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	06/09/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the physician and resident representative for one of three sampled residents (Resident 1), when Resident 1 experienced a significant change in condition.This failure resulted in delayed timely treatment, during which Resident 1 experienced a preventable decline in functional status, losing strength in the right arm and becoming unable to independently perform personal care tasks.Findings:During a review of the facility's policy and procedure (P&P) titled, Change in a Resident's Condition or Status, dated 12/2025, the P&P indicated that when a resident experiences a change in condition, nursing staff are to promptly conduct a comprehensive assessment, document relevant changes in the resident's medical record, and notify the physician and resident representative. The policy defined a significant change in condition as a major decline that would not normally be resolved without staff intervention or standard disease-related clinical interventions and that impacts more than one area of the resident's health.During a review of Resident 1's admission record indicated that Resident 1 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), heart failure, emphysema (a long-term lung disease that makes it hard to breathe), and high blood pressure.During a review of Resident 1's Minimum Data Set (MDS, an assessment and care screening tool), dated 1/30/26, the MDS indicated that Resident 1 had a brief interview for mental status (BIMS) score of 15 out of 15, indicating no cognitive impairments.During a review of Resident 2's admission record indicated that Resident 2 was admitted to the facility on [DATE] with diagnoses including hemiplegia (paralysis of one side of the body) and hemiparesis (muscle weakness or partial paralysis affecting one side of the body) following cerebral infarction (stroke, when a blood vessel in the brain becomes blocked cutting off the oxygen supply), hyperlipidemia (high cholesterol and triglycerides in the blood), and a depressive disorder.During a review of Resident 2's most recent MDS, dated [DATE], the MDS indicated that Resident 2 had a BIMS score of 15 out of 15, indicating no cognitive impairment.During an interview on 4/16/26 at 1:45 pm, with Resident 2, Resident 2 stated that on 4/11/26, while speaking with Resident 1, they observed Resident 1's right arm twitch, after which Resident 1 was unable to use the arm. Resident 2 stated that although Resident 1 was able to speak, his speech sounded different and he appeared very tired. Resident 2 stated that they reported Resident 1's change to the Activities Director (AD). Resident 2 further stated that over the next few days, Resident 1 continued to be unable to use his right side, had slurred speech, spent most of the time in bed, and stopped going out for routine cigarette breaks. Residents 2 stated that the nursing staff did not appear to recognize the changes. During an interview on 4/16/26 at 1:55 pm, with the AD, the AD stated that on 4/11/26, Resident 2 informed them that Resident 1 was not acting like himself. The AD stated that Resident 1 had missed both cigarette breaks, which was unusual, and observed facial drooping, slurred speech, and an inability to use one arm. The AD stated that they escorted Resident 1 to the nurse's station, informed Registered Nurse (RN) B of these observations, and expressed concern that the resident may be having a stroke. The AD stated that two nurses then accompanied Resident 1 to his room. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Approximately 30 minutes later, the AD returned and observed that Resident 1 remained in his room, complaining of headache and neck pain, which the AD reported to nursing staff. The AD stated that Resident 1 was typically independent and that the change in condition was concerning. During an interview on 4/16/26 at 2:05 pm, with RN B, RN B confirmed that on 4/11/26, AD requested that Resident 1 be assessed. RN B stated that, because it was near the end of the shift, Licensed Nurse (LVN) D assessed Resident 1. RN B stated they did not personally assess Resident 1 and, as no concerns were communicated to them, no physician or provider was notified. During an interview on 4/16/26 at 3:15 pm, LVN D stated that on 4/13/26, AD reported concerns that Resident 1 was exhibiting stroke-like symptoms. Upon LVN D's assessment, Resident 1 was unable to raise their right arm. LVN D stated that Resident 1 required a hospital evaluation; however, before emergency medical services (EMS) could be contacted, a family member transported Resident 1 from the facility. LVN D confirmed that neither EMS nor the provider (Doctor) had been notified prior to Resident 1 leaving the facility, and that the provider was notified after Resident 1 had departed. During an interview on 4/16/26 at 3:35 pm, with the facility Temporary Director of Nursing (TDON), the TDON stated that when nursing staff are alerted to a resident's change in condition, they are expected to perform a comprehensive assessment, including evaluating signs and symptoms of a stroke, and promptly notify the provider of their findings. The TDON confirmed there was no documentation reflecting notification of the provider or Resident 1's family member until 4/13/26, and that the provider was notified only after Resident 1 had been transported from the facility by a family member to a local hospital. During an interview on 4/16/26 at 3:50 pm, with the Administrator (ADMIN), the ADMIN confirmed there was no nursing documentation that a nurse assessed Resident 1 for a possible stroke or notified his doctor on 4/11/26 or 4/12/26, when RN B and LVN D had knowledge that Resident 1's