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	06/08/2026

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. Based on observation, interview, and record review, the facility failed to timely identify a right hip fracture (a broken or cracked bone) for one of three residents (Resident 3) following an unwitnessed fall on 1/14/26, when nursing staff failed to conduct a comprehensive post-fall assessment (a thorough evaluation completed after a fall to identify possible injuries, pain, causes of the fall, and changes in the resident's condition), failed to adequately reassess Resident 3's reported hip pain and changes in condition, failed to complete required post-fall neurological monitoring (neuro checks - assessments used to identify changes in alertness, thinking, behavior, movement, sensation, and function following a fall) within required timeframes, and failed to complete a weekly summary (a routine nursing documentation that provides an overview of a resident's condition during the previous week) due on 1/19/26. Despite Resident 3 reporting hip pain following the fall and later experiencing severe, worsening pain, nursing staff failed to identify a potential fracture until the physician identified a right hip deformity on 1/21/26, which prompted diagnostic imaging on 1/21/26 that confirmed an acute right hip fracture.These failures delayed identification of Resident 3's fracture, resulting in severe pain and delayed implementation of appropriate interventions to address pain and promote comfort.Findings:Review of Resident 3's admission RECORD indicated Resident 3 was admitted to the facility with diagnoses including open wound to the right thigh, unstageable pressure ulcer (pressure sore covered with dead tissue that prevents determination of the wound depth) to the left hip, stage 4 pressure ulcer (severe pressure sore extending into muscle, tendon, or bone) to the right hip, stage 3 pressure ulcer (pressure sore involving full thickness skin loss) to the right buttock, stage 3 pressure ulcer to the right lower back, severe protein calorie malnutrition (not getting enough protein and calories for the body's needs), pressure deep tissue injuries (injury to skin and underlying tissue caused by pressure) to the right and left heels, palliative care (care focused on comfort and quality of life), need for assistance with personal care, and muscle weakness.Review of Resident 3's Minimum Data Set (MDS, an assessment tool) Brief Interview for Mental Status (BIMS - an assessment of a resident's thinking and memory), dated 1/13/26, indicated Resident 3's BIMS score was 5, reflecting severe cognitive impairment (13-15 = Intact, 8-12 = Moderate Impairment, 0-7 = Severe Impairment), which limited the resident's ability to communicate pain, describe how the fall occurred, or report signs and symptoms of injury following the fall.Review of Resident 3's communication log with hospice indicated that on 1/14/26 at 2:09 PM, the facility contacted hospice to report that Resident 3 had sustained an unwitnessed fall and complained of hip pain.Review of Resident 3's Post Fall Evaluation, dated 1/14/26, at 2:11 PM, indicated Resident 3 had an unwitnessed fall on 1/14/26 at 1:25 PM in Resident 3's room while attempting to get out of bed, but there was no assessment of factors that may have contributed to Resident 3's attempt to get out of bed, and no indicators pain was documented despite Resident 3's communication log with hospice dated 1/14/26 at 2:09 PM indicating Resident 3 complained of hip pain following the fall. Resident 3's Post Fall Evaluation also did not reflect that a comprehensive post-fall assessment was completed, as there was no detailed musculoskeletal assessment, assessment for signs of injury, identification of resident-specific fall risk factors, review of medications associated with falls, and documentation describing how Resident 3 was found after the fall, including the resident's position on the (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	of the thigh bone near the hip joint) with moderate displacement (movement of the broken bone fragments out of normal alignment), which was identified seven days after the fall.During a concurrent interview and record review on 6/11/26, at 2:03 PM ,with the Director of Nursing (DON), Resident 3's weekly nursing summary and neuro checks were reviewed for the month of January, 2026. Resident 3's weekly summary showed that Resident 3 did not have a weekly summary from 1/14/26 through 1/21/26. The DON stated Resident 3's weekly summary was due on 1/19/26 and was not completed by nursing. Resident 3's neuro checks were also reviewed with the DON. The DON stated that Resident 3 had missing neuro checks that were not completed within the required timeframes. The DON further stated that failure to complete weekly summaries and neuro checks could result in missed critical information regarding changes in condition. The DON acknowledged that Resident 3's Post Fall Evaluation dated 1/14/26 at 2:11 PM did not reflect that a complete and thorough assessment was completed following the fall on 1/14/26 and that failure to perform a thorough post-fall assessment could result in missed or delayed identification of injuries and delayed implementation of appropriate interventions.Review of the facility's policy and procedure (P&P) titled Comprehensive Assessments, revised 3/22, the P&P indicated, .Comprehensive assessments are conducted and coordinated by a registered nurse.Review of the facility's P&P titled Resident Examination and Assessment, revised 2/14, the P&P indicated, .The