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	02/12/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan that includes measurable objectives and timeframes for three of three sampled residents (Resident 1, 2, and 3), when:1. Resident 1 had an unwitnessed fall on [DATE] and there was no care plan following a left hip fracture.This failure had the potential to result in delayed detection of post-operative complications such as pain, infection and immobility to Resident 1's left hip following surgery.2. Resident 2 had an unwitnessed fall on [DATE] and the neuro check (a focused neurological evaluation used to monitor changes in a patient's functional status such as blood pressure, temperature, pulse, respiration, right pupil [the black, circular opening in the center of the eye that regulates the amount of light] size, left pupil size, right hand grip, and left hand grip) was not completed according to Resident 2's care plan and the Interdisciplinary Team (IDT - a group of staff members consisting of physicians, nursing, dietary, rehabilitation, social services, activities, and administration who meet regularly to discuss incidents that occurred involving the well-being of residents and staff) note was not completed after the fall.This failure had the potential for delayed detection of neurological changes which could lead to irreversible functional impairment for Resident 2 and the IDT to miss opportunities to discuss, intervene, prevent, and care plan for the needs of Resident 2.3. Resident 3 had an unwitnessed fall on [DATE] and there was no documentation to validate Resident 3 was monitored every two hours according to Resident 3's care plan.This failure had the potential for unanticipated assistance from staff to check on Resident 3's pain, positioning, and toileting needs.Findings:During a concurrent observation and interview on [DATE] at 10 a.m. with Resident 1, in Resident 1's room, Resident 1 was lying in bed with an incision on the left hip. The incision was clean, dry, and intact. Resident 1 stated she spilled water on the floor, and when she stood up to go to the closet, she slipped on the floor with her legs split apart and fractured her left hip. Resident 1 stated she had surgery on the left hip. Resident 1 stated the pain to her left hip was 5 out of 10 (scale used to measure the level pain a person is experiencing with a score of 0 indicating no pain up to a score of 10 indicating worse pain imaginable).During a concurrent observation and interview on [DATE] at 10:12 a.m. with Resident 2, in Resident 2's room, Resident 2 was lying in bed. Resident 2 stated he fell a long time ago in the facility. Resident 2 was unable to provide information about the fall. Resident 2 denied pain or discomfort.During a concurrent observation and interview on [DATE] at 10:26 a.m. with Resident 3, Resident 3 was sitting in his wheelchair in the activities room. Resident 3 was escorted to the conference room for an interview. Resident 3 stated he fell a month ago while he was walking toward his bed. Resident 3 denied pain or discomfort.During a record review of Resident 1's admission Record, dated [DATE], the AR indicated Resident 1 had a diagnosis of Chronic Obstructive Pulmonary Disease (a progressive lung condition characterized by chronic respiratory symptoms and persistent irreversible airflow (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

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	02/12/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	limitation), Peripheral Vascular Disease (condition in which narrowed arteries reduce blood flow to the arms or legs), Malignant Neoplasm of Anal Canal (a cancer that affects the tissues of the anus), Colostomy (a surgical procedure that creates an opening in the abdominal wall, connecting the colon to the outside of the body to allow stool to bypass a damaged or diseased part of the intestines), and Dementia (a condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking).During a record review of Resident 1's Minimum Data Set (MDS - process for clinical assessment of all residents of long term care nursing facilities). dated [DATE], the MDS indicated, Resident 1's Brief Interview for Mental Status (BIMS - an assessment of a resident's cognitive status; the ability to remember, concentrate, learn new things, and/or make decisions that affect their everyday life) score was 14 (a score of 0 to 7 indicated severe impairment, 8 to 12 indicated moderate impairment, and 13 to 15 indicated minimal to no impairment). Resident 1's Functional Abilities for Activities of Daily Living (ADL- dressing, toileting, washing, feeding, mobility, and transferring) score was 3, indicating Resident 1 required partial or moderate assistance and helper does less than half the effort.During a concurrent interview and record review on [DATE] at 10:40 a.m. with the Director of Nursing (DON), Resident 1's Post Fall Evaluation (PFE), dated [DATE] was reviewed. The PFE indicated Resident 1's pre-fall risk and post-fall risk score was not completed. The DON stated Resident 1's pre-fall risk and post-fall risk score should have been completed to determine