

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 02/26/2026
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)		
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, and record review, the facility failed to: 1. Ensure one of 25 sampled residents' (Resident 92) medical record contained accurate documentation. This failure resulted in inaccurate medical documentation and had the potential to result in inaccurate monitoring of wound progression, inappropriate treatment, and wound treatment complications. 2. Ensure one of 6 sampled residents (Resident 92) had a physician order prior to changing a wound treatment. This failure had the potential to result in inappropriate treatment and wound treatment complications. 3. Ensure one of 4 sampled residents (Resident 10) had a physician order to discontinue weekly/monthly weights. This failure had the potential for Resident 10's weight gain or loss to go unmonitored. Findings: 1. During a concurrent observation and interview on 2/23/26 at 10:06 a.m. with Resident 92, in Resident 92's room, Resident 92 was sitting in his wheelchair, and both of his lower legs were wrapped with Kerlix gauze (cotton medical dressing/wrap that was designed to absorb moderate to heavy wound drainage) dated 2/22/26. During a concurrent observation and interview on 2/24/26 at 8:38 a.m. with Resident 92, in Resident 92's room, Resident 92 was sitting in a chair, both of his lower legs were covered with pink foam dressings (highly absorbent bandage) dated 2/23/26. Resident 92 stated he had a reaction to the gauze dressing that made his skin itch. Resident 92 stated the treatment nurse applied a different wound dressing. During an observation on 2/25/26 at 10:40 a.m. in Resident 92's room, Resident 92 was sitting on his bed, both of his lower legs were covered with pink foam dressings dated 2/24/26. During a concurrent interview and record review on 2/25/26 at 11:01 a.m. with Licensed Vocational Nurse (LVN) 1, Resident 92's Physician Orders (PO) dated 2/20/26 were reviewed. The PO indicated, Resident 92 was to have daily wound treatment to both of his lower legs that consisted of cleaning wounds with normal saline [NS, a sterile solution of salt dissolved in water that is gentle and non-irritating for wound care], pat dry, apply silver med gel [brand name, a water based gel mixed with silver ions (active ingredient) used to manage infections and keep a moist wound bed] to wound bed, cover with Adaptec [mesh dressing designed to protect the wound bed and prevent bandages from sticking to healthy tissue], layer with ABD pad [abdominal pad, highly absorbent cotton filled dressing], wrap with Kerlix every day shift. LVN 1 stated Resident 92's current wound treatment order was NS, Silver med gel, Adaptec, ABD pad and Kerlix wrap. During a concurrent interview and record review on 2/25/26 at 11:09 a.m. with LVN 1, Resident 92's Treatment Administration Record (TAR), dated February 2026 was reviewed. The TAR indicated, on 2/23/26 and 2/24/26, Resident 92's wounds to his bilateral legs were cleaned with NS, patted dry, silver med gel, Adaptec, and ABD pad applied and wrapped with Kerlix gauze. LVN 1 stated she had changed Resident 92's dressing to a foam dressing on 2/23/26 and 2/24/26. LVN 1 stated she had not placed a new treatment order in Resident 92's chart. LVN 1 stated she should not have documented under the current order in the TAR if it was not the treatment being provided. LVN 1 stated she should have obtained a new physician order. LVN 1 stated this was inaccurate documentation. During a review of the facility's policy and procedure (P&P) titled, Charting and Documentation, dated July 2017, the P&P indicated, All services provided to the resident, progress towards the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition shall be documented in the resident's medical record. 2. The following information is to be documented in the resident's medical (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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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	record.c. Treatments or services performed.3. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. 2. During a concurrent observation and interview on 2/23/26 at 10:06 a.m. with Resident 92, in Resident 92's room, Resident 92 was sitting in a wheelchair with bilateral (both) lower legs wrapped with Kerlix gauze (white cotton medical dressing/wrap that was designed to absorb moderate to heavy wound drainage) dated 2/22/26. During a concurrent observation and interview on 2/24/26 at 8:38 a.m. with Resident 92, in Resident 92's room, Resident 92 was sitting in a chair, his bilateral lower legs were covered with pink foam dressings (highly absorbent bandage) dated 2/23/26. Resident 92 stated he had a reaction to the Kerlix gauze dressing that made his skin itch. Resident 92 stated the treatment nurse applied a different dressing. During an observation on 2/25/26 at 10:40 a.m. in Resident 92's room, Resident 92 was sitting on his bed, his bilateral lower legs were covered with pink foam dressings, dated 2/24/26. During a concurrent interview and record review on 2/25/26 at 11:01 a.m. with Licensed Vocational Nurse (LVN) 1, Resident 92's Physician Orders (PO) dated 2/20/26 was reviewed. The PO indicated, Resident 92 was to have daily wound treatment to his bilateral lower legs that consisted of cleaning wounds with normal saline [NS, a sterile solution of salt dissolved in water that is gentle and non-irritating for wound care], pat dry, apply silver med gel [brand name, a water based gel mixed with silver ions (active ingredient) used to manage infections and keep a moist wound bed] to wound bed, cover with Adaptec [mesh dressing designed to protect the wound bed and prevent bandages from sticking to healthy tissue], layer with ABD pad [abdominal pad, highly absorbent cotton filled dressing], wrap with Kerlix every day shift. LVN 1 stated Resident 92's current wound treatment order was NS, Silver med gel, Adaptec, ABD pad and kerlix wrap. During an interview on 2/25/26 at 11:09 a.m. with LVN 1, LVN 1 stated she had changed Resident 92's wound treatment to a foam dressing on 2/23/26 and 2/24/26 due to Resident 92's request. LVN 1 stated there were no POs in Resident 92's chart to change Resident 92's wound treatment to a foam dressing. LVN 1 stated she should have obtained a PO for the foam dressings. During a review of the facility's policy and procedure (P&P) titled, Dressings, Dry/Clean, dated September 2013, the P&P indicated, The purpose of this procedure is to provide guidelines for the application of dry clean dressings.1. Verify that there is a physician's order for this procedure.2. Review the resident's care plan, current orders, and diagnosis. 3. During review of Resident 10's Electronic Medical Record (eMAR) on 2/26/26, the eMAR indicated, Resident 10's last recorded weekly/monthly weight was 7/14/25, with a recorded weight of 104 pounds (unit of weight). During a review of Resident 10's Order Summary Report (OSR), dated 2/26/26, the OSR indicated, Resident 10 was admitted to hospice (compassionate care for near end of life within a facility) on 1/8/26 with a diagnosis of Parkinson's disease (incurable, disorder, tremors, stiffness, and slow movement). During a review of Resident 10's Physician Order Sheet (POS), dated 12/30/26, the POS indicated, No weekly weights only monthly - daughter has agreed to monthly weights. During a concurrent interview and record review on 2/26/26 at 3:34 p.m., with Director of Nursing (DON), Resident 10's eMAR was reviewed. The eMAR indicated Resident 10's last daily weight 7/14/25. DON stated, The weights were not completed after July, 2025 there's no Physician order to discontinue the weights. During a review of the facility's policy and procedure (P&P) titled, Physician Services, dated 2001, the P&P indicated, The medical care of each resident is supervised by a licensed physician . 1. A physician must recommend in writing that an individual be admitted to the facility . 2. Once a resident is admitted , orders for the resident's immediate care and needs can be provided by a physician, physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS) . 3. Supervising the medical care of residents includes (but not limited to): b. monitoring changes in resident's medical status. During a review of the facility's policy and procedure (P&P) titled, Weight Assessment and Intervention, dated 2001, the P&P indicated, Resident weights are monitored for undesirable or unintended weight loss or gain . Weight Assessment 1. Residents are weighed upon admission and at intervals established by the interdisciplinary team. 2. Weights are recorded in each unit's weight record chart and in the individual's medical record. 3. Any changes of 5% or more since the last weight assessment is retaken the next day for confirmation.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement their care plan (a comprehensive, personalized document created by an interdisciplinary team [IDT - a collaborative group of healthcare professionals, including nurses, doctors, therapists, social workers, and the resident/family, who work together to create and implement personalized care plans] to guide a resident's medical, nursing, and rehabilitative care) intervention for monitoring five of 13 sampled residents (Resident 27, Resident 67, Resident 36, Resident 42, and Resident 3). This failure had the potential to result in resident harm/injury, and/or failure to provide appropriate interventions for Resident 27, Resident 67, Resident 36, Resident 42, and Resident 3 safety. Findings: During a review of Resident 27's Care Plan Report (CP), dated 11/13/23, the CP indicated, Resident 27 was at risk for unavoidable falls with major injury. On 11/3/25, an intervention was implemented for one-to-one monitoring (dedicated 24-hour staff for the purpose of resident monitoring). During a review of Resident 67's CP, dated 1/13/25, the CP indicated, Resident 67 had multiple falls including falls with injury. On 1/25/25, an intervention was implemented to place Resident 67 on one to one monitoring. During a review of Resident 36's CP, dated 6/8/25, the CP indicated, Resident 36 was a high risk for falls. On 12/16/25, an intervention was implemented to place Resident 36 on one to one monitoring. During a review of Resident 42's CP, dated 1/30/26, the CP indicated, Resident 