STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555496	A. BUILDING _____ B. WING _____	**03/06/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RIVERWOOD HEALTH CARE	**5320 CARRINGTON CIRCLE STOCKTON, CA 95210**

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 0558 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Reasonably accommodate the needs and preferences of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide an individualized environment for one of 21 sampled residents (Resident 51), when Resident 51's overbed table, with water, was out of reach. Resident 51 was not able to use the facility water cup and the cup he was able to use was not filled and was not in reach. This failure had the potential for Resident 51 to have discomfort from dry mouth and feelings of helplessness. Findings: Resident 51 was admitted to the facility early 2020 with [DIAGNOSES REDACTED]. Review of Resident 51's MDS (minimum data set-an assessment and care screening tool) dated 1/22/20, indicated Resident 51 required extensive assistance with eating and drinking, and for .Bed mobility-how resident moves to and from lying position, turns side to side, and positions body while in bed . During an interview upon initial screening on 3/3/20, Resident 51 stated, .I live with a dry mouth . During an observation on 3/3/20, at 3:13 p.m. a large plastic mug with a lid was on Resident 51's overbed table. There was a plastic straw in the lid. The mug was wide and tall. Approximately inch of the straw was visible in the opening. Resident 51 was able to lift the mug with his left hand but was not able to drink from the opening. The lid was positioned for someone right handed. Resident 51's right arm was weak, and he was not able to use it for drinking or eating. During a concurrent observation and interview on 3/6/20, at 1:15 p.m., Resident 51 was in bed. His overbed table was adjacent to the right side of his bed. Resident 51 stated, I never use the big cup. I've tried. It's too big .my table is on the wrong side. Sometimes they put the table here and sometimes they put it there (pointed to left side of the bed). No consistency .My mouth always feels dry. I only drink a few sips at a time . During a concurrent observation and interview on 3/6/20, at 1:21 p.m., with Certified Nurses Assistant (CNA) 1, CNA 1 stated, .His lips do look dry. Before when he had GT (gastrostomy tube-a tube inserted through the belly into the stomach or small intestine, used to give liquid food) only, no food, we used swabs (a foam piece on a stick, used to moisturize the mouth). Now he can have water. He uses the little cup . CNA 1 indicated the small plastic disposable cup on the overbed table. When asked by the Department how Resident 51 was able to reach the cup, CNA 1 stated, .He can't reach it now. If it's over there he can (indicated the left side of Resident 51's bed). Straw in the big cup is so small it falls in . There was no water in the small disposable cup and CNA 1 poured some into the small cup from the large mug. She placed the table with water on the left side of Resident 51's bed, to extend across the bed. Resident 51 was able to drink from the small disposable cup. CNA 1 stated, .It's better for the table to be over the bed so he can reach . During an interview on 3/6/20, at 1:32 p.m., with the director of staff development (DSD), the DSD stated, .I know we've had a few residents say it's (the large mug like water container) too big .CNA should offer fluids .The tray should be accessible to the resident .
F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, the facility failed to accurately assess two of 21 sampled residents (Resident 75 and Resident 89) when: 1. Resident 75 did not have a gradual dose reduction (GDR - is the stepwise tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued) done due to miscoding on the Minimum Data Set (MDS-a comprehensive assessment tool) and; 2. Resident 89's MDS discharge was miscoded. This failure had the potential to result in Resident 75 receiving unnecessary medications and Resident 89 receiving an inappropriate discharge plan. Findings: 1. Resident 75 was admitted to the facility in 2019 with [DIAGNOSES REDACTED]. A review of Resident 75's, Order Listing Report, dated, February 6, 2020, indicated, Resident 75 had an order for [REDACTED]. on 2/6/20, 2/7/20, 2/8/20, 2/9/20, and 2/10/20, at 5 p.m. A review of Resident 75's MDS, section N, subsection, N0410. Medication Received; Indicate the number of DAYS the resident received the following medications .during the last 7 days or since admission/entry . The response in the box titled, Enter Days, was 5. This indicated that Resident 75 had received antipsychotic medication for 5 out of 7 days. A review of the MDS, Section N, subsection, N0450. Antipsychotic Medication Review; A. Did the resident receive antipsychotic medications since admission/entry or reentry . for Resident 75, had four coded responses available; 0. No - Antipsychotics were not received -> skip N0450B, N0450C, N0450D, and N0450E; 1. Yes - Antipsychotics were received on a routine basis only -> Continue to N0450B, Has a GDR been attempted? 2. Yes - Antipsychotics were received on a PRN (as needed) basis only -> Continue to N0450B, Has a GDR been attempted? 3. Yes - Antipsychotics were received on a routine and PRN basis -> Continue to N0450B, Has a GDR been attempted? In the box labeled, Enter Code, a response of 0 was entered, indicating that Resident 75 had not received any antipsychotic medications, when, according to Section N0410, Resident 75 had received antipsychotic medication for 5 of 7 days. During an interview on 3/6/20, at 10:45 a.m., with MDS Coordinator (MDSC) 2, she indicated that without N0450 being marked, a GDR would not be prompted for Resident 75, denying Resident 75 the opportunity to see if his behavioral symptoms could be managed with a lower dose of the antipsychotic medication. A review of the facility policy titled, Antipsychotic Medication Use, revised December 2016, indicated, Antipsychotic medications will be prescribed at the lowest possible dosage for the shortest period of time and are subject to gradual dose reduction and re-review .5 .b. Re-evaluate the use of the antipsychotic medication at the time of admission and/or within two weeks (at the initial MDS assessment) to consider whether or not the medication can be reduced, tapered, or discontinued. 2. Resident 89 was admitted to the facility in 2019 with [DIAGNOSES REDACTED]. A review of Resident 89's MDS (minimum data set, an assessment tool), Section A2100, dated 12/31/19, coded the discharge status as, Acute hospital. A review of a nurses note dated 12/31/19, indicated Resident 89 left with a family member via private car. A review of the physical therapy discharge summary, dated 12/31/19, indicated discharge destination was, Family member's home, and discharge reason was, Highest Practical Level Achieved. During a concurrent interview and record review on 3/6/20, at 1:46 p.m., the MDSC 2 confirmed Resident 89 went home with a family member and not to the hospital. She further confirmed that the MDS was coded incorrectly and stated, I'll fix it now.