condition had changed. The ADMIN stated that when the staff report a resident's change in condition to nursing staff, the expectation is that an assessment is completed, documented, and the provider is notified of the findings. During an interview on 5/27/26 at 10 am, with the facility Nurse Practitioner (NP), the NP stated that when nursing staff are alerted to a resident exhibiting stroke like symptoms, the expectation is that the resident is immediately assessed and that the provider promptly notified. The NP stated that had they been notified of possible stroke symptoms, they would have immediately directed the resident to the hospital for emergency medical evaluation, as timely intervention is critical and delays can result in permanent neurological damage. The NP confirmed they were not notified of the resident's stroke like symptoms until after Resident 1 had already been transported from the facility by a family member to a local hospital. During a review of Resident 1's medical record titled, Progress Note - Alert Note, dated 4/13/26, indicated that the receptionist notified nursing staff that a family member had removed Resident 1 from the facility and reported Resident 1 was exhibiting signs and symptoms of a stroke, including arm weakness and changes in speech. The family member reported they were transporting the resident to the local hospital. The progress note indicated the nurse practitioner was notified and that Resident 1 left the facility at approximately 1:15 pm.

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to protect one of three sampled residents (Resident 1) from neglect when nursing staff failed to recognize and appropriately respond to slurred speech, facial drooping, and right sided arm weakness, which represented of a significant change in condition. The facility failed to ensure timely assessment, provider notification (the physician), and medical intervention.This failure resulted in delayed recognition and treatment of Resident 1's brain bleed, contributing to a permanent and preventable decline in functional abilities, including decreased use and strength of the right arm and loss of independence in performing personal tasks.During a review of the facility's policy and procedure (P&P) titled, Change in a Resident's Condition or Status, dated 12/2025, the P&P indicated that when a resident experiences a change in condition, nursing staff are to promptly conduct a comprehensive assessment, document relevant changes in the resident's medical record, and notify the physician and resident representative. The policy defined a significant change in condition as a major decline that would not normally be resolved without staff intervention or standard disease-related clinical interventions and that impacts more than one area of the resident's health.During a review of the facility's policy and procedure (P&P) titled, Acute Condition Changes, undated, the P&P indicated that physicians and staff are to identify residents at risk for acute changes in condition, including those related to medications with potential adverse side effects. Nursing staff are required to assess, document, and report pertinent clinical information, including vital signs, neurological status, level of consciousness, and cognitive status. The policy further states that direct care staff, including nursing assistants, must be trained to recognize and communicate significant changes in a resident's condition.A review of Resident 1's admission record indicated that Resident 1 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), heart failure, emphysema (a long-term lung disease that makes it hard to breathe), and high blood pressure.During a review of Resident 1's Minimum Data Set (MDS - an assessment and care screening tool), dated 1/30/26, the MDS indicated that Resident 1 had a brief interview for mental status (BIMS) score of 15 out of 15, indicating no cognitive impairment.During a review of Resident 2's admission record indicated that Resident 2 was admitted to the facility on [DATE] with diagnoses including hemiplegia (paralysis of one side of the body) and hemiparesis (muscle weakness or partial paralysis affecting one side of the body) following cerebral Infraction (stroke, when a blood vessel in the brain becomes blocked cutting off the oxygen supply), hyperlipidemia (high cholesterol and triglycerides in the blood), and a depressive disorder.During a review of Resident 2's most recent MDS, dated [DATE], the MDS indicated that Resident 2 had a BIMS score of 15 out of 15, indicating no cognitive impairment.A review of Resident 1's physician order, dated 1/12/26, indicated Eliquis (a medication to prevent blood clots) 2.5 milligrams (mg, a unit of measure), one tablet by mouth twice daily, was prescribed for deep vein thrombosis (a blood clot). A review of Resident 1's Medication Administration Record (MAR), for April 2026, indicated that Resident 1 received the scheduled dose of Eliquis on 4/11/26, 4/12/26, and the 8 am dose on 4/13/26. The record indicated Resident 1 was monitored for symptoms associated with anticoagulant (blood thinner) use, including severe headache and sudden changes in mental status. Documentation reflected that no such symptoms were identified during the month of April 2026.A review of Resident 1's medical record titled, Change in Condition Assessment/ SBAR, dated 4/13/26 at 1:34 pm, indicated that Resident 1 had muscle weakness, however, the assessment did not identify the affected area of the body, describe the severity of the weakness, or indicate the onset or duration of the symptom. The section titled, Reason for Assessment, indicated that the receptionist notified nursing staff that a family member had removed Resident 1 from the facility