

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 12/19/2025
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)		
F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to ensure garbage and refuse were properly disposed for a census of 85, when:1. A garbage dumpster lid was not closed; and,2. A trash can in the kitchen did not have a working cover lid on it. These failures had the potential to expose the residents' environment to pests, odors, or diseases.Findings:1. During a concurrent observation and interview on 12/16/25, at 8:57 AM, with the Certified Dietary Manager (CDM) in the outside dumpster area of the facility, a garbage dumpster was observed to have a lid open. The CDM confirmed that the garbage dumpster's lid was open.During an interview on 12/18/25, at 9:53 AM, with the CDM, the CDM stated that the dumpster lid should always be closed when not in use. The CDM further stated that she did not want people getting into the dumpsters. The CDM stated that the risk of cross-contamination would be increased with having the dumpster lids left uncovered.During an interview on 12/18/25, at 1:30 PM, with the Registered Dietician (RD), the RD stated that by not having the dumpster lids closed, pest and other debris issues could arise. The RD further stated that the dumpster lids should have been closed securely after each use and should not have been left open.During a review of the facility's policy and procedure (P&P) titled, MISCELLANEOUS AREAS, dated 2023, the P&P indicated, .Garbage and trash cans must be inspected daily that no debris is on the ground or surrounding area, and that the lids are closed.2. During a concurrent observation and interview on 12/16/25, at 8:56 AM, with the Certified Dietary Manager (CDM) in the kitchen, a trash can was observed without a lid covering. The CDM confirmed that the trash can lid was broken.During an interview on 12/18/25, at 9:53 AM, with the CDM, the CDM stated that that the trash cans should have had working cover lids and be closed. The CDM further stated that the bugs could enter the facility by not having the trash cans closed securely.During an interview on 12/18/25, at 1:30 PM, with the RD, the RD stated that the trash cans in the kitchen should have lids on them. The RD further stated cross-contamination risks would increase by not having a working cover lid on the trash cans. The RD stated that pests could potentially enter the facility if trash cans were not closed properly. The RD stated that a foot-pedal trash can would have been the best choice to use in the kitchen.During a review of the facility's P&P titled, MISCELLANEOUS AREAS, dated 2023, the P&P indicated, .All food waste must be placed in sealed leak-proof, non-absorbent, tightly closed containers (i.e., plastic bags) and shall be disposed of as necessary to prevent a nuisance or unsightliness.Adequate, clean, vermin-proof areas must be provided for storage of garbage and rubbish.The trash collection area is a potential feeding ground for vermin and rodents and must be kept clean.During a review of the facility's P&P titled, SANITATION, dated 2023, the P&P indicated, .Kitchen wastes which are not disposed of by garbage disposal units shall be kept in leakproof, non-absorbent and tightly closed containers and shall be disposed of as necessary to prevent a nuisance or unsightliness.		

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 12/19/2025
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)		
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to ensure pharmacy services were maintained for a census of 85 when:1. Non-narcotic (medications that are not opioids-not addictive) prescription medication destruction records were either not signed and/or co-signed by licensed nurses in 17 out of 24 destruction records reviewed in one of two medication rooms (Med Room Unit 1) observed; and,2. Three unidentified pills were found in a medication cup on top of a storage container beside Resident 40's bed unattended and unsupervised.This failure had the potential for drug diversion (unlawful use of prescription drug by unauthorized individuals) or misuse of prescribed medications due to unsafe disposition practices and Resident 40 not receiving important medication as prescribed.Findings:1. During an interview and record review on 12/18/25, at 9:58 a.m. with Licensed Nurse (LN) 4, the non-narcotic destruction records from 2024 and 2025 titled, Medication Disposition Sheet, dated 7/18/24, 1/2/25, 1/30/25, 3/1/25, 6/18/25, 7/10/25, and 9/26/25 were reviewed. There were 17 out of 24 sheets reviewed that did not have signature of a licensed nurse who disposed the medication and/or a signature of a licensed nurse who witnessed the disposal of the medication. LN 4 confirmed the non-narcotic destruction records reviewed were not signed and/or co-signed by a licensed nurse. LN 4 stated licensed nurses should be signing the destruction sheets and should have 2 signatures. LN 4 stated it was important to have 2 signatures because improper disposition of unused and discontinued prescription medications could increase the risk for drug diversion and/or misuse.During an interview on 12/18/25, at 1:56 p.m. with the Director of Nursing (DON), the DON stated she expected destruction records of non-narcotic prescription drugs should have 2 licensed nurses' signatures because risk for drug diversion and misuse would be increased.During a record review of the facility's policy and procedure (P&P) titled, Disposal of Medications and Medication-Related Supplies Medication Destruction, revised 11/11, the P&P indicated, .Medication destruction occurs only in the presence of at least two licensed healthcare professionals.The licensed healthcare professionals witnessing the destruction ensure that the following information is entered on the [medication disposition form].Signatures of witnesses.2. During a review of Resident 40's clinical record titled, admission RECORD, indicated Resident 40 was admitted to the facility with diagnosis of, but not limited to diabetes mellitus (a chronic condition where the body either doesn't use insulin effectively [insulin resistance] or can't produce enough insulin, leading to high blood sugar [hyperglycemia]), hypotension (low blood pressure [below 90/60 mmHg], occurs when blood pressure is too low to supply vital organs with enough oxygenated blood, causing symptoms like dizziness, fainting, fatigue, nausea, or blurry vision) atrial fibrillation (a common type of irregular heartbeat [arrhythmia] where the heart's upper chambers quiver instead of beating effectively, leading to a rapid, erratic pulse that can feel like fluttering or pounding in the chest, causing fatigue, dizziness, or shortness of breath), and metabolic encephalopathy (a brain dysfunction from a chemical imbalance, often due to liver, kidney, or diabetes issues, causing confusion, memory problems, mood changes, or coma).During a concurrent observation and interview on 12/16/25, at 9:55 AM, with Resident 40, in her room, three unidentified pills were found in a medication cup on top of a storage container beside her bed. Resident 40 stated she did not know how long the medications were in her room or what they were for.During a concurrent observation and interview on 12/16/25, at 10:11 AM, with Certified Nurse Assistant (CNA) 1 and CNA 2, Resident 40's storage area in her room was observed. CNA 1 and CNA 2 both confirmed that three pills were in a medication cup on top of a storage container. CNA 2 stated she was not sure how long the pills had been there.During a concurrent observation and interview on 12/16/25, at 10:15 AM, with LN 2, LN 2 confirmed that three pills were in a medication cup on top of a storage container. LN 2 stated that she was unsure of how the medications were placed on the storage container. LN 2 then proceeded to remove the pills from the room and returned to the medication cart.During an interview on 12/18/25, (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 12/19/2025
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)		
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	at 11:59 AM, with the DON, the DON stated that pills should not have been left unattended in a resident's room. The DON further stated that her expectations were for the nurses to watch the residents take the medication prior to leaving the room. The DON stated that other residents could take the medications and that possible allergic reactions or overdoes could occur. During a review of the facility's P&P titled, STORAGE OF MEDICATIONS, revised 08/2014, the P&P indicated, .Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications .Nurses may not transfer medications from one container to another or return partially used medication to the original container. During a review of the facility's P&P titled, MEDICATION ADMINISTRATION-GENERAL GUIDELINES, revised 08/2014, the P&P indicated, .Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so .The facility has sufficient staff and a medication distribution system to ensure safe administration of medications without unnecessary interruptions .The resident is always observed after administration to ensure that the dose was completely ingested.		

