STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555658	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Walk Care Center	1100 West Morton Avenue Porterville, CA 93257

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 38993 Based on interview, and record review, the facility failed to ensure physician orders were followed for one of three sampled residents (Resident 1) when treatments were not done as ordered. This failure had the potential for Resident 1's wounds to worsen. Findings: During a review of Resident 1's Treatment Administration Record (TAR) dated 9/2024, the TAR indicated, Cleanse right side of abdomen with wound cleanser pat dry and leave open to air one time a day for abrasion start date 9/13/24.cleanse with Dakin's (antiseptic solution), pat dry, apply dakins soaked gauze and cover with abd (abdominal) pad, and enforce with tape one time a day for abd post surgical old scar tissue open area start date 9/10/24.L (left) heel diabetic blister cleanse with wound cleanser, pat dry and swab with betadine.one time a day start date 9/13/24.R (right) heel diabetic blister.cleanse with wound cleanser, pat dry and swab with betadine one time a day start date 9/13/24.sacrum shearing.cleanse with wound cleanser pat dry and apply calmoseptine (medication) one time a day for shearing start date 9/13/24. R heel diabetic blister.keep elevated to prevent pressure every shift start date 9/13/24.Enhanced barrier precautions every shift for wound start date 8/30/24.Keep L heel elevated to prevent pressure every shift start date 9/6/24.Keep R heel elevated to prevent pressure start date 9/13/24.L heel diabetic blister.monitor for s/s of infection or worsening every shift start date 9/6/24.Monitor Abd post-surgical old scar tissue open area.every shift for s/sx) signs and symptoms) infection or worsening start date 8/30/24.Monitor discoloration to BUE (bilateral upper extremity) every shift for s/sx infection or worsening start date 8/30/24. Monitor R heel diabetic blister.for s/s of infection or worsening every shift start date 9/13/24.Monitor right abdomen for s/s of infection every shift for observation start date 9/12/24. The TAR indicated R heel blister. keep elevated to prevent pressure every shift start date 9/6/24.L heel diabetic blister.monitor for s/s (signs and symptoms) of infection or worsening start date 9/13/24. Monitor R heel blister.for s/s of infection or worsening every shift start date 9/6/24. Monitor sacrum for s/s of infection every shift for observation start date 9/12/24. The TAR contained blanks on 9/12/24 and 9/14/24 (indicating the treatment was not done). (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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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's TAR dated 1/2025, the TAR indicated, left lower abd auto immune wound . cleanse with wound cleanse pat dry and swab with betadine one time a day.cleanse left lateral leg with wound cleanser apply medihoney (medication) then cover with dry dressing change daily one time a day for re-opening of old scar tissue.air mattress with halos on low pressure mode @ (at) 0210 lbs. (pounds) every shift.Abd fold MASD (moisture associated skin damage) cleanse with wound cleaner, pat dry, and apply antifungal cream every shift.bariatric air mattress with 1/2 upper rails bilat (bilateral) with setting of alternating mode with cycle time of 20 minutes and pt weight of <250 every shift.Bariatric bed with air mattress on alternate mode, level 5 @ 20 min for wound healing every shift.F/C care every shift.IAD to peri area cleans with wound cleanser, pat dry and apply calmoseptine .L lat (lateral) leg discoloration monitor for s/s of infection or worsening every shift.monitor abd fold MASD for s/s of infection or worsening every shift.monitor BUE (bilateral upper extremity) discoloration or worsening.monitor L Abd full thickness.for s/s of infection or worsening every shift.monitor L arm scab.for s/s of infection or worsening.monitor left lower abd auto immune wound.monitor for s/s of infection or worsening.monitor R abd full thickness trauma.for s/s of infection or worsening every shift.monitor right ankle scab.for s/s of infection or worsening every shift.monitor R lower leg venous ulcer.for s/s of infection or worsening every shift.monitor unstageable to sacrum.for s/s of infection or worsening every shift.negative heel pressure at all times. The TAR contained blanks 1/1-1/2, 1/4-1/6, 1/8-1/10, and 1/13-1/31. During a review of Resident 1's TAR dated 2/25, the TAR indicated, Abd fold MASD cleanse with wound cleaner, pat dry and apply antifungal cream every shift.bariatric air mattress with 1/2 upper rails bilat (bilateral) with setting of alternating mode with cycle time of 20 minutes and pt weight of < 250 every shift.L lat leg discoloration monitor for s/s of infection or worsening every shift.monitor abd fold MASD for s/s of infection or