STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055084	A. Building B. Wing	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverbank Post-Acute	2649 Topeka Street Riverbank, CA 95367

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a comprehensive person-centered care plan (CP - a detailed approach to care customized to an individual resident's needs) was developed and implemented for two of five residents (Resident 1 and Resident 4) when:1. Resident 1's care plan was not implemented for refusal of care and notification of Resident 1's Responsible Party (RP) and physician.2. Resident 4's care plan was not developed and implemented for refusal of care.These failures had the potential to result in Resident 1 and Resident 4 receiving inadequate person-centered care and put Resident 1 and Resident 4 at risk of not having their needs met.Findings:1. During a concurrent observation and interview on 9/10/25 at 11:40 a.m. with Resident (R) 1 in the hallway outside Resident 1's room. R 1 was observed at the end of the hallway in a geriatric chair (Geri-chair - a semi-specialized seating for older adults that achieves a reclined position and elevated leg rest) covered with a sheet, wearing a gown with both hands contracted (a permanent tightening of the muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff). R 1 was observed moving his left leg and kicked off his sheet. R 1's fingernails and toenails were observed to be long with jagged edges. R 1 stated the podiatrist trimmed his nails and he had his nails trimmed last week. R 1 stated the nurse trimmed his fingernails and the podiatrist trimmed his fingernails.During a review of R 1's admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 9/10/25, the AR indicated R 1 was admitted to the facility from a nursing home on 3/25/22 with diagnoses of schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), pain, muscle weakness, anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), and depression (persistent feelings of sadness, despair, loss of energy, and difficulty dealing with normal daily life).During a review of R 1's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 7/25/2, the MDS section C indicated R 1 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive (involving the process of thinking, learning and understanding) understanding on a scale of 1-15) score of 15 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested R 1 was cognitively intact.During a concurrent interview and record review on 9/10/25 at 12:12 p.m. with Licensed Vocational Nurse (LVN) 1, R 1's Care Plan (CP), undated was reviewed. The CP indicated, . (Resident 1 Name) is non-compliant with care manifested by (m/b) refusing fingernail trimming, check and change medication, Activities of Daily Living (ADL) care, as manifested by refusal of the following . date initiated; 3/10/2025 . interventions . notify physician (MD) of their non-compliance . date initiated: 3/10/25 . notify resident representative . date initiated 3/10/2025 . LVN 1 stated R 1 had a lot of refusals of care and the nurse had notified R 1's physician and R 1's Responsible Party (RP) of incidents. LVN 1 was unable to find documentation of notification of RP or physician notification of Resident 1's refusal of nail care.During an interview on 9/10/25 at 4:20 p.m. with Registered Nurse (RN) 1, RN 1 stated if a resident was diabetic (when the blood sugar levels in the body are too high), the licensed nurse only trimmed the resident's fingernails. RN 1 stated if there was too much nail or disease, or if the resident was a diabetic, the resident needed to see the podiatrist for nail care. RN 1 stated R 1's nails should have been addressed. RN 1 stated if a resident refused care, staff had to respect the resident's rights, and should have notified the RP and physician, and initiate a care plan for the residents' refusal of nail care.During an interview on 9/12/25 at 11:30 with the Interim Director of Nursing (IDON), the IDON stated R 1 had a CP entered on 3/10/25 for non-compliance with interventions for RP notification and physician notification. The IDON stated the only documented RP notification attempt was on 3/25/22, and there was no documentation of physician notification. The IDON stated there was no current documentation of attempts to call R 1's RP or physician for refusal of care. The IDON stated R 1's refusals and RP and physician notifications should have been documented and followed up on. The IDON stated if it was not documented, then it was not done. The IDON stated if a resident was refusing care, nurses should have called the RP if they had time. The IDON stated if the refusal was not emergent, the nurse should have called the next morning.2. During a concurrent observation and interview on 9/10/25 at 11:26 a.m. with Certified Nursing Assistant (CNA) 1 in the hallway outside R 4's room. Resident 4 was non-verbal and