42 was an elopement risk (any instance where a resident leaves a safe, designated care environment without authorization, knowledge, or supervision of staff)/wanderer (a person who travels aimlessly). On 11/22/23, an intervention was implemented to monitor Resident 42 location every 15 minutes. During a review of Resident 3's CP, dated 5/6/25, the CP indicated, Resident 3 was at risk for falls. On 10/28/25, an intervention was implemented for Resident 3 to be monitored every 15 minutes. During a review of the facility document titled FALL PROGRAM (FP), undated, the FP indicated facility staff are to be Resident 27, Resident 67, Resident 36) on one-to-one monitoring. The FP indicated the are to facility staff to monitor Resident 3 and Resident 42 every 15 minutes. During a concurrent interview and record review on 2/25/26 at 3:16 p.m. with Director of Staff Development (DSD), the facility forms titled Resident with Behaviors Monitoring (RBM), was reviewed. The RBM indicated Resident 27, Resident 26, Resident 42, Resident 67, and Resident 3 required narrative notes needed to be taken every 15 minutes on the RBM to indicate what the residents were doing at that time. DSD stated the forms were supposed to be filled out every 15 minutes by the morning shift (6:30 a.m. to 2:45 p.m.), the evening shift (2:30 p.m. to 10:45 p.m.), and the night shift (10:30 p.m. to 6:45 a.m.). DSD stated once the day was completed the RBM was to be turned into her office for record keeping and review. DSD confirmed the RBM indicated the following: 1. For Resident 27: 1/1/26 - there was no documentation for the morning shift and night shift 1/2/26 - there was no documentation for the night shift. 1/3/26 - there was no documentation for the evening and night shift. 1/4/26 - there was no documentation for the evening and night shift 1/6/26 - there was No documentation for all three shifts 1/8/26 - there was no documentation for the evening shift 1/9/26 - there was no documentation for the evening and night shift 1/12/26 - there was no documentation for the night shift 1/13/26 - there was no documentation for the morning and evening shift 1/14/26 - there was no documentation for the night shift. 1/17/26 - there was no documentation for the morning shift 1/20/26 - there was no documentation for the evening shift 1/21/26 - there was No documentation for the morning shift 1/22/26 - there was no documentation for the night shift 1/23/26 - there was no documentation for the night shift 1/24/26 - documentation was not complete for the morning shift 1/25/26 - documentation was not complete for the evening shift 2/19/26 - there was no documentation for the evening shift 2/20/26 - there was no documentation for the morning shift 2/22/26 - there was no documentation for the night shift 2/23/26 - documentation was not complete for the evening shift 2. For Resident 67: 1/1/26 - there was no (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	documentation for the night shift and documentation for the evening shift was not complete 1/2/26 - there was no documentation for the night shift1/3/26 - there was no documentation for the evening shift1/4/26 - there was no documentation for the evening and night shift 1/6/26 - there was no documentation for the evening shift and documentation for the morning and evening shifts were not complete1/7/26 - documentation for the morning shift was not complete1/10/26 - documentation for the evening shift was not complete1/11/26 - there was no documentation for the night shift1/13/26 - there was no documentation for the morning shift1/14/26 - there was no documentation for the night shift1/17/26 - there was no documentation for the night shift1/21/26 - there was no documentation for the morning shift1/22/26 - there was no documentation for the night shift1/23/26 - there was no documentation for the night shift1/25/26 - there was no documentation for the night shift1/28/26 to 1/31/26 - there was no documentation for all three shifts 2/1/26 to 2/6/26 - there was no documentation for all three shifts 2/18/26 - there was no documentation for the morning shift2/19/26 - there was no documentation for the evening shift2/22/26 - there was no documentation for the night shift 3. For Resident 36 1/1/26 - there was no documentation for the evening and night shift 1/2/26 - there was no documentation for the evening and night shift 1/3/26 to 1/6/26 - there was no documentation for all three shifts 1/7/26 - there was no documentation for the evening and night shift1/8/26 - there was no documentation for the evening and night shift1/9/26 - there was no documentation for the night shift1/11/26 and 1/12/26 - there was no documentation for all three shifts1/13/26 - there was no documentation for the morning and night shift. The documentation for the evening shift was not completed1/14/26 to 1/16/26 - there was no documentation for all three shifts1/17/26 - there was no documentation for the night shift1/18/26 - there was no documentation for all three shifts1/19/26 - there was no documentation for the morning and night shift1/21/26 - there was no documentation for the night shift1/23/26 - there was no documentation for the evening and night shift1/24/26 - there