F 0655 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted** Based on observation, interview, and clinical record review, the facility failed to create a baseline care plan for one of 21 sampled residents (Resident 242) which included information vital to her care, when hospital discharge orders to weigh Resident 242 daily and walk four to six times daily were not included. This failure resulted in Resident 242 not receiving care specific to her needs. Findings: Resident 242 was admitted to the facility in 2020 from a general acute care hospital (GACH) following open heart surgery. Review of the GACH Inpatient Discharge Instructions for Resident 242, dated

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

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F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, clinical record review, and facility policy review, the facility failed to develop and implement a [MEDICAL CONDITION] (a sudden, uncontrolled electrical disturbance in the brain) care plan for one of 21 sampled residents (Resident 75). This failure placed Resident 75 at risk for not receiving appropriate care during and following a [MEDICAL CONDITION] episode. Findings: Resident 75 was admitted to the facility with [DIAGNOSES REDACTED]. A review of, Physician Orders, dated 2/5/20, for Resident 75, indicated, [MEDICATION NAME] Sodium (medication used to treat various types of [MEDICAL CONDITION] disorders) Capsule Delayed Release Sprinkle 125 MG (milligrams a unit of measure) Give 1 capsule by mouth two times a day for [MEDICAL CONDITION]. A review of, Medication Administration Record, [REDACTED]. A review of, Medication Administration Record, [REDACTED]. During an interview on 3/5/20, at 10 a.m., with Licensed Nurse (LN) 2, LN 2 confirmed there was not a care plan in place for a [MEDICAL CONDITION] disorder for Resident 75. During an interview on 3/5/20, at 10:05 a.m., with the director of nurses (DON), the DON indicated there should have been a care plan in place for Resident 75 for [MEDICAL CONDITION] disorder. A review of the facility policy titled, [MEDICAL CONDITION] and [MEDICAL CONDITION] - Clinical Protocol, revised November, 2018, indicated, Assessment and Recognition; 1. The physician and staff will help identify individuals who have a history of [MEDICAL CONDITION] or [MEDICAL CONDITION], and individuals who are receiving antiepileptic medications (medications to prevent [MEDICAL CONDITION]) for any reason; for example, [MEDICAL CONDITION] (protective or preventive treatment) . 2. In addition, the nurse shall assess and document/report the following: a. vital signs; b. Neurological assessment; c. Change in level of consciousness; d. Any [MEDICAL CONDITION] activity in detail . e. Injury occurring with [MEDICAL CONDITION] . A review of the facility policy titled, Care Plans, Comprehensive Person Centered, revised December 2016, indicated, Policy Statement; A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident . 8 . The comprehensive, person-centered care plan will: . h. Incorporate risk factors associated with identified problems; .l. Identify the professional services that are responsible for each element of care; .m. Aid in preventing or reducing decline in the resident's functional status and/or functional levels; .o. Reflect currently recognized standards of practice for problem areas and conditions . 10. Identifying problem areas and their causes, and developing interventions that are targeted and meaningful to the resident, are the endpoint of an interdisciplinary process; . b. The resident's physician (or primary healthcare provider) is integral to this process.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, clinical record review, and facility policy review, the facility failed to provide needed care and services for one of 21 sampled residents (Resident 242) when; 1. Pertinent care orders from Resident 242's hospital stay were not included in the initial plan of care; 2. The facility did not apply Resident 242's TED hose ([MEDICAL CONDITION]-Embolic Deterrent stockings, used for individuals after surgery to help prevent pooling of blood in the legs that could lead to a blood clot, and help with swelling in the legs) as ordered; 3. Resident 242 did not receive assistance with walking four to six times a day, as directed by her heart surgeon; 4a. A hospital discharge order to weigh Resident 242 daily was overlooked; 4b. Resident 242's primary facility physician did not notice that the facility admission orders [REDACTED]. A subsequent order to check a daily weight was not followed; 5. Resident 242 did not receive a diuretic (a water pill, helps the body expel excess fluid) as ordered and the facility did not consult with the physician about the missed dose; and 6. The facility did not promptly identify signs of heart failure (the heart muscle is weak and does not pump adequately. This may result in swelling and shortness of breath when fluid builds up in the lungs) and fluid overload (too much fluid in the body, can cause breathlessness and swelling) in Resident 242 and intervene appropriately. These failures resulted in Resident 242's re-hospitalization with [MEDICAL CONDITION], respiratory distress, and pneumonia. Findings: Resident 242 was admitted to the facility in 2020 from a general acute care hospital (GACH) following open heart surgery. During the initial screening on 3/3/20, Resident 242 was observed in her recliner. Her legs were swollen. Resident 242 did not understand English. She was receiving oxygen from a tank, through tubing into her nose. Resident 242's family member (FM) 2 indicated Resident 242 had been to see her heart surgeon (MD) 3 and recently returned. FM 2 indicated Resident 242 was more swollen and was started on oxygen on 3/2/20, for shortness of breath. FM 2 indicated MD 3 ordered water pills for the swelling and wanted her to wear the TED stockings. She was not wearing TED stockings. During an observation and concurrent interview on 3/4/20, at 8 a.m., Resident 242 was in bed eating breakfast. Her arms and legs were swollen. Resident 242's swelling in her arms was not present during the observation on 3/3/20. She was breathing rapidly, 24 times per minute (normal rate is between 12-18 breaths per minute) and had to stop eating to catch her breath. FM 1 stated, .They were walking her five times a day at acute hospital. She's gotten worse here, gone downhill the last couple

