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	04/09/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47298 Based on interview and record review, the facility failed to ensure medications were administered to meet the needs of one of five sampled residents (Resident 1) when nursing staff did not administer lorazepam (medication used to treat anxiety [mental condition which causes intense and persistent worry]) at the specified time frame according to the physician's order. This failure resulted in Resident 1 to receive his medication earlier than the prescribed time and had the potential to cause respiratory depression (characterized by slow and ineffective breathing), drowsiness (tiredness), change in consciousness (how alert and awake someone is), dry mouth, loss of appetite, memory impairment, trouble sleeping, abnormal movements of the body, constipation, and weakness. Findings: During a review of Resident 1's Admission Record (AR- a document that provides resident contact details, a brief medical history) , dated [DATE], the AR indicated, Resident 1 had diagnoses which included .TYPE 2 DIABETES MELLITUS [DM- a disorder characterized by difficulty in blood sugar control and poor wound healing] .UNSPECIFIED DEMENTIA [a progressive state of decline in mental abilities] .WITH ANXIETY . DEPRESSION [persistent state of sadness or loss of interest or pleasure in activities which interferes with daily life] .POST-TRAUMATIC STRESS DISORDER [PTSD- a disorder in which a person has difficulty recovering after experiencing or witnessing a traumatic event] . During an interview on [DATE] at 2:40 p.m. with the Assistant Director of Nursing (ADON), the ADON stated, Resident 1 was admitted to the facility for respite care (temporary relief for caregivers, allowing them to take a break from their caregiving responsibilities). The ADON stated, a medication error occurred on [DATE] when Registered Nurse (RN) 2 incorrectly administered lorazepam to Resident 1. The ADON stated, the side effects of lorazepam included drowsiness, appetite change, memory impairment and respiratory depression. The ADON stated, staff should have made sure to administer medications according to physician's orders in order to avoid overdosing the resident and to give residents the correct medication for their care. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview on [DATE] at 9:41 a.m. with RN 2, RN 2 stated, he had administered lorazepam 0.5 milligrams (mg-unit of weight measurement) to Resident 1 on [DATE] at approximately 4:45 p.m. RN 2 stated, he realized he gave the lorazepam to Resident 1 too early according to MD orders when he went to chart the administration. RN 2 stated, he notified the physician promptly afterwards and was instructed to monitor Resident 1 to see if there were any reactions. RN 2 stated, prior to administration of lorazepam, he should have checked the five rights of medication administration including the right resident, right drug, right dose, right route and right time. RN 2 stated, side effects of lorazepam included drowsiness, changes in level of consciousness, sleep disturbances, abnormal body movements, and weakness. RN 2 stated, he should have followed the physician's orders when administering the lorazepam to Resident 1 to ensure the resident was being taken care of properly. During a concurrent phone interview and record review on [DATE] at 2:20 p.m. with the Director of Nursing (DON), Resident 1's Progress Notes (PN) , dated [DATE] was reviewed. The PN indicated, .[patient] accidentally given [lorazepam] [at] [4 pm] instead of Metformin [medication used to lower blood sugar]. [Patient] is assessed with no new changes present. Will continue to monitor . The DON stated, RN 2 had given a dose of lorazepam to Resident 1 on [DATE] in the afternoon. The DON stated, RN 2 had not verified when the last dose was previously administered due to being distracted during medication administration. The DON stated, RN 2 had administered the lorazepam to Resident 1 too early according to physician's orders. The DON stated, RN 2 should have checked the five rights of medication administration which included the right resident, right drug, right dose, right route and right time. The DON stated, side effects of lorazepam included lethargy (lack of energy), constipation (difficulty passing stool) and dry mouth. The DON stated, it was important to follow the physician's orders for continuity (unbroken and consistent operation) of care and to do the correct thing for the resident. During a concurrent phone interview and record review on [DATE] at 2:41 p.m. with the DON, Resident 1's Medication Administration Record (MAR) , dated [DATE] was reviewed. The MAR indicated, .