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	03/18/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on observation, interview, and record review, the facility failed to protect the residents' right to be free from physical abuse (intentional act of causing injury or trauma to another person through bodily contact) for one of three sampled residents (Resident 2) when on 3/3/26 Resident 1 became upset, started yelling at Resident 2 and hit Resident 2 on the back of the head with a fist. This failure had the potential to cause physical injury and psychosocial distress (anxiety, depression, fear, social withdrawal, or behavioral changes) to Resident 2.Findings:A review of Resident 2's admission RECORD, indicated Resident 2 was admitted to the facility with diagnoses which included but not limited to epilepsy (chronic brain disorder characterized by a tendency to have recurring, unprovoked seizures), depression (long lasting mood disorder that goes beyond feeling sad), muscle weakness, unsteadiness on feet, and traumatic brain injury (a brain injury caused by a sudden external physical force like being hit in the head).A review of Resident 2's minimum data set (MDS -a resident assessment and screening tool which identifies care needs), dated 2/24/26, under the section titled, .Section C: Cognitive Patterns, - (an assessment of the mental abilities and functions the brain uses to think, learn, remember, pay attention, process information and solve problems) indicated, Resident 2's Brief Interview for Mental Status (BIMS - a screening tool used in long-term care to assess a resident's cognitive function [the mental processes like thinking, memory, and perception, that a person uses to understand and respond to their environment]) was 7 out of 15 which indicated Resident 2 had severe cognitive impairment (a significant decline in mental abilities including memory).During an interview on 3/17/26 at 11:48 AM, with Certified Nursing Assistant (CNA) 1, CNA 1 stated on 3/3/26, while she was getting Resident 2 ready to go the shower room, she heard Resident 1 yelling at Resident 2. CNA 1 stated Resident 1 was upset, so she moved Resident 2 into the hallway while she gathered shower supplies to prevent the incident from escalating. CNA 1 explained, once she moved Resident 2 into the hallway, she went and notified Resident 1's Licensed Nurse (LN) that Resident 1 was upset and was yelling at Resident 2. CNA 1 further stated she told the LN that the residents should be separated. CNA 1 stated she returned to Resident 2 and escorted him to the shower room. CNA 1 explained, when she returned to the room with Resident 2 after his shower about 15 minutes later, she moved Resident 2 into the room toward the back of the room in front of Resident 2's bed. CNA 1 stated that as she was along the back wall getting Resident 2's toothbrush from his nightstand, she observed Resident 1 get up from his bed, approach Resident 2, and hit Resident 2 in the back of the head with a fist. CNA 1 explained that she called for help and staff came to the room and separated the residents.During a follow-up observation and interview on 3/18/26 at 8:34 AM, the room shared between Resident 1 and Resident 2 was observed with CNA 1. CNA 1 demonstrated where Resident 1's bed was closest to the entrance of the room, and where Resident 2 sat in the wheelchair in front of his bed toward the back of the room. CNA 1 explained that Resident 2 had his back to the door and Resident 1's bed and could not see Resident 1 approach him. CNA 1 demonstrated how she was standing along the back wall at Resident 2's nightstand when she observed Resident 1 get up and hit Resident 2.During an interview on 3/17/26 at 1:37 PM. with LN 1, LN 1 stated she responded to the call for help from CNA 1 on 3/3/26 and observed Resident 1 (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	standing in the middle of the room between the two beds. LN 1 further stated that she and CNA 1 tried to calm Resident 1 down, and they had to separate Resident 1 and Resident 2 because they were yelling at each other. LN 1 stated Resident 2 told her he was sucker punched in the back of the head. LN 1 further stated Resident 2 was upset.During an interview on 3/18/26 at 8:57 AM, with LN 2, LN 2 confirmed he was the nurse assigned to Resident 1 and Resident 2 on 3/3/26 and responded to their room after a CNA told him about the residents fighting. LN 2 explained by the time he got to the room Resident 1 and Resident 2 were already separated. LN 2 stated Resident 2 was checked for injuries. LN 2 stated Resident 2 told him that Resident 1 came over and hit him in the back of the head. LN 2 further