and transported the resident to the hospital.During an interview (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	on 4/16/26 at 1:10 pm, with a family member (FM), the FM stated that upon arriving at the facility on 4/13/26, they observed Resident 1 was having difficulty following conversations, was unable to use his right side normally, and had slurred speech. When FM approached nursing staff, they were informed that Resident 1 had not gone out for a cigarette for several days and had been sleeping more than usual. FM stated that two nursing staff members assessed Resident 1 and recommended hospital evaluation. FM then transported Resident 1 to the hospital because they were concerned Resident 1 needed immediate medical attention. FM stated that upon arrival at the hospital, Resident 1 was diagnosed with a brain bleed, transferred by helicopter to another facility, required a machine to breathe, and was admitted to the intensive care unit (ICU).During an interview on 4/16/26 at 1:45 pm, with Resident 2, Resident 2 stated that on 4/11/26, while speaking with Resident 1, they observed Resident 1's right arm twitch, after which Resident 1 was unable to use the arm. Resident 2 stated that although Resident 1 was able to speak, his speech sounded different and he appeared very tired. Resident 2 stated that they reported the change to the Activities Director (AD). Resident 2 further stated that over the following days, Resident 1 continued to be unable to use his right side, had slurred speech, spent most of the time in bed, and stopped going out for routine cigarette breaks. Residents 2 stated that the nursing staff did not appear to recognize the changes.During an interview on 4/16/26 at 1:55 pm, with the AD, the AD stated that on 4/11/26, Resident 2 informed them that Resident 1 was not acting like himself. The AD stated that Resident 1 had missed both cigarette breaks, which was unusual, and observed facial drooping, slurred speech, and an inability to use one arm. The AD stated that they escorted Resident 1 to the nurse's station, informed Registered Nurse (RN) B of these observations, and expressed concern that the resident may be having a stroke. The AD stated that Licensed Vocational Nurse (LVN) E and RN G then accompanied Resident 1 to his room. Approximately 30 minutes later, the AD returned and observed that Resident 1 remained in his room, complaining of headache and neck pain, which the AD reported to nursing staff; however, the AD did not recall the names of the staff notified. The AD stated that Resident 1 was typically independent and that the change in condition was concerning.During an interview on 4/16/26 at 2:05 pm, with RN B, RN B stated that on 4/11/26 the AD requested that Resident 1 be assessed. RN B stated that, because it was near the end of the shift, another nurse assessed Resident 1. RN B stated they did not personally assess Resident 1 and, as no concerns were communicated to them, no physician or provider was notified.During an interview on 4/16/26 at 2:28 pm, with Certified Nurse Assistant (CNA) A, CNA A stated that on the evening of 4/11/26, the AD expressed concern that Resident 1 may have been experiencing a stroke. CNA A checked on Resident 1 and observed that Resident 1 was unusually quiet and not acting like themselves. CNA A stated that these observations and concerns, including the possibility of a stroke, were reported to RN B.During an interview on 4/16/26 at 2:40 pm, with RN C, RN C stated that on 4/13/26, CNA F expressed concern because Resident 1 had not gone out for a cigarette break. RN C checked on Resident 1 and reported no unusual observations. RN C stated they were not informed that Resident 1 may have been experiencing stroke-like symptoms and that an assessment was not completed.During an interview on 4/16/26 at 3:15 pm, with LVN D, LVN D stated that on 4/13/26, CNA F reported concerns that Resident 1 was exhibiting stroke-like symptoms. Upon assessment, Resident 1 was unable to raise their right arm. LVN D stated that Resident 1 required a hospital evaluation; however, before emergency medical services (EMS) could be contacted, a family member transported Resident 1 from the facility. LVN D confirmed that neither EMS nor the provider had been notified prior to the resident leaving the facility, and that the provider was notified only after the resident had departed.During an interview on 4/16/26 at 3:35 pm, with the facility Temporary Director of Nursing (TDON), the TDON stated that when nursing staff are alerted to a resident's change in condition, they are expected to perform a comprehensive assessment, including evaluating signs and symptoms of a stroke, and promptly notify the provider of their findings. The TDON confirmed there was no documentation reflecting notification of the provider or Resident 1's family member until 4/13/26, and that the (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	provider was notified only after Resident 1 had been transported from the facility by a family member to a local hospital.During an interview on 4/16/26 at 3:50 pm, with the Administrator (ADMIN), the ADMIN confirmed there was no documentation of an assessment for a possible stroke or notification of the provider on 4/11/26, when staff first reported a change in Resident 1's condition, or on 4/12/26. The ADMIN stated that when the staff report a resident's change in condition to nursing staff, the expectation is that an assessment is completed, documented, and the provider is notified of the findings.During an interview on 4/22/26 at 9 am, with LVN E, LVN E stated that on 4/11/26, the AD reported concerns that Resident 1 was not acting normal and had facial drooping. LVN E stated that they and a RN G assessed Resident 1 