STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555496	A. Building B. Wing	04/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverwood Health Care	5320 Carrington Circle Stockton, CA 95210

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 - Few	Ensure services provided by the nursing facility meet professional standards of quality. 43071 Based on interview and record review, the facility failed to ensure services provided met professional standards of quality, when one of three sampled residents (Resident 1) physician order to reduce gabapentin (medication used to treat nerve pain) was not carried out on 4/6/24. This failure resulted in Resident 1 not receiving medication as per her physician's order and had the potential for ineffective treatment and unwanted side effects of the medication. Findings: Review of an Admission Record indicated Resident 1 was admitted to the facility with multiple diagnoses including but not limited to surgical aftercare following surgery on the nervous system and diabetes mellitus (abnormal blood sugar levels). Review of Resident 1's physician note dated 4/6/24, indicated .Taper off [reduce] gabapentin to 300mg [milligram: unit of measurement] PO [per oral] daily per patient request. Discussed with RN [Registered Nurse] . Review of Resident 1's active physician's orders indicated Resident 1 had an active order for gabapentin 400 mg 1 capsule by mouth every eight hours for neuropathy (weakness, numbness, and pain from nerve damage) since 3/26/24 and failed to show the physician's order to taper off the gabapentin to 300mg daily was carried out. Review of Resident 1's Medication Administration Record (MAR) for the month of April indicated Resident 1 was scheduled to receive gabapentin 400mg 1 capsule every eight hours at 6am, 2pm and 10pm. Further review of Resident 1's MAR indicated Resident 1 refused to take her 10 pm dose of gabapentin on 4/6/24, her 6 am and 10 pm dose on 4/7/24, and her 6 am and 2 pm dose on 4/8/24. Review of Resident 1's nurse progress note dated 4/7/24, indicated, .Gabapentin Oral Capsule 400 MG Give 1 capsule by mouth every 8 hours for neuropathy Refused; per patient, her current orders are way too much Gabapentin, and it causes trouble for her legs. Per patient she has discussed this with the nurse practitioner . Review of Resident 1's nurse progress note dated 4/8/24, indicated Resident 1 left the facility against medical advice on 4/8/24. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555496	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/16/2024
NAME OF PROVIDER OR SUPPLIER Riverwood Health Care		STREET ADDRESS, CITY, STATE, ZIP CODE 5320 Carrington Circle Stockton, CA 95210	

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 - Few	During a concurrent interview and record review on 4/16/24, at 3:31 p.m., the Assistant Director of Nursing (ADON) stated physicians would give new orders or change an order when they came to the facility and would communicate the change with a nurse. The ADON stated physicians would write new orders or change an order in different areas of the resident's medical record or would give a verbal order to a nurse. The ADON further stated a nurse should check the physician's note for new orders, should notify the resident/resident representative, and should carry out the order. Resident 1's physician progress note, physician orders, and MAR were reviewed with the ADON. The ADON verified the physician gave a new order to taper down Resident 1's gabapentin to 300mg daily from 400mg every eight hours and the new order was communicated to the RN. The ADON verified Resident 1's gabapentin physician order was not carried out. The ADON stated Resident 1's physician order should have been carried out the same day. The ADON confirmed from the nurse's progress note that Resident 1 refused the gabapentin and informed the nurse that she spoke with the physician to lower her gabapentin dose. The ADON stated the nurse should have checked Resident 1's physician note for any new orders and called the physician for any questions. During a concurrent interview and record review on 4/16/24, at 4:08 p.m., the Director of Nursing (DON) stated physicians gave orders via phone, verbally, or written in the resident's medical record. The DON stated the nurse should carry the order out. The DON stated staff should have reviewed Resident 1's physician note and should have carried out the order. The DON stated staff should have clarified the order when Resident 1 refused the medication and informed the nurse that she requested the dose to be adjusted. Review of an undated care plan of Resident 1's indicated, Alteration in comfort due to pain related to . disease of spinal cord .spinal stenosis [spaces inside the bones of the spine get too small that can put pressure on the spinal cord and the nerves that travel through the spine and can cause pain, tingling or weakness] .Interventions .Administer prescribed pain medication . Review of a facility policy titled, Medication Orders revised November 2014, indicated, .A current list of orders must be maintained in the clinical record of each resident . Review of a facility policy titled, Administering Medications revised December 2012, indicated, .Medications shall be administered .as prescribed .Medications must be administered in accordance with the orders .