[lorazepam] Oral Tablet 0.5 MG [unit of weight measurement] .Give 1 tablet by mouth every 8 hours as needed for anxiety -Order Date- [DATE] 1027 . The MAR indicated, Resident 1 was administered lorazepam on [DATE] at 11:27 a.m. and no other administrations of lorazepam were documented on [DATE]. The DON stated, RN 2 had documented on [DATE] the administration of Resident 1's lorazepam on the Controlled Substance Accountability Sheet (CSAS) at 4:43 p.m. but failed to document the administration on the MAR according to policy and procedure (P&P). The DON stated, it was important for RN 2 to document Resident 1's lorazepam administration on the MAR to make sure the physician's orders were followed correctly. During a review of Resident 1's Order Listing Report (OLR) , dated [DATE], the OLR indicated, .[lorazepam] Oral Tablet 0.5 MG .Give 1 tablet by mouth every 8 hours as needed for anxiety . During a review of Resident 1's CSAS , dated [DATE], the CSAS indicated .[Resident 1] .Medication Name/ Strength LORAZEPAM TAB 0.5 MG .Directions TAKE ONE TABLET BY MOUTH EVERY 8 HOURS AS NEEDED FOR ANXIETY .Charting on the medication record is required for each dose administered XXX[DATE] [4:43 p.m.] .Amount Administered 1 .Nurse Signature .[RN 1's initials] . (continued on next page)

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of RN 2's Documented Statement (DS) , dated [DATE], the DS indicated, .On [DATE] [at] approximately ,d+[DATE] pm as I was passing medication I was also attempting to redirect [Resident 1] from entering other rooms and singing louder thus, protecting the milieu [the physical or social setting] of my unit. I read [Resident 1] had [lorazepam] 0.5 mg ordered. My error was not confirming the last dose given, thereby I recognized the symptoms warranted the medication. I gave the medication [lorazepam] 0.5 mg when I checked the medication I realized he had received the dose earlier. The [medical doctor] was notified by phone and I promptly reported the error to her. New orders were given to monitor for any changes . During a review of Resident 1's PN , dated [DATE], the PN indicated, .Resident continues on monitoring for medication error . During a review of Resident 1's Care Plan Report (CPR) , undated, the CPR indicated, .The resident uses anti-anxiety [to reduce feelings of worry or fear] [lorazepam] 0.5 mg [related to] Anxiety disorder .Administer ANTI-ANXIETY medications as ordered by physician . During a review of the Mayo Clinic website, https://www.mayoclinic.org/drugs-supplements/lorazepam-oral-route/description/drg-20072296, dated [DATE], the website indicated, .Lorazepam is used to treat anxiety disorders .Take this medicine only as directed by your doctor. Do not take more of it, do not take it more often .This medicine may cause respiratory depression (serious breathing problem that can be life- threatening) .Side Effects .Drowsiness .Change in consciousness .Dry mouth . General feeling of tiredness or weakness .Loss of appetite .Problems with memory .Trouble sleeping . Twisting movements of body .Uncontrolled movements, especially of the face, neck and back .Constipation . During a review of the facility's P&P titled, MEDICATION ADMINISTRATION- GENERAL GUIDELINES , dated ,d+[DATE], the P&P indicated, .Medications are administered as prescribed in accordance with good nursing principles and practices .FIVE RIGHTS- Right resident, right drug, right dose, right route and right time, are applied for each medication being administered .The medication administration record (MAR) is always employed during medication administration the physician's orders are checked for the correct dosage schedule .Medications are administered in accordance with written orders of the prescriber .Medications are administered within [60 minutes] of scheduled time .The individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given. At the end of each medication pass, the person administering the medications reviews the MAR to ensure necessary doses were administered and documented .When PRN [as needed] medications are administered, the following documented is provided .Date and time of administration, dose, route of administration (if other than oral) . Signature or initials of person recording administration .

