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	03/16/2026

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 - 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 observation, interview, and record review, the facility failed to ensure a person-centered comprehensive care plan was implemented for one of four sampled residents (Resident 1) when Resident 1 was diagnosed with cellulitis of the right foot surgical wound and started on antibiotics with no implementation of a comprehensive care plan.This failure had the potential for Resident 1's needs to go unmet. (cross reference F658)During a concurrent observation and interview on 2/16/26 at 10:03 a.m. with Resident 1, Resident 1 was lying in bed, there was gauze secured by an ace bandage on his right foot and the second, third and fourth toes had surgical pins (small, thin metal rods used to hold broken bone pieces together while they heal) sticking out. Resident 1 stated he had foot surgery in mid-February on his right foot. Resident 1 stated about a week and a half after surgery a CNA had come into his room to get him up for a shower. Resident 1 stated the CNA had placed a clear plastic trash bag over his right foot and secured it with tape to keep his dressing dry during the shower. Resident 1 pointed to a role of clear plastic bags he kept at bedside inside a wash basin and stated those were his shower supplies. Resident 1 stated when he took his shower, the tape had slid down causing water to enter the plastic bag. Resident 1 stated after his shower he removed his foot out of the bag and there was approximately three inches of water in the bottom of the bag and his dressing was wet. Resident 1 stated the nurses did not change or reinforce his wet dressing. Resident 1 stated he had the wet dressing in place for four to five days until he went for a post-operative visit with the podiatrist (foot and ankle specialist). Resident 1 stated his foot was red and swollen at the physician's office and he was started on antibiotics (medications used to kill or stop growth of bacteria causing infection) for an infection.During a review of Resident 1's admission Record, undated, the admission record indicated, Resident 1 was admitted to the facility on [DATE] with diagnoses that included orthopedic aftercare (ongoing care and treatment a patient receives after musculoskeletal surgery), pain in right ankle and joints of right foot, type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage) right ankle and foot and arthropathy (disease or abnormality affecting the joints).During a review of Residents 1's Minimum Data Set (MDS- a resident assessment tool used to identify resident cognitive and physical function) assessment dated [DATE], indicated Resident 1's Brief Interview of Mental status assessment (BIMS - assessment of cognitive status for memory and judgement) scored 15 of 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment). The BIMS assessment indicated Resident 1 was not cognitively impaired.During a concurrent interview and record review on 3/16/26 at 12:06 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 1 had foot surgery on 3/18/26. Resident 1's Order Summary Report (OSR), dated 3/16/26 was reviewed, the OSR indicated, . keep sterile surgical bandages clean and dry. No bandage change needed. Notify the office if there is a problem with the bandage. Order date 2/18/2026. Amoxicillin-Pot Clavulanate Tablet 875-125 mg [unit of measurement] Give 1 tablet by mouth every 12 hours for bacterial infection for 14 days. Order date 3/4/2026 . LVN 1 stated Resident (continued on next page)

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	1 had a post-operative appointment with the podiatrist on 3/3/26 and was started on antibiotics the day after the appointment. LVN 1 reviewed Resident 1's care plans and stated there was no care plan related to Resident 1's foot infection or antibiotic.During a concurrent interview and record review on 3/16/26 at 2:11 p.m. with the Treatment Nurse (TN), Resident 1's OSR, dated 3/16/26 was reviewed, the TN stated Resident 1 was started on antibiotics after his post-operative appointment on 3/3/26 for a bacterial infection. The TN stated she had noted swelling to Resident 1's right foot around the time of his appointment with the POD and the resident had voiced his concern regarding his wound. The TN was unable to locate a care plan for Resident 1's foot infection or antibiotic. The TN stated Resident 1 should have a care plan in the medical record with interventions addressing the ordered treatment.During a concurrent telephone interview and record review on 3/18/26 at 11:35 a.m. with the Director of Nursing (DON), the DON reviewed Resident 1's OSR and stated the order was for Resident 1's sterile post-operative dressing to be kept dry with no bandage change necessary. Resident 1's Office Visit, dated 3/3/26, written by the POD, was reviewed. The Office Visit, indicated, . Postoperative Exam. Date of Surgery: 2/18/26. right 2nd, 3rd, 4th toe arthrodesis [joint fusion-a surgical procedure that permanently connects two or more bones]. returns 13 days post surgery. last Wednesday he wet his dressings in the shower