

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

Printed: 10/09/2026
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 07/10/2026
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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview, and record review, the facility failed to notify the Responsible Party (RP) of a significant change in condition and the physician's intervention for one of three sampled residents (Resident 1), when Resident 1 was prescribed an antibiotic for a urinary tract infection (UTI - a urine infection) and Resident 1's RP was not notified. This deficient practice had the potential to deprive Resident 1's RP of the opportunity to participate in Resident 1's care, be informed of Resident 1's change in condition and treatment plan, ask questions, and make informed decisions regarding Resident 1's care and services. Findings: Review of Resident 1's admission RECORD, indicated Resident 1 was admitted to the facility with diagnoses of, but not limited to, multidrug-resistant organisms (MDRO-germs that many antibiotics cannot kill), vascular dementia (memory loss and problems with thinking caused by reduced blood flow to the brain), and history of falling. The admission RECORD also indicated, .Responsible Party .Daughter .Review of Resident 1's [Name of Facility] Physician Progress Notes, dated 5/28/26, indicated, .Patient was seen and examined. stated she has dysuria [painful urination]. Plan. UA [Urinalysis-testing the urine] with C&S [Culture and Sensitivity - a laboratory test to find the germ and the right antibiotic]. Review of Resident 1's Order Details, dated 6/1/26, indicated, .Ciprofloxacin (antibiotic medication) tablet. for UTI for 5 days. Review of Resident 1's laboratory results, received date 6/1/26, indicated, .Culture, Urine. Enterobacter (a type of germ that can cause infections). During a concurrent interview and record review on 7/10/26, at 2:08 PM, with the Interim Director of Nursing (DON), Resident 1's electronic medical record (EMR) was reviewed. The DON stated that it was his expectation that follow-up documentation in the form of nursing progress notes, should have been completed for Resident 1's urinary change in condition. The DON confirmed that the Nurse Practitioner (NP) reviewed the C&S results and, on 6/1/26, ordered an antibiotic for treatment of a UTI. The DON further confirmed that the NP's progress note documented that Resident 1 had positive findings consistent with a UTI. The DON stated that it was his expectation that the nurse who received and implemented the antibiotic order would notify Resident 1's RP of the new treatment. Further review of Resident 1's EMR, the DON confirmed there was no documentation that the RP had been notified of Resident 1's UTI diagnosis or the initiation of antibiotic treatment. The DON stated that notification of the RP was important so they would be informed of Resident 1's condition and plan of care. The DON further stated that if the initial nurse did not provide the notification, subsequent shifts should have ensured the RP was updated. Review of facility policy and procedure titled, Acute Condition Changes - Clinical Protocol, revised 3/18, indicated, Assessment and Recognition: The physician will help identify individual with a significant risk for having acute changes of condition during their stay. In addition, the nurse shall assess and document/report the following . recent labs. All current diagnoses. All current medications. The physician and nursing staff will review the details of any (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	recent hospitalization.the physician will discuss with the staff and resident/patient and/or family the pros and cons of diagnosing and managing the situation.this discussion should consider the patient's overall condition, prognosis, and wishes (either direct or as conveyed by a substitute decision-maker).		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interview, and record review, the facility failed to ensure proper post-fall assessment or interventions were implemented for 1 of 4 sampled residents (Resident 1) when:1) The facility did not hold a post fall Interdisciplinary Team (IDT) meeting for Resident 1's fall on 6/17/26. 2) Resident 1's fall care plan was not updated with new specific interventions after Resident 1's fall on 6/17/26; and,3) Resident 1's neurological checks (focused assessment to monitor a resident's neurological (brain, spinal cord, and nerves) function) was not completed at the designated intervals after Resident 1's unwitnessed fall on 6/17/26.This failure could have delayed the identification of any changes in Resident 1's condition after her unwitnessed fall on 6/17/26, hindered the timely introduction of personalized fall prevention strategies, increased the risk of recurrent falls and further injury, and had the potential to negatively impact the health, safety, and overall well-being of Resident 1.Findings:Review of Resident 1's admission RECORD, indicated Resident 1 was admitted to the facility with diagnoses of, but not limited to anxiety disorder (a condition of constant worry or fear), vascular dementia (memory problem caused by poor blood flow to the brain), and history of falling.Review of Resident 1's clinical record titled, Change In Condition Evaluation, dated 6/17/26, indicated, .patient found lying on the floor on her back with knees bent and crossed with pillow behind her head.patient stated I fell I fell but was unable to provide context as to why she fell.Recommendation of Primary Clinician(s).neuro checks and monitoring.Review of Resident 1's clinical record titled, Neurological Assessment (Head Injury/Unknown Fall), dated 6/17, indicated a facility