STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555496	A. Building B. Wing	09/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverwood Health Care	5320 Carrington Circle Stockton, CA 95210

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, and interview, and record review, the facility failed to ensure that staff treated residents with dignity and respect for 1 of 24 sampled residents (Resident 40) when staff referred to Resident 40 as a feeder during care, rather than addressing the resident by name or in a manner that upheld his dignity. This failure had the potential to demean Resident 40, negatively impact his self-esteem, and compromise Resident 40's right to be treated with dignity and respect. Findings:During a review of Resident 40's admission RECORD, indicated Resident 40 was admitted to the facility with multiple diagnoses including dysphagia (difficulty swallowing) and anxiety disorder (a condition in which a person has excessive worry, feelings of fear, dread, and uneasiness).During an observation on 9/9/25, at 11:59 a.m., in Resident 40's room, Certified Nursing Assistant (CNA) 3 was observed helping CNA 2 to provide care to Resident 40. CNA 3 stated to CNA 2, He [Resident 40] is a feeder now? During an interview on 9/9/25, at 12 p.m. with CNA 3, CNA 3 stated that staff should not have labeled Resident 40 as a feeder because it could have affected the resident's self-esteem. During an interview on 9/12/25, at 10:03 a.m., with the Assistant Director of Nursing (ADON), the ADON stated that all staff were expected to treat residents with dignity and respect at all times. The ADON further stated that staff should have been mindful of their words and actions because demeaning language toward Resident 40 could have caused mistrust and low self-esteem.During an interview on 9/12/25, at 10:49 a.m., with the Director of Nursing (DON), the DON stated that her expectation was for staff to treat all residents with dignity and respect. The DON further stated that using terms such as feeder in front of residents could have negatively impacted Resident 40's psychosocial well-being. A review of the facility policy titled, Dignity, revised February 2021, indicated, .Each resident shall be cared for in a manner that promotes.feelings of self-worth and self-esteem.8. Staff speak respectfully to residents at all times, including addressing the resident by his or her name of choice and not labeling.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the safe storage and use of a resident's personal medication for 1 of 14 residents observed during a medication pass (Resident 102) when over the counter medications (OTC, a medication that can be obtained without prescription) and supplements (pills that provide nutrients like vitamins, minerals and herbs that may be missing from a person's daily food intake) were found at Resident 102's bedside without a physician's order.This failure had the potential to result in unsafe and/or unauthorized use of OTC medications and/or supplements that could have resulted in illness or injury to Resident 102 and/or other residents in the facility. Findings:During a concurrent observation and interview on 9/9/25, at 12:15 p.m., with Licensed Nurse (LN) 1, the following OTC medications and supplements were found at Resident 102's bedside:Two yellow capped bottles of a product labeled as Sualin, Natural cough and Cold Remedy, contained three different herbs on the bottle label.Two red capped bottles of a product labeled in a foreign language, contained 12 different ingredients listed on the bottle label.One purple colored bottle labeled as Hajmola, contained multiple herbal products and chemicals from [NAME]. One large bottle of a supplement called Nature Made Multi+ Omega-3 gummies (a supplement made in the United States, US)One large bottle of a supplement called Nature Made C 250 mg [milligrams - unit of measurement] Gummies, a vitamin product made in the US.LN 1 stated she was unaware of these medications and was surprised to see them at Resident 102's bedside.During a concurrent interview and record review on 9/9/25, at 12:30 p.m., with LN 1, Resident 102's electronic medical record (EMR) was reviewed. LN 1 confirmed Resident 102's EMR did not show any orders for Resident 102 to keep medications and/or supplements at the bedside, and the EMR did not show any orders to administer the medications and/or supplements found at the bedside. LN 1 stated she did not know the purpose of the foreign-labelled medications. LN 1 explained that the facility only administered medications prescribed by the attending physician. LN 1 identified the following risks of unauthorized medications and supplements at the bedside: Possible overdose Medication duplication Unauthorized access of medications by other residents Unknown side effects from the administration of non-prescribed medications During an interview on 9/10/25, at 3:50 p.m., with the Director of Nursing (DON), the DON stated Resident 102 had been at the facility for one week when the unauthorized medications were discovered. The DON further stated a care conference (a resident focused meeting with health care providers that focuses on the individual goals and needs of the resident) should have been held to address medication reconciliation (formal process of creating the most accurate and complete list of a resident's current medications and comparing that list against newly ordered medications) with the family. A review of the facility's policy titled, Administering Medications, revised 12/12, indicated, .Medications must be administered in accordance with the orders.A review of the facility's policy titled, Adverse Consequences and Medication Errors, revised 4/14, indicated, .The interdisciplinary team [a group of diverse professionals with different areas of expertise who collaborate to address complex problems and achieve shared goals] reviews the resident's medication regimen for efficacy and actual or potential medication-related problems on an ongoing basis.A review of the facility's policy titled, Medication Brought to the Facility by the Resident/Family, revised in 4/07, indicated, .Residents and families must report to the nursing staff any medications that they want to bring, or have brought into the facility.