

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

Printed: 10/31/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055849	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/15/2024
NAME OF PROVIDER OR SUPPLIER Modesto Post Acute Center		STREET ADDRESS, CITY, STATE, ZIP CODE 159 E. Orangeburg Avenue Modesto, CA 95350	
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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 35314 Based on interview, record review, facility document review, and facility policy review, the facility failed to provide 1 (Resident #40) of 1 sampled resident reviewed for preadmission screening and resident review (PASARR) with the recommended specialized services identified by the resident's PASAR) Level II. Specifically, the PASARR determination report dated 04/18/2024 for Resident #40 recommended specialized services of psychotherapy/counseling which were not provided by the facility. Findings included: A facility policy titled, Admission Criteria, revised 03/2019, indicated, c. Upon completion of the Level II evaluation, the state PASARR representative determines if the individual has a physical or mental condition, what specialized or rehabilitative services he or she needs, and whether placement in the facility is appropriate. An Admission Record revealed the facility admitted Resident #40 on 03/02/2017. According to the Admission Record, the resident had a medical history that included diagnoses of major depressive disorder and post-traumatic stress disorder. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/24/2024, revealed Resident #40 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. The MDS indicated Resident #40 had active diagnoses that included post-traumatic stress disorder, anxiety, and depression. Resident #40's Preadmission Screening and Resident Review Individualized Determination Report dated 04/18/2024, revealed recommended specialized services that included psychotherapy/counseling. During an interview on 08/13/2024 at 2:10 PM, the Social Services (SS) Supervisor stated nursing staff should have obtained an order for a psychological referral. The SS Supervisor stated the referral had not been completed and it appeared to have been an oversight. During an interview on 08/14/2024 at 10:10 AM, the Director of Nursing (DON) stated it was her expectation that the SS Supervisor made sure the appropriate referrals were in place for residents. The DON stated there had been a delay with psychiatric services, but she had escalated the referral after the surveyor inquiry. (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 055849	Facility ID: 055849 If continuation sheet Page 1 of 15

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/15/2024 at 11:13 AM, the Administrator stated PASARR was a gray area to her, but if there were recommendations for services, the facility should have completed the referral.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35314 Based on observation, interview, and facility policy review, the facility failed to ensure windows on the secure unit were locked and secure for 2 (room [ROOM NUMBER] and room [ROOM NUMBER]) of 9 residents' rooms located on the secure unit. Specifically, room [ROOM NUMBER] and room [ROOM NUMBER] had missing and/or damaged window screens and no locking mechanism to prevent the windows from opening fully. Findings included: A facility policy titled, Safety and Supervision of Residents, revised 07/2017, revealed, Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. The policy indicated, 3. The type and frequency of resident supervision may vary among residents and over time for the same resident. For example, resident supervision may need to be increased when there are temporary hazards in the environment (such as construction) or if there is a change in the resident's condition. During an observation of the secure unit on 08/14/2024 at 1:45 PM, room [ROOM NUMBER] and room [ROOM NUMBER] windows were both observed fully opened. The window screen in room [ROOM NUMBER] was damaged with enough space for a resident to exit through the damaged screen. room [ROOM NUMBER] did not have a window screen. Additionally, room [ROOM NUMBER] and room [ROOM NUMBER] were observed to not have a locking mechanism to prevent the windows from opening fully. The windows for room [ROOM NUMBER] and room [ROOM NUMBER] led into the parking lot. During an interview on 08/14/2024 at 1:53 PM, the Maintenance Supervisor stated the facility staff documented any repair issues into a binder kept at the nurses' station. The Maintenance Supervisor said there were no current reports in the binder regarding any windows or screens in the secure unit that needed to be repaired. He stated he put in some new screens last month. During a concurrent observation and interview on 08/14/2024 at 1:55 PM, of rooms [ROOM NUMBERS] on the secure unit, the Maintenance Supervisor stated he was not aware of the windows missing screens or not having a locking mechanism. He stated visual checks were performed monthly to ensure screens were in place and said the last check was completed on 07/16/2024. The Maintenance Supervisor stated the screen in room [ROOM NUMBER] was not damaged at the time of that check. The Maintenance Supervisor stated he purchased devices to prevent the windows from opening completely, but had not had a chance to put the devices on the windows. During an interview on 08/14/2024 at 2:03 PM, Certified Nurse Assistant (CNA) #10 stated there had not been any issues with any of the residents attempting to leave the facility through a window. During an interview on 08/14/2024 at 2:18 PM, Licensed Vocational Nurse (LVN) #11 stated staff were required to monitor the door and windows in the secure unit. LVN #11 said if the windows needed to be repaired, the staff should notify the Maintenance Supervisor. She was not aware of any issues currently with the windows and said the residents were not able to fully open the windows but could only open them a little. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/14/2024 at 2:24 PM, the Maintenance Supervisor stated room [ROOM NUMBER] had an emergency in which the room had smoke, and the fire department requested the locking mechanism be removed. He said room [ROOM NUMBER]'s window was replaced after a resident broke it, but the window locking mechanism was not. During an interview on 08/15/2024 at 9:43 AM, the Director of Nursing (DON) stated she did not expect the windows on the secure unit to be fully opened. The DON said there had not been any elopements from the facility. The DON said she expected the staff to identify any dangerous items in the unit including if screens were falling off and to notify the Maintenance Supervisor. During an interview on 08/15/2024 at 11:16 AM, the Administrator stated the windows on the secure unit should be locked. The Administrator stated the window locking mechanism and screens not being replaced was a mistake by the facility and was just missed.		

