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	03/10/2026

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 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** Based on interview and record review the facility failed to timely review and revise residents' comprehensive, personˆcentered care plans after significant changes in condition and or behavior following a residentˆtoˆresident aggression on 02/20/2026 and 02/21/2026 when: Three of four sampled residents ((Res) 1, Res 3, and Res 4), did not have care plan updates documented in accordance with the facility policy. 2. Two of four sampled residents (Res 1 and Res 2), had no interdisciplinary team (IDT - a collaborative group of professionals including nurses, doctors, therapists, social workers, and dietitians who meet regularly to plan and manage a resident's care) documentation after the significant incident on 2/20/26. 3. One of four sampled residents (Res 2), had lack of documented followˆup on roomˆchange and safety measures after being followed by social services.These failures to timely reassess, implement interventions, and revise care plans placed Res 1, Res 2, Res 3, and Res 4 at risk for psychosocial distress (emotional suffering that may include fear, anxiety, agitation or decrease sense of safety resulting from unaddressed stressful events), and concerns for their physical wellbeing. Findings:During a review of the Res 1's (Physician (MD)/Nurse Practitioner (NP)) Progress note, dated 3/4/26, the MD/NP Progress note indicated Res 1 was a [AGE] year-old male who was admitted to the facility on [DATE] after hospitalization. Res 1 had a significant past medical history of high blood pressure (force of blood pushing against the walls of blood vessels is too high), hyperlipemia (high level of fat in blood), prostate cancer (cancer happens when cells in the prostate (small, walnut-sized gland that is part of the male reproductive system) start growing abnormally and uncontrollably), depression (common mood disorder causing persistent sadness, loss of interest, fatigue, and cognitive difficulties that impair daily functioning), dementia (decline in mental ability that is severe enough to interfere with a person's daily life, such as forgetting names, misplacing items, or losing the ability to perform familiar tasks), and Obstructive Sleep Apnea (OSA - common, serious disorder where breathing repeatedly stops and starts during sleep due to throat muscle relaxation, causing loud snoring, choking, and daytime fatigue). The MD/NP Progress note indicated RES 1 presented to [Hospital A] with altered mental status and had a recurrent right subdural hematoma (life-threatening collection of blood between the brain's outer covering (dura) and its surface) and was admitted for further evaluation and management.During a concurrent interview and record review on 3/10/26 at 12:08 p.m. with the Director of Nursing (DON) and the Medical Record Director (DMR), Res 1's electronic medical record (EMR), dated 2/20/26 through 2/23/26 were reviewed. The DON stated the Nurses note indicated on 2/20/26 at 7:36 p.m. Res 1 went in to Res 2's room and Res 1 . began throwing [Res 2's] items everywhere and then grabbed [Res 2] by ankles and began shaking [and] squeezing . [REPORT OF SUSPECTED DEPENDENT ADULT/ELDER ABUSE (SOC 341)] completed. The DON stated Res 1 had another incident on 2/21/26 and the Nurses note on 2/21/26 at 7:05 p.m. indicated, .This writer was called in the [Res 1's] room [at 7:10 p.m.], resident was very aggressive behavior towards the roommate and the family member, resident also physically aggressive towards this writer, resident was redirected and moved away from other residents, [responsible party] was also notified and 911 was also called. The DON stated the Nurses (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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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	note on 2/22/26 at 12:32 a.m. indicated, . At the start at shift. Resident was out in the hallway yelling and throwing walker, glove boxes, ice chest, and anything he could get his hands on at staff and other residents. Writer responded and wheeled residents away from [Res 1] to prevent injury in results of resident's aggressive behavior. When writer was responding resident spit on writers face and said . Multiple staff assisted with situating and [Res 1] eventually was redirected to his room. After speaking to resident's roommates' daughter, she stated that she was visiting with her father and resident started yelling at her and demanding that they get out of the room. [Res 1] then began to spit at them and throwing his walker towards resident, daughter got in between. per resident's daughter he hit her with his walker. MD notified, RP notified, 911 called. The DON stated the IDT notes on 2/23/26 at 2:11 p.m. did not indicate the first incident on 2/20/26 was discussed or reviewed in the IDT meeting. The DON stated the second incident on 2/21/26 was discussed along with interventions and recommendations. The DON stated the care plans were not updated after the first incident on 2/20/26, however, after the second incident, the care plan was reviewed and