

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056258	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/02/2024
NAME OF PROVIDER OR SUPPLIER River Valley Healthcare & Wellness Centre, LP		STREET ADDRESS, CITY, STATE, ZIP CODE 2490 Court Street Redding, CA 96001	

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 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49859</p> <p>Based on observation and interview, the facility failed to ensure that one of four sampled residents (Resident 1) got an activities schedule and a newsletter (a written document about facility news and upcoming activities), for the months of June and July 2024.</p> <p>These failures caused Resident 1 to not know when activities were scheduled, what activities were being offered, or what the current news of the facility was, which violated his right to be informed and make decisions regarding his activities.</p> <p>Findings:</p> <p>Review of Resident 1's Face Sheet (a document in a patient's medical chart or electronic health record that summarizes important information about the patient), indicated that Resident 1 was admitted to the facility on [DATE] with diagnoses that included Epilepsy (seizure disorder which is caused by excessive and abnormal nerve cell activity in the brain), muscle weakness, difficulty walking, and depression.</p> <p>During an interview and observation on 7/2/24 at 2:30 PM, in Resident 1's room, Resident 1 pointed out a clear plastic wall sign holder and stated that it used to have a calendar that informed him what activities were going on in the facility for the month, and it had been empty for the entire month of June 2024. Resident 1 stated that the residents used to get a schedule of activities but have not been provided with this schedule, for the month of June 2024. Resident 1 stated the last newsletter he received was May 6, 2024.</p> <p>During an interview and observation on 7/24/24 at 12:02 PM, in Resident 1's room, the clear plastic wall sign holder did not contain a calendar of activities. Resident 1 stated there was a new activities director, and activities were being conducted. Resident 1 stated that there were some activities going on now, but he did not know when the activities were happening or what they were because there was no activities calendar in his room, as there was in the past. Resident 1 stated he was tired of watching TV and reading the newspaper as his only activities.</p> <p>During an interview on 7/24/24 at 2:14 PM, with the Administrator (ADM), the ADM stated the facility's weekly activities room calendars and newsletter were not being made or put in resident rooms during the time when the facility did not have an activities director.</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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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49859</p> <p>Based on interview and record review, the facility failed to ensure one or four sampled residents (Resident 2's) dignity was honored and that Resident 2 was respected when Certified Nursing Assistant (CNA) X did not stop when Resident 2 asked CNA X to stop trying to move her without the help of another person.</p> <p>This failure resulted in Resident 2 feeling afraid because the lack of respect shown by CNA X triggered Resident 2's Post Traumatic Stress Disorder (PTSD - anxiety and flashbacks triggered by a traumatic event).</p> <p>Findings:</p> <p>Review of Resident 2's Face Sheet (a document in a patient's medical chart or electronic health record that summarizes important information about the patient), indicated that Resident 2 was admitted to the facility on [DATE] with diagnoses that included depression, morbid obesity (body weight more than 80-100 pounds above their ideal body weight, Epilepsy (seizure disorder which is caused by excessive and abnormal nerve cell activity in the brain), PTSD, developmental delay (when a child falls behind other children of the same age in one or more area of emotional, mental, or physical growth), previous surgery of the nervous system (surgery that involves diagnosing and treating injuries and disease of the nervous system, including the brain, spinal cord, and nerves), and difficulty with mobility (moving of the body).</p> <p>Review of Resident 2's progress notes Lookback weekly evaluation (a weekly assessment of the facility's residents' conditions completed by a facility nurse) on 7/1/24 indicated that Resident 2 weighed 470 pounds.</p> <p>During an interview on 7/2/24 at 2:20 PM, with Resident 2 in her room, Resident 2 stated that she told CNA X to stop and ouch it hurts when CNA X was trying to roll Resident 2 in bed to provide cleaning for incontinence (inability to control the flow of urine from the bladder or the escape of feces from the rectum). CNA X did not request the help of another staff member with rolling and cleaning Resident 2 and continued to physically help roll her onto her side, even though Resident 2 asked CNA X to stop and get help.</p> <p>During a review of a written signed account by CNA X of this incident with Resident 2 (physical copy provided by the facility Administrator), undated, CNA X wrote, The other CNAs were busy doing their rooms and their rounds . and I tried to tend to [Resident 2] by myself . The end of the letter indicated that CNA X completed the task of rolling and cleaning Resident 2 alone.</p> <p>During an interview on 8/1/24 at 12:50 PM, with CNA X, CNA X stated that she wrote an account of this incident with Resident 2, and she had never worked with Resident 2 before 7/1/24. CNA X indicated that she normally works night shift, and did not know how many people were needed to assist Resident 2 with rolling in bed when the incident happened on 7/2/24, and was unprepared for Resident 2's size.</p> <p>(continued on next page)</p>		

