

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 07/15/2026
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to implement appropriate infection prevention and control practices for 2 of 3 sampled residents (Resident 1 and Resident 2) when:1. Resident 1's urinal (a portable plastic container that male residents use to urinate when they cannot get to the bathroom) was full of urine and was hanging on the edge of the bed without a lid cover; and,2. Resident 2's urinal was not labeled.These failures had the potential to spread infection and cause adverse health outcomes for Resident 1, Resident 2, and other residents residing in the facility.Findings:1. A review of Resident 1's admission RECORD, indicated that Resident 1 was admitted to the facility with diagnoses including necrotizing fasciitis (a rare, severe, and fast-spreading bacterial infection that destroys the tissue beneath the skin, commonly known as the flesh-eating disease), chronic viral hepatitis C (a long-term blood-borne infection caused by the hepatitis C virus [HCV] that lasts longer than six months), and lymphedema (a chronic condition causing swelling, tight skin, and a heavy feeling in the arms or legs due to blocked lymph fluid).During a concurrent observation and interview on 7/15/26, at 9:21 AM, with Licensed Nurse (LN) 1, Resident 1's urinal was observed. LN 1 confirmed that Resident 1's urinal was not labeled with identifying information and should have been labeled. LN 1 further confirmed that Resident 1's urinal did not have a covered lid on top and was full of urine while hanging off the end of the bed frame.2. A review of Resident 2's admission RECORD, indicated that Resident 2 was admitted to the facility with diagnoses including chronic respiratory failure (a long-term condition where the lungs cannot get enough oxygen into the blood or remove enough carbon dioxide), chronic congestive heart failure (a long-term condition where the heart cannot pump blood well, causing fluid to back up into the lungs and body tissues), and type 2 diabetes mellitus (a chronic condition where high blood sugar occurs because the body cannot use insulin properly or make enough of it).During a concurrent observation and interview on 7/15/26, at 9:20 AM, with LN 1, Resident 2's urinal was observed. LN 1 confirmed that Resident 2's urinal was not labeled with identifying information and should have been labeled.During an interview on 7/15/26, at 9:25 AM, with LN 1, LN 1 stated that it was her expectation for urinals to be labeled and have a covered lid on them. LN 1 further stated that urinals could get mixed up between residents if they were not labeled and that it was especially important to do so when there were more multiple residents using them in the same room. LN 1 further stated that having urinals labeled would allow the residents to not be confused as to which urinals belonged to them. LN 1 stated that a covered lid on the urinals would prevent them from spilling.During an interview on 7/15/26, at 10:29 AM, with the Infection Preventionist (IP), the IP stated that it was his expectation for urinals to be labeled and have a covered lid on them. The IP further stated that urinals that have urine in them without a lid could fall over and cause a dignity issue for the residents. The IP stated that staff should be emptying out the urinals as soon as they can. The IP further that he would not want to be in a situation where his urinal was full of urine without being emptied or (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	covered.During an interview on 7/15/26, at 10:55 AM, with the Director of Nursing (DON), the DON stated that it was his expectation for urinals to be labeled and have a covered lid on them. The DON further stated that urinals could get mixed up if they were not properly labeled. The DON stated that urinals could tip over and spill which could cause an infection control issue. The DON further stated that his expectations were not met by having urinals not being labeled and without covers.During a review of the facility's policy and procedure (P&P) titled, Biohazard Labeling, revised 7/16, the P&P indicated, .Materials contaminated with blood or body fluids shall be labeled and discarded appropriately.During a review of the facility's P&P titled, Bedpan/Urinal, Offering/Removing, revised 2/18, the P&P indicated, .Remove the urinal from the bedside stand. Be sure that it is clean and dry.		