STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056346	A. Building B. Wing	06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridgeview Post Acute	521 Lorel Way Yuba City, CA 95991

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure two of three sampled residents (Resident 1 and Resident 2) were free from accidents and hazards when: a) post fall evaluations did not determine the reason for the falls. b) residents care plan interventions were not reevaluated for effectiveness. c) new interventions were not developed prevent further falls and injuries. d) direct care staff did not know how to identify high risk fall residents and find their fall plan of care. This resulted in multiple repeated resident falls and had the potential for all residents to be at risk for fall/injuries. Findings: A review of the facility ' s policy titled Clinical Protocol for Falls, revised March 2018, indicated under: Treatment/Management 2. If underlying causes cannot be readily identified or corrected, staff will try various relevant interventions, based on assessment of the nature or category of falling, until falling reduces or stops or until a reason is identified for its continuation (for example, if the individual continues to try to get up and walk without waiting for assistance). Monitoring and Follow-Up 2. The staff and Physician will monitor and document the individual ' s response to interventions intended to reduce falling or the consequences of falling. a. Frail elderly individuals are often at greater risk for serious adverse consequences of falls. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. Risks of serious adverse consequences can sometimes be minimized even if falls cannot be prevented. 4. If the individual continues to fall the staff and physician will re-evaluate the situation and reconsider possible reasons for the resident ' s falling (instead of, or in addition to those that have already been identified) and reconsider the current interventions. 1. A review of Resident 1 ' s records indicated they were admitted to the facility on [DATE], with diagnoses which included unspecified dementia, difficulty in walking, anxiety disorder, and repeated falls. A review of a Minimum Data Set (MDS, resident assessment) dated 2/06/2025, indicated Resident 1 was cognitively intact. A review of a fall risk assessment dated [DATE], indicated Resident 1 was a high fall risk. A review of Interdisciplinary (IDT, a group of healthcare disciplines that develop plan of care) note dated, for a fall on 2/27/2025 at 12 am, Resident 1 fell outside his room in the hallway, unwitnessed with a skin tear to left elbow. New intervention was to provide one on one (1:1, direct staff observation always) for evening (PM) and night shift (NOC). A review of Resident 1 ' s Care Plan, dated 2/27/2025 interventions: Will provide 1:1 Certified Nursing Assistant (CNA) for PM and NOC shifts. A review of IDT note dated, for a fall on 3/01/2025 at 12:15 am, Resident 1 wandered into room [ROOM NUMBER] another resident ' s room to use the bathroom and was found on laying on his back on the floor near the toilet. New intervention toileting program (timed assistance for bathroom use). A review of Resident 1 ' s Care Plan, dated 3/01/2025 interventions: encourage resident to use call bell initiated 3/01/2025 (repeated intervention). Toileting program initiated 3/03/2025. A review if Resident 1 ' s IDT dated, for a fall on 3/04/2025 at approximately 3:00 am Resident 1 became agitated and wanted to get out of bed. Resident 1 was transferred into a wheelchair. Resident 1 became verbally abusive to staff at the nurse ' s station. Resident 1 kept attempting to pull himself on the rails of the hallway. Nursing staff tried to redirect Resident 1, and he became combative. Resident 1 began to roam the hallways. Nursing staff was stationed in the hallways to monitor the resident ' s whereabouts. At 4 :30 am, the Resident 1 was observed in the hallway lying supine (flat on his back, face up) on ground with Hoyer Lift (resident assistive device for transfers) on top of him. New Intervention transfer to the hospital for treatment and evaluation. Encourage ambulation with assistance. A review of Resident 1 ' s Care Plan, dated 3/04/2025 interventions: assess for injury, vital signs taken, and send resident to emergency department for evaluation and treatment. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 1 ' s IDT note dated, for a fall on 3/06/2025 at 9:30 am, Resident 1 had and unwitnessed fall in the therapy room. Ten minutes prior to fall Resident 1 was in his room eating and activities of daily living) was being done. Resident 1 propelled himself into the hallway. Resident 1 was assessed by nurse, no injuries, vital signs within normal limits and metal status remained baseline. New intervention: Refer to Restorative Nursing Assistant (RNA, specializes in care and support for residents with mobility, strength, or functional limitations) for ambulation. No evaluation of effectiveness of 1:1 for PM and NOC shifts and no discussion of increasing supervision for day shift falls. A review of Resident 1 ' s IDT note dated, for a fall on 3/25/2025 at 6:30 pm, nursing staff witnessed Resident 1 sliding off the bed. Immediate assistance was provided, ensuring the resident safely came to rest on the landing pad adjacent to the bed. No injuries or trauma sustained. New intervention: re-implement one-to-one supervision after following acute care back on 3/4/25. No evaluation of effectiveness of previous fall interventions such as how it was determined to remove the 1:1 for Resident 1. A review of Residents 1 ' s Care Plan, dated 3/25/2025 Intervention: transferring the patient to a room near the nurse ' s station. Educating the resident about bed controls and call bell (repeated intervention). A review