Resident 1's fall risk status and it was not.During a record review of Resident 1's ER (emergency room) Transfer Out (ERTO), dated [DATE], the ERTO indicated, .received a phone call from resident, resident stated I'm in my room and I'm not ok. Upon arrival, resident was found sitting in the recliner chair, when asked what's going on, resident replied that she attempted to get up and slipped on a small puddle of water near her bed and did a full slip, and her left hip is hurting and she's not able to bear weight. Resident denied falling or hitting her head. attempted to assess the left hip, resident screamed in agony. NP (Nurse Practitioner) notified, ordered to send to ER for possible hip fracture.During a record review of Resident 1's IDT Post Incident Meeting (IDT), dated [DATE], the IDT indicated, Date of fall event: [DATE]. Immediate corrective action: Resident was assessed with injuries. Noted to have left foot turned outward slightly and complained of pain with mobility. Notifications to NP and son with orders processed for transfer to [name of hospital] ER. Root Cause Analysis: Resident elects to be independent in all ADLs (Activities of Daily Living; dressing, toileting, washing, feeding, mobility, and transferring). Initiates activities and ambulation. Resident identified water on the floor caused me to slip. A small cup of water spill on the floor was noted and presumed to be from her own water cup. Plan of Correction: Transfer to ER. Upon return will provide [name of Resident 1] with a water container that has a lid and straw attached to prevent spills. Upon her return, she will be instructed to ask for help with ADLs. Upon return will conduct frequent rounds.During a record review of Resident 1's Immediate Post Operative Note (IPON), dated [DATE], the IPON indicated, Pre-Procedure Diagnosis: Left femoral [upper leg bone] neck fracture. Procedure(s) Performed: Left hip hemiarthroplasty [a surgical procedure that replaces only one half of a joint, typically the femoral head in the hip while leaving the natural socket intact].During an interview on [DATE] at 12 p.m. with the DON, the DON stated the admitting nurse should have implemented a care plan for Resident 1 when Resident 1 returned from hospital and did not.During an interview on [DATE] at 1:08 p.m. with the Registered Nurse (RN), the RN stated he readmitted Resident 1 on [DATE] when Resident 1 returned from the hospital. The RN stated Resident 1 had a fall on [DATE] and fractured her left hip. The RN stated Resident 1 was transferred to the hospital after the fall and had hip surgery. The RN stated a care plan was required to be completed (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	02/12/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	during the admission process and it was not. The RN stated the care plan should have been implemented to address Resident 1's needs after having hip surgery to ensure ongoing issues were resolved. The RN stated care plans should be resident specific and should be implemented immediately upon admission and when the resident had a change in condition.During an interview on [DATE] at 1:38 p.m. with Licensed Vocation Nurse (LVN) 1, LVN 1 stated care plans should be implemented immediately upon admission and any change in condition. LVN 1 stated any licensed staff could implement a care plan. LVN 1 stated the purpose of the care plan was to monitor the residents' progress, ensure continuity of care and anticipate the residents' needs.During a record review of Resident 2's AR, dated [DATE], the AR indicated Resident 1 had a diagnosis of Chronic Obstructive Pulmonary Disease, Schizophrenia (a chronic, severe brain disorder that causes individuals to lose touch with reality, disrupting their thoughts, emotions, and behaviors), Orthostatic Hypotension (a sudden drop in blood pressure when blood flow to the brain is temporarily reduced upon standing causing lightheadedness, dizziness, blurred vision, weakness, and fainting), and Unsteadiness on Feet (unable to stand or walk normally).During a record review of Resident 2's MDS, dated [DATE], the MDS indicated, Resident 2's BIMS score was 13. Resident 2's Functional Abilities for ADLs score was between 3 and 4, indicating Resident 1 required partial or moderate assistance and helper does less than half the effort.During a record review of Resident 2's PFE, dated [DATE], the PFE indicated Resident 2's pre-fall risk score was 75 and Resident 2's post-fall score was 80 indicating Resident 2 had a high risk of falling.During a record review of Resident 2's Care Plan Report (CPR), dated [DATE], the CPR indicated, [name of Resident 2] has had an actual fall with no injury. Unsteady gait/poor safety awareness. Interventions: Initiated Neuro checks 72 [hours].During an interview on [DATE] at 10:40 a.m. with the DON, the DON stated Resident 2's IDT record was not completed after the unwitnessed fall on [DATE]. The DON stated the IDT met to discuss Resident 2's fall but she did not document the meeting took place and should have.During a concurrent interview and record review on [DATE] at 10:40 a.m. with the DON, Resident 2's Neuro checks (NC), dated [DATE] was reviewed. The NC indicated the form was completed on [DATE] in the Electronic Medical Record (EMR). The DON stated the remaining neuro check from [DATE] through [DATE] should have been completed in paper form and uploaded to the EMR. The DON stated the remaining neuro check could not be located. The DON stated if the remaining documentation for the neuro check was not located, the neuro check was not completed.During an interview on [DATE] at 1:38 p.m. with LVN 2, LVN 2 stated Resident 2 can walk but was unsteady and had a high fall risk. LVN 2 stated neuro checks were required for all unwitnessed falls in case the resident had a head injury which could lead to severe neurological impairment. LVN 2 stated the neuro check was to make sure the vital signs (blood pressure, heart rate, respiratory rate and oxygen level), strength, pain, and pupils were stable. LVN 2 stated early changes could detect head injury. LVN 2 stated when the neuro check was completed, the nurse was required to place the neuro check form in the medical record box located at the nursing station for the Medical Record Director to scan and upload into the resident's EMR. LVN 2 stated medical records should be complete and accurate to reflect the care provided to the residents.During a record review of Resident 3's AR, dated [DATE], the AR indicated Resident 3 had a diagnosis of Chronic Obstructive Pulmonary Disease, Schizophrenia, Muscle Weakness, Malignant Neoplasm of Left Lung (a cancer that affects the tissues of the lung), Cervical Disc Disorder at C5-C6 level with Radiculopathy (damage to the lower neck compressing nerve roots, causing neck pain that radiates into the shoulder, arm, biceps, or thumb), and Unsteadiness on Feet.During a record review of Resident 3's MDS, dated [DATE], the MDS indicated Resident 3's BIMS score was 11 . Resident 3's Functional Abilities for ADLs score was 3, indicating Resident 1 required partial or moderate assistance and (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	02/12/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	helper does less than half the effort.During a record review of Resident 3's PFE, dated [DATE], the PFE indicated Resident 3's pre-fall risk score was 55 and Resident 3's post-fall score was 65 indicating Resident 3 had a high risk of falling.During a record review of Resident 3's IDT, dated [DATE], the IDT indicated, Description of Event: Unwitnessed fall event on [DATE] at approximately 3:30 p.m. [name of Resident 3] was found sitting on the floor by his bed. No injuries noted on observation of his skin. He initiated transfer from bed with intent to go to the bathroom. Outcomes of Physical Assessment: .Decrease urine output. Nursing observations, evaluation, and recommendations are: Patient lower abdomen is distended. LN [Licensed Nurse] check with bladder scanner noting 999 ml [milliliter - unit of measurement] of urine in bladder, attempted to straight cath [a procedure used to drain the bladder with a flexible hollow tube] patient to empty bladder was unsuccessful. NP gave order to send patient out to ER for evaluation.During a record review of Resident 3's CPR, dated [DATE], the CPR indicated, Unwitnessed fall even on [DATE] at approximately 3:30 p.m. [name of Resident 3] was found sitting on the floor by his bed. Interventions: Frequent rounding [every two hours] check for pain, placement, position, and toilet needs.During an interview on [DATE] at 10:40 a.m. with the DON, the DON stated the facility could not produce documentation that staff checked on Resident 3 every two hours. The DON stated if there was no documentation that staff checked on Resident 3 every two hours, staff did not check on Resident 3 every two hours.During an interview on [DATE] at 12:48 p.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated staff were required to check on a resident every two hours to see if the resident needed to go to the bathroom, needed the briefs changed, had pain or to see if the resident needed anything. CNA 1 stated checking on the residents frequently was required to prevent skin breakdowns, infections, and falls. CNA 1 stated when staff checked on a resident, staff documented the check in the resident's EMR. CNA 1 was unable to locate documentation when Resident 3 was last checked on.During an interview on [DATE] at 1:25 p.m. with CNA 2, CNA 2 stated staff was required to check on residents frequently to prevent skin breakdown from soiled briefs, prevent infection and falls. CNA 2 stated staff were required to check on Resident 3 at least two times an hour. CNA 2 stated when residents did not need assistance during the check, staff were required to select not applicable in the resident's ADL's section of Point of Care in the EMR. CNA 2 stated the program will date and time stamp the selection. CNA 2 was unable to locate documentation when Resident 3 was last checked on.During an interview on [DATE] at 2:09 p.m. with the Medical Records Director (MRD), the MRD stated she audited the EMR quarterly (every three months) to ensure care plans were updated when there was a change in condition, the physician's history and physical were completed