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	03/27/2025

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 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. 47298 Based on interview and record review, the facility failed to report an injury of unknown origin in accordance with the facility's policy and procedure (P&P) and state regulations, for one of five sampled residents (Resident 1), when Resident 1 had a lump to the right shoulder, lump to the right side of the chest with bruising due to an unknown cause and it was not reported to the California Department of Public Health (CDPH, a government agency for the State of California in charge of protecting the public's health and helping shape positive health outcomes for individuals, families and communities) and the ombudsman (an advocate for residents of nursing homes, board and care centers, and assisted living facilities) within 2 hours as required by law. This failure resulted in a delayed investigation of the injury of unknown origin and placed Resident 1 at risk for physical harm and delayed care. Findings: During a review of Resident 1's Admission Record (AR- a document that provides resident contact details, a brief medical history) , dated 3/27/25, the AR indicated, Resident 1 had diagnoses which included . TRANSIENT CEREBRAL ISCHEMIA ATTACK [TIA- a temporary lack of blood flow to the brain] . ESSENTIAL (PRIMARY) HYPERTENSION [high blood pressure] .MUSCLE WEAKNESS .NEED FOR ASSISTANCE WITH PERSONAL CARE . During a review of Resident 1's Minimum Data Set (MDS- a standardized assessment and care screening tool) , dated 12/2/24, the MDS indicated, Resident 1's Brief Interview for Mental Status (BIMS- an evaluation of attention, orientation, and memory recall) indicated a score of 15 (0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, 13-15 no cognitive impairment), indicating Resident 1 had no cognitive impairment. During a phone interview on 4/3/25 at 11:00 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated, Resident 1 came to her reporting pain to her right shoulder. LVN 1 stated, she assessed Resident 1's right shoulder and saw a lump that felt like a knot. LVN 1 stated, Resident 1 did not know how it happened, and staff also did not know what caused the injury. LVN 1 stated, an injury of unknown origin, abuse or neglect needed to be reported immediately but no longer than 2 hours to CDPH and the ombudsman. LVN 1 stated, prompt reporting of an injury of unknown origin, abuse and neglect was important because the matter was serious and needed to be investigated. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview on 4/3/25 at 11:33 a.m. with the Director of Staff Development (DSD), the DSD stated, after the discovery of an injury of unknown origin to a resident, the staff should have called CDPH and the ombudsman and filed an SOC 341 form (document used to report suspected cases of dependent adult and elder abuse and neglect) immediately but no later than 2 hours later. The DSD stated, prompt reporting of an injury of unknown origin, abuse or neglect was important to address the safety of the resident. During a concurrent phone interview and record review on 4/3/25 at 11:53 a.m. with the Director of Nursing (DON), Resident 1's fax sheet (FS) , dated 12/3/24 was reviewed. The FS indicated, Date: 12/3/24 . [Resident 1] .Nursing Concerns & Assessments: Please [evaluate] lump to [right upper chest (RUC)]. Measured 12 [centimeter (cm)- unit of length] x 7 cm. Deep purple bruise accompanied by [right (R)] shoulder pain. R shoulder x-ray [a medical imaging test commonly used to see the bones and other dense structures inside the body] clear .Pending ultrasound [a medical imaging test that uses sound waves to look at tissues and organs inside the body] report, but tech had stated it looked like a fluid filled sac .-Pectoralis [muscle in the chest] muscle tear .-Consult orthopedics [branch of medicine concerned with the bones and muscles] .12/3/24 . The DON stated, Resident 1 reported to staff that she was hurting and had bruising to the nurses. DON stated, Resident 1 had a lump to the right shoulder, a lump to the right side of her chest and bruising to her chest which extended under her right arm. The DON stated, Resident 1 and staff did not know the exact cause of the injury Resident 1 sustained. The DON stated, the doctor had ordered a right shoulder x-ray and a chest ultrasound. The DON stated, the FS indicated that the nurse had written an update about Resident 1's status to the doctor in the upper portion of the document. The DON stated, the FS indicated on the lower portion of the document that the doctor had a hand-written reply with a suspected pectoralis muscle tear diagnosis and orders to consult an orthopedic doctor on 12/3/24. The DON stated, the staff were expected to report any injury of unknown origin, abuse or neglect to the DON or to the Administrator (ADM), who is the abuse coordinator. The DON stated, CDPH and the ombudsman should have been promptly notified. The DON stated, the Abuse P&P speaks clearly to reporting immediately but no later than 2 hours after identification of an injury of unknown origin. The DON stated, the reporting of Resident 1's injury of unknown origin was not completed according to the facility P&P. During a review of Resident 1's SBAR Summary for Providers (SBAR) , dated 12/1/24, the SBAR indicated, . The Change in Condition [CIC]/s reported on this CIC Evaluation are/were: Pain .Resident came to [licensed nurse] this evening stating she had pain to the R shoulder, when LN assessed shoulder noticed a lump on the right shoulder. [Nurse Practitioner (NP)] was noticed via phone .NP gave order for [hydrocodone and acetaminophen- pain medication] 5/325 [milligram (mg)- unit of weight] q [every] 8 hours and xray to area . During a review of Resident 1's Progress Notes (PN) , dated 12/1/24, the PN indicated, .Lump to R chest is causing resident increased pain . During a review of Resident 1's PN, dated 12/2/24, the PN indicated, .