was no documentation for the morning and night shift1/25/26 and 1/26/26 - there was no documentation for all three shifts1/27/26 - there was no documentation for the morning and night shift1/28/26 - there was no documentation for all three shifts2/1/26 to 2/3/26 - there was no documentation for all three shifts2/4/26 - there was no documentation for the morning and night shift2/6/26 and 2/7/26 - there was no documentation for all three shifts2/8/26 and 2/9/26 - there was no documentation for the evening and night shift2/10/26 - there was no documentation for the morning and night shift2/14/16 - there was no documentation for the evening and night shift2/15/26 and 2/16/26 - there was no documentation for all three shifts2/17/26 - there was no documentation for the evening and night shift. Documentation for the morning shift was not completed2/18/26 - there was no documentation for all three shifts2/19/26 - there was no documentation for the morning and night shift2/20/26 and 2/21/26 - there was no documentation for the evening and night shift2/22/26 - there was no documentation for all three shifts2/23/26 - there was no documentation for the night shift and documentation for the day shift was not completed2/24/26 - there was no documentation for the night shift 4. For Resident 421/1/26 to 1/7/26 - there was no documentation for all three shifts1/8/26, 1/9/26, and 1/10/26 - there was no documentation for the morning and night shift1/11/26 and 1/12/26 - there was no documentation for all three shifts1/13/26 - there was no documentation for the morning and night shift. Documentation for the evening shift was not complete 1/14/26 to 1/16/26 - there was no documentation for all three shifts1/17/26 - there was no documentation for the morning shift and the night shift1/18/26 - there was no documentation for all three shifts 1/19/26 - there was no documentation for the morning and night shift1/20/26 - there was no documentation for all three shifts1/21/26 - there was no documentation for the night shift1/22/26 - there was no documentation for all three shifts1/23/26 - there was no documentation for the evening and night shift1/24/26 - there was no documentation for the morning and night shift1/25/26 - there was no documentation for the morning and night shift1/26/26 - there was no documentation for all three shifts1/27/26 and 1/28/26 - there was no documentation for the morning and night shift 1/29/26 to 1/31/26 - there was no documentation for (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	all three shifts2/1/26 to 2/13/26 - there was no documentation for all three shifts2/14/26 - there was no documentation for the morning and night shift. Documentation for the evening shift was not complete2/15/26 and 2/16/26 - there was no documentation for all three shifts2/17/26 - there was no documentation for the evening and night shift2/18/26 and 2/19/26 - there was no documentation for all three shifts2/20/26 - there was no documentation for the evening and night shift2/21/26 and 2/22/26 - there was no documentation for all three shifts2/23/26 - there was no documentation for the evening and night shift. Documentation for the morning shift was not complete5. For Resident 3 1/1/26 - there was no documentation for the night shift1/2/26 - there was no documentation for the evening and night shift1/3/26 and 1/4/26 - there is no documentation for all three shifts1/5/26 to 1/7/26 - there is no documentation for the evening and night shift1/8/26 - there was no documentation for the night shift1/9/26 - there was no documentation for the night shift1/10/26 and 1/11/26 - there was no documentation for all three shifts1/12/26 - there was no documentation for the night shift1/13/26 - there was no documentation for the evening and night shift. Documentation for the morning shift was not complete1/14/26 and 1/15/26 - there was no documentation for the evening and night shift1/16/26 - there was no documentation for all three shifts1/17/26 and 1/18/26 - there was no documentation for the night shift1/19/26 and 1/20/26 - there was no documentation for the evening and night shift1/21/26 - there was no documentation for the night shift1/22/26 - there was no documentation for all three shifts1/23/26 and 1/24/26 - there was no documentation for the evening and night shift1/25/26 and 1/26/26 - there was no documentation for the night shift1/27/26 and 1/28/26 - there [NAME] no documentation for the evening and night shift1/29/26 - there was no documentation for all three shifts1/31/26 - there was no documentation for the night shift2/1/26 and 2/2/26 - there was no documentation for the evening and night shift2/3/26 - there was no documentation for the morning and night shift2/4/26 - there was no documentation for all three shifts2/5/26 - there was no documentation for the morning and night shift2/6/26 to 2/8/26 - there was no documentation for the evening and night shift2/9/26 and 2/10/26 - there was no documentation for all three shifts2/11/26 - there was no documentation for the evening and night shift2/13/26 to 2/15/26 - there was no documentation for the evening and night shift2/16/26 - there was no documentation for the night shift2/17/26 - there was no documentation