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	10/31/2024

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 - Some	Ensure services provided by the nursing facility meet professional standards of quality. 40903 Based on observation, interview, and record review, the facility failed to ensure professional standards for safe injection practices were followed when: 1. The Infection Preventionist (IP) stored pre-drawn, unlabeled, and undated flu (influenza, a respiratory disease) vaccine syringes in the staff food refrigerator. 2. Pneumonia vaccines (a vaccine that helps prevent an elderly resident get pneumonia, a serious lung infection) for three residents (Resident 1, Resident 2, and Resident 3) were documented as given, when the actual products were found among medication stored for destruction in the staffs ' food refrigerator. These failures could contribute to unsafe and ineffective use of vaccines and subsequent adverse outcomes for residents and staff. Findings: A concurrent interview with the facility ' s Director of Staff Development (DSD), in her office, and inspection of a dorm-style refrigerator next to her desk, on 10/10/24, at 3:45 PM, revealed stored food items/drinks in addition to a drawer full of injectable (shot into skin or vein) medications and 14 unlabeled pre-drawn syringes with needles attached. The pre-drawn syringes contained a clear liquid at 1/2 mL (0.5 mL; mL is milliliter, a unit of volume) and was not dated or labeled with the contents or who had pre-drawn them. The DSD stated the prefilled, unlabeled syringes belonged to the facility ' s Infection Prevention (IP) nurse who had a desk in the same room. During an interview with the IP, on 10/10/24, at 4:10 PM, the IP stated she prepared the pre-drawn syringes found in the office refrigerator. The IP stated they were flu vaccine syringes for administration to facility staff. The IP stated she did not keep the original vaccine vials used to fill the pre-drawn syringes. The IP stated she felt there was no need to label the syringes as they were going to be given to staff. The IP stated the refrigerator ' s temperature was not monitored and storing the personal food items with medication was not a good idea. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555496	A. Building B. Wing	10/31/2024

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 - Some	During an interview with the DON, on 10/11/24, at 1:42 PM, the DON stated she was shocked at finding those medication and prefilled syringes in the office refrigerator and she was not aware of it. The DON stated pre-drawn flu vaccine syringes with no label was not a safe practice and was unacceptable. The DON did not give a reason why resident ' s medications and vaccine products were kept in a refrigerator in an office setting where non-licensed staff and the facility ' s DSD and IP worked or used on a daily basis. Review of the facility ' s policy, titled Administering Medications, dated 4/2019, indicated, The director of nursing services supervises and directs all personnel who administer medications and/or have related functions. The policy on section 11 indicated, The expiration/beyond use date on medication label is checked prior to administering. When opening a multidose container, the date opened is recorded on the container. Review of the facility ' s policy, titled Vaccination of Residents, dated 10/2019, indicated, All residents will be offered vaccine that aid in preventing infectious diseases . The Policy on section 6 indicated, If the resident receives a vaccine, at least the following information shall be documented in the resident ' s medical record: Lot number of the vaccine (located on the vial); Expiration date (located on the vial) The policy on section 8, indicated, Inquiries concerning this policy should be referred to the infection preventionist or the administrator. Review of the Centers for Disease Control (or CDC, a federal agency with mission to protect public health) guideline titled, Vaccine Administration: General Best Practices for Immunization, last accessed on 10/30/24 via https://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/administration.html, the document indicated, Vaccines should be drawn up in a designated clean medication area that is not adjacent to areas where potentially contaminated items are placed. Multi-dose vials to be used for more than one patient should not be kept or accessed in the immediate patient treatment area. This is to prevent inadvertent contamination of the vial through direct or indirect contact with potentially contaminated surfaces or equipment that could then lead to infections in subsequent patients. The guideline further indicated, ACIP (Advisory Committee on Immunization Practices, a group of medical and public health experts who advise the CDC on how to use vaccines) discourages the routine practice of providers ' prefilling syringes for several reasons. Because the majority of vaccines have a similar appearance after being drawn into a syringe, prefilling might result in administration errors. Because unused prefilled syringes also typically must be discarded if not used within the same day that they are filled, vaccine wastage might occur. The FDA does not license administration syringes for vaccine storage. 2. During a concurrent interview with facility ' s Director of Staff Development (DSD), in her office, and inspection of a dorm-style food refrigerator next to her desk, on 10/10/24, at 3:45 PM, the refrigerator stored three labeled pneumonia vaccines for Resident 1, Resident 2 and Resident 3. The stack of injectable medications in the bottom drawer of the staffs ' food refrigerator, were mostly discontinued or unused drugs belonging to residents no longer in the facility. a. During a concurrent interview and review of the Medication Administration Record (MAR) with the Assistant Director of Nursing (ADON), on 10/31/24, at 12 Noon, the MAR indicated documentation that Resident 1 was given the pneumonia vaccine on 12/19/23 at 10:09 AM. The ADON could not comment on how the vaccine product was found inside a food refrigerator almost one year later. (continued on next page)