[Resident (Res)] on [continued (cont)] monitoring due to Lump to RUC. LN asked to eval [evaluate] and measure, res agreed and complained of increased pain .Deep purple bruise noted to site .bruise noted to middle of chest and L [left] breast. Lump measured 12cm x 7cm. Res also complained of R shoulder pain with very minimal movement .NP notified and gave order for STAT [immediate] ultrasound to RUC and STAT x-ray to R shoulder . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's MD/NP Progress Notes (NPPN) , dated 12/2/24, the NPPN indicated, .Pain in right shoulder .Contusion [bruise] of right front wall of thorax [area between the neck and abdomen], initial encounter .Pain right shoulder: Xray ordered Pain medication adjusted .Right breast hematoma [a closed wound where blood collects and pools]: [ultrasound] ordered . During a review of Resident 1's Clinical Physician Orders (CPO) , undated, the CPO indicated .Refer to Ortho r/t suspected torn muscle fibers to RUC .STAT X-RAY of R shoulder .STAT ultrasound to RUC . During a review of Resident 1's Radiology Interpretation (RI) , dated 12/2/24, the RI indicated .HISTORY: LUMP AND A BRUISE IN THE RIGHT AXILA [armpit or underarm] .5.6 cm cyst [sac containing fluid]/hematoma .right axillary [pertaining to the armpit area] . The RI indicated a handwritten note, dated 12/3/24, Consult Orthopedics . During a review of Resident 1's PN, dated 12/3/24, the PN indicated, .Res is on cont monitoring due to Lump to RUC .Sent over ultrasound with significant find: Cyst and hematoma. Requested eval by MD today. MD evaluated. Bruising to area significantly worse and spread to R breast, chest, L breast, and upper abdomen. Res cont to [complain of (c/o)] pain .MD suspecting torn muscle fibers to pectoralis. Gave order for sling to R arm, referredres to Ortho, and to hold blood thinners x 3 days .Management made aware and updatedto situation . During a review of the facility's P&P titled, ABUSE REPORTING POLICY , dated 8/22, the P&P indicated, . To promote an environment free from any form of resident abuse, neglect, misappropriation of resident property, exploitation and/or mistreatment .Type of Abuse: . ' Injury of unknow source' is defined as an injury that meets both the following conditions: (1) the source of the injury was not observed by any person or the source of the injury could not be explained by the resident .(2) the injury is suspicious because of the extent of the injury, the location of the injury .the number of injuries observed at one particular point in time, or the incidence of injuries over time . The facility shall conduct mandatory Facility Staff training programs during orientation, annually, and as needed on .Reporting .injuries of unknown sources .The facility's Abuse Prevention Coordinator/Designee shall initiate the investigation process immediately within the required time frame in accordance to regulation .The Facility shall report any and all allegation of abuse to the District CDPH, Local Ombudsman and Local Law enforcement .

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 47298 Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for one of five sampled residents (Resident 1) when Resident 1 had a newly developed lump to the right shoulder and a lump to the right side of the chest with bruising and the care plan did not include thorough and individualized objectives, timeframes, goals, and interventions. This failure placed Resident 1 at risk for complications and delayed healing to her right shoulder and chest. Findings: During a review of Resident 1's Admission Record (AR- a document that provides resident contact details, a brief medical history) , dated 3/27/25, the AR indicated, Resident 1 had diagnoses which included . TRANSIENT CEREBRAL ISCHEMIA ATTACK [TIA- a temporary lack of blood flow to the brain] . ESSENTIAL (PRIMARY) HYPERTENSION [high blood pressure] .MUSCLE WEAKNESS .NEED FOR ASSISTANCE WITH PERSONAL CARE . During a review of Resident 1's Minimum Data Set (MDS- a standardized assessment and care screening tool) , dated 12/2/24, the MDS indicated, Resident 1's Brief Interview for Mental Status (BIMS- an evaluation of attention, orientation, and memory recall) indicated a score of 15 (0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, 13-15 no cognitive impairment), indicating Resident 1 had no cognitive impairment. During a concurrent interview and record review on 3/27/25 at 1:30 p.m. with the ADON, Resident 1's Care Plans (CP), undated were reviewed. The CP indicated, . [Resident 1] has a Lump to R [right] Chest . Interventions .Encourage good nutrition and hydration in order to promote healthier skin .Identify potential causative factors and eliminate/resolve when possible . The ADON stated, Resident 1 had complained of right shoulder pain to Licensed Vocational Nurse (LVN) 1. The ADON stated, LVN 1 had assessed Resident 1 and found a right shoulder lump. The ADON stated, LVN 1 called Resident 1's doctor, completed the change of condition (COC- a significant, clinically