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	09/03/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. (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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(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	Based on interview and record review, the facility failed to ensure a reasonable accommodation of needs were honored for one of four sampled residents (Resident 2) when the facility did not have a mechanical lift sling (soft fabric padded sling that wraps around the body and attaches to a mechanical lift to assist in a transfer from one location to another) available to transfer Resident 2 out of bed.This failure caused Resident 2 to not attend the activities of her choice and had the potential to negatively impact Resident 2's quality of life and psychosocial well-being.A review of Resident 2's admission RECORD, indicated, she was admitted to the facility in mid 2022.A review of Resident 2's clinical document titled, Care Plan Report, initiated, 7/4/22, indicated, .The resident has an ADL [Activities of Daily Living, personal care tasks which include bathing, dressing, eating, and transferring in and out of bed] self-care deficit.TRANSFER: Mechanical Lift and (X2) [two] staff for transferring.During an interview on 9/2/25, at 9:46 AM, with Family Friend (FF) 1, FF 1 stated Resident 2 had asked to attend morning activities on several days, including 8/18/25, and staff had not honored the request to get her out of bed.A review of the facility activity calendar for September 2025, indicated, morning activities were scheduled for 9 AM, 9:30 AM, 10 AM ,and 11:45 AM daily.A review of Resident 2's clinical documentation of care provided, titled, .Task.CHAIR/BED-TO CHAIR TRANSFER. indicated, Resident 2 was transferred out of bed on the dates and times as follows:8/6/25 at 12:02 PM8/11/25 at 6:29 PM8/15/25 at 2:34 PM8/18/25 at 12:26 PM8/20/25 at 2:10 PM8/24/25 at 1:41 PM8/27/25 at 3:42 PM8/28/25 at 2:34 PM8/29/25 at 6:14 PMDuring an interview on 9/3/25, at 10 AM, with certified nurse assistant (CNA) 2, CNA 2 stated there were three to four mechanical lifts in the facility and occasionally it was hard to find a lift or sling for transferring residents. CNA 2 further stated uncharged lift batteries and a lack of slings sometimes delayed resident care, causing Resident 2 to miss scheduled activities.During an interview on 9/3/25, at 11:26 AM, in the circle dining area, with Resident 2, Resident 2 stated she had planned to attend activities yesterday and was told there were not enough slings. Resident 2 further stated due to a shortage of regular slings she was required to use a shower sling (a sling made of mesh for easy access to skin during bathing) which irritated her skin, in order to get out of bed today.During an interview on 9/3/25, at 12:29 PM, with CNA 2, CNA 2 confirmed there were no slings available on 9/2/25, during the am shift (6 am - 6:30 PM) to transfer Resident 2 out of bed. During an interview on 9/3/25, at 12:43 PM, with the Director of Nurses (DON), the DON stated the facility should have the equipment available to meet Resident 2's needs. The DON further stated Resident 2's psychosocial well-being could be negatively affected if she was unable to attend activity programs.A review of a facility policy titled, Resident Self Determination and Participation, revised 8/2022, indicated, .Our facility respects and promotes the right of each resident to exercise his or her autonomy regarding what the resident considers to be important facets of his or her life. Each resident is allowed to choose activities.that are consistent with his or her interests, values, assessments and plans of care, including.daily routine.activities.residents are provided assistance as needed to engage in their preferred activities on a routine basis.A review of a facility policy titled, Dignity, revised 2021, indicated, .Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem.When assisting with care, residents are supported in exercising their rights. For example, residents are.encouraged to attend the activities of their choice.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to ensure an allegation of abuse was reported to the Department timely for one of three sampled residents (Resident 1) when Resident 1 alleged certified nursing assistant (CNA) 3 forcefully grabbed her legs on 8/2/25 but the incident was not reported to the Department until 8/7/25. This failure resulted in a delay in the abuse investigation process and decreased the facility's potential to protect Resident 1 and other residents in the facility from physical and psychosocial harm.A review of Resident 1's admission RECORD, indicated, she was admitted to the facility in late 2024 with diagnoses which included bipolar disorder (a mental health condition that causes changes in a person mood, energy, and ability to function). A review of Resident 1's minimum data set (MDS, a federally mandated resident assessment and screening tool which identifies care needs) dated 7/29/25, indicated, . Section C-Cognitive Patterns. Brief Interview for Mental Status (BIMS) [a tool used to screen for cognitive impairment]. indicated, a score of 14 points which suggested cognition/thinking/decision making was intact. A review of Resident 1's clinical document, written by the Administrator in Training (AIT), titled, Progress Notes, dated 8/7/25, at 5 PM, indicated, .At around 4:30pm, resident informed writer that a CNA had hurt her legs over a week ago and was concerned why the same CNA was scheduled to work the night shift with her again.[Resident 1] explained.the saturday [sic] before (on the evening of 7/26/25).CNA, forcefully grabbed her behind the ankles and squeezed while trying to drag her off the bed. She was very upset and crying at this time.A review of Resident 1's clinical document, written by the AIT, titled, Progress Notes, dated 8/7/25, at 10:41 PM, indicated, .when resident was interviewed by officer [police].she added to her report that the CNA started the altercation by throwing her resident's arms around before grabbing her legs. She [Resident 1] also stated that she is starting to believe that it could have been last Saturday (8/2/25).During a telephone interview on 9/3/25, at 7:34 AM, with licensed nurse (LN) 2, LN 2 stated, on 8/2/25, Resident 1 reported CNA 3 grabbed her by the ankles and pulled on her. LN 2 further stated she assessed Resident 1's ankles and no redness or marks were observed.During an interview on 9/3/25, at 9:05 AM, in Resident 1's room, Resident 1 stated when she had needed help to go to the bathroom CNA 3 flung her arms over and then grabbed her by the back of the ankles and squeezed hard. Resident 1 stated CNA 3 caused her pain and made bruises like finger marks on her left ankle. During a telephone interview on 9/3/25, at 10:39 AM, with LN 4, LN 4 stated the incident with Resident 1 occurred on Saturday 8/2/25, at approximately 6 PM. LN 4 further stated CNA 3 had reported that Resident 1 was angry and asked LN 4 to check on her. LN 4 stated Resident 1 was agitated when they went to check on her and asked LN 4 and CNA 3 to leave her room. LN 4 stated she had assumed the other nurse (LN 2) would document the incident. LN 4 further stated after the incident happened, training on abuse reporting was conducted and now she understood the reporting process and what should have been done because it was a serious issue. During a telephone interview on 9/3/25, at 10:48 AM, with LN 2, LN 2 confirmed she had not documented or reported Resident 1's allegation of abuse, but she should have. LN 2 further stated she should have made sure the allegation was documented and reported for the safety of Resident 1, the facility, and everyone.During an interview on 9/3/25 at 12:11 PM, the AIT confirmed two LN's and CNA 3 were aware of Resident 1's allegations of abuse on 8/2/25, but the incident did not come to his attention until 8/7/25. The AIT confirmed because he did not learn about the incident until five days later, the report to the Department was delayed.During an interview on 9/3/25, at 2:54 PM, with the Director of Nurses (DON), the DON stated it was her expectation that allegations of abuse would be reported to the Department within two hours of the occurrence. The DON further stated it was important to report abuse for the safety of the residents.A review of a facility policy titled, Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, revised 9/22, indicated, .If resident abuse.is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law.Immediately is defined as.within two hours of an allegation involving abuse.or within 24 hours of an allegation that does not involve abuse.