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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of a document titled, 5-Day Report (a document used by the facility to summarize the facility's internal investigation and steps taken after the event, and written by the facility's administrator), the document indicated that CNA X took accountability for handing the resident in a way that may not have been sensitive enough to her unique needs.</p> <p>During an interview on 7/9/24 at 1:08 PM, with Licensed Vocational Nurse (LVN) A, LVN A stated that Resident 2 complained of being afraid when CNA X rolled her over in bed on 7/2/24.</p> <p>During a review of Resident 2's Activities of Daily Living care plan dated 3/31/22, the document indicated Resident 2 needed extensive assistance with one to two persons to help (helper does ALL the effort, resident does none of the effort to complete the activity) to roll over in bed.</p> <p>A review of Resident 2's Activities of Daily Living (ADLs, CNA documentation of what kind of activities residents are doing and how much help they need to do the activities), dated 6/16/24 to 6/28/24, indicated that CNAs documented the following support that Resident 2 required, when rolling onto her side:</p> <p>Resident 2 needed dependent (helper does ALL the effort, resident does none of the effort to complete the activity), help 13 out of 35 incidents of rolling in bed to reposition for incontinent care or other activities that required rolling in bed.</p> <p>Resident 2 needed substantial/maximal (helper does MORE THAN HALF the effort to complete the activity), help 19 out of 35 incidents of rolling in bed to reposition for incontinent care or other activities that required rolling in bed.</p> <p>Resident 2 needed partial/moderate (helper does LESS THAN HALF the effort to complete the activity), help 2 out of 35 incidents of rolling in bed to reposition for incontinent care or other activities that required rolling in bed.</p> <p>Resident 2 was independent (resident completes the activity by themselves with no assistance from a helper), 1 out of 35 incidents of rolling in bed to reposition for incontinent care or other activities that required rolling in bed.</p> <p>During a review of Resident 2's progress notes titled, Lookback weekly evaluation (a weekly assessment of the residents' conditions completed by a facility nurse), from 4/7/24 to 7/1/24 indicated that Resident 2's range of motion (ability to move the body) was assessed by facility nurses to be impaired in both legs and both arms on 6 out of 12 assessments.</p> <p>During a review of Resident 2's Minimum Data Set (MDS, a standardized assessment tool that measures the health status in nursing home residents), dated 7/8/24, section GG assessment for functional mobility (assessment information on a residents need for assistance with moving), indicated that Resident 2 needed partial/moderate assistance to roll left to right and substantial/maximal assistance for toileting hygiene (the ability to clean after urinating or having a bowel movement and adjusting clothing before and after toileting).</p> <p>(continued on next page)</p>		

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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 7/24/24 at 2:18 PM, with the ADM (Administrator), the ADM stated that there are several ways that a CNA can get information on how many people are needed to assist a resident with moving, such as the resident's care plan or asking the resident's nurse. The ADM stated that their expectation is that the CNAs communicate and ask for help when they need it.</p>

