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	10/15/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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

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	10/15/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and records review, the facility failed to report a major injury for one of three sampled residents (Resident 4), when Restorative Nursing Assistant H (RNA H) left Resident 4 alone outside on a patio for 30 minutes, where Resident 4 fell and sustained a subdural hematoma (bleeding between the brain and its lining) This failure resulted in delaying an investigation into a major injury, and had the potential for other incidents not to be reported. FindingsDuring a review of the Centers for Medicare & Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.19.1, page J-26, dated [DATE]. The CMS document defined Major Injury as Including bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma. During a review of facility policy titled Assessing Falls and Their Causes, revised [DATE], the policy indicated that the facility should attempt to identify the cause of a fall, and Within 24 hours of a fall, begin to try to identify possible or likely causes of the incident.whether the resident was trying to get to the toilet.whether any environmental risk factors were involved; and/or Whether there is a pattern of falls for this resident. This policy also indicated, Report other information in accordance with facility policy and professional standards of practice. During a review of facility policy titled Unusual Occurrence Reporting, revised 2007, the policy indicated, Our facility reports unusual occurrences and other reportable events which affect the health, safety, or welfare of our residents. During a review of Resident 4's Facility admission Record, the admission Record indicated that Resident 4 was admitted on [DATE] with diagnoses that included Vascular Dementia (a condition where the brain doesn't get enough blood flow, causing problems with memory and thinking), hemiplegia and hemiparesis (weakness and difficulty moving one side of the body) following nontraumatic intracerebral hemorrhage (a stroke, where brain tissue is damaged by a leaking blood vessel), and muscle weakness.During a review of Resident 4's Minimum Data Set (MDS: a standardized resident assessment and care screening tool), dated [DATE], the MDS indicated that the resident had a Brief Interview for Mental Status (BIMS) score of 99 (BIMS: a quick, verbal quiz that tests memory and shows how a person's brain is working) indicating the resident had been unable to fully participate in the assessment due to their mental state, and was likely confused. The MDS indicated that Resident 4's functional status required one-person assistance with bed mobility, and transfers, and Resident 4's ability to walk was unsteady. During a review of Resident 4's Progress Note: Alert Note dated [DATE], indicated Resident was found on the ground outside the patio. Resident was found to be unresponsive to verbal or tactile stimuli (trying to cause a patient to respond verbally or physically), he has a pulse and has shallow breathing. The Progress Note also indicated Resident 4 was unresponsive, had unstable vital signs, and was soon transported to local hospital for evaluation. This Progress Note also indicated according to investigation of fall, [RNA H] took [Resident 4] outside to the patio, and [Resident 4] was found on the ground afterward.During a review Hospital A's records titled History and Physical Examination (H&P) by Medical Doctor (MD) X, dated [DATE], the H&P indicated that Resident 4 was taken via ambulance to Hospital A's emergency room immediately following the fall. The H&P indicated Resident 4 was assessed and received advanced Computer Tomography (CT) (a special type of camera that takes detailed images of inside the brain and body) to look for injuries. The CT of the brain results indicated CT Brain without Contrast [DATE] Impression: 1. Small acute left frontotemporal (the area of brain between the ears and forehead) subdural hematoma causing 3 mm of left-to-right midline or subfalcine shift (a small bleed inside the brain, that pushes the brain against the skull). The H&P also shows Fall leading to subdural hematoma. This H&P indicated the patient condition as having a poor outlook.During a review of records titled Progress Note: Interdisciplinary Team (IDT-a group of professionals from different disciplines who collaborate to provide care for the resident) Note, dated [DATE], indicated that Resident 4 was brought back to facility on [DATE], after treatment at local hospital, and was placed on Hospice Care (treatment and care that focuses on comfort near the end of life). During a review of records titled Progress Note: Alert Note, dated [DATE], indicated that Resident 4 had died at facility at approximately 9:21 pm that evening. During an interview with Facility Administrator (Admin) on [DATE] at 12:30 pm, Admin stated that the facility did not report Resident 4's fall because they did not consider the injury significant. Admin stated, It wasn't an unusual occurrence. During an interview with the Director of Nursing (DON) on [DATE] at 2:27 pm, DON stated No, we didn't report [the injury]. We didn't think it was an unusual occurrence.