stated he thought Resident 2 was surprised, scared, and startled that Resident 1 hit him.During an interview on 3/18/26 at 9:32 AM, with CNA 2, CNA 2 stated that she was assigned to Resident 1 on 3/3/26. CNA 2 stated that she was told in morning report (standard communication between healthcare workers where outgoing staff exchange information with oncoming staff about resident's care, behaviors, and plans) on 3/3/26 a few hours before Resident 1 hit Resident 2 that Resident 1 could get agitated or upset easily and was rude.During an interview on 3/18/26 at 9:57 AM, with LN 3, LN 3 stated Resident 1 and Resident 2 had been known to have disagreements and argued about the lights being on in the room and the television being too loud during the night. LN 3 stated it happened a few different times about two weeks after they were roomed together. LN 3 further stated Resident 1 was known to yell out for staff to come to his room, and he was not patient with them. LN 3 stated she did not document or report to anyone the previous arguments between Resident 1 and Resident 2 because she felt she resolved them.During a concurrent interview and record review on 3/17/26 at 3:33 PM, with the Social Services Director (SSD), the SSD reviewed the medical record of Resident 1. The SSD verified there was no record of previous behaviors or incidents documented in Resident 1's medical record. The SSD stated she was surprised when she learned Resident 1 hit Resident 2 on 3/3/26. The SSD further stated when she checked on Resident 2, he told her he was shocked by it because the hit came from behind and he had not expected it.During a concurrent interview and record review on 3/18/26 at 11:43 AM, Resident 1's and Resident 2's medical record was reviewed with the Director of Nursing (DON). The DON stated when an LN was notified that residents argued, she expected the LN to address it immediately to prevent it from escalating. The DON reviewed both Resident 1 and Resident 2's medical record. The DON confirmed she could not find any documentation of previous disagreements between Resident 1 and Resident 2, and she could not find any documented concerns with Resident 1's behaviors. The DON stated it was her expectation that staff document and share all incidents between residents that could lead to abuse. The DON further confirmed she had no knowledge of any previous incidents between Resident 1 and Resident 2. The DON explained that had she or her team been aware of the previous incidents between Resident 1 and Resident 2 they would have initiated a room change for resident safety.A review of Resident 1's care plan titled, History of substance use disorder.Use of/addiction to illegal drugs., dated 2/12/26, indicated, .Interventions.Report any changes in mood status.A review of Resident 2's care plan titled, Impaired mood secondary to depressive symptoms.Feeling down, depressed, or hopeless., dated 2/21/26, indicated, .Interventions.Explore the resident's reason/s for social withdrawal and other episodes of depressive symptoms .Identify any triggers.A review of the facility's policy and procedure (P&P) titled, Alleged or Suspected Abuse and Crime Reporting, revised 10/25, the P&P indicated, .Each resident has the right to be free from abuse.Physical abuse includes.hitting, slapping, pinching.4. Prevention.Facility will implement policies and procedures to prevent and prohibit abuse.Identifying and remediating situations in which abuse.is more likely to occur.Assessment and care planning appropriate interventions and monitoring of residents with needs and behaviors which might lead to conflict.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview and record review, the facility failed to thoroughly investigate an allegation of resident-to-resident abuse for two of two sampled residents when:1. The facility did not complete a thorough interview of a Certified Nursing Assistant (CNA) witness who had reported an argument between Resident 1 and Resident 2 to the Licensed Nurse (LN) on 3/3/26, prior to Resident 1 hitting Resident 2;2. The facility's investigation did not reveal information regarding Resident 1's behavior, and incidents that showed arguments between Resident 1 and Resident 2 or interviews from staff with knowledge of them; and,3. The Director of Nursing (DON) was tasked with the responsibility of completing the investigation by the previous Administrator, even though the DON had never completed an investigation before.These failures prevented the implementation of interventions (specific, purposeful actions performed by healthcare professionals to address a resident's needs, prevent complications, and achieve established, measurable