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49859</p> <p>Based on interview and record review, the facility failed to ensure Certified Nursing Assistant (CNA) X had knowledge about how much assistance was needed for one of four sampled residents (Resident 2), when CNA X provided cleaning for incontinence (inability to control the flow of urine from the bladder or the escape of feces from the rectum), without the help of a second person to roll Resident 2 in bed.</p> <p>This failure resulted in Resident 2 experiencing unnecessary discomfort during incontinent care.</p> <p>Findings:</p> <p>Review of Resident 2's Face Sheet (a document in a patient's medical chart or electronic health record that summarizes important information about the patient), indicated that Resident 2 was admitted to the facility on [DATE] with diagnoses that included depression, morbid obesity (body weight more than 80-100 pounds above their ideal body weight), Epilepsy (seizure disorder which is caused by excessive and abnormal nerve cell activity in the brain), Post Traumatic Stress Disorder (PTSD - anxiety and flashbacks triggered by a traumatic event), developmental delay (when a child falls behind other children of the same age in one or more area of emotional, mental, or physical growth), previous surgery of the nervous system (surgery that involves diagnosing and treating injuries and disease of the nervous system, including the brain, spinal cord, and nerves), and difficulty with mobility (moving of the body).</p> <p>A review of Resident 2's progress notes Lookback weekly evaluations (weekly assessments of the facility's residents' conditions completed by a facility nurse) for 7/1/24 indicated that Resident 2 weighed 470 pounds.</p> <p>During an interview on 7/2/24 at 2:20 PM, with Resident 2, in Resident 2's room, she stated that she had told CNA X to, stop trying to move her and ouch it hurts when CNA X was trying to reposition Resident 2 in bed by pushing on her right shoulder to roll Resident 2 over onto her side, and that CNA X did not request the help of another staff member with rolling and cleaning Resident 2 and continued to roll and clean her without the help of a second person.</p> <p>During an interview on 7/9/24 at 1:08 PM, with Licensed Vocational Nurse (LVN) A, LVN A stated that Resident 2 complained to her the morning of the incident at 7:30 AM on 7/2/24, of being afraid due to CNA X not stopping when Resident 2 told her to stop trying to roll her without the help of a second person.</p> <p>During an interview on 7/24/24 at 2:18 PM, with the ADM (Administrator), the ADM stated that there are several ways that a CNA can get information on how many people are needed to assist a resident with moving, such as the resident's care plan or asking the resident's nurse. The ADM stated that the expectation is that the CNAs communicate and ask for help when they need it.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 8/1/24 at 12:50 PM, with CNA X, CNA X stated that she had only worked for this facility for about a month and usually worked night shift. CNA X stated she wrote an account of this incident that happened on 7/2/24 with Resident 2, and she had never worked with Resident 2 before 7/1/24. CNA X stated that she did not know how many people were needed to assist Resident 2 with rolling in bed. CNA X stated that no one told her this resident needed two people to assist with moving her and that she was unprepared for Resident 2's size. CNA X stated she was told that Resident 2 needed two people to assist with moving her. CNA X stated she thought that Resident 2 needed three people to assist with moving her.</p> <p>Review of Resident 2's Minimum Data Set (MDS, a standardized assessment tool that measures the health status of nursing home residents), dated 7/8/24, section GG assessment for functional mobility (assessment information on a resident's need for assistance with moving) dated 7/8/24 indicated that for roll left to right Resident 2 needed partial/moderate assistance (Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.) And for toileting hygiene (the ability to clean after urinating or defecating and adjusting clothing before and after toileting) Resident 2 needed substantial/maximal assistance (Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.)</p> <p>During a review of Resident 2's Activities of Daily Living (ADL) chart, dated 6/16/24 to 6/28/24 (ADL - a chart used by CNAs to record what kind of activities residents are doing and how much help they need to do them) indicated that the facility's CNAs documented that for rolling left to right (the movement residents need to make to move and reposition in bed):</p> <p>Resident 2 needed dependent (helper does ALL the effort, resident does none of the effort to complete the activity) help 13 out of 35 incidents of rolling in bed to reposition for incontinence care or other activities that required rolling in bed.</p> <p>Resident 2 needed substantial/maximal (helper does MORE THAN HALF the effort to complete the activity) help 19 out of 35 incidents of rolling in bed to reposition for incontinence care or other activities that required rolling in bed.</p> <p>Resident 2 needed partial/moderate (helper does LESS THAN HALF the effort to complete the activity) help 2 out of 35 incidents of rolling in bed to reposition for incontinence care or other activities that required rolling in bed.</p> <p>Resident 2 was independent (resident completes the activity by themselves with no assistance from a helper) 1 out of 35 incidents of rolling in bed to reposition for incontinence care or other activities that required rolling in bed.</p> <p>Review of Resident 2's progress notes Lookback weekly evaluation (a weekly assessment of the facility's residents' conditions completed by facility nurses) from 4/7/24 to indicated that Resident 2's range of motion (ability to move the body) was assessed by facility nurses to be impaired in both legs and both arms 6 out of 12 assessments.</p> <p>During a review of a written and signed account of the incident of 7/2/24 between Resident 2 and CNA X, written by CNA X, undated, CNA X wrote, I've never tended to [Resident 2] before 7/1/24. So I was unfamiliar with her and not prepared for her size.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of a document titled, 5-Day Report (a document used by the facility to summarize the facility's internal investigation and steps taken after the event and written by the facility administrator), about the incident of 7/2/24 between Resident 2 and CNA X, the facility administrator wrote that CNA X .lacked the expertise to facilitate high quality care.</p> <p>Review of a document titled, In-Service/Meeting Sign-In Sheet dated 7/3/24, the day after the incident, indicated that CNA X attended a training which indicated that the Employee was educated on always having at least 2 staff members when caring for patients.</p> <p>During an interview on 7/9/24 at with the ADM, he stated that the Director of Staff Development (DSD, a nurse who coordinates the education, competencies, and staff development programs for nursing staff in healthcare facilities), had been out for two months and she was not expected back until August 2024. The ADM stated that he had requested help for the DSD's position from the facility's corporate office in June 2024 via email.</p> <p>A review of an email document titled, DSD dated 6/17/24 written by the ADM to the facility's corporate office indicated, We are overwhelmed and need support. We need someone to step in and fulfill the DSD duties such as orientation, competencies [Competencies is a combination of knowledge, skills, and judgement needed by nursing staff to provide safe care to patients]), staff inservices, license verification, etc.</p>		