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, interview, and record review, the facility failed to ensure the protection of residents' personal information for a census of 81 when licensed nurse (LN) 8 left residents personal medical information unattended on the computer screen visible to anyone who walked by in the facility's dining room. This failure had the potential for misuse of residents personal information including identity theft. Findings:During a concurrent observation and interview in the facility's dining room on 9/9/25 at 12:15 PM, a computer was observed unattended with a residents medical information visible. Once LN 8 returned, they closed the computer and stated prior to stepping away from the computer the lock screen button should have been pressed to protect the residents privacy. LN 8 stated the purpose of locking the screen was to protect the resident's information from anyone accessing it who was not authorized. LN 8 stated that not protecting the residents health information places them at risk for identity theft.During an interview with the Director of Nursing (DON) on 9/12/25 at 12:42 PM, the DON stated after reviewing resident health information the expectation she had for her staff was to protect the residents information by locking the screen therefore an unauthorized person would not have access to it. The DON stated not doing so would place the residents' personal information at risk for theft.A record review of a facility provided document titled, Confidentiality of Information and Personal Privacy, dated October 2017, indicated, Policy Statement Our facility will protect and safeguard resident confidentiality and personal privacy. Policy Interpretation and Implementation 1. The facility will safeguard the personal privacy and confidentiality of all residents' personal and medical records. 2. The facility will strive to protect the resident's privacy regarding his or her: a. accommodations; b. medical treatment; c. written and telephone communications.4. Access to resident personal and medical records will be limited to authorized staff and business associates.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a clean, comfortable, and homelike environment for 5 out of 41 facility rooms when window blinds were broken in Residents rooms (room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER] and room [ROOM NUMBER]).These failures removed residents' rights to a dignified homelike environment, with the potential to result in psychosocial harm.Findings:During an observation on 9/09/25, at 10:58 AM, in room [ROOM NUMBER], the window blinds were observed to be broken.During a concurrent observation and interview on 9/09/25, at 12:59 PM, in room [ROOM NUMBER], Licensed Nurse (LN) 3 confirmed the window blinds were broken. LN 3 stated broken blinds were a dignity issue for the residents. LN 3 confirmed window blinds had spaces when they were closed and anyone could have looked inside room [ROOM NUMBER] from outside the window. LN 3 further stated there was a lack of privacy when window blinds were missing. During a concurrent observation and interview on 9/10/25, at 10:07 AM, in room [ROOM NUMBER], Certified Nursing Assistant (CNA) 1 confirmed the window blinds were broken. CNA 1 stated the window blinds had been broken since the morning of 9/10/25, and she had not notified the Director of Maintenance Services (DES).During a concurrent observation and interview between 9/10/25, at 8:36 AM, and 9/11/25, at 3:46 PM, the DES confirmed the window blinds in room [ROOM NUMBER] had three broken blind slats, room [ROOM NUMBER]'s blinds were twisted and shorter than the window frame, room [ROOM NUMBER] had dented blinds, room [ROOM NUMBER] had two blind slats broken, and in room [ROOM NUMBER] a blind slat was broken and missing. The DES stated staff did not notify him the blinds needed to be fixed. The DES stated the risk was that anyone could have peeped inside the resident's rooms through the broken and missing blinds.During an interview on 9/10/25, at 2:25 PM, the Administrator (Admin) stated facility staff members had verbalized to the DES that morning that blinds were missing/broken. The Admin stated the expectation was to have staff log in the maintenance logbook that there were missing/broken blinds. The Admin stated Residents may not have full privacy when window blinds were missing/broken.During a concurrent observation and interview on 9/12/25, at 11:18 AM, in room [ROOM NUMBER] Responsible Party (RP) 1 stated the window blinds had been broken for two weeks. RP 1 stated anyone could see inside room [ROOM NUMBER] and the blinds should have been fixed.A review of a facility document titled, Safe and Homelike Environment, dated 2022, indicated, .In accordance with resident's rights, the facility will provide a safe, clean, comfortable and homelike environment.A review of a facility document titled, Work Orders, Maintenance, dated 2010, indicated, .In order to establish a priority of maintenance service, work orders must be filled out and forwarded to the Maintenance Director.It shall be the responsibility of the department directors to fill out and forward such work orders to the Maintenance Director.