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F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) of days. I've asked therapy to teach us so we can walk with her but now she's so weak and short of breath .she's still short of breath today . (heart surgeon) yesterday said she needs to get up more . when she first got here, she was pretty good. I told the nurse yesterday she was having the same symptoms yesterday she was having before she went in, very tired and sleepy. They did tell me they changed her med (medication) yesterday. They weighed her in therapy a few days ago . 1. Review of the GACH Inpatient Discharge Instructions for Resident 242, dated 2/24/20, indicated, .Activity .OOB (out of bed), ambulate (walk) 4-6 times daily .daily weight . Review of Resident 242's record, indicated a GACH form titled, PHYSICIAN INFORMATION dated 2/24/20, included, .Physician orders to be carried out in new facility .daily weights . Review of a GACH note titled, INTERFACILITY TRANSFER RECORD dated 2/24/20, indicated Resident 242 was able to walk with a walker if supervised. Review of Resident 242's clinical record, Baseline Care Plan Summary (a baseline care plan is intended to promote continuity of care and protect against adverse events that may occur after admission, to prevent re-hospitalization) dated 2/28/20, indicated Resident 242's goal was to be able to go home and resume her usual activities. The treatment planned for Resident 242 did not include the need to monitor daily weights or to walk four to six times a day. During an interview on 3/4/20, at 8:20 a.m., with Licensed Nurse (LN) 1, LN 1 stated, .indicated Resident 242's weight was scheduled to be checked weekly on Fridays. During a concurrent interview and record review on 3/5/20, at 9:37 a.m., MDS Coordinator (MDSC-a nurse who completes resident care assessments and screening) 2 reviewed Resident 242's hospital discharge orders and baseline care plan. MDSC 2 indicated when a resident came in to the facility, the admitting nurse entered the orders. She indicated all residents are weighed daily for the first three days in the facility. MDSC 2 stated, .No other weights were taken. She should have had daily weight .she was at high risk for fluid accumulation .the baseline care plan should have the need for daily weights .ambulation four to six times a day should have been on there (the baseline care plan). MDSC 2 indicated she assisted with Resident 242's admission and stated, .I didn't see the admission order when I did it .I help them do care plans when they don't have a desk nurse . During a concurrent interview and record review on 3/6/20, at 11:56 a.m., with MDSC 1, MDSC 1 reviewed Resident 242's clinical record, weight log and care plans. MDSC 1 stated, .They weighed (Resident 242) three days per protocol. They should have continued after the three days .it should have been in the care plan . During a concurrent interview and record review on 3/6/20, at 11:56 a.m., with the director of nursing (DON), the DON reviewed Resident 242's care plans. The DON indicated Resident 242 was at higher risk for fluid overload due to her recent heart surgery. She indicated this risk should have been explained in Resident 242's initial care plan. During a telephone interview on 3/10/20, at 9:06 a.m., with Resident 242's heart surgeon (MD) 3, MD 3 stated, .They (facility staff) weren't walking her .Pneumonia is a risk when a patient doesn't walk .She came in (back to the hospital) with signs of heart failure .She was definitely in fluid overload .they should have weighed her every day. They might have noticed the signs sooner . Information from the American Association of Heart Failure Nurses (AAHFN) at the following address: https://www.aahfn.org/mpage/dailyweights, indicated, Weight gain is one of the first signs of retaining fluid . Changes in your weight may be a sign of fluid retention. Often increases in weight can be easily dealt with by changing your diuretic (water pill). Contact your health care team right away to report weight gain Review of the facility policy titled, Care Plans-Baseline revised 12/2016, indicated, .To assure that the resident's immediate care needs are met and maintained .review the healthcare practitioner's orders and implement a baseline care plan to meet the resident's immediate care needs . 2. Review of the GACH Inpatient Discharge Instructions for Resident 242, dated 2/24/20, indicated, .TED hose on both legs if swollen. Wear during the day, take off before bed and then put back on the next morning if legs are still swollen . Review of physician orders dated 2/24/20, indicated, .TED hose on both legs if swollen. Wear during the day, take off before bed and then put back on the next morning if legs are still swollen . This order was signed by Resident 242's primary physician at the facility, MD 1 on 2/28/20. During the initial screening on 3/3/20, Resident 242 was observed in her recliner. Her legs were swollen. She was not wearing TED stockings. Resident 242 had recently returned from an appointment with a physician, her heart surgeon (MD) 3. During an interview on 3/10/20, at 9:06 a.m., with MD 3, MD 3 stated, .I saw (Resident 242) last Tuesday (3/3/20) .Her legs were swollen .