important deviation from a resident's baseline that requires intervention) documentation and an SBAR (a communication framework which stands for Situation, Background, Assessment and Recommendation). The ADON stated, Resident 1's doctor ordered an x-ray (a medical imaging test commonly used to see the bones and other dense structures inside the body), an ultrasound (a medical imaging test that uses sound waves to look at tissues and organs inside the body), and an orthopedic (branch of medicine concerned with bones and muscles) consult. The ADON stated, there was no comprehensive person-centered care plan regarding Resident 1's right shoulder lump. The ADON stated, a CP should have been developed and implemented for the right shoulder lump because a change in condition (CIC) was completed. The ADON stated, the CP was an individualized, patient- specific plan of care for the resident that the staff should have followed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview on 4/1/25 at 10:48 a.m. with LVN 1, LVN 1 stated, Resident 1 had come to her, pointed to her right shoulder and stated it was hurting. LVN 1 stated, she assessed the right shoulder and a lump was identified. LVN 1 stated, she called the nurse practitioner (NP) and received an order for pain medication. LVN 1 stated, orders for an x-ray and an ultrasound were also received for Resident 1. LVN 1 stated, she completed the SBAR documentation, CIC documentation and started a CP. LVN 1 stated, the importance of a CP was to indicate that the staff had identified a problem, created a goal to solve it and formed ways to intervene if issues arose. LVN 1 stated, the CP was important to keep the issue from happening again and to help the issue improve. During a concurrent phone interview and record review on 4/2/25 at 12:41 p.m. with the Director of Nursing (DON), Resident 1's CPs, undated were reviewed. The CP indicated, . [Resident 1] has a Lump to [right] Chest .Interventions .Encourage good nutrition and hydration in order to promote healthier skin .Identify potential causative [contributing] factors and eliminate/resolve when possible . The DON stated, there was no care plan for the lump to the right shoulder or the bruising to her chest. The DON stated, the CP was very generic, needed more detail and was not sufficient to show what staff were doing or were needing to do. The DON stated, the purpose of a care plan was to identify a problem or a potential problem and required a resident-specific goal. The DON stated, a minimum of 3-4 resident- specific interventions should have been included to direct the staff to mitigate the problem from getting worse or to reduce the risk of the problem. During a review of Resident 1's SBAR Summary for Providers (SBAR) , dated 12/1/24, the SBAR indicated, . The Change in Condition [CIC]/s reported on this CIC Evaluation are/were: Pain .Resident came to [licensed nurse] this evening stating she had pain to the [Right (R)] shoulder, when LN assessed shoulder noticed a lump on the right shoulder. NP was noticed via phone .NP gave order for [hydrocodone and acetaminophen-pain medication] 5/325 [milligram (mg)- unit of weight] [every] 8 hours and xray to area . During a review of Resident 1's Progress Notes (PN) , dated 12/1/24, the PN indicated, .Lump to R chest is causing resident increased pain . During a review of Resident 1's PN, dated 12/2/24, the PN indicated, .[Resident (Res)] on [continued (cont)] monitoring due to Lump to [right upper chest (RUC)]. LN asked to [evaluate] and measure, res agreed and complained of increased pain .Deep purple bruise noted to site .bruise noted to middle of chest and [left] breast. Lump measured 12 [centimeter (cm)- unit of length] x 7cm. Res also complained of R shoulder pain with very minimal movement .NP notified and gave order for STAT [immediate] ultrasound to RUC and STAT x-ray to R shoulder . During a review of Resident 1's Medical Doctor (MD)/Nurse Practitioner (NP) Progress Notes (NPPN) , dated 12/2/24, the NPPN indicated, .Pain in right shoulder .Contusion [bruise] of right front wall of thorax [area between the neck and abdomen], initial encounter .Pain right shoulder: Xray ordered Pain medication adjusted .Right breast hematoma [a closed wound where blood collects and pools]: US [ultrasound] ordered . During a review of Resident 1's PN, dated 12/3/24, the PN indicated, .Res is on cont monitoring due to Lump to RUC .MD evaluated. Bruising to area significantly worse and spread to R breast, chest, L breast, and upper abdomen .MD suspecting torn muscle fibers to pectoralis [muscle in the chest]. Gave order for sling to R arm, referredres to Ortho, and to hold blood thinners x 3 days .Management made aware and updatedto situation . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered , dated 3/22, the P&P indicated, .A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and function needs is developed and implemented for each resident .The care plan interventions are derived from a thorough analysis of the information gathered a part of the comprehensive assessment .The comprehensive, person-centered care plan .includes measurable objectives and timeframes .describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being .interventions address the underlying source(s) of the problem areas(s), not just symptoms or triggers .Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change .The interdisciplinary team reviews and updates the care plan .when there has been a significant change in the resident's condition .