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. 46659 Based on interview, record review, facility document review, and facility policy review, the facility failed to obtain psychiatric consultation as ordered for 1 (Resident #58) of 19 sampled residents. Findings included: A facility policy titled, Physician Services, revised 02/2021, indicated, 8. Consultative services are made available from community-based consultants or from a local hospital or medical center. An Admission Record revealed the facility readmitted Resident #58 on 07/15/2024. According to the Admission Record, the resident had a medical history that included diagnoses of vascular dementia, moderate with other behavioral disturbance and depression. A significant change in status Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/21/2024, revealed Resident #58 had a Staff Assessment for Mental Status (SAMS), which indicated the resident had severely impaired cognitive skills for daily decision making. The MDS indicated Resident #58 had physical and behavioral symptoms directed toward others and behaviors not directed toward others one to three days during the assessment period. Resident #58's care plan, included a focus area initiated 07/18/2024, that indicated the resident used psychotropic medications (Olanzapine) related to behavior management. Interventions directed staff to administer medications as ordered, to monitor/document for side effects and effectiveness, and to consult with pharmacy/physician to consider dosage reduction when clinically appropriate. A document titled, Note To Attending Physician/Prescriber, for Resident #58, dated 08/01/2024, indicated the consultant pharmacist recommended to re-evaluate if the medication olanzapine was still needed as the resident had not been on an antipsychotic prior to their hospitalization . The physician/prescriber response revealed the physician agreed and documented Consult Psych for recommendation. An untitled document for Resident #58, revealed an order dated 08/03/2024 that indicated Resident may have psych [psychiatric] evaluation. Resident #58's Progress Notes revealed a note dated 08/03/2024 at 4:44 PM, that indicated an order was received for a psychiatric consultation recommendation due to re-evaluate if olanzapine still needed. The Progress Notes revealed no evidence of a psychiatric evaluation. During an interview on 08/15/2024 at 8:36 AM, the Social Services Supervisor stated she was not aware of a psychiatric evaluation for Resident #58 until the previous day, 08/14/2024. During an interview on 08/15/2024 at 8:51 AM, Licensed Vocational Nurse (LVN) #4 said Resident #58 was supposed to have a psychiatric evaluation to see if the resident needed they psychotropic medication. (continued on next page)		

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/15/2024 at 9:27 AM, the Medical Director (MD) stated he had not been notified that the psychiatric consultation he ordered for Resident #58 had not been scheduled until he spoke with the Director of Nursing (DON) on 08/15/2024. The MD stated he thought it was necessary to have the resident evaluated to see if the resident needed Olanzapine. During an interview on 08/15/2024 at 10:22 AM, the DON stated she expected the staff to follow the physician orders. During an interview on 08/15/2024 at 10:38 AM, the Administrator stated she expected the staff to follow physician orders and all consultations needed to be scheduled.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. 45555 Based on interview, record review, and facility policy review, the facility failed to ensure a significant medication error did not occur for 1 (Resident #46) of 5 residents reviewed for unnecessary medications. Specifically, facility staff failed to follow a physician's order to hold midodrine hydrochloride (a medication used to treat low blood pressure) when the resident's systolic blood pressure (SBP, the top number in a blood pressure reading) was greater than 130 millimeters of mercury (mmHg) and failed to only administer losartan potassium (a medication used to treat high blood pressure) when the resident's SBP was greater than 130 mmHg. Findings included: A facility policy titled, Administering Medications, revised 04/2019, indicated, Medications are administered in a safe and timely manner, and as prescribed. The policy indicated, 4. Medications are administered in accordance with prescriber orders, including any required time frame. The policy indicated, 11. The following information is checked/verified for each resident prior