

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 07/01/2026
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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, and record review, the facility failed to exercise reasonable care to protect the personal property of one of three sampled residents (Resident 1) from potential loss when Resident 1's Inventory of Personal Effects (a list of a resident's personal belongings) had not been updated since 10/28/20, continued to list hearing aids that were no longer available for Resident 1's use, and did not accurately reflect Resident 1's current clothing. This failure had the potential for Resident 1's personal property to not be adequately safeguarded and accounted for, placing Resident 1's personal belongings at risk for loss or misplacement. Findings: Review of Resident 1's admission RECORD indicated Resident 1 was admitted to the facility in 2020 with diagnoses including mood disorder (a mental health condition that affects a person's emotions and behavior), psychosis (a mental health condition that can cause difficulty recognizing what is real), and bilateral hearing loss (reduced hearing in both ears). Review of Resident 1's Brief Interview for Mental Status (BIMS, an assessment used to evaluate a resident's thinking and memory) dated 6/11/26 indicated Resident 1 had a BIMS score of 3, which reflected severe cognitive impairment (13-15 = intact, 8-12 = moderate impairment, 0-7 = severe impairment). Review of Resident 1's Care Plan, in the section titled Focus, initiated on 11/5/20, indicated, [Resident 1] Communication Deficit R/T [related to] uses hearing aid, with periods of confusion and forgetfulness. In the section titled Interventions, indicated .Assist with hearing aid placement and maintenance. Review of Resident 1's INVENTORY OF PERSONAL EFFECTS dated 10/28/20 indicated Resident 1 had two hearing aids, one dress, one sweater, and one pair of underwear. During a concurrent observation and interview on 7/1/26 at 1:40 PM with Resident 1 in Resident 1's room, Resident 1 was not wearing hearing aids in either ear and demonstrated difficulty hearing by not responding to questions, repeating similar sounding words, stated she did not understand, and requested to be left alone. During an interview on 7/1/26 at 2:10 PM with Certified Nursing Assistant (CNA) 1, CNA 1 stated Resident 1 had hearing problems. CNA 1 further stated she was unaware Resident 1 had hearing aids. During a concurrent interview and record review on 7/1/26 at 4:12 PM with Minimum Data Set Coordinators (MDSC - nurses responsible for completing federally required assessments) 1 and MDSC 2, Resident 1's MDS Assessment (Minimum Data Set - an assessment used to evaluate a resident's care needs) dated 6/11/26 was reviewed. In the section titled Section B - Hearing, Speech, and Vision, indicated Resident 1's hearing was adequate and that Resident 1 used hearing aids. MDSC 1 stated Resident 1's hearing was not adequate and acknowledged Resident 1 did not have hearing aids available, contrary to the MDS assessment on 6/11/26. During an interview on 7/1/26 at 4:52 PM with Resident 1's family (RF), the RF stated Resident 1 had hearing aids upon admission to the facility and that the hearing aids were lost while at the facility and replaced by the facility. The RF stated Resident 1 did not like the fit of the replacement hearing aids, so the family took them home years ago. During a concurrent observation and interview on 7/1/26 at 5:02 PM with the Assistant Director of Nursing (ADON) in Resident 1's room, Resident 1's closet contained multiple clothing items, including a black jacket that was not listed on Resident 1's Inventory of Personal Effects. The ADON also confirmed Resident 1 did not have hearing aids available although hearing aids were listed on Resident 1's Inventory of (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Personal Effects. The ADON stated Resident 1's Inventory of Personal Effects, dated 10/28/20, had not been updated when changes occurred to Resident 1's personal belongings, including the addition of the black jacket and the removal of the hearing aids. The ADON stated staff were expected to update the inventory whenever family members brought or removed personal belongings. The ADON stated the inaccurate Inventory of Personal Effects prevented the facility from accurately accounting for Resident 1's personal belongings, increasing the risk that the resident's personal property could be lost or misplaced and preventing the facility from ensuring the resident's belongings were properly safeguarded. Review of the facility's policy and procedure (P&P) titled Safeguarding Personal Property/Theft-and-Loss Policy, revised in 10/2025, indicated, .Facility will exercise reasonable care to protect and promote the safety and security of personal belongings. A property inventory shall be completed to identify personal property brought into the facility upon admission. Subsequent updates shall be made following the addition or removal of personal property from the facility. Facility staff shall update inventory records promptly upon request.