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 12/19/2025
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)		
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to provide safe and effective use of medications including administering, storing, and dispensing, of all drugs and biologicals for a census of 85 when:1. A bag for IV (intravenous, into the vein) infusion containing 0.9% normal saline (electrolyte supplement in water) and a vial of ertapenem (antibiotic for infection) one gram (a unit of measurement) connected to the bag had a label indicating DO NOT USE AFTER 12/15/25 was stored in the Med (medication) Room Unit 1 together with other active medications and available for use; and,2. Prescribed medications found in the pharmaceutical waste container (where unused and/or discontinued prescribed medications were held for ultimate safe disposal) in Med Room Unit 1 were not disposed of properly when bottles, insulin pens, pills, solutions were still recognizable and retrievable by hand. These failures had the potential for medication errors due to inadvertent administration of an expired medication, or misuse of prescribed medications due to unsafe disposition practices. Findings: 1. During an concurrent observation and interview, in the medication room on Unit 1, on 12/18/25, at 9:58 a.m., with Licensed Nurse (LN) 3, a bag for IV infusion containing 0.9% normal saline and a vial of ertapenem one gram connected to the IV bag had a label indicating DO NOT USE AFTER 12/15/25 was found stored together with other active medications and available for use. LN 3 confirmed the date on the label was beyond the use date and the IV bag with the antibiotic should have been removed from the active medications in the medication room and should have been placed in a separate area for destruction. LN 3 stated the medication was expired and should not be used after 12/15/25. LN 3 further stated the medication should have been removed from the medication room. During an interview on 12/18/25, at 1:56 p.m., with the Director of Nursing (DON), the DON stated she expected as a standard of care to remove and destroy expired medications in a timely manner. The DON further stated the expired medications if stored with other active medications could potentially be administered to a resident. The DON stated that administering an expired medication could have adverse effects (undesirable outcome) on the resident. During a review of the facility's policy and procedure titled, Medication Storage in the Facility Storage of Medications, revised November 2011, indicated, .All expired medications will be removed from the active supply and destroyed in the facility, regardless of amount remaining. The medication will be destroyed in the usual manner . 2. During an concurrent observation and interview, in the medication room on Unit 1, on 12/18/25, at 9:58 a.m., with LN 3, prescribed medications found in the pharmaceutical waste container were not disposed of properly when bottles, insulin pens, pills, and solutions were still recognizable and retrievable by hand. LN 3 confirmed the medications in the waste container were still recognizable. LN 3 stated the medications discarded in the waste containers should have been mixed to make it unretrievable. During an interview on 12/18/25, at 1:56 p.m., with the DON, the DON explained the pharmaceutical waste containers should have an absorption pads, charcoal packets, and/or coffee grounds that would bind with the discarded medications to make it unrecognizable and unretrievable to prevent diversion and misuse of medications. The DON stated the liquid medications should have been poured out and it was not a standard of practice to throw medications in the pharmaceutical waste containers that were still whole and recognizable. During a review of the facility's policy and procedure titled, Disposal of Medications and Medication-Related Supplies Medication Destruction, revised November 2011, indicated, .Remove medication from their original containers. Mix drugs with an undesirable substance, such as cat litter or used coffee grounds. Put the mixture into a disposable container with lid, such as a 5-gallon bucket.		