(Resident 242) didn't have them on (the TED stockings) at my office . MD 3 indicated he gave the order for Resident 242 to wear the stockings when she discharged from the hospital and stated, .I wrote another order for them (the facility) to do it . Review of Resident 242's clinical record indicated an order from MD 3, dated 3/3/20, .Ted hose both legs for 8 weeks . 3. Review of the GACH Inpatient Discharge Instructions for Resident 242, dated 2/24/20, indicated, .Activity .OOB (out of bed), ambulate (walk) 4-6 times daily . Review of a GACH note titled, INTERFACILITY TRANSFER RECORD dated 2/24/20, indicated Resident 242 was able to walk with a walker if supervised. During the initial screening on 3/3/20, Resident 242 was observed in a wheelchair. A staff member pushed the wheelchair into the bathroom. During a concurrent interview and record review on 3/5/20, at 9:37 a.m., MDS (miminum data set, an assessment tool) Coordinator (MDSC-a nurse who completes resident care assessments and screening) 2 reviewed Resident 242's hospital discharge orders and the facility orders entered on admission 2/24/20. MDSC 2 indicated she assisted with Resident 242's admission to the facility and missed the admission order for Resident 242 to walk four to six times a day. MDSC 2 indicated any staff member trained to ambulate residents could have walked with Resident 242. MDSC 2 further indicated she worked on Resident 242's MDS and Resident 242 was able to stand up from a sitting position on her own on 2/29/20. MDSC 2 stated, .usually the therapist is aware they need to ambulate . Review of Resident 242's MDS dated [DATE], indicated Resident 242 was able to walk in her room with limited assistance by one person. The MDS assessment further indicated, Walk in corridor did not occur. Resident 242's mobility device was a wheelchair. Review of Resident 242's nursing care plans indicated no interventions for Resident 242 to ambulate four to six times a day. Review of Resident 242's clinical record, Documentation Survey Report v2 (a record on which certified nursing assistants recorded their tasks) for February 2020, indicated certified nurses assistant (CNA) task, ADL (activities of daily living)-Walk in corridor was documented not applicable on 2/25/20-2/29/20. Review of Resident 242's clinical record, Documentation Survey Report v2 for March 2020, indicated CNA task, ADL (activities of daily living)-Walk in corridor was documented not applicable on 3/1/20-3/4/20. There was no documented evidence in Resident 242's clinical record that a restorative nurses assistant (RNA) or a nurse ambulated Resident 242. Review of Resident 242's clinical record, Physical Therapy PT Evaluation & Plan of Treatment dated 2/25/20, indicated, .Frequency: 5 time(s)(week) .Daily .PLOF (prior level of function); pt. (Resident 242) lives in single level home with family, was ambulatory with 4WW (a walker), IND (independent) with most ADL's (activities of daily living) . During an interview on 3/5/20, at 10:37 a.m., with the director of rehab (DOR), the DOR stated, .I talked to the cardiologist and stated it counts to just get her up to side of bed . The DOR indicated Resident 242's orders for therapy were five times a week. She indicated cardiac patients needed to walk four times a day and the therapist would split the treatment to ensure more frequent walking than one time during the day of treatment. The DOR indicated there was no therapy documentation that Resident 242 was ambulated more often in one day than the single time of treatment. There was no treatment scheduled on 3/1/20, as the orders were five times a week and 3/1/20, was the sixth day. The DOR stated, .The evaluating therapist is supposed to review the chart (for hospital discharge information). It's so impossible to make sure they (residents) walk the halls that often. Our frequency is five times a week, so not on the weekend. She was still new so we didn't feel she could walk with RNA or CNA or family. We have to train the family. They wanted to take her home AMA (against medical advice) . The DOR indicated resident 242's limitation of therapy services was determined by insurance. Review of Resident 242's clinical record indicated an order written [REDACTED]. The order indicated, .Pt (Resident 242) needs (underlined twice) to ambulate with assist 6-7 x/day (times per day) .Pt was walking (more than) 100 ft 6 x/d (times per day) before discharge .Pt has taken steps back since @ (at) ECF (extended care facility) . During a review of Resident 242's clinical record, Nurses Notes dated 3/5/20, indicated Resident 242 went to the hospital by ambulance at 7:35 p.m. on 3/4/20. During a telephone interview on 3/6/20, at 4:30 p.m., with FM 1, FM 1 stated, .She was not getting any exercise. The nurse (at the hospital) told me if they were not walking the way they were supposed to, she could end up with pneumonia. She has pneumonia . During a telephone interview on 3/10/20, at 9:06 a.m., with MD 3, MD 3 stated, .I saw her last Tuesday (3/3/20). I was concerned. In the hospital she was walking 100 steps six times a day. She was walking with the walker .She took steps back. They weren't walking her. No one called to ask if it was OK to just use short trips to the bathroom or bedside. To bathroom in my mind is not a walk. In the hospital she was walked by the nurses. Not just PT (physical therapy) and that was with chest tubes, IV's (intravenous-used to administer medication or fluid into a vein) tubes everywhere .pneumonia is a risk when a patient doesn't walk . Review of the clinical record from the general acute care hospital (GACH), History and Physical dated 3/4/20, indicated Resident 242 was admitted with [DIAGNOSES REDACTED]. Review of Resident 242's record, indicated a GACH form titled, PHYSICIAN INFORMATION dated 2/24/20, included, .Physician orders to be carried out in new facility .daily weights . Review of physician orders dated 2/24/20, indicated, .Weekly Weights x 4 (for four weeks) .every Fri (Friday) . This order was

