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	11/06/2025

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to use a resident-specific pain assessment for one resident (Resident 1) when it inaccurately assessed Resident 1's pain levels.This failure had the potential to cause Resident 1 increased pain due to improperly assessed pain levels and psychosocial harm.During a record review of facility policy titled Pain Assessment and Management dated October 2022, indicated staff were to monitor for the effectiveness of interventions. Policy also indicated cognitive, cultural, familial, or gender-specific influences on the resident's ability or willingness to verbalize pain are considered when assessing or treating pain. Policy further indicated staff were to assess pain using a consistent approach and a standardized pain assessment instrument appropriate to the resident's cognitive level.During a record review of Resident 1's admission record, she was admitted to the facility on [DATE] with diagnoses that included bipolar disorder (mental illness characterized by extreme mood swings, including emotional highs and lows), dementia (a condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking), and abnormalities of gait and mobility (any deviation from a typical walking pattern, characterized by symptoms like limping, shuffling, or an unsteady gait, often caused by neurological, musculoskeletal, or other medical conditions).During a record review of Resident 1's physician orders dated 10/30/25, indicated give Tramadol 50 milligrams (mg) (a pain medication used to treat moderate to severe pain in adults) every six hours as needed for moderate to severe pain. During a record review of Resident 1's care plan dated 12/15/22, indicated staff were to monitor and report any signs or symptoms of non-verbal pain such as changes in breathing, yelling out or silence, changes in mood such as restlessness, irritability, aggressive, eyes wide open, narrow, glazed, tearing, or no focus, face sad, worried, clenched teeth, body tense, rigid, curled up, or tense.During a record review of Resident 1's Medication Administration Record (MAR - a legal document used by healthcare professionals to record and track all medications administered to a patient) dated October 2025 and November 2025, indicated the facility assessed Resident 1's pain levels and used only the 0-10 numerical pain scale (a scale, typically from 0 to 10, where 0 is no pain and 10 is the worst imaginable pain).During an interview on 11/6/25 at 10:50 am with Licensed Vocational Nurse (LN) B, LN B stated Resident 1's pain was assessed by looking at her face. LN B stated if Resident 1 grimaced or said ow when staff touched her, she was administered Tramadol 50 mg every six hours. LN B could not confirm if she reassessed Resident 1 for pain medication effectiveness. LN B confirmed it was facility policy and best practice to reassess a resident for pain medication effectiveness after a pain medication was administered. LN B confirmed she documented Resident 1's pain levels using the numerical pain scale of 0-10 even if Resident 1 was unable to verbalize a number. LN B stated she assigned a number to the facial expression Resident 1 made. LN B confirmed this was not best practice. LN B confirmed Resident 1's pain assessments were difficult because sometimes she talks, sometimes she doesn't.During an interview on 11/6/25 at 10:53 am with Director of Staff Development (DSD), DSD confirmed Resident 1 was unable to consistently verbalize her pain level on a 0-10 numerical scale. DSD stated she expected staff to write descriptive words on Resident 1's MAR as well as utilize different pain assessment methods if Resident 1 was unable to verbalize her pain level on a 0-10 numerical scale. DSD stated facility expectation and policy was for staff to reassess a resident's pain after a pain medication was administered.During a concurrent observation and interview on 11/6/25 at 10:56 am with DSD and Director of Nursing (DON), DON stated Resident 1 stated ow whenever staff touched her body. DON stated, this is just a behavior. DON stated Resident 1 was assessed for pain by looking at her face. DON stated facility expectation for staff was to write descriptive words on the MAR if a pain medication was administered. DON stated the 0-10 numerical pain assessment scale would be inappropriate to use if a resident could not verbalize their pain with a number. During an interview on 11/6/25 at 11:44 am with Medical Director (MD), MD stated she assessed Resident 1's pain by facial expressions because Resident 1 was unable to consistently verbalize her pain level on a 0-10 numerical scale. MD stated she expected staff to assess any resident's pain with one of three pain assessment methods (0-10 numerical scale, FACES (uses pictures of faces to represent different levels of pain) or Wong-Baker (a self-assessment tool that uses a series of six cartoon-like faces to help individuals communicate their pain level.)) MD confirmed that Resident 1 was sometimes able to verbalize her pain on a 0-10 numerical scale, and sometimes unable. MD confirmed facility staff inappropriately assessed Resident 1's pain levels During an interview on 11/6/25 at