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 12/19/2025
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)		
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety when:1. A microwave was placed in the kitchen,2. A bun toaster was dirty with black residue,3. The kitchen walls were chipped and had cracking paint,4. Multiple pots, pan, and other cooking items were flaky and had black residue buildup,5. The stove top and drip pan were dirty and had grease buildup,6. The walk-in refrigerator and freezer had ice buildup; and,7. Vents and fans were dirty in the food prep area.These failures had the potential of leading to food borne illness (an illness that comes from eating contaminated food) for the 81 residents eating facility prepared meals.Findings:1. During a concurrent observation and interview on 12/16/25, at 8:53 AM, with the Certified Dietary Manager (CDM), in the kitchen, a microwave was observed placed next to the stove top range oven. The CDM confirmed that there was a microwave in the kitchen.During an interview on 12/18/25, at 9:53 AM, with the CDM, the CDM stated that the microwave should not have been in the kitchen.During an interview on 12/18/25, at 1:30 PM, with the Registered Dietician (RD), the RD stated there should not have been a microwave in the kitchen. The RD further stated that if the staff were to use the microwave, certain food items would not reach the proper cooking temperatures. The RD stated that she did not think the staff were checking the temperatures on all food items being prepared in the kitchen. The RD further stated that there would be a cross-contamination risk by having a microwave in the kitchen.2. During a concurrent observation and interview on 12/16/25, at 8:53 AM, with the CDM, in the kitchen, a bun toaster was observed having black residue, food crumbs, and other debris. The CDM confirmed that the bun toaster was dirty.During an interview on 12/18/25, at 9:53 AM, with the CDM, the CDM stated that she was unable to get the black residue and debris off of the bun toaster. The CDM further stated that the facility may need to get rid of the current bun toaster and potentially get a new one. The CDM stated that the debris and residue could get on the bread and other food items.During an interview on 12/18/25, at 1:30 PM, with the RD, the RD stated that the bun toaster should not have been dirty. The RD further stated that the bun toaster should have been cleaned routinely. The RD stated that the bun toaster should have been on a cleaning schedule.During a review of the facility's policy and procedure (P&P) titled, ELECTRICAL FOOD MACHINES, dated 2023, the P&P indicated, .Keep and maintain all food machines in good operating, sanitary condition. This includes mixers, grinders, slicers, and toasters.Clean daily.Remove crumbs from the crumb tray daily and wipe the toaster case with a soft, clamp cloth. If the case is greasy, use a non-abrasive cleaning compound to clean it .3. During a concurrent observation and interview on 12/17/25, at 11:45 AM, with the CDM, in the kitchen, the kitchen walls were noted to have been chipped and had cracking paint. The CDM confirmed that the kitchen walls were chipped and had faded paint. The CDM stated that removing the microwave from the kitchen allowed for better visuals of the kitchen walls. The CDM further stated she had not noticed how the walls were discolored and had fading paint issues.During an interview on 12/18/25, at 9:53 AM, with the CDM, the CDM stated that the kitchen walls should be as smooth as possible and not have any holes or missing parts.During an interview on 12/18/25, at 1:30 PM, with the RD, the RD stated that having chipped paint and scraped walls posed a hazard in the kitchen. The RD further stated the kitchen should not have chipped walls.During an interview on 12/19/25, at 9:05 AM ,with the Director of Maintenance (DM), the DM stated that the kitchen walls should have been smooth and not chipped.During a review of the facility's P&P titled, WALLS, CEILINGS, AND LIGHT FIXTURES, dated 2023, the P&P indicated, .Walls and ceilings must be free of chipped and/or peeling paint.It is important to repair peeling paint areas as soon as they appear.4. During a concurrent observation and interview on 12/16/25, at 8:48 AM, with the CDM, in the kitchen, various pots, pans, and other food holding containers were noted to have black residue buildup and dirty edges. The CDM confirmed that multiple pots, pans, and other food holding containers were dirty and damaged due to use.During an (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 12/19/2025
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)		
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interview on 12/18/25, at 9:53 AM, with the CDM, the CDM stated that the pots, pans, and cooking trays should have been clean and not flaky. The CDM further stated that the flakes of the cooking trays could get into the food or be cooked into the food and become dangerous for the residents. During an interview on 12/18/25, at 1:30 PM, with the RD, the RD stated that the cookware should not have been chipped or discolored. The RD further stated that the lining of the cooking utensils could get in the food. During a review of the facility's P&P titled, SANITATION, dated 2023, the P&P indicated, .All utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seam, cracks, and chipped areas. Plastic ware, china, and glassware that becomes unsightly, unsanitary, or hazardous because of chips, cracks, or loss of glaze shall be discarded. During a review of the facility's P&P titled, KITCHEN SAFETY, dated 2023, the P&P indicated, .All chipped enamelware should be discarded in favor of stainless steel or other non-chip pots and pans. All chipped or cracked dishes should also be discarded when found. 5. During a concurrent observation and interview on 12/16/25, at 8:54 AM, with the CDM, in the kitchen, the stove top and the drip pan had grease, black residue, and other food debris. The CDM confirmed that the stove top and the drip pan were dirty and had grease accumulation. During an interview on 12/18/25, at 9:53 AM, with the CDM, the CDM stated that the drip pan and stove top should have been clean. The CDM further stated that there were years of grease and food buildup. The CDM stated that there was a fire risk with all the grease accumulation. The CDM further stated that food items could be contaminated with the dirty stove top. During an interview on 12/18/25, at 1:30 PM, with the RD, the RD stated that there was a fire risk having grease buildup in the drip pan and stove top. The RD further stated that a specialized cleaning company should have come to the facility to clean the stove top range oven. During a review of the facility's P&P titled, RANGES AND OVENS, dated 2023, the P&P indicated, .Range drip pans must be emptied and washed on a routinely scheduled basis. Grills must be cleaned after each use. Always empty and wash the grease pan after each use. 6. During a concurrent observation and interview on 12/16/25, at 8:52 AM, with the CDM, in the kitchen, the walk-in refrigerator and freezer had ice buildup throughout. The CDM confirmed that there was ice buildup on the door frames and hinges between the walk-in refrigerator and freezer. The CDM further confirmed that there were icicles forming under the compressor unit in the freezer. During an interview on 12/18/25, at 9:53 AM, with the CDM, the CDM stated that the ice buildup in the walk-in refrigerator and freezer could contaminate the food that was stored there. The CDM further stated that the door between the walk-in refrigerator and freezer should have been sealing properly and not have ice buildup. The CDM stated that the staff have to constantly clean the water that is leaking from the compressor unit. During an interview on 12/18/25, at 1:30 PM, with the RD, the RD stated that the compressor in the freezer should have been replaced a while back. The RD further stated that cross-contamination could happen with the icicles that were formed over the stored frozen food. The RD stated that the temperatures of the food items could be impacted by not having a properly sealing freezer door. During a review of the facility's P&P titled, REFRIGERATOR AND FREEZER, dated 2023, the P&P indicated, .Maintaining a clean refrigerator and freezer can improve the safety and quality of your foods . Periodically, check door gaskets and replace, if damaged. Clean the evaporator and condensing coils at least twice a year. During a review of the facility's P&P titled, PROCEDURE FOR REFRIGERATED STORAGE, dated 2023, the P&P indicated, .Refrigeration equipment should be routinely cleaned. Refrigerator doors are to close tightly and should be opened as little as possible to prevent storage temperature fluctuations. During a review of the facility's P&P titled, PROCEDURE FOR FREEZER STORAGE, dated 2023, the P&P indicated, .Freezer doors are to close tightly and should be opened as little as possible to prevent storage temperature fluctuations. Food items should be stored on clean surfaces in a manner that protects it from contamination. During a review of the facility's P&P titled, SAFETY AND INFECTION CONTROL, dated 2023, the P&P indicated, .The kitchen will be equipped with safe equipment, which is to be maintained in good working order. 7. During a concurrent observation and interview on 12/16/25, at 8:42 AM, with the CDM, in the kitchen, two fans (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 12/19/2025
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)		
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and two vents were dirty, dusty, and had grayish colored debris. The CDM confirmed that the fans and vents in the kitchen were dirty and dusty. During an interview on 12/18/25, at 9:53 AM, with the CDM, the CDM stated that the dust and debris from the fans and vents could end up in the food. The CDM further stated that the maintenance department was responsible for cleaning the fans and vents. During an interview on 12/18/25, at 1:30 PM, with the RD, the RD stated that the fans and the vents should have been clean and maintained on a cleaning or maintenance schedule. During an interview on 12/19/25, at 9:05 AM, with the DM, the DM stated that the kitchen fans and vents should have been cleaned and not dirty. During a review of the facility's P&P titled, HOODS, FILTERS, AND VENTS, dated 2023, the P&P indicated, . Vents must be free of dust and dirt .		

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 12/19/2025
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)		
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, and record review, the facility failed to provide and maintain a safe, clean, comfortable, and homelike environment for a census of 85, when:1. Resident 19's overbed headlight remained continuously on because the pull string was broken; and,2. Resident 40, and Resident 7 had chipped walls and cracked paint behind their bed frames. These deficient practices demonstrated a lack of effective systems to identify, report, and correct environmental concerns resulting in Resident 19, Resident 40, and Resident 7 not feeling supported, treated with dignity and comfort, or provided a home-like living environment. Findings: 1. A review of Resident 19's admission RECORD, indicated Resident 19 was admitted to the facility with diagnoses of, but not limited to need for assistance with personal care, and generalized muscle weakness. During an interview on 12/16/25, at 10 AM, in Resident 19's room, with Resident 19, Resident 19 stated that for the past three days, the overbed headlight remained continuously on because the pull string was broken. Resident 19 stated the issue was reported to two certified nursing assistants (CNAs); however, no staff came to the room to assess or repair the light. Resident 19 further stated she had reported the issue to another CNA today and when the CNA checked the maintenance logbook, they found that nothing had been reported. Resident 19 stated she was unable to sleep well at night due to the constant light exposure. Resident 19 further stated that not sleeping well made her feel tired and affected her ability to join activities. During a concurrent observation and interview on 12/16/25, at 10:09 AM, in Resident 19's room, with the Director of Staff Development (DSD), the DSD confirmed Resident 19's overbed headlight was on and the pull string was broken. The DSD stated that staff who noticed problems or received complaints would write them in the maintenance logbook and the Director of Maintenance (DM) would then check and fix the issues, signing off once completed. The DSD further stated Resident 19 could not turn the overbed headlight on and off because the pull string was broken. The DSD stated that the broken pull string prevented Resident 19 from turning the overbed headlight on and off and this issue affected Resident 19's safety and comfort and made it difficult to sleep. During an interview on 12/17/25, at 8:15 AM, in Resident 19's room, with Resident 19, Resident 19 stated she had not been able to sleep well last night because the light was continuously on. Resident 19 stated it was easy to fix the broken pull string, but no one came back yesterday even though the certified nursing assistant (CNA) and the licensed nurse (LN) had reported it in the maintenance logbook. During an interview on 12/18/25, at 12:09 PM, with certified nurse assistant (CNA) 3, CNA 3 stated that on the morning of 12/15/25, Resident 19 told her that the overbed headlight wasn't turning off. Resident 19 stated she had already reported the broken pull string to two other CNAs. CNA 3 stated that she checked the maintenance logbook to see if anyone reported Resident 19's broken pull string and found nothing documented. CNA 3 stated on 12/15/25, she made a report stating that Resident 19's overbed headlight needed to be fixed. During an interview on 12/18/25, at 1:31 PM, with the Medical Record Director (MRD), the MRD stated that when she made her morning rounds with Resident 19, the overbed headlight was still broken. The MRD stated that she checked the maintenance logbook and found that CNA 3 reported it on 12/15/25, (continued on next page)		

