STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055869	A. Building B. Wing	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Skilled Nursing Center	515 East 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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48713 Based on observation, interview, and record review the facility failed to develop and implement a comprehensive person-centered care plan per facility ' s policy and procedure titled Care Planning-Interdisciplinary Team for one of three sampled residents (Resident 1), when Resident 1 sustained a fracture (broken bone) of left arm on 7/24/24 and there was no care plan created for Resident 1 ' s care of the fractured right arm. This failure had the potential for harm when the facility staff did not create a care plan with interventions to monitor Resident 1 ' s fractured right arm with bandage that could have led to skin breakdown, pain, and acute compartment syndrome (bandage or cast placed on injured arm or leg too tightly) causing swelling, numbness, weakness, difficulty moving the affected body part. Findings: During an observation on 8/13/24 at 11:22 a.m. of Resident 1 in Resident 1 ' s room. Resident 1 was observed walking around facility with four wheeled walker. Resident 1 was observed to have an arm brace to the right arm, the right arm was observed wrapped in bandage appearing as an arm cast. Resident was dressed, clean and groomed. During a review of Resident 1's Admission Record (AR-a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), the AR indicated Resident 1 was admitted to the facility on [DATE] with diagnoses of syncope (fainting), fall, unsteadiness (off balance) on feet. During a review of Resident 1's Minimum Data Set [MDS - a resident assessment tool used to identify cognitive (mental processes) and physical functional level assessment] dated 6/18/24, the MDS indicated, Resident 1's Brief Interview for Mental Status (BIMS screening tool used to assess resident cognitive level) score was 15 out of 15 (0- 7 indicated severe cognitive impairment [memory loss, poor decision making skills] 8 -12 moderate cognitive impairment, 13- 15 cognitively intact) which indicated Resident 1 was cognitively intact. During a record review of Resident 1 ' s Acute Hospital radiology (x-ray) report, dated 7/24/24, the x-ray report indicated, . There are acute fractures of the olecranon process/proximal ulna and radial neck (a bone injury in the elbow that can be caused by a direct blow or a fall) . (continued on next page)

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
	055869	A. Building B. Wing	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Skilled Nursing Center	515 East 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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 8/13/24 at 12:22 p.m. with Registered Nurse (RN) 1, Resident 1 ' s Care Plan (CP), initiated date 2/20/24, the CP indicated, there was no care plan created for Resident 1 ' s fracture following unwitnessed fall on 7/24/24. RN 1 stated there was no care plan created for Resident 1 ' s fracture. RN 1 stated it was important to have a care plan in place to know what new interventions would be part of Resident 1 ' s care. RN 1 stated the facility expectation was for the charge nurse to initiate the care plan to monitor Resident 1 ' s cast and possible complications such as change in color and sensation. During an interview on 8/13/24 at 2:07 p.m. with the director of nursing (DON), the DON stated that the facility did not create and implement a care plan for Resident 1 ' s fracture resulting from the unwitnessed fall on 7/24/24. The DON stated it was the expectation for the facility to create a care plan for Resident 1 for the new fracture to ensure all staff were implementing the same interventions. During a review of the facility ' s policy and procedure (P&P) titled, Care Planning-Interdisciplinary Team, dated 03/2022, the P&P indicated, . the interdisciplinary team (IDT) is responsible for the development of resident care plans . comprehensive person-centered care plans are based on resident assessments and developed by an IDT. The IDT includes but not limited to the resident ' s attending physician, a registered nurse, a nursing assistant, a member of the food and nutrition services staff, to the extent practicable, the resident and/or the resident ' s representative and other staff as appropriate or necessary to meet the needs of the resident, or as requested by the resident . [

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055869	A. Building B. Wing	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Skilled Nursing Center	515 East 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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48713 Based on interview and record review, the facility failed to meet professional standards of quality for two of three sampled residents (Resident 1 and Resident 2), when: 1. Resident 1 had an unwitnessed fall on 7/24/24 and facility staff did not complete a change of condition (COC) assessment (used to describe situation, background, assessment of resident and physician recommendations). 2. Resident 2 had a change in urine patterns on 7/28/24, blood in urine on 7/30/24 and the facility did not complete a COC for both instances for Resident 2. These failures resulted in incomplete documentation for Resident 1 and Resident 2 putting Resident 1 at risk for falls and Resident 2 at risk for delay in care when there was no documentation of change in condition to inform other facility staff of changes in resident care. Findings: 1. During a record review of Resident 1 ' s Post Fall Evaluation (PFE), dated 7/25/24, the PFE indicated, Resident 1 had an unwitnessed fall on 7/24/24 resulting in fracture to the olecranon process/proximal ulna and radial neck (a bone injury in the elbow that can be caused by a direct blow or a fall). The PFE indicated, . fall was unwitnessed fall occurred in the bathroom. Resident was attempting to self-toilet at time of fall . injury redness left upper abdomen . During a concurrent interview and record review on 8/13/24 at 12:22 p.m. with Registered Nurse (RN) 1, Resident 1 ' s Post Fall Evaluation (PFE), dated 7/25/24, the PFE indicated Resident 1 had an unwitnessed fall on 7/24/24 resulting in fracture to the olecranon process/proximal ulna and radial neck. The PFE indicated, . fall was unwitnessed fall occurred in the bathroom. Resident was attempting to self-toilet at time of fall . injury redness left upper abdomen . RN 1 stated after review of Resident 1 ' s Electronic Medical Record (EMR), there was no change of condition report completed for Resident 1 ' s fall with fracture. RN 1 stated the facility process was for the charge nurse to complete a COC to ensure the circumstances were documented in Resident 1 ' s EMR. During an interview on 8/13/24 at 2:07 p.m. with the director of nursing (DON), the DON stated it was the facility process for the charge nurse on shift to complete a COC for all changes in resident health. The DON stated it was important to complete a COC because it gave more information of the circumstances and who was notified of the change. During a review of Resident 1's Admission Record (AR-a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), the AR indicated Resident 1 was admitted to the facility on [DATE] with diagnoses of syncope (fainting), fall, unsteadiness (off balance) on feet. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055869	A. Building B. Wing	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Skilled Nursing Center	515 East 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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 1's Minimum Data Set [MDS - a resident assessment tool used to identify cognitive (mental processes) and physical functional level assessment] dated 6/18/24, the MDS indicated, Resident 1's Brief Interview for Mental Status (BIMS screening tool used to assess resident cognitive level) score was 15 out of 15 (0- 7 indicated severe cognitive impairment [memory loss, poor decision making skills] 8 -12 moderate cognitive impairment, 13- 15 cognitively intact) which indicated Resident 1 was cognitively intact. During a review of the facility ' s policy and procedure (P&P) titled, Charting and Documentation, dated 07/2017, the P&P indicated, . all services provided to the resident, progress toward the care plan goals, or any changes in the resident ' s medical, physical, functional or psychosocial condition, shall be documented in the resident ' s medical record . the following information is to be documented in the resident medical record, objective observations, changes in the resident ' s condition, events, incidents or accidents involving the resident . documentation in the medical record will be objective, complete, and accurate . During a professional reference review titled, Lippincott Manual of Nursing Practice 11th Edition dated 2020, pages 15 indicated, . Standards of Practice . General Principles . These standards describe what nursing is, what nurses do, and the responsibilities for which nurses are accountable . A deviation from the protocol should be documented in the patient ' s chart with clear, concise statements of the nurse ' s decisions, actions, and reasons for the care provided, including any apparent deviation. This should be done at the time the care is rendered because passage of time may lead to a less than accurate recollection of the specific events . Common Departures from the Standards of Nursing Care . Legal claims most commonly made against professional nurses include the following departures from appropriate care: .follow physician orders, follow appropriate nursing measures, communicate information about the patient . document appropriate information in the medical record . and follow physician ' s orders that should have been questioned or not followed . Common Legal Claims for Departure from Standards of Care . Failure to implement a physician ' s . order properly . 2. During a review of Resident 2's the AR indicated Resident 2 was admitted to the facility on [DATE] with diagnoses of orthopedic aftercare (care and treatment received after surgery to recover and regain function) following surgical amputation (procedure that removes part of the body, such as arm or leg), osteomyelitis (a bone infection that causes swelling), muscle weakness, anemia (blood disorder that occurs when body doesn ' t have enough red blood cells to carry oxygen throughout the body), end stage renal disease (terminal condition when kidneys no longer function and don ' t filter waste from the blood), presence of urogenital implants (injection of material to help control urine leakage). During a record review of Resident 2 ' s Orders Administration Note (OAN), dated 7/30/24, the note indicated, . Blood in urine and bruising noted per MD hold [medication brand name] for 3 days . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055869	A. Building B. Wing	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Skilled Nursing Center	515 East 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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 8/13/24 at 12:39 p.m. with RN 1, Resident 2 ' s Progress note-Health status (PN), dated 7/28/24 and Resident 2 ' s OAN, dated 7/30/24 were reviewed. The PN indicated, . Burning during urination MD gave order to change foley catheter (device that drains urine from the bladder) if resident continues to have discomfort . The OAN indicated, . Blood in urine and bruising noted per MD hold [medication brand name] for 3 days . RN 1 stated the facility process was for the charge nurse on shift to complete a COC for any changes in resident status. RN 1 stated it was important for a COC to be completed to be aware of what was happening, what the change was, what time the incident occurred, instances and what interventions were implemented at the time of change in health. During an interview on 8/13/24 at 2:07 p.m. with the director of nursing (DON), the DON stated it was the facility process for the charge nurse on shift to complete a COC for all changes in resident health. The DON stated it was important to complete a COC because it gave more information of the circumstances and who was notified of the change. During a review of the facility ' s policy and procedure (P&P) titled, Charting and Documentation, dated 07/2017, the P&P indicated, . all services provided to the resident, progress toward the care plan goals, or any changes in the resident ' s medical, physical, functional or psychosocial condition, shall be documented in the resident ' s medical record . the following information is to be documented in the resident medical record, objective observations, changes in the resident ' s condition, events, incidents or accidents involving the resident . documentation in the medical record will be objective, complete, and accurate . During a professional reference review titled, Lippincott Manual of Nursing Practice 11th Edition dated 2020, pages 15 indicated, . Standards of Practice . General Principles . These standards describe what nursing is, what nurses do, and the responsibilities for which nurses are accountable . A deviation from the protocol should be documented in the patient ' s chart with clear, concise statements of the nurse ' s decisions, actions, and reasons for the care provided, including any apparent deviation. This should be done at the time the care is rendered because passage of time may lead to a less than accurate recollection of the specific events . Common Departures from the Standards of Nursing Care . Legal claims most commonly made against professional nurses include the following departures from appropriate care: .follow physician orders, follow appropriate nursing measures, communicate information about the patient . document appropriate information in the medical record . and follow physician ' s orders that should have been questioned or not followed . Common Legal Claims for Departure from Standards of Care . Failure to implement a physician ' s . order properly .