in the resident's room and did not identify any abnormalities. LVN E confirmed that this assessment was not documented in Resident 1's medical record and acknowledged that documentation should have been completed.During a concurrent observation and interview in Resident 1's room, on 5/26/26 at 11 am, with Resident 1, Resident 1 stated they had recently experienced a stroke but could not recall how much time had passed before being taken to the hospital or how they arrived there. When asked how long it took to receive help, Resident 1 stated, They would have waited so long that they would have let me die. Resident 1 further stated that since the stroke, they have been unable to use their right arm and hand, which had been their dominant hand, and are no longer able to independently dress themselves, button clothing, or write. Resident 1 stated that he was unable to hold his urinal (a disposable device to collect urine when residents are bedbound) and spilled urine because he could not use his right hand. During the interview, Resident 1 was observed sitting at the edge of his bed and unable to lift his right arm.During an interview on 5/26/26 at 1:50 pm, with RN G, RN G stated that on 4/11/26 they assessed Resident 1 in his room with LVN E and did not observe any abnormalities. RN G stated that the assessment was not documented because Resident 1 was not assigned to them. RN G further stated that, even after Resident 1 returned from the hospital, the resident appeared to be themself and that they had not observed any obvious signs of stroke. When asked whether they were aware that Resident 1 had lost the use of their right arm, RN G stated that they were aware and confirmed that loss of use of an arm would be a sign of a stroke.During an interview on 5/26/26 at 2:20 pm, with CNA F, CNA F stated that Resident 1 had not been acting like themself for approximately three days before being taken to the hospital. CNA F stated that on 4/12/26, Resident 1 remained in bed throughout the day and did not go out for cigarette breaks. CNA F further stated that on 4/13/26, they requested that a nurse check on Resident 1 earlier in the day due to concerns regarding the resident's condition and were told that the resident appeared fine. Later that day, a family member visited Resident 1 and expressed concern that the resident may have had a stroke, prompting another nursing assessment. CNA F stated that during the assessment, Resident 1 was unable to raise their right arm. CNA F further stated that after the nurse left the room, the family member assisted Resident 1 into a wheelchair, transferred the resident's oxygen to the wheelchair, and transported the resident to the local hospital. CNA F stated they did not observe emergency medical services arriving at the facility to transport Resident 1.During an interview on 5/26/26 at 2:35 pm, with the Director of Nursing (DON), the DON stated that the assessment documented for Resident 1 on 4/13/26 could have been more thorough, including clarification of whether the muscle weakness was new, the location of the weakness, and a more comprehensive neurological assessment appropriate for reported stroke-like symptoms. The DON confirmed there was no documented assessment of resident condition on 4/11/26 or 4/12/26. The DON stated that when a change in condition is reported or suspected, nursing staff are expected to complete and timely document an assessment that either confirms or rules out the change in condition. The DON further stated that additional intervention should have occurred for Resident 1, including notification of the provider, family and referral to the local hospital for further evaluation.During an interview on 5/27/26 at 10:00 am, with the facility Nurse Practitioner (NP), the NP stated that when nursing staff are alerted to stroke-like symptoms, the expectation is that the resident is immediately assessed, including vital signs and a neurological assessment for (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	deficits such as facial droop, slurred speech, arm weakness, and decreased grip strength, and prompt provider notification. The NP stated that normal vital signs do not rule out stroke, making a comprehensive assessment important, and that deficits such as loss of use of an extremity are expected to persist, not resolve and recur. The NP further stated that residents on anticoagulants (blood thinners) such as Eliquis (a medication used to thin the blood) are at increased risk for bleeding, and reported stroke-like symptoms should prompt immediate assessment and provider notification. The NP confirmed they were not notified of Resident 1's symptoms until after the resident had already been transferred to the hospital by a family member, and stated that, had they been notified, they would have directed an immediate emergency evaluation, as delays can result in permanent neurological damage.During a review of Resident 1's medical record titled, ED [Emergency Department] Physician Notes, dated 4/14/26 at 3:14 pm, indicated that Resident 1 arrived at the hospital with a reported two-to-three-day history of decreased right arm movement, weakness, increased fatigue, and being less vocal than usual. Physical examination findings included right-sided weakness compared to the left. The note further indicated that a computed tomography (CT- a medical imaging test) scan identified a thalamic (a structure located deep in the brain) bleed in a distribution consistent with the resident symptoms. Resident 1 required reversal (treatment used to stop or reduce the effects) of the medication Eliquis and was airlifted to another hospital for higher level of care. The final diagnosis was intracranial hemorrhage (bleeding within the brain).