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 02/19/2026

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on interview and record review, the facility failed to ensure a baseline care plan including the interventions and instructions needed to provide effective and person-centered care as per professional standards of quality care was developed for one of three sampled residents (Resident 1), when Resident 1 was admitted to the facility with oxygen therapy and an oxygen care plan was not developed for Resident 1. This failure had the potential to receive inadequate respiratory care for Resident 1.Review of Resident 1's admission RECORD, indicated Resident 1 was admitted to the facility with diagnoses including acute osteomyelitis (a serious bone infection usually caused by bacteria that spread through the bloodstream, nearby tissues, or open injuries), sepsis (a life threatening body's extreme response to an infection causing tissue damage), cellulitis and abscess of mouth (a common, potentially serious bacteria skin infection and underlying tissues, often causing rapid-spreading redness, warmth, swelling, and pain), diabetes type 2 (a chronic condition where the body resist insulin or fails to produce enough causing high blood sugar), essential hypertension (is a type of high blood pressure that has no clearly identifiable cause), blindness of both eyes, depression (a mood disorder causing persistent sadness, a loss of interest in activities, and an inability to function in daily life), sleep apnea (a common serious disorder where treating repeatedly stops and starts during sleep often causing loud snoring, choking and severe daytime tiredness), morbid obesity (a chronic malfunctional disease characterized by excessive fat storage), and anxiety.Review of Resident 1's Hospital Inpatient Discharge Instructions, indicated, . visit date 1/20/26.SKILLED NURSING FACILITY[SNF] admission ORDERS.Oxygen Orders: Start oxygen at 2 L/min [liters per minute] for shortness of breath, chest pain, oxygen saturation less than 90% and notify physician immediately.Notify physician for Change in Condition: If patient has one or more of the following conditions, conduct full assessment and notify Physician .Abnormal lung sounds with new or increased O2 [oxygen] requirement to maintain O2 sat> [greater than] 88% .Shortness of breath while sitting still .Any abnormal labs . Facility staff had Resident 1's Hospital Inpatient Discharge Instructions signed that Resident 1's hospital discharge orders were noted and carried out on 1/23/26.Review of Resident 1's Physician's Orders dated 1/23/26, indicated, . Oxygen @ [at] 2 L/min via nasal canula [a thin flexible tube with two prongs inserted into the nostril allowing oxygen to flow directly into the nose] continuously every shift. Review of Resident 1's care plans failed to show that an oxygen care plan was developed.During a concurrent interview and record review on 3/10/26, at 12:11 p.m., the DON verified Resident 1 was admitted to the facility with oxygen therapy. The DON stated baseline care plan summary served as residents' baseline care plan. The DON confirmed Resident 1's baseline care plan summary dated 1/25/26, did not include specific interventions and instructions to provide effective and person-centered care plan for oxygen therapy. The DON stated a specific oxygen care plan was not developed for Resident 1.During an interview on 3/10/26, at 12:11 p.m., the DON stated the importance of developing an oxygen care plan for a resident who would be admitted with oxygen therapy was (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 02/19/2026

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to help improve continuation of care.Review of facility policy titled, Baseline Care Plan Summary revised October 2025, indicated, .The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. Policy Explanation and Compliance Guidelines: 1. The baseline care plan shall: a. Be developed within 48 hours of a resident's admission. b. Include the minimum healthcare information necessary to properly care for a resident .