goals) to protect Resident 1 from being hit by Resident 2. The failure to thoroughly investigate and interview additional staff also resulted in the facility not being aware of several past incidents, by not getting a full picture of the events that led to the abuse.Findings:A review of Resident 1's care plan titled, History of substance use disorder.Use of/addiction to illegal drugs. dated 2/12/26, indicated, .Interventions.Report any changes in mood status.During an interview on 3/17/26 at 11:48 AM with Certified Nursing Assistant (CNA) 1, CNA 1 stated on 3/3/26 while she was getting Resident 2 ready to go the shower room, she heard Resident 1 yelling at Resident 2. CNA 1 stated Resident 1 was upset, so she moved Resident 2 into the hallway while she gathered shower supplies to prevent the incident from escalating. CNA 1 explained once she moved Resident 2 into the hallway, she went and notified Resident 1's Licensed Nurse (LN) that Resident 1 was upset and was yelling at Resident 2. CNA 1 further stated she told the LN that the residents should be separated. CNA 1 stated she returned to Resident 2 and escorted him to the shower room. CNA 1 explained when she returned to the room with Resident 2 after his shower about 15 minutes later, she moved Resident 2 into the room toward the back of the room in front of Resident 2's bed. CNA 1 added that as she was along the back wall getting Resident 2's toothbrush from his nightstand, she observed Resident 1 get up from his bed, approached Resident 2, and hit Resident 2 in the back of the head with a fist. CNA 1 explained that she called for help and staff came to the room and separated the residents.During an interview on 3/18/26 at 8:57 AM, with LN 2, LN 2 confirmed he was the nurse assigned to Resident 1 and Resident 2 on 3/3/26 and responded to their room after a CNA told him about the residents fighting. LN 2 explained by the time he got to the room Resident 1 and Resident 2 were already separated. LN 2 stated Resident 2 told him that Resident 1 came over and hit him in the back of the head. LN 2 stated that he did not document the incident between the residents in their medical record since the Assistant Director of Nursing (ADON) and the Director of Nursing (DON) were already in the room taking statements from the residents and witnesses. During an interview on 3/18/26 at 9:32 AM, with CNA 2, CNA 2 stated that she was assigned to Resident 1 on 3/3/26. CNA 2 stated that she was told in morning report (standard communication between healthcare workers where outgoing staff exchange information with oncoming staff about resident's care, behaviors, and plans) on 3/3/26 a few hours before Resident 1 hit Resident 2 that Resident 1 could get agitated or upset easily and was rude.During an interview on 3/18/26 at 9:57 AM, with LN 3, LN 3 stated Resident 1 and Resident 2 had been known to have disagreements and argued about the lights being on in the room and the television being too loud during the night. LN 3 stated it happened a few different times about two weeks after they were roomed together. LN 3 further stated Resident 1 was known to yell out for staff to come to his room, and he was not patient with them. LN 3 stated she did not document or report to anyone the previous arguments between Resident 1 and Resident 2 because she felt she resolved them. During a concurrent interview and record review on 3/18/26 at 12:55 PM with the ADON, the facility document titled, Verification of Incident Investigation/Administrative Summary, dated 3/7/26, was reviewed. The ADON confirmed he took the (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	statement on the document that indicated, .CNA witness reported [Resident 1] approached [Resident 2] and struck once on the back of the head with a closed fist while [Resident 2] was seated. The ADON confirmed that only two staff were interviewed for the incident. The ADON stated he and the DON split the statements and he took a statement from CNA 1 and the DON took the statement from LN 1. The ADON stated he asked CNA 1, What happened and What did she witness? The ADON further stated he did not ask any follow up questions or ask clarifying questions. The ADON could not recall whether he received any formal training on taking statements from staff or residents and investigating abuse.During a concurrent interview and record review on 3/18/26 at 11:43 AM, with the Director of Nursing (DON), Resident 1's and Resident 2's medical record was reviewed. The DON stated when a LN was notified that residents argued, she expected the LN to address it immediately to prevent it from escalating. The DON reviewed both Resident 1 and Resident 2's