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 12/19/2025
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)		
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and the DSD reported it on 12/16/25. The MRD stated that on 12/17/25, at around 7:30 AM, the MRD saw that the pull string was still not fixed and stated that she added another report to the maintenance logbook. The MRD stated that when Resident 19's overbed headlight was still not fixed, it caused many problems like grumpiness, frustration, poor sleep, discomfort, and tiredness. During a concurrent interview and record review on 12/18/25, at 4:10 PM, with the Assistant Director of Nursing (ADON), the ADON stated that she expected the broken light string over Resident 19's bed to be fixed quickly. The ADON confirmed that the broken pull string for Resident 19's overbed headlight had been reported three times in the maintenance logbook on 12/15/25, 12/16/25, and 12/17/25, with all entries signed off as completed. The ADON stated that documenting the issue as fixed when it wasn't was incorrect and unacceptable. The ADON further stated that failing to fix Resident 19's broken pull string for the overbed headlight in a timely manner affected Resident 19's comfort, health, and safety and potentially harmed Resident 19's trust in the facility, which should not have happened. During an interview on 12/19/25, at 8:12 AM, with the Administrator (ADM), the ADM stated that fixing Resident 19's broken pull string for the overbed headlight was an urgent issue. The ADM further stated he expected the problem to be fixed the same day it was first reported in the maintenance logbook. The ADM stated that issues like the broken pull string in Resident 19's room, which affected Resident 19's health, safety, and well-being, were important and needed immediate attention. Review of a facility's document titled, JOB DESCRIPTION Maintenance Director, revised 3/1/14, indicated, .POSITION: The Maintenance Director is responsible to maintain the facility in good repair at all times .The interior and the exterior surfaces, fixtures and mechanical systems are the responsibility of the Maintenance Director.ESSENTIAL JOB FUNCTIONS.Ensure that all interior fixtures in good repair including.light fixtures.in accordance with established procedures. Review of a facility P&P titled, Homelike Environment, revised 2/21, indicated, .Policy Statement: Residents are provided with a safe, clean, comfortable and homelike environment.Policy Interpretation and Implementation Staff provides person-centered care emphasizes the residents' comfort, independence and personal needs and preferences.The facility staff and management maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include a. clean, sanitary and orderly environment; b. comfortable (minimum glare) yet adequate (suitable to the task) lighting .Comfortable and adequate lighting is provided .to promote a safe, comfortable and homelike environment. The lighting design emphasizes.sufficient general lighting in resident-use areas; task lighting as needed; even light levels.night lighting to promote safety and independence. 2a. During a concurrent observation and interview on 12/16/25, at 9:55 AM, with Resident 40, in her room, the wall behind her bed was observed to be chipped and had cracked paint. Resident 40 stated that she would have already painted the walls in her room if she had the means to do so. Resident 40 further stated that the walls in her room should have been only one color and not multiple colors because of the chips and cracks. During a concurrent observation and interview on 12/16/25, at 10:11 AM, with CNA 1 and CNA 2, the walls in Resident 40's room were observed. CNA 2 stated that she had been working at the facility for two years and the walls in Resident 40's room had always been chipped and had missing paint. During a concurrent observation and interview on 12/18/25, at 11:07 AM, with the DSD, the walls in (continued on next page)		

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 12/19/2025
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)		
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 40's room were observed. The DSD confirmed that the walls in Resident 40's room had chipped and cracked paint. The DSD stated that the appearance of the walls in Resident 40's room did not feel like a homelike environment. The DSD further stated that the walls should have been smooth and even as possible. During a concurrent observation and interview on 12/19/25, at 9:04 AM, with the DM, the wall in Resident 40's room was observed. The DM confirmed that the paint was chipped and cracking. The DM stated that the walls should have been nice and smooth. During an interview on 12/18/25, at 11:59 AM, with the Director of Nursing (DON), the DON stated that her expectations for the walls in resident rooms were to be reasonably smooth and provide a homely environment. The DON further stated the walls in the affected rooms should have been fixed in a timely manner. 2b. During a concurrent observation and interview on 12/16/25, at 10:41 AM, with Resident 7, in her room, the wall behind her bed was observed to be chipped and had cracked paint. Resident 7 stated that the wall in her room had been scraped for a while. Resident 7 further stated that it would have been nice to have a wall that was fixed and not like it currently was. During a concurrent observation and interview on 12/18/25, at 11:05 AM, with the DSD, the walls in Resident 7's room were observed. The DSD confirmed that the walls in Resident 7's room had chipped and cracked paint. The DSD stated that the appearance of the walls in Resident 7's room did not feel like a homelike environment. The DSD further stated that the walls should have been smooth and even as possible. During a concurrent observation and interview on 12/19/25, at 9:03 AM, with the DM, the wall in Resident 7's room was observed. The DM confirmed that the paint was chipped and cracking. The DM stated that the walls should have been nice and smooth. During a review of the facility's P&P titled, Resident Rights, revised 02/2021, the P&P indicated, .Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to.a dignified existence. During a review of the facility's P&P titled, Homelike Environment, revised 02/2021, the P&P indicated, .Staff provides person-centered care that emphasizes the residents' comfort, independence and personal needs and preferences.The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include.clean, sanitary and orderly environment .inviting colors and d&eacute;cor.personalized furniture and room arrangements.		