worsening every shift.monitor BUE discoloration or worsening every shift.monitor L abd full thickness.for s/s of infection or worsening every shift.monitor R abd full thickness trauma.for s/s of infection or worsening every shift.monitor R ankle scab.for s/s of infection or worsening every shift.monitor R lower leg venous ulcer.for s/s of infection or worsening.monitor unstageable to sacrum.for s/s of infection or worsening. negative heel pressure at all times every shift.The TAR contained blanks on 2/1, 2/4-2/6, and 2/13-2/14. During a concurrent interview and record review on 3/26/24 at 11:38 a.m. with Director of Nursing (DON), DON reviewed the TAR's dated 9/24, 1/25 and 2/25. DON stated when the treatment was completed, the nurse should have documented it on the TAR and there was no way of knowing if the treatment was done. During a review of the facility's policy and procedure (P&P) titled Wound care dated 10/10, the P&P indicated, The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. The following information should be recorded in the resident's medical record.The type of wound care given. the date and time the wound care was given.the name and title of the individual performing the wound care. the signature and title of the person recording the data. During a review of the facility's policy and procedure titled Pressure Ulcers/Skin Breakdown - Clinical Protocol dated 4/18, the P&P indicated, In addition, the nurse shall describe and document/report the following.current treatments, including support surfaces.The physician will order pertinent wound treatments, including pressure reduction surfaces, wound cleansing and debridement approaches, dressings (occlusive, absorptive, etc.), and application of topical agents.

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F 0688 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38993 Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1) was provided: 1. A restorative nursing program (program where restorative nursing assistants [RNA]-assist residents with performing exercises to maintain their ability to perform daily activities and tasks, impacting their quality of life and overall well-being and independence) from February 2024-December 2024. 2. Physical therapy (PT-exercises, massages and various treatments used to relieve pain, help you move better or strengthen weakened muscles) and Occupational therapy (OT-focuses on everyday tasks and activities that people value and need to do, such as self-care, work, play, and social participation) as ordered by the physician in August 2024 and December 2024. These failures resulted in a decline in Resident 1's bed mobility (ability to move around in bed, including scooting, rolling, and moving from lying to sitting and back) which can lead to a decline in Resident 1's ability to participate in daily activities of living (ADL's) and the potential for developing pressure ulcers (damage to an area of the skin caused by constant pressure on the area for a long time). Findings: During a review of Resident 1's Admission Record (AR) dated 3/26/25, the AR indicated, Resident 1 was admitted to the facility on [DATE], with diagnoses including metabolic encephalopathy (condition where the brain does not receive enough nutrients or oxygen to function properly, leading to altered brain function). Type 2 diabetes mellitus without complications (condition in which the body has trouble controlling blood sugar and using it for energy).Personal history of transient ischemic attack (TIA-episode of nervous system (complex network of cells, tissues, and organs that controls and coordinates all bodily functions) dysfunction due to inadequate blood supply). During a review of Resident 1's Quarterly Minimum Data Set (MDS-resident assessment tool) dated 2/28/25, the MDS indicated, Brief Interview for Mental Status (BIMS-used to identify cognitive impairment) .08 (moderately impaired cognition-the ways people think, process information, and make judgments). 1. During a review of Resident 1's PT Discharge Summary (PDS) dated 2/27/24, the PDS indicated, Discharge Recommendations: discharge to restorative.Restorative Program Established/Trained = Restorative Bed Mobility Program.Prognosis (outcome of a disease) to Maintain CLOF (current level of function-how well a resident is currently able to perform everyday tasks and activities in their daily life) = good with consistent staff follow-through. During a review of Resident 1's Admission MDS dated [DATE], the MDS indicated, Restorative Nursing Programs.Number of days.0 (look back period 5/16/24-5/22/24) (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's Quarterly MDS dated [DATE], the MDS indicated, Restorative Nursing Programs.Number of days.0 (look back period 8/15/24-8/21/24) During a review of Resident 1's PT Evaluation & Plan of Treatment (PEPT) dated 10/17/24 (approximately eight months after RNA program was recommended on 2/27/24), the