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F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) signed by Resident 242's primary physician at the facility, (MD) 1 on 2/28/20. During an observation and concurrent interview on 3/4/20, at 8 a.m., Resident 242 was in bed. Her arms and legs were swollen. She was breathing rapidly, 24 times per minute (normal rate is between 12-18 breaths per minute) and had to stop eating to catch her breath. FM 2 stated, .they weighed her in therapy a few days ago . During an interview on 3/4/20, at 8:20 a.m., with Licensed Nurse (LN) 1, LN 1 indicated Resident 242's weight was scheduled to be checked weekly on Fridays. During a concurrent interview and record review on 3/5/20, at 9:37 a.m., MDS Coordinator (MDSC-a nurse who completes resident care assessments and screening) 2 reviewed Resident 242's hospital discharge orders. MDSC 2 indicated when a resident came in to the facility, the admitting nurse entered the orders. She indicated all residents are weighed daily for the first three days in the facility. MDSC 2 stated, .No other weights were taken. She should have had daily weight .she was at high risk for fluid accumulation . MDSC 2 indicated she assisted with Resident 242's admission and stated, .I didn't see the admission order when I did it . MDSC 2 indicated the orders were entered and submitted to MD 1 for signature. During a concurrent interview and record review on 3/6/20, at 11:56 a.m., with MDSC 1, MDSC 1 reviewed Resident 242's clinical record and weight log. MDSC 1 stated, .They weighed (Resident 242) three days per protocol. They should have continued after the three days . Resident 242's weight log indicated three daily weights were obtained on 2/25/20, 2/26/20, and 2/27/20. 4b. Review of Resident 242's record, indicated a GACH form titled, PHYSICIAN INFORMATION dated 2/24/20, included, .Physician orders to be carried out in new facility .daily weights . Review of physician orders dated 2/24/20, indicated, .Weekly Weights x 4 (for four weeks) .every Fri (Friday) . This order was signed by Resident 242's primary physician at the facility, (MD) 1 on 2/28/20. During a telephone interview on 3/5/20, at 3:14 p.m., with MD 1, MD 1 stated, .To my knowledge I didn't change anything (order for daily weight changed to weekly weight). I may have overlooked the daily weight the surgeon ordered in her (Resident 242's) discharge paperwork . When asked if the facility asked her to change the weight order, MD 1 stated, .I wouldn't have changed it (weight order) based on her situation and her recent heart surgery . 4c. Review of physician orders dated 3/4/20, at 10:31 a.m., indicated, Daily Weights x 3 days. every day shift for 3 Days . There was no documented evidence Resident 242 was weighed on 3/4/20. During a telephone interview on 3/10/20, at 9:06 a.m., with MD 3, MD 3 stated, .She (Resident 242) was definitely in fluid overload when I saw her in my office (3/3/20). We had her in good fluid status when she discharged (after surgery) .They (facility) should have weighed her every day. They might have noticed the signs sooner . MD 3 indicated Resident 242 was readmitted to the hospital with [REDACTED].heart failure .fluid overload . Information from the American Association of Heart Failure Nurses (AAHFN) at the following address: https://www.aahfn.org/mpage/dailyweights, indicated, Weight gain is one of the first signs of retaining fluid . Changes in your weight may be a sign of fluid retention. Often increases in weight can be easily dealt with by changing your diuretic (water pill). Contact your health care team right away to report weight gain Review of information from the American Heart Association at the following address: https://www.heart.org/en/health-topics/heart-failure/warning-signs-of-heart-failure, indicated signs and symptoms of heart failure included swelling, shortness of breath, tiredness and fatigue. 5. During the initial screening on 3/3/20, Resident 242 was observed in her recliner. Her legs were swollen. Resident 242's family member (FM) 2 indicated Resident 242 had been to see her heart surgeon (MD) 3 and recently returned. FM 2 indicated MD 3 ordered a diuretic for her swelling. During an observation and concurrent interview on 3/4/20, at 8 a.m., Resident 242 was in bed eating breakfast. Her arms and legs were swollen. She was breathing rapidly. FM 2 stated, .She's gotten worse here, gone downhill the last couple of days .They did tell me they changed her medication yesterday . Review of Resident 242's clinical record indicated an order from MD 3, dated 3/3/20, .(brand name [MEDICATION NAME]-a diuretic used to treat fluid retention) 20 mg PO (by mouth) BID (twice daily) x (for) 7 days . Review of the physician order entered into Resident 242's electronic health record, dated 3/3/20, indicated, .