

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

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 07/17/2026
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)		
F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the interview and record review, the facility failed to ensure it treated residents in a dignified manner for one of eight residents (Resident 1) sampled for resident rights when: Certified Nursing Assistant (CNA) A entered Resident 1's room without explaining the purpose for being there and pulled Resident 1's pajama bottoms down without asking permission to see if he needed his brief (adult diaper) changed and was unaware that Resident 1 did not wear briefs. This upset and embarrassed Resident 1, who complained to staff about the care he received from CNA A, and Resident 1's family member (FM) expressed she was dissatisfied with the care her husband had received. Findings A review of the facility's Dignity policy and procedures, dated 10/2025, indicated on Line 9, Staff inform and orient resident to their environment. Procedures are explained before they are performed. Line 12 indicated, Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity. A review of Resident 1's admission Report, dated 1/15/2026, indicated Resident 1 was admitted on [DATE] with diagnoses that included dependence on renal dialysis (a life sustaining treatment used to filter the blood for persons with kidney failure), atherosclerotic heart disease (plaque buildup in the heart arteries), and cirrhosis of the liver (permanent scarring of the liver caused by long term damage). A review of Resident 1's Minimum Data Set (MDS, comprehensive assessment), dated 2/4/2026, indicated, Resident had a Brief Interview for Mental Status (BIMS, thinking and memory assessment) score of 15 out of 15, meaning Resident 1 has no thinking and memory impairments. MDS Section GG Functional Abilities (assessment of a person's mental, physical, and social capacity to perform routine daily activities), dated 2/9/2026, indicated, Resident 1 was continent (having normal voluntary control of bowel and bladder) and was able to independently go to the bathroom and provide personal hygiene. A review of the facility's 5 day Follow Up Report dated 1/20/2026, indicated the Administrator followed up with Resident 1 on 1/15/2026, and Resident 1's account of the event was on 1/13/2026 at 3:00 am, a CNA entered his room and put his finger inside the waistband of his boxer shorts and began to pull them. He said that the CNA suddenly said, Oops, wrong patient and left his room. The resident stated that no introductions had been made, and he didn't know why the CNA needed to do anything at 3:00 am in the morning. Resident 1's FM was also present, and she expressed dissatisfaction with the care her husband received. The report indicated the Director of Staff Development (DSD, CNA supervisor and educator) B spoke with CNA A, and CNA A acknowledged going into Resident 1's room at 3:00 am, but did not turn on the light. The report indicated CNA A states that he woke the resident and told the resident (Resident 1) that he would like to check his brief. He states that the resident (Resident 1) grunted in response. He states that he inserted his fore-finger inside of the resident's waistband and pulled them out and down, approximately one inch. He stated that he immediately recognized that the resident (Resident 1) was (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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wearing boxer shorts instead of a brief. At that point, he removed his finger, apologized, and left the room. A review of the facility's nursing assignment schedule for 1/13/2026 indicated CNA A was assigned to Resident 1 for the night shift (10:00 pm to 6:30 am). During a telephone interview on 7/17/2026 at 9:45 am with CNA A, CNA A confirmed they were a registry (temporary staffing agency) CNA. CNA A indicated on 1/14/2026 they were assigned to Resident 1, and they had not worked with Resident 1 before. CNA A indicated they had not identified Resident 1 before rolling him over to change him. CNA A indicated they touched Resident 1's hip and saw boxer shorts and immediately apologized to Resident 1, acknowledging Resident 1 was not the resident who needed peri care. CNA A indicated for the rest of their shift they provided Resident 1 with space and understood Resident 1 was upset about what happened. CNA A indicated they should have checked Resident 1's wrist band before touching him. CNA A indicated they did not review Resident 1's medical records before entering Resident 1's room. During an interview and record review on 7/17/2026 at 1:52 pm, with DSD B, DSD B indicated it is the facility's expectation were that CNAs knock on the resident's room door, introduce themselves to the resident, and ask permission before performing care tasks. DSD B indicated at night; CNAs check residents who are known to be incontinent to determine if the residents' briefs are wet and if peri care is needed. DSD B confirmed CNA A should have knocked on the door, awoken Resident 1, introduced themselves, and asked permission before touching him. DSD B indicated CNAs do walking rounds (outgoing and incoming CNAs visit residents at shift change to visually check residents' status, review immediate needs, and hand off care) at the beginning of each shift. DSD B indicated during walking rounds CNAs should have identified which residents were incontinent and need routine peri care. DSD B indicated CNA A should have known Resident 1 was continent.		