

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555658	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2025
NAME OF PROVIDER OR SUPPLIER River Walk Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>38993</p> <p>Based on interview and record review, the facility failed to follow its policy and procedure for a change of condition for one of three sampled residents (Resident 1) when a S (Situation) B (Background) A (Appearance) R (Review and Notify) (SBAR-document used to notify the physician of a change of condition) was not completed, and Resident 1 was not monitored for a change of condition when experiencing a dislocated hip. This failure had the potential for staff to be unaware of Resident 1's worsening condition and the potential for a delay in care.</p> <p>Findings:</p> <p>During a review of Resident 1's Progress Notes (PN) dated 1/27/25 at 1:58 p.m., the PN indicated, Xray results received. The prosthetic (artificial body part) head is dislocated (joint that is no longer in proper alignment) superior (above another structure) to the acetabular cup (a prosthetic implant used in total hip replacement surgery to replace the natural acetabulum). No evidence of acute fracture or dislocation. [Physician name] made aware. New orders: Refer to [Physician name] .</p> <p>During a review of Resident 1's PN dated 1/29/25 (two days after the facility was aware of the dislocation) at 2:28 p.m., the PN indicated, T.O. (telephone order) noted by (Physician name) to send resident to ER (emergency room) (Hospital name) for eval (evaluation) and treat as indicated to Rt (right) hip per family request. Resident and daughter R/P (responsible party) aware.</p> <p>During a review of Resident 1's PN dated 1/29/25 at 2:51 p.m., the PN indicated, Radiology Result. Resident c/o (complain of) pain d/t (due to) dislocation of prosthetic head of left hip arthroplasty (damaged parts of a joint are removed and replaced with artificial components). Resident has sustained no falls or trauma. Resident and family stated that resident has history of spontaneous dislocation, but it normally resets itself. Due to continued pain and dislocation, received order to send to ER for further eval and treatment.</p> <p>During a review of Resident 1's PN dated 1/30/25 at 7:36 a.m., the PN indicated, This nurse called (hospital name) for update. Resident was admitted to med (medical) surg (surgical) for left hip dislocation. Pending orthopedic surgeon (physician that treats disorders of the bones, joints, ligaments, tendons and muscles) consult.</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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 4/22/25 at 2:31 p.m. with Director of Nursing (DON), Resident 1's PN's were reviewed. DON was unable to provide a completed SBAR and monitoring for Resident 1 regarding the dislocation. DON stated there should have been an SBAR completed when notifying the physician of the change of condition and Resident 1 should have been monitored for any changes.</p> <p>During a review of the facility's policy and procedure (P&P) titled Change in a Resident's Condition or Status dated 2/2021, the P&P indicated, Prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including (for example) information prompted by the Interact SBAR Communication Form. The nurse will record in the resident's medial record information relative to changes in the resident's medical/mental condition or status.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>38993</p> <p>Based on interview and record review, the facility failed to ensure physician's orders were followed for one of three sampled residents (Resident 1) when:</p> <ol style="list-style-type: none"> The physician was not notified when blood sugar results were greater than 400; Antibiotics were not administered for osteomyelitis (bone infection). <p>These failures had the potential for Resident 1 to experience adverse side effects such as delayed wound healing and the potential for wounds to worsen.</p> <p>Findings:</p> <p>1. During a review of Resident 1's Order Summary Report (OSR-physician orders) dated 1/1/25, the OSR indicated, Humulin R (medication used to control high blood sugar).inject as per sliding scale: if 70-200 = 0 (units); 201-250 = 2; 251-300 = 4; 301-350 = 6; 351-400 = 8, subcutaneously (under the skin) three times a day for diabetes mellitus (chronic metabolic disorder characterized by high blood sugar levels, due to a deficiency in insulin production or the body's inability to effectively use insulin) hold if BS (blood sugar) < (less than) 70 or > (greater than) 400. Notify MD.