STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055011	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River View Post Acute	1611 Scenic Drive Modesto, CA 95355

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. (continued on next page)

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

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to provide a safe and comfortable homelike environment for two of seven sampled residents (Resident 6 and Resident 7) when:1. Resident 6 and Resident 7 requested their room doors be kept closed due to the disruptive behavior of another resident (Resident 3) in the hallway outside of their rooms; and2. Resident 7 did not stay in the activities room for activities due to another Resident (Resident 3) yelling and cussing at everyone. These failures removed Resident 6 and Resident 7's right to a dignified homelike environment, with the potential to result in a negative psychosocial outcome.Findings:A review of Resident 3's admission Record indicated Resident 3 was admitted to the facility with diagnoses which included bipolar disorder (a serious mental illness that causes unusual shifts in mood, ranging from extreme highs (mania or manic episodes) to extreme lows (depression or depressive episode).A review of Resident 6's admission Record indicated Resident 6 was admitted to the facility with diagnoses which included depression.A review of Resident 7's admission Record indicated Resident 7 was admitted to the facility with diagnoses which included depression.During an interview on 6/12/25, at 11:54 a.m., Resident 6 stated Resident 3 was crazy and liked his room door to be kept closed.During an interview on 6/12/25, at 11:54 a.m., Resident 7 stated he kept his room door closed because of Resident 3. Resident 7 stated he had seen Resident 3 wandering in the hallway outside his room and cussing at everyone. Resident 7 stated he had turned around from the activities room and went back to his room because Resident 3 was cussing and yelling at everyone in the activities room. Resident 7 stated he was not able to do activities in the activities room with Resident 3 present. Resident 7 further stated he did not like it when Resident 3 cussed and yelled at someone and wanted the cussing and yelling to stop. During an interview on 6/12/25, at 12:39 p.m., Certified Nurse Assistant (CNA) 1 stated Resident 3 had cussed and yelled at residents in the hallway. CNA 1 further stated she felt bad for the residents that Resident 3 had cussed and yelled at. CNA 1 stated Resident 6 had asked for his room door to be kept closed because it was too noisy outside his room due to Resident 3's disruptive behavior.During an interview on 6/12/25, at 1:10 p.m., CNA 2 stated Resident 3 was aggressive and Resident 3 had cussed at another resident in the hallway. CNA 2 further stated it was not good, and she felt sad when Resident 3 cussed at other residents. CNA 2 stated the other residents should not have been treated like that. CNA 2 stated Resident 7 had asked for his room door to be kept closed due to Resident 3's disruptive behavior.During an interview on 6/12/25, at 1:39 p.m., CNA 3 stated Resident 3 had screamed at other residents in the hallway. CNA 3 confirmed Resident 6 and Resident 7 had asked for their room doors to be kept closed because it was too loud outside their rooms due to Resident 3's disruptive behavior. During an interview on 6/12/25, at 2:31 p.m., Licensed Nurse (LN) 1 stated, Resident 3 had yelled at residents. LN 1 stated she had told Resident 3 it was not ok for her to yell at other residents. LN 1 further stated she felt it made other residents feel uncomfortable and unsafe when Resident 3 yelled and cussed at them.During an interview on 6/12/25, at 4:52 p.m., the Director of Nursing (DON) stated screaming at another resident was considered to be a verbal altercation and it could cause psychosocial and emotional stress to the other resident. The DON further stated Resident 3 had a raised tone to her voice at times depending on her bad days.During an interview on 6/16/25, at 8:13 a.m., LN 2 stated Resident 3 yelled and cussed at other residents. LN 2 stated it was not the other resident's fault. LN 2 further stated she felt irritated when she saw Resident 3 yell and cuss at other residents.Review of Resident 3's Care Plan, initiated on 8/2/24, indicated, .Goal: .will not become aggressive with other residents during activities.Review of Resident 3's Care Plan, initiated on 1/23/23, indicated, .Focus.has behaviors that impact others.sudden and abrupt episodes of verbal and or physical aggression towards others without precursors [warning].Review of Resident 3's Progress Note, dated 12/18/24, indicated, .resident was yelling at other residents for no apparent reason when in the hallway at 10:45 AM.Review of Resident 3's Progress Note, dated 12/17/24, indicated, .yelling at staff and other residents when pacing hallway at 0852 [8:52 a.m.] .A review of a facility policy and procedure (P&P) titled Homelike Environment, revised 2/21, the document indicated, .Residents are provided with a safe, clean, comfortable and homelike environment . 2. The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: .i. comfortable sound levels.