STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056301	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Modesto Care Center	1900 Coffee Road Modesto, CA 95355

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. (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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure residents' rights to be treated with respect and dignity were followed for one of seven sampled residents (Resident 7), when Resident 7 did not receive scheduled showers on 7/18/25, 7/25/25, and 7/29/25 while in the facility.This failure placed Resident 7 at risk for an undignified existence that could have resulted in poor hygiene and cleanliness.During a review of Resident 7's admission Record (AR- a summary of information regarding a resident which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), the AR indicated, Resident 7 was admitted to the facility on [DATE] with diagnosis for Diabetes Mellitus (DM- increased sugar in the blood), bacterial infections, kidney failure, obesity, muscle weakness, hypertension (high blood pressure), heart failure, bradycardia (slow heart rate).During a review of Resident 7's Minimum Data Set [MDS a resident assessment tool used to identify cognitive (mental processes) and physical functional level assessment] dated 5/20/2025, the MDS indicated, Resident 7's Brief Interview for Mental Status (BIMS screening tool used to assess resident cognitive level) score was 15 out of 15 (0 - 7 indicated severe cognitive impairment [memory loss, poor decision making skills] 8-12 moderate cognitive impairment, (13 -15) cognitively intact) which indicated Resident 7 was cognitively intact.During a telephone interview on 8/21/25 at 10:40 a.m. with family member (FM), the FM stated that while Resident 7 resided in the facility, she had only three showers during her stay. FM stated the facility staff was unaware that Resident 7 had not been receiving her weekly showers. During a review of Resident 7's, Shower Schedule, dated 6/25/25, the shower schedule indicated that Resident 7 should have received scheduled weekly showers on Tuesdays and Fridays.During a review of Resident 7's, Certified Nursing Assistant (CNA) Shower Review Forms, dated 7/15/25 and 7/22/25, were reviewed. The forms indicated Resident 7 received a total of two showers for the month of July. The forms indicated Resident 7 had not received a scheduled shower on 7/18/25, 7/25/25, 7/29/25.During an interview on 8/21/25 at 12:54 p.m. with licensed vocational nurse (LVN) 3, LVN 3 stated it was the facility expectations that all showers and baths be completed for all residents on their scheduled date, any deviation from the schedule should have been communicated to the nurse. LVN 3 stated if a resident refused a shower, the expectation was for the CNA to attempt and offer a shower or bed bath throughout the shift in case the resident changed their mind. LVN 3 stated the expectation was to inform the nurse if the resident continued to refuse and for the CNA to document the refusal to alert staff that the resident had not received their shower. LVN 3 stated that the CNAs would document a shower or refusal on the residents' Electronic Medical Record (EMR) and Shower Review Form should have been written, completed and signed by the CNAs and the nurse. LVN 3 stated if the resident requested a different day or time to have a shower, the expectation was for the CNA to document the refusal and request from the resident. LVN 3 stated all residents have the right to a dignified existence that included dressing, grooming and showering.During a concurrent interview and record review on 8/21/25 at 1:12 p.m. with CNA 3, Resident 7's, Point of Care (POC)-Showers, dated 7/1/25-7/31/25, was reviewed. The POC indicated there were no documented refusals or changes in Resident 7's schedule to move showers to a different date, shift or time. CNA 3 stated the facility process was to give all resident showers on the scheduled date, document the shower, refusal to shower or any changes in the schedule on the residents POC. CNA 3 validated Resident 7 had not received a scheduled shower on 7/18/25, 7/25/25 and 7/29/25. CNA 3 stated all residents have the right to shower and live with dignity and respect.During a concurrent interview and record review on 8/21/25 at 1:40 p.m. with the director of staff development (DSD), Resident 7's, CNA Shower Review Forms, dated 7/15/25 and 7/22/25, were reviewed. The forms indicated Resident 7 received a total of two showers for the month of July. The forms indicated Resident 7 had not received a scheduled shower on 7/18/25, 7/25/25, and 7/29/25. The DSD stated the facility expectation was for the CNAs to follow the shower schedule for each resident and to document the showers, baths or refusals on the POC and notify the nurse. The DSD stated it was not acceptable to have a resident refuse a shower and not document it to alert the nurse and other staff. The DSD stated Resident 7 had not received a shower on 7/18/25, 7/25/25 and 7/29/25 after review of all CNA documentation.During an interview on 8/21/25 at 2:12 p.m. with the director of nursing (DON), the DON stated the facility expectation was for all residents to receive their scheduled showers on the scheduled dates. The DON stated if the resident was refusing the showers, the CNA should have alerted the nurse and completed documentation in the POC and on the shower forms

