feet or lower legs). The IPN indicated that toenails could harbor dirt, bacteria and fungi, leading to infections like athletes' foot and toenail fungus. The IPN stated that poor foot hygiene could increase the risk of infections, particularly residents with diabetes or weakened immune system. 2. During a review of Resident 22's AR, dated 5/2024, the AR indicated Resident 22 had diagnoses which included dementia (a progressive state of decline in mental abilities) and embolism (block in an artery caused by blood clots) of deep veins of lower left extremity (LLE). During a review of Resident 22's PO, dated 5/24/24, the PO indicated Resident 22 had mental capacity to make healthcare decisions. During a concurrent observation and interview on 8/14/25 at 10:15 a.m., in Resident 22's room, Resident 22 was in bed, her big left toenail was long, jagged, untrimmed, mycotic (caused by a fungus), and curled outward. Resident 22 stated her big left toenail hurt when it gets pushed or touched and wanted it to be trimmed. During a concurrent observation and interview on 8/14/25 at 10:15 a. m. in Resident 22's room with the IPN, the IPN confirmed the findings, and indicated Resident 22's big left toenail had to be trimmed. The IPN stated untreated mycotic and discolored toenails could lead to nail damage or loss, could get infected and spread to surrounding tissues. 3. During a review of Resident 27's AR, dated 5/2025, the AR indicated Resident 27 had diagnoses which included diabetes and peripheral vascular disease (PVD, a slow progressive narrowing of blood flow to the arms and legs).During a review of Resident 27's PO, dated 5/7/25, the PO indicated Resident 27 had mental capacity to make healthcare decisions. During a concurrent observation and interview on 8/13/25 at 12:06 p.m. in Resident 27's room, Resident 27's toenails were long, mycotic, jagged and untrimmed. Resident 27 indicated he wanted his toenails to be trimmed and cleaned. Resident 27 stated his toenails hurt when he wore his shoes.During a concurrent observation and interview on 8/14/25 at 9:31 a.m., in room [ROOM NUMBER]'s room with the IPN, the IPN confirmed the findings, and indicated Resident 27's long and untrimmed toenails created a warm, moist environment conducive to the growth of fungi which could eventually lead to nail infection. The IPN confirmed Resident 27's dirty, overgrown nails could cause discomfort when wearing shoes and were more prone to cause ingrown. The IPN stated regular cleaning and trimming of toenails could help maintain comfort.4. During a review of Resident 60's AR, dated 9/2014, the AR indicated Resident 60 had diagnoses which included diabetes, contracture (a stiffening/shortening at any joint, that reduces the joints range of motion) and blepharitis (an inflammation along the edges of the eyelids). During a review of Resident 60's PO, dated 4/30/20, the PO indicated Resident 60 had no mental capacity to make healthcare decisions. During an observation on 8/13/25 at 10:09 a.m. in Resident 60's room, Resident 60 was in bed, his

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview and record review, the facility failed to ensure the resident's environment was free from accidents or hazards for one of 30 sampled residents (Resident 61), when Resident 61 had a traumatic fall with injury. This failure resulted in Resident 61's decline in physical and psychosocial well-being. During a review of Resident 61's admission Record (AR), the AR indicated Resident 61 was admitted to the facility in late 2022 with diagnoses which included diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing) and hypertension (high blood pressure).During a review of Resident 61's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 6/1/25, the MDS indicated Resident was cognitively intact.During a review of Resident 61's Care Plan (CP), revised and updated 6/18/23, the CP indicated Resident 61 was at risk for falls and injury due to bilateral above the knee amputations, paraplegia and muscle wasting and interventions included frequent checks and keeping the environment free of hazards.During a review of Resident 61's eInteract Change of Condition Evaluation (eCoC) dated 1/3/25 at 9:36 a.m., the eCoC indicated, [Resident 61] had a fall from a shower bed during enter (sic) in shower room, assigned CNA [Certified Nursing Assistant] pulled shower bed from head side of shower bed because of bump before to enter shower room bed tilted down and resident fell, resident head hit floor and