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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. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview, and record review, the facility failed to ensure safe handling of Hazardous drugs (or HD, drugs that have the potential to cause harm to healthcare workers or patients when not handled properly), safe use of resident care devices (small devices that measure blood pressure (or BP, the force exerted by the blood on the walls of the arteries as it flows through the body) or heart beat), and timely measurement of blood sugar levels, based on standards of practice with a resident census of 87, when:Hazardous medications were not consistently labeled as hazardous to alert nursing staff on safe handling as observed during Resident 56's medication administration, and during a medication cart inspection for Resident 42, Resident 16, and Resident 76.Staff's personal blood pressure devices were used when the facility's blood pressure device malfunctioned during a medication administration observation for Resident 92.Resident 5's blood sugar was measured after Resident 5 consumed most of her meal tray but the doctor's order indicated the sugar level to be measured prior to the meal for insulin (drug to treat blood sugar disease) administration.These failed practices could contribute to unsafe resident care, undesirable resident outcomes, and the safety of both staff and residents could be compromised.Findings:1. During a medication administration observation, accompanied by Licensed Nurse 3 (LN 3), in the facility's Hall number 4, on 9/9/25, at 9:27 AM, LN 3 administered 12 medications to Resident 56. LN 3 without gloved hands administered a hazardous medication called Divalproex Sprinkle capsule (Same as valproic acid, drug used to treat mood disorder or used to prevent brain seizure) in a pill cup to Resident 56.The label on the Divalproex Sprinkle bubble pack did not have an alert for hazardous drug handling. The label, at the bottom, with a very small font wording, indicated If you become pregnant, do not take this drug.In an interview with LN 3, at the main nursing station, on 9/12/25, at 10:13 AM, LN 3 stated she was not aware that valproic acid was hazardous and required handling with use of gloves. LN 3 stated pharmacy labeling and Medication Administration Record (or MAR, a document that listed drug orders and instructions on when or how to administer) instructions would have helped with knowing to use gloves during drug administration.During an observation and inspection of the facility's medication cart for Hall number 2, accompanied by LN 4, on 9/9/25, at 10:20 AM, the cart stored two medications in pill form as follows:Valproic Acid for Resident 16 and Oxcarbazepine (medication for treatment of seizure) for Resident 76 that did not have a label for safe handling as a hazardous drug.During an observation and inspection of the facility's treatment cart (a mobile cart that stores skin medications and supplies), in Hallway number 2, accompanied by LN 7, on 9/10/25, at 11:07 AM, the treatment cart stored a tube of a topical skin product called Tacrolimus ointment (used to treat the symptoms of eczema (severely dry and itchy patches of skin) by suppressing the body's immune system) for Resident 42. The Tacrolimus ointment label was not marked for being hazardous to touch and it was co-mingled with other topical products in the top drawer without being stored in a Ziplock bag.In a concurrent interview with LN 7, at the main nursing station, and review of Resident 42's MAR, on 9/12/25, at 9:02 AM, LN 7 stated the MAR did not have a comment on safe handling of the ointment. LN 7 stated she used one pair of gloves when administering any topical products.During an interview with the Director of Nursing (DON), on 9/12/25 at 10:55 AM, the DON stated that her expectation was for nurses to use gloves when handling hazardous medications. The DON stated pharmacy should have labeled hazardous drugs and the MAR should have had directions on handling hazardous drugs to help with compliance and safety. During a concurrent interview and review of the facility's policy, titled Care of Patients On Chemotherapy (drugs used to treat cancer), dated 12/2019, the policy did not address handling of non-chemotherapy drugs listed as hazardous. The DON stated currently the facility had a policy regarding hazardous chemotherapy drugs, but she needed to coordinate with pharmacy to help with a policy on other hazardous drug use and handling. During a phone interview with the Consultant Pharmacist (CP) on 9/12/25 at 1:07 PM, the CP stated he will inform the pharmacy regarding the inconsistency with labeling hazardous medications and would recommend to the facility through his review to add HD handling instructions on the MAR.Review of the Center for Disease Control's National Institute for Occupational Safety and Health (CDC, and NIOSH, a federal agency sets standard of safety in health care) document, titled Managing Hazardous Drug Exposures: Information for Healthcare Settings, dated 12/2024, last accessed on 9/15/25 via https://www.cdc.gov/niosh/docs/2023-130/default.html and https://www.cdc.gov/niosh/docs/2025-103/default.html , the documents indicated Workplace exposure to hazardous drugs can result in negative acute and chronic health effects in healthcare workers including adverse reproductive outcomes. Efforts should be made to