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record reviews, the facility failed to provide adequate respiratory care services, immediate ongoing clinical assessment, treatment, and identified changes in condition as per professional standards of practice for one out of two sampled residents (Resident 1) when,1. LVN (Licensed Vocational Nurse) 1 did not notify the Physician of Resident 1's change in condition when he had shortness of breath and low oxygen saturation level on [DATE],2. LVN 1 increased Resident 1's oxygen therapy from 2 liters to 4 liters without a Physician's order, 3. LVN 1 adjusted Resident 1's oxygen liter flow and did not escalate Resident 1's care to a qualified healthcare professional, not following their scope of practice, and,4. Hospital discharge orders for Resident 1's weekly CBC were not transcribed over and were not followed.These failures resulted in physician not being aware of Resident 1's change in condition, delay in adequate assessment with potential of need for higher level of care not being identified, delay in adequate care and treatment and Resident 1 died within 2 hours of change in condition on [DATE].Findings:A review of Resident 1's admission RECORD, indicated Resident 1 was admitted to the facility in 2026 with diagnoses including acute osteomyelitis (a serious bone infection usually caused by bacteria that spread through the bloodstream, nearby tissues, or open injuries), sepsis (a life threatening body's extreme response to an infection causing tissue damage), cellulitis and abscess of mouth (a common, potentially serious bacteria skin infection and underlying tissues, often causing rapid-spreading redness, warmth, swelling, and pain), diabetes type 2 (a chronic condition where the body resist insulin or fails to produce enough causing high blood sugar), essential hypertension (is a type of high blood pressure that has no clearly identifiable cause), blindness of both eyes, depression (a mood disorder causing persistent sadness, a loss of interest in activities, and an inability to function in daily life), sleep apnea (a common serious disorder where treating repeatedly stops and starts during sleep often causing loud snoring, choking and severe daytime tiredness), morbid obesity (a chronic malfunctional disease characterized by excessive fat storage), and anxiety.A review of Resident 1's Minimum Data Set (MDS, a resident assessment tool use to guide care) dated [DATE], indicated Resident 1 had a score of 12 on the Brief Interview for Mental Status exam (BIMS, a scoring system used to determine the resident's cognitive status regarding attention, orientation, and ability to register and recall information, a BIM score of 13-15 indicates intact cognition). Resident 1's BIMS score of 12 indicated moderate cognitive impairment (thinking and memory problems are noticeable and affect daily function).A review of Resident 1's Hospital Inpatient Discharge Instructions, indicated, . visit date [DATE].Your diagnosis Facial cellulitis Sepsis without acute organ dysfunction DM type 2 .Hypertension.SKILLED NURSING FACILITY[SNF] admission ORDERS.Oxygen Orders: Start oxygen at 2 L/min [liters per minute] for shortness of breath, chest pain, oxygen saturation less than 90% and notify physician immediately.CBC [Complete Blood Count: a blood test that measures the number, size, and characteristics of blood cells and platelets to assess overall health and detect medical conditions] and Chem 7 [a blood panel test that measures seven key chemical components to evaluate kidney function, electrolyte balance, and overall metabolic health] to be drawn weekly after SNF admission.Notify physician for Change in Condition: If patient has one or more of the following conditions, conduct full assessment and notify Physician .Abnormal lung sounds with new or increased O2[Oxygen] requirement to maintain O2 sat> [greater than] 88% .Shortness of breath while sitting still .Any abnormal labs . Facility staff had Resident 1's Hospital Inpatient Discharge Instructions signed that Resident 1's hospital discharge orders were noted and carried out on [DATE].A review of Resident 1's Physician's Orders dated [DATE], indicated, . Oxygen @ [at] 2 L/min via nasal (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	canula [a thin flexible tube with two prongs inserted into the nostril allowing oxygen to flow directly into the nose] continuously every shift. A review of Resident 1's Physician's Orders dated [DATE], indicated, .CPAP [machine that delivers continuous air through the nose or mouth to keep the airways open while a person sleeps] ON at 9pm and OFF at 7 am. Review of Resident 1's care plan initiated on [DATE], indicated, .Focus .Requires IV therapy [a medical process that administers fluids, medications and nutrients directly into a