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	10/31/2024

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 - Some	During a review of a provider pharmacy [Pharmacy A] medication delivery slip, for Resident 1, dated 12/19/23, the record indicated the pharmacy dispensed one syringe of Pneumovax-23 PF 0.5 mL (pneumonia vaccine, PF prefilled syringe, mL stands for milliliter) during Resident 1 ' s stay at the facility. b. During a concurrent interview and record review of the MAR, with the ADON, on 10/31/24, at 12 Noon, the MAR indicated Resident 2 was administered the pneumonia vaccine on 11/28/23 at 1:25 AM. The ADON could not comment on how the vaccine was found inside a food refrigerator almost one year later and why it had to be administered in the middle of the night. During a review of a provider pharmacy [Pharmacy A] medication delivery slip, for Resident 2, dated 11/27/23, the record indicated the pharmacy dispensed one syringe of Pneumovax-23 PF 0.5 mL during Resident 2 ' s stay at the facility. c. During a concurrent interview and record review of the MAR, with the ADON, on 10/31/24, at 12 Noon, the MAR indicated Resident 3 was administered the pneumonia vaccine on 10/4/24 at 2:07 PM. The ADON could not comment on how the vaccine was found inside a food refrigerator. During a review of a provider pharmacy [Pharmacy A] medication delivery slip, for Resident 3, dated 10/4/24, the record indicated the pharmacy dispensed one syringe of Prevnar-20 PFS 0.5 mL (pneumonia vaccine) during Resident 3 ' s stay at the facility. In an Interview with DON, on 10/11/24, at 5:07 PM, the DON stated the pneumonia vaccines were ordered through the provider pharmacy for individual residents and the nurses administer it. In an interview with Licensed Nurse (LN) 1, on 10/10/24, at 5:43 PM, LN 1 stated when she administered a drug, she checked the expiration date of the product and for vaccines she needed to put the Lot number (a special number by manufacturer of the vaccine for quality control purposes) of the vaccine in the computer system. In an interview with DON and Administrator (ADMIN), on 10/31/24, at 12:30 PM, the administrator stated he was told the medications found in the food refrigerator were in the process of destruction. When asked why they kept the discontinued medications in a refrigerator when they had a cabinet in the medication room, the ADMIN and DON did not have an answer. Review of the facility ' s policy, titled Vaccination of Residents, dated 10/2019, the policy indicated All residents will be offered vaccine that aid in preventing infectious diseases. The Policy on section 6 indicated If the resident receives a vaccine, at least the following information shall be documented in the resident ' s medical record: . Lot number of the vaccine (located on the vial); Expiration date (located on the vial; The policy on section 8, indicated Inquiries concerning this policy should be referred to the infection preventionist or the administrator. Review of the facility ' s policy, titled Administering Medications, dated 4/2019, the policy indicated The director of nursing services supervises and directs all personnel who administer medications and/or have related functions. The policy on section 11 indicated The expiration/beyond use date on medication label is checked prior to administering. When opening a multidose container, the date opened is recorded on the container.