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 12/19/2025
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)		
F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on interview, and record review, the facility failed to ensure the Preadmission Screening and Resident Review (PASARR- a service to ensure that individuals with mental illness are able to receive specialized services) Level II screening was completed for 1 of 24 sampled residents (Resident 6).This failure had the potential for Resident 6 not to receive adequate services to prevent mental health decline.Findings:A review of Resident 6's admission RECORD, indicated Resident 6 was admitted to the facility with a diagnosis of, but not limited to unspecified schizophrenia (a serious, chronic brain disorder that disrupts thinking, feeling, and behavior, making it hard to distinguish reality from imagination, often involving hallucinations [like hearing voices] and delusions [false beliefs]).During a review of Resident 6's clinical record titled, Preadmission Screening and Resident Review (PASRR) Level I Screening, dated 2/25/25, the record indicated, .Result of Level I Screening : Level I - Positive for SMI (Serious Mental Illness).Diagnosis and symptoms of Schizophrenia Disorder.Combative/Abusive Behavior.Grandiose Delusions, Irritability & Anger.The individual has been prescribed psychotropic medications for serious mental illness.Case State : Level II.During a review of Resident 6's clinical record titled, SUBJECT: NOTICE OF PASRR LEVEL I SCREENING RESULTS, dated 2/25/25, the record indicated, .Your Level I Screening indicates that a SMI Level II Mental Health Evaluation is required.Your facility will be contacted within two to four days to set up an appointment for an evaluator to conduct a Level II Mental Health Evaluation.During a review of Resident 6's clinical record titled, SUBJECT: NOTICE OF ATTEMPTED EVALUATION, dated 3/2/25, the record indicated, .UNABLE TO COMPLETE LEVEL II EVALUATION FOR SERIOUS MENTAL ILLNESS (SMI).Facility staff were unresponsive to two or more separate attempts of communication within 48 hours of the Level I Screening.During a concurrent interview and record review on 12/18/25, at 11:19 AM, with the Director of Staff Development (DSD), Resident 6's clinical record was reviewed. The DSD confirmed that Resident 6 had a diagnosis of Schizophrenia, and his Level I screening was positive. The DSD further confirmed that a Level II screening did not occur. The DSD stated that a Level II screening should have taken place for Resident 6 in a reasonable time frame and that he should not have had to wait 10 months to potentially get a screening done. The DSD further stated that all residents should be able to get the help that they need so the facility would know what interventions would be needed to care for them.During an interview on 12/18/25, at 11:59 AM, with the Director of Nursing (DON), the DON explained that the PASSR was a screening tool used mostly to help residents that are dealing with mental health issues. The DON stated that 10 months was too long to wait to conduct a screening and that it should have been done in a timely manner for Resident 6. The DON further stated the level of care that should have been provided for Resident 6 would not be met by being unable to assess the specific needs for him. During a review of the facility policy and procedure (P&P) titled, admission Criteria, revised 3/2019, the P&P indicated, .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. The facility conducts a Level I PASARR screen for all potential admissions, regardless of payer source, to determine if the individual meets the criteria for a MD, TD or RD. If the level I screen indicates that the individual may meet the criteria for a MD, LO, or RD, he or she is referred to the state PASARR representative for the level II (evaluation and determination) screening process.		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 12/19/2025
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)		
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interview, and record review, the facility failed to develop or revise a comprehensive care plan for 1 of 24 sampled residents (Resident 34) when a care plan (guide that healthcare workers use to ensure a resident receives the best possible care tailored to their individual needs and goals) was not developed for pain. This failure placed Resident 34's physical and emotional well being at risk. Findings: A review of Resident 34's admission RECORD, indicated Resident 1 was admitted to the facility with diagnoses including, but not limited to muscle weakness (generalized), cerebral infarction (a type of stroke where a blood clot blocks a brain artery, cutting off oxygen and nutrients, causing brain cells to die), hemiplegia (one-sided weakness) and hemiparesis (one sided paralysis) following a cerebral infarction affecting right dominant side, aphasia (disorder that affects the ability to communicate). During a review of Resident 34's clinical record titled, Order Summary Report, dated 12/17/2025, indicated Resident 34 was prescribed Tramadol, a prescription pain medication. During a concurrent interview and record review on 12/17/25, at 11:45 a.m., with the Director of Nursing (DON), Resident 34's care plan and pain levels documented from the last 30 days were reviewed. The DON confirmed Resident 34 did not have a care plan in place for pain. The DON stated Resident 34's pain should have been care planned to identify goals, monitor progression, and to evaluate the effectiveness of interventions. The DON further stated not care planning for Resident 34's pain put Resident 34 well being at risk both physically and mentally. During a review of the facility's policy and procedure titled, Pain Assessment and Management, dated 10/2022, the policy and procedure indicated, .defined as the process of alleviating the residents pain based on his or her clinical condition and established treatment goals. Developing and implementing approaches to pain management. Monitoring for the effectiveness of interventions. Modifying approaches as necessary.		

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 12/19/2025
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)		
F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. Based on interview and record review, the facility failed to ensure that residents received appropriate medical evaluation and treatment for a reported vision concern for 1 out of 24 sampled residents (Resident 65) when Resident 65 was not seen or examined by an ophthalmologist (a medical doctor who specializes in diagnosing and treating all eye diseases). This failure placed Resident 65 at risk for continued visual impairment, functional decline, and psychosocial distress. Findings: A review of Resident 65's admission RECORD, indicated Resident 65 was admitted to the facility with a diagnosis of, but not limited to diabetes mellitus (a condition where the body cannot control blood sugar levels), dry eye syndrome (when your eyes don't make enough good quality tears to stay lubricated leading to a scratchy, burning feeling, redness, and blurry vision), depression (a condition causing persistent sadness and loss of interest), anxiety disorder (a mental condition where you experience excessive, persistent worry, fear or nervousness that doesn't go away and interferes with daily life), need for assistance with personal care, and generalized muscle weakness. During an interview on 12/16/25, at 10:23 AM, in Resident 65's room, with Resident 65, Resident 65 stated that she had seen an optometrist (an eye healthcare provider who performs eye exams and prescribes corrective glasses) earlier in the year. Resident 65 further stated she was diagnosed with cataracts (a clouding of the eye's natural lens) and that wearing glasses did not help much. Resident 65 stated she could see better before coming to the facility, but now her vision was very poor. Resident 65 further stated that watching TV was just like seeing shadows, her vision kept worsening, and she had trouble reading books and moving around her room. Resident 65 stated that both her Medical Doctor (MD) and the optometrist told her she needed to see an ophthalmologist because her vision was getting worse. Resident 65 further stated no one helped her make an appointment and she had not seen an ophthalmologist yet. Resident 65 stated that she loved watching TV, reading books and enjoyed walking outside. Resident 65 further stated that she felt that seeing an ophthalmologist was very important for her and not being able to see one affected her emotionally and physically. During an interview on 12/18/25, at 9:47 AM, with the Activity Director (AD), the AD stated Resident 65 was not completely blind and with the help of a magnifying lens, Resident 65 still enjoyed reading novels and watching TV in her room. The AD confirmed that Resident 65's preference for activities such as reading and watching TV was very important to Resident 65. During a concurrent interview and record review on 12/18/25, at 10:11 AM, with the Minimum Data Set (MDS - clinical assessment tool used in nursing homes) Coordinator, the MDS Coordinator confirmed that on 8/14/24, the MD had ordered a referral for Resident 65 to see an ophthalmologist. The MDS Coordinator stated she did not find any record showing that Resident 65 had been referred to or seen by an ophthalmologist after the doctor made the order. The MDS Coordinator further stated there was no record showing that Resident 65 was informed about the ophthalmologist appointment, refused it, or that the appointment was being scheduled. During a concurrent interview and record review on 12/18/25, at 2:26 PM, with the Social Service Director (SSD), the SSD confirmed that an optometrist had seen and evaluated Resident 65 on 4/25. The SSD stated the optometrist recommended that Resident 65 be seen by an ophthalmologist due to cataracts in both eyes. The SSD further stated that they had informed the Receptionist Clerk (RC) about the optometrist's referral for Resident 65 to see an ophthalmologist and admitted that this referral was not communicated until today (12/18/25). The SSD stated that there was no system in place for managing referrals. The SSD further stated that no follow-up was done when the MD first ordered the ophthalmologist referral on 8/14/24 and when the optometrist recommended an ophthalmologist consult due to Resident 65's cataracts in both eyes on 4/25. The SSD stated that not referring Resident 65 to an ophthalmologist promptly increased the risk of her vision getting worse. During an interview on 12/18/25, at 3:38 PM, with the Receptionist Clerk (RC), the RC stated she was helping with referrals and appointments related to ancillary services. The RC confirmed that she received the communication to refer Resident 65 to an ophthalmologist today (12/18/25). During (continued on next page)		

