

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  07/25/2024
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)
<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>40141</p> <p>Based on observation, interview, record review, and facility policy review, the facility failed to ensure a medication error rate less than 5%. There were two errors out of 26 opportunities, which resulted in a 7.69% medication error rate for 2 (Resident #23 and Resident #82) of 5 residents observed for medication administration.</p> <p>Findings included:</p> <p>A facility policy titled, Medication Administration (General), dated 08/18/2022, indicated, 4. Medications shall be administered in accordance with the orders, including any required time frame.</p> <p>An Admission Record revealed the facility admitted Resident #23 on 02/23/2024. According to the Admission Record, the resident had a medical history that included a diagnosis of multiple sclerosis.</p> <p>A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/05/2024, revealed Resident #23 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition.</p> <p>Resident #23's Order Summary Report, revealed an order dated 02/23/2024, for multivitamin with minerals oral tablet, give one tablet by mouth in the morning for supplement.</p> <p>During medication administration observation on 07/23/2024 at 8:36 AM Licensed Vocational Nurse (LVN) #5 prepared Resident #23's medications and administered one plain multivitamin to the resident.</p> <p>An Admission Record revealed the facility admitted Resident #82 on 05/23/2024. According to the Admission Record, the resident had a medical history that included diagnoses of anemia and moderate protein-calorie malnutrition.</p> <p>An admission MDS, with an ARD of 05/28/2024, revealed Resident #82 had a BIMS score of 5, which indicated the resident had severe cognitive impairment.</p> <p>Resident #82's Order Summary Report, revealed an order dated 05/23/2024, for centrum silver adult 50+ oral tablet, give one tablet by mouth in the morning for supplement.</p> <p>During medication administration observation on 07/23/2024 at 8:49 AM, LVN #5 prepared Resident #82's medications and administered one plain multivitamin to the resident.</p> <p>(continued on next page)</p>

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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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 07/24/2024 at 10:50 AM, LVN #6 indicated there was a difference between a multivitamin and a multivitamin with minerals. LVN #6 stated if the physician order read multivitamin with minerals, then the residents should get a multivitamin with mineral tablet. LVN #6 reviewed the physician orders for Resident #23 and Resident #82 then indicated that both physician orders were for multivitamin with minerals.</p> <p>During an interview on 07/24/2024 at 12:44 PM, the Nurse Practitioner (NP) indicated the multivitamin with minerals might have a mineral that a resident specifically needed. The NP stated she expected if the physician order said multivitamin with minerals, then that was what should be administered to Resident #23 and Resident #82. The NP stated she expected the residents to receive the multivitamin with mineral as ordered.</p> <p>During a telephone interview on 07/25/2024 at 9:23 AM, LVN #5 stated he administered a plain multivitamin to Resident #23 and Resident #82 during the medication administration on 07/23/2024. LVN #5 stated the Director of Nursing (DON) informed him that administering the plain multivitamin instead of the multivitamin with mineral was an error. LVN #5 stated there was a difference between multivitamin and multivitamin with minerals and that there were so many multivitamins that he was not sure what to administer.</p> <p>During an interview on 07/25/2024 at 11:14 AM, the DON stated she expected nurses to review the order and make sure to follow the medication rights. The DON stated she expected for staff to review the order and confirm on the bottle what was to be administered to Resident #23 and Resident #82. The DON stated she expected staff to observe the medication bottle for specifically what the physician ordered because there were different doses of so many medications.</p> <p>During an interview on 07/25/2024 at 11:43 AM, the Administrator stated he expected staff to understand and follow orders for the medication that were prescribed. The Administrator stated he expected for the physician orders to be followed.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>31524</p> <p>Based on interview, record review, and facility policy review, the facility failed to follow a physician's order to hold carvedilol (a medication used to treat high blood pressure and heart failure) when a resident's systolic blood pressure (SBP, the top number in a blood pressure [BP] reading) was below 130 millimeters of mercury (mmHg) and to not administer midodrine (a medication used to treat low blood pressure) when the SBP was above 120 mmHg for 1 (Resident #21) of 5 sampled residents reviewed for unnecessary medications.</p> <p>Findings included:</p> <p>A facility policy titled, Medication Administration (General), dated 08/18/2022, indicated, Policy To be able to safely administer in a timely manner, and as prescribed, in accordance to nursing scope and practices. The policy indicated, 4. Medication shall be administered in accordance with the orders, including any required time frame.</p> <p>An Admission Record revealed the facility admitted Resident #21 on 03/03/2024. According to the Admission Record, the resident had a medical history that included diagnoses of end stage renal disease, hypertensive heart, and chronic kidney disease with heart failure and with stage five chronic kidney disease.</p> <p>An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/10/2024, revealed Resident #21 had a Brief Interview for Mental Status (BIMS) score of 8, which indicated the resident had moderate cognitive impairment.</p> <p>Resident #21's care plan included a focus area initiated revised on 03/04/2023, that indicated the resident was at risk for falls and injury related to multiple medical diagnoses. Interventions directed staff to administer prescribed medication as ordered and to observe for possible adverse reactions.