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47298 Based on interview and record review, the facility failed to ensure medical records were complete and accurately documented in accordance with accepted professional standards of practice for one of five sampled residents (Resident 1) when Resident 1's dose of lorazepam (medication used to treat anxiety [mental condition which causes intense and persistent worry])was not documented in the Medication Administration Record (MAR) on [DATE] and the complete record of the medication error was not documented in an incident report and Resident 1's clinical record. This failure had the potential to affect the delivery of care and services to Resident 1 and the potential to cause errors in medical treatment and plan of care. Findings: During a review of Resident 1's Admission Record (AR- a document that provides resident contact details, a brief medical history) , dated [DATE], the AR indicated, Resident 1 had diagnoses which included .TYPE 2 DIABETES MELLITUS [DM- a disorder characterized by difficulty in blood sugar control and poor wound healing] .UNSPECIFIED DEMENTIA [a progressive state of decline in mental abilities] .WITH ANXIETY . DEPRESSION [persistent state of sadness or loss of interest or pleasure in activities which interferes with daily life] .POST-TRAUMATIC STRESS DISORDER [PTSD- a disorder in which a person has difficulty recovering after experiencing or witnessing a traumatic event] . During an interview on [DATE] at 2:40 p.m. with the Assistant Director of Nursing (ADON), the ADON stated, Resident 1 was admitted to the facility for respite care (temporary relief for caregivers, allowing them to take a break from their caregiving responsibilities). The ADON stated, a medication error occurred on [DATE] when Registered Nurse (RN) 2 incorrectly administered lorazepam to Resident 1. The ADON stated, an incident report should have been completed due to the medication error that occurred on [DATE]. During a phone interview on [DATE] at 9:41 a.m. with Registered Nurse (RN) 2, RN 2 stated, he had administered lorazepam 0.5 milligrams (mg- unit of weight) to Resident 1 on [DATE] at approximately 4:45 p. m. RN 2 stated, he realized he gave the lorazepam to Resident 1 too early according to MD orders when he went to chart the administration. RN 2 stated, he notified the physician promptly afterwards and was instructed to monitor Resident 1 to see if there were any reactions. RN 2 stated, he did not document the call to the physician. During a phone interview on [DATE] at 10:01 a.m. with the Licensed Vocational Nurse (LVN), the LVN stated, if a medication error occurred, the physician and Director of Nursing (DON) should have been notified. The LVN stated, the physician would have given orders like obtaining blood work or monitoring for 72 hours for any adverse reactions (an undesirable and unexpected effect experienced as a result of taking a medication) to the medication. The LVN stated, risk management should have been notified of the medication error as well as the responsible party (RP). (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent phone interview and record review on [DATE] at 2:20 p.m. with the DON, Resident 1's Progress Notes (PN) , dated [DATE] was reviewed. The PN indicated, .[patient] accidentally given [lorazepam] [at] [4 pm] instead of Metformin [medication used to lower blood sugar]. [Patient] is assessed with no new changes present. Will continue to monitor . The DON stated, RN 2 administered a dose of lorazepam to Resident 1 on [DATE] in the afternoon. The DON stated, RN 2 did not verify when the last dose was previously administered due to being distracted during medication administration. The DON stated, RN 2 administered the lorazepam to Resident 1 too early according to physician's orders. The DON stated, when the medication error occurred, the physician, DON or ADON and the RP should have been notified. The DON stated, physician's orders should have been followed and the oncoming staff should have been given report to know what to do. The DON stated, documentation in an incident report and in Resident 1's clinical record, including what the medication error was, notification of all parties, subsequent physician's orders and monitoring, should have been completed. The DON stated, the PN inadequately documented what the medication error was and did not include all the required documentation according to the policy and procedure (P&P). During a concurrent phone interview and record review on [DATE] at 2:41 p.m. with the DON, Resident 1's Medication Administration Record (MAR) , dated [DATE] was reviewed. The MAR indicated, .