person's vein] R/T [related to]: (Facial Cellulitis) .Interventions . Observe for signs and symptoms of embolism: shortness of breath; chest pain; cough; wheezing; skin that's cool, clammy, or bluish; rapid or irregular heartbeat; weak pulse .if air embolism is suspected .notify MD and call emergency personnel (911) .Review of Resident 1's care plan initiated on [DATE], indicated, .Focus .At risk for Cardiac Distress [a condition in which the heart suddenly and unexpectedly stops beating] R/T: Hyperlipidemia [high cholesterol level], HTN [Hypertension: high blood pressure] .Goal .Resident will be free signs and symptoms of cardiac distress .Observe and notify MD when resident is experiencing change in level of consciousness, shortness of breath, chest pain .Follow up labs .Review of Resident 1's care plan initiated on [DATE], indicated, .Focus .Elevated Cholesterol/Lipid Level [a blood test that is used to monitor and screen a person's risk of heart disease] .Goal .Resident will not develop complications of hypercholesterolemia/hyperlipidemia [high cholesterol levels] such as shortness of breath .Interventions .Observe for signs and symptoms of shortness of breath, chest pain secondary to heart disease .Follow up labs as ordered and report to MD .A review of Resident 1's nurse progress note, dated [DATE], indicated, . LATE ENTRY. Received resident in bed, Lying in bed comfortably, alert, and oriented x [times] 3, CPAP machine in place, oxygen in place at 2 LPM [liter per minute] via nasal canula around 07:50 AM. At same time Resident c/o [complained of] SOB [shortness of breath], checked O2 sat [oxygen saturation] 88 %. Increased Oxygen to 4 LPM via nasal canula and administered Albuterol [a medicine that relaxes airway muscles and help with breathing] 2 puffs as ordered. re check resident O2 sat at 08:15 a.m., O2 sat reading was 94 % to 95% .At 10:10 AM NP [Nurse Practitioner] make[sic] rounds and noted resident non-responsive, call the attention of writer, Code Blue [an emergency code signally a life-threatening medical situation] announce[sic] rightaway [sic] initiated CPR [Cardiopulmonary resuscitation: a critical, life-saving emergency procedure performed on people whose breathing or heart has stopped] called 911 at 10:13.10:26 AM Paramedics(911) pronounced death. Further review of Resident 1's progress notes failed to show that physician was notified of Resident 1's change in condition sooner than 10:10am, when NP found him unresponsive.A review of Resident 1's Situation Background Assessment Recommendation (SBAR; a communication framework used in healthcare to ensure accurate, concise and timely transfer of information, especially during critical situations or patients handover) Form and Progress Notes, dated [DATE], at timestamped 11:00 a.m., indicated, . Appearance, summarize your observation and evaluation, Resident c/o sob, checked O2 sat 88 %, increased oxygen at 4 LPM and administered albuterol 2 puffs, all am medication administered as ordered, tolerating well. Recheck O2 saturation reading was 94 to 95% . Further review of Resident 1's SBAR indicated physician was not notified of Resident 1's change in condition until 10:10 a.m. on [DATE].During an interview on [DATE], at 3:00 p.m., with LVN1, LVN1 confirmed during change of shift, on [DATE] at around 7:40 a.m., the Certified Nursing Assistant (CNA) on morning shift informed LVN 1 that Resident 1 was complaining of shortness of breath and had a low saturation of 88%. LVN 1 further stated she gave Resident 1 his Albuterol 2 puffs as per orders. LVN 1 added she increased his oxygen therapy from 2 LPM to 3 LPM, gradually to 4 LPM via nasal cannula, and kept it at 4 LPM. LVN 1 further stated she stayed in Resident 1's room till 8:15 a.m. to monitor Resident 1's condition. LVN 1 stated she did not get any orders from the (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	order. The NP further stated if a residents' condition had changed, it was the facility's responsibility to immediately notify the Physician. The NP stated no one from the facility notified her or the Physician about Resident 1's change of condition on [DATE] until she herself found Resident 1 unresponsive at 10:10 a.m., during her rounding. The NP stated whatever orders were on Resident 1's hospital discharge form were valid orders and facility staff should have transcribed them into facility admission orders, especially for any lab orders such as CBC pertaining to Resident's 1 antibiotic therapy.During an interview on [DATE], at 2:16 p.m., with the Facility's Medical Director (MD), the MD stated he did not recall he received any telephone call or notification from the facility about Resident 1's change of condition the morning prior to finding him unresponsive, no pulse, and no respiration. The MD further stated it was the