

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055011	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/03/2025
NAME OF PROVIDER OR SUPPLIER River View Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.</p> <p>(continued on next page)</p>

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: 055011	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/03/2025
NAME OF PROVIDER OR SUPPLIER River View Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview and record review, the facility failed to ensure one of two sampled residents (Resident 2) was free from unnecessary medication when, Resident 2 was prescribed an as needed lorazepam (anti-anxiety) medication that did not have the required 14-day stop date or a note from the doctor explaining why the lorazepam did not need a stop date. This failure had the potential for Resident 2 to not be properly evaluated for the continued need of lorazepam and could result in continued use of an unnecessary medication and possible harmful side effects. Findings: Review of Resident 2's admission RECORD, indicated Resident 2 was admitted to the facility with diagnosis including but not limited to, anxiety disorder (excessive, persistent fear and worry that significantly disrupt daily life) and depression. During a concurrent interview and record review on 12/3/25 at 12:16 PM with Licensed Nurse (LN) 1, Resident 2's .Order Summary: Lorazepam Oral Tablet 0.5 milligram [mg-a unit measure] (Lorazepam) Give 1 tablet by mouth every 6 hours as needed for anxiety/restlessness ., signed by the doctor on 12/1/25, was reviewed. LN 1 stated that any as-needed psychotropic medications (drugs that affect how a person thinks, feels, or acts) like anti-anxiety medication must have a 14 day stop date so the resident could be checked to make sure the medicine was still needed and safe. LN 1 further stated that if Resident 2 kept receiving lorazepam without a stop date and without evaluation, Resident 2 would be at risk for side effects. During an interview on 12/3/25 at 4:13 PM, with the Assistant Director of Nursing (ADON), the ADON stated that when nurses received an order for an as-needed anti-anxiety medication, nurses were expected to ensure the medication had a 14-day stop date. The ADON stated that the purpose of the 14-day stop date was to give temporary relief of the resident's symptoms, and if the medication needed to continue, the doctor had to provide a new order after re-assessment. The ADON further stated that anti-anxiety medications could cause harmful side effects in elderly residents and could lead to a potential addiction, which was why anti-anxiety medications needed to have a 14-day stop date. During a concurrent interview and record review on 12/5/25 at 9:38 AM with Minimum Data Set Coordinator (MDSC), Resident 2's doctor's Progress Notes, dated 11/27/25, were reviewed. Resident 2's doctor's progress notes indicated, .Assessment: Depression/Anxiety: Continue. and [lorazepam]. The MDSC stated that the doctor's last assessment of Resident 2 was on 11/27/25, as documented in the progress notes, before Resident 2 received an as-needed order for lorazepam for anxiety on 12/1/25. The MDSC stated that the doctor did not document a reason for why the lorazepam order on 12/1/25 did not include a stop date. The MDSC further stated that as-needed anti-anxiety medication required a stop date or the resident would be at risk for chemical restraint (drug used to control behavior or limit movement that is not part of normal treatment) and harmful side effects. During a concurrent interview and record review on 12/5/25 at 9:45 AM with the MDSC, Resident 2's Medication Administration Record (MAR), dated for the month of 12/25, was reviewed. Resident 2's MAR indicated, on 12/1/25 at 10:15 PM, on 12/2/25 at 10:26 PM and 12/3/25 at 11:12 PM, Resident 2 received lorazepam 0.5mg as needed for anxiety. The MDSC stated that the nurses gave Resident 2 the as-needed lorazepam on 12/1/25, 12/2/25 and 12/3/25 without a stop date. During an interview on 12/5/25 at 11:44 AM, with the Pharmacist (Pharm), the Pharm stated that as-needed anti-anxiety medications required a duration or stop date. The Pharm further stated that the purpose of placing a duration on any as-needed anti-anxiety medications was to make sure the resident was re-evaluated before the medication was continued. During a review of an undated facility's policy and procedure (P&P) titled, Psychoactive/Psychotropic Medication Use, the P&P indicated, .2. Psychotropic Medication Management .K. PRN Psychotropic drug orders (other than PRN Antipsychotics) are limited to 14 days. If it is appropriate to extend the order beyond 14 days, the Attending Physician or prescribing practitioner shall document the rationale in the medical record and indicate a duration for the PRN order.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055011	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/03/2025
NAME OF PROVIDER OR SUPPLIER River View Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>Based on interview and record review, the facility failed to ensure one of three sampled resident's (Resident 1) Preadmission Screening and Resident Review (PASRR: required screening done before admission to identify mental illness, intellectual disability, or related conditions and ensure proper placement and services) was completed accurately when, Resident 1's diagnosis of intellectual disability (a condition that involves limitations on intelligence, learning and everyday abilities necessary to live independently) and related condition of cerebral palsy (a person's brain is injured or did not develop normally before, during, or shortly after birth) were not marked on Resident 1's PASRR. This failure had the potential for Resident 1 not being evaluated and able to receive the care and services appropriate for the resident's needs. Findings: Review of Resident 1's admission RECORD, indicated Resident 1 was admitted to the facility with diagnosis including but not limited to, mild intellectual disabilities and cerebral