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview, and record review the facility failed to ensure safe pharmaceutical services with a resident census of 87 when:Emergency medication Kits (Ekit, a supply of prescription medication reserved for emergency use when needed) use, opening, and its contents were not accounted for in the IV medication Ekit (Intravenous, into the vein) and refrigerator medication Ekit in the main medication room. Facility staff's personal purse was stored in the medication room counter-top where prescription and controlled drugs (drugs that required doctor's prescription and subject to abuse) were stored.Pharmaceutical delivery records for prescription and controlled drugs were not signed and reviewed by licensed staff upon delivery. These failed practices could contribute to lack of accountability and risk of drug diversion (diversion is unauthorized use of drugs).Findings:During a concurrent interview and inspection of facility's main medication room, accompanied by the Assistant Director of Nursing (ADON) and Licensed Nurse 2 (LN 2), on 9/9/25 at 10:39 AM, two opened Ekits, including an IV Ekit and Refrigerator Ekit, were reviewed for accuracy of content and its use. The opened Ekits had a yellow color seal tag indicating it was opened after delivery by the provider pharmacy as confirmed by ADON. The refrigerator Ekit review did not show any items removed. The IV Ekit contents did not show any medication was removed. The IV Ekit content included an antibiotic (medication used to kill bacteria) called clindamycin in IV form that was not listed on the Ekit's content list. The IV Ekit content additionally included two zip-lock bags with two opened syringe boxes of Dextrose 50% (percent) carpujet (prefilled syringe of IV form of sugar used during an emergency for blood sugar disease; 50% is percent, a fraction of 100). ADON acknowledged the findings and stated he needed to contact the provider pharmacy for clarification.During a concurrent interview and review of Ekit binder (a binder with sheets that recorded Ekit use by nursing staff), with the ADON, in the main medication room, on 9/9/25 at 11:28 AM, the binder marked as Emergency Kit Pharmacy Log, did not have any paper documentation of use by nursing staff since 2/2025. The binder did not show records of opening the refrigerator EKit or IV Ekit after pharmacy delivery of a new red-sealed (pharmacy sealed kits were marked by a red color seal) Ekits. ADON stated that when a kit was opened, the documentation should have been recorded in the Ekit form followed by a call to pharmacy for delivery of a new kit.Review of undated Ekit paper form titled, Emergency Kit Pharmacy Log, the log sheet indicated, Call order . into pharmacy; Fill out appropriate areas in log; When completed, place copy on pharmacy log clipboard; Return yellow copy to pharmacy in emergency kit. The form further indicated the white copy was for the facility.During an interview with the Director of Nursing (DON) on 9/10/2025 at 3: 50 p.m., the DON confirmed that a yellow EKit seal indicated the Ekit has been opened, while a red seal means the Ekit was intact and had not yet been opened by facility staff. The DON further stated that the facility's process for accessing the Ekit required a physician order first. The DON stated that when staff removed a medication from the Ekit, the removal should have been documented on the Ekit sheet provided by the pharmacy and the yellow copy should have gone back to the pharmacy while the white copy was retained by the facility. The DON stated the staff were expected to call the pharmacy to request a replacement medication. The DON stated she would consult with the pharmacist about the clindamycin IV found inside the Ekit that was not included on the medication list. The DON stated the opened box of D50% IV were not acceptable as she would not feel comfortable administering an opened, unsealed medication container to a resident. During a phone interview with the facility's Consultant Pharmacist (CP) on 9/12/2025 at 1:07 PM, the CP confirmed that a yellow tag indicated the Ekit had been opened, and all Ekit access should have been documented. The CP stated the facility should have informed the pharmacy when the Refrigerator Ekit seal was broken. The CP stated he was unsure if the clindamycin IV bag inside the IV Ekit without being listed was due to a shortage or the list not updated. Regarding the open D50% carpujet box, the CP stated the box should have been sealed, and he acknowledged the potential risk of contamination.Review of the facility's policy titled, Emergency Medications, revised on April 2007 indicated, .The contents of each emergency medication kit will be clearly listed.The consultant Pharmacist shall inspect the emergency medication kits monthly and record the findings on the record maintained with each kit.Records of monthly inspection are maintained for at least one (1) year or as required by applicable laws and regulations. 2. During a concurrent interview and inspection of facility's main medication room, accompanied by ADON, on 9/9/25 at 11:30 AM, a dark color personal purse was located on the main countertop just below the discontinued drugs cabinet. ADON stated the staff could have their purses stored in the medication room temporarily. During an interview with the DON on 9/10/2025