[lorazepam] Oral Tablet 0.5 MG [unit of weight measurement] .Give 1 tablet by mouth every 8 hours as needed for anxiety -Order Date- [DATE] [10:27 a.m.] . The MAR indicated, Resident 1 was administered lorazepam on [DATE] at 11:27 a.m. and no other administrations of lorazepam were documented on [DATE]. The DON indicated, RN 2 had documented on [DATE] the administration of Resident 1's lorazepam on the Controlled Substance Accountability Sheet (CSAS) but failed to document the administration on the MAR according to the P&P. The DON stated, it was important for RN 2 to document Resident 1's lorazepam administration on the MAR to make sure the physician's orders were followed correctly. The DON stated, there was not an incident report completed by RN 2. The DON stated, according to the Adverse Consequences and Medication Errors P&P, it was important to document an incident report and in the patient's clinical record an account of the medication error to ensure that the mistake was observed and corrected so it would not happen again. During a review of Resident 1's Order Listing Report (OLR) , dated [DATE], the OLR indicated, .[lorazepam] Oral Tablet 0.5 MG .Give 1 tablet by mouth every 8 hours as needed for anxiety . During a review of Resident 1's CSAS , dated [DATE], the CSAS indicated .[Resident 1] .Medication Name/ Strength LORAZEPAM TAB 0.5 MG .Directions TAKE ONE TABLET BY MOUTH EVERY 8 HOURS AS NEEDED FOR ANXIETY .Charting on the medication record is required for each dose administered XXX[DATE] [4:43 p.m.] .Amount Administered 1 .Nurse Signature .[RN 1's initials] . During a review of Resident 1's PN , dated [DATE], the PN indicated, .Resident continues on monitoring for medication error . During a review of RN 2's Documented Statement (DS) , dated [DATE], the DS indicated, .On [DATE] [at] approximately ,d+[DATE] pm as I was passing medication I was also attempting to redirect [Resident 1] from entering other rooms and singing louder thus, protecting the milieu [the physical or social setting] of my unit. I read [Resident 1] had [lorazepam] 0.5 mg ordered. My error was not confirming the last dose given, thereby I recognized the symptoms warranted the medication. I gave the medication [lorazepam] 0.5 mg when I checked the medication I realized he had received the dose earlier. The [medical doctor] was notified by phone and I promptly reported the error to her. New orders were given to monitor for any changes . (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 review of Resident 1's Care Plan Report (CPR) , undated, the CPR indicated, .The resident uses anti-anxiety [to reduce feelings of worry or fear] [lorazepam] 0.5 mg [related to] Anxiety disorder .Administer ANTI-ANXIETY medications as ordered by physician . During a review of the facility's P&P titled, Documentation of Medication Administration , dated ,d+[DATE], the P&P indicated, .A medication administration record is used to document all medications administered .A nurse .documents all medications administered to each resident on the resident's medication administration record (MAR) .Administration of medication is documented immediately after it is given .Documentation of medication administration includes, as a minimum .the resident's name .name and strength of the drug . dosage .route of administration .date and time of administration .initials, signature and title of the person administering the medication . During a review of the facility's P&P titled, MEDICATION ADMINISTRATION- GENERAL GUIDELINES , dated ,d+[DATE], the P&P indicated, .Medications are administered as prescribed in accordance with good nursing principles and practices .The individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given. At the end of each medication pass, the person administering the medications reviews the MAR to ensure necessary doses were administered and documented .When PRN [as needed] medications are administered, the following documented is provided .Date and time of administration, dose, route of administration (if other than oral) . Signature or initials of person recording administration . During a review of the facility's P&P titled, Adverse Consequences and Medication Errors , dated ,d+[DATE], the P&P indicated, .A ' medication error' is defined as the preparation or administration of drugs .which is not in accordance with physician's orders .Examples of medication errors include .Wrong drug .Wrong time . Document the following information in an incident report and in the resident's clinical record .The resident's name and age .Medication, route, dose, date and time of administration .Factual description of the error . Name of provider and time notified .Provider's orders .Treatment therapy or interventions Resident's condition for 24 to 72 hours or as directed .