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on observation, interview, and record review, the facility failed to ensure treatment and care in accordance with professional standards of practice was provided for one of three sampled residents (Resident 1) when:1. Resident 1's skin conditions during the nurse's required weekly long-term care evaluations (Weekly Summary - a weekly nursing assessment used to evaluate and document changes in a resident's condition based on a comprehensive assessment of the resident), completed on 2/13/26 and 2/20/26, were not identified and documented. Additionally, the facility failed to ensure Resident 1's weekly long-term care evaluation, due on 5/1/26, was completed; and,2. The facility staff failed to implement the communication care plan intervention to assist with hearing aid placement and maintenance for Resident 1. These failures resulted in inaccurate assessments being added to Resident 1's health care record, and had the potential to delay treatment, and implementation of resident-specific interventions, increasing the risk for skin breakdown, infection, and further skin deterioration, and had the potential for Resident 1 not to reach her highest practicable physical, mental, and psychosocial well-being due to hearing loss. Findings:1. Review of Resident 1's admission RECORD indicated Resident 1 was admitted to the facility with diagnoses including type 2 diabetes mellitus (high blood sugar), osteoarthritis (joint pain and stiffness), mood disorder (a mental health condition that affects a person's emotions and behavior), psychosis (a mental health condition that can cause difficulty recognizing what is real), and unspecified bilateral hearing loss (reduced hearing in both ears). Review of Resident 1's Brief Interview for Mental Status (BIMS, an assessment used to evaluate a resident's thinking and memory) dated 6/11/26 indicated Resident 1 had a BIMS score of 3, which reflected severe cognitive impairment (13-15 = intact, 8-12 = moderate impairment, 0-7 = severe impairment). During an interview with Resident 1's family (RF) on 7/1/26 at 9:46 AM, the RF stated Resident 1 had multiple skin issues that were not identified by facility staff, including a sore on the left heel and rashes under Resident 1's breasts, which the RF discovered and reported to nursing staff. The RF further stated that skin issues would not have been identified or treated without the RF bringing them to the facility's attention. During a concurrent interview and record review on 7/1/26 at 3:27 PM with the Nurse Supervisor (NS), Resident 1's assessments were reviewed. Resident 1's eINTERACT Change in Condition Evaluation .[a nursing assessment completed when a resident has a change of condition to evaluate the resident and notify the provider] dated 2/18/26 at 9:40 PM indicated the RF reported Resident 1's left heel skin felt hard. Nursing staff assessed the area as a callous and obtained treatment orders from the provider. Resident 1's Weekly Summary dated 2/13/26 indicated Resident 1 did not have skin issues. The Weekly Summary dated 2/20/26 documented no skin issues or skin changes since the previous evaluation. The NS acknowledged the Weekly Summary dated 2/20/26 was inaccurate because Resident 1 experienced a skin change between 2/13/26 and 2/20/26, as evidenced by the callous assessed on 2/18/26. Resident 1's Weekly Summaries were further reviewed with the NS and indicated the required Weekly Summary due on 5/1/26 was not completed. Resident 1's eINTERACT Change in Condition Evaluation . dated 5/4/26 at 1:23 PM documented redness under Resident 1's right breast, and treatment orders were obtained from the provider. The NS acknowledged the missed Weekly Summary due on 5/1/26 could have identified the skin change earlier. During an interview on 7/1/26 at 5:05 PM with the Assistant Director of Nursing (ADON), the ADON stated nursing staff were expected to complete Weekly Summaries by the required due date and accurately evaluate residents to identify changes in condition, including skin issues. The ADON further stated that missed or inaccurate Weekly Summaries could delay the identification and treatment of skin conditions and could lead to further skin deterioration. Review of the facility's policy and procedure titled Weekly Summary, revised 1/2029, indicated, .It is the policy of this facility for licensed nurses to complete progress notes on a weekly basis. It is the responsibility of the licensed charge nurse to evaluate a resident's status and condition, including progress thereof, with any treatment programs, on a weekly basis. When (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	evaluating the resident and completing the weekly licensed progress notes, the licensed charge nurse should document the resident's skin condition and complete a body assessment. It is important that the licensed nurse accurately report the resident's status and condition. 