bump on left side of head.During a review of Resident 61's Emergency Department (ED) Provider Notes, dated 1/3/25, the ED Provided Notes indicated Resident 61 was brought in to the ED after a ground level fall when going from hospital bed and fell backward when transferring and was diagnosed with a traumatic intracerebral hemorrhage (brain bleed) and was admitted to the intensive care unit (ICU). During a review of Resident 61's eCoC dated 7/6/25 9:46 p.m., the eCoC indicated Resident 61's change of condition was reduced glenohumeral articulation with anterior glenoid rim acute fracture after Resident 61 reported pain to his left shoulder.During a concurrent observation and interview on 8/13/25 at 11:13 a.m. in Resident 61's room, Resident 61 was observed laying on his back in bed, with his left hand swollen and fingers curled into his palm, unable to make a fist. Resident 61 indicated he recently had a fracture to his left shoulder. Resident 61 stated, I had severe pain to that [left] shoulder and the x-ray showed there was a fracture. Resident 61 further stated, I was dropped on my head when I was on the shower bed going into the shower room about five months ago. The whole shower chair fell over. I don't trust going into the shower room anymore. I told the CNA [Certified Nursing Assistant] to not bring me into the shower room headfirst. I don't know if she was irritated or annoyed, or if she did it on purpose, but she pulled on the towel that was underneath me so hard I fell off and hit my head. A lot of people had to come and help me get off the floor. I was taken to the ER [emergency room] and I was diagnosed with a brain bleed. I've had a lot of problems since then that fall. During an interview on 8/14/25 at 4:58 p.m. with LN 2, LN 2 confirmed she was the LN who completed the eCoC on 7/6/25. LN 2 stated Resident 61 complained of severe pain to the left shoulder and an x-ray was ordered. LN 2 said the x-ray was done and the results showed a left shoulder fracture. LN 2 acknowledged she did not complete a full physical assessment or evaluation of Resident 61 and did not know how the left shoulder got fractured. LN 2 confirmed she did not alert the DON or Admin of the incident. During an interview on 8/15/25 at 10:18 a.m. with LN 3, LN 3 recalled the fall incident on 1/3/25. LN 3 indicated Resident 61 had a fall in the shower room and was sent to the emergency room (ER). Resident 61 was diagnosed with a brain bleed from the fall. On Resident 61's recent diagnoses of a left shoulder fracture on 7/6/25, LN 3 stated Resident 61 reported, my shoulder hurts. An x-ray was completed, and it was discovered that Resident 61 had fractured his left shoulder. During an interview on 8/15/25 at 1:51 p.m. with the Administrator (ADM), the ADM confirmed he was aware of the 1/3/25 fall but was unaware of the injury. The ADM stated the DON and Assistant Director of Nursing (ADON) should discuss the incidents and residents change of conditions during the morning IDT (interdisciplinary team) meetings. When questioned about Resident 61's recent diagnosis of a left shoulder fracture on 7/6/25 the admin stated he was unaware of the recent fracture. During a concurrent interview and record review on 8/15/25 at 2:53 p.m. with the DON and Regional Consultant (RC) the DON stated she was aware Resident 61 had a fall with injury on 1/3/25. The DON stated she knew how the fall occurred but did not conduct interviews with Resident 61 or other staff members who were involved. There was no evidence to show the shower floor had been assessed. The DON confirmed she did not initiate an incident report. The DON acknowledged she was aware of Resident 61's recent fracture to his left shoulder on 7/6/25. There was no evidence an incident report had been initiated. The DON agreed an injury would be classified as an injury of unknown origin without knowledge of