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 12/19/2025
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)		
F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	an interview on 12/18/25, at 3:55 PM, with the Assistant Director of Nursing (ADON), the ADON stated that she expected the MD order and the optometrist's recommendation for Resident 65 to see an ophthalmologist to be addressed immediately to meet Resident 65's care needs. The ADON further stated that Resident 65 was at an increased risk for worsening vision, decreased mobility, higher risk of falls, risk of infection, potential loss of eyesight, and negative impact on her lifestyle. The ADON stated that the delay in referring Resident 65 to an ophthalmologist showed a failure in the facility's process. During an interview on 12/19/25, at 8:04 AM, with the Administrator (ADM), the ADM stated that not sending Resident 65 to an ophthalmologist as ordered by the MD and recommended by the optometrist was unacceptable. The ADM stated that the delay in referring Resident 65 to an ophthalmologist was a clear gap in leadership. Review of a facility policy and procedure (P&P) titled, Visually Impaired Resident, Care of, revised 3/21, indicated, .Policy Interpretation and Implementation. it is our responsibility to assist the resident. scheduling appointments. to obtain needed services. Review of a facility P&P titled, Referrals, Social Services, revised 12/08, indicated, .Policy Statement: Social Services personnel shall coordinate most resident referrals with outside agencies. Policy Interpretation and Implementation. Referrals for medical services must be based on physician evaluation of resident need and a related physician order. Social services will collaborate with the nursing staff or other pertinent disciplines to arrange for services that have been ordered by the physician. Social services will document the referral in the resident's medical record.		

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 12/19/2025
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)		
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview, and record review, the facility failed to ensure one of two sampled residents (Resident 76) was provided with appropriate care and services with enteral feeding (also referred to as G-Tube feeding, gastrostomy tube feeding, the delivery of food and nutrients through a feeding tube directly into the stomach or part of the intestines) when Resident 76's enteral feeding orders were not carried out as recommended by the Registered Dietitian (RD). This failure had the potential for Resident 76 not to receive adequate enteral nutrition and hydration. Findings: A review of Resident 76's admission RECORD, indicated Resident 76 was admitted to the facility with diagnoses including, but not limited to end stage renal disease (when kidneys are failing and cannot filter waste and extra fluid from the blood anymore), dependence on renal dialysis (medical treatment that acts like artificial kidneys filtering waste products and extra fluid from blood when kidneys can no longer do it), dysphagia (difficulty swallowing foods or liquids), and encounter for attention to gastrostomy (a surgical procedure to create an opening from the outside of the abdomen directly into the stomach, usually to insert a tube (a G-tube) for long-term feeding, medication delivery, or stomach drainage when a person cannot eat or swallow properly). During a review of Resident 76's clinical record titled, Progress Notes, dated 11/25/25, the progress note by the RD indicated, . Stop feeds [sic] from 0600-1200 on dialysis days (MWF) due to dialysis as well as ADL [activities of daily living] care, which is about 20 min [minutes] per shift per day. Recommend stopping feeds if patient will need to be transported for any reasons authorized by SNF [skilled nursing facility]. Please notify RD if feeds stop for non-ADL care or non-dialysis reasons so he may make recommendations to the medical provider on adjusting rate in order for patient to still meet at least 75% of estimated nutritional needs . During an observation on 12/18/25, at 10:01 a.m., in Resident 76's room, Resident 76's enteral feeding was not running. During a concurrent interview and record review on 12/18/25, at 11:15 a.m., with the Assistant Director of Nursing (ADON), Resident 76's order summary was reviewed. The ADON confirmed Resident 76's enteral feed order was missing, and the tube feeding should have been running, today is not a dialysis day for Resident 76. The ADON further stated Resident 76 was at risk of not meeting nutritional needs if the enteral feeding order was not carried out as the RD recommended. During a concurrent observation and interview on 12/18/25, at 11:20 a.m., with the ADON in Resident 76's room, the ADON confirmed Resident 76's enteral feed was not running. The ADON stated it was her expectation for the RD recommendations to be followed. During an interview on 12/18/25, at 1:30 p.m., with the RD, the RD stated Resident 76 was at risk of weight loss, wounds, and dehydration if the RD recommendations were not carried out. During a review of the facility's policy and procedure (P&P) titled, Enteral Nutrition, dated November 2018, the P&P indicated, . Adequate nutritional support through enteral nutrition is provided to residents as ordered. Enteral nutrition is ordered by the provider based on the recommendations of the dietitian.		

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 12/19/2025
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)		
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on observation, interview, and record review, the facility failed to provide a comprehensive and effective pain management for one of three sampled residents (Resident 97) when pain management interventions were not implemented when indicated. This failure had the potential for Resident 97 to experience ongoing discomfort and pain. Findings: A review of Resident 97's admission RECORD, indicated Resident 97 was admitted to the facility with a diagnosis including, but not limited to, covid 19, peripheral vascular disease (circulation problem where narrowed or blocked blood vessels (arteries or veins) outside your heart and brain reduce blood flow to your limbs and organs, most commonly the legs, causing pain), and chronic obstructive pulmonary disease (progressive lung disease that blocks airflow, making it hard to breathe). During an interview on 12/16/25, at 4 p.m., with Resident 97, Resident 97 stated she reported to a licensed nurse her pain today was a 6 out of 10 (a simple, 0- to-10 tool where patients rate their pain intensity, with 0 being no pain and 10 being the worst imaginable pain) and denied receiving any intervention from staff to manage her pain. During a review of Resident 97's clinical record titled, Order Summary, dated 12/17/25, the order summary listed an order for acetaminophen (pain medication) with a start date of 12/15/25, the order for acetaminophen indicated, .as needed for general pain. Use Non-pharmacological intervention for pain first if appropriate. During a review of Resident 97's clinical record titled, Weights and Vitals Summary, dated 12/16/25, at 8:12 a.m., indicated Resident 97 had pain level at a 6 out of 10. During an interview on 12/17/25, at 10:55 a.m., with Licensed Nurse (LN) 1, LN 1 confirmed he was the nurse assigned to Resident 97 when Resident 97 reported a pain level of 6 out of 10 on 12/16/25. LN 1 stated he did not offer Resident 97 any non-pharmacological or pharmacological interventions for pain. During a concurrent interview and record review on 12/17/25, at 11:30 a.m., with the Director of Nursing (DON), Resident 97's clinical records, Weights and Vitals Summary, dated 12/25 and Order Summary, dated 12/17/25 were reviewed. The DON confirmed Resident 97 reported a pain level of 6 out of 10 and it was not acted on by staff. The DON stated it was her expectation for licensed staff to provide nonpharmacological interventions and pharmacological interventions to address Resident 97's pain. The DON further stated Resident 97 was at risk of prolonged pain and discomfort if her pain was not addressed. During a review of the facility's policy and procedure (P&P) titled, Pain Assessment and Management, dated 10/22, the P&P indicated, .Addressing the underlying causes of the pain. Monitoring for the effectiveness of interventions. The resident's goals for pain management and his or her satisfaction with the current level of pain control .		