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	10/31/2024

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40903 Based on observation, interview, and record review, the facility failed to ensure safe medication use and destruction practices in the facility with a census of 86 when: 1. Prescription medication destruction and disposition logs (Refers to paperwork that outlines the process for permanently getting rid of medications, including when and how they were destroyed) were not dated, witnessed and/or cosigned by licensed staff. 2. A discontinued medication called semaglutide (injectable drug used to treat blood sugar disease and for weight loss) prescribed to Resident 4 was stored in an active storage area in the main medication room after Resident 4 was discharged and included two boxes (prescriptions) of semaglutide. (One prescription was brought in by the family, and the second was delivered by the facility ' s pharmacy (Pharmacy A). 3. Three Pneumonia vaccines (an injectable vaccine that helps prevent an elderly resident from getting pneumonia, a serious lung infection) belonging to three different residents (Resident 1, Resident 2, and Resident 3), were found among other medications held for destruction in the staffs ' food refrigerator but were documented as given in the Medication Administration Record (MAR). These failures could contribute to the risk of drug diversion (unauthorized use of the resident ' s medications) and unsafe drug use. Findings: 1. During a concurrent interview and inspection of the facility ' s main medication room, accompanied by the Director of Nursing (DON), on 10/10/24, at 3:20 PM, the binder for medication destruction was overfilled with pages that were not dated or co-signed by a witnessed licensed staff. The cabinet for discontinued medications had a handful of bubble packed (a packing format or card that packages doses of medication within plastic bubbles or blisters) medications for destruction. The DON was not sure about the need for a witness co-signature and was not sure when the last time was the nursing staff destroyed medications. During a concurrent review of the undated destruction binder documents, titled Universal Destruction Log, with the DON, on 10/10/24, at 3:25 PM, the record indicated many pages with no date and had only one initial under the column Nurse Signature(s). At the bottom section of each page indicated, We hereby certify that these drugs were disposed of as required by law: Registered Nurse [signature section] Licensed Nurse [signature section], and no co-signature was noted. The DON stated any nursing staff were able to destroy the discontinued and unusable medications. In a telephone interview with the facility ' s Consultant Pharmacist (CP), on 10/11/24, at 12:35 PM, the CP stated she mostly worked with the ADON for controlled drug destruction. The CP states she had not looked at the non-controlled prescription destruction process or documentation. The CP stated all prescription destructions should have been documented and witnessed by two licensed nurses. (continued on next page)

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	10/31/2024

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the DSD on 10/11/24, at 2:03 PM, the DSD stated the medications found in the refrigerator in her office should not have been there. The DSD stated the single labeled box of semaglutide in the refrigerator belonged to a staff member and the rest of medications were resident medications. The DSD stated the medications placed in her refrigerator were to be destroyed. The DSD could not explain why there was destruction medication kept in a refrigerator in her office and why they were not in the medication room cabinet for discontinued drugs. The DSD did not explain why most of the injectable medications did not have a resident name or prescription label on them. 2. During a concurrent inspection of the medication refrigerator, in the main medication room, accompanied by the DON, on 10/10/24, at 5 PM, the refrigerator stored two boxes of a medication called semaglutide, labeled with Resident 4 ' s name who was discharged from the facility. In a telephone interview with Resident 4, on 10/11/24, at 3:54 PM, Resident 4 who was discharged on [DATE] from the facility, stated she was asked to bring her own semaglutide. Resident 4 stated her family bought a new supply from her local pharmacy [Pharmacy B] and brought it to the facility. Review of a facility ' s provider pharmacy [Pharmacy A] medication delivery slip, for Resident 4, dated 9/3/24, indicated a box of semaglutide was delivered by the provider pharmacy to the facility. Review of Resident 4 ' s electronic medical record indicated on 9/6/24 the doctor stopped semaglutide and started insulin instead, and the semaglutide was never used. Review of an undated medication destruction log for Resident 4 indicated one blood pressure medication called losartan was disposed of by the facility for Resident 4 but semaglutide was not part of the destruction. In an interview with LN 1, on 10/10/24, at 5:43 PM, LN 1 stated when a resident discharged home, they gave all the ordered medications to the resident, or the care giver based on the doctor ' s order. In a concurrent interview and record review with the Assistant Director of Nursing (ADON), on 10/31/24, at 11:26 AM, the ADON stated the resident ' s discontinued prescription medications should have been stored in a locked cabinet in the medication room until they were ready to be destroyed. Review of the facility ' s policy, titled Medication Labeling and Storage, dated 2/2023, the policy indicated If the facility has discontinued, outdated or deteriorated medication the dispensing pharmacy is contacted for instruction regarding returning or destroying these items. 3. During a concurrent interview with the DSD, in her office, and inspection of a dorm-style food refrigerator next to her desk, on 10/10/24, at 3:45 PM, the refrigerator stored three labeled pneumonia vaccines for Resident 1, Resident 2 and Resident 3. The stack of injectable medications in the bottom drawer of the staffs ' food refrigerator, were mostly discontinued or unused drugs belonging to residents no longer in the facility. a. During a concurrent interview and record review of the MAR, with the ADON, on 10/31/24, at 12 Noon, the MAR indicated Resident 1 was administered the pneumonia vaccine on 12/19/23 at 10:09 AM. The ADON could not comment on how the vaccine product was found inside a food refrigerator almost one year later. (continued on next page)