palsy. During a review of Resident 1's PASRR Level I determination letter dated 9/1/16, the letter indicated .LEVEL 1 SCREEN INDICATES NO NEED FOR A PASRR LEVEL II EVALUATION [a state conducted assessment to determine specialized service needs and placement appropriateness]. During a review of Resident 1's Care Plan, initiated on 11/1/24, in the section titled Focus, indicated, .PASRR Level 1 indicates no need for Level 2 evaluation. During a concurrent interview and record review, on 12/3/25 at 2:03 PM, with Minimum Data Set Coordinator (MDSC), Resident 1's Preadmission Screening and Resident Review (PASRR) Level 1 Screening Document, dated 9/1/16, was reviewed. Resident 1's PASRR Level 1 Screening indicated, Section VI-Intellectual or Developmental Disability (ID)/(DD) or Related (RC) Screen, the answer was No to the question, Does the resident have or is suspected of having a primary diagnosis of ID/DD/RC? The MDSC stated that Resident 1's PASRR did not match Resident 1's diagnosis of intellectual disabilities. The MDSC stated that if Resident 1's intellectual disabilities had been identified in the PASRR, it would have created a PASRR Level 2 evaluation. The MDS stated that Resident 1's PASSR dated 2016 was completed in the facility but was never reviewed for accuracy. The MDSC further stated that not completing the PASRR accurately was a safety risk for Resident 1, as it could lead to unmet behavioral, functional, and safety needs. During an interview on 12/3/25 at 4:13 PM, with the Assistant Director of Nursing (ADON), the ADON stated that facility staff were expected to review the completed PASRR to ensure the assessment was accurate. The ADON further stated that having inaccurate PASRR documentation placed the resident at risk for decline because the resident would not be properly evaluated and would not receive needed care services. During a review of the facility's policy and procedure (P&P) titled admission Criteria, dated 12/19, the P&P indicated, .9. All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) per the Medicaid Pre-admission Screening and Resident Review (PASARR) process. a. The facility conducts level 1 PASARR screen. to determine if the individual meets the criteria for a MD, ID, or RD. b. If the level 1 screen indicates that the individual may meet the criteria for a MD, ID, or RD, he or she is referred to the state PASARR representative for the level II (evaluation and determination) screening process. c. Upon completion of level II evaluation, the state PASARR representative determines if the individual has a physical or mental condition, what specialized or rehabilitative services he or she needs, whether placement in the facility is appropriate.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055011	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/03/2025
NAME OF PROVIDER OR SUPPLIER River View Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident must receive and the facility must provide necessary behavioral health care and services.</p> <p>Based on interview and record review, the facility failed to provide the needed behavioral health care and services (treatments that support a person's mental and emotional well-being) for one of three sampled residents (Resident 1), when Resident 1's psychotherapy (talking treatment that helps a person manage emotions, behaviors and stress) sessions scheduled two times per week were missed on two occasions, and the facility failed to ensure timely follow-up or alternative interventions. This failure put Resident 1 at risk for worsening mental health symptoms, social withdrawal, and decreased quality of life. Findings: Review of Resident 1's admission RECORD, indicated Resident 1 was admitted to the facility with diagnosis including but not limited to, adjustment disorder with depressed mood (a condition where a person feels very sad or stressed after a difficult event and has trouble coping) and anxiety disorder. During a concurrent interview and record review on 12/3/25 at 12:16 PM, with Licensed Nurse (LN) 1, Resident 1's Psychologist Progress Notes dated 11/6/25 and 11/20/25 were reviewed. Resident 1's psychologist's progress notes on 11/6/25 and 11/20/25 indicated, .Diagnosis. Adjustment Disorder, with depressed mood. Plan Patient may benefit from psychotherapy. Recommendation: Continue current therapeutic focus Prescribed Frequency of Twice a Week. LN 1 stated that Resident 1 missed both psychotherapy visits during the week of 11/10/25. LN 1 stated there was no documentation to show psychotherapy services were provided that week. LN 1 further stated that missing psychotherapy visits could negatively affect Resident 1's mental condition. During an interview on 12/3/25 at 2:30 PM with the Social Services Director (SSD), the SSD stated that psychology referrals and appointments were handled by the Social Services Department (SS). The SSD stated that if psychology services missed seeing a resident, staff were expected to communicate the missed visit so the facility could implement a backup plan. The SSD further stated that missing psychotherapy could negatively affect the resident's psychosocial (a person's emotional, social, and mental wellness) status. During a concurrent interview and record review on 12/12/25 at 10:56 AM, with the Director of Nursing (DON), Resident 1's doctor's Order Summary, dated 12/22/24, was reviewed. Resident 1's order summary indicated, .Refer patient to PSYCH CONSULT. The DON stated that a psychology consult required a doctor's order. The DON further stated that once a doctor's order was in place, nursing staff were responsible for following up with the psychologist and notifying the doctor whenever a scheduled psychotherapy visit was missed to make sure care was provided in a timely manner. During a review of Resident 1's Confirmation of missed visit week of 11.10.2025 letter, dated 12/3/25, the letter of confirmation of missed visit indicated, Resident 1 . was not seen the week of 11/10/25 . was seen the week prior on 11.6.2025 and the week after on 11.18. 2025.</p>		