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	05/29/2026

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 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 interview and record review, the facility failed to ensure a physician-ordered anticonvulsant medication (medication to prevent a seizure [a sudden, uncontrolled surge of electrical activity in the brain]) was implemented and administered as ordered for one of three sampled residents when, Resident 1 returned from the hospital on 4/27/26 with physician instructions to resume medication for a seizure disorder and the nursing staff failed to implement the order, obtain physician order clarification, notify the physician of the medication omission, and administer the medication, resulting in Resident 1 not receiving the ordered anticonvulsant medication for approximately 25 days, from 4/27/26 through 5/21/26.This failure had the potential to result in uncontrolled seizure activity, injury, neurological decline, delated physician intervention, hospitalization, and the need for emergency medical treatment. Findings:A review of Resident 1's admission Record, indicated Resident 1's diagnoses included epilepsy (a condition that causes repeated episodes where a person may shake, stare, or become unaware of their surroundings). A review of Resident 1's Medication Review Report, [includes physician's orders] dated 4/1/26 through 4/26/26 and the Medication Administration Record, (MAR - records used to document medications administered to residents) dated 4/1/26 through 4/30/26, indicated Resident 1 routinely received physician-ordered oxcarbazepine (anti-seizure medication). Physician's orders included: Oxcarbazepine 150 milligram (mg, unit of measurement) - Give 1 tablet by mouth in the afternoon for seizures and 1 tablet at 1 PM (150 mg total at noon [12 PM]). Oxcarbazepine 300 mg - Give 1 tablet by mouth one time a day for seizures (450 mg total at noon). Oxcarbazepine 600 mg - Give 1 tablet by mouth at bedtime for seizures.A review of Resident 1's Inter-Facility Transfer Report (IFT - transfer document containing resident medical information and instructions when moving between healthcare facilities), dated 4/27/26, indicated Resident 1 returned to the facility with instructions to resume home medications, including oxcarbazepine. A review of Resident 1's Medication Review Report, dated 4/27/26 through 5/21/26, and the MAR, dated 4/2026 through 5/2026, indicated oxcarbazepine was not entered into the electronic medical record upon Resident 1's return to the facility on 4/27/26. Further review of the records indicated there was no documented administration of oxcarbazepine from 4/27/26 through 5/21/26.During a concurrent interview and record review on 5/22/26 at 1:44 PM with the Assistant Director of Nursing (ADON), Resident 1's Hospitalist Discharge summary, dated [DATE]; the Medication Review Report, dated 4/27/26 through 5/21/26; and the MAR, dated 4/2026 through 5/2026, were reviewed. The ADON stated she reviewed the hospital discharge orders when Resident 1 returned to the facility on 4/27/26. The ADON stated she did not enter the oxcarbazepine order into the electronic medical record because she wanted clarification regarding the medication order. The ADON stated she contacted the physician regarding the medication order; however, she was unable to provide documentation or other evidence to support physician communication occurred and confirmed the medication order was not entered into the electronic medical record until 5/22/26. The ADON further acknowledged Resident 1 did not receive oxcarbazepine from 4/27/26 through 5/21/26. A review of Resident 1's Progress Notes, dated 4/27/26 through 5/21/26; the Medication Review Report, dated 4/27/26 through 5/21/26; and entire clinical record during that timeframe indicated (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	there was no documentation that the attending physician was notified that Resident 1 had not received the physician-ordered oxcarbazepine. Further review revealed no documentation of physician clarification, medication error reporting, incident reporting, corrective action, investigation, or follow-up regarding the medication omission.During an interview on 5/22/26 at 2:11 PM with the Director of Nursing (DON), the DON stated nursing staff were expected to review and implement physician's orders, obtain physician clarification when questions arose regarding medication orders, notify the physician of significant medication issues, and document physician communication in the resident's medical record.During a concurrent telephone interview and record review on 5/22/26 at 3:34 PM with the Pharmacy Consultant (PC), Resident 1's Medication Review Report, dated 4/27/26 through 5/21/26; the Hospitalist Discharge summary, dated [DATE], and the MAR, dated 4/2026 through 5/2026 were reviewed. The PC verified Resident 1 returned to the facility with physician instructions to continue oxcarbazepine for seizure disorder; however, the medication order was not entered into the electronic medical record until 5/22/26 and the medication was not administered from 4/27/26 through 5/21/26. The PC stated nursing staff should have contacted the attending physician and/or pharmacy for clarification if questions existed regarding the medication order. The PC further stated failure to administer the physician-ordered anticonvulsant medication had the potential to result in seizure activity.A review of the facility policy titled, Adverse Consequences and Medication Errors, revised 2/2023, indicated, .2. Examples of medications errors include: a. Omission - a drug is ordered but not administered; . 6. Promptly notify the provider of any significant error or adverse consequence Review of the facility policy titled, Administering Medications, revised 4/2019, indicated, Medications are administered in a safe and timely manner, and as prescribed . 4. Medications are administered in accordance with prescriber orders, including any required time frame .