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	10/31/2024

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the provider pharmacy [Pharmacy A] medication delivery and records of dispensing, for Resident 1, dated 12/19/23, the record indicated the pharmacy dispensed one syringe of Pneumovax-23 PF 0.5 mL (brand name for pneumonia vaccine, PF prefilled syringe, mL stands for milliliter) during Resident 1 ' s stay at the facility. b. During a concurrent interview and record review of the MAR, with the ADON, on 10/31/24, at 12 Noon, the MAR indicated Resident 2 was administered the pneumonia vaccine on 11/28/23 at 1:25 AM. The ADON could not comment on how the vaccine product was found inside a food refrigerator almost one year later or why it would have been administered in the middle of the night. c. During a review of a provider pharmacy [Pharmacy A] medication delivery slip, for Resident 2, dated 11/27/23, the slip indicated the pharmacy dispensed one syringe of Pneumovax-23 PF 0.5 mL during Resident 2 ' s stay at the facility. d. During a concurrent interview and record review of the MAR, with the ADON, on 10/31/24, at 12 Noon, the MAR indicated Resident 3 was administered the pneumonia vaccine on 10/4/24 at 2:07 PM. The ADON could not comment on how the vaccine was found inside a food refrigerator. A review of a provider pharmacy [Pharmacy A] medication delivery slip, for Resident 3, dated 10/4/24, the slip indicated the pharmacy dispensed one syringe of Prevnar-20 PFS 0.5 mL (a brand name for pneumonia vaccine) during Resident 3 ' s stay at the facility. Review of the facility ' s policy, titled Vaccination of Residents, dated 10/2019, the policy indicated All residents will be offered vaccine that aid in preventing infectious diseases. The Policy on section 6 indicated If the resident receives a vaccine, at least the following information shall be documented in the resident ' s medical record: Lot number of the vaccine (located on the vial); Expiration date (located on the vial; The policy on section 8, indicated Inquiries concerning this policy should be referred to the infection preventionist or the administrator. Review of facility ' s policy, titled Discarding and Destroying Medications, dated 11/2022, the policy indicated Medications that cannot be returned to the dispensing pharmacy are disposed of in accordance with federal, state, and local regulations. The policy on section 10 indicated The medications disposition record will contain the following information: The name of the dispensing pharmacy, Date medication destroyed and Signature of witnesses.

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	10/31/2024

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 40903 Based on observation, interview, and record review, the facility failed to ensure safe medication storage practices in the facility with a census of 86 when: A dorm style refrigerator in an office shared by the Director of Staff Development (DSD), Infection Preventionist (IP) and the staffing coordinator, contained personal food items and a drawer full of prescription injectable (shot into skin or veins) medications including vaccines and unlabeled pre-drawn syringes of a flu (or influenza, a respiratory infection) vaccine. There was no temperature monitoring performed for this refrigerator. The refrigerator in the main medication room stored: 1. Opened vials of flu vaccine and Tuberculosis testing agent (or TB, a serious lung infection) without any marking for a beyond use date (the date after which the drug should not be used). 2. Discontinued medications belonging to a discharged resident (Resident 4) were stored in an active storage area in the refrigerator. These failures could contribute to unsafe medication storage, the risk of drug diversion (unauthorize use of drugs) and the safety of the residents. Findings: 1. A concurrent interview with the facility ' s DSD, in her office, and inspection of a dorm-style refrigerator next to her desk, on 10/10/24, at 3:45 PM, revealed stored food items, drinks, in addition to a drawer full of injectable (shot into skin or vein) medications and 14 unlabeled pre-drawn syringes. Further inspection of the bottom drawer indicated labeled unopened prescription medications and many unlabeled and unused prescription medications as follows: a. Two unlabeled, unopened boxes of semaglutide. b. One labeled, unopened box of semaglutide. c. Multiple unopened insulin vials (Lantus and Novolog, used to treat blood sugar disease). d. Multiple unopened Insulin Pens (Lantus and Lispro, used to treat blood sugar disease preloaded with insulin) e. Three unopened, unused, and labeled syringes of pneumonia vaccines (used to prevent serious lung infections). f. Unopened vial of a testing agent (used to test for TB, or tuberculosis, a serious lung infection) (continued on next page)