[MEDICATION NAME] Tablet 40 MG (mg-a unit of measure) Give 1 tablet by mouth two times a day [MEDICAL CONDITION](hypertension-high blood pressure) . Review of Resident 242's clinical record, Medication Administration Record [REDACTED]. This indicated, Other/See Progress Notes. Review of Resident 242's clinical record, Orders-Administration Note dated 3/3/20, at 6:48 p.m., indicated, New medication from appointment today, faxed to pharmacy will follow up. During an interview on 3/5/20, at 9:37 a.m., MDSC 2 indicated Resident 242 did not receive her [MEDICATION NAME] on 3/3/20. MDSC 2 stated, .I believe it was very important to have her ([MEDICATION NAME]) . During a concurrent observation and interview on 03/05/20, at 10:13 a.m., in the medication storage room, MDSC 2 placed the emergency kits (e-kit) on the counter to check for [MEDICATION NAME]. One of the e-kits contained [MEDICATION NAME] as an injectable medication. The facility had 2 vials of (brand name [MEDICATION NAME]) 20mg/2ml (milligram per milliliter-measures the concentration of a medication). During a telephone interview on 3/5/20, at 3:14 p.m., MD 1 stated, .Not aware they did not give her the ([MEDICATION NAME]) on 3/3/20. If they (staff) would have called me I would have ordered IM (intramuscular-injection) ([MEDICATION NAME]) . During an interview on 3/5/20, at 4:04 p.m., with the pharmacist (PHM) 1, PHM 1 indicated the pharmacy received the order for [MEDICATION NAME] on 3/3/20, at 2:33 p.m. The medication was delivered to the facility on [DATE], at 11:10 p.m. During a concurrent interview and record review on 3/6/20, at 11:56 a.m. with MDSC 1 and the DON, MDSC 1 reviewed Resident 242's clinical record and indicated the [MEDICATION NAME] dose for 3/3/20, was not given when it arrived at the facility, and Resident 242 did not receive the medication until 3/4/20. MDSC 1 indicated the nurse should have notified the physician on 3/3/20, when the [MEDICATION NAME] was not available. The DON indicated the heart surgeon would not have been called. He was not in their system. Resident 242's primary physician, MD 1 was considered her ordering doctor. The DON stated, .There is nothing that said we called the MD (physician) to notify medication was not available . During a telephone interview on 3/6/20, at 4:30 p.m., with FM 1, FM 1 indicated Resident 242 was admitted to the hospital and was in poor condition. FM 1 stated, .She's getting (brand name [MEDICATION NAME]) because she's full of fluid . During a telephone interview on 3/10/20, at 9:06 a.m., with MD 3, MD 3 stated, .She (Resident 242) didn't have much swelling when she left (the hospital discharge 2/24/20) .She came in (re-hosptalized on [DATE]) with signs and symptoms of [MEDICAL CONDITION] .She needed to be [MEDICATION NAME] (fluid removed using diuretic) .She was definitely in fluid overload when I saw her in my office (3/3/20) .She needed to be started on the (brand name [MEDICATION NAME]) that day (3/3/20) . MD 3 indicated he was not aware Resident 242 did not receive [MEDICATION NAME] on 3/3/20. Review of the facility policy, MEDICATION ORDERS dated April 2008, indicated, .The prescriber is contacted for direction when the medication will not be available . 6. During an observation and concurrent interview on 3/4/20, at 8 a.m., Resident 242's arms and legs were swollen. Resident 242's swelling in her arms was not present during the observation on 3/3/20. She was breathing rapidly, 24 times per minute (normal rate is between 12-18 breaths per minute) and had to stop eating to catch her breath. FM 1 stated, .She's gotten worse here, gone downhill the last couple of days .now she's so weak and short of breath .When she first got here, she was pretty good. I told the nurse yesterday she was having the same symptoms yesterday she was having before she went in, very tired and sleepy. They did tell me they changed her med yesterday. they weighed her in therapy a few days ago . During a concurrent observation and interview on 3/4/20, at 8:20 a.m., Licensed Nurse (LN) 1 went into Resident 242's room. LN 1 returned and stated, .Lungs are diminished (quiet sounds-decreased air flow) and has wheezing (a high-pitched sound). She (Resident 242) had a change of condition. I plan to ask for some breathing treatment (medication is turned into mist to be inhaled, used to relieve symptoms of tight airways by opening the airway). When asked by the Department if Resident 242 had a chest x-ray recently, LN 1 stated, .I could ask the doctor for that too . LN 1 indicated Resident had more swelling. When asked by the Department if Resident 242 was being weighed, LN 1 indicated she was weighed weekly on Fridays. LN 1 indicated when there was a change of condition he went directly to the physician. LN 1 indicated he had not requested a registered nurse to assess Resident 242. During a telephone interview on 3/5/20, at 3:14 p.m., with MD 1, MD 1 stated, .They contacted us with a request for orders .they (nurses) need to give the physician an accurate picture and assessment so we can make a decision . Review of Resident 242's record, indicated a GACH form titled, PHYSICIAN INFORMATION dated 2/24/20, included, .Physician orders to be carried out in new facility .daily weights . Review of Resident 242's clinical record indicated the following progress notes: COMS (clinical outcomes management system)-Skilled Evaluation . dated 2/26/20, at 3:06 p.m., indicated, .O2 sats (oxygen saturation level-normal is 95-100%) .97.0% .Room Air .No [MEDICAL CONDITION] (swelling) present .Lungs clear .No difficulty breathing . COMS- Skilled Evaluation . dated 2/28/20, at 1:06 p.m., indicated, .O2 sats .97% .Room Air .Lungs clear .No difficulty breathing . COMS- Skilled Evaluation . dated 3/1/20, at 4:15 p.m., indicated, .O2 sats .97% .Room Air .Lower extremity (s): +2 [MEDICAL CONDITION] (a slight indentation on the swollen part rebounds in 15 seconds or less) .Other [MEDICAL CONDITION]: No .Room Air .Lungs clear .No difficulty breathing . COMS- Skilled Evaluation . dated 3/2/20, at 10:20 a.m., indicated, .O2 sats .89% .Room Air . Lower extremity (s): +2 [MEDICAL CONDITION] . Other [MEDICAL CONDITION]: No .No difficulty breathing . This note listed Resident 242's weight as 177.8, last taken on 2/27/20. Change of Condition dated 3/2/20, at 12:55 p.m., indicated, .Noted to be c/o (complaining of) SOB (shortness of breath) .new orders for PRN (as needed) oxygen . COMS- Skilled Evaluation .