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	02/17/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview and record review, the facility failed to ensure immediate notification was made to the residents physician of a significant x-ray report for one of three sampled residents (Resident 1), when Resident 1 had a STAT (immediate) x-ray completed on 2/8/26 of the left leg that indicated a fracture (break) of the left lower leg as well as osteomyelitis (a severe infection within the bone, causing inflammation (swelling) and destruction of bone tissue) of the left lower leg and left heel. This failure resulted in delayed care and placed Resident 1 at risk for pain, suffering, and medical complications related to the identified injury and infection.Findings:A review of Resident 1's admission RECORD, indicated Resident 1 was admitted to the facility with diagnoses that included but were not limited to hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominate side (severe weakness or completed loss of the ability to move the left side of the body following a right-side brain stroke (blood flow to the brain is blocked), pressure ulcer of the left ankle stage 4 (a severe, deep, and open wound that exposes underlying muscle, tendon, or bone), type 2 diabetes mellitus (a chronic condition where the body cannot properly manage the sugar in the blood, leading to consistently high blood sugar level), peripheral vascular disease (a slow, progressive circulatory condition where blood vessels outside the heart and brain-usually in the legs-become narrowed, blocked, or spasmed), and anemia (a common blood condition where you don't have enough healthy red blood cells or hemoglobin to carry adequate oxygen to your body's tissues).A review of Resident 1's Minimum Data Set (MDS, an assessment tool), dated 1/20/26, the section titled BIMS (Brief Interview for Mental Status, an assessment tool used by facilities to screen and identify the memory, orientation, and judgment status of the resident), had a score of 11 out of 15 total indicating that Resident 1 was moderately cognitively impaired.A review of Resident 1's clinical document titled Nurse's Note, dated 2/8/26 indicated .approx [sic] 1100 [11 AM] writer called by the CNA [Certified Nursing Assistant] staff member to check on resident's L [left] foot. upon [sic] checking writer and supervisor nurse see's the L foot in a twisted position down from the ankle, resident has a stage 4 wound on L foot which was being treated.skin color purple and skin cold to touch.MD [medical doctor] ordered a [sic] x-ray order carried out pending results at the time of writing.A review of Resident 1's physician order dated 2/8/26 indicated that a verbal order was given by Resident 1's physician to a licensed nurse (LN) and was entered in Resident 1's clinical record at 12:34 PM for a STAT x-ray to the left ankle, left foot, and left knee.A review of Resident 1's clinical document titled Radiology [a medical specialty that uses imaging techniques] Results Report, dated 2/8/26, indicated the results of the x-ray was reported to the facility on 2/8/26 at 10:20 PM. The report indicated that Resident 1 had a fracture and osteomyelitis of the distal (a body part located farther away from the center of the body or the point of attachment to the trunk) lower leg. During a concurrent interview and record review on 3/4/26, at 7:59 AM, with LN 3, Resident 1's clinical document titled Daily Skilled Note, dated 2/8/26 and Resident 1's (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	clinical document titled Nurse's Note, dated 2/9/26 were reviewed. LN 3 confirmed that on 2/8/26 during the handoff report Resident 1's foot injury was communicated and that the x-ray had been taken, but the results were still pending. LN 3 stated that STAT x-ray results are uploaded by the x-ray company automatically in the resident's electronic health record when the results are ready to be reviewed. LN 3 stated that when an x-ray is ordered STAT, it was also faxed to nurses' station 1. LN 3 stated that the LN working at station 1 was informed of the pending results and asked if the nurse would notify LN 3 when the results came in. LN 3 stated that on 2/8/26 at around 8 PM, LN 3 checked in Resident 1's electronic health record and the fax machine at station 1 and did not see any results for the x-ray. LN 3 denied checking again and confirmed that a call to the x-ray providing company to see when the results were going to be ready was not made. LN 3 stated that on 2/9/26 at 1 AM the LN from station 1 brought the x-ray result that had been faxed to LN 