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	07/30/2025

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on interview and record review, the facility failed to ensure appropriate notification was provided for one of four sampled residents (Resident 1) when, Resident 1's responsible party (RP, health care decision maker) was not informed of Resident 1's allegation of abuse.This failure had the potential to affect the ability of the RP to be informed of and participate in Resident 1's plan of care.Findings:A review of Resident 1's admission RECORD, indicated, she was admitted to the facility with diagnoses which included schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves).A review of Resident 1's clinical document titled, Progress Notes, dated 7/21/25, at 1:43 PM, indicated, .DON [director of nurses] NOTE.Report received that resident claimed she was hit on the head early this morning. Resident stated that around 2 AM, a tall man hit him with a stick.stated I have lumps and bumps up here on my head.A review of Resident 1' s clinical document titled, Care Plan Report, initiated 7/21/25, indicated, .The resident has a potential psychosocial well-being problem r/t [related to] claim of someone hitting my head.Goal .The resident will have no psychosocial well being problem.Interventions.Increase communication between resident/family/caregivers.During a concurrent interview and record review on 7/30/25, at 2:31 PM, with the DON, the DON confirmed there was no documentation in Resident 1's clinical record to indicate the RP had been informed of the allegation of abuse and there should have been. The DON stated it was important to inform the RP and to keep them updated on what was happening with the resident.A review of a facility policy titled, Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, dated 9/22, indicated, .All reports of resident abuse.are reported.and thoroughly investigated.The administrator or the individual making the allegation immediately reports his or her suspicion to.The resident's representative.the resident and/or representative are notified of the outcome immediately upon conclusion of the investigation.

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 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. Based on interview and record review, the facility failed to ensure care plan interventions were implemented for two out of three sampled residents (Resident 1 and Resident 2) when, Resident 1 and Resident 2's care plan intervention of alert charting (documentation of assessments completed after an incident occurs to monitor for negative affects to health or well-being) was not completed for Resident 1 after an allegation of abuse was made and for Resident 2 after a verbal altercation occurred.This failure had the potential for Resident 1 and Resident 2 to have unassessed care needs that could negatively impact their health and well-being.Findings:A review of Resident 1's admission RECORD, indicated, she was admitted to the facility with diagnoses which included schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves).A review of Resident 1's clinical document titled, Progress Notes, dated 7/21/25, at 1:43 PM, indicated, .DON [director of nurses] NOTE.Report received that resident claimed she was hit on the head early this morning. Resident stated that around 2 AM, a tall man hit him with a stick.stated I have lumps and bumps up here on my head.A review of Resident 1' s clinical document titled, Care Plan Report, initiated 7/21/25, indicated, .The resident has a potential psychosocial well-being problem r/t [related to] claim of someone hitting my head.Goal .The resident will have no indications of psychosocial well being problem. Interventions.Alert charting x 72 hours for possible psychosocial effect of reported incident.A review of Resident 1's clinical document titled, Order Audit Report, dated 7/21/25, indicated, .Alert Charting x 72 hours for report of alleged physical harm.During a concurrent interview and record review on 7/30/25, at 2:14 PM, the DON confirmed alert charting was not completed by the licensed nurse's for Resident 1 on 7/22/25 and 7/23/25 and it should have been.A review of Resident 2's clinical document titled, Progress Notes, dated 7/19/25, at 6 PM, indicated, .Around 1710 [5:10 PM] [Resident 3] was observed sitting in W/C [wheelchair] in the hallway.yelling and mentioning name of [Resident 2] with inappropriate names. Then [Resident 2] . responded back by yelling similar offensive language.Educated staff to monitor both patients for any behaviors.A review of Resident 2' s clinical document titled, Care Plan Report, initiated 7/21/25, indicated, . Potential impaired Social Interaction r/t [related to] verbal altercation.Goal.Will not have any adverse psychosocial effect r/t verbal altercation.Interventions.Alert Charting per nursing x 72 hours for psychosocial effect.A review of Resident 2's clinical document titled, Order Audit Report, dated 7/21/25, indicated, .Alert Charting x 72 hours r/t verbal altercation.During a concurrent interview and record review on 7/30/25, at 2:14 PM, the DON confirmed there was no alert charting by the licensed nurse's in Resident 2's clinical record for 7/21/25 and 7/23/25 and there should have been. The DON further stated the documentation should have been completed for both Resident 1 and Resident 2 to make sure they did not have delayed adverse effects from the incidents.A review of a facility policy titled, Resident-to -Resident Altercations, dated 9/22, the policy indicated, .All altercations, shall be .investigated.document the occurrence and subsequent care in the residents clinical record every shift along with new interventions and their effectiveness for no less than 72 hours.