for the evening and night shift2/18/26 - there was no documentation for the night shift2/19/26 - there was no documentation for the night shift2/20/26 - there was no documentation for the evening and night shift2/21/26 - there was no documentation for all three shifts2/22/26 to 2/24/26 - there was no documentation for the evening and night shiftDuring an interview on 2/25/26 at 4:09 p.m. with Director of Nursing (DON), DON stated the RBM forms are used to determine if resident centered interventions are successful and/or if there is more to be done to ensure safety. DON stated she and Assistant Director of Nursing (ADON) look at the RBM forms weekly. DON stated the RBM forms from last week were looked at.During an interview on 2/26/26 at 3:48 p.m. with DON, DON stated the purpose of the RBM forms is to decrease or prevent whatever resident action is of concern listed on the care plan. DON stated the RBM forms are used to rationalize or modify interventions for the residents. DON stated, The expectation is the [facility] staff are to be filling out the [RBM] forms as expected so that a decision can be made on future interventions and action [for the residents].During a review of the facility's policy and procedure (P&P) titled, Safety and Supervision of Residents, dated 7/2017, the P&P indicated, Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. Our individualized, resident centered approach to safety addresses safety and accident hazards for individualized residents. The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices. Implementing interventions to reduce accident risks and hazards shall include the following . Ensuring that interventions are implemented correctly and consistently . Evaluating the effectiveness of interventions . Evaluating (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the effectiveness of new or revised interventions. Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs and identified hazards in the environment. These risk factors and environmental hazards include . Falls . unsafe wandering.		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review, the facility failed to ensure one of 29 sampled residents (Resident 5) was provided with meal at a palatable (pleasant to taste) and safe temperature. This failure had the potential for food borne illnesses to affect all residents eating from the facility kitchen and/or result in meals not being palatable leading to potential unintended weight loss. Findings: During a concurrent observation and interview on 2/25/26 at 12:55 p.m. with Dietary Supervisor (DS), the last lunch meal tray was served, and food temperatures were taken. DS observed and confirmed the following food temperatures: Fish temperature was at 116 degrees Fahrenheit (F- a unit of measurement). DS stated the temperature was supposed to be at 140 F Broccoli temperature was at 113 F. DS stated the temperature was supposed to be at 140 F Rice temperature was at 128 F. DS stated the temperature was supposed to be at 140 F Cucumber salad was at 70 F. DS stated the temperature was supposed to be below 68 F Milk was at 52 F. DS stated the milk was supposed to be 40 F or lower. During a review of Resident 5's Brief Interview for Mental Status (BIMS - an assessment of cognition [how well a person thinks, remembers, and learns] with scores ranging from 0 - 15, the higher the score the more intact the resident's cognition is. A score of 0 - 7 suggests severe cognitive impairment, 8 - 12 suggests moderate cognitive impairment and 13 - 15 suggests the cognition is intact. A score of 99 suggest the resident was unable to complete the interview and therefore unable to determine the resident's cognition), dated 2/21/26 the BIMS indicated Resident 5's score was 15. During an interview on 2/26/26 at 8:44 a.m. with Resident 5, Resident 5 stated he attended resident council (group of residents who meet to discuss facility/resident concerns) meetings on a regular basis. Resident 5 stated the facility kitchen had been sending out meals that were not heated or chilled correctly for approximately the last three months. Resident 5 stated, The hot food is cold, and the cold food is hot. During a review of the facility's policy and procedure (P&P) titled, MEAL SERVICE, UNDATED, the P&P indicated, Meals that meet the nutritional needs of the resident will be served in an accurate and efficient manner and served at the appointment temperatures. Hot food serving temperature must be at or above minimum holding temperature of 140 F. The temperatures of the food should be periodically monitored throughout the meal service to ensure proper hot and cold temperature. Temperature of the food when the resident receives it is based on palatability. The goal is to serve cold food cold and hot food hot. Recommended Temp (temperature) at Delivery to Resident . Cold entree . (at or lower than) 50 F . Salads . (at or lower than) 45 F . Milk/cold beverage . (at or lower than) 45 F . Hot entree . (at or higher than) 120 F . Vegetables . (at or higher than) 120 F.		

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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 02/26/2026
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.			