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted (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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop and implement a baseline care plan (included initial goals based on admission orders, physician orders, summary of residents medication, services and treatments to be administered by the facility, and conditions and risks affecting the residents health and safety) within 48 hours of residents admission according to the facility's policy and procedure (P&P) titled, Baseline Care Plan, for one of seven sampled residents (Resident 7) when Resident 7 did not have a baseline care plan for diagnosis and treatment for Chronic Kidney failure (a condition where the kidneys gradually lose their ability to filter waste products and excess fluid from the blood), heart failure (condition where the heart muscle cannot pump blood effectively enough to meet the body's needs) and hypertension (condition characterized by persistently elevated blood pressure readings).This failure placed Resident 7 at risk of delay in care and needs going unmet upon admission and during her stay in the facility.During a review of Resident 7's admission Record (AR- a summary of information regarding a resident which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), the AR indicated, Resident 7 was admitted to the facility on [DATE] with diagnosis for Diabetes Mellitus (DM- increased sugar in the blood), bacterial infections, kidney failure, obesity, muscle weakness, hypertension (high blood pressure), heart failure, bradycardia (slow heart rate). During a review of Resident 7's Minimum Data Set [MDS a resident assessment tool used to identify cognitive (mental processes) and physical functional level assessment] dated 5/20/2025, the MDS indicated, Resident 7's Brief Interview for Mental Status (BIMS screening tool used to assess resident cognitive level) score was 15 out of 15 (0 - 7 indicated severe cognitive impairment [memory loss, poor decision making skills] 8-12 moderate cognitive impairment, (13 -15) cognitively intact) which indicated Resident 7 was cognitively intact.During a concurrent interview and record review on 8/21/25 at 11:05 a.m. with the minimum data set (MDS) nurse, Resident 7's electronic medical record (EMR) for care plans was reviewed. The EMR indicated the baseline care plan was not completed for Resident 7. The MDS stated the process was to initiate the baseline care plans on admission to the facility by the admitting nurse. The MDS stated the importance of the baseline care plans was to establish a plan of care based on Resident 7's needs upon admission. The MDS stated it was important to have a plan of care established to ensure all staff were meeting Resident 7's needs.During an interview on 8/21/25 at 12:58 p.m. with licensed vocational nurse (LVN) 4, LVN 4 stated it was the facility process to ensure all care plans were complete and accurate according to the residents' needs. LVN 4 stated it was important to complete a baseline care plan upon admission to ensure all residents' needs were met and to know how to properly care for each individual resident.During an interview on 8/21/25 at 1:40 p.m. with the director of staff development (DSD), the DSD stated the facility process was for the admitting nurse to initiate the baseline care plan upon resident admission. The DSD stated the baseline care should have been completed within 48 hours from admission for Resident 7. The DSD stated that there should have been a care plan initiated for every diagnosis Resident 7 was being admitted to the facility with. The DSD stated it was important to establish a baseline care plan to ensure residents were being treated with the appropriate interventions. The DSD stated every resident was different and had different needs therefore the care plan was used to ensure all resident needs and preferences were met. The DSD stated if there was no baseline care plan created upon admission, there was a risk that the residents needs would not be met and staff would not be aware of the appropriate interventions to assist them.During an interview on 8/21/25 at 2:12 p.m. with the director of nursing (DON), the DON stated there was no expectation for the facility staff to initiate a baseline care plan. The DON stated the baseline care plan should not have included every diagnosis residents had upon admission if the diagnosis was being treated with medications or other services. The DON stated the baseline care plan should have consisted of new diagnosis or changes in condition while in the facility.During a review of the facility's policy and procedure (P&P) titled, Baseline Care Plan, dated 7/2025, the P&P indicated, .A baseline plan of care (BPOC) is developed and provided to each resident and/or his/her Representative, following admission. The facility develops the baseline plan of care for each resident, within 48 hours of admission. The baseline plan of care includes information regarding care and services sufficient to promote safe delivery of care. The baseline plan of care consists of the following, Physician Orders, Dietary Orders, Therapy Services, Applicable Social Services Intervention, Applicable PASARR Recommendations, Initial Goals