3. LN 3 confirmed that Resident 1's physician was notified of the result on 2/9/26 at 1:40 am via text message. LN 3 confirmed that no other attempt to contact the physician regarding the abnormal result was done for the rest of the shift. LN 3 stated that the facility procedure is to report abnormal x-ray results immediately to a resident's physician. LN 3 stated that immediate meant right away and that if the results of the Resident 1's left foot x-ray were ready from review on 2/8/26 at 10:20 PM, that reporting those results to Resident 1's physician on 2/9/26 at 1:40 am did not meet the expectation of immediate reporting. LN 3 stated that Resident 1's physician had not contacted the facility after LN 3 sent the text message with a picture of the results of the x-ray. LN 3 confirmed that no phone call was made by LN 3 to the physician when the physician did not respond to the text message. LN 3 stated the lack of direct confirmation of the receipt of the x-ray results with Resident 1's physician placed Resident 1 at risk for complications from the injury and the acute infection and potentially delayed Resident 1's transfer to the acute hospital.During a concurrent interview and record review on 2/17/26, at 10:22 AM with LN 1, Resident 1's clinical document titled Nurse's Note, dated 2/9/26, was reviewed. LN 1 stated that when he arrived on 2/9/26 for his shift, he received handoff report (process of transferring patient-specific information, authority, and responsibility from one healthcare provider or team to another) from the night shift licensed nurse, that Resident 1's x-ray result had come in, and the physician had not responded to the message. LN 1 stated that after the handoff report process was completed, he spoke to the shift supervisor and was told to contact the Assistant Director of Nurses (ADON). LN 1 stated he called the ADON at approximately 9 AM and was told that the ADON would call Resident 1's physician. LN 1 stated that he never heard back from the ADON but that around 9:45 AM the supervisor informed him that the MD had given an order to transfer Resident 1 to the acute hospital. LN 1 confirmed that Resident 1 left the facility at approximately 10 AM.During a concurrent interview and record review on 2/17/26 at 11:02 AM with LN 2, Resident 1's clinical document titled eINTERACT [a set of dashboards, checklists, and automatic triggers designed to work together to assist care teams in preventing unnecessary resident hospitalizations] SBAR [Situation Background Assessment Recommendation; a communication tool used primarily in healthcare to ensure accurate, efficient, and standardized reporting of resident information] Summary for Provider, dated 2/9/26 was reviewed. LN 2 confirmed that she received a phone call from the ADON, who stated that the MD had been contacted and to send Resident 1 to the acute hospital for further evaluation. LN 2 confirmed that the eINTERACT SBAR Summary for Provider was completed for Resident 1 on 2/9/26 at 9:45 AM after speaking with the ADON.During an interview on 2/17/26 at 11:38 AM, with the ADON, the ADON stated that Resident 1's physician had sent a text message on 2/9/26 at 8:19 AM to the ADON's cell phone instructing the facility to send Resident 1 to the hospital. The ADON stated that right after receiving that (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	message, she contacted LN 2 and informed LN 2 of the physician's order to transfer Resident 1 to the acute hospital.During an interview on 2/17/26 at 12:30 PM, with the Director of Nurses (DON), the DON stated that the LN should have been looking for the STAT X-Ray results to come through to the fax machine and into Resident 1's radiology portal through the electronic health record system. The DON stated that the LN that received the results of the STAT X-Ray should have been an immediate notification to Resident 1's physician and when the physician didn't respond within 30 minutes, the LN should have called again. The DON stated that the LN not calling and speaking to Resident 1's physician delayed the order to transfer Resident 1 to the acute hospital by twelve hours which placed Resident 1 at risk for pain and increased the risk for complications based on the nature of the injury.During a review of the facility's policy and procedure (P&P) titled, Guidelines for Notifying Physician of Clinical Problems, dated 9/19, the P&P indicated, .The charge nurse or supervisor should contact the attending physician if a clinical situation appears to require immediate discussion and management.The practitioner is responsible for:.Responding in a