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on interview and record review, the facility failed to monitor refrigerator/freezer temperatures used to store residents' food. This failure had the potential to spread foodborne illnesses to residents. Findings: During a concurrent interview and record review on 2/23/25 at 9:26 a.m. with Dietary Supervisor (DS), the facility document titled, Refrigerator and Freezer Temperature Log (RFTL), was reviewed. The RFTL indicated, the refrigerator/freezer temperatures where to be taken in the a.m. and the p.m. The RFTL indicated, the following: On 12/31/25 - there was no temperature taken in the a.m. On 11/29/25 - there was no temperature taken in the in the p.m. On 10/31/25 - there was no temperature taken in the a.m. DS stated the temperatures should have been taken but were not. During a review of the facility's policy and procedure (P&P) titled, COLD STORAGE TEMPERATURE MONITORING AND RECORD KEEPING, undated, the P&P indicated, Food and Nutrition staff shall review and record temperature of all refrigerators and freezers to ensure they are at the correct temperature for food storage and handling. Food (and) Nutrition Services staff will check the inside temperature of refrigerators and freezers. Food (and) Nutrition Services staff will record and initial the temperatures on the Healthcare Menu Direct, LLC.'s Cold Storage Temperature Log . at the beginning of the AM and PM shifts.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to follow standard practice for infection control when: 1. Two of eight sampled staff members (Certified Nursing Assistant [CNA] 1 and Physical Therapy Assistant [PTA] 1) did not apply appropriate personal protective equipment (PPE- gowns, gloves, face masks, face shields or other equipment designed to protect the wearer from injury or the spread of infection or illness) prior to providing high contact care (involving direct contact with a resident) to a resident on enhanced barrier precautions (EBP- an infection control practice that utilizes the use of gown and gloves during high contact care activities to stop the spread of multi-drug resistant organisms [MDRO]).2. Facility failed to implement their policy and procedure on Handling Soiled Linen, for one of 29 sampled residents (Resident 65). These failures had the potential to spread infection and cause illness to residents, staff, and visitors. Findings: 1. During a concurrent observation and interview on 2/24/26 at 8:42 a.m. with CNA 1 and PTA 1 in Resident 33's room, CNA 1 and PTA 1 were providing high contact resident care to Resident 33. CNA 1 and PTA 1 were not wearing a gown. Resident 33 had a gauze dressing applied to the right lower leg. CNA 1 stated Resident 33 had a wound to her right lower leg. PTA 1 and CNA 1 stated they were unsure if Resident 33 was on EBP. During a concurrent observation and interview on 2/24/26 at 8:46 a.m. with CNA 1, outside of Resident 33' room, an EBP sign was on Resident 33's door and there was an orange dot next to Resident 33's name. CNA 1 stated the orange dot next to Resident 33's name indicated that Resident 33 was on EBP. CNA 1 stated she should have looked at the sign and used a gown prior to providing care to Resident 33. During an interview on 2/26/26 at 9:13 a.m. with Infection Preventionist (IP), IP stated residents with wounds that require a dressing change are placed on EBP. IP stated it was her expectation for staff to wear a gown and gloves while providing care to residents on EBP. During a review of Resident 33's Physician Orders (PO), dated 2/3/26, the PO indicated, Enhanced Barrier Precautions (EBP)-Staff to utilize gowns and gloves for high-contact resident care activities due to a colonized MDRO. During a review of the facility's policy and procedure (P&P) titled, Enhanced Barrier Precautions, dated March 2024, the P&P indicated, Enhanced barrier precautions (EBPs) are utilized to reduce the transmission of multi-drug resistant organisms (MDROs) to residents.EBPs employ targeted gown and glove use in addition to standard precautions during high contact resident care.a. Gloves and gown are applied prior to performing the high contact resident care activity.5. EBPs are indicated.for residents with wounds and/or indwelling medical devices regardless of MDRO. 2.During a review of Resident 65's Care Plan Report (CP), dated 10/7/24, the CP indicated, Resident 65 is incontinent (unable to control bowel and/or bladder) of bowel and bladder. During an observation on 2/24/26 at 12:08 p.m. in Resident 65 room, CNA 3 was changing Resident 65's bed linen. CNA 3 placed Resident 65's bowel movement covered sheets onto the floor at her bedside leading out toward the entry door while he was providing care. During an interview on 2/24/26 at 12:11 p.m. with CNA 3, CNA 3 stated Resident 65's bowel movement soiled bed linens were placed on the floor while he was providing care, but he should not (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	have done that because it could spread infection. During an interview on 2/24/26 at 12:21 p.m. with IP, IP stated resident soiled bed linen should be rolled off the mattress and placed directly into a designated container. IP stated soiled bed linen