updated as needed along with IDT recommendations. The DON stated the care plans and IDT notes should have been updated after the first incident on 2/20/26. The DON stated it was important to update care plans and discuss each incident in the IDT meeting to ensure the appropriate precautions and interventions were in place to ensure resident safety and appropriate care. The DON stated the incident occurred on Friday and she was on the phone with the staff the same day, interventions were discussed and implemented, however, the documentation did not reflect any of that. The DON stated Res 1 was placed on close monitoring, and the facility had brought in extra staff for frequent monitoring and observation. The DON stated documentation did reflect Res 1 was observed throughout the night and after the second incident, Res 1 was placed with a sitter. The DON stated she expected facility nursing staff to update care plans after any unusual occurrences and also expected the IDT to discuss and make recommendations to ensure resident safety and appropriate care.During a review of the Res 2's MD/NP Progress note, dated 2/25/26, the MD/NP Progress note indicated Res 2 was a [AGE] year old male admitted to the facility initially on 08/02/24 after hospitalization and Res 2 had a significant past medical history that included Atrial fibrillation (A-fib - a common, irregular, and often rapid heart rate causing the heart's upper chambers to quiver instead of beating effectively), congestive heart failure (CHF - chronic, progressive condition where the heart pumps inefficiently, causing fluid backup (congestion) in the lungs or body and fatigue), Transient ischemic attack (TIA - temporary blockage of blood flow to the brain causing sudden, stroke like symptoms), sleep apnea (a common, serious disorder where breathing repeatedly stops and starts during sleep, leading to low blood oxygen levels), asthma (respiratory disease that causes inflammation, swelling, and tightening of the airways). Res 2 was readmitted to this facility on 11/19/25 after hospitalization for evaluation of shortness of breath.During a concurrent interview and record review on 3/10/26 at 12:45 p.m. with the DON and the DMR, Res 2's EMR, dated 2/20/26 through 2/23/26 were reviewed. The DMR stated the nurses note on 2/20/26 at 7:33 p.m. indicated, [Res 2] was lying in his room when offending resident came into his room via the bathroom. Resident said that the offending resident began throwing his items and grabbed him by his ankles and began squeezing shaking. Resident assessed for injury, No redness noted to affected site. Management notified. MD Notified. Family notified. Police notified. Ombudsman notified. SOC 341 completed. The DMR stated she was unable to find any IDT notes regarding this incident in Res 2's EMR. The DMR stated the care plan was updated after the incident on 2/20/26. The DMR also stated the social worker and social services note on 2/23/26 at 2:06 p.m. indicated, . Writer met with resident in his room to follow up on incident from 02/20/2026 involving another male resident. Writer greeted resident and asked how he was doing. Resident answered, I'm breathing. Resident conversed with resident for a while and asked him if he felt safe. Resident stated, As long as that idiot [Res 1] next door stays in his room. Writer asked resident what had occurred on Friday. Resident stated, He came out of the bathroom and asked me what I was doing in his room. I tried to tell him that this was my room but he grabbed me by the ankles and tried to pull (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	me out of bed. I was going to kick him but I had no strength. Resident stated that the other resident [Res 1] then left the room and did not return. Resident continues to state he feels safe in his room as long as other resident [Res 1] does not come back in. IDT to discuss room changes or other measures to ensure resident safety and wellbeing. The DMR stated she was unable to find any documentation regarding the discussion of room changes or follow-up with the IDT team. The DON stated and validated that she was unable to find any IDT notes or any other documentation regarding the room change options or other measures to ensure resident safety was discussed or evaluated as recommended options to consider by social services notes or other staff members. The DON stated multiple discussions occurred and a sitter was placed for Res 1, however, the IDT failed to document in notes. The DON stated it was important to formally discuss an incident of abuse, and document the planned recommendations and interventions to ensure resident safety and to ensure care was personalized to each resident's needs.During an interview on 3/10/26 at 10:24 a.m. with Res 2, Res 2 stated Res 1 came to his room, through the shared bathroom between both of their rooms. Res 2 stated Res 1 grabbed him by the ankles and attempted to pull him off of his bed. Res 2 stated Res 1 was yelling, screaming and was using profanity at him. Res 2 stated Res 1 threw his blanket on the floor. Res 2 stated he did not feel safe with Res 1 being around him in the room next door with shared a bathroom. Res 2 stated his other room mate [Res 