and didn't think they needed to be changed or if it was a serious matter. Operative Lower Extremity Exam. Dressing are soiled and malodorous [very strong, unpleasant or foul smell]. Absorbable sutures [specialized threads used by doctors and surgeons to sew together the edges of a wound or surgical incision] mostly intact holding appropriate tension with some dehiscence [separation of wound edges] noted proximally to the 2nd toe incision, otherwise skin edges are coapted [joining the edges of a surgical wound to promote healing] well. No drainage, dehiscence, or ecchymosis [bruising]. +erythema [positive for redness] noted to dorsal midfoot [top surface of the middle part of the foot] with increased warmth. Skin maceration [occurs when skin is in contact with moisture for too long] noted. Assessment/Plan. Oral abx [antibiotics] prescribed for cellulitis [common, potentially serious bacterial (microorganisms) infection of the deeper layers of the skin and tissue]. The DON stated Resident 1's POD documented in the note Resident 1's wound had cellulitis and was started on antibiotics. The DON reviewed Resident 1's care plans and stated there was no care plan entered for cellulitis or antibiotic use. The DON stated it was important to document in the care plan the diagnosis, the treatments and what to monitor the resident for.During a review of the facility's policy and procedure (P&P) titled Care Plans, Comprehensive Person-Centered, dated 3/2022, the P&P indicated, . A comprehensive, person-centered care plan should include measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident . The comprehensive, person-centered care plan . Include measurable objectives and time frames. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including. which professional services are responsible for each element of care. 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. interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure services provided meet professional standards of practice for one of four sampled residents (Resident 1) when the nursing staff failed to keep Resident 1's surgical dressing dry and did not notify the physician the bandage was soiled according to the physician's post-operative order.This failure had the potential to cause Resident 1's wound to dehisce (surgical complication where the edges of a closed incision separate) or become infected (pathogens enter the wound and cause symptoms such as pain, increased redness and swelling). (cross reference F657)During a concurrent observation and interview on 2/16/26 at 10:03 a.m. with Resident 1, Resident 1 was lying in bed, his right foot was covered in gauze secured by an ace bandage with the second, third and fourth toes exposed and surgical pins (small, thin metal rods used to hold broken bone pieces together while they heal) sticking out. Resident 1 stated he had foot surgery in mid-February on his right foot. Resident 1 stated about a week and a half after surgery a CNA had come into his room to get him up for a shower. Resident 1 stated the CNA had placed a clear plastic trash bag over his right foot and secured it with tape to keep his dressing dry during the shower. Resident 1 pointed to a roll of clear plastic bags he kept at bedside inside a wash basin and stated those were his shower supplies. Resident 1 stated when he took his shower, the tape had slid down his leg causing water to enter the plastic bag. Resident 1 stated after his shower he removed his foot out of the bag and there was approximately three inches of water in the bottom of the bag and his dressing was wet. Resident 1 stated he notified the nurses his dressing was wet, but the nurses did not change or reinforce his dressing. Resident 1 stated he had the wet dressing in place for four to five days until he went for a post-operative visit with the podiatrist (POD-foot and ankle specialist). Resident 1 stated his foot was red and swollen at the podiatrist's office and he was started on antibiotics (medications used to kill or stop growth of bacteria causing infection) for an infection.During a review of Resident 1's admission Record, undated, the admission record indicated, Resident 1 was admitted to the facility on [DATE] with diagnoses that included orthopedic aftercare (ongoing care and treatment a patient receives after musculoskeletal surgery), pain in right ankle and joints of right foot, type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage) of the right ankle and foot and arthropathy (disease or abnormality affecting the joints). During a review of Residents 1's Minimum Data Set (MDS- a resident assessment tool used to identify resident cognitive and physical function) assessment dated [DATE], indicated Resident 1's Brief Interview of Mental status assessment (BIMS - assessment of cognitive status for memory and judgement) scored 15 of 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment). The BIMS assessment indicated Resident 1 was not cognitively impaired.During an interview on 3/16/26 at 11:28 a.m. with CNA 1, CNA 1 stated she was taking care of Resident 1. CNA 1 stated she had not given Resident 1 a shower because he preferred them on night shift. CNA 1 stated