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555496	A. BUILDING _____ B. WING _____	03/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RIVERWOOD HEALTH CARE	5320 CARRINGTON CIRCLE STOCKTON, CA 95210

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 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4) dated 3/3/20, at 2:44 p.m., indicated, .O2 sats .97% .Oxygen (while using oxygen) . Lower extremity (s): +3 [MEDICAL CONDITION] (a deeper indentation and rebounds slower-this indicated worsening swelling) . Other [MEDICAL CONDITION]: No .Difficulty breathing noted .Lungs: CTA (clear to auscultation-when listened to) . Nurses Notes dated 3/3/20, at 10:59 p.m., indicated, .On O2 .O2 sat 93% . Nurses Notes dated 3/4/20, at 5:30 a.m., indicated, .episode of SOB (shortness of breath), O2 sat 83-86%, sat resident up and instructed her in deep breathing, able to stabilize O2 at 90-92% . Nurses Notes dated 3/4/20, at 9:31 a.m., indicated, (MD 1) contacted in regards of resident worsening [MEDICAL CONDITION] (swelling) to bilateral (both) upper and lower extremities (arms and legs), mild wheezing and shortness of breath .(MD 1) with order for (brand name nebulizer medication-a machine which creates mist from the medication, inhaled to help control the symptoms of lung diseases, such as asthma, [MEDICAL CONDITION] and [MEDICAL CONDITION]) .and .chest x-ray to rule out PNA (pneumonia) . Nurses Notes dated 3/4/20, at 10:38 a.m. indicated, .Per (MD 1) to also do daily weights x (for) 3 days . Nurses Notes dated 3/5/20, at 12:11 a.m., indicated, @ (at) 1700 (5 pm) O2 sat 87% @ 3 lpm (the oxygen flow rate) .Respirations labored, use of accessory muscles (other muscles used to assist with getting a breath when breathing is difficult) .administered ([MEDICATION NAME]) for generalized [MEDICAL CONDITION] .chest x-ray received and reviewed by (MD 2-the medical director) .new orders to send out to hospital for further evaluation .Resident left facility @ 1935 (7:35 p.m. on 3/4/20). During a concurrent interview and record review on 3/6/20, at 11:56 a.m. with MDSC 1 and the DON, MDSC reviewed Resident 242's respiratory (breathing) nursing care plan and stated, .should have dealt with fluid overload as potential after heart surgery . The DON indicated Resident 242 should have had a care plan explaining the signs of fluid overload. The DON indicated the physician should have sent Resident 242 to the hospital early on 3/4/20, when her oxygen level dropped to 83-86%. There was no documented evidence the physician was contacted at that time. Review of the clinical record indicated there was no evidence Resident 242's decline in condition was identified as fluid overload and possible heart failure. There was no documented evidence Resident 242 was weighed after 2/27/20. During a telephone interview on 3/10/20, at 9:06 a.m., with MD 3, MD 3 stated, .She (Resident 242) didn't have much swelling when she left (the hospital after surgery) .I saw her Tuesday (3/3/20). She was swollen and on oxygen .I thought she took steps back .(lungs) had crackles (a crackling sound similar to Velcro torn open-often indicates fluid in the lung) .She was definitely in fluid overload when I saw her in my office .She needed to be started on the (brand name [MEDICATION NAME]) that day (3/3/20) .They should have weighed her every day. They might have noticed the signs sooner . Review of information from the American Heart Association at the following address: https://www.heart.org/en/health-topics/heart-failure/warning-signs-of-heart-failure, indicated signs and symptoms of heart failure included swelling, shortness of breath, tiredness and fatigue. Review of Resident 242's clinical record provided by the general acute care hospital (GACH), the History and Physical dated 3/4/20, indicated, .admitted to emergency department for worsening shortness of breath associated with leg swelling .Assessment/Plan .Acute [MEDICAL CONDITION] .heart failure .fluid overload . Resident 242's breathing was assisted by a [MEDICAL CONDITION] (bilevel positive airway pressure- a machine used to support breathing in episodes of respiratory distress). Review of Resident 242's clinical record from the GACH titled, Emergency Documentation-MD dated 3/4/20, indicated, .Tachypneic (rapid breathing), increased work of breathing, bilateral (both sides) crackles .Suspected that tachypnea is secondary to increased fluid overload . Review of the GACH note titled Discharge Summary dated 3/10/20, indicated Resident 242 was in the intensive care unit while at the hospital. The summary indicated, .suggestion was normally to discharge patient to rehab for further care .Patient's family strongly declined this offer . Review of the facility policy, Heart Failure-Clinical Protocol revised November 2018, indicated, .The physician will review and make recommendations for relevant aspects of the nursing care plan; for example, what symptoms to expect, how often and what (weights, .) to monitor, when to report findings to the physician .