3] and him were using a wheelchair with locked wheels to block off the door to prevent Res 1 from entering their room and hurting them. Res 2 stated he had expressed his concerns to the case manager and facility staff. Res 2 stated Res 1 still had access to the bathroom and it opened on both sides, which meant Res 1 could enter their room any time. Res 2 stated he was not sure what the facility was doing to make sure he was safe in his room from Res 1 but Res 1 had not entered his room since the incident.During a phone interview on 3/12/26 at 2:40 p.m. with the Director of Social Services (DSS), the DSS stated she was familiar with Res 2. The DSS stated she had communicated the room change interventions to consider for Res 2 to the facility leadership team. The DSS stated she was unable to find any IDT notes. The DSS stated it was important to have the IDT meetings and document everything to ensure residents were receiving safe care. The DSS stated Res 2 felt safe and did not want to change his room when she followed up with Res 2. The DSS stated the IDT team met to discuss interventions and recommendations with the leadership team and developed appropriate care plans for the residents. The DSS stated she expected all the IDT interventions to be documented and care plans to be updated as needed, however, she would have to defer to nursing leadership for care plan expectations.During a review of Res 3's History and Physical (H&P), dated 8/31/24, the H &P indicated Res 3 was admitted to the skilled nursing facility for generalized weakness. Res 3's past medical history included hypothyroidism (condition where thyroid gland is underactive and does not make enough of its special hormones), osteoarthritis (chronic degenerative joint disease where cartilage breaks down, causing pain, swelling, and reduced motion, commonly in the hands, hips, knees, and spine), anemia (condition characterized by a lack of body's ability to carry sufficient oxygen to body tissues, resulting in fatigue, weakness, and pale skin) and hyperlipemia (excess of fat in blood). The H&P indicated Res 3 had generalized weakness and was unable to take care of himself.During a concurrent interview and record review on 3/10/26 at 1:10 p.m. with the DON and the DMR, Res 3's EMR, dated 2/20/26 through 2/23/26 were reviewed. The DMR stated she was unable to find any IDT notes, care plan updates or nursing assessments regarding the incident on 2/20/26 when Res 2 went in to Res 1 & Res 3's room and grabbed resident Res 1 and attempted to pull him off the bed. The DMR stated the social services note indicated social services saw and evaluated resident on 2/23/26 at 2:18 p.m. The DON stated the DSS note on 2/23/26 at 2:18 p.m. indicated, Writer met with resident in his room regarding the event on 02/20/2026 involving his roommate and another resident. This resident states he feels safe in his room and he is doing fine but concerned for his roommate [Res 2]. Writer assured him this facility is taking steps to ensure safety of all residents. Resident expressed gratitude and continued to state he feels safe in his current room. SSD to continue to follow. The DON stated Res 3 was in the (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	room and was a witness to the incident, however, the altercation occurred between Res 1 and Res 2. The DON stated and validated Res 3 was present, witnessed the entire incident and was also present when Res 1 was yelling, using profanity and screaming at Res 2, however, she was not aware if Res 1 said anything to Res 3. The DON stated she was unable to comment on why the nurses did not document and update his care plan as Res 3 was assessed after the incident on 2/20/26. The DON stated Res 3's care plan should have been updated, and she would have expected to see nursing assessments documented as Res 3 experienced yelling and screaming by another resident. The DON stated the documentation was important and although the staff informed her Res 3 was assessed for injuries and wellbeing, without documentation she was not able to confirm it was done. The DON stated social services assessed Res 3 and no concerns were observed.During a phone interview on 3/12/26 at 2:45 p.m. with the DSS, the DSS stated the social services team evaluated Res 3 on 2/23/26 after the incident on 2/20/26 and Res 3 did not express any concerns. The DSS reviewed her note from 2/23/26 at 2:18 p.m. and stated Res 3 felt safe, however, he did express concerns for his roommate [Res 2's] safety. The DSS stated those concerns were shared with the IDT team. The DSS stated the care plan should have been updated as per the facility policy.During an interview on 3/10/26 at 2 p.m. with Res 3, Res 3 stated he was concerned about Res 1 coming into the room and hurting Res 2. Res 3 stated him and Res 2 had to keep the bathroom door secure by placing a wheelchair with locked wheels outside the bathroom door to prevent Res 1 from entering their room. Res 3 stated he was the president for resident council and was concerned for other residents' safety. Res 3 stated he felt safe for himself, but Res 2, his neighbor needed help. Res 3 stated Res 1 came in their room, started yelling profanity and screaming