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility had a 25.81% error rate, with eight medication errors out of 31 opportunities observed during a medication pass for two of five residents (Resident 3 and Resident 76).These failures resulted in medications not being administered in accordance with the prescriber's orders and may have affected the residents' clinical conditions.During a concurrent observation and interview on 8/13/25 commencing at 4:27 p.m., a medication pass observation was conducted with Licensed Nurse (LN 4), LN 4 was observed preparing and administering seven medications for Resident 3. LN 4 combined and crushed together six medications: Aspirin 81 mg (milligram unit of measurement, blood thinning medication), docusate sodium 100 mg (a stool softener medication), Magnesium oxide 400mg (a supplement medication), Metoprolol tartrate 12.5 mg (a blood pressure medication), Risperidone 1mg (a medication used to treat psychiatric conditions), famotidine 20mg (a medication used to tread high stomach acid). LN 4 stated that Resident 3 had an order that allowed medications to be crushed and combined together. LN 4 further prepared 5ml (milliliters, unit of measurement) of Valproic Acid 250mg/5ml (milligram/milliliter unit of concentration, a medication used for seizures or psychiatric conditions). LN 4 poured Valproic Acid suspension into the measuring cup without shaking the medication prior to pouring. LN 4 came to Resident 3's room and administered 6 combined crushed medications diluted in water, followed by 5ml Valproic acid without flushing in-between administrations through PEG tube (percutaneous endoscopic gastrostomy tube, a tube inserted through a skin incision directly into the stomach) with 30ml water flushes before and after administration. After administering medications, LN 4 came out of the room and confirmed that she administered six combined and crushed medications, followed by valproic acid without flushing in-between. LN 4 also stated that she did not shake the valproic acid medication bottle prior to administration, and she showed the bottle with directions on the label to shake for 15 seconds prior to administration.During a review of Resident 3's Physician's Orders (PO), the PO indicated the following:1. Aspirin 81 Oral Tablet Chewable, give 1 tablet via PEG-Tube one time a day for Heart health. Start Date 10/10/2024;2. Docusate Sodium, oral tablet 100mg give via PEG-tube two times a day for bowel care. Start date- 05/12/2025;3. Magnesium Oxide, oral tablet 400mg, give 1 tablet via PEG-tube one time a day for supplement. Start date 10/10/2024;4. Metoprolol Tartrate tablet, give 12.5mg via PEG-Tube two times a day for Sinus Tachycardia. Start date 11/17/2024;5. Risperidone, oral tablet 1mg, give 1 tablet via PEG-Tube two times a day for continuousyelling/screaming. Start date 01/24/2025;6. Famotidine Tablet 20mg, give 1 tablet via PEG-tube every 12 hours for GI PPx (gastrointestinal prophylaxis). Start date 10/10/2024;7. Valproic Acid oral solution 250 mg/5ml, give 5 ml via PEG tube two times a day for moodswings and irritability. *shake well for 15 sec*. Start date 05/19/2025; 8. ENTERAL: May Crush Medications And Give Via GTube Unless Contraindicated -D/C [discontinue] Date-08/13/2025 1714. The order was active since 10/10/24.9. ENTERAL: Flush before and after administration of medication, 30 ml, and 10 ml in between administration of each medication. Active [since] 10/10/24.During an interview on 8/14/25 at 4:47 p.m. with LN4, LN 4 confirmed that Resident 3's chart did not have a specific order to combine and crush medications together at the time of medication pass observation on 8/13/25, but it did have an order to flush between each medication.During a concurrent observation and interview on 8/14/25 commencing at 8:34 a.m., medication pass observation was conducted with LN 5, LN 5 prepared and administered ten medications for Resident 76. Preparation and administration included Polyethylene Glycol 3350 powder (a laxative medication). LN 5 measured Polyethylene glycol 3350 powder using a medication bottle cup with a white inner measurement mark. LN 5 poured powder to the top of the inner cap thread with about 1/4 of the distance to the top of the white inner cap exposed unfilled and diluted measured powder in 4 ounces (oz) of water before providing it to Resident 76 who took the medication orally. After administering medications, LN 5 returned to the medications cart and confirmed filling the Polyethylene glycol 3350 measuring cup to the top of the cap's thread and not covering the entire white inner cup. LN 5 confirmed that engraving on the inner cap indicated 17g [17 gram, unit of mass] with an arrow pointing to the edge of the white cup and not to the thread line. LN 5 also confirmed that directions on the bottle stated, fill to top of white section in cap which is marked to indicate the correct dose (17g). During a review of Resident 76's PO, the PO indicated, Polyethylene Glycol 3350 Give 17 gram by mouth two times a day for bowel care Mix with 4-8 oz of water, juice, coffee or tea. Hold for loose stools. Start Date- 04/30/2024.During an interview on 8/15/25 at 3:54 p.m. with the Director of Nursing (DON), the DON indicated that nurses should