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure safe medication storage practices in two of four Medication carts (a mobile cart that holds patient medications and supplies), in one out one treatment carts (a mobile cart that holds medical and wound treatment supplies) and in one out of one medication rooms (a locked room used to store medications and supplies) with a resident census of 87 when:1.Medication cart in hallway #2 stored an undated Humalog insulin pen (drug used for blood sugar disease in a pen shape product) 2.Main medication room stored two opened vials of Aplisol (same as Tuberculin Purified Protein, use to test for TB, or tuberculosis, a serious lung infection) which was not dated when it was first opened. The medication room stored an opened and undated eye drop bottle called Timolol (or Timoptic, used to treat eye disease). 3.Treatment cart in hallway #2 stored opened sterile (free from germs) wound care supplies and/or products without any expiration date (the date that product was no longer should be used).These failures had the potential to result in unsafe medication storage, increase the risk of medication errors, and negatively affect the well-being of residents. Findings: 1. On 9/9/2025 at 10:19 a.m., during a concurrent interview and inspection of the Hall-2 medication cart, with licensed Nurse (LN) 4, an undated Humalog pen was stored inside the cart. LN 4 stated that the insulin pen was safe for use within 28 days after opening and should have been labeled when it was first used/opened. 2. On 9/9/2025 at 10:30 a.m., during a concurrent interview and inspection of the main medication room, with LN 2 and the Assistant Director of Nursing (ADON), the following were observed:a. Two opened Aplisol testing agent vials were stored in the refrigerator without open-date markings. The manufacturer label on the Aplisol box indicated . Once entered (opened), vial should be discarded after 30 days .b. A Timolol eye drop bottle was found in the medication room with a broken seal and no open date markings. The prescription label on the bottle indicated, .Discard unused portion after 28days . LN 2 acknowledged the findings.During an interview with the Director of Nursing (DON), in her office, on 9/10/25 at 3:50 p.m., the DON stated she expected the nursing staff to write the date on the product when they first opened a drug with limited beyond use date. 3. On 9/10/2025 at 10:55 a.m., during a concurrent interview and inspection of the treatment cart with LN 7, the following were observed:a. A sterile ComfortFoam (wound dressing used for weeping wounds) packet was found open and stored in the treatment cart together with other closed/sealed products. The label on the packet indicated Do Not Use if Damaged, Do Not Reuse and Sterilized product. LN 7 stated the sterile ComfortFoam should have been discarded and not returned to the treatment cart.b. A large number of DermaSeptin Ointment (single use packets of an ointment used to protect the skin) packets were found stored in a bin without expiration dates.LN 7 was unable to locate the expiration dates on the DermaSeptin Ointment packets and explained that she routinely stacks new ointment in the bin each morning due to high daily usage. LN 7 stated she could not find the expiration date on the ointment packet, and it may have been on the original container from the manufacturer.A review of the facility's policy titled, Administering Medications, revised in December 2012 indicated, .The expiration/beyond date on the medication label must be checked prior to administering. When opening a multi-dose container, the date opened shall be recorded on the container.A review of the facility's policy titled, Adverse Consequence and Medication Errors, revised in April 2014, indicated, .Examples of medication errors include.Failure to follow manufacturer instruction and/or accepted professional standards.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. (continued on next page)