should not be placed on the floor. IP stated the reason soiled linen should not be placed on the floor is due to staff, visitors, and/or other residents can step on that area and spread infection. During a review of the facility's policy and procedure (P&P) titled, Handling Soiled Linen, undated, the P&P indicated, It is the policy of this facility to handle, store, process, and transport linen in a safe and sanitary method to prevent the spread of infection. Linen can become contaminated with pathogens (tiny organisms that can cause sickness and disease) from contact with intact skin, body substances, or from environmental contaminants. Transmission of pathogens can occur through direct contact with linens or aerosols generated from sorting and handling contaminated linen. All used linen should be handled using standard precautions (basic methods to control infection such as washing hands, wearing gloves and other appropriate protective equipment) . and treated as potentially contaminated . Linen should not be allowed to touch the uniform or floor and should be handled as little as possible . Used or soiled linen shall be collected at the bedside . and placed in a linen bag or designated linen receptacle. When task is complete, the bag shall be closed securely and placed in the soiled linen utility room.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to follow its policy and procedure (P&P) titled Psychotropic Medication [medication that affects brain activity, resulting in changes in mood, behavior, thoughts, and perception] Use for one of two sampled residents (Resident 45) when psychotropic medication was administered to Resident 45 for 50 days without IDT (Interdisciplinary team- a collaborative group of healthcare professionals, including nurses, doctors, therapists, social workers, and the resident/family, who work together to create and implement personalized care plans) approval and consent. This failure had the potential for Resident 45 receiving a larger dose of medication than what the facility determined was appropriate causing potential for harm and/or serious side effects. Findings: During a review of Resident 45's admission RECORD (AR), dated 2/26/26, the AR indicated Resident 45 was admitted to the facility on [DATE] with diagnosis of muscle weakness, history of falling, unspecified dementia (progressive state of decline in mental abilities) and depression (common, serious mental health condition characterized by a persistent feeling of sadness, emptiness, or a loss of interest in activities). During a review of Resident 45's Brief Interview for Mental Status (BIMS- an assessment of cognition [how well a person thinks, remembers, and learns] with scores ranging from 0 - 15, the higher the score the more intact the resident's cognition is. A score of 0 - 7 suggests severe cognitive impairment, 8 - 12 suggests moderate cognitive impairment and 13 - 15 suggests the cognition is intact. A score of 99 suggest the resident was unable to complete the interview and therefore unable to determine the resident's cognition), dated 1/30/26, the BIMS indicated, Resident 45 had a score of 4. During an interview on 2/23/26 at 10:05 a.m. with Resident 45, Resident 45 was alert but confused and could not provide any responses that made sense. During a concurrent interview and record review on 2/26/26 at 10:34 a.m. with Social Services Director (SSD), Resident 45's Electronic Medical Record (EMR), was reviewed. SSD stated according to the EMR Resident 45 was started on Trazadone (medication for depression) 25 mg (milligram - a unit of measurement) on 9/11/23 for depression manifested by inability to sleep. SSD stated Resident 45 was placed on 50 mg of Trazadone in September 2024. SSD stated on 5/26/25 Resident 45 had a gradual dose reduction (GDR- a structured decreasing of medication dosage to determine if a residents symptoms, conditions, or risks can be managed with a lower dose, or if the medication can be discontinued) of his Trazadone down to 25 mg and remained on 25 mg dosage until 7/26/25. SSD stated Resident 45 was sent to the acute hospital on 7/21/25 with his Trazadone order remaining at 25 mg a day, but when he returned on 7/26/25 he was placed back onto 50 mg a day due to possible error in medication reconciliation (the safety-focused process of comparing a resident's actual, current medication list against their new, ordered medications at every care transition) from hospital to facility. SSD stated the facility IDT did not meet to discuss Resident 45 increase in Trazadone until 18 days later (8/13/25) and consent for the 50 mg of Trazadone was not obtained until 9/15/25 (50 days after Trazadone medication was increased). During a review of Resident 45's Psychiatric (relating to mental illness or its treatment) F/U (follow up) Note (PFUN), dated 5/26/25, the PFUN indicated, Resident 45 had a psychiatric consult in which a recommendation was made to decrease his Trazadone 50 mg every night to 25 mg every night. During a review of Resident 45's Order Summary Report (OSR), dated 7/21/25, the OSR indicated, Resident 45 was on Trazadone 25 mg a day. During a review of Resident 45's Hospital Course, under the section Discharge Plan (DP), dated 