at both him and Res 2, but did not say anything to him or came close to him. Res 3 stated Res 1 was mostly in Res 2's personal space. During a review of Res 4's Progress Note, dated 9/4/25, the Progress note indicated Res 4 had dementia and used a wheelchair. Res 4 was admitted to the skilled nursing facility for generalized weakened. The Progress Note indicated Res 4's past medical history included Gastroesophageal Reflux Disease (GERD - a chronic condition where stomach acid frequently flows back into the esophagus, causing persistent heartburn, chest pain, and potential esophageal damage), high blood pressure, dementia, and benign prostatic hypertrophy (BPH - noncancerous enlargement of the prostate gland, common in men over 50, causing bladder outlet obstruction).During a concurrent interview and record review on 3/10/26 at 1:10 p.m. with the DON and the DMR, Res 4's EMR, dated 2/21/26 was reviewed. The DON stated Res 4 was Res 1's roommate on 2/21/26 and this was the second incident with Res 1 that was reported for resident-to-resident aggression. The DON stated Res 4's daughter was visiting him and was present at bedside when Res 1 started to get aggressive and verbally hostile towards Res 4 and his daughter. The DON stated Res 4's daughter felt that Res 1 was going towards Res 4 and she placed herself in the middle to prevent any harm to Res 4. The DON stated staff intervened and had both Res 4 and his daughter removed to ensure safety. The DON stated Res 1 started to throw things at the residents and staff. The DON stated the situation was de-escalated, law enforcement and responsible parties were notified. The DON stated Res 4's daughter elected to take Res 4 home that day and it was arranged with the provider. The DON stated Res 4 returned the next day and was placed in a new room. The DON stated the DSS followed up, however, she was unable to find any updates to the care plan regarding the incident. The DON stated she expected staff to update care plans after any unusual occurrences. The DON stated it was important to update the care plan for Res 4 after the incident with Res 1 to ensure resident safety and resident centered care.During a phone interview on 3/12/26 at 2:50 p.m. with the DSS, the DSS stated the care plan for Res 4 should have been updated after the incident with Res 1 as per the facility's policy. The DSS stated the DON would be the best person to comment on the expectations for care plans. The DSS stated Res 4 was assessed for a room change and no issues were identified by social services.During a review of the facility's policy and procedures (P&P) titled, Care Plans, Comprehensive Person-Centered, dated March 2022, the P&P indicated, A comprehensive, person-centered care plan that includes measurable (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident . The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident . The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MOS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission . The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment . The comprehensive, person-centered care plan . describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . reflects currently recognized standards of practice for problem areas and conditions . Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making . 11. 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 . when the desired outcome is not met .During a review of the facility's P&P titled, Behavioral Assessment, Intervention and Monitoring, dated March 2019, the P&P indicated, . The facility will provide and residents will receive behavioral health services as needed to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care . As part of the comprehensive assessment, staff will evaluate, based on input from the resident, family and caregivers, review of medical record and general observations . The resident's usual patterns of cognition, mood and behavior . The nursing staff will identify, document, and inform the physician about specific details regarding changes in an individual's mental status, behavior, and cognition . New onset or changes in behavior will be documented regardless of the degree of risk to the resident or others . The interdisciplinary team will thoroughly evaluate new or changing behavioral symptoms in order to identify underlying causes and address any modifiable factors that may have contributed to the resident's change in condition . The interdisciplinary team will evaluate behavioral symptoms in residents to determine the degree of severity, distress and potential safety risk to the resident, and develop a plan of care accordingly . Interventions will be individualized and part of an overall care environment that supports physical, functional and psychosocial needs, and strives to understand, prevent or relieve the resident's distress or loss of abilities . If the resident is being treated for altered behavior or mood, the IDT will seek and document any improvements or worsening in the individual's behavior, mood, and function . The IDT will monitor the progress of individuals with impaired cognition and behavior until stable. New or emergent symptoms will be documented and reported .