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	555496	A. Building B. Wing	09/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on observation, interview, and record review, the facility failed to provide safe food storage and preparation, as well as maintain kitchen equipment and food contact surfaces in accordance with professional standards for food safety for the 87 residents who ate facility prepared meals when:1. Over ripe and spoiled produce was available for use in the walk-in refrigerator; 2. Black small bugs were found crawling on the onions and flying within the container that encompassed the onions; 3. Cutting boards and tray line pans were found with food particles, black, and brown colored substances on them; and,4. Several pots, pans, bowls, and trays were found stacked wet (in ready-to-use areas).These failures had the potential to put residents who ate the facility prepared meals at risk for foodborne illnesses.Findings:1. During a concurrent observation and interview on 9/9/25, at 8:18 AM in the walk-in refrigerator with the Dietary Service Supervisor (DSS), the following items were observed available for use and the following findings were confirmed with the DSS: a. Approximately 7 of 25 tomatoes were mushy to touch, had broken skin, and had a fuzzy black and green substance on them. b. Approximately 8 of 12 lettuce heads were discolored, noted to be brown and soft in texture with a brown moisture at the base of them. c. Approximately 3 of 6 stalks of celery were found to have various shades of brown with some brown leaves fallen off and stem soft in texture and wilted. d. Approximately 20 of 20 zucchini had a black and white fuzzy spotted substance scattered around them. e. Approximately 1 of 7 containers of strawberries had a white fuzzy substance scattered around them. f. Approximately 13 of 13 potatoes were found sprouted and with circular dark brown spots and have a soft texture. During an interview on 9/9/25 at 8:18 AM, the DSS acknowledged the condition of the product and stated that they were not in a condition to be served. The DSS removed the damaged produce and had it discarded. The DSS stated the staff would discard the produce prior to serving if found in that condition. During an interview on 9/12/25 at 10:49 AM, the Registered Dietician (RD) stated the expectation was for produce to be free of mold, discoloration, and any signs of breakdown. The RD stated the risk to the residents when the produce is compromised, germs could be present. The RD stated these germs could make the residents sick with foodborne illnesses (getting sick after eating or drinking something contaminated with nasty germs). The RD stated the quality of the food is negatively affected as well. The RD stated her expectations were that produce that was found should be discarded. Review of facility policy STORING PRODUCE, dated 2023, indicated, .1. Check boxes of fruit and vegetables for rotten, spoiled items. One rotten tomato, apple, or potato in a box can cause the rest of the produce to spoil faster. Throw away all spoiled items. 7. Keeping fresh vegetables tightly wrapped with as little air in the bag/container as possible will keep them fresh longer. 8. When storing vegetables that should remain crisp, such as lettuce and other leafy greens, fresh herbs, celery. stay fresh longer if you place them in a sealed bag.9. Remove the wilted or spoiled portions of lettuce, celery, and other vegetables in the refrigerator often so they don't cause the rest of the vegetables to spoil.2. During the initial kitchen tour with the Dietary Service Supervisor (DSS), on 9/9/25 at 8:48 AM, the DSS confirmed the onions had black spots and circular discoloration on them with a soft texture. The DSS also confirmed the presence of small black bugs crawling on the onions and flying withing the white container they were stored in. During a follow up observation of the kitchen with the DSS on 9/10/25 at 2:19 PM, the DSS confirmed more onions were added to the container. The DSS stated that the facility just received their food delivery. During an observation of the container, the container was noted to have black small bugs crawling on the onions and flying within the container. The DSS confirmed the presence of the bugs and attempted to swat them with her hand. The DSS stated when this occurs the facility would contact a company that would provide a spray to kill the bugs. During an interview with the Registered Dietician (RD), on 9/12/25 at 11:35 AM, The RD stated the quality of the onions did not meet her expectations. The RD stated, the expectations were for the onions to be discarded and not for any chemicals or repellents to be sprayed on them. The RD stated, the onions found that were soft in texture, with black spots, and discoloration pose a risk for food borne illness for the residents. The RD stated, the presence of the bugs on the onions indicated that the food was old and needed to be discarded. A record review of a facility provided document titled, MISCELLANEOUS AREAS, dated 2023, indicated, .FLY AND VERMIN CONTROL Flies are carriers of disease and are a constant enemy of high standards of sanitation in Food & Nutrition Services Department . A record review of a facility provided document titled, STORING PRODUCE, dated 2023, indicated, .Check boxes of fruit and vegetables for rotten, spoiled items. One rotten tomato, apple, or potato in a box can cause the rest of the produce to spoil faster. Throw away all spoiled