timely manner to calls; especially regarding Immediate Notification problems.Immediate implies that the physician should be notified as soon as possible.these situations include: Sudden in onset OR a marked change.compared to usual (baseline) status.Any lab result for which the physician requests immediate or STAT reporting.During a review of the facility's P&P titled, General Guidelines for Reporting Abnormal Test Results to Physicians, dated 9/17, the P&P indicated that an .X-ray.New or unsuspected finding such as fracture. fell under the Immediate category for reporting to a physician.During a review of the facility's P&P titled, Lab and Diagnostic Test Results - Clinical Protocol, dated 11/18, the P&P indicated that .A nurse will identify the urgency of communicating with the Attending Physician based on physician request, the seriousness of any abnormality.Nursing staff will consider the following factors to help identify situation requiring prompt physician notification.whether the physician has requested to be notified as soon as a result is received.Whether the result should be conveyed to a physician regardless of other circumstances (that is, the abnormal result is problematic regardless of any other factors).Whether the resident/patient's clinical status.has signs and symptoms of acute illness or condition change.Direct voice communication with the physician is the preferred means for presenting any results requiring immediate notification.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews and clinical record review and facility polity review, the facility failed to ensure that a comprehensive assessment was completed for one of three sampled residents (Resident 1) when, a Licensed Nurse failed to reassess Resident 1's left foot after receiving Resident 1's x-ray results which indicated a left lower leg fracture and acute osteomyelitis of the left heel. This failure placed Resident 1 at risk for experiencing pain, suffering and further medical declines.Findings:A review of Resident 1's admission RECORD, indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included but were not limited to hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominate side (severe weakness or completed loss of the ability to move the left side of the body following a right-side brain stroke (blood flow to the brain is blocked), pressure ulcer of the left ankle stage 4 (a severe, deep, and open wound that exposes underlying muscle, tendon, or bone), type 2 diabetes mellitus (a chronic condition where the body cannot properly manage the sugar in the blood, leading to consistently high blood sugar level), peripheral vascular disease (a slow, progressive circulatory condition where blood vessels outside the heart and brain-usually in the legs-become narrowed, blocked, or spasmed), and anemia (a common blood condition where you don't have enough healthy red blood cells or hemoglobin to carry adequate oxygen to your body's tissues).A review of Resident 1's Minimum Data Set (MDS; an assessment tool) indicated that Resident 1's clinical document titled BIMS (Brief Interview for Mental Status, an assessment tool used by facilities to screen and identify the memory, orientation, and judgment status of the resident), dated 1/20/26, had a score of 11out of 15 total indicating that Resident 1 was moderately cognitively impaired.A review of Resident 1's clinical document titled Nurse's Note, dated 2/8/26 indicated approx [sic] 1100 [11:00 AM] writer called by the CNA [Certified Nursing Assistant] staff member to check on resident's L [left] foot. upon [sic] checking writer and supervisor nurse see's the L foot in a twisted position down from the ankle, resident has a stage 4 wound on L foot which was being treated.skin color purple and skin cold to touch.MD [medical doctor] ordered a [sic] x-ray order carried out pending results at the time of writing.A review of Resident 1's physician order dated 2/8/26 indicated that a verbal order was given to a licensed nurse (LN) by Resident 1's physician and entered in Resident 1's clinical record at 12:34 PM for a STAT (immediately or without delay) X-Ray to the left ankle, left foot, and left knee.A review of Resident 1's clinical document titled Radiology Results Report, dated 2/8/26, indicated the results of the X-Ray was reported to the facility on 2/8/26 at 10:20 PM. The report indicated that Resident 1 had a fracture (break of a bone) and osteomyelitis (a severe infection within the bone, causing inflammation (swelling) and destruction of bone tissue) of the distal (a body part located farther away from the center of the