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	10/15/2025

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to honor an activity preference that was developed in the activity care plan for one of three residents (Resident 1).This failure had the potential for Resident 1's mental and psychosocial needs not to be met.Findings:A review of a facility policy titled Activity Programs revised June of 2018, indicated activity programs are designed to meet the Interests of and support the physical, mental and psychosocial well-being of each resident. The Activities Program is provided to support the well-being of residents and to encourage both Independence and community interaction. Activities offered are based on the comprehensive resident-centered assessment and the preferences of each resident. The Activities Program is ongoing and includes facility-organized group activities, independent individual activities and assisted individual activities. Activities are considered any endeavor, other than routine ADLs, in which the resident participates, that is intended to enhance his or her sense of well-being and to promote or enhance physical, cognitive or emotional health. Individualized and group activities are provided that reflect the schedules, choices and rights of the residents, are offered at hours convenient to the residents, including evenings, holidays and weekends; and reflect the cultural and religious Interests, hobbies, life experiences and personal preferences of the residents.A review of Resident 4's record indicated he was admitted on [DATE], with diagnoses of dementia and left sided weakness. Resident 4 was unable to make his own health care decisions.A review of a quarterly activity participation review dated 7/30/25, indicated Resident 4 enjoyed being outdoors. A review of an activity care plan dated 8/23/22, indicated staff will take Resident 4 out to sit in sun when the weather was nice.A review of Resident 4's activity participation notes dated from 1/3/25 to 9/11/25, indicated no activity for going outside on the patio was documented in the record.During an interview on 10/15/25 at 1:50 pm, Activity Assistant (AA) stated Resident 4 had one on one activities. AA confirmed that they did not have an activity for residents as a group to go outside in either of the two outside patios at the facility. AA stated she had not taken Resident 4 out on the patios and was not aware that it was in his care plan. During a concurrent observation and interview on 10/15/25 at 2 pm, Activity Director (AD) stated she was not aware that Resident 4 had a care plan which indicated he liked to go sit outside. AD confirmed there was not a group activity for residents to sit outside on the two patios at the facility. AD confirmed the activity department had not provided an outside activity for Resident 4 due staff not getting him up in his wheelchair. AD confirmed that the care plan did not give clear direction to staff if Resident 4 required supervision and how often while out on either patio. AD stated Resident 4 could be out there alone if they door was open to allow staff to hear him if he called out for assistance. AD confirmed all areas of the patio were not visible depending on where a resident was placed.

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	10/15/2025

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 - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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	10/15/2025

