

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555535	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2025
NAME OF PROVIDER OR SUPPLIER River Valley Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43739</p> <p>Based on observation, interview, and record review, the facility failed to ensure the safety measures were provided to prevent accident hazards for three of five residents sampled for accidents (Resident 1, 4, 8) when the wheels attached to the headboard of the bed were not locked.</p> <p>This failure had the potential to negatively affect the residents' well-being and increased the risk of accidents or injuries to the residents.</p> <p>Findings:</p> <p>During a review of U.S. Food & Drug (FDA) document titled, A Guide to Bed Safety Bed Rails in Hospitals, Nursing Homes and Home Health Care: The Facts , revised 4/2010 , indicated that to meet the patients' needs for safety, keep the bed in the lowest positions with wheels locked was one of the recommended practices.</p> <p>During a review of the American Parkinson Disease Association (APDA) website document titled, Impaired Balance and Falls in people with Parkinson's Disease , dated 6/8/21 , indicated, One of the most challenging symptoms of Parkinson's disease (PD) that fundamentally affects quality of life is balance impairment that can lead to falls.</p> <p>During a review of Resident 1's clinical record, indicated that Resident 1 was admitted to the facility on [DATE] with diagnoses which included right hip fracture, fall, and Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements) without dyskinesia (uncontrolled, involuntary muscle movement). Resident 1 was her own healthcare decision maker.</p> <p>During a review of Resident 1's Minimum Data Set (MDS - an assessment and care screening tool), dated 12/25/24, the MDS indicated that Resident 1 had a brief interview for mental status (BIMS) score of 15, at section C Cognitive Patterns indicating that her cognition was intact.</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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 1's MDS, dated [DATE], at the section GG (refers to a section on the MDS assessment form used in nursing homes, which stands for Functional Abilities and Goals; it specifically assesses a patient's ability to perform self-care tasks and mobility activities, including their admission performance, discharge goals, and how much assistance they require for these functions) - Functional Abilities - Admission, Self-Care and Mobility (Assessment period is the first 3 days of the stay), indicated that Resident 1 needed maximal assistance (helper does more than half the effort) for:</p> <ol style="list-style-type: none"> 1. Toileting hygiene: the ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. 2. Lower body dressing: the ability to dress and undress below the waist. 3. Sit to lying: the ability to move from sitting on side of bed to lying flat on the bed. 4. Lying to sitting on side of bed: the ability to move from lying on the back to sitting on the side of the bed and with no back support. 5. Sit to stand: the ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed. 6. Chair/bed-to-chair transfer: the ability to transfer to and from a bed to a chair (or wheelchair). 7. Toilet transfer: the ability to get on and off a toilet or commode. <p>During a review of Resident 1's Fall care plan, dated 12/19/24, indicated, Resident is at risk for falls with or without injury related to history of falls resulting in fracture/major injury, current mobility limitations related to recent hip fracture repair.</p> <p>During a review of Resident 4's clinical record, indicated that Resident 4 was admitted to the facility on [DATE] with diagnoses which included diabetes (high blood sugar), unspecified sequelae of cerebral infarction (known as the long-term effects of a stroke, can include: difficulty speaking, weakness or paralysis on one side of the body .), and muscle weakness. Resident 4 was her own healthcare decision maker.</p> <p>During a review of Resident 4's MDS, dated [DATE], the MDS indicated that Resident 4 had a BIMS score of 15, at section C Cognitive Patterns indicating that her cognition was intact.</p> <p>During a review of Resident 4's MDS, dated [DATE], at the section GG - Functional Abilities - Admission, Self-Care and Mobility (Assessment period is the first 3 days of the stay), indicated that Resident 4 needed moderate assistance (helper does more than half the effort) for: Toileting hygiene, Shower/bath, Lower body dressing, Sit to stand, Chair/bed-to-chair transfer, and Toilet transfer.</p> <p>During a review of Resident 8's clinical record, indicated that Resident 8 was admitted to the facility on [DATE] with diagnoses which included unspecified sequelae of cerebral infarction, abnormalities of gait and mobility, and dementia (a progressive state of decline in mental abilities). Resident 8 was his own healthcare decision maker.