</p> <p>Resident #21's Order Summary Report contained an order dated 11/07/2023 for carvedilol oral tablet 3.125 milligrams (mg), give one tablet by mouth in the evening for hypertension (high blood pressure), hold if SBP below 130 mmHg. There was also an order dated 10/16/2023, for midodrine hydrochloride (HCL) oral tablet 10 mg, give one tablet by mouth one time a day on every Tuesday, Thursday, and Saturday for hypotension (low blood pressure) one hour prior to dialysis, give for SBP less than 120 mmHg.</p> <p>Resident #21's Medication Administration Record [MAR] for the timeframe 06/01/2024 to 06/30/2024, revealed evidence to indicate staff administered carvedilol oral tablet 3.125 mg to the resident when the resident's SBP was less than 130 mmHg on 06/11/2024, 06/15/2024, 06/16/2024, 06/24/2024, 06/29/2024, and 06/30/2024. The MAR revealed evidence to indicate staff administered midodrine HCL oral tablet 10 mg to the resident when the resident's SBP was greater than 120 mmHg on 06/06/2024 and 06/29/2024.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #21's MAR for the timeframe 07/01/2024 to 07/31/2024, revealed evidence to indicate staff administered carvedilol oral tablet 3.125 mg to the resident when the resident's SBP was less than 130 mmHg on 07/03/2024, 07/04/2024, 07/05/2024, and 07/13/2024. The MAR revealed evidence to indicate staff administered midodrine HCL oral tablet 10 mg to the resident when the resident's SBP was greater than 120 mmHg on 07/04/2024 and 07/16/2024.</p> <p>During an interview on 07/24/2024 at 12:44 PM, the Nurse Practitioner (NP) stated the purpose of including parameters in the physician's order for BP medications was just another measure of safety to prevent an adverse reaction such as hypotension or bradycardia (slow heart rate). Per the NP, staff should only administer medications that affected a resident's BP when their BP was within the listed parameters, and she expected staff to follow the physician's order when administering medications.</p> <p>During an interview on 07/24/2024 at 3:13 PM, Licensed Vocational Nurse (LVN) #3 stated that when administering medications, he referred to the physician's order for guidance. Per LVN #3, if there was a parameter included in the order, he obtained the resident's BP and compared it to the listed parameters. LVN #3 further stated that when he administered Resident #21's medication when their BP was outside of the parameters, he mistook it as being correct because parameters typically listed for carvedilol was to hold it when the SBP was below 100 mmHg, not 130 mmHg.</p> <p>During an interview on 07/24/2024 at 3:23 PM, LVN #4 stated she read the complete order, including any parameters listed when administering medications. LVN #4 stated if a resident's BP was outside the listed parameters, she held the medication but made a mistake when she administered medications to Resident #21 when the resident's BP was outside the specified parameters.</p> <p>During an interview on 07/25/2024 at 11:13 AM, the Director of Nursing (DON) stated she expected the nurses to review a medication order prior to administration. The DON stated when there were directions to hold or give a medication depending on a resident's BP, those parameters should be followed.</p> <p>During an interview on 07/25/2024 at 11:43 AM, the Administrator stated he expected the nurses to follow medication orders as prescribed and to follow any listed parameters on whether to administer a medication.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>37935</p> <p>Based on observation, interview, record review, and facility policy review, the facility failed to ensure enhance barrier precautions (EBP) were implemented for 1 (Resident #196) of 18 sampled residents.</p> <p>Findings included:</p> <p>A facility policy titled, Enhanced Barrier Precaution, dated 04/05/2024, indicated, 4. Facility staff shall perform hand hygiene and will don [put on] gown and gloves before performing the following high-contact resident care activities: * Dressing.</p> <p>An Admission Record indicated the facility admitted Resident #196 on 07/17/2024. According to the Admission Record, the resident had a medical history that included diagnoses of encounter for fitting and adjustment of other gastrointestinal appliance and device, gastrostomy status, and dysphagia.</p> <p>Resident #196's Order Summary Report indicated an order dated 07/18/2024, for enhanced standard precautions related to gastrostomy tube every shift.</p> <p>Resident #196's care plan, included a focus area initiated on 07/18/2024, that indicated the resident was at risk for aspiration and required a feeding tube.</p> <p>During an observation on 07/22/2024 at 10:55 AM, Certified Nursing Assistant (CNA) #2 put on a pair of gloves and a mask and entered Resident #196's room to provide care to the resident. There was a sign posted that gave instructions to the staff on how to properly put on personal protective equipment (PPE) and what PPE should be worn during the provision of care.</p> <p>During an interview on 07/22/2024 at 11:09 AM, CNA #2 stated she worked at the facility for a year and a half and had received training on infection control, to include enhanced barrier precautions (EBP). CNA #2 stated she was supposed to wear a gown, gloves, and a mask when she provided care to a resident on EBP. CNA #2 stated Resident #196 had a gastrostomy tube and staff should follow EBP when care was provided to the resident. CNA #2 acknowledged she changed the resident's clothing and washed the resident's face. Per CNA #2 she should have worn a gown when she provided care to the resident, but she did not. provided care to Resident #196.</p> <p>During an interview on 07/25/2024 at 11:18 AM, the Director of Nursing (DON) stated there was a large in-service for all staff on EBP, to include donning (put on) and doffing (take off) and what the proper PPE was for residents on EBP. The DON stated there was signage outside the resident's room that notified staff of who was on EBP and what to PPE to wear. The DON stated staff should wear masks, gown, and gloves when they provide care to the residents on EBP. The DON stated she expected all staff to follow the proper PPE requirements in rooms that had residents on EBP.</p> <p>During an interview on 07/25/2024 at 11:45 AM, the Administrator stated he expected staff to recall and follow the in-services they had been taught as well as follow the instructions on the signage posted outside the residents' rooms who were on EBP.</p>		