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 - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a plan of care for safety and supervision for one of three sampled residents (Resident 4), when Restorative Nursing Assistant (RNA) H left Resident 4 alone outside on a patio for 30 minutes, where Resident 4 fell and sustained a subdural hematoma (bleeding between the brain and its lining). This deficient practice resulted in Resident 4 experiencing a major head injury, emergency care at hospital, and a significant decline in their quality of life. Resident 4 was transferred to the hospital on [DATE] after he fell. Resident 4 returned to the facility on [DATE], with Hospice services (specialized end of life care). Resident 4 passed away at the facility on [DATE], 13 days following the fall.Refer to F609, F679 and F726.FindingsDuring a review of facility policy titled Assessing Falls and their Causes, revised [DATE], indicated falls are a leading cause of morbidity and mortality among the elderly in nursing homes. Falling may be related to underlying clinical or medical conditions, overall functional decline, medication side effects, and/or environmental risk factors. Residents must be assessed upon admission and regularly afterward for potential risk of falls. Relevant risk factors must be addressed promptly.During a review of Resident 4's Facility admission Record, indicated that Resident 4 was admitted on [DATE], with diagnoses that included Vascular Dementia (a condition where the brain doesn't get enough blood flow, causing problems with memory and thinking), hemiplegia and hemiparesis (weakness and difficulty moving one side of the body) following nontraumatic intracerebral hemorrhage (a stroke, where brain tissue is damaged by a leaking blood vessel), and muscle weakness. During a review of Resident 4's Minimum Data Set (MDS: a standardized resident assessment and care screening tool), dated [DATE], indicated that the Resident 4 had a Brief Interview for Mental Status score of 99 (a quick, verbal quiz that tests memory and shows how a person's brain is working) indicating the resident had been unable to fully participate in the assessment due to their mental state, and was likely confused. The MDS indicated that Resident 4's functional status required one-person assistance with bed mobility, and transfers. The MDS data indicated that Resident 4's ability to walk was unsteady. During a review of Resident 4's Care Plan on Fall, last revised on [DATE], indicated [Resident 4] had hx (history) of falls r/t (related to) weakness, poor balance, impaired in communication, impaired decision making ability, poor safety awareness, incontinence (unable to control urine flow or bowels), on cardiac meds (heart medications), on narcotics (strong pain medications) and diagnosis of CVA (a stroke, where brain tissue is damaged by a leaking blood vessel) with left sided weakness. This Care Plan on Fall indicated interventions for Resident 4 that included activities that minimize the potential for falls while providing diversion and distraction. [Resident 4] needs a safe environment with even floors free from spills and/or clutter.Educate [Resident 4]/family/caregivers about safety reminders and what to do if a fall occurs. This care plan also indicated [Resident 4] has an ADL (activities of daily living) self-care performance deficit r/t CVA with left hemiplegia, impaired cognition, impaired in communication, poor endurance, with interventions listed including Provide appropriate assistance in all ADLs. This Care Plan on Fall also indicated that staff should provide Resident 4 with prompt response to all requests for assistance. This Care Plan on Fall also indicated [Resident 4] needs a safe environment with even floors free from spills and/or clutter, adequate, glare-free light; a working and reachable call light, and the bed in low position.During a review of Resident 4's activity Care Plan Report, revised [DATE], indicated preferred activities are sitting in the sun. This Care Plan Report also indicated that Resident 4 needs activities that minimize the potential for falls while providing diversion and distraction. This Care Plan Report does not indicate how to provide those activities, or what kind of supervision was needed. During a review of Resident 4's Progress Note: Alert Note dated [DATE], indicated Resident was found on the ground outside the patio. Resident 4 was found to be unresponsive to verbal or tactile stimuli (trying to cause a patient to respond verbally or physically), he has a pulse and has shallow breathing. The Progress Note also indicated Resident 4 was unresponsive, had unstable vital signs, and was soon transported to local hospital for evaluation. This Progress Note also indicated according to investigation of fall, [RNA H] took [Resident 4] outside to the patio, and [Resident 4] was found on the ground afterward. During a review of local Hospital A records titled History and Physical Examination (H&P) by Medical Doctor (MD) X, dated [DATE], the H&P indicated that Resident 4 was taken via ambulance to Hospital A's emergency room immediately following the fall. The H&P indicated Resident 4 was assessed, and received advanced Computer Tomography (CT) (a special type of camera that takes detailed images of inside the

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	10/15/2025

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. (continued on next page)