to administering medications: a. Allergies to medications; and b. Vital signs, if necessary. An Admission Record indicated the facility admitted Resident #46 on 02/27/2024. According to the Admission Record, the resident had a medical history that included diagnoses of essential (primary) hypertension (high blood pressure) and atrial fibrillation (irregular heartbeat). A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/23/2024, revealed Resident #46 had a Brief Interview for Mental Status (BIMS) score of 6, which indicated the resident had severe cognitive impairment. The MDS indicated the resident had an active diagnosis to include hypertension. Resident #46's care plan, included a focus area initiated 06/02/2024, that indicated the resident had episodes of syncope (temporary loss of consciousness). Interventions directed staff to assess orthostatic blood pressure (blood pressure taken after standing from a lying or sitting position) twice a day, monitor, and notify the physician accordingly. Resident #46's care profile contained a physician's order with a start date of 03/11/2024 for midodrine hydrochloride 2.5 milligrams (mg) two tablets by mouth three times a day, with instructions to hold if the resident's SBP was greater than 130 mmHg. Resident #46's medication administration record (MAR) for the timeframe 06/01/2024 to 06/30/2024, revealed evidence to indicate staff administered midodrine hydrochloride 2.5 mg to the resident when the resident's SBP was greater than 130 mmHg on 06/01/2024 at 8:00 AM, 06/04/2024 at 8:00 AM, 06/05/2024 at 8:00 AM, 06/06/2024 at 8:00 AM, 06/07/2024 at 8:00 AM, 06/09/2024 at 8:00 AM, 06/10/2024 at 12:00 AM and 8:00 AM, 06/12/2024 at 8:00 AM, 06/13/2024 at 8:00 AM, 06/15/2024 at 4:00 PM, 06/16/2024 at 8:00 AM and 4:00 PM, 06/18/2024 at 8:00 AM, 06/24/2024 at 8:00 AM, 06/25/2024 at 8:00 AM and 06/29/2024 at 8:00 AM. (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #46's MAR for the timeframe 07/01/2024 to 07/31/2024, revealed evidence to indicate staff administered the midodrine hydrochloride 2.5 mg to the resident when the resident's SBP was greater than 130 mmHg on 07/03/2024 at 4:00 PM, 07/08/2024 at 4:00 PM, 07/09/2024 at 4:00 PM, 07/10/2024 at 4:00 PM, 07/12/2024 at 8:00 AM, 07/15/2024 at 8:00 AM, 07/16/2024 at 8:00 AM, 07/17/2024 at 8:00 AM, 07/19/2024 at 8:00 AM, 07/23/2024 at 4:00 PM and 07/24/2024 at 8:00 AM. Resident #46's MAR for the timeframe 08/01/2024 to 08/13/2024, revealed evidence to indicate staff administered the midodrine hydrochloride 2.5 mg to the resident when the resident's SBP was greater than 130 mmHg on 08/05/2024 and 08/06/2024 at 8:00 AM. Resident #46's care profile also contained a physician's order with start date of 03/21/2024, for losartan potassium 50 mg one tablet by mouth one time a day with instructions to give the medication if the resident's SBP was greater than 130 mmHg. Resident #46's MAR for the timeframe 06/01/2024 to 06/30/2024, revealed evidence to indicate staff administered the losartan potassium 50 mg when the resident's SBP was not greater than 130 mmHg on 06/11/2024, 06/17/2024, 06/19/2024, 06/20/2024, 06/22/2024, 06/26/2024, and 06/30/2024 at 8:00 AM. Resident #46's MAR for the timeframe 07/01/2024 to 07/31/2024, revealed evidence to indicate staff administered the losartan potassium 50 mg when the resident's SBP was not greater than 130 mmHg on 07/01/2024, 07/13/2024, 07/27/2024, and 07/30/2024 at 8:00 AM. Resident #46's MAR for the timeframe 08/01/2024 to 08/13/2024, revealed evidence to indicate staff administered the losartan potassium 50 mg when the resident's SBP was not greater than 130 mmHg on 08/02/2024, 08/11/2024, and 08/12/2024 at 8:00 AM. During an interview on 08/14/2024 at 2:09 PM, Registered Nurse (RN) #2 confirmed that it was her initials on the MAR for 07/23/2024 at 4:00 PM and that based on the resident's blood pressure reading, the midodrine should have been held. RN #2 stated she should have paid closer attention to the orders. During an interview on 08/14/2024 at 2:41 PM, RN #1 reviewed the June 2024 and July 2024 MARs for Resident #46 and confirmed that it was her initials on the midodrine on 06/15/2024, 06/16/2024, 07/08/2024, 07/09/2024, and 07/10/2024 at 4:00 PM and stated that according to the resident's blood pressure reading, the medication should have been held. RN #1 stated she should have put in the code to indicate the blood pressure was out of parameter and a progress note as to why it was held and then notified the resident, resident representative, and physician. During an