the process for giving a shower when a resident needs to keep their dressing dry was to take a plastic trash bag and place around the foot and secure it with tape to keep water from making the dressing wet.During a concurrent interview and record review on 3/16/26 at 12:06 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 1 had foot surgery on 3/18/26. Resident 1's Order Summary Report (OSR), dated 3/16/26 was reviewed, the OSR indicated, . keep sterile surgical bandages clean and dry. No bandage change needed. Notify the office if there is a problem with the bandage. Order date 2/18/2026. Amoxicillin-Pot [potassium] Clavulanate [an antibiotic] Tablet 875-125 mg [unit of measurement] Give 1 tablet by mouth every 12 hours for bacterial infection for 14 days. Order date 3/4/2026 . LVN 1 stated Resident 1 had a post-operative appointment with the podiatrist on 3/3/26 and was started on antibiotics the day after the appointment. Resident 1's Progress Note, dated 3/8/26, was reviewed (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and indicated, . Pt [patient] reports his foot became wet in the shower approximately one week ago and states he believes it is infected. Pt complains of pain and swelling to the affected foot. Foot wrapped to prevent it from getting wet for Saturday nights shower. LVN 1 stated Resident 1 was convinced his wound became infected from getting wet in the shower. LVN 1 stated Resident 1 frequently refused his diabetes medication placing him at a higher risk for wound infection. LVN 1 reviewed Resident 1's care plans and stated there was no care plan related to Resident 1's foot infection or antibiotic.During a concurrent interview and record review on 3/16/26 at 1:49 p.m. with Resident 1's Physician (PHY), Resident 1's Office Visit, dated 3/3/26, written by the POD, was reviewed. The note indicated, . last Wednesday he wet his dressings in the shower and didn't think they needed to be changed or if it was a serious matter . Assessment/Plan. Oral abx [antibiotics] prescribed for cellulitis [common, potentially serious bacterial (microorganisms) infection of the deeper layers of the skin and tissue]. The PHY stated the POD had started Resident 1 on antibiotics for cellulitis. The PHY stated when specialists ordered medications or treatment, she would approve them so the facility can follow the orders. The PHY stated she was unsure if the resident's dressing could be wet or not, but the facility was supposed to follow the post-operative instructions and orders from the specialists.During a concurrent interview and record review on 3/16/26 at 2:11 p.m. with the Treatment Nurse (TN), the TN reviewed Resident 1's OSR, dated 3/16/26 and stated the orders specified to keep the dressing clean and dry and if the dressing became wet, the nurse should have contacted the physician on call for orders. The TN stated the dressing should not be left wet for an extended period unless ordered because it was a surgical wound and could have complications if left wet. The TN stated Resident 1 had a post-operative appointment on 3/3/26 and was started on antibiotics after the appointment for a bacterial infection. The TN stated she had noted swelling to his right foot around the time of his appointment, but she thought it did not appear infected. The TN stated Resident 1 had voiced his concern regarding his wound to her. Resident 1's progress note, dated 3/8/26, was reviewed and indicated, . Pt [patient] reports his foot became wet in the shower approximately one week ago and states he believes it is infected. Pt complains of pain and swelling to the affected foot. Foot wrapped to prevent it from getting wet for Saturday nights shower. The TN stated the note did not indicate which shower day the resident was referring to.During a concurrent telephone interview and record review on 3/18/26 at 11:35 a.m. with the Director of Nursing (DON), the DON reviewed Resident 1's OSR and stated the order was for Resident 1's sterile post-operative dressing to be kept dry with no bandage change necessary. The DON stated Resident 1 usually wrapped his own feet with plastic bags to shower and would take two-to-three-hour showers, increasing the risk of moisture in the bandage. The DON stated there were no nurses' notes indicating if Resident 1's bandage became wet during a shower. The DON stated if Resident 1's dressing had become wet; her expectation would have been for the nurses to call the physician for new orders. Resident 1's Office Visit, dated 3/3/26, written by the POD, was reviewed. The Office Visit, indicated, . Postoperative Exam. Date of Surgery: 2/18/26. right 2nd, 3rd, 4th toe arthrodesis [joint fusion-a surgical procedure that permanently connects two or more bones]. returns 13 days post surgery. last Wednesday he wet his dressings in the shower and didn't think they needed to be changed or if it was a serious matter. Operative Lower Extremity Exam. Dressing are soiled and malodorous [very strong, unpleasant or foul smell]. Absorbable sutures [specialized threads used by doctors and surgeons to sew together the edges of a wound or surgical incision] mostly intact holding appropriate tension with some dehiscence [