NP who called him to notify him that Resident 1 was found unresponsive, no respiration, and no pulse. The MD stated he expected facility staff to notify him or his NP immediately of a resident's change in condition such as chest pain, shortness of breath, low oxygen saturation, or change in mental status. The MD stated staff should not be titrating oxygen orders, that if he ordered to give oxygen at 2 LPM, it needed to have been carried out as such. The MD added that when staff increased Resident 1's oxygen from 2 LPM to 4 LPM due to shortness of breath and low oxygen saturation, this was a change in condition and should have been reported to him immediately. The MD stated the reason staff should have notified him of Resident's 1's change in condition was so he could do further work up, look for the causes to prevent any adverse events, for patient safety, and comfort. The MD stated if facility could have notified him of Resident 1's change in condition immediately he might have given the orders to send him to the emergency for further evaluation and high-level care. A review of facility's policy and procedure titled, Change in a Resident Condition or Status, dated 2017, indicated, . Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing payments, resident rights, etc.). 1. The nurse will notify the resident's Attending Physician or Physician on call when there has been a (an): . c. adverse reaction to medication. d. significant change in the resident's physical/emotional/mental condition. i. specific instruction to notify the Physician of changes in the resident's condition. 2. A significant change of condition is a major decline or improvement in the resident's status that: a. will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions (is not self-limiting); b. impacts more than one area of the resident's health status. d. Ultimately is based on the judgement of the clinical staff and the guidelines outlined in the Resident Assessment Instrument [a mandatory, standardized system used in nursing homes to assess resident's clinical/functional status, develop individualized care plans, and monitor health changes] .A review of facility's in-service record on topic Respiratory Guidance LVN/RN Scope of Practice dated [DATE], indicated, .The Respiratory Care Board (RCB) has established a new regulation at California Code ofRegulations section 1399.365 that specifies the basic respiratory tasks and services LVNs may perform without conducting respiratory assessments that went into effect [DATE]. The regulation aims to enhance patient safety .some of the FAQ [Frequently Asked Questions] .Can LVNs initiate or adjust oxygen therapy? No. Initial setup or adjustment of oxygen liter flow or concentration is specifically excluded under 16 CCR section 1399.365(c)(6). Initiation of oxygen therapy requires a respiratory assessment and clinical judgment, which must be performed by a licensed RCP [Respiratory Care Practitioner] or, in certain settings, a RN under their own overlapping scope of practice. LVNs and other non-RCP personnel may assist by physically applying oxygen delivery devices (e.g., nasal cannula, face mask) only after an RCP or RN has made the clinical decision (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	to initiate therapy. They may not independently decide to start or adjust oxygen, even under a standing PRN order, since determining when oxygen is needed requires a respiratory assessment. *Review residents on oxygen therapy. Have specific oxygen orders and discuss with the physician if titration orders are needed. The RN and/or Respiratory Therapist will initiate or titrate/adjust oxygen as ordered .LVNs mustcontinue to work under the supervision of a licensed respiratory care practitioner, registered nurse, or physician.According to Board of Vocational Nursing and Psychiatric Technicians, Changes to Respiratory Care Scope of Practice Go Into Effective [DATE] The Board of Vocational Nursing and Psychiatric Technicians (BVNPT) would like to inform licensees, employers and educators of regulations adopted by the Respiratory Care Board (RCB) impacting the scope of practice licensed vocational nurses (LVNs) going into effect on [DATE]. These regulations impact the LVN scope of practice with various changes, as described below. BVNPT licensees, employers and educators are expected to comply with the regulations. LVNs CANNOT perform the following: Manipulation of an invasive or non-invasive ventilator.Assessment or evaluation of observed and gathered data from chest auscultation, palpation, and percussion.Pre-treatment or post-treatment assessment.Preoxygenation or endotracheal or nasal suctioning.Initial setup, change out, or replacement of a breathing circuit or adjustment of oxygen liter flow or oxygen concentration.https://www.bvnpt.ca.gov