interview on 08/15/2024 at 9:59 AM, RN #3 stated she checked the resident's blood pressure before giving the medication. RN #3 reviewed Resident #46's June 2024, July 2024, and August 2024 MARs and agreed that according to the orders and the resident's blood pressure readings, the medication should not have been given. RN #3 stated she should have followed the five rights - right resident, right medication, right dose, right time, right route, and should have verified the label of the medication and the order on the MAR three times. (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/15/2024 at 9:36 AM, the Medical Director (MD) stated it was important for the nurses to follow the parameters for blood pressure medications to ensure there were no adverse effects. The MD stated the midodrine was used to keep the resident's blood pressure from going too low and the losartan was to keep the blood pressure from going too high. The MD stated it was his expectation that the order be followed and if the medication was being held consistently, then he would expect to be notified. During an interview on 08/15/2024 at 10:11 AM, the Director of Nursing (DON) stated the nurse should look at the parameters and follow the directions as ordered. The DON stated the nurse should check the orders with the medication the label and notify the physician if parameters were out of range or if clarification was needed. During an interview on 08/15/2024 at 11:57 AM, the Administrator stated when administering medications, the nurses should follow the parameters put into place by the physician.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 46659 Based on interview, record review, and facility policy review, the facility failed to ensure nursing staff did not document the monitoring of peripheral intravenous (IV) site when the resident no longer had the IV because it had been removed for 1 (Resident #297) of 19 sampled residents. Findings included: A facility policy titled, Medication and Treatment Orders, revised 07/2016, revealed, Orders for medications and treatments will be consistent with principles of safe and effective order writing. An Admission Record revealed the facility admitted Resident #297 on 07/29/2024. According to the Admission Record, the resident had a medical history that included diagnoses of adult failure to thrive and liver disease. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/02/2024, revealed Resident #297 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident had intact cognition. The MDS indicated the resident had active diagnoses to include malnutrition and failure to thrive. Resident #297's care plan included a focus area, initiated 08/01/2024, that indicated the resident faced a nutritional issue related to poor meal and fluid intake. Interventions directed staff to administer medications as ordered. An order detail for Resident #297 revealed an order dated 08/09/2024, to monitor peripheral intravenous (IV) site to right hand dorsum for signs or symptoms (s/s) of infection, infiltration every shift. Resident #297's Medication Administration Record [MAR] for the timeframe 08/01/2024 to 08/31/2024, revealed an order entry for staff to monitor the resident's peripheral IV site to the right hand dorsum for s/s of infection, infiltration every shift. Staff documented on the MAR on 08/12/2024 and 08/13/2024 for all three shifts, and on 08/14/2024 for the 6:00 AM to 2:00 PM shift to indicate they monitored the resident's IV site. An observation on 08/12/2024 at 1:42 PM, revealed Resident #297 did not have an IV site to their right hand. During an interview on 08/14/2024 at 2:20 PM, Registered Nurse (RN) #5 said Resident #297's IV came out prior to 08/13/2024 and that she should not have signed off that she monitored the IV site because the resident did not have an IV to monitor. During an interview on 08/15/2024 at 7:38 AM, Registered Nurse (RN) #3 said Resident #297's IV site was removed on the night shift on 08/11/2024. RN #3 said she should not have charted on 08/12/2024 because the resident did not have an IV site at that time. (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 08/15/2024 at 11:18 AM, RN #7 said that she was told Resident #297 had pulled out their IV on the night shift on 08/11/2024. She said she should not have charted on the MAR for monitoring of the IV site because the resident did not have an IV. During a telephone interview on 08/15/2024 at 9:27 AM, the Medical Director said he expected the staff to document accurately on the MAR. During an interview on 08/15/2024 at 10:38 AM, the Administrator stated she expected the staff to chart accurately on the resident's MAR.