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	06/13/2025

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. Based on interview and record review, the facility failed to ensure one of six sampled residents (Resident 1) had the right to retain and use personal possessions when Resident 1 reported a missing pair of shoes and a hinged knee brace on 5/23/25 and staff did not follow facility policy to investigate and offer to replace or reimburse the missing items. This failure resulted in the loss of Resident 1 ' s pair of shoes and hinged knee brace without being replaced or reimbursed for the value of the items. Findings: During a review of Resident 1 ' s admission Record (AR- a document that provides resident contact details, a brief medical history), dated 6/13/25, the AR indicated Resident 1 had diagnoses which included .TYPE 2 DIABETES MELLITUS WITHOUT COMPLICATIONS [a disorder characterized by difficulty in blood sugar control and poor wound healing] .UNSTEADINESS ON FEET .ESSENTIAL (PRIMARY) HYPERTENSION [high blood pressure] .DIFFICULTY IN WALKING . During a review of Resident 1's Minimum Data Set (MDS- a standardized assessment and care screening tool), dated 5/23/25, 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 (an intense inability to think, remember, use judgement and make decisions), 8-12 moderate cognitive impairment (lessened ability to think, remember, use judgement and make decisions), 13-15 no cognitive impairment), which indicated Resident 1 had no cognitive impairment. During an interview on 6/13/25 at 10:29 a.m. with the Social Services Director (SSD), the SSD stated when a resident ' s personal belonging was reported missing, staff searched the resident ' s room, dining room, laundry room, outside and other common areas for the item. The SSD stated staff checked the resident ' s INVENTORY OF PERSONAL EFFECTS (IPE) to see what personal belongings had been reported upon admission by the resident. The SSD stated if the item was still missing after the search, a THEFT AND LOSS MONITORING (TLM) form was completed by the SSD. The SSD stated if the missing item was listed on the resident ' s IPE, it was easier to replace since there was evidence the resident had it upon admission. The SSD stated a missing item not listed on the resident ' s IPE required further investigation but still had the opportunity to be replaced by the facility. The SSD stated the missing item was eligible to be replaced with the same item, a similar item or cash. The SSD stated Resident 2 was discharged on 5/23/25 and had reported his missing items to the SSD during the discharge process. The SSD stated she could not find a TLM form for Resident 1. (continued on next page)