following information should be recorded in the resident's medical record.All assessment data obtained during the procedure.Review of the facility's P&P titled Falls - Clinical Protocol, revised 3/18, the P&P indicated, .the nurse shall assess and document/report the following.Musculoskeletal function, observing for change in normal range of motion.Neurological status.Pain.Precipitating factors, details on how fall occurred.All current medications, especially those associated with dizziness or lethargy, and.All active diagnoses.The staff will evaluate and document falls that occur.when and where they happen, any observations of the events.For an individual who has fallen, the staff and practitioner will begin to try to identify possible causes within 24 hours of the fall.The staff will follow up on any fall with associated injury until the resident is stable and delayed complications such as late fractures have been ruled out.Delayed complications such as late fractures may occur hours or days after a fall.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interview and record review, the facility failed to ensure the required licensed nurses' 72-hour progress notes (post-incident monitoring and assessment) for resident-to-resident altercations was completed for all required shifts for two of two residents (Resident 1 and Resident 2) when Resident 2, who had a history of aggression and cognitive impairment, struck Resident 1 on the arm.This failure placed Resident 1 and Resident 2 at risk for emotional distress, delayed identification of injuries and changes in condition, and increased the risk for additional resident-to-resident altercations within the facility.Findings:Review of Resident 1's admission RECORD indicated Resident 1 was admitted to the facility with diagnoses including mood disorder (condition that affects emotions and mood), epilepsy, history of falling, depression, anxiety disorder, muscle weakness, need for assistance with personal care, and difficulty in walking.Review of Resident 1's [Facility Name] Progress Notes., dated 12/31/25 at 10:34 AM indicated that on 12/24/25 at approximately 10:30 AM, Resident 1 asked Resident 2 about the contents of Resident 2's pink gift box, causing Resident 2 to become upset and strike Resident 1 on the right arm.Review of Resident 1's Minimum Data Set (MDS, an assessment tool) Brief Interview for Mental Status (BIMS - to check a resident's thinking and memory), dated 4/29/26, Resident 2 BIMS score was 14 which showed that Resident 1 had intact cognition (13-15 = Intact, 8-12 = Moderate, 0-7 = Severe).Review of Resident 1's progress notes, in the section titled IDT [Interdisciplinary Team - a group of staff from different departments who work together to plan and review resident care] Review, dated 12/26/25 at 5:45 PM, indicated .IDT Recommendations.Complete 72-hour nursing.monitoring.Review of Resident 2's admission RECORD indicated Resident 2 was admitted to the facility with diagnoses including metabolic encephalopathy (a condition that affects brain function due to a medical illness), altered mental status (changes in thinking), need for assistance with personal care, adjustment disorder with mixed disturbance of emotions and conduct (difficulty coping with stress that affects emotions and behavior), major depressive disorder, and primary insomnia (trouble falling asleep or staying asleep).Review of Resident 2's MDS Brief Interview for Mental Status, dated 4/13/26, Resident 2 BIMS score was 10 which showed that Resident 2 had moderately impaired cognition (13-15 = Intact, 8-12 = Moderate, 0-7 = Severe).Review of Resident 2's Progress Notes, in the section titled IDT Review, dated 12/26/25 at 5:38 PM, indicated, IDT Recommendations.Complete 72-hour nursing. observations.Review of Resident 2's Care Plan, in the section titled Focus, initiated on 1/25/24, indicated, .Resident 2 has periods of delirium [sudden confusion and changes in thinking] manifested by inattention, aggression, threatening behavior toward healthcare staff and other residents, and disorganized thinking. In the section titled Interventions, indicated, .Monitor, record, and report new onset s/sx [signs and symptoms] of delirium, changes in behavior, altered mental status [changes in thinking, awareness, or behavior], wide variation in cognitive function throughout the day, communication decline, disorientation [confusion about person, place, or time], lethargy [unusual drowsiness], restlessness, and agitation.During a concurrent interview and review of the facility's abuse binder on 6/8/26 at 3:17 PM with the Director of Nursing (DON), the abuse binder contained abuse reporting instructions which indicated, .Monitor and document for 72 hours q [every] shift prog [progress] notes on both residents and document if victim feels safe. The DON stated the abuse binder was maintained at the nurse's station to provide nursing staff with clear instructions to follow when an allegation of abuse occurred. The DON stated licensed nurses (LN) were expected to complete 72-hour progress notes following resident-to-resident altercations to monitor for changes in condition and evaluate the effectiveness of interventions. Resident 1's progress notes dated 12/24/25 through 12/27/25 were reviewed with the DON. Resident 1's progress notes indicated required 72-hour progress notes were not completed during the 12/24/25 night shift, 12/25/25 night shift, and 12/26/25 night shift. Resident 2's progress notes dated 12/24/25 through 12/27/25 were (continued on next page)

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