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 35314 Based on observation, interview, and facility policy review, the facility failed to ensure facility staff used appropriate hand hygiene during meal service for 1 (Resident #66) of 10 sampled residents observed for dining. Findings included: A facility policy titled, Handwashing/Hand Hygiene, revised 10/2023, revealed, 2. All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors. The policy indicated, 1. Hand hygiene is indicated: a. immediately before touching a resident; b. before performing an aseptic task (for example, placing an indwelling device or handling an invasive medical device); c. after contact with blood, body fluids, or contaminated surfaces. A facility policy titled, Assisting the Resident with In-Room Meals, revised 12/2013, revealed, 11. Employees must wash their hands before serving food to residents. It is not necessary to wash hands between each resident tray; however, if there is contact with soiled dishes, clothing or the resident's personal effects, the employee must wash his/her hands before serving food to the next resident. During the lunch meal service observation on 08/12/2024 at 11:40 AM, Certified Nurse Assistant (CNA) #8 used her left finger to wipe her nose and then used the same soiled left hand to then remove the plastic wrapping that covered the resident food items. CNA #8 continued to use the hand to unwrap residents' food items. At no time did CNA #8 use any hand sanitation method. During an interview on 08/13/2024 at 1:16 PM, CNA #8 stated all staff should sanitize their hands when passing residents' meal trays. CNA #8 stated staff should never touch their face or hair. CNA #8 said she had allergies and used her hands to wipe her nose. She stated she should have sanitized her hands after touching her nose but had not. During an interview on 08/15/2024 at 7:45 AM, Infection Preventionist #14 stated during meal service staff should sanitize their hands before passing out meal trays. During an interview on 08/15/2024 at 9:54 AM, the Director of Nursing (DON) stated during meal service, the staff should sanitize their hands before handling the trays. The DON said if staff touched their bodies, then they should sanitize their hands. She stated the staff should use soap and water if available or utilize hand sanitizer. During an interview on 08/15/2024 at 11:25 AM, the Administrator stated staff should use hand sanitizer and wash their hands during meal service. The Administrator stated staff should not touch their face without sanitizing their hands with soap, water, and/or hand sanitizer.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055849	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/15/2024
NAME OF PROVIDER OR SUPPLIER Modesto Post Acute Center		STREET ADDRESS, CITY, STATE, ZIP CODE 159 E. Orangeburg Avenue Modesto, CA 95350	
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 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35314 Based on observation, interview, facility document review, and facility policy review, the facility failed to ensure residents rooms measured at least 80 square (sq) feet (ft) per resident in 26 (Rooms 101-108, Rooms 115-124, and Rooms 130-137) of 36 resident rooms in the facility. Findings included: A facility policy titled, Bedrooms, revised 05/2017, revealed, 1. Bedrooms accommodate no more than two residents at a time. 2. Bedrooms measure at least 80 square feet per resident in double rooms, and at least 100 square feet of space in single rooms. The Client Accommodations Analysis, completed by the Administrator and dated 08/15/2024 revealed: - In room [ROOM NUMBER], the total floor area measured 229.99 sq ft and three beds occupied the room, which yielded 76.66 sq ft for each resident. - In room [ROOM NUMBER], the total floor area measured 229.99 sq ft and three beds occupied the room, which yielded 76.66 sq ft for each resident. - In room [ROOM NUMBER], the total floor area measured 229.99 sq ft and three beds occupied the room, which yielded 76.66 sq ft for each resident. - In room [ROOM NUMBER], the total floor area measured 229.99 sq ft and three beds occupied the room, which yielded 76.66 sq ft for each resident. - In room [ROOM NUMBER], the total floor area measured 229.99 sq ft and three beds occupied the room, which yielded 76.66 sq ft for each resident. - In room [ROOM NUMBER], the total floor area measured 229.99 sq ft and three beds occupied the room, which yielded 76.66 sq ft for each resident. - In room [ROOM NUMBER], the total floor area measured 229.99 sq ft and three beds occupied the room, which yielded 76.66 sq ft for each resident. - In room [ROOM NUMBER], the total floor area measured 229.99 sq ft and three beds occupied the room, which yielded 76.66 sq ft for each resident. - In room [ROOM NUMBER], the total floor area measured 216 sq ft and three beds occupied the room, which yielded 72 sq ft for each resident. - In room [ROOM NUMBER], the total floor area measured 216 sq ft and three beds occupied the room, which yielded 72 sq ft for each resident. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055849	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/15/2024
NAME OF PROVIDER OR SUPPLIER Modesto Post Acute Center		STREET ADDRESS, CITY, STATE, ZIP CODE 159 E. Orangeburg Avenue Modesto, CA 95350	
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 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- In room [ROOM NUMBER], the total floor area measured 216 sq ft and three beds occupied the room, which yielded 72 sq ft for each resident. - In room [ROOM NUMBER], the total floor area measured 216 sq ft and three beds occupied the room, which yielded 72 sq ft for each resident. - In room [ROOM NUMBER], the total floor area measured 216 sq ft and three beds occupied the room, which yielded 72 sq ft for each resident. - In room [ROOM NUMBER], the total floor area measured 219 sq ft and three beds occupied the room, which yielded 73 sq ft for each resident. - In room [ROOM NUMBER], the total floor area measured 219 sq ft and three beds occupied the room, which yielded 73 sq ft for each resident. - In room [ROOM NUMBER], the total floor area measured 219 sq ft and three beds occupied the room, which yielded 73 sq ft for each resident. - In room [ROOM NUMBER], the total floor area measured 219 sq ft and three beds occupied the room, which yielded 73 sq ft for each resident. - In room [ROOM NUMBER], the total floor area measured 219 sq ft and three beds occupied the room, which yielded 73 sq ft for each resident. - In room [ROOM NUMBER], the total floor area measured 228.99 sq ft and three beds occupied the room, which yielded 76.33 sq ft for each resident. - In room [ROOM NUMBER], the total floor area measured 228.99 sq ft and three beds occupied the room, which yielded 76.33 sq ft for each resident. - In room [ROOM NUMBER], the total floor area measured 228.99 sq ft and three beds occupied the room, which yielded 76.33 sq ft for each resident. - In room [ROOM NUMBER], the total floor area measured 228.99 sq ft and three beds occupied the room, which yielded 76.33 sq ft for each resident. - In room [ROOM NUMBER], the total floor area measured 228.5 sq ft and three beds occupied the room, which yielded 76.16 sq ft for each resident. - In room [ROOM NUMBER], the total floor area measured 228 sq ft and three beds occupied the room, which yielded 76 sq ft for each resident. - In room [ROOM NUMBER], the total floor area measured 218.5 sq ft and three beds occupied the room, which yielded 72.83 sq ft for each resident. (continued on next page)		

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/14/2024 at 9:11 AM, Registered Nurse (RN) #2 revealed there had been issues with staff completing mechanical lift transfers of residents in the rooms. RN #2 said if a mechanical lift was used, there was not enough space for the nurse assistant to complete the transfer. During an interview on 08/14/2024 at 9:25 AM, Certified Nurse Assistant (CNA) #12 stated the rooms were too small and the resident's bed got in the way of providing care to residents. She stated sometimes they must move other residents' beds to ensure care was provided adequately. During an interview on 08/14/2024 at 9:30 AM, CNA #13 stated when they performed transfers with the mechanical lift, there was not enough space. CNA #13 said some of the residents complained about the rooms being too small. She stated it was difficult to provide care when there were three residents in the room. During an interview on 08/15/2024 at 9:41 AM, the Director of Nursing (DON) stated that sometimes the residents complained the rooms were too small for three residents. The DON said there had also been issues with staff completing transfers with the mechanical lift in the residents' rooms. During an interview on 08/15/2024 at 11:16 AM, the Administrator stated she was not aware the room size was too small and was not aware of any resident complaints or concerns about the room size.		