STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555535	A. Building B. Wing	01/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Valley Care Center	9000 Larkin Road Live Oak, CA 95953

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46147 Based on interview, and record review, the facility failed to treat one out of three sampled residents (Resident 1) with dignity and respect when direct care staff made Resident 1 wear an incontinent brief and would not take Resident 1 to the bathroom for toileting. This failure had the potential to result in emotional stress, anger, embarrassment, feelings of neglect, and the potential for negative clinical outcomes. Findings: During a review of the facility's policy revised 2/2021, titled, Dignity, indicated each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and esteem. This policy also indicated residents are treated with respect and dignity at all times. The facility culture supports dignity and respect for residents by honoring resident goals, choices, preferences, values, and beliefs. This process starts with the initial admission and continues throughout the resident's facility stay. Individual needs and preferences of the resident are identified through the assessment process. During a review of the facility's policy revised 2/2021, titled, Resident Rights, indicated employees shall treat all residents with kindness, respect and dignity, This policy also indicated all residents will be supported by the facility in exercising rights, and will be informed of, and participate in his or her care planning and treatment. During a review of Resident 1's medical record, the Admission Record, indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included fracture of neck of right femur (hip fracture), unspecified fall, Parkinson's disease, (a progressive nervous system disease that affects movements, coordination, and can cause involuntary movements such as shaking, and stiffness), depression (a constant feeling of sadness and loss of interest), and history of right breast cancer, and acquired absence (surgical removal) of the right breast). A review of the most recent Minimum Data Set, (MDS, a resident assessment tool) dated 12/25/24, indicated that Resident 1 had a Brief Interview for Mental Status, (BIMS) score of 15 out of 15 and was cognitively intact (able to think and reason). This MDS also indicated Resident 1 required substantial/maximum assistance with toileting, lower body dressing, all transfers, and assistance with all positioning from lying down position to sitting up. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 1/2/24 at 12:06 pm, the Social Worker (SW) confirmed Resident 1 had a discharge order for Weight Bearing as tolerated (WBAT) on the right leg. SW stated, I always keep a copy of the referral for myself, the nursing staff should see the weight bearing status as well. During an interview on 1/2/25 at 3:00 pm, Certified Nursing Assistant (CNA) B confirmed Resident 1 was alert and oriented and was continent of bowel and bladder. CNA B stated, [Resident 1] was upset due to staff not getting her out of bed (OOB) to toilet and the staff did make her wear an incontinent brief for seven days. During an interview on 1/2/24 at 3:30 pm, Resident 1 stated, The staff refused to take me to the bathroom, and they made me wear a diaper and use the bedpan. I was so frustrated and upset. Now, I am angry that I could not get up to the bathroom for days. During an interview on 1/2/25 at 4:30 pm, Licensed Nurse (LN) 2 confirmed Resident 1 did not get OOB for seven days to use the bathroom, and Resident 1 was continent of bowel and bladder. LN 2 stated, We missed this on the admission, and it was not added to the care plan. We now have a note on her white board in her room that states no briefs, and we get Resident 1 up for toileting. We should never wait on therapy when the discharge orders stated OOB as tolerated, WBAT to the Right Lower Extremity. I confirm the nursing staff should have reviewed the discharge orders and we will educate the staff moving forward. I confirm this was a dignity issue.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46147 Based on observation, interview, and record review, the facility failed to ensure a complete comprehensive care plan was developed for one of two sampled residents (Resident 1) to reflect current individual needs upon admission when: 1-Resident 1 did not have restrictions listed for staff to not use Right arm for blood pressures or any procedures for Resident 1's Right arm due to a previous mastectomy (a surgical operation to remove a breast). 2-Resident 1 did not have weight bearing restrictions listed on the care plan after a Right hip surgery. 3-Resident 1 had no interventions to monitor surgical incision site to right leg with 13 staples every shift for signs and symptoms of infection. This failure resulted in Resident 1's individual care needs to go unrecognized, and the potential for a further decline in Resident 1's physical, mental, and psychological status. Findings: 1. During a review of the facility's policy revised 3/2022, titled, Care Plans, Comprehensive Person-Centered, indicated 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 care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. This policy also indicated care plans are ongoing and care plans are revised as information about the residents and the residents' condition changes. During a review of Resident 1's medical record, the Admission Record, indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included fracture of neck of right femur (hip fracture), unspecified fall, Parkinson's disease, (a progressive nervous system disease that affects movements, coordination, and can cause involuntary movements such as shaking, and stiffness), depression (a constant feeling of sadness and loss of interest), and history of right breast cancer, and acquired absence (surgical removal) of the right breast). A review of the most recent Minimum Data Set, (MDS, a resident assessment tool) dated 12/25/24, indicated that Resident 1 had a Brief Interview for Mental Status, (BIMS) score of 15 out of 15 and was cognitively intact (able to think and reason). This MDS also indicated Resident 1 required substantial/maximum assistance with toileting, lower body dressing, all transfers, and assistance with all positioning from lying down position to sitting up. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 1/2/25 at 3:30 pm, Resident 1 was wearing a pink right wrist bracelet applied by a local hospital that stated, limb restriction alert . Resident 1 stated, Look at my band from the hospital, they don't even know what this means around here. I have to tell the everyone they cannot use my right arm for blood pressures or anything. I have had this restriction since 1991 from my mastectomy. During an interview on 1/2/25 at 4:30 pm, Licensed Nurse (LN) 2 confirmed the care plan for Resident 1 did not include any restrictions for the use of the right arm. 2. During a concurrent interview and record review on 1/2/24 at 12:06 pm, the Social Worker (SW) confirmed Resident 1 had a discharge order for Weight Bearing as tolerated (WBAT) on the right leg. SW stated, I always keep a copy of the referral for myself, the nursing staff should see the weight bearing status as well. During an interview on 1/2/25 at 4:40 pm, LN 2 confirmed the care plan did not include a WBAT status for Resident 1's right leg for nursing to follow to get out of bed and toilet as needed. 3. During an observation on 1/2/25 at 3:50 pm, Resident 1 had a three separate surgical incision sites with a total of 13 staples in the upper right leg. During an interview on 1/2/25 at 4:45 pm, LN 2 confirmed the care plan developed for Resident 1 did not include specific instructions to monitor the surgical incision sites for signs and symptoms of infection, and no treatment directions or scheduled staple removal.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46147 Based on interview, and record review, the facility nursing staff failed to get one of two sampled residents (Resident 1) out of bed (OOB) following a hip surgery and per Resident 1's right to get OOB per request for seven consecutive days. This failure had the potential to result in emotional stress, anger, embarrassment, feelings of neglect, and the potential for negative clinical outcomes related to surgical complications of immobility for seven days. Findings: During a review of the facility's policy revised 2/2021, titled, Dignity, indicated each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and esteem. This policy also indicated residents are treated with respect and dignity at all times. The facility culture supports dignity and respect for residents by honoring resident goals, choices, preferences, values, and beliefs. This process starts with the initial admission and continues throughout the resident's facility stay. Individual needs and preferences of the resident are identified through the assessment process. This facility's policy indicated these resident rights include .to be supported by the facility to exercise his or her rights, exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility, to be notified of his or her medical condition and any changes of his or her condition, and be informed and participate in, his or her care planning and treatment. During a review of the facility's policy revised 2/2021, titled, Resident Rights, indicated employees shall treat all residents with kindness, respect and dignity, This policy also indicated all residents will be supported by the facility in exercising rights, and will be informed of, and participate in his or her care planning and treatment. During a review of Resident 1's medical record, the Admission Record, indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included fracture of neck of right femur (hip fracture), unspecified fall, Parkinson's disease, (a progressive nervous system disease that affects movements, coordination, and can cause involuntary movements such as shaking, and stiffness), depression (a constant feeling of sadness and loss of interest), and history of right breast cancer, and acquired absence (surgical removal) of the right breast). A review of the most recent Minimum Data Set, (MDS, a resident assessment tool) dated 12/25/24, indicated that Resident 1 had a Brief Interview for Mental Status, (BIMS) score of 15 out of 15 and was cognitively intact (able to think and reason). This MDS also indicated Resident 1 required substantial/maximum assistance with toileting, lower body dressing, all transfers, and assistance with all positioning from lying down position to sitting up. A review of Resident 1's medical record, a document dated 1/2/25, titled, Active Orders, indicated Resident 1 had an order date of 12/19/24 that indicated, Resident 1 may go out on pass with responsible party. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1's medical record, a document dated 1/2/25, titled, Active Orders, indicated Resident 1 had an order date of 12/19/24 that indicated, Resident 1does have the capacity to make her own decisions. A review of Resident 1's medical record, a document dated 1/2/25, titled, Active Orders, indicated Resident 1 had an order date of 12/19/24 that indicated, Resident 1may participate in activities not in conflict with treatment plan. A review of Resident 1's medical record, a document dated 12/19/24 at 8:27 am, titled, Orthopedic Progress Note, from a local hospital indicated Resident 1 had a surgical procedure on 12/17/24 at 13:09, Femur IM Rodding Antegrade, Right (surgical repair of right thigh bone that connects to the pelvis at the hip joint). Assessment/Plan: Weight bearing as tolerated (WBAT). A review of Resident 1's medical record, a document dated 12/19/24 at 10:34, titled, Discharge Summary, from a local hospital indicated resident 1's Activity: Activity as tolerated . A review of Resident 1's medical record a document dated 12/31/24, titled, Nurse Practitioner Note, indicated Resident 1 was seen today for initial follow up and resting in bed, no distress noted, no shortness of breath noted. Denies pain or discomfort, no health concerns at this time. Vitals stable, weight stable, working with therapy, walks five feet with front wheeled walker .Will continue to monitor. No restrictions were given to Resident 1 to not get OOB by the NP note. During a concurrent interview and record review on 1/2/24 at 12:06 pm, the Social Worker (SW) confirmed Resident 1 had a discharge order for WBAT on the right leg. SW stated, I always keep a copy of the referral for myself, the nursing staff should see the weight bearing status as well. During an interview on 1/2/25 at 4:30 pm, Licensed Nurse (LN) 2 confirmed Resident 1 did not get OOB for seven days to use the bathroom or go to the dining room for meals. LN 2 stated, We missed this on the admission, and it was not added to the care plan. We should never wait on therapy when the discharge orders stated OOB as tolerated. I confirm the nursing staff should have got Resident 1 OOB after her hip surgery to avoid further complications.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46147 Based on interview, and record review, the facility nursing staff failed to complete and accurately document medical records for one of three sampled residents (Resident 1) for activities of daily living (ADLs, basic tasks completed every day that include personal hygiene or grooming, bathing, dressing, toileting, transferring or ambulating, and eating). This failure of incomplete documentation had the potential for resident needs to not be identified or met which could have a negative clinical outcome. Findings: During a review of the facility's policy revised 7/2017, titled, Charting and Documentation, indicated all services provided to the resident, progress towards care plan goals, or changes in the residents' medical, physical, functional, or psychosocial condition shall be documented in the residents' medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. During a review of the facility's policy revised 3/2018, titled, Activities of daily Living, (ADL), Supporting, indicated all residents will be provided care, treatment, and services as appropriate to maintain or improve their ability to carry out Adls. The residents will be provided with appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with hygiene (bathing, dressing, grooming, and mouth care), mobility (transfer or walking), toileting, eating meals and snacks, and communication. This policy also indicated care and services to prevent and/or minimize functional decline will include pain management and treatment for depression. During a review of Resident 1's medical record, the Admission Record, indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included fracture of neck of right femur (hip fracture), unspecified fall, Parkinson's disease, (a progressive nervous system disease that affects movements, coordination, and can cause involuntary movements such as shaking, and stiffness), depression (a constant feeling of sadness and loss of interest), and history of right breast cancer, and acquired absence (surgical removal) of the right breast). A review of the most recent Minimum Data Set, (MDS, a resident assessment tool) dated 12/25/24, indicated that Resident 1 had a Brief Interview for Mental Status, (BIMS) score of 15 out of 15 and was cognitively intact (able to think and reason). This MDS also indicated Resident 1 required substantial/maximum assistance with toileting, lower body dressing, all transfers, and assistance with all positioning from lying down position to sitting up. A review of Resident 1's medical record dated 12/19/2024 to 12/31/24, titled, Documentation Survey Report v2, indicated there no was no documentation for the days of 12/24/24, 12/25/24, 12/26/24 and 12/31/24 for bathing, bed mobility, bladder incontinence, bowel incontinence, dressing, fluid intake, transfers, positioning, walking, wheelchair mobility, and hygiene. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1's medical record dated 12/19/2024 to 12/31/24, titled, Documentation Survey Report v2, indicated there no was no documentation for the days of 12/23/24, 12/24/24, 12/25/24, 12/29/24 and 12/31/24 for the amount of food eaten by Resident 1. ,A review of Resident 1's medical record dated 12/19/2024 to 12/31/24, titled, Documentation Survey Report v2, indicated there no was no documentation for the days of 12/24/24, 12/25/24, and 12/31/24 for vital signs for the morning shift. During an interview on 1/2/25 at 4:45 pm, Licensed Nurse (LN) 2 confirmed there was missing documentation for Resident 1. LN 2 stated, I don't know why there are blanks, we will do an inservice to make sure all the documentation is completed and accurate. During an interview on 1/2/25 at 4:55 pm, the administrator confirmed incomplete and blank documentation for the ADL sheets for Resident 1.