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 observations, interviews, and record review, the facility failed to ensure proper infection prevention practices were implemented and followed to provide a safe and sanitary environment and help prevent the spread of infection with a resident census of 87 when: 1. The facility stored a resident's kidney basin with clean dishes in the kitchen, creating a risk of cross-contamination; 2. Dietary staff failed to follow infection control practices of hand hygiene during tray line service; 3. Shared glucometer devices (a device used to measure blood sugar) were not cleaned and disinfected in-between resident care per manufacturer's specification for Resident 5 and Resident 105; and,4. A pill cutter was not cleaned before and after each use for Resident 108. These failed practices had the potential to place the residents at risk for developing an infection and the potential to result in the spread of the infection within the facility. These lapses in infection prevention and control practices placed the residents at risk for avoidable harm.1. Findings: 1. During a concurrent observation and interview with the Dietary Service Supervisor (DSS) during the initial kitchen tour on 9/9/25 at 8:18 AM, a kidney basin was observed stocked and stored with the clean dishes. During a concurrent interview and record review with the Registered Dietician (RD), on 9/12/25 at 11:20 AM, the RD confirmed the presence of a used kidney basin stored with clean dishes. The RD stated that kidney basins did not belong in the kitchen and was a resident's personal item. The RD stated once the basin was identified in the kitchen it should have been thrown away immediately. The RD stated the kidney basin presented an infection control risk of cross contamination and this type of practice did not meet her expectations. During an interview with the DSS on 9/12/25 at 2:30 PM, the DSS stated if she was aware of the kidney basin being stocked and stored in the kitchen she would have thrown it away. The DSS stated the kidney basin should not have been in the kitchen and placed with the dishes. 2. During an observation of lunch tray line service on 9/11/25 at 12:15 PM, the [NAME] (CK 1) was observed grabbing her phone with gloved hands and continued to serve the lunch tray line. Multiple times during the tray line the cook was observed placing a full gloved hand on her clothing and continued to serve the residents without initiating hand hygiene. During an interview on 9/12/25 at 1 PM, CK 1 acknowledged touching her phone and stated her alarm was going off which is why she touched her phone and stated that phones carry a lot of germs. CK 1 acknowledged touching her clothing excessively with her gloved hands and stated that she knew that she was not supposed to be doing that but got distracted. CK 1 stated that she was aware of the proper protocol and acknowledges that she should have removed her gloves and washed her hands after touching her phone and personal items. CK 1 stated not washing her hand placed the residents at risk for becoming sick because the phone had a lot of germs. During an interview with the Registered Dietician (RD) on 9/12/25 at 11:34 AM, the RD stated the expectation of staff during tray line if they were to touch their clothing or any personal items while serving or preparing food was to remove their gloves, perform hand hygiene, and put a new set of gloves on. The RD stated the risk of not following the infection control practices for hand hygiene is food borne illness and cross contamination. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of a facility provided document titled, GLOVE USE POLICY, dated 2023, the policy indicated, .POLICY: The appropriate use of gloves is essential in preventing food borne illness. Gloved hands are considered a food contact surface that can get contaminated or soiled.WHEN GLOVES NEED TO BE CHANGED.5. As soon they become soiled as when.using the phone. Review of the FDA 2022 Food Code, Section 2-301.14, titled, When to Wash, dated 1/18/23, the document indicated, .(A) After touching bare human body parts other than clean hands and clean, exposed portions of arms.(D) Except as specified in 2-401.11(B).(I) After engaging in other activities that contaminate the hands. (https://www.fda.gov/food/fda-food-code/food-code-2022) 3. During concurrent medication administration observation and interview with Licensed Nurse (LN) 5, on 9/9/25 at 4:50 PM, LN 5 was observed taking a glucometer device along with supplies into the Resident 105's room. LN 5, with gloved hands, poked the left middle finger with a sharp lancet device (a disposable device used to poke finger to get blood for testing) to get blood from the finger. LN 5, then soaked the test strip attached to glucometer with Resident 105's blood to get the blood sugar number. The glucometer dropped on the bed sheet when LN 5 tried to wipe the finger with an alcohol pad. LN 5 exited the room and changed her gloves and used one Clorox healthcare bleach germicidal wipe (brand name of wipe used to clean and kill germs on the surfaces) to wipe the outer surface of the glucometer for less than 5 seconds. LN 5 then placed the glucometer with the same wipe on the top of the cart. LN 5 stated that she needed to administer insulin (drug to treat blood sugar disease) to Resident 105 as ordered by the doctor. During concurrent medication administration observation and interview with Licensed Nurse (LN) 5, on 9/9/25 at 5:22 PM, LN 5 was observed taking the same glucometer device along with supplies