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	10/15/2025

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure that direct care staff had competencies necessary to care for one out of three sampled residents (Resident 4) when Restorative Nursing Assistant H (RNA H) left Resident 4 alone on a patio for 30 minutes, where Resident 4 fell and sustained a major head injury. This deficient practice resulted in Resident 4 experiencing a major head injury, admission to an acute care hospital, a decline in condition, and eventually death. This failure also had the potential for incompetent staff to care for other residents. FindingsDuring a review of records titled Restorative Nursing Assistant (RNA) Job Description, indicated that RNA H signed the document on 8/26/25, indicating they understood the duties and responsibilities outlined. The RNA Job Description indicated that RNA H's Duties and Responsibilities included Follow established safety precautions in the performance of all duties.Help residents to perform tasks for him/herself as appropriate as assigned in resident's plan of care.Follow appropriate safety, hygiene and infection control measures.Review care plans daily and Keep the nurses' call system within easy reach of the resident.During a review of Resident 4's Facility admission Record, indicated that Resident 4 was admitted on [DATE] with diagnoses that included Vascular Dementia (a condition where the brain doesn't get enough blood flow, causing problems with memory and thinking), hemiplegia and hemiparesis (weakness and difficulty moving one side of the body) following nontraumatic intracerebral hemorrhage (a stroke, where brain tissue is damaged by a leaking blood vessel), and muscle weakness.During a review of Resident 4's Minimum Data Set (MDS: a standardized resident assessment and care screening tool), dated 7/29/25, the MDS indicated that the resident had a Brief Interview for Mental Status (BIMS) score of 99 (BIMS: a quick, verbal quiz that tests memory and shows how a person's brain is working) indicating the resident had been unable to fully participate in the assessment due to their mental state, and was likely confused. The MDS indicated that Resident 4's functional status required one-person assistance with bed mobility, and transfers, and Resident 4's ability to walk was unsteady. During a review of Resident 4's Care Plan on Fall, last revised on 8/4/25, indicated [Resident 4] had hx (history) of falls r/t (related to) weakness, poor balance, impaired in communication, impaired decision making ability, poor safety awareness, incontinence (unable to control urine flow or bowels), on cardiac meds (heart medications), on narcotics (strong pain medications) and diagnosis of CVA (a stroke, where brain tissue is damaged by a leaking blood vessel) with left sided weakness. This Care Plan on Fall indicated interventions for Resident 4 that included activities that minimize the potential for falls while providing diversion and distraction. [Resident 4] needs a safe environment with even floors free from spills and/or clutter.Educate [Resident 4]/family/caregivers about safety reminders and what to do if a fall occurs. This care plan also indicated [Resident 4] has an ADL (activities of daily living) self-care performance deficit r/t CVA with left hemiplegia (one side of he body is weak or paralyzed), impaired cognition, impaired in communication, poor endurance, with interventions listed including Provide appropriate assistance in all ADLs. This Care Plan on Fall also indicated that staff should provide Resident 4 with prompt response to all requests for assistance. [Resident 4] needs a safe environment with even floors free from spills and/or clutter, adequate, glare-free light; a working and reachable call light, and the bed in low position.During a review of Resident 4's Progress Note: Alert Note dated 9/1/25, indicated Resident was found on the ground outside the patio. Resident was found to be unresponsive to verbal or tactile stimuli (trying to cause a patient to respond verbally or physically), he has a pulse and has shallow breathing. The Progress Note also indicated Resident 4 had unstable vital signs, and was soon transported to local hospital for evaluation. This Progress Note also indicated, According to investigation of fall, [RNA H] took [Resident 4] outside to the patio, and [Resident 4] was found on the ground afterward.During a review of Registered Nurse (RN) C's untitled written statement, dated 9/1/25, the untitled statement indicated [RNA H] did not tell me when she took [Resident 4] outside to the patio [in his wheelchair]. And I did not know [Resident 4] was outside until his CNA told me that he is on the ground. During an interview with the Director of Nursing (DON) on 9/11/25 at 10:18 am, DON confirmed that RNA H did not tell appropriate staff the location of Resident 4 on the patio. Yes, [RNA H] should have told more people. DON also verbally confirmed that the nursing station was empty at the time of the incident. During an interview with RN C on 9/11/25 at 10:07 am, RN C stated they had cared for Resident 4 many times in the past few years, and knew Resident 4's abilities and habits. RN C stated that Resident 4 was dependent on staff for all mobility, including in a wheelchair. RN C stated they were the assigned bedside nurse for Resident 4 on 9/1/25, the day of the fall incident. RN C