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055887	A. Building B. Wing	08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Bend Nursing Center	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)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure medications were stored securely for a census of 86, when:1. An open container of glucometer test strips was not labeled with the open date;2. One eye drop medication had no legible open date;3. Keys to the controlled substance cabinets and refrigerator were not secured.These failures had the potential for residents to receive medications or treatments that were unsafe or with reduced potency or accuracy, and increased risk of access to controlled substances by unauthorized individuals.During a concurrent observation and interview on 8/14/25 at 10:55 a.m. with Licensed Nurse (LN 6) in the hallway near room [ROOM NUMBER], the medication cart was inspected and found an open box of glucometer test strips that was not labeled with an open date. The directions on the box indicated use within 6 months after first opening. LN 6 confirmed the box should have been labeled with an open date. LN 6 was not able to state how long after opening test strips can be stored and used.During a concurrent observation and interview on 8/15/25 at 12:04 p.m. with the Assistant Director of Nursing (ADON) in Station #1 medication storage room, latanoprost (an eye drop medication) was found in the fridge labeled with open date 02/10 and refill date 3/11/25. The ADON confirmed the observation and indicated the area was used for storing active medications. The ADON confirmed the directions on the package indicated that the medication should be used within 6 weeks of opening and verified that the latanoprost had been more than 6 weeks from the opening date.During a concurrent observation and interview on 8/15/25 at 12:25 p.m. with LN 8 in Station #1's medication storage room, a set of keys was observed hanging in a plastic bag on the wall. The keys were tested and opened the drawers and the refrigerator storing the controlled substances. LN 8 confirmed the set of keys were not secured. During an interview on 8/15/25 at 3:52 p.m. with the Director of Nursing (DON), the DON confirmed that opened glucometer test strip containers should be labeled with the open date to ensure the strips are not used beyond the indicated number of days after opening for accuracy of testing. The DON stated the latanoprost eye drop medication container open date was not legible or accurate [open date predated refill date] and had to be discarded after a certain number of days. The DON stated that keeping keys unsecured to the controlled substances cabinets and the refrigerator inside the medication room increased the potential for unauthorized access. During a review of the facility's policy and procedure (P&P) titled, Storage of Medications, revised 11/ 2020, the P&P indicated, Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity controls. Only persons authorized to prepare and administer medications have access to locked medications.Drug containers that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy for proper labeling before storing. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed.Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals are locked when not in use. Unlocked medication carts are not left unattended.Schedule II-V controlled medications are stored in separately locked, permanently affixed compartments. Access to controlled medication is separate from access to non-controlled medications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055887	A. Building B. Wing	08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure food preparation in accordance with professional standards for food service safety were provided for a census of 86, when:1. A kitchen staff's personal food item was found in refrigerator opened and expired;2. Low temperature dishwasher logs showed documentation of 200 parts per million (ppm - a unit of concentration to measure pollutants in water) for June, July, and August 2025; and 3. Kitchen staff did not know how to calibrate thermometers to determine food time/temperature control during lunch tray line. These failures had the potential to cause food-borne illnesses in a vulnerable population.1. During a concurrent observation and interview on 8/12/25 at 