of Resident 1 ' s IDT note dated, for a fall on 4/12/2025 at 3:10 pm Resident 1 was seen sliding down in his wheelchair with his feet in front of him and upper body in his wheelchair. Staff intervened and tried to reposition him, but resident slid down to the floor. Prior to incident resident was last seen sitting in his wheelchair with nonskid shoes on, when resident was asked what happened resident stated, he wanted to get up and walk. Skin assessment revealed new trauma wound to right great toe. New Interventions wound nurse evaluated and treated, cushion for wheelchair. A review of Resident 1 ' s Care Plan, dated 4/12/25 interventions: Orient the resident to the environment and safety measures. Advise the resident about the location of the Educate the resident about bed controls and call bell. Keep bed position low. Place slip resistant shoes or socks with grips (all repeated prior interventions). No evaluation of effectiveness of previous fall interventions. A review of Resident 1 ' s records indicated he had eleven falls at facility since admission. Five of 11 falls occurred on day shift on 1/31/2025 at approximately 7:15 am, 3/01/2025 at approximately 12:15 pm, 3/06/2025 at approximately 9:30am, 3/25/2025 at approximately 6:30 pm, and 4/12/2025 at approximately 3:10 pm. IDT did not address the day shift falls for Resident 1. The 1:1 for Resident 1 was only for PM and NOC shifts. 2. A review of Resident 2 ' s admission record indicated they were readmitted to the facility 7/03/2021 with diagnoses including unspecified dementia, history of falling, anxiety disorder, and major depression. A review of a fall risk assessment dated [DATE] indicated Resident 2 was a moderate fall risk. A review of a Minimum Data Set (MDS, resident assessment) dated 2/27/2025, indicated Resident 2 was unable to complete Brief Interview for Mental Status (BIMS, a cognitive screening tool) and inability to complete it indicated a significant level of cognitive impairment likely moderate to severe. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 2 ' s Fall care plan dated 11/8/25, revised 4/16/25, indicated Resident 2 had an unwitnessed fall and was to have frequent checks. A review of Resident 2 ' s IDT dated 12/24/2024 at 7:53 am, indicated no documentation of date or time of fall. Resident 2 had an unwitnessed fall in their room. Resident 2 was found sitting on the floor on the landing mat next to her bed with her back to the bed. The call light was not pressed. Resident 1 assisted back into their wheelchair with two persons assist. No injuries noted. No complaints of pain or discomfort. New intervention bright neon sign will put to remind Resident 2 to use the call light for assistance (severe cognitive impairment). During an interview on 4/11/2025 at 10:05 am, CNA B stated, Resident 2 was falling a lot before. Not aware of recent falls Falls usually around bathroom. CNA B stated she does not use Point of Care (electronic information about residents) for information about residents fall risk interventions. CNA B stated Resident 2 was unable to use her call light. During an observation on 4/22/2025 at 9:30 am, Resident 2 was asleep with bed in low position. There was a neon sigh posted about her bed that stated, please remember to use call light for assistance. During an interview on 4/22/2025 at 9:35 am, CNA A explained she knew a resident was a high fall risk, when in the room there were devices like fall mat, bed rails, etcetera as a sign of a fall risk. CNA A was observed looking at Resident 2 ' s Point of Care system where CNAs use to view care plans. CNA A stated Resident 2 did not have a fall care plan only one page, the care plan Kardex (lists resident specific care needs) mentioned frequent falls in the middle of a paragraph, with no special instructions to fall risk. CNA A stated, some facilities have star on their room plaque that identifies them as falls risk, not here. Resident 1 ' s care plan had 12 pages, and had no falls listed on Kardex nor care plans for fall risk. During a concurrent interview and record review on 4/22/2025 at 12:20 with the Director of Nursing (DON) confirmed that a reminder to use call light was not an effective intervention for Resident 2 due to her low BIMS severely cognitively impaired. DON confirmed they do not use a falling star or leaf on the name plate or in a residents ' rooms to identify residents to staff that they are a high fall risk and have used it in the past. DON confirmed the IDT can improve on determining the root cause analysis of a fall to develop resident specific interventions for care planning to reduce falls and injuries. DON explained she recently started a binder to collect details about resident falls f to see patterns. DON confirmed having ongoing issues related to resident falls in the facility. DON explained IDT does not include CNAs in developing fall plan of care. DON explained the care plan interventions for Resident 1, frequent checks was not addressed or care planned in the record. DON confirmed no frequency of time given for these frequent checks for Resident 2. DON was not aware that in the Point of Care system the CNAs use only one page of the 12 pages of care plans are visible to the CNAs. DON was not aware of what tools CNAs use to determine a resident is a high fall risk, an issue for registry staff who do not consistently work in the facility. DON confirmed the IDT did not evaluate the effectiveness of the PM and NOC shift 1:1 for Resident 1. DON stated most of his falls were on the evening shift although some were on the day shift. DON confirmed no evaluation of 1:1 effectiveness found in the IDT notes. DON explained the family members will have Resident 1 on a 1:1 when he is home due to his impulsiveness. DON stated she is working on developing and improving the fall program in the facility.