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure medications were administered with adequate clinical indication and clear parameters for one of four sampled residents (Resident (Res) 1), when Res 1 had two active as needed medication orders for the same medication with different dosages and the same administration criteria, which required nurses to select the dose based on their personal judgment rather than physician directed parameters.This failure had the potential to result in over medication or undermedication of Res 1 and placed Res 1, an already vulnerable patient in a nursing home at risk of receiving an unnecessary medication dose.Findings:During a review of Res 1's [Physician (MD)/ Nurse Practitioners(NP)] Progress note, dated 3/4/26, the MD/NP Progress note indicated Res 1 was a [AGE] year old male who was admitted to the facility on [DATE] after hospitalization. The MD/NP Progress note indicated Res 1 had a significant past medical history of high blood pressure (force of blood pushing against the walls of blood vessels is too high), hyperlipemia (high level of fat in blood), prostate cancer (cancer happens when cells in the prostate (small, walnut-sized gland that is part of the male reproductive system) start growing abnormally and uncontrollably), depression (common mood disorder causing persistent sadness, loss of interest, fatigue, and cognitive difficulties that impair daily functioning), dementia (decline in mental ability that is severe enough to interfere with a person's daily life, such as forgetting names, misplacing items, or losing the ability to perform familiar tasks), and Obstructive Sleep Apnea (OSA - common, serious disorder where breathing repeatedly stops and starts during sleep due to throat muscle relaxation, causing loud snoring, choking, and daytime fatigue). The MD/NP Progress note indicated Res 1 presented to [Hospital A] with altered mental status and had a recurrent right subdural hematoma (life-threatening collection of blood between the brain's outer covering (dura) and its surface) and was admitted for further evaluation and management.During a concurrent interview and record review on 3/10/26 at 12:08 p.m. with the Director of Nursing (DON) and the Medical Record Director (DMR), Res 1's electronic medical record (EMR), dated 3/7/26 was reviewed for the current medication orders (MO) and medication administration records (MAR). The MO indicated two active orders for Lorazepam (prescription medication used to help people feel calm when they are extremely anxious, panicked, or having trouble sleeping). The DON stated the MO indicated, [brand name for Lorazepam] Oral Tablet 0.5 [milligram (MG -Unit of measurement)] (Lorazepam) Give 1 tablet by mouth every 12 hours as needed for anxiety [manifested by] aggressive behavior for 14 days. The DON stated the MO indicated [brand name for Lorazepam] Oral Tablet 1 MG (Lorazepam) Give 1 tablet by mouth every 24 hours as needed for anxiety [manifested by] aggressive behavior for 14 days. The DON stated as far as she could tell, Res 1 had two active orders for Lorazepam. The DON stated the 1 mg Lorazepam order was started on 3/7/26 after the recent incident of aggression by Res 1 to Res 2. The DON stated the other active order of 0.5 mg Lorazepam was renewed on 3/7/26 and continued from previous 14 days. The DON stated both orders were for as needed administration for anxiety manifested by aggressive behavior. The DON stated the medication nurse would be the best to explain and confirm the rationale for two orders for Lorazepam. The DON stated and acknowledged that both orders used the same as needed indication and did not specify the administration criteria differentiating the two doses.During a concurrent interview and record review on 3/10/26 at 12:21 p.m. with the DON, the DMR, and Licensed Vocational Nurse (LVN) 1, Res1's MO for Lorazepam, dated 3/7/26 were reviewed. LVN 1 stated that she was the assigned medication nurse for the day and was familiar with Res 1. LVN 1 stated and validated that Res 1 had two active orders for Lorazepam. LVN 1 stated both MO were written for aggressive behavior and it was up to the nursing judgement to choose 0.5 MG every twelve hours or 1 mg every 24 hours as needed and administer for aggressive behavior. LVN 1 stated it was possible for nurses to select different dosages (0.5 MG or 1 MG) based on their experience and comfort level with the resident. The DON (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated and acknowledged the order required clarification with the administration instructions and should not have been left up to nurses to decide whether to administrator 0.5 MG every 12 hours or 1 MG every 24 hours. The DON stated that she would need to call the physician and clarify the administration instructions for as needed administration for Lorazepam MO. The DON stated both orders have the same instructions, as needed for anxiety manifested by aggressive behavior for 14 days and it was confusing. During a concurrent interview and record review on 3/10/26 at 1:40 p.m. with LVN 2, Res 1's MO for Lorazepam, dated 3/7/26 were reviewed. LVN 2 stated she was the assigned nurse for Res 1. LVN 2 stated she was very familiar with Res 1. LVN 2 stated the MO indicated Lorazepam was ordered and she aware of the MO for Res 1. LVN 2 stated Res 1 had two orders for Lorazepam and nurses could choose which order to administer based on their nursing judgement of whether to administer 0.5 mg every 12 hours or 1 mg every 24 hours. LVN 2 stated and agreed that each nurse could decide and there was a potential for Res 1 to receive different dosages based on the nurse that was caring for Res 1. LVN 2 stated both orders