F 0742 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, clinical record review, and facility policy review, the facility failed to implement and monitor appropriate behavioral health care for one of 21 sampled residents (Resident 75), when Resident 75 was not followed by a psychiatrist (a medical practitioner specializing in the [DIAGNOSES REDACTED]. These failures resulted in Resident 75 not receiving appropriate behavioral health care and had the potential to result in psycho-social harm. Findings: Resident 75 was admitted to the facility with [DIAGNOSES REDACTED]. During an observation on 3/3/20, at 10:50 a.m., Resident 75 was observed wandering around the facility in his wheelchair. During an observation on 3/3/20, at 11:45 a.m., Resident 75 attempted to leave the dining room and was redirected 3 times by staff while waiting for lunch to arrive. Resident 75 stayed at the table when lunch arrived and finished lunch. During an interview on 3/5/20, at 11:19 a.m., with the social services director (SSD), the SSD stated, He should be managed by psych (psychiatrist) if he's on (brand name for [MEDICATION NAME], an antipsychotic medication) .no, he's not being managed by psych. The SSD further indicated Resident 75 was due for a Behavioral Management Committee meeting. During an interview on 3/5/20, 11:46 a.m., the director of nursing, the DON indicated, Resident 75 should have been followed by psych. A review of, Progress Notes, for Resident 75, from social services indicated there were no social service progress notes from 7/9/19 to 12/17/19. A review of, Physician's Progress Notes, dated, 9/17/19, for Resident 75, indicated, Addendum - Pt (patient) with hx (history) of dementia and now portraying signs and symptoms of [MEDICAL CONDITION] disorder. Pt started on (Brand name for [MEDICATION NAME]) to treat the condition. A review of, Resident Care Conference Attendance Sheet, dated 9/30/19, for Resident 75, indicated no discussion of Resident 75's initiation of antipsychotic medication and indicated no discussion of Resident 75 being referred to the Behavioral Management Committee. A review of, Resident Care Conference Attendance Sheet, dated 2/10/20, for Resident 75, indicated no discussion of Resident 75's continued use of antipsychotic medication and indicated no discussion of Resident 75 being referred to the Behavioral Management Committee. A review of the facility policy, Behavior Management Committee, revised January 2019, indicated, Policy: It is the policy of this facility that the residents exhibiting behavior problem will be assessed thoroughly and less restrictive interventions will be offered prior to the administration of the psychoactive (a drug which alters brain function, resulting in temporary changes in perception, mood, consciousness and behavior) medications: [REDACTED]. Residents identified to have persistent behavior outburst will be referred to the Behavior Management Committee consists of the Interdisciplinary Team members including the Attending Physician, Psychologist and Psychiatrist. 4. The Behavior Management Committee will: .Decide further intervention in collaboration with the Attending Physician and Psychiatrist to support the need of [MEDICAL CONDITION] medication not to exclude gradual dose reduction. 5. The Behavior Management Committee will meet once a month and as indicated to address: .The appropriateness of the ongoing use of the [MEDICAL CONDITION] medication .12. Social Services will make the appropriate referral to the Psychologist or Psychiatrist if needed . 14. Social Services will document in the Social Service note information discussed during the Behavior Management Committee Meeting which includes the intervention, psychological or psychiatric referral and gradual dose reduction . 16. The Administrator, Director of Nursing Services and Social Services will ensure that the Behavior Management Committee address the appropriate use of the [MEDICAL CONDITION] medication.
F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, clinical record review, and facility policy review, the facility failed to ensure one of 21 sampled residents (Resident 79) received an antipsychotic (used to manage mental illness) medication appropriately, when the physician renewed an as needed (PRN) order for an antipsychotic but did not evaluate Resident 79. This failure had the potential for Resident 79's condition and response to the medication to be managed. Findings: Resident 79 was admitted to

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	555496	A. BUILDING _____ B. WING _____	**03/06/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RIVERWOOD HEALTH CARE	**5320 CARRINGTON CIRCLE STOCKTON, CA 95210**

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F 0758 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 5) the facility in early 2020 with [DIAGNOSES REDACTED]. Review of physician orders for Resident 79 indicated the following: .(Brand name for quetiapine-an antipsychotic) Tablet 50 MG (milligram-a unit of measurement) Give 1 tablet every 24 hours as needed .for 14 days . dated 2/10/20. .(Brand name for quetiapine) Tablet 50 MG .Give 1 tablet every 24 hours as needed .for 14 days . dated 2/20/20. .(Brand name for quetiapine) Tablet 50 MG .Give 1 tablet every 24 hours as needed .for 14 days . dated 3/1/20. During a concurrent interview and record review with the director of nursing (DON) on 3/5/20, at 4:33 p.m., the DON indicated there were no psychiatry notes in Resident 79's clinical record. She stated, .no psych (psychiatry) visits we can see . During an interview on 3/5/20, at 4:40 p.m., Resident 79 indicated he had not seen his psychiatrist since he was admitted to the facility. During a concurrent interview and record review on 3/5/20, at 4:47 p.m., the DON indicated Resident 79 should have been evaluated by a physician when the antipsychotic to be given prn was started on 2/10/20, and then renewed on 2/20/20, and 3/1/20. The DON reviewed Resident 79's clinical record and indicated the facility physician (MD) 2 ordered the renewal on 2/20/20, and 3/1/20. There was no record MD 2 evaluated Resident 79 at that time. During a telephone interview on 3/6/20, at 10:39 a.m., with the pharmacist (PHM) 2, PHM 2 indicated the facility sent faxed orders for Resident 79's antipsychotic medication. The orders were filled. PHM 2 stated, .the nurses aren't supposed to get the order filled with no MD (physician) evaluation . Review of the facility policy titled, Antipsychotic Medication Use revised 12/2016, indicated, .PRN orders for antipsychotic medications will not be renewed beyond 14 days unless the healthcare practitioner has evaluated the resident for the appropriateness of that medication .