neurological monitoring flow sheet used to document post-fall neurological assessments. The form included designated intervals for assessments every 15 minutes, 30 minutes, and 1 hour, with sections to document: Vital signs, including blood pressure, temperature, pulse, and respirations; Respiratory pattern; Right and left pupil (the dark opening in the center of the eye) size and reaction; Upper and lower extremity strength; Level of consciousness (oriented, disoriented, restless, drowsiness); Speech (clear or garbled); Response to name and pain; Presence or absence of environmental awareness, seizure activity (sudden abnormal electrical activity in the brain), headache, and vomiting; and Nursing signature. The document contained completed neurological assessments at 2:10 p.m., 2:25 p.m., 2:40 p.m., and 2:55 p.m. (15-minute intervals). The remaining sections designated for subsequent 30-minute and 1-hour neurological assessments were blank.During a review of Resident 1's clinical record titled, Care Plan Report, in the section titled, Interventions/Tasks, indicated, .fall mat [cushion placed on the floor to reduce injury if a person falls] as ordered Date initiated 5/26/26.Bilateral floor mat as ordered Date initiated 6/10/26.During a review of Resident 1's clinical record titled, Care Plan Report, in the section titled, Focus, Date Initiated 6/15/26, Date Revised 6/16/26, indicated, .High Risk for falls and injury related to .Poor judgement, poor safety awareness, limitation of mobility, Recent fall in the last 30 days, Functional range of motion limitation . Further review of the document under the section titled, Interventions/Tasks, Date Initiated 6/15/26, indicated, .Orient resident to person, place, time, routine and event.Provide assistance needed with ADL care.Keep bed in low position.Keep room and common areas free from clutter.Review of Resident 1's clinical record titled, Post Fall Evaluation, dated 6/17/26, indicated, .Fall Details.Activity at the time of fall.3. Other.Other activity.unable to determine.Contributing Factors.5. Floor mat on floor.a. Yes.6. Poor lighting.a. Yes.During a concurrent interview and record review on 7/9/26, at 9:20 AM, with the Social Services Director (SSD), Resident 1's medical record was reviewed. The SSD stated that IDT care conferences were conducted for new (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	admissions, quarterly and annual reviews, and whenever a resident experiences a significant change in condition. The SSD explained that the purpose of the IDT care conference was to discuss significant changes or concerns with the resident and/or the responsible party (RP), collaborate with the physician (MD) and other IDT members, and update the resident's care plan as needed to reflect individualized interventions. The SSD confirmed that Resident 1's last documented care conference occurred on 5/20/26. The SSD further acknowledged that fall incidents should have prompted an IDT care conference to identify the root cause of the fall, evaluate whether appropriate fall prevention interventions were in place, develop additional recommendations as needed, communicate those recommendations to the MD and the RP, and revise Resident 1's care plan accordingly to promote Resident 1's safety and well-being. During a concurrent interview and record review on 7/10/26, at 12:51 PM, with Licensed Nurse (LN) 1, Resident 1's EMR was reviewed. LN 1 confirmed that Resident 1 sustained an unwitnessed fall on 6/17/26. LN 1 stated that the fall represented a change in condition (CIC - a change in the person's health) requiring a comprehensive post-fall evaluation and assessment. LN 1 stated because the fall was unwitnessed that neurological (neuro) checks should have been completed to monitor for potential neurological changes or injury. LN 1 explained that the neuro check documentation was maintained on a paper form and, upon review, confirmed that the neuro checks were incomplete for Resident 1's fall on 6/17/26. LN 1 further reviewed the post-fall evaluation and confirmed the nurse who filled out the form documented that they were unable to determine what Resident 1 was doing at the time of the fall, indicating that additional follow-up through an IDT review was needed to identify the root cause of the fall and determine whether revisions to Resident 1's fall care plan were warranted. LN 1 stated that completing the post-fall process, including the IDT review, updating the care plan, and performing neuro checks, was important to help prevent future falls, promote resident safety, and reduce the risk of injury. LN 1 stated that the licensed nurse could initiate updates to the care plan based on the initial post-fall assessment, with additional revisions made after the IDT developed further recommendations. LN 1 further stated that completing neuro checks was essential because they help identify any neurological decline or other changes in Resident 1's condition that require ongoing monitoring and timely intervention. During a concurrent interview and record review on 7/10/26, at 2:08 PM, with the Interim Director of Nursing (DON), Resident 1's EMR was reviewed. The DON confirmed that after Resident 1's 6/17/26 fall, no IDT meeting had been conducted, the fall care plan had not been updated, and the neurological (neuro) checks were not completed consistently. The DON stated that all of these actions were expected components of the facility's post-fall process but acknowledged that they did not occur for Resident 1. The DON further stated that failure to complete these interventions placed Resident 1 at risk for delayed identification of neurological changes or decline, worsening of the resident's condition, delayed