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	10/31/2024

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	g. Fourteen unlabeled syringes with needles attached which contained a clear liquid at 1/2 mL (0.5 mL; mL is milliliter, a unit of volume) markings. The DSD stated she was not sure how long these prescription medications had been in the refrigerator next to her desk. The DSD stated there was no temperature monitoring of the refrigerator done. The DSD stated she was aware of not storing medications with personal food storage. The DSD stated these medications may belong to facility staff. The DSD could not explain the labeled medications with resident ' s name on them. The DSD stated the prefilled, unlabeled syringes belong to the facility ' s Infection Prevention (IP) nurse who had a desk in the same room. During a concurrent interview with the DON and review of prescription medications found in the DSD office refrigerator, on 10/10/24, at 3:54 PM, the DON stated she was not aware of these medications stored in this room. During an interview with the IP, on 10/10/24, at 4:10 PM, the IP stated she prepared the pre-drawn syringes found in the office refrigerator. The IP stated they were flu vaccine syringes for administration to facility staff. The IP stated she did not keep the original vaccine vials that were used to fill the pre-drawn syringes. The IP stated she felt there was no need to label the syringes as they were going to be given to staff. The IP stated the refrigerator ' s temperature was not monitored and storing the personal food items with medication was not a good idea. The IP stated she had noticed other medications stored in the bottom drawer and had no idea why they were there. The IP stated those medications were typically stored in the medication room. During an interview with the DON, on 10/11/24, at 1:42 PM, the DON stated she was shocked at finding those medications in the office refrigerator. The DON stated she needed to counsel her staff. The DON stated pre-drawn flu vaccine syringes with no label was not a safe practice and unacceptable. The DON did not give a reason why resident ' s discontinued medications were kept in a refrigerator in an office setting where non-licensed staff and the facility ' s DSD and IP worked and used on a daily basis. In a concurrent interview and record review with Assistant Director of Nursing (ADON), on 10/31/24, at 11:26 AM, the ADON stated the resident ' s discontinued prescription medications should not have been in the unsecured office and he was not sure why they were stored in the office refrigerator. The ADON stated resident medications should not be stored with staff food in a personal refrigerator. The ADON stated the medication room had a cabinet for storing discontinued medications. During a concurrent inspection of the main medication room and interview with the DON, on 10/10/24, at 5 PM, the medication refrigerator stored an opened multi-dose vial of flu vaccine and two vials of a testing agent used for testing for TB infection with no marking for the date they were opened or the beyond use date for both products. The DON acknowledged the findings. 2. During a concurrent inspection of the medication refrigerator, in the main medication room, accompanied by the DON, on 10/10/24, at 5 PM, the refrigerator stored two packages of a medication called semaglutide, labeled with Resident 4 ' s name who was discharged from the facility. In a telephone interview with Resident 4, on 10/11/24, at 3:54 PM, Resident 4 who was discharged on [DATE] from the facility, stated she was asked to bring her own semaglutide. Resident 4 stated her family bought a new supply from her local pharmacy [Pharmacy B]. (continued on next page)

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	10/31/2024

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility ' s provider pharmacy [Pharmacy A] medication delivery and dispensing records, for Resident 4, dated 9/3/24, the record indicated another box of semaglutide was delivered by the provider pharmacy to the facility. Review of Resident 4 ' s electronic medical record, indicated on 9/6/24 the doctor stopped the semaglutide and started insulin instead, and semaglutide was not used. In a concurrent interview and record review with the Assistant Director of Nursing (ADON), on 10/31/24, at 11:26 AM, the ADON stated the resident ' s discontinued prescription medications should have been stored in a locked cabinet in the medication room until they were ready to be destroyed and not in the refrigerator. Review of the facility ' s policy, titled Medication Labeling and Storage, dated 2/2023, the policy indicated Facility stores all medications and biologicals in locked compartments under proper temperature, humidity, and light controls. Only authorized personnel have access to keys. The policy on section 3 indicated If the facility has discontinued, outdated or deteriorated medication or biologicals, the dispensing pharmacy is contacted for instruction regarding returning or destroying these items. The policy on section 6 indicated Medications are stored separately from food and are labeled accordingly. The Policy under medication labeling indicated Labeling of medications and biologicals dispensed by the pharmacy is consistent with applicable federal and state requirement and currently accepted pharmaceutical practices. The policy further indicated Multi-dose vials that have been opened or accessed (e.g., needle punctured) are dated and discarded within 28 days unless the manufacturer specifies a shorter or a longer date for the open vial . Review of facility ' s policy, titled Discarding and Destroying Medications, dated 11/2022, the policy indicated Medications that cannot be returned to the dispensing pharmacy are disposed of in accordance with federal, state, and local regulations. The policy on section 10 indicated The medications disposition record will contain the following information: The name of the dispensing pharmacy, Date medication destroyed, and Signature of witnesses.