PEPT indicated, Current Referral.Pt (patient) presents to therapy with significant deficits in bed mobility and functional transfers (safe and effective movement from one surface or position to another), as well as increased risk for falls (to move downward, typically rapidly and freely without control, from a higher to a lower level), immobility and further deconditioning (decline that occurs due to prolonged inactivity or reduced physical activity). During an interview on 3/24/25 at 11:17 a.m. with Director of Rehabilitation (DOR-a healthcare leader who plans, administers, and directs the operation of the rehabilitation program), DOR stated Resident 1 received PT services from 2/8/24-2/26/24 and when Resident 1 was discharged from PT services, there was an RNA (Restorative Nursing Assistant) program recommended by the physical therapist. DOR stated the facility's practice was for the PT to provide the nursing department the RNA program recommendations, nursing department was to input the physician orders and schedule the RNA program. DOR stated the RNA program recommended on 2/27/24 for Resident 1 was a bed mobility program designed to keep Resident 1 active, avoid general decline (like bed mobility and transfers) and help to minimize, decrease or prevent pressure ulcers. During a concurrent interview and record review on 3/24/25 at 12:21 p.m. with Licensed Vocational Nurse (LVN) 1, Resident 1's clinical record was reviewed. LVN 1 stated when PT recommended Resident 1 for an RNA program on 2/27/24, it was the responsibility of the PT to enter the RNA program physician orders into the clinical record and it was her (LVN 1) responsibility to schedule the RNA program. LVN 1 was unable to provide documentation indicating the RNA program was provided to Resident 1 (2/27/24). LVN 1 stated there was no physician order for RNA program in the clinical record nor was there a record of the RNA program being provided. During a concurrent interview and record review on 3/25/25 at 3:24 p.m. with DOR, Resident 1's clinical record was reviewed. DOR was unable to locate the physician orders for the RNA program to be provided when Resident 1 was discharged from PT on 2/27/24. DOR stated the physician orders should have been entered in the clinical record by nursing and Resident 1 should have been provided the RNA program recommended on 2/27/24 to prevent/minimize resident from developing a pressure ulcer. During an interview on 3/26/25 at 12:14 p.m. with RNA, RNA stated she could not recall Resident 1 being provided an RNA program (2/27/24-12/2024). During a concurrent interview and record review on 4/1/25 at 3:55 p.m. with Director of Nursing (DON), Resident 1's clinical record was reviewed. DON was unable to provide documentation indicating RNA program was provided and there was no care plan (outlines specific healthcare needs, goals, and interventions for an individual resident) developed for RNA program. DON stated the RNA program was not provided when PT recommended it on 2/27/24. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled Restorative Nursing Services dated 7/2017, the P&P indicated, Restorative nursing care consists of nursing interventions that may or may not be accompanied by formalized rehabilitative (restore to a good condition or a useful and constructive activity) services.resident may be started on a restorative nursing program upon admission, during the course of stay or when discharged from rehabilitative services.restorative goals and objectives are individualized and are resident-centered, and outlined in the residents plan of care. 2. During a review of Resident 1's Order Summary Report (OSR-Physician's orders) dated 8/31/24, the OSR indicated, Occupational therapy evaluation and treatment as indicated.start date 8/29/24.Physical therapy evaluation and treatment as indicated.start date 8/29/24. During a review of Resident 1's OSR dated 12/31/24, the OSR indicated, Occupational therapy evaluation and treatment as indicated.order date 12/31/24.Physical therapy evaluation and treatment as indicated.order date 12/31/24. During a review of Resident 1's Quarterly MDS dated [DATE], the MDS indicated, .Functional Abilities and Goals.Functional Limitation in Range of Motion (ROM- extent and direction to which a joint can move).No impairment.roll left and right.02.sit to lying.03 (Partial/moderate assistance-helper does more than half the effort) .lying to sitting on side of bed.03. During a review of Resident 1's OT evaluation & Plan of Treatment (OTPT) dated 8/30/24, the OTPT indicated, Patient Goals: I wanted to get stronger as pt (patient) stated.Patient demonstrates good rehab (rehabilitation-restoring function) potential as evidence by ability to follow multi-step directions and motivated to participate. Focus on Plan of Treatment = Restoration.Reason for skilled services (specialized form of nursing) .patient presents with impairments in mobility and strength resulting in limitations and/or participation restrictions in the areas of self-care and general tasks and demands which requires skilled (treatment provided by licensed therapist) OT services to increase independence with ADLs (activities of daily living) and increase functional activity tolerance. During a review of Resident 1's Quarterly MDS dated [DATE] (three months after OT evaluation was completed and after the last MDS [8/21/24]), the MDS indicated, Functional Abilities and Goals .Functional Limitation in Range of Motion. 