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	12/04/2025

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. (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

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 12/04/2025

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to maintain acceptable parameters of nutrition for one of three sample residents (Resident 1) when Resident 1's 21-pound weight loss in a 10-day period was not recognized, addressed, or reported to the physician in a timely manner.This failure had the potential to lead to malnutrition, nutrient deficiencies, loss of muscle mass, and increased muscle weakness for Resident 1.Findings:A review of Resident 1's, admission RECORD, indicated that Resident 1 was admitted to the facility with diagnoses which include, but not limited to: Malignant neoplasm of colon (cancer of the colon-large intestine), dehydration (body loses too much water), surgical aftercare following surgery on the colon, post-hemorrhagic anemia (lack of iron in the blood due to a large volume of blood loss), vitamin D deficiency (lack of enough vitamin D), muscle weakness, and need for assistance with personal care. A record review of weights for Resident 1 indicated the following:9/23/25 = 136.4 pounds (pounds or lbs.- a unit of measure)9/29/25 = 136.4 lbs.10/3/25 = 115.0 lbs. This was a loss of 21.4 lbs. or 15.7% of body weight over 10 days.11/1/25 = 104.6 lbs. This was a loss of 31.8 lbs. and 23.3% of body weight over 5 weeks. During a concurrent observation and interview on 12/2/25 at 12:40 PM, in Resident 1's room, Resident 1's lunch meal tray was observed. Resident 1 had an opened and mostly full nutrition shake on her tray table. Resident 1 had consumed approximately 75% of her lunch tray. Resident 1 stated she was full and tried to drink the nutritional health shakes they give her at each meal. Resident 1 stated she was not aware she had lost a significant amount of weight but was aware that she was started on a medication recently to help her appetite. Resident 1 further stated she assumed the medication was to make her feel hungry since she was diagnosed with colon cancer. During a concurrent observation and interview on 12/2/25 at 2:18 PM, the Restorative Nursing Assistant (RNA) was observed weighing residents and documenting the weights on a handwritten log. The RNA stated the facility policy was to weight each resident once a week after admission for 4 weeks, then once a month. The RNA stated once she was done with the log she documented the weights on the log and turned it into the Assistant Director of Nursing (ADON) and the Director of Nursing (DON). The RNA further stated she was supposed to tell the ADON and DON of any drastic weight changes, a difference of 3 lbs., gained or lost. The RNA did not recall if she notified anyone of Resident 1's severe weight loss in October. During a concurrent interview and record review on 12/3/25 at 10:15 AM, Resident 1's medical record was reviewed with Licensed Nurse (LN) 1. LN 1 stated he was not aware Resident 1 was being monitored for weight loss. LN 1 further stated a 21 lb. weight loss in 10 days was a lot, and the physician and Registered Dietician (RD) should have been notified when the weight loss first occurred on 10/3/25, and not over a month later. LN 1 confirmed he did not see any documentation in Resident 1's medical record from 10/3/25 to 11/5/25 the physician was notified or any documentation or change of condition (COC -Significant decline or improvement in a patient's physical, mental or functional health status from their baseline, requiring intervention and care plan revision) was done regarding the weight loss. LN 1 stated it was important to notify the physician to prevent malnutrition and other health complications. During a concurrent interview and record review on 12/2/25 at 4:29 PM, Resident 1's medical record was reviewed with the Director of Nursing (DON) and the Administrator (ADM). The DON stated the expectation for new residents was to be weighed once a week, for 4 weeks, and then monthly, unless weight loss had been established. The DON further stated the RNA that weighed the residents was expected to alert her of any weight loss or gain of roughly 3 lbs., in a week. The DON added that once weight loss had been observed the expectation was to notify the physician, and the weight loss committee would hold an interdisciplinary team (IDT -a collaborative meeting where healthcare professionals coordinate and discuss complex cases and create person-centered plans for better health outcomes) meeting to determine cause, and plan interventions to monitor the weight loss closely. The DON reviewed Resident 1's medical record and confirmed there was no documentation of physician notification or change of condition related to Resident 1's weight loss. The DON further reviewed Resident 1's medical record and confirmed Resident 1 was not weighed weekly per expectation and acknowledged the weight loss was not caught until 11/6/25, more than 4 weeks after it occurred on 10/3/25. The ADM stated in October 2025, the weight loss was most likely missed due to the facility being in between DON's and Registered Dieticians. The DON stated the risk to Resident 1 for the facility not catching the weight loss was continued weight loss, skin break down, muscle loss, and overall worsening of health conditions. The ADM stated the IDT meetings were important for weights to make sure the staff were all on the same page and that the correct monitoring and interventions