</p> <p>During a review of Resident 1's OSR dated 2/1/25, the OSR indicated, Humulin R. inject as per sliding scale: if 70-150 = 0 (units); 151-200 = 2 units; 201-250 = 4 units; 251-300 = 6 units; 301-350 = 8 units, 351-400 = 10 units; 401+ = 12 units, subcutaneously three times a day for diabetes mellitus fingerstick prior to administration. Hold if BS <100. Notify MD if BS <70 or > 400.</p> <p>During a review of Resident 1's OSR dated 3/1/25, the OSR indicated, Novolin R.inject as per sliding scale: if 0-150 = 0; 151-200 = 2 units; 201-250 = 4 units; 251-300 = 6 units; 301-350 = 8 units, 351-400 = 10 units; 401+ = 12 units, subcutaneously before meals for DM2 (diabetes mellitus type 2) fingerstick prior to administration. Hold if BS <100. Notify MD if BS <70 or > 400.</p> <p>During a concurrent interview and record review on 4/22/25 at 2:31 p.m. with Director of Nursing (DON), Resident 1's Medication Administration Record (MAR)'s dated 1/2025, 2/2025 and 3/2025, were reviewed. Resident 1's blood sugars were as follows:</p> <p>1/20/25 6:06 a.m. 415</p> <p>2/1/25 4:30 p.m. 445</p> <p>2/13/25 4:30 p.m. 401</p> <p>2/14/25 4:30 p.m. 456</p> <p>2/16/25 6:00 a.m. 510</p> <p>3/7/25 4:30 p.m. 413.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>DON was unable to provide documentation the physician was notified of the blood sugars greater than 400. DON stated the physician should have been notified when the blood sugar result was greater than 400.</p> <p>2. During a review of Resident 1's OSR dated 1/1/25-1/31/25, the OSR indicated, ceftriaxone (medication used to treat infection) .use 2 gram intravenously (administered through the vein) every 24 hours for infection related to other chronic osteomyelitis, left ankle and foot.until 2/4/25.</p> <p>During a concurrent interview and record review on 4/22/25 at 2:33 p.m. with DON, Resident 1's 1/2025 MAR was reviewed. The MAR indicated Resident 1 did not receive ceftriaxone on 1/21, 1/22 and 1/28. DON was unable to provide documentation the medication was administered. DON stated when medication was administered the nurse was expected to document it in the medical record. DON stated if it was not documented there was no way to know if Resident 1 received the medication.</p> <p>During a review of the facility's policy and procedure (P&P) titled Diabetes - clinical protocol dated 11/2020, the P&P indicated, The Physician will order desired parameters for monitoring and reporting information related to blood sugar management. a. The staff will incorporate such parameters into the Medication Administration Record and care plan.The staff will identify and report issues that may affect, or be affected by, a patient's diabetes and diabetes management such as foot infections, skin ulceration.</p> <p>During a review of the facility's policy and procedure (P&P) titled Administering Medications dated 4/19, the P&P indicated, Medications are administered in accordance with prescriber orders, including any required time frame.The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones.</p>

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<p>F 0808</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law.</p> <p>38993</p> <p>Based on observation, interview, and record review, the facility failed to ensure the therapeutic menu was followed for one of three sampled residents (Resident 1). This failure resulted in Resident 1 being served the incorrect dessert.</p> <p>Findings:</p> <p>During a review of Resident 1's Order Summary Report (OSR-physician orders) dated 4/1/25, the OSR indicated, CCHO (consistent carbohydrate diet for diabetes [condition where the body either doesn't produce enough insulin or can't effectively use the insulin it does produce, leading to high blood sugar levels])/NAS (no added salt) diet.</p> <p>During a review of the Cooks Spreadsheet (CS) dated 4/22/25, the CS indicated, the CCHO diet was to be served vanilla mousse no chocolate chips.</p> <p>During a concurrent observation and interview on 4/22/25 at 12:30 p.m. with Certified Nursing Assistant (CNA) 1, in Resident 1's room, Resident 1's lunch tray was sitting on the over bed table. The lunch tray contained vanilla mousse pudding with chocolate chips. CNA 1 stated Resident 1 was provided pudding with chocolate chips.</p> <p>During an interview on 4/30/25 at 3:16 p.m. with Dietary Services Supervisor (DSS), DSS stated Resident 1 was on a CCHO/NAS diet and should not have been served the vanilla mousse with chocolate chips.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Menu planning dated 2023, the P&P indicated, 1. The facility's diet manual and the diets ordered by the physician should mirror the nutritional care provided by the facility. 2. Menus are written for regular and therapeutic diets in compliance with the diet manual.</p>