medical record. The DON confirmed she could not find any documentation of previous disagreements between Resident 1 and Resident 2, and she could not find any documented concerns with Resident 1's behaviors. The DON stated it was her expectation that staff documented and shared all incidents between residents that could lead to abuse. The DON further confirmed she had no knowledge of any previous incidents between Resident 1 and Resident 2. The DON explained that had she or her team been aware of the previous incidents between Resident 1 and Resident 2 they would have initiated a room change for resident safety. The DON stated she was assigned to complete the abuse investigation and five-day follow-up investigation report (a requirement for long-term care facilities to submit a detailed report to the State Agency [SA] within five working days of an alleged incident of abuse, neglect, or mistreatment)) that was submitted to the State Agency (SA) by the previous Administrator and confirmed it was her first time fully completing an investigation. The DON confirmed she shared the duties of the investigation with the ADON. The DON further confirmed she did not have any additional documentation to provide for the investigation and was not trained in how to complete an abuse investigation.During an interview on 3/18/26 at 1:38 PM, with the Acting Administrator (ADM), the ADM confirmed it was not a normal facility process for the DON to complete the five-day follow-up investigation and added that the DON stepped up to help out. The ADM explained it was important for the DON and the ADON to have been trained in the investigative process to better understand and grasp interviewing and compliance. The ADM further stated he had expected the DON and ADON to check in with each other to find out what happened and added, there needed to be some communication. The ADM explained risk of not completing a thorough investigation was that missed key parts of the investigation could put the residents at risk when the facility should have already intervened. A review of the facility policy titled, Alleged or Suspected Abuse and Crime Reporting, revised 10/25, indicated, .Each resident has the right to be free from abuse.Employees are responsible for immediately reporting to the facility administrator.any incidents of suspected or alleged abuse.Reports shall be thoroughly investigated.Investigation will focus on determining whether abuse.has occurred, identifying the extent and cause, and providing complete and through [sic] documentation of events. Within 5 working days of the incident, facility will complete a verification of incident investigation report.to the state agency.

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F 0844 Level of Harm - Potential for minimal harm Residents Affected - Many	Follow rules about disclosure of ownership requirements and tell the state agency about changes in ownership and/or administrative personnel. Based on interview and record review, the facility failed to provide written notice at the time of the position change of the Director of Nursing (DON) to the State Agency (SA) for a census of 85 residents, when the current DON started the DON position on 12/10/25, and the facility did not report the change of the DON position to the SA until 1/7/26.This failure delayed the SA from verifying that the DON was qualified to lead clinical services at the skilled nursing facility, which had the potential to compromise resident safety and compliance with federal and state regulation for a census of 85 residents.Findings:During an interview on 3/18/26 at 11:43 AM with the DON, the DON confirmed she started her position as the DON with the facility on 12/10/25. The DON stated she was asked by the corporate (typically oversee billing, payroll, human resources, clinical compliance, and strategic management to ensure facilities meet state and federal standards) for all her licensing information but did not know when the change of leadership notification was sent to the SA.During a concurrent interview and record review on 3/18/26 at 1:38 PM, with the acting Administrator (ADM), the ADM reviewed the change of DON documents dated 1/7/26. The ADM confirmed the DON's documents were mailed to the SA on 1/7/26 and not at the time the change occurred. The ADM stated he was not aware of the time requirement.A review of the facility provided letter address to the SA, dated 1/7/2026, indicated, .CHANGE OF DIRECTOR OF NURSING Application. Further review revealed the letter was signed and dated by the DON on 1/7/26A review of the SA database revealed a received receipt of the DON application from the facility on 1/13/2026.