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 8's MDS, dated [DATE], the MDS indicated that Resident 8 had a BIMS score of 14, at section C Cognitive Patterns indicating that her cognition was intact.</p> <p>During a review of Resident 8's MDS, dated [DATE], at the section GG - Functional Abilities - Admission, Self-Care and Mobility (Assessment period is the first 3 days of the stay), indicated that Resident 8 needed moderate assistance (helper does more than half the effort) for: Toileting hygiene, Shower/bath, Lower body dressing, Sit to stand, Chair/bed-to-chair transfer, and Toilet transfer.</p> <p>During a concurrent observation and interview on 1/23/25, at 11:09 am, in Resident 1's room, Resident 1 stated she needed to go to the bathroom. She then pressed the call light, and the Assistant of Director of Nursing (ADON) entered the room within a minute and asked Resident 1 what Resident 1 needed. While Resident 1 told the ADON that she needed to go to the bathroom, the ADON told Resident 1 that she needed to find another staff to help her to transfer Resident 1 to the wheelchair. Resident 1 stated, No, I need to go now!! and insisted the ADON to stay with her. Resident 1 then attempted to sit up in the bed and tried to get out of the bed. While the ADON attempted to explain to Resident 1 the importance of the safe transfer, License Nurse (LN) A walked by Resident 1's room, LN A was asked to come into the room to assist the ADON. The ADON and LN A were observed positioning themselves on either side of Resident 1, while they were holding Resident 1's upper arms, and assisting Resident 1 to stand up from the side of the bed, the bed moved away from Resident 1. The ADON and LN A were then observed attempting to sit Resident 1 back down to the bed, Resident 1 was screaming and saying, No! No! I need to go now !! . Resident 1 was then assisted to sit down on the wheelchair and brought to the bathroom. The ADON later confirmed that Resident 1 had an accident (Resident 1 soiled herself) and she had to help Resident 1 to clean up.</p> <p>Inspection of Resident 1's bed with the Director of the Maintenance (DOM), the DOM confirmed that the bed wheels at the headboard were not locked. The DOM stated, It's not my job to check each bed and to make sure the wheels were locked. The ADON stated, CNAs should have checked the wheels were locked It usually happened while the CNAs were providing shower to the resident, they had to move the bed to use the lifter, and perhaps forgot to lock the wheels The ADON agreed that Resident 1 could have fallen if the staff were not with her.</p> <p>During a concurrent observation and interview on 1/23/25 at 11:19 am, with the DOM, in ROOM D, observed the DOM pushed the bed that near the entrance door (bed A), and the bed was moved. The DOM confirmed that the wheels at the headboard of the bed were not locked.</p> <p>During a concurrent observation and interview on 1/23/25 at 11:30 am, in ROOM E, with the ADON, observed the ADON pushed the bed that near the entrance door (bed A), and the bed was locked, the bed did not move. The ADON stated, I expected the bed wheels to be locked at all times. CNAs should ensure all the wheels were locked while providing care to the residents.</p> <p>During a concurrent observation and interview on 1/23/25 at 11:40 am, in Resident 8's room, observed Resident 8 was lying in bed, and the ADON confirmed the wheels at the headboard of the bed were not locked. Observed the ADON pushed the bed, and the bed was moved. Resident 8 stated, Wow, I did not know it wasn't locked.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent observation and interview on 1/23/25 at 11:43 am, in Resident 4's room, observed the Occupational Therapy (OT) transferring the roommate from standing to sitting position from the bed. Observed Resident 4 was lying in the bed, while inspected Resident 4's bed, the wheels at the headboard of the bed were not locked and the bed was moved. Resident 4 stated, Oh, I did not know it was not locked. The OT stated, It happened to me couple times. The bed was moved while I was trying to get the residents out of the bed. I was by myself, so I had to sit the residents back down, lock the wheels, and get the residents up again The residents could have a fall if the bed was not locked!</p> <p>During an interview on 1/23/25, at 2:07 pm with DON, in DON's office. The DON stated, I could not find a policy for bed safety; however, the staff need to ensure the wheel brakes were locked. It should be CNAs' job to make sure it's locked. If it's malfunction, it would be the maintenance's job.</p>		