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

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 6/13/25 at 10:43 a.m. with the Registered Nurse (RN), Resident 1 ' s IPE, dated 3/10/25 was reviewed. The IPE indicated, .At the time of admission, record the resident ' s personal belongings by indicating quantity of those items listed .The original copy shall be kept in the resident ' s medical record .Update as needed throughout the resident ' s stay by using the space provided. Upon discharge, use the [check mark symbol] columns to indicate that all personal belongings are accounted for .USE THIS SPACE TO RECORD MISCELLANEOUS INFORMATION (i.e. LOST, STOLEN, RETURNED/GIVEN TO FAMILY, ETC.) . The IPE indicated notes written below the miscellaneous information section was [Brand name of shoes]- Black lost and Hinged Knee Brace- lost. The RN stated an IPE was filled out on admission for each resident. The RN stated if an item was reported missing, the staff checked the IPE to see if the missing item was listed on the IPE. The RN stated Resident 1 ' s IPE was signed by Resident 1 and staff members on admission and discharge. The RN stated Resident 1 ' s IPE indicated Resident 1 was missing a black pair of (Brand name of shoes) shoes and a hinged knee brace. During an interview on 6/13/25 at 11:25 a.m. with the SSD, the SSD stated she did not have Resident 1 ' s TLM form and should have had one. The SSD stated she was responsible for the process of resolving missing resident belongings within ten days. The SSD stated she was past due on resolving Resident 1 ' s missing belongings since it was past the ten-day limit when the items were reported missing. The SSD stated when residents arrived to the facility, they were often in a difficult situation and should not have felt like their missing items were not taken seriously by the staff. The SSD stated Resident 1 ' s missing shoes and hinged knee brace was important to Resident 1 and may have had sentimental value. The SSD stated it was important to validate Resident 1 regarding the importance of the missing items. During a concurrent interview and record review on 6/13/25 at 2:30 p.m. with the Assistant Director of Nursing (ADON), Resident 1 ' s TLM, dated 6/13/25, and Resident 1 ' s Progress Notes (PN), dated 6/13/25 were reviewed. The TLM indicated, .[Resident 1] .DATE: 06/13/2025 .PERSON MAKING REPORT .[SSD] . DATE ITEM WENT MISSING: reported on 05/23/2025 .ITEM LOST .Black [Brand name of shoes] .resident aware .ESTIMATED VALUE OF MISSING ITEMS: ~$100 .ITEM FOUND .NO . The PN indicated, .Placed call to prior resident to follow up on missing black sketcher shoes and hinged knee brace .Writer initiated new theft and loss form .Author: [SSD] . The ADON stated if a resident reported a personal item was missing, the staff asked more questions to investigate the missing item and searched the resident ' s room. The ADON stated the staff referred to the resident ' s IPE for a list of the resident ' s belongings. The ADON stated the facility has replaced resident ' s missing items, even if it wasn ' t listed on the resident ' s IPE. The ADON stated a TLM was filled out for any resident missing items. The ADON stated there was no TLM created when Resident 1 reported the missing shoes and hinged knee brace to staff. The ADON stated the SSD created a new TLM on 6/13/25 which only mentioned the missing pair of shoes, however a PN was also created by SSD indicating Resident 1 was missing both a pair of shoes and a hinged knee brace. The ADON stated the facility should have replaced the missing items as soon as possible. The ADON stated Resident 1 considered the facility his home and Resident 1 ' s belongings should have been in the facility as long as he was. The ADON stated Resident 1 should have had the assurance his belongings were safe and would not have gone missing. (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview on 6/18/25 at 2:47 p.m. with the Director of Nursing (DON), the DON stated when a resident ' s personal belongings were missing, staff searched around the resident ' s room with verbal permission from the resident. The DON stated the resident ' s missing item was then reported to the SSD. The DON stated the SSD was responsible for the process of replacing the missing item or providing a reimbursement if the missing item was not found. The DON stated the resident ' s IPE was referenced in the investigation of the missing item. The DON stated the resident ' s missing item investigation was discussed in the department head meetings. The DON stated Resident 1 reported his missing pair of shoes and hinged knee brace while being discharged on 5/23/25. The DON stated the process of investigating Resident 1 ' s missing items and offering a refund or replacement for the missing items should have been done as quickly as possible, but not longer than a week. The DON stated there was no theft and loss form completed for Resident 1 ' s missing items and there was no follow up after Resident 1 was discharged . The DON stated it was important to ensure Resident 1 had the right to retain and use his personal possessions to promote his emotional health and the usual routine he desired. During a review of the facility ' s policy and procedure (P&P) titled, THEFT & LOSS, undated, the P&P indicated, .While recognizing that the facility cannot safeguard all personal property and valuables that are in the possession of a resident, and that all theft and loss cannot be completely eliminated, the facility nevertheless will make reasonable efforts to safeguard resident ' s property and reduce the incidence of theft and loss .Any property with the value of $25 or more lost within [facility name acronym] must be reported to the Director of Nursing. This report will be handled as a normal Public Safety Department Incident Report which must include: (a) A description of the lost article (b) Estimated value (c) Date and time the loss as discovered (d) If determinable, the date and time the theft or loss occurred (e) Any action taken .A written resident personal property inventory is establishes upon admission with nursing and retained during the resident ' s stay in the long-term health-care and/or acute care facility .All reported losses will be documented and reported on the [facility name acronym] Occurrence/Incident Report .