2. Review of Resident 1's Care Plan, in the section titled Focus, initiated on 11/5/20, indicated, .[Resident 1] Communication Deficit R/T [related to] uses hearing aid, with periods of confusion and forgetfulness. The Goal included, Resident will communicate needs without frustration. Resident's ability to interact with others will be enhanced with interventions through next review date. The section titled Interventions, indicated . Observe and report to MD [Physician] with decrease hearing function .Assist with hearing aid placement and maintenance.Coordinate with responsible party/surrogate decision maker regarding hearing aid battery replacement.Review of Resident 1's INVENTORY OF PERSONAL EFFECTS dated 10/28/20 indicated Resident 1 had two hearing aids, one dress, one sweater, and one pair of underwear.During a concurrent observation and interview on 7/1/26 at 1:40 PM with Resident 1 in Resident 1's room, Resident 1 was not wearing hearing aids in either ear and demonstrated difficulty hearing by not responding to questions, repeating similar sounding words, stated she did not understand, and requested to be left alone. No other types of communication devices were observed with Resident 1.During an interview on 7/1/26 at 2:10 PM with Certified Nursing Assistant (CNA) 1, CNA 1 stated Resident 1 had hearing problems. CNA 1 further stated she was unaware Resident 1 had hearing aids.During a concurrent interview and record review on 7/1/26 at 4:12 PM with Minimum Data Set Coordinators (MDSC - nurses responsible for completing federally required assessments) 1 and MDSC 2, Resident 1's MDS Assessment (Minimum Data Set - an assessment used to evaluate a resident's care needs) dated 6/11/26 was reviewed. In the section titled Section B - Hearing, Speech, and Vision, indicated Resident 1's hearing was adequate and that Resident 1 used hearing aids. MDSC 1 stated Resident 1's hearing was not adequate and acknowledged Resident 1 did not have hearing aids available, contrary to the MDS assessment on 6/11/26. The MDSC 2 stated no other hearing assistive device was used during the interview of Resident 1 to complete Section B - Hearing, Speech, and Vision. When MDSC 2 was asked whether Resident 1's hearing impairment could have affected the interview, the MDSC 2 acknowledged it could have.During an interview on 7/1/26 at 4:52 PM with Resident 1's family (RF), the RF stated Resident 1 had hearing aids upon admission to the facility and that the hearing aids were lost while at the facility and replaced by the facility. The RF stated Resident 1 did not like the fit of the replacement hearing aids, so the family took them home years ago.During a concurrent observation and interview on 7/1/26 at 5:02 PM with the Assistant Director of Nursing (ADON) in Resident 1's room, Resident 1's closet contained multiple clothing items, including a black jacket that was not listed on Resident 1's Inventory of Personal Effects. The ADON also confirmed Resident 1 did not have hearing aids available although hearing aids were listed on Resident 1's Inventory of Personal Effects. The ADON stated Resident 1's Inventory of Personal Effects, dated 10/28/20, had not been updated when changes occurred to Resident 1's personal belongings, including the addition of the black jacket and the removal of the hearing aids. The ADON stated staff were expected to update the inventory whenever family members brought or removed personal belongings. The ADON stated the inaccurate Inventory of Personal Effects prevented the facility from accurately accounting for Resident 1's personal belongings, increasing the risk that the resident's personal property could be lost or misplaced and preventing the facility from ensuring the resident's belongings were properly safeguarded.During an interview on 7/1/26 at 5:05 PM with the ADON, the ADON stated the facility had hearing amplifiers and communication boards available and stated they should have been offered to Resident 1 to assist with communication. ADON acknowledged Resident 1's refusal of care could partially be related to difficulty understanding staff because of Resident 1's hearing impairment. The ADON stated Resident 1 already had confusion and that not being able to hear or understand staff could increase confusion, frustration, anxiety, resistance to care, miscommunication, and trigger adverse behaviors. ADON agreed the communication assessment (MDS) was not accurate because it did not reflect Resident 1's current (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hearing impairment or communication needs.Review of the facility's policy and procedure (P&P) titled Safeguarding Personal Property/Theft-and-Loss Policy, revised in 10/2025, indicated, .Facility will exercise reasonable care to protect and promote the safety and security of personal belongings. A property inventory shall be completed to identify personal property brought into the facility upon admission. Subsequent updates shall be made following the addition or removal of personal property from the facility. Facility staff shall update inventory records promptly upon request.		