implementation of appropriate interventions, and potential rehospitalization. Review of the facility policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, revised date 12/16, indicated, Policy Statement: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident. The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan. The care planning process will facilitate resident and/or representative involvement. describe services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Identifying problem areas and their causes, and developing interventions that are targeted and meaningful to the resident, are the endpoint of an interdisciplinary process. Care plan (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interventions are chosen only after careful data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes. interventions address the underlying source(s) of the problem area(s).The Interdisciplinary Team must review and update the care plan.Review of facility P&P titled, Falls - Clinical Protocol, revised date 3/18, indicated, Assessment and Recognition.the nurse shall assess and document/report.Vital signs.Change in cognition or level of consciousness; Neurological status.Monitoring and Follow-Up: . The staff, with physician's guidance, will follow up on any fall . Delayed complications such as late fractures and major bruising may occur hours or days after a fall, while signs of subdural hematomas (a blood clot inside the head after a head injury) or other intracranial bleeding (bleeding inside the skull or around the brain) could occur up to several weeks after a fall.The staff and physician will monitor and document the individual's response to interventions intended to reduce falling or the consequences of falling.Review of the facility P&P titled, Neurological Assessment, revised date 10/10, indicated, .Purpose: The purpose of this procedure is to provide guidelines for neurological assessment.upon physician order, when following an unwitnessed fall.when indicated by resident condition.When assessing neurological status, always include frequent vital signs.Particular attention should be paid to widening pulse pressure (difference between systolic and diastolic pressures).This may be indicative of increasing intracranial pressure (ICP - the pressure inside the brain). Documentation.information should be recorded in the resident's medical record.		

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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 notification to the State Agency (SA) at the time of the position change of the facility's Director of Nursing (DON) for a census of 87 residents, when the Assistant Director of Nursing (ADON) assumed the role of the Interim Director of Nursing (DON) on 6/29/26, and the facility did not report the change of the DON position as of 7/10/26. 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 87 residents. Findings: During an interview on 7/9/26, at 3:48 PM, with the Interim Director of Nursing (DON), the DON stated that he assumed the role of Interim Director of Nursing effective 6/29/26 and had been performing all responsibilities of the Director of Nursing since that date. The DON further stated that based on his understanding from the previous Director of Nursing, a change in the facility's nursing leadership, including the Director of Nursing position, should be reported to the appropriate State Agency. The DON stated that he had not completed, signed, or submitted any forms or documentation related to the required reporting of his appointment. The DON further stated that notifying the State Agency of a change in the Director of Nursing position was important to ensure the facility identified the individual serving as the primary clinical nursing leader and point of contact for the nursing department. The Interim DON explained that such notification established the appropriate chain of command, promoted accountability for nursing services, and allowed the State Agency to verify that the individual serving in the Director of Nursing role possessed the qualifications necessary to oversee the facility's clinical operations. During an interview on 7/9/26, at 12:36 PM, with the Operations Manager (OM), the OM stated that the Assistant Director of Nursing (ADON) assumed the role of Interim Director of Nursing (DON) effective 6/29/26. The OM further stated that the facility had not submitted any notification or application to the SA because the facility believed submission was not required until a permanent DON was hired. The OM stated that the facility was waiting to hire a permanent DON before submitting the required documentation and acknowledged uncertainty regarding the regulatory process for reporting an Interim DON. The OM further stated that it would be important for the SA to know that a qualified Registered Nurse (RN) was serving in the role of the DON because that individual would oversee the facility's nursing services. The OM confirmed that despite the change in nursing leadership effective 6/29/26, the facility had not submitted written notification or any documentation to the and was waiting until a permanent DON was hired before making any notification. A review of the SA database did not indicate the DON application was received from the facility. Review of an undated facility provided job description titled, Director of Nursing, indicated, .Position Summary: Plan, organize, develop and direct the overall operation of the Clinical/Nursing Services Department in accordance with current federal, state, and local standards, guidelines, and regulations to ensure that the highest degree of quality care is maintained at all times. Qualifications: Valid state RN License, in good standing.		