

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056346	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/27/2025
NAME OF PROVIDER OR SUPPLIER Bridgeview Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report an abuse allegation for one of five sampled residents (Resident 4) when Resident 4 informed staff that they had been slapped in the face by another resident on 6/20/25. This failure had the potential to result in psychosocial and emotional harm for Resident 4 and had the potential to place all the residents at risk for undetected/unreported elder neglect or abuse. Findings:During a review of the facility's policy titled, Abuse Investigation and Reporting, revised 7/2017, indicated that:1. All reports and findings of resident abuse shall be reported to local, state and federal agencies, and thoroughly investigated by facility management.2. All alleged violations involving abuse will be reported by the facility Administrator to the state licensing/certification agency responsible for surveying/licensing the facility. During a review of Residents 4's admission record, indicated Resident 4 was admitted on [DATE] with diagnoses that included Parkinson's Disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), high blood pressure, and muscle weakness. During a review of Resident 4's most recent Minimum Data Set (MDS - an assessment and care screening tool), dated 6/19/25, the MDS indicated that Resident 4 had a brief interview for mental status (BIMS) score of 15 out of 15, indicating her cognition was not impaired. During a review of record titled progress Notes, dated 6/22/25, indicated that staff reported an incident between Resident 4 and Resident 5 where Resident 5 ran into Resident 4 with their wheelchair and then slapped Resident 4 on the face and chest. During a concurrent interview and record review on 8/12/25 at 12:30 pm with the Administrator (ADN), the record titled, Report of Suspected Dependent Adult/Elder Abuse, dated 6/20/25, indicated, that Resident 4 had been slapped on the face and chest by Resident 5 leaving Resident 4 with discoloration and scratches on the chest. ADN confirmed that the incident had occurred but was not reported to the state licensing/certification agency. ADN stated that it was their understanding that the facility was not required to report abuse if the perpetrator had a diagnosis of dementia. During an interview on 8/12/25 at 1 pm with the Director of Nursing (DON), the DON confirmed that there had been an incident on 6/20/25, where Resident 4 had been slapped by Resident 5. The DON stated that according to an All Facilities Letter (AFL) the facility was no longer required to report abuse that involved a perpetrator with a dementia diagnosis. The DON confirmed that the abuse incident had not been reported to the state licensing/certification agency.</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 056346
		If continuation sheet Page 1 of 1