2 (impairment on both sides [a decline from MDS 8/21/24]) lower extremities (hip, knee, ankle, foot).roll left and right.01 (dependent -helper does all of the effort [a decline from MDS 8/21/24]).sit to lying.88 (not attempted due to medical condition or safety concerns).lying to sitting on side of bed.88. During a review of Resident 1's Significant change MDS dated [DATE] (three months after prior assessment 11/21/24), the MDS indicated, Functional Abilities and Goals.Functional Limitation in Range of Motion. 2 (impairment on both sides) lower extremities (hip, knee, ankle, foot).roll left and right.01 (dependent -helper does all of the effort).sit to lying.01.lying to sitting on side of bed.01. During a concurrent interview and record review on 3/25/25 at 3:24 p.m. with DOR, Resident 1's clinical record was reviewed. DOR stated Resident 1 had developed foot drop (condition where it is difficult or impossible to lift the front part of the foot, causing it to drag on the ground while walking, often due to nerve or muscle weakness) due to a TIA. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	During an interview on 3/26/25 at 11:38 a.m. with DON, DON stated she was made aware of Resident 1's decline during the investigation and stated physician orders were received on 8/29/24 and 12/31/24 for Resident 1 to be evaluated and treated by PT and OT to assess Resident 1 for a change in function and the need for therapy (PT/OT). DON stated Resident 1 did not receive a PT evaluation on 8/29/24 or 12/31/24 nor did she receive the PT and OT treatments that were ordered on 8/29/24 and 12/31/24. DON stated when Resident 1 was noted with a decline the nurses should have made her or therapy aware so the facility could get to the root cause of what was happening and intervene. DON stated somewhere between nursing and therapy communication fell between the cracks and nothing was put into place when Resident 1 declined and there should have been. During an interview on 3/27/25 at 10:36 a.m. with DOR, DOR stated Resident 1 had physician orders for PT and OT evaluations and treatment on 8/29/24 and 12/31/24. DOR stated Resident 1 received an OT evaluation on 8/31/24 but did not receive OT treatment or PT evaluation and treatment. DOR stated when the OT evaluation was completed a need for treatment was identified but due to Resident 1's insurance (provides financial protection against healthcare costs) not covering therapy treatment services, only the OT evaluation was completed. DOR stated Resident 1 was dropped from OT therapy on 8/31/24 and no PT services were provided. DOR stated RNA program should have been established to continue the bed mobility program and it would have prevented some of the decline in Resident 1's bed mobility. During a review of the facility's policy and procedure (P&P) titled, Functional Impairment - Clinical Protocol dated 3/2018, the P&P indicated, Upon admission to the facility, whenever a significant change of condition occurs, and periodically during a resident/patient's stay, the physician and staff will assess the resident/patient's function along with their physical condition.The staff and physician will identify individuals with potential for significant improvement in function or significant decline in function, including the ability to perform activities of daily living (ADLs).The staff and physician will collaborate to identify a rehabilitative or restorative care plan to help improve function and quality of life and meet a resident/patient's goals and needs and attain other desired outcomes such as discharge to the community.Based on a review of available information (including results of the evaluation), the physician will determine if a resident/patient meets the criteria for skilled therapy services.The staff will monitor and document the resident/patient's function (for example, evidence of reduced ADL dependency, improved ambulation, improved balance and gait, etc.) and will discuss this with the physician periodically in conjunction with a discussion of medical interventions and plans of care.The physician will identify the subsequent relevance of therapy services, based on reviewing the resident/patient's progress relative to his/her care goals (e.g., functional stabilization or improvement) and the status of conditions and the current treatment regimen that have been identified as affecting his/her function.