into Resident 5's room while she was eating her dinner. LN 5 with gloved hands poked Resident 5's left middle finger with a sharp lancet device to get blood from the finger. LN 5, then soaked the test strip attached to glucometer with Resident 5's blood to get the blood sugar number. LN 5 exited the room and changed her gloves and used one Clorox bleach wipe to clean the outer surface of the glucometer for less than 5 seconds. LN 5 then placed the glucometer with the same wipe on the top of the cart. LN 5 proceeded to administer insulin to Resident 5 as ordered by the doctor. LN 5 stated she was trained to use one wipe to clean the glucometer, then wrap it with the same wipe and let it dry. LN 5 acknowledged that there was a risk of spreading infection if a device was not cleaned and sanitized properly. During an interview with the Director of Nursing (DON), on 9/12/25 at 10:55 AM, the DON stated that the facility's policy was to follow the manufacturer's instructions. The DON further stated that a two-step process using two different disinfectant wipes was important to clean and disinfect equipment to prevent the spread and risk of infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview with the Infection Prevention Nurse (IP), on 9/12/25 at 9:25 AM, and review of facility's policy on use of shared glucometer in between resident care, the IP stated that the cleaning process was to use a disinfectant wipe to clean the glucometer, after which nurses may either wrap the device with the same wipe or let it air dry for two minutes. The IP stated that if a bleach-based disinfectant (same as Clorox Healthcare Bleach Germicidal Wipes) was used, the device must air dry for three minutes. After reviewing the manufacturer's instructions for both the Sani-Cloth Germicidal Disposable Wipes (brand name wipe used to kill germs) and Clorox Healthcare Bleach Germicidal Wipes, the IP confirmed that the instructions required a two-step cleaning and disinfecting process to ensure safe use of a glucometer in-between resident care. The IP stated that failure to follow the manufacturer's instructions when wiping equipment could result in contamination. The IP further stated that the facility's written equipment cleaning policy was outdated and deferred to the DON for an updated version. During a concurrent review of the facility's policy, titled Cleaning and Disinfecting of Glucometer, dated 1/19, and interview with the DON on 9/12/25, at 10:56 AM, the policy indicated, The following policy provides guidance for cleaning and disinfection of glucometer in between resident use . Clean glucometer surface after EACH use . Disinfect (after each use) after cleaning the exterior surfaces following manufacturers' direction . The DON confirmed the two-step process of cleaning and sanitization based on policy and stated the policy needed to be updated. A review of the facility's policy, titled Administering Medications, dated 12/12, indicated, .Staff shall follow established facility infection control procedures.for the administration of medications. A review of the manufacturer's instruction of Sani-Cloth Germicidal Disposable Wipe box indicated, . CLEANING PROCEDURE: All blood and other body fluids must be thoroughly cleaned from surfaces and objects before disinfection by the germicidal wipe. Open, unfold and use first germicidal wipe to remove heavy soil.CONTACT TIME: Use second germicidal wipe to thoroughly wet surface. Allow to remain wet tow (2) minutes, let air dry.Do not reuse towelette. A review of the Clorox Healthcare Bleach Germicidal Wipes labeling information titled Technical Information Clorox Healthcare Bleach Germicidal Wipes, dated June 2017, indicated, To Clean and Disinfect and Deodorize Hard, Nonporous Surfaces: Wipe hard, nonporous surfaces to be disinfected. Use enough wipes for treated surface to remain visibly wet for the contact time listed on label. https://www.cloroxpro.ca/wp-content/uploads/2018/09/Clorox-HC-Bleach-Grm-Wipes-tech-info-NI-38488.pdf Review of the manufacturer of Assure Platinum glucometer, a brand name glucometer used by the facility, (by ARKRAY, the manufacturer of the glucometer), titled ARKRAY Technical Brief: Cleaning and Disinfecting the Assure Platinum Blood Glucose Monitoring System, dated 9/24, last accessed on 9/18/25, via https://www.cdc.gov/injection-safety/hcp/infection-control/index.html, the documents under Cleaning and Disinfecting FAQ (Frequently Asked Questions), indicated, .Can cleaning and disinfecting be accomplished with one wipe? No, Each time the cleaning and disinfecting procedure is performed, two wipes are needed. One wipe to clean the meter and the second wipe to disinfect the meter. What will happen if a blood glucose meter is not clean and disinfected after use? . It is important that long term care facility establish a program for infection control . Program include addressing the cleaning and disinfecting of blood glucose meters along with other equipment and environmental surfaces . It is also important to provide education on infection control and the proper use of products. (continued on next page)

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