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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056258	A. Building B. Wing	02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Valley Healthcare & Wellness Centre, LP	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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43031 Based on interview and record review, the facility failed to inform one of three sampled resident's (Resident 1) representative (RP), of a change in Resident 1's condition which required the resident to have oxygen administered. This failure violated Resident 1 and her RP's right to be fully informed of a need to alter treatment before the treatment was initiated, and make choices that were consistent with Resident 1's wishes. Findings: During a review of the facility's policy and procedure (P&P) titled, Change of Condition Notification dated April 1, 2015, Change of Condition Notification indicated, The Licensed Nurse will notify the family/surrogate decision-makers of any changes in the resident's condition as soon as possible. A review of Resident 1's medical record indicated that Resident 1 was admitted on [DATE] with diagnoses that included Metabolic Encephalopathy (a problem in the brain caused by a chemical imbalance in the blood due to illness or organs not working adequately), Urinary Tract Infection, and Severe Protein Calorie Malnutrition (poor nutritional intake). A review of Resident 1's Minimum Data Set (MDS, an assessment tool) dated 10/23/24, indicated a Brief Interview for Mental Status (BIMS, an assessment of memory and decision making abilities), was 2 out of 15, which indicated Resident 1 had poor decision making skills and memory recall. During a record review of Resident 1's Medication Administration Record (MAR) for December 2024, the MAR indicated that on 12/28/24 Resident 1 was given oxygen (O2) at 2 liters (2L, a unit of measure) by nasal cannula (a tube in the nose). During an interview on 1/2/25 at 11:30 am, with Resident Representative (RP) on the phone, RP stated, The facility put oxygen on [Resident 1] without notifying me. I went in to visit and discovered [Resident 1] was wearing oxygen around her nose. [Resident 1] had never used oxygen before. I talked to [Licensed Nurse (LN 2] who apologized for not notifying me. I have asked to be notified about anything and everything. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 1/2/25 at 12:00 pm, with LN 2 at the nurse's station, LN 2 reviewed Resident 1's MAR for December 2024 and confirmed Resident 1 was given O2 on 12/28/24, due to an O2 sat (reading of low oxygen in the blood by a device placed on a finger) of 88 percent (normal is between 92 to 100 percent). LN 2 confirmed that Resident 1's RP was not notified and indicated that LN 2 was responsible to notify Resident 1's RP as the desk nurse on duty. During a concurrent interview and record review on 1/23/25 at 3:00 pm, with Director of Nurses (DON) in the conference room, DON acknowledged there was no documentation to indicate Resident 1's RP had been notified when Resident 1's condition changed and she required oxygen use.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43031 Based on interview and record review, the facility administered oxygen (02) without a physician's order to one of three sampled residents (Resident 1). This failure had the potential to lead to negative resident clinical outcomes when nurses choose to administer medications without an order to do so by a physician. Findings: During a review of the facility ' s policy and procedure (P&P) titled, Medication Administration, dated January 1, 2012, Medication Administration indicated, Medication will be administered directly by a licensed nurse and upon the order of a physician or licensed independent practitioner. A review of Resident 1 ' s medical record indicated that Resident 1 was admitted on [DATE] with diagnoses that included Metabolic Encephalopathy (a problem in the brain caused by a chemical imbalance in the blood due to illness or organs not working adequately), Urinary Tract Infection, and Severe Protein Calorie Malnutrition (poor nutritional intake). A review of Resident 1's Minimum Data Set (MDS, a standardized assessment), Brief Interview for Mental Status (BIMS, Section C an assessment of memory and decision making ability) score dated 10/23/2024, indicated Resident 1 rated 2 of 15, which indicated a severe impairment in memory and ability to make decisions. During a record review of Resident 1's Medication Administration Record (MAR) for December 2024, the MAR indicated that on 12/28/24 oxygen was administered to Resident 1 at a rate of 2 liters (L, a unit of measurement) by nasal cannula (nose applicators) for an oxygen saturation (O2 sat, a measurement of the amount of oxygen in the blood by placing a device on a finger) of 88 percent (%, normal O2 sat is considered between 92 to 100%). During a concurrent interview and record review on 1/2/25 at 12:00 pm, with Licensed Nurse (LN) 2 at the nurse ' s station, LN 2 reviewed Resident 1's MAR and Physician's Orders for December 2024, LN 2 confirmed that he applied O2 to Resident 1 on 12/28/24 and confirmed he did not get a physician's order to do so. LN 2 stated, Applying oxygen was an acceptable nursing intervention for immediate treatment. During a concurrent interview and record review on 1/23/25 at 3:00 pm, with Director of Nurses (DON) in the conference room while reviewing Resident 1's MAR and Physician's Orders for December 2024, DON confirmed that O2 is considered a medication and requires a physician's order for a nurse to administer.