monthly, order history and evaluations were uploaded. The MRD stated residents should have care plans specific to their needs and implemented during the admission process and when there is a change in condition. The MRD stated licensed nurses were required to submit the neuro check form once completed into the medical records inbox located at each nursing station to be uploaded into the resident's EMR. The MRD stated she was unable to locate Resident 2's neuro checks for [DATE] through [DATE]. The MRD stated licensed nurses were notified and an audit binder with the licensed nurse's name was required to locate or produce the [DATE] and [DATE] neuro checks for Resident 2. The MRD stated she could generate the percentage of staff checking on a resident every two hours to ensure the residents were checked on as required but was unable to locate documentation of when the resident was last checked on. The MRD stated maintaining complete and accurate documentation was required to stay in compliance with federal regulations and to ensure care was provided for the residents as ordered.During an interview on [DATE] at 2:19 p.m. with the DON, the DON stated care plans were required to ensure continuity of care for each resident. The DON stated a resident's care plan was (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	02/12/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	implemented on admission and when there was a change in condition. The DON stated each department was responsible for developing specific care plans to meet the residents' needs. The DON stated neuro checks were required to be complete and accurate to detect changes in the residents' neurological status. The DON stated an IDT note was required to be documented to indicate the IDT met to discuss the incident, cause, and implement interventions for the care plan. The DON stated every two hourly check was required when there was a change in condition to reduce risk for falls, to check on the resident's bowel and bladder status, and to ensure the residents' needs were met. The DON stated the facility should be able to generate reports that staff checked on the residents evert two hours but could not. The DON stated medical records should be complete and accurate to reflect the care provided.During an interview on [DATE] at 2:40 p.m. with the Administrator (ADM), the ADM stated not implementing a care plan for Resident 1 upon return from the hospital after having surgery, missing the neuro check records and not completing the IDT note for Resident 2 after an unwitnessed fall, and not being able to provide documentation that Resident 3 was checked on every two hours according to the care plans were unacceptable. The ADM stated licensed nurses, the DON and the MRD were responsible for ensuring the completeness and accuracy of the residents' medical records. The ADM stated care plans should be resident specific and address the residents' preferences and orders to ensure the residents' needs were met. The ADM stated care plans should be implemented upon admission, return from the hospital and any change in the residents' condition. The ADM stated medical records should be complete and accurate to reflect the care provided.During a review of the facility's policy and procedure (P&P) titled, Fall Risk Assessment, dated 3/2018, the P&P indicated, Policy Statement: The nursing staff, in conjunction with the attending physician, consultant pharmacist, therapy staff, and others, will seek to identify and document resident risk factors for falls and establish a resident-centered falls prevention plan based on relevant assessment information.During a review of the facility's P&P titled, Goals and Objectives, Care Plan, dated 4/2009, the P&P indicated, Policy Statement: Care plans shall incorporate goals and objectives that lead to the resident's highest obtainable level of independence. Policy Interpretation and Implementation: 1. Care plan goals and objectives are defined as the desired outcomes for a specific resident problem. 3. Care plan goals and objectives are driven from information contained in the resident's comprehensive assessment and: a. are resident oriented; b. are behaviorally stated; c. are measurable; and d. contain timetables to meet the resident's needs in accordance with the comprehensive assessment.During a review of the facility's P&P titled, Care Planning - Interdisciplinary Team, dated 3/2022, the P&P indicated, Policy Statement: The interdisciplinary team is responsible for the development of resident care plans. Policy Interpretation and Implementation: .2. Comprehensive, person-centered care plans are based on resident assessments and developed by an interdisciplinary team (IDT).During a review of the facility's policy and procedure (P&P) titled, Charting and Documentation, dated 4/2021, the P&P indicated, Policy Statement: 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 medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Policy Interpretation and Implementation: 1. Documentation in the medical record may be electronic, manual or a combination. 3. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.