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	02/10/2026

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 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that the physician's orders for psychiatric evaluation and treatment were implemented and incorporated into the care plan for two of the three residents (Residents 1 and 2). This failure resulted in Resident 1 and 2 not receiving mental health evaluation and had the potential for both residents not to reach their highest practicable level of mental and psychosocial well-being.Findings: A record review of the facilities policy and procedures titled, Behavioral Assessment, Intervention and Monitoring dated 2/2025, indicated: - Behavioral symptoms are identified using facility approved behavioral screening tools and a comprehensive assessment. - Behavior is the response of an individual to a wide variety of factors. These factors may include medical, physical, functional, psychosocial, emotional, psychiatric, or environmental causes. - Behavior can be a way for an individual in distress to communicate unmet needs, indicate discomfort, or express thoughts that cannot be articulated. - The nursing staff identify, document, and inform the physician about changes in an individual's mental status, behavior, and cognition including onset, duration, intensity, and frequency of behavioral symptoms. - The Interdisciplinary Team (IDT- a coordinated group of healthcare professionals who collaborate to manage a resident's comprehensive care) thoroughly evaluates new or changing behavioral symptoms to identify underlying causes and address any modifiable factors that may have contributed to the resident's change in condition, including, emotional, psychiatric, or psychological stressors such as depression and loneliness; functional, social, or environmental factors such as alteration in routine, sleep disturbances, decline in ability to perform self-care or tasks that they could previously complete without help. 1. A record review of Resident 1's admission record, indicated Resident 1 was admitted to the facility on [DATE] with diagnoses which included major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest), cognitive communication deficit, and history of alcohol abuse. (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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NAME OF PROVIDER OR SUPPLIER Bridgeview Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 521 Lorel Way Yuba City, CA 95991	

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident 1's Minimum Data Set (MDS, resident assessment tool), dated 7/27/25, indicated, Resident 1's had no cognitive impairment and had depression. Resident 1's MDS Mood assessment indicated Resident 1 was feeling tired, had a poor appetite, and felt their life was a failure. MDS indicated Resident 1 expressed they had little interest or pleasure in doing things. A record review of Resident 1's hospital Discharge Summary dated 7/14/25 indicated Resident 1 was discharged with a medication order for Paroxetine (anti-depressant) for depression. A record review of Resident 1's physician order from 7/14/25 to 12/14/25, indicated, Resident 1 was not prescribed Paroxetine or other anti-depressant medications. A record review of Resident 1's physician order, dated 7/14/25, indicated Resident 1 had an order for Psychiatric evaluation and treatment per psychiatrist for management of psychotropic meds and Psychological services as needed. A record review of Resident 1's Care Plans dated 7/19/25, indicated a care plan was initiated due to Resident sometimes feels lonely or isolated from those around them. A record review of Resident 1's Nurse Practitioner (NP) progress notes, dated 7/22/25, indicated that NP ordered a psychiatric referral to assess for depression. A record review of Resident 1's Physical Therapy (PT) progress notes, indicated, from 7/19/25 to 8/9/25, Resident 1 refused PT 6 out of 15 times. PT progress notes indicated Resident 1 had low motivation and required maximum encouragement to participate in therapy. A record review of Resident 1's Occupational Therapy (OT) progress notes, dated, from 7/30/25 to 8/1/25, and 8/6/25 to 8/8/25, Resident 1 refused to get out of bed. OT progress note, dated 8/7/25, indicated that the nursing was made ware of Resident 1's Lack of participation. A record review of Resident 1's care plans indicated a care plan was initiated on 9/4/25 for episodes of refusing showers. A record review of Resident 1's Social Services (SS) progress note, dated 11/6/25, indicated, Resident 1 immediately shut down and did not respond verbally when Family member (FM) notified him of the intent to file for divorce. During an interview on 1/29/26 at 11:51 am with CNA A, CNA A stated that Resident 1 was upset that FM was divorcing them and sometimes asked, Why did FM leave me here?. CNA A stated Resident 1 minimally participated in personal hygiene care. During a concurrent interview and record review with the Social Serves Director (SSD) on 1/29/26 at 12:26 pm, Resident 1's admission assessment was reviewed. When asked if Resident 1 had received any type of counseling or psychological evaluation, SSD stated, No. SSD confirmed that Resident 1 was identified to have depression during admission assessment. When asked about Resident 1's emotional state after Resident 1 was informed about FM wanting a divorce, SSD stated Resident 1 shut down and wouldn't talk to anyone. SSD confirmed that the facility did not initiate a new care plan or change in condition. During an interview with Director of Nursing (DON) on 1/29/26 at 1:23 pm DON stated Resident 1's (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	orders for Paroxetine were discontinued by the NP upon admission [DATE]). DON confirmed Resident 1 was not prescribed medications for treating depression from 7/15/25 to 12/14/25. DON confirmed Resident 1 had orders for a psychiatric evaluation dated 7/22/25. DON confirmed Resident 1 should have been evaluated by psychiatry following their admission MDS assessment which identified depression. During an interview with DON on 2/5/26 at 2:02pm DON stated, Resident 1's psychiatric referral Got away from them and confirmed Resident 1 had no psychiatric services while at the facility. During a concurrent interview and record review with NP on 2/5/26 at 3:15 pm NP stated, they avoid prescribing Paroxetine for Residents due to the medicine's anticholinergic (dry mouth, constipation, urinary retention, blurry vision, and confusion) effects. NP stated at the time of admission Resident 1 did not want to continue Paroxetine however Resident 1's MDS Mood assessment indicated depression, and a new psychiatric referral was ordered on 7/22/25. NP verbalized that they were unaware that Resident 1 had not been evaluated by psychiatry and acknowledged Resident 1's psychiatric referral was not followed up on by the nursing staff or the clinicians. 2. A record review of Resident 2's admission Summary Report, indicated that Resident 2 was admitted to the facility on [DATE] to with diagnoses of major depressive disorder, cognitive decline, and cancer. A record review of Resident 2's MDS Cognitive and Mood assessments, dated 11/15/25, indicated Resident 2 had mild cognitive impairment and depression. Mood assessment indicated Resident 2 had expressed that they felt bad about themselves, down and depressed, having little pleasure in doing things, and difficulty staying asleep. A record review of Resident 2's physician order, indicated that Resident 2 had a psychiatric referral, evaluation, and treatment orders, dated 11/7/25 and 12/15/25. No psychiatric evaluations were found in Resident 2's medical record. A record review of Resident 2's NP progress notes dated 11/7/25 indicated, Resident 2 had orders for monitoring for signs and symptoms of depression as evidenced by episodes of crying. A record review of Resident 2's NP progress notes dated 12/15/25 indicated, Resident 2 had been monitored for sign and symptoms of depression as evidenced by poor oral intake. During a concurrent interview and record review with Registered Nurse (RN) B on 2/6/26 at 10:40 am, Resident 2's medical record was reviewed. RN B was unable to locate any documentation regarding Resident 2 having a psychiatric evaluation or treatment. RN B stated whoever received the order for psychiatric referral is responsible for placing the order in the electronic health record (EHR) and to communicate to the appropriate staff to coordinate care. During an interview with Activities Assistant (AA) on 2/6/26 at 11:35 am, AA stated, on Monday (2/2/26) Resident 2 was upset and crying. AA stated Resident 2 told them that they were upset because they were dying. During an interview with SSD on 2/6/26 at 11:40 am, SSD stated, [Resident 2] does get emotional and had episodes of crying.