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 12/19/2025
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)		
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to ensure safe medication administration practices when the medication error rate was more than 5% (% or percentage-number or ratio that expressed as a fraction of 100) with a resident census of 85. Medication administration observations were conducted over multiple days, at varied times, in random locations throughout the facility. The facility had a total of 2 errors out of 26 opportunities which resulted in a facility wide medication error rate of 7.69% in 1 of 9 residents (Resident 6) observed for medication administration. These failures had the potential to result in unsafe medication use and medication errors affecting the health and well-being of Resident 6. Findings: 1. During a medication administration observation on 12/17/25, at 3:44 p.m., in the facility's Unit 3 hallway outside Resident 6's room, with Licensed Nurse (LN) 2, LN 2 administered a total of 3 medications to Resident 6. LN 2 emptied out a capsule and hand crushed 2 pills including a pain medication called Morphine Sulfate 15 mg ER (mg stands for milligram-a unit of measurement, ER stands for Extended Release which means the drug is specially formulated to release the active ingredient slowly and steadily into the body over a prolonged period, typically 8 to 24 hours). LN 2 stated Resident 6 preferred his medications crushed. During a review of Resident 6's medication labeling written on the bubble pack indicated, .MORPHINE SUL [SULFATE] TAB [TABLET] 15MG ER .TAKE ONE TABLET BY MOUTH EVERY 8 HOURS FOR PAIN . The label on the bubble pack further indicated, .Swallow Whole. Do Not Chew Or Crush . During a review of Resident 6's Medication Administration Record (MAR-a record that guides the nurses for medication administration) indicated, .Morphine Sulfate ER Oral Tablet Extended Release 15 MG .Give 1 tablet by mouth every 8 hours for pain . There was no documented evidence of a warning to tell the nursing staff not to crush this medication. During an interview on 12/17/25, at 5:04 p.m., with LN 2, LN 2 stated Resident 6's Morphine should not have been crushed. LN 2 further stated Resident 6 preferred his medications to be crushed so she crushed the Morphine. LN 2 explained she could have called the primary physician to change the Morphine tablet to something crushable or in liquid form. LN 2 further explained that crushing an extended-release medication is unsafe because the body would absorb the medication quickly. 2. During a medication administration observation and interview on 12/17/25, at 3:44 p.m., in the facility's Unit 3 hallway outside Resident 6's room, with LN 2, LN 2 took the glucometer (a device used to measure the amount of sugar in the blood) out from the medication cart and she stated Resident 6 needed his fasting blood sugar (FBS) measured. LN 2 then stated Resident 6 needed to receive his medication as ordered. LN 2 read the order from the eMAR (electronic Medication Administration Record) and stated, Insulin Aspart Injection Solution [insulin aspart-is a medication to manage blood sugar for people with diabetes]. Inject 10 units [units-measures the concentration and volume of the insulin] subcutaneously [delivers medicine into the fatty tissue just under the skin] before meals for hyperglycemia [high blood sugar]. Hold for FBS below 120. LN 2 administered the insulin to Resident 6. During a review of Resident 6's eMAR with LN 2, the insulin order indicated, .Insulin Aspart Injection Solution (Insulin Aspart) Inject 10 unit subcutaneously before meals for hyperglycemia Hold for FBS <120 [less than 120] . Upon further inspection of the insulin vial LN 2 used to withdraw the medication from on 12/17/25, at 3:44 p.m. the vial indicated a different resident name and a different dose. LN 2 explained she used a different resident's insulin vial because Resident 6's own insulin vial was not available in the medication cart and it was just ordered from the pharmacy and had not arrived at the time Resident 6 needed to receive his medication. During a subsequent interview on 12/17/25, at 3:44 p.m. with LN 2, LN 2 explained it was wrong to use another resident's insulin vial because the label would read a wrong patient and wrong dose. LN 2 stated she could have checked the automated drug dispenser or the emergency kit for an insulin vial that she could have used for Resident 6. LN 2 further stated using someone else's insulin vial could increase the risk for cross contamination. During an interview on 12/18/25, at 2:19 p.m., with the Director of Nursing (DON), the DON stated she expected that (continued on next page)		

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 12/19/2025
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)		
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medications would be available and delivered timely or find other resources and alternative places to order medications from, and staff should be alerted to reorder when a medication was running low to be refilled timely. The DON further stated it was not a standard of practice to borrow medications from another resident because it could accidentally be misread and there would be the potential to give the incorrect dose of the medication that could lead to violation of the 5 rights for medication administration. The DON stated using another residents medication vial could have an increased risk of cross contamination (spreading of germs) leading to infection. The DON further stated that she expected that ER medications should not have been crushed and staff could have called the physician to ask for an alternate form of the medication. The DON stated crushing Morphine would be unsafe because it could increase the risk of overdose that could result in respiratory depression and decrease of level of consciousness. During a review of the facility's policy and procedure (P&P) titled, Medication Administration - General Guidelines, revised 11/11, the P&P indicated, .Medications are administered as prescribed in accordance with good nursing principles and practices .Medications supplied for one resident are never administered to another resident . During a review of the facility's P&P titled, Medication Administration - General Guidelines, revised 11/11, the P&P indicated, .Crushing tablets may require a physician's order, per facility policy .Long-acting .forms should not be crushed; an alternative should be sought .Please consult with the product literature, Do Not Crush lists which the facility may have or with the pharmacist if there is a question about medications to be crushed .		