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. Based on interview and record review, the facility failed to ensure the psychosocial well-being for one of three sampled residents (Resident 1), when the Social Services Department failed to process a referral for a psychiatric evaluation for Resident 1 in a timely manner. This failure had the potential to worsen Resident 1's feelings of sadness, loneliness, and depression. Findings: A review of Resident 1's clinical record titled, admission RECORD, indicated Resident 1 was admitted to the facility with diagnoses which included, but was not limited to: Hemiplegia (paralysis of one side of the body) and hemiparesis (a condition characterized by partial weakness on one side of the body) following cerebral infarction (a type of stroke caused by a blockage in an artery that supplies blood to the brain), malignant neoplasm of the colon (cancer that forms in the large intestine characterized by abnormal cells that grow and invade healthy tissue), surgical aftercare following surgery on the colon (partial colon removal), muscle weakness and need for assistance with personal care. A review of Resident 1's clinical record titled, Order Summary, dated 12/3/25, indicated the following order: .Psych (Psychiatric) referral, resident refusing therapy, per [Physical] therapist had tears on [Resident 1's] eyes.Prescriber Written.Date Ordered 11/06/25. During an interview on 12/3/25 at 10:20 AM, Resident 1 stated she was not happy and felt, upset and depressed, about the colon cancer and the possibility of having further surgery. Resident 1 denied seeing a therapist or having anyone to talk to about her current diagnosis. Resident 1 further stated that talking to family or a counselor might help, but the facility had not offered the help. Resident 1 began to cry and stated she did not want to hurt herself but added that if she did not wake up tomorrow she would be okay with it. Resident 1 denied a plan for self-harm. Resident 1 further stated she had been feeling sad, lonely, and depressed about being in the facility and her medical diagnosis of colon cancer. During a concurrent interview and record review on 12/2/25 at 1:08 PM, with the Social Services Director (SSD), Resident 1's clinical record was reviewed for a referral. The SSD confirmed an order was entered by a Nurse Practitioner (NP) on 11/6/25 indicated, .Psych Referral. The SSD stated the referral process steps included anytime an order for a referral for a psychiatric or psychological evaluation was entered into the resident's medical record, the nursing staff was supposed to print a copy and give it to her. The SSD confirmed the referral was never processed. During an interview on 12/3/25 at 3:38 PM with the Director of Nursing (DON), the DON stated the expectation for a referral was to be completed in a timely manner. The DON further stated it was important for the residents to feel safe and secure and for Resident 1's mental health to be whole. The DON added it was important for Resident 1 to have an outlet for her feelings. During an interview on 12/8/25 at 3:51 PM with the Nurse Practitioner (NP) that referred Resident 1 for a psychiatric evaluation, the NP stated she was not aware the psychiatric referral was never completed. The NP stated the purpose of the psychiatric referral was so they could get more detailed information from Resident 1. The NP stated, medication or an end-of-life discussion could be beneficial, if Resident 1 was willing. The NP stated the risk to Resident 1 for not getting the psychiatric evaluation was further depression or mental health worsening if it went untreated. Review of the facility policy and procedure titled, Referrals, Social Services, revised 12/08, indicated, .Social services personnel shall coordinate most resident referrals. Social services will collaborate with the nursing staff.to arrange for services that have been ordered.Social services will document the referral in the resident's medical records.