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to meet professional standards of practice for two of five sampled residents (Resident 1 and Resident 4) when the physician and Resident Responsible Party (RP) were not notified of Resident 1 and Resident 4's refusal of care with having their nails trimmed. Findings:During a concurrent observation and interview on 9/10/25 at 11:26 a.m. with Certified Nursing Assistant (CNA) 1 in the hallway outside Resident (R) 4's room, R 4 was non-verbal and observed wearing a gown, laying in a geriatric chair (Geri-chair - a semi-specialized seating for older adults that achieves a reclined position and elevated leg rest) in the hallway with his left foot uncovered. R 4's left foot toenails were observed to be long, yellow, thick and jagged with dark crusted substance under his left big toenail. CNA 1 stated if a resident was not diabetic (when the blood sugar levels in the body are too high), the nurses trimmed the resident's nails. CNA 1 stated the CNAs filled out the resident's shower sheet, which indicated areas of concern for the nurse to review, and marked if the resident's toenails needed to be trimmed. CNA 1 stated if a resident refused a shower staff encouraged the resident, and if the resident still refused, staff left the resident and went back after a while and asked the resident again. CNA 1 stated if residents refused a bath or care, the charge nurse was informed, and she asked the residents the reason for the refusal. CNA 1 stated R 4's toenails needed to be trimmed.During a review of R 4's admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information, dated 9/10/25, the AR indicated R 4 was admitted to the facility from an acute care hospital on [DATE] with diagnoses of traumatic brain injury (a brain dysfunction caused by an outside force, usually a violent blow to the head), seizure (a burst of uncontrolled electrical activity between brain cells that causes temporary abnormalities in muscle tone or movements, behaviors, sensations, or states of awareness), dysphagia (difficulty swallowing), dystonia (a movement disorder that causes the muscles to contract), acquired absence of right leg above the knee, and major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities).During a review of R 4's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 6/30/25, the MDS indicated R 4 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive (involving the process of thinking, learning and understanding) understanding on a scale of 1-15) score of 00 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which indicated R 4 was severely cognitively impaired.During a concurrent interview and record review on 9/10/25 at 12:25 p.m. with the Director of Staff Development (DSD), pictures of R 4's toenails dated 9/10/25 were reviewed. The DSD stated R 4 needed his toenails trimmed. The DSD stated R 4 should have had nail care marked yes on his 9/9/25 shower sheet (SS) and should have been put on the list for nail care. The DSD stated there were no refusals for care from R 4 this month in system.During an interview on 9/10/25 at 12:35 p.m. with the Infection Preventionist (IP), the IP stated proper nail care was important for the residents' comfort and to prevent the residents from scratching themselves. The IP stated the facility's resident population was at a higher risk of infection due to the residents had a low immune system. The IP stated bacteria can stay under the resident's nails and be a risk for infection for the resident. During a concurrent interview and record review on 9/10/25 at 12:43 a.m. with the Social Services Director (SSD), R 4's record was reviewed. The SSD stated on 4/14/25 R 4 refused nail care, so the podiatrist would not have seen him for six months. The SSD stated R 4 was also not diabetic, so nursing should have provided nail care. The SSD stated if a resident was refusing care, nursing should have let her know and she would have sent out a request to the podiatrist office if it was urgent. The SSD reviewed R 4's picture of his toenails dated 9/10/25 and the SSD stated she felt R 4's left toenail looked like it needed urgent care. During a concurrent interview and record review on 9/10/25 at 4:20 p.m. with Registered Nurse (RN) 1, Resident 4's picture of his toenails was reviewed. RN 1 stated R 4's nail care should have been completed right away once the nurse was notified. RN 1 stated R 4's nail care should have been documented in the nurses' tasks or nurses' notes that a resident requiring nail care was reported to the social worker or noted on the resident's shower sheet. RN 1 stated R 4's nails should have been addressed. RN 1 stated if a resident refused care, staff had to respect the resident's rights, and should have notified the RP and physician, and initiate a care plan for the residents' refusal of nail care.During an interview on 9/12/25 at