8:30 a.m., in the kitchen with the Certified Dietary Manager (CDM), the CDM confirmed a seafood item in an opened plastic container found in a cardboard box labeled, Liquid Cage Free Whole Eggs, was unlabeled with expiration date of 8/8/25 in the refrigerator door. The CDM stated this food item belonged to one of the kitchen staff. The CDM indicated that expectations were that all food items were labeled with a date, expired foods were thrown out, and kitchen staff were to use the staff refrigerators on the nursing units to keep personal food. CDM acknowledged personal food in the kitchen's refrigerator was cross contamination and could make the residents sick.During a telephone interview on 8/15/25 at 8:50 a.m., with the Registered Dietician (RD), the RD stated, that is not acceptable at all. RD indicated expectations were for staff to use the refrigerators on the nursing units to store their food, all food in refrigerators should be labeled with a name, dated when opened, and expired foods should be thrown out. The RD acknowledged that these practices prevent residents from getting sick from cross contamination of old food.During a review of the facility's policy and procedure (P&P) titled, Food Storage: Cold Foods, revision date 2/2023, the P&P stipulated, All Time/Temperature Control for Safety (TCS) foods.refrigerated, will be.stored in accordance with guidelines of the FDA Food Code.5. All foods will be stored wrapped or in covered containers, labeled and dated, and.in a manner to prevent cross contamination.2. During a concurrent observation, interview and record review on 8/13/25 at 9:30 a.m. in the kitchen with Dietary Aid 1 (DA 1), DA 2, and CDM, DA 1 was asked to demonstrate and explain the dishwasher procedure. DA 1 said the dishwasher was a low temperature washer and she did not know the cleaning chemical used. DA 1 performed a test strip at the end of the fourth cycle final rinse, and the results were 200 ppm. DA 1 presented the Dish Machine Log test strip documentation for August 2025. The documentation showed 200 parts per million (ppm) test strip results written daily for all three meals. DA 1, DA 2 and the CDM could not explain what 200 ppm meant and could not reference an instruction manual for answers. The CDM stated, I am not a dishwasher technician. During a concurrent observation and interview on 8/14/25 at 3 p.m., in kitchen with the CDM and the Dishwasher Service Technician (DST) to discuss the dishwasher sanitizing test strip results, the DST stated he did not look at the test strip results logged by the kitchen staff. The DST reviewed the documentation for August 2025 and stated the 200 ppm number was too high. The DST confirmed the ppm results should read 50-100. The CDM stated he had not provided training or in-services for kitchen staff on how to perform sanitizing test strips for the dishwasher. The CDM acknowledged residents could get sick from too much sanitizing chemical left on plates and could have created an adverse interaction with the food.During a telephone interview on 8/15/25 at 8:50 a.m., with the RD, the RD stated her spreadsheet for July 2025 showed the dishwasher's ppm was too high. The RD stated the sanitizing test results should be between 50 to 100. The RD acknowledged the dishes have to be disinfected correctly, the right concentration must be used so that residents do not get sick from possibly ingesting sanitizing solution when eating meals.During a review of the facility's policy and procedure (P&P) titled, LOW TEMP DISH MACHINE, no date, the P&P stipulated, .Step 4:.(Test sanitizer = 50-100 PPM).During a review of the facility's P&P titled, Warewashing , revised 2/2023, the P&P stipulated, 1. The Dining Services staff will be knowledgeable in the proper.handling of sanitized dishware.2. All dish machine water temperatures will be maintained in accordance with manufacturer's recommendations for.low temperature machines.3. During a concurrent observation and interview on 8/14/25 at 11:20 a.m., in the kitchen with the [NAME] and the Certified Dietary Manager (CDM), before the start of the lunch tray-line service, the [NAME] was asked to demonstrate and explain the procedure for thermometer calibration. The [NAME] grabbed a red thermometer from a cup located on the countertop at the end of the steam table area. The cup held two other thermometers, one black thermometer and one silver thermometer. The [NAME] went over to the pan of cooked lasagna positioned on stovetop and stuck his thermometer into