body or the point of attachment to the trunk) lower leg. A review of Resident 1's clinical document titled Nurse's Note, dated 2/9/26 indicated that Resident 1's physician was notified of the results of the X-Ray at 1:40 AM, but did not indicate that Resident 1's foot had been reassessed for changes or that Resident 1 had been assessed for pain, following the initial assessment completed on 2/8/26 at 11 AM.During an interview on 3/4/26 at 7:59 AM with LN 3, LN 3 indicated that LN 1 had reported during the handoff report (process of transferring patient-specific information, authority, and responsibility from one healthcare provider or team to another) that Resident 1's left foot was in an abnormal position and was twisted around. LN 3 indicated that together they went in to look at Resident 1's foot. LN 3 stated that a comprehensive assessment was not completed by her at that time. LN 3 confirmed that the results of the STAT x-ray, taken on 2/8/26, was reported to Resident 1's physician on 2/9/26 at 1:40 AM. LN 3 confirmed (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that a comprehensive assessment was not completed prior to or after sending the abnormal x-ray result to Resident 1's physician. LN 3 stated that a comprehensive assessment on Resident 1's left leg and foot should have been completed before notifying Resident 1's physician of the abnormal x-ray results so that the physician would have a complete picture of Resident 1's condition. LN 3 stated not completing a comprehensive assessment placed Resident 1 at risk for developing sepsis, pain, and further decline in Resident 1's overall medical condition.During a concurrent interview and record review on 2/13/26, at 2:22 PM, with the Director of Nursing (DON), Resident 1's x-ray result dated 2/8/26 and Resident 1's nurses progress notes dated from 2/8/26 through 2/9/26 were reviewed. The DON stated that the Registered Nurse assigned to Resident 1 during 2/8/26 through 2/9/26 should have completed and documented a comprehensive assessment using the SBAR Communication Form (SBAR stands for Situation, Background, Assessment, and Recommendation. It's a structured communication tool used to convey essential information quickly and clearly) on Resident 1's left leg and foot, and the assessment should have contained a description of how the leg and foot looked, if there was any evidence of circulation in the left leg and foot, if there was any bleeding, necrosis or further twisting of the foot or leg, and if Resident 1's was expressing any pain or discomfort during the assessment process. The DON further stated that the facility does not always have a Registered Nurse scheduled that can complete a full comprehensive assessment of resident's when they have had a significant change of condition.During a review of the facility's policy and procedure (P&P) titled, Change in a Resident's Condition or Status, dated 2/21, the P&P indicated .the nurse will notify the resident's attending physician or physician on call when there has been a(an): discovery of injuries of an unknown source .significant change in the resident's physical/emotional/mental condition.prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including (for example) information prompted by the Interact SBAR Communication Form.During a review of the facility's job description titled, JOB DESCRIPTION Licensed Vocational Nurse (LVN) DEPARTMENT: Nursing, dated 3/1/14, the job description indicated .Under the direct supervision of the RN, assists with the planning, coordination, and provision of individualized resident care in accordance with the established policies and procedures of the facility.complete initial and ongoing assessments by gathering data.During a review of the facility's job description titled, JOB DESCRIPTION Registered Nurse - SNF or Sub-acute DEPARTMENT: Nursing, dated 03/01/14, the job description indicated .the primary function of the Registered Nurse is to insure effective and efficient nursing care is provided as prescribed by the physician and as required by the facility's policies and procedures.Assist the Charge Nurse as required which includes but is not limited to assessment of residents on change of condition.During a review of the facility's job description titled, JOB DESCRIPTION Nursing Supervisor DEPARTMENT: Nursing, dated 11/25, the job description indicated, .The role provides shift-level leadership to ensure safe, effective, and compliant care delivery within the legal scope of LVN practice.the LVN Nursing Supervisor may: Observe residents for changes in condition and initiate required notifications.