were active and the administration instructions were the same, as needed for anxiety with aggressive behavior. LVN 2 stated the MAR indicated she had administered a 1 mg dose twice, once on 3/8/26 at 6:27 p.m. and earlier this morning at 9:55 a.m. LVN 2 was asked the rationale for using 1 MG instead of 0.5 MG dosage and LVN 2 stated she used her nursing judgement as the order administration instructions were the same for both orders. LVN 2 stated Res 1 was very agitated and was yelling in hallway, she felt Res 1 would benefit from a higher dose. LVN 2 stated Res 1's family wanted Res 1 comfortable, and family was made aware of the two doses ordered prior to administration and family were okay with the administration.During an interview on 3/10/26 at 2:05 p.m. with the DON, the DON stated she had spoken with MD 1, who was the primary physician for Res 1 and MD 1 informed her, he was going to review and modify the Lorazepam orders. The DON stated she agreed that current orders for Lorazepam had the potential for an error or unnecessary medication as it should have clear administration instructions and the nurses should not be making the decision for the administration dosage without any parameters. The DON stated she expected all as needed (PRN- as needed medication, not routinely scheduled) orders to have clear indications and parameters to guide nursing staff to determine when and what dose to administer.During a concurrent phone interview and record review on 3/12/26 at 2:21 p.m. with the pharmacist consultant (PHC) Res1's MO, dated 3/7/26 and MAR for Lorazepam, dated 3/7/26 to 3/10/26 were reviewed. The PHC stated he had finished monthly review for Res 1 on 3/5/26 and Res 1 only had one order for Lorazepam at the time of the monthly medication review by the pharmacist. The PHC stated the 1 MG order was added later on 3/7/26. The PHC stated Res 1 could potentially receive a total dosage of 2 MG in 24 hours if both orders were carried out. The PHC stated MD 1 should have discontinued one order or added more clarification under the administration instructions. The PHC stated the MO should not be a judgement call by nurses and rather should have clear defined parameters when and what dose the MO should be administered. The PHC stated the MAR indicated the 1 MG of Lorazepam was administered twice, on 3/8/26 and 3/10/26 and 0.5 mg was not administered since 3/7/26. The PHC stated the expectation was to always administer the lowest safe dosage for Psychotropic medications (chemical substances that affect brain function, altering perception, mood, consciousness, and behavior to treat mental health conditions) like Lorazepam. The PHC stated a MO without clear administration instructions which relied on judgement call could potentially cause harm to the residents. The PHC stated and agreed that Res 1's two as needed MO for Lorazepam with the same administration instructions with different dosages had the potential for Res 1 to be over-medicated or under-medicated.During a review of Res 1's MO for Lorazepam, dated 3/10/26, the MO indicated Lorazepam order for 0.5 mg was discontinued and Res 1 now only had one order for Lorazepam. The MO indicated . [brand name for Lorazepam] Oral Tablet 1 MG (Lorazepam) Give 1 tablet by mouth every 24 hours as needed for Anxiety [manifested by] uncontrolled belligerent behaviors . Threatening or hitting staff or others, if behavior does not improve call MD .During a review of the facility's policy and procedures (P&P) titled, (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	03/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Skilled Nursing Center	515 East Orangeburg Avenue Modesto, CA 95350

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medication Therapy, with a revise date of 2007, the P&P indicated, . Each resident's medication regimen shall include only those medications necessary to treat existing conditions and address significant risks . All medication orders will be supported by appropriate care processes and practices . The resident's clinical record must contain a written order for all prescription and over-the-counter medications taken by the resident . All decisions related to medications shall include appropriate elements of the care process . Upon or shortly after admission, and periodically thereafter, the staff and practitioner (assisted by the Consultant Pharmacist) will review an individual's current medication regimen, to identify whether . There is a clear indication for treating that individual with the medication . The dosage is appropriate . The frequency of administration and duration of use are appropriate. Potential or suspected side effects are present .During a review of the facility's P&P titled, Administering Medications, with a revise date of April 2019, the P&P indicated, . Medications are administered in a safe and timely manner, and as prescribed . As required or indicated for a medication, the individual administering the medication records in the resident's medical record . The date and time the medication was administered . The dosage . The route of administration . The injection site (if applicable) . Any complaints or symptoms for which the drug was administered . Any results achieved and when those results were observed; and . The signature and title of the person administering the drug . If a resident uses PRN medications frequently, the Attending Physician and Interdisciplinary Care Team, with support from the Consultant Pharmacist as needed, shall reevaluate the situation, examine the individual as needed, determine if there is a clinical reason for the frequent PRN use, and consider whether a standing dose of medication is clinically indicated .