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement a comprehensive systemic approach to ensure effective monitoring and systems to maintain acceptable parameters of nutritional status for one of five sampled residents (Resident 1), when Resident 1 had one documented weight on 6/6/25 since being admitted to the facility on [DATE]. Staff did not complete a weight on admission and weekly as ordered by the physician, Resident 1 was not consuming meals to its entirety or refused meals, the facility was aware of Resident 1's refusal to be weighed and the Restorative Nursing Assistant (RNA) did not follow up with the licensed nurses.This failure resulted in a 16% weight loss of 21.2 pounds (lbs.) in two (2) months placing Resident 1 at risk for unmonitored significant weight loss that could have worsened Resident 1's diagnosed heart condition and placed her at risk for inadequate nutritional intake.During a review of Resident 1's admission Record (AR- a summary of information regarding a resident which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), the AR indicated, Resident 1 was admitted to the facility on [DATE] with diagnosis of congestive heart failure (condition in which the heart doesn't pump blood as it should), Dementia (loss of memory, language and other thinking abilities), osteomyelitis (inflammation of a bone caused by infection), Diabetes Mellitus (DM- increased sugar in the blood).During a review of Resident 1's Minimum Data Set [MDS a resident assessment tool used to identify cognitive (mental processes) and physical functional level assessment] dated 5/20/2025, the MDS indicated, Resident 1's Brief Interview for Mental Status (BIMS screening tool used to assess resident cognitive level) score was 15 out of 15 (0 - 7 indicated severe cognitive impairment [memory loss, poor decision making skills] 8-12 moderate cognitive impairment, (13 -15) cognitively intact) which indicated Resident 1 was cognitively intact.During a telephone interview on 8/12/25 at 12:00 p.m. with family member (FM) 1, FM 1 stated, there were concerns regarding Resident 1 refusing meals and possible weight loss. FM 1 stated, Resident 1 had expressed that the facility food did not taste good and therefore Resident 1 did not consume her meals. FM 1 stated Resident 1 appeared to have lost weight since admission to the facility but was unaware how much weight she had lost.During a concurrent observation and interview on 8/12/25 at 1:01 p.m. with Resident 1, in Resident 1's room, Resident 1 was observed lying in bed appearing thin and frail. Resident 1 stated she had resided in the facility for a few months. Resident 1 stated she disliked the food in the facility and would consume a small portion or none of the food served during mealtimes. Resident 1 stated she was unaware if the facility staff had noticed weight loss or weight gain since admission and stated she was unaware if she had experienced weight loss during her stay.During a review of Resident 1's, Nutrition Evaluation, dated 5/18/25, the evaluation indicated, . At risk for weight fluctuations r/t PO [related to by mouth] intake, DM, and diuretic (medication used to eliminate excess fluid buildup in the body) therapy. Resident with obesity which can have a negative effect on their health, including but not limited to altered cardiac output, fluid retention, altered blood sugars, ineffective breathing patterns. estimated total daily 1544-1930 calories, protein intake daily 77-93 gram (g). The evaluation indicated the nutritional evaluation was completed by the Registered Dietitian (RD) and documented risks for weight fluctuations after review of Resident 1's evaluation.During a record review of Resident 1's, Order Summary, dated 8/19/2025, the order summary indicated, . Weekly Weights one time a day every Fri (Friday) for Admission.During a review of Resident 1's Electronic Medical Record (EMR) titled, Weights, the EMR indicated, Resident 1 had a documented weight of 130 pounds on 6/6/2025. The document indicated there were no other weights documented on the EMR since admission on [DATE].During a review of the facility's handwritten document titled, Daily weights, dated 5/15/25 for Resident 1, the document indicated, Resident 1 had refused weights from 5/15/25 to 6/3/25, 6/5/25, 6/26/25 to 7/7/25. The document did not indicate any further attempts for weight check after 7/7/25. The document did not indicate if the nurse or physician was made aware of Resident 1's refusals. Concurrent review of the document and Resident 1's EMR indicated there was no documentation or evidence indicating the nurse and the physician were made aware of Resident 1's refusals and multiple attempts to re weigh.During a concurrent interview and record review on 8/12/25 at 1:40 p.m. with licensed vocational nurse (LVN) 1, Resident 1's electronic medical record (EMR) was reviewed, including document titled Weights. The document indicated Resident 1 was only weighed on 6/6/2025 since the admission to the facility and there were no other weights documented in the EMR. The EMR indicated there was no documentation indicating Resident 1 had refused