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to provide a safe environment and adequate supervision for one of seven sampled residents (Resident 1) when Resident 1 fell from her wheelchair in the facility's smoking area, unsupervised, at 12:25 a.m. on 12/11/25. This failure resulted in a broken nasal bone (broken nose), a nosebleed, and subarachnoid hemorrhage (bleeding in the area between the brain and the thin tissues that cover and protect it) for Resident 1.Findings:A review of Resident 1's admission Record indicated Resident 1 was admitted to the facility with diagnoses which included muscle weakness and osteoarthritis (a degenerative joint disease in which the tissues in the joint break down over time).During an interview on 6/12/25, at 10:15 a.m., Resident 1 stated, . my nose got hurt, there was blood on my nose, my nose broke. I was outside in the smoking area. I was sitting on my wheelchair.I think I fell. I was trying to have a cigarette.During an interview on 6/12/25, at 12:39 p.m., Certified Nurse Assistant (CNA) 1 stated Resident 1 used to be a smoker. CNA 1 further stated the expectation was to have a staff always present when a resident smoked in the smoking area.During an interview on 6/12/25, at 12:39 p.m., CNA 2 stated Resident 1 had tried to get out of her wheelchair in the past. CNA 2 further stated, staff were expected to keep an eye on Resident 1, to prevent Resident 1 from falling. CNA 2 stated Resident 1 should not have been alone outside.During an interview on 6/12/25, at 2:31 p.m., Licensed Nurse (LN) 1 stated Resident 1 had tried to go outside on her own before. LN 1 stated she had reminded Resident 1 not to go outside on her own as she could fall. LN 1 stated Resident 1 should have been supervised when she went outside.During an interview on 6/12/25, at 4:52 p.m., the Director of Nursing (DON) stated Resident 1 had an unwitnessed fall approximately twenty-five minutes after midnight. The DON further stated Resident 1 should not have been alone. The DON stated accidents like falls could happen when residents were left alone.During an interview on 6/16/25, at 8:13 a.m., LN 2 stated Resident 1 had tried to elope (leave the facility without informing anyone) in the past and staff had to keep an eye on Resident 1. LN 2 stated, Resident 1 should not have been left alone in the smoking area. LN 2 stated Residents could fall when they were left alone. LN 2 further stated Resident 1 had wheeled her wheelchair past the nurse's station and went outside into the smoking area without anybody seeing her. LN 2 stated the door to the smoking area was not locked and there was no active alarm when the door was opened. LN 2 stated she heard Resident 1 cry for help and when she went outside to the smoking area, she found Resident 1 on the ground in front of her wheelchair. LN 2 stated Resident 1 was alone in the smoking area. LN 2 stated Resident 1 had blood on her forehead and on her face. LN 2 stated Resident 1 stated she was trying to reach for something on the ground. LN 2 stated the door to the smoking area was left unlocked at night as staff used the same area to smoke and use the vending machine.During an interview on 6/16/25, at 11:02 a.m., Resident 1's Responsible Party (RP) stated Resident 1 had swelling that blocked both her eyes and she had a broken nose as a result of the fall. The RP stated it would have been nice if someone was with Resident 1 since Resident 1 had safety and mobility concerns. The RP stated the fall would not have happened if a staff was there to help Resident 1 pick the stuff up from the ground that she was trying to get. During an interview on 6/17/25, at 3:24 p.m., the Assistant Maintenance Director (AMD) stated the door to the smoking area had always been left unlocked from inside the facility and the alarm was inactive. The AMD stated staff used the smoking area to smoke. The AMD further stated the expectation was to have nurses keep an eye on residents to prevent residents from falling and getting hurt. The AMD stated he had reviewed the camera when Resident 1 fell. The AMD stated the video showed Resident 1 was alone in the smoking area and she was trying to reach for something on the ground when she fell.Review of Resident 1's Progress Note, dated 12/11/24, at 1:15 a.m., indicated, .resident had an unwitnessed fall. Resident went outside to back patio and fell to the floor from her wheelchair and landed on her face. Possible nose fracture and scraped left knee.Review of Resident 1's Progress Note, dated 12/11/24, at 6:43 a.m., indicated, .patient being sent to [hospital name] for unwitnessed fall on 12/11/24. per ER [emergency room] RN [registered nurse] patient has broken nose that has packing to one side and minimal subarachnoid hemorrhage.Review of Resident 1's Progress Note, dated 12/11/24, at 11:04 a.m., indicated, .pt is noted to have purplish discoloration to right side of face and eye related to fall. Review of Resident 1's IDT NOTE, dated 12/11/24, at 12:41 p.m., indicated, .Resident was found on the patio floor. Resident noted with a bloody nose and scraped left knee. Per resident, she was wanting to smoke, was reaching for item on ground and fell out of wheelchair.Review of Resident 1's (hospital name) visit summary dated 12/11/24 at 1:06 a.m., indicated, .Patient Diagnosis 1. Fall. 2. Nasal bone fracture. 3.