STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555118	A. Building B. Wing	04/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Almond Vista Healthcare	2030 Evergreen 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 - Some	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** 44708 Based on observation, interview, and record review, the facility failed to review, revise, and implement a person-centered comprehensive care plan for two of three sampled residents (Resident 1 and Resident 2) when: 1. Resident 1 had a left hip hemiarthroplasty (a surgical procedure where only one half of a joint is replaced, typically the ball portion of the hip joint, while the socket remains intact) on [DATE] and the care plan did not indicate how often Resident 1's left hip dressing should be changed, how Resident 1 should bathe, and if Resident 1 can bear weight on the left leg. This failure placed Resident 1 at an increased risk to develop a surgical site infection to the left hip, further injury to the left hip, and had the potential to result in Resident 1's care needs to go unmet. 2. Resident 2 experienced a fall on [DATE] and sustained a one-inch laceration (a cut or open wound, typically caused by tearing of the skin or soft tissue) to the left eyebrow and the care plan did not indicate how to provide care to Resident 2's left eyebrow laceration. This failure placed Resident 2 at an increased risk to develop an infection to the left eyebrow and had the potential to result in Resident 2's care needs to go unmet. Findings: During an observation and interview on [DATE] at 10:08 a.m. with Resident 1 in Resident 1's room, Resident 1 was in bed with a palm size dressing (a gauze applied to a wound or injury to protect it, promote healing, and control bleeding) on Resident 1's left hip. Resident 1 stated he fell and broke his hip. Resident 1 stated his pain level was 8 (scale used to measure the level of pain a person is experiencing with a score of 0 indicating no pain up to a score of 10 indicating worse pain imaginable). Resident 1 was unable to recall when staff changed the dressing, when he was bathed, and when staff assisted him out of bed. (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 - Some	During a review of Resident 1's Admission Record (AR), dated [DATE], the AR indicated, Resident 1 was admitted on [DATE] with a history of Nontraumatic Subdural Hemorrhage (a type of bleeding in the brain where blood collects between the inner layer of the dura mater; the outermost protective layer surrounding the brain), Encounter for Surgical Aftercare following Surgery on the Nervous System and Fracture of Left Femur (broken upper leg bone). During a 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 9 (a score of 0 to 7 indicated severe impairment, 8 to 12 indicated moderate impairment, and 13 to 15 indicated minimal to no impairment). The MDS indicated Resident 1 was dependent (helper does all the effort) with transfer from bed to chair and required substantial/maximal assistance (helper does more than half the effort) with bathing. During a review of Resident 1's Progress Notes (PN), dated [DATE], the PN indicated, Interdisciplinary (IDT; a group of staff members consisting of nursing, dietary, rehabilitation, social services, activities, and administration who meet regularly to discuss incidents that occurred involving the well-being of residents and staff) Progress Notes: On [DATE] this resident c/o (complained of) pain to left hip which was reported during therapy session. An order for x-ray (a type of imaging test that uses electromagnetic radiation to create pictures of the inside of the body, particularly bones and internal organs) and ultrasound (a diagnostic imaging technique that uses high-frequency sound waves to create images of internal organs and structures) were ordered. The ultrasound indicated PVD (Peripheral Vascular Disease; a circulatory condition where blood vessels outside the heart and brain narrow, become blocked, or spasm, leading to reduced blood flow and potential tissue damage in the arms, legs, and other organs) and the x-ray showed a fx (fracture) to the left hip. MD (Medical Doctor) was notified and sent to the hospital for evaluation . During a review of Resident 1's Operative Note (ON), dated [DATE], the ON indicated, PROCEDURE(S) PERFORMED: Left hip hemiarthroplasty . During a review of Resident 1's Order Summary Report (OSR), dated [DATE], the OSR indicated, apply skin prep (a protective barrier applied to the skin to prevent irritation, damage, or maceration; the softening and breakdown of tissue due to prolonged exposure to moisture from adhesives) and dry dressing QOD (every other day) to left hip surgical site, allow steri-strips (thin, adhesive strips used to help close small cuts or wounds, often as an alternative to stitches) to fall off on their own, do not remove . During an interview on [DATE] at 10:11 a.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated Resident 1 was able to make his needs known but was confused. CNA 1 stated she did not know Resident 1 had hip surgery. CNA 1 stated Resident 1 was able to walk with supervision. CNA 1 stated she was going to give Resident 1 a bed bath. CNA 1 stated she did not know if Resident 1's left hip dressing can get wet during bathing. CNA 1 stated the charge nurse should know how to care for Resident 1's left leg. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on [DATE] at 10:15 a.m. with Licensed Vocational Nurse (LVN), Resident 1's Care Plan Report (CPR), dated [DATE] was reviewed. The CPR did not indicate how often Resident 1's left hip dressing should be changed. The CPR did not indicate whether Resident 1 can get the incision wet during bathing. The CPR indicated, Follow MD (Medical Doctor) orders for weight bearing status. See MD orders and/or PT (physical therapy) treatment plan. LVN stated Resident 1 was able to make his needs known but was oriented to himself only (not aware of place or time) and had a craniotomy (surgical opening into the skull) and left hip surgery. LVN stated there were no orders to keep Resident 1's left hip dressing dry. LVN stated it was assumed the dressing can get wet during bathing if there were no order to keep the dressing dry. LVN stated she did not know if Resident 1's left hip dressing should be changed or how often. LVN 1 stated she did not know if Resident 1 can bear weight on his left leg. LVN stated she would have to review Resident 1's physical therapy (a healthcare discipline that utilizes a variety of methods including exercises, physical modalities, and assistive devices to help patients regain or improve their physical abilities) progress notes to see how much weight Resident 1 can apply to the left leg. LVN stated the care Resident 1 required should be on Resident 1's CPR. During a review of Resident 2's Admission Record (AR), dated [DATE], the AR indicated, Resident 2 was admitted on [DATE] with a history of Alzheimer's Disease (a progressive brain disorder that primarily affects memory, thinking, and reasoning skills) and Dementia (the progressive loss of cognitive function, including memory, thinking, and reasoning, that significantly impairs a person's ability to perform daily activities) During a review of Resident 2's Progress Notes (PN), dated [DATE], the PN indicated, IDT fall: The resident has had an actual fall, sustained laceration to above left eyebrow on [DATE] . Send to ER (emergency room) for evaluation . During a review of Resident 2's Procedure Note (PN), dated [DATE], the PN indicated, PROCEDURE NOTE: Laceration Repair of left eyebrow . Description of Wound (s): 5 cm (centimeter; unit of measurement) simplelinear (a straight line). Width: 1 (cm) Depth: Full thickness (wounds that extend past the two layers of skin). Length: 5 (cm) wound . The wound was reapproximated (to bring separated parts back together, often to close a wound) in one layer (s) utilizing # 4 sutures (total of four stiches) . During a review of Resident 2's Order Summary Report (OSR), dated [DATE], the OSR indicated, apply skin prep to left eyebrow laceration and leave OTA (out to air) every day shift QOD (every other day) for wound care . The OSR dated [DATE] indicated, Staple/Suture removal within ,d+[DATE] days from ER (emergency room) visit on [DATE] . During a review of Resident 2's Care Plan Report (CPR), dated [DATE], the CPR did not indicate how to provide care to Resident 2's left eyebrow laceration. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 11:20 a.m. with the Director of Nursing (DON), the DON stated the IDT should have discussed the treatment plan for Resident 1 and Resident 2 after they returned from the hospital and updated their care plans and did not. The DON stated the IDT was required to review, revise, and implement a comprehensive person-centered care plan for Resident 1 and Resident 2 to meet their needs after a change in condition. The DON stated staff should be able to refer to Resident 1 and Resident 2's care plans and know what care was to be provided as ordered by the physician. The DON stated wound care was provided by the Treatment Nurse (a licensed staff member dedicated to provide wound care) but the Treatment Nurse was not always available. The DON stated staff should not have to look through the resident's EMR (electronic medical records) in different areas to find the information they needed to implement the required care. During an interview on [DATE] at 11:25 a.m. with the Administrator (ADM), the ADM stated the IDT needed to revise and update Resident 1 and Resident 2's care plan when they returned from the hospital and did not. The ADM stated a comprehensive person-centered care plan was required for Resident 1 and Resident 2, so staff understood what care was to be provided to meet their needs. The ADM stated the IDT was required to review, revise, and implement a comprehensive person-centered care plan for each resident after a change in condition to meet their needs. During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, dated ,d+[DATE], the P&P indicated, Policy Statement: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation: 1. The interdisciplinary team in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident . 11. Assessments of residents are ongoing and care plans are revised as information about the residents and the resident's conditions change. 12. The interdisciplinary team reviews and updates the care plan: a. when there has been a significant change in the resident's condition; b. when the desired outcome is not met; c. when the resident has been readmitted to the facility from a hospital stay .