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate foot care. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide foot care and treatment, in accordance with professional standards of practice for two of four sampled residents (Resident 1 and Resident 4) when Resident 1 and Resident 4 had long, overgrown toenails. This failure had the potential to result in Resident 1 and Resident 4 cutting their skin with their long toenails, leading to poor wound healing, infection, and hospitalization. Findings:During a concurrent observation and interview on 9/10/25 at 11:26 a.m. with Certified Nursing Assistant (CNA) 1 in the hallway outside Resident (R) 4's room, R 4 was non-verbal and observed wearing a gown, laying in a geriatric chair (Geri-chair - a semi-specialized seating for older adults that achieves a reclined position and elevated leg rest) in the hallway with his left foot uncovered. R 4's left foot toenails were observed to be long, yellow, thick and jagged with dark crusted substance under his left big toenail. CNA 1 stated if a resident was not diabetic (when the blood sugar levels in the body are too high), the nurses trimmed the resident's nails. CNA 1 stated the CNAs filled out the resident's shower sheet, which indicated areas of concern for the nurse to review, and marked if the resident's toenails needed to be trimmed. CNA 1 stated R 4's toenails needed to be trimmed.During a review of R 4's admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information, dated 9/10/25, the AR indicated R 4 was admitted to the facility from an acute care hospital on [DATE] with diagnoses of traumatic brain injury (a brain dysfunction caused by an outside force, usually a violent blow to the head), seizure (a burst of uncontrolled electrical activity between brain cells that causes temporary abnormalities in muscle tone or movements, behaviors, sensations, or states of awareness), dysphagia (difficulty swallowing), dystonia (a movement disorder that causes the muscles to contract), acquired absence of right leg above the knee, and major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities).During a review of R 4's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 6/30/25, the MDS indicated R 4 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive (involving the process of thinking, learning and understanding) understanding on a scale of 1-15) score of 00 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which indicated R 4 was severely cognitively impaired.During a concurrent observation and interview on 9/10/25 at 11:40 a.m. with Resident (R) 1 in the hallway outside R 1's room. R 1 was observed at the end of the hallway in a Geri-chair covered with a sheet, wearing a gown with both hands contracted (a permanent tightening of the muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff). R 1 was observed moving his left leg and kicked off his sheet. R 1's fingernails and toenails were observed to be long with jagged edges. R 1 stated the podiatrist trimmed his nails and he had his nails trimmed last week. R 1 stated the nurse trimmed his fingernails and the podiatrist trimmed his fingernails.During a review of R 1's AR, dated 9/10/25, the AR indicated R 1 was admitted to the facility from a nursing home on 3/25/22 with diagnoses of schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), pain, muscle weakness, anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), and depression (persistent feelings of sadness, despair, loss of energy, and difficulty dealing with normal daily life).During a review of R 1's MDS, dated [DATE], the MDS section C indicated R 1 had a BIMS score of 15, which suggested R 1 was cognitively intact.During a concurrent observation and interview on 9/10/25 at 12:07 p.m. with Licensed Vocational Nurse (LVN) 1 in the hallway near R 1's room, R 1 was observed at the end of his hallway in a Geri-chair wearing a gown, covered with a sheet with his feet uncovered exposing R 1's toenails. LVN 1 stated she had been at the facility for two years and was familiar with R 1. LVN 1 stated the nurses trimmed the residents' nails. LVN 1 stated the CNAs reported if the resident's nails were long. LVN 1 stated the podiatrist came out when called, otherwise LVN 1 thought he came to the facility once a month. LVN 1 stated R 1's nails needed to be trimmed.During a concurrent interview and record review on 9/10/25 at 12:25 p.m. with the Director of Staff Development (DSD), Resident 1's Skin Monitoring: Comprehensive CNA Shower Review (SS), dated 9/9/25 was reviewed. The SS indicated, . does the resident need his/her toenails cut? . No . Resident 1's SS, dated 9/5/25 was reviewed. The SS indicated, . does the resident need his/her toenails