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 12/19/2025
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)		
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observation, interview, and record review, the facility failed to ensure residents were free of any significant medication errors (the observed or identified preparation or administration of medications or biologicals which are not in accordance with the prescriber's order, manufacturer's specifications, and accepted professional standards) for one of nine sampled residents (Resident 6) observed for medication administration by failing to follow the manufacturer's specific recommendation when an extended release (ER-means the drug is specially formulated to release the active ingredient slowly and steadily into the body over a prolonged period, typically 8 to 24 hours) medication was crushed and administered to Resident 6. This failure resulted in Resident 6 receiving the medication in a manner that altered its intended use in the body and could potentially affect its therapeutic effectiveness (its intended, beneficial outcome) and increased risk for adverse reactions (an undesirable effect). Findings: A review of Resident 6's admission RECORD, indicated Resident 6 was admitted to the facility with diagnoses including heart failure and stroke. During a review of Resident 6's care plan, dated 12/7/24, the care plan indicated Resident 6 had pain related to Diabetic Neuropathy (nerve damage caused by prolonged high blood sugar). The care plan also indicated to give pain medication as ordered. During a medication administration observation on 12/17/25, at 3:44 p.m., in the facility's Unit 3 hallway outside Resident 6's room, with Licensed Nurse (LN) 2, LN 2 administered a total of 3 medications to Resident 6. LN 2 emptied out a capsule and hand crushed 2 pills including a pain medication called Morphine Sulfate 15 mg ER (mg stands for milligram-a unit of measurement, ER stands for Extended Release which means the drug is specially formulated to release the active ingredient slowly and steadily into the body over a prolonged period, typically 8 to 24 hours). LN 2 stated Resident 6 preferred his medications crushed. During a review of Resident 6's medication labeling written on the bubble pack indicated, .MORPHINE SUL [SULFATE] TAB [TABLET] 15MG ER .TAKE ONE TABLET BY MOUTH EVERY 8 HOURS FOR PAIN . The label on the bubble pack further indicated, .Swallow Whole. Do Not Chew Or Crush . During a review of Resident 6's Medication Administration Record (MAR- a record that guides the nurses for medication administration) indicated, .Morphine Sulfate ER Oral Tablet Extended Release 15 MG .Give 1 tablet by mouth every 8 hours for pain . There was no documented evidence of a warning to tell the nursing staff not to crush this medication. During an interview on 12/17/25, at 5:04 p.m., with LN 2, LN 2 stated Resident 6's Morphine should not have been crushed. LN 2 further stated Resident 6 preferred his medications to be crushed so she crushed the Morphine. LN 2 explained she could have called the primary physician to change the Morphine tablet to something crushable or in liquid form. LN 2 further explained that crushing an extended-release medication was unsafe because the body would absorb the medication quickly. During an interview on 12/18/25, at 2:19 p.m., with the Director of Nursing (DON), the DON stated that she expected ER medications not to be crushed. The DON stated staff could have called the physician to ask for an alternate form of medication. The DON further stated crushing Morphine would be unsafe because it could increase the risk of overdose that could result in respiratory depression and a decrease of level of consciousness. During a review of the facility's policy and procedure titled, Medication Administration - General Guidelines, revised November 2011, indicated, .Crushing tablets may require a physician's order, per facility policy .Long-acting .forms should not be crushed; an alternative should be sought .Please consult with the product literature, Do Not Crush lists which the facility may have or with the pharmacist if there is a question about medications to be crushed . During a review of the facility's record titled, JOB DESCRIPTION Registered Nurse-SNF or Sub-acute DEPARTMENT: Nursing, revision date 3/1/14, indicated, .Accurately prepare, administer and document medications according to the physician's orders and as directed by the facility's policies and procedures. During a review of an online article from the National Library of Medicine (a center for biotechnology information) titled, Extended-Release Morphine Sulfate in /treatment of Severe Acute and Chronic Pain, dated 9/21/2010, indicated, (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 12/19/2025
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)		
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.Furthermore, there is a clear disadvantage of the sustained-release formulations in that they are very sensitive to conditions that alter their modified-release mechanisms. Therefore, most of these products must be swallowed whole and never broken, chewed, crushed or dissolved, due to the risk of rapid opioid release and absorption of potentially fatal doses. (last accessed 12/26/25; https://pmc.ncbi.nlm.nih.gov/articles/PMC3004644/)		

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 12/19/2025
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)		
F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on observation, interview, and record review, the facility failed to ensure 1 of 24 sampled residents (Resident 3) received recommended dental services; when Resident 3 was not scheduled for dental care to adjust loose upper partials when it was identified on 9/5/25. This finding resulted in Resident 3 to have missing partials and had the potential to result in problems chewing food, weight loss, and decreased self-esteem. Findings: A review of Resident 3's admission RECORD, indicated Resident 3's diagnoses included anxiety disorder (a mental health condition causing persistent and excessive worry) and major depressive disorder (a serious mood disorder causing persistent sadness, hopelessness, and loss of interest in activities). During a review of Resident 3's clinical record titled, MDS [Minimum Data Set, an assessment tool] 3.0 Nursing Home Quarterly, dated 11/26/25, indicated Resident 3's BIMS (Brief Interview for Mental Status) assessment for cognitive patterns scored 14 out of 15 suggesting an intact cognitive functioning. During a concurrent observation and interview on 12/17/25, at 8:28 a.m., with Resident 3 in his room, Resident 3 opened his mouth and pointed to his upper teeth and stated his upper partials were missing and he had not seen a dentist regarding replacing his partials. During a review of Resident 3's care plan titled, Resident with Impaired Dentition, dated 9/5/25, indicated, .resident verbalized difficulty in chewing r/t [related to] noted with loosely fitting dentures . The recommendations listed in this care plan, initiated on 9/5/25, indicated, .Assist resident in booking an appointment for dentures to be adjusted .Assess resident's ability to chew . During a review of Resident 3's care plan titled, The resident is at nutritional risk, dated 9/5/25, indicated, .r/t Chewing Issues .resident will have no significant wt [weight] changes . During an interview on 12/18/25, at 4:39 p.m., with the Social Service Director (SSD), the SSD stated she was not aware Resident 3's upper partials were missing and Resident 3 was not seen by a dentist regarding replacing his upper partials. The SSD confirmed Resident 3 did not have an appointment to see the in-house dentist nor his own dentist. During an interview on 12/19/25, at 7:24 a.m., with the SSD, the SSD confirmed there were no appointments done for Resident 3 to see a dentist. The SSD explained dental visits to the facility were scheduled every other month and Resident 3 should have been offered to be seen by the in-house dentist or an appointment with his dentist should have been made since the need for dental care was identified in September, 2025. The SSD stated the recommendations listed in Resident 3's care plan were not followed and should have been addressed. The SSD further stated Resident 3's missing upper partials could be the result of loose partials and could have affected Resident 3's weight changes due to chewing issues. During an interview on 12/19/25, at 11:08 a.m., with the Administrator (ADM), the ADM stated the ancillary services (such as dental services) were not being provided adequately for Resident 3. The ADM further stated residents should be on the list for any ancillary services needed as per the physician's orders or any concerns relayed by staff and to be seen for dental care at least monthly. During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, revised 3/22, the P&P indicated, .Each resident's care plan is consistent with the resident's rights to participate in the development and implementation of his or her plan of care, including the right to .receive the services .included in the plan of care . During a review of the facility's P&P titled, Dental Services, revised 12/16, the P&P indicated, .Routine and emergency dental services are available to meet the resident's oral health services in accordance with the resident's assessment and plan of care .Social services representatives will assist residents with appointments .		