7/22/25, the DP indicated, Resident 45 would be discharged from the acute hospital soon with, trazadone 50 mg tablet . (give) 25 mg (every night). During a review of Resident 45's MEDICATION RECONCILIATION FORM (MRF), dated 7/26/25, the MRF indicated, the facility wrote Resident 45's order for Trazadone to be 50 mg every night and not 25 mg. During a review of Resident 45's IDT - Psychotropic Medication Quarterly (PMQ), dated 8/13/25, the PMQ indicated, the facility (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	IDT met to discuss Resident 45's order for Trazadone 50 mg every night. The PMQ indicated, IDT recommends continuing current medication as a GDR may hinder his [Resident 45] quality of life and overall emotional well-being. During a review of Resident 45's Interim Medication Regimen Review (IMRR), dated 7/28/25, the IMRR indicated, the facility pharmacy reviewed Resident 45's medication and recommended a consent be obtained for Resident 45's Trazadone 50 mg every night. During a review of Resident 45's Psychoactive Medication Evaluation and Consent (PMEC), dated 9/15/25, the PMEC indicated, on 9/15/25 the facility obtained a consent for Resident 45's Trazadone 50 mg every night (50 days after the medication was started). During an interview on 2/26/26 at 3:33 p.m. with Director of Nursing (DON), DON stated the error in not obtaining consent for Resident 45's Trazadone was discovered in September 2025. DON stated the facility did not follow their policy and procedure for psychotropic medication on obtaining IDT and consent. During a review of the facility's P&P titled, Psychotropic Medication Use, dated 2/2025, the P&P indicated, Residents do not receive psychotropic medications that are not clinically indicated and necessary to treat a specific condition documented in the medical record. Psychotropic medication is any medication that affects brain activity associated with mental processes and behavior. Medications in the following categories are considered psychotropic medications and are subject to prescribing, monitoring, and review requirements specific to psychotropic medications. Psychotropic medication management is an interdisciplinary process that involves the resident, family, and/or the representative and includes . determining adequate indications for use . establishing appropriate dose . and duration . Psychotropic medications are never used to sedate or alter a resident's behavior for discipline or for the convenience of staff. When determining whether to initiate, modify, or discontinue medication therapy, the interdisciplinary team conducts and documents an evaluation of the resident. The evaluation includes the resident's . physical, behavioral, mental, and psychosocial status . Circumstances that warrant an evaluation of the resident's underlying medical condition and medications include . admission or readmission . an irregularity identified during drug regimen review . Diagnosis alone does not necessarily warrant the use of psychotropic medication. Prior to initiating the use of, increasing the dose of, or switching to a different psychotropic medication, the staff and physician will review the following with the resident/representative prior to obtaining documented consent or refusal . the indications and rationale for the recommendation . the potential risk and benefits . the resident's/representative right to accept or decline the treatment.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview and record review the facility failed to follow the steps in checking the placement of G-Tube (surgical tube place in stomach delivering nutrient supplement) prior to administering two medications for one of four sampled Residents (Resident 79). This failure the had potential for Resident 79 to have discomfort and aspiration (food or liquid enters the airway).Findings:During a review of Resident 79's Order Summary (OS), dated 1/1/25, the OS indicated, Every shift check tube placement. By gastric [stomach] aspiration of contents. Report residuals > [greater than] 100 cc [cubic centimeters-unit of measurement].During a review of Resident 79's OS, dated 1/1/25, the OS indicated, Every shift for Diet Flush with 15 cc [cubic centimeter/milliliter] of water before and after each medication.During a concurrent observation and interview on 2/25/26 at 12:35 p.m. with Licensed Vocational Nurse (LVN) 2 in Resident 79's room, LVN 2 did not check stomach residual prior to administering Resident 79's two crushed medications. LVN 2 did not give 15 ml (millimeters- unit of measurement) in-between medication one and medication two. LVN 2 stated she did not check residual after checking placement of the G-tube. LVN 2 stated she did not give the 15 ml of water between the two medications after they were administered. During an interview on 2/25/26 at 3:36 p.m. with Director of Nursing (DON), DON stated it is basic nursing to flush between medications, and it is an expectation for her staff.During a review of the facility policy and procedure (P &P) titled, Enteral Tube Feeding via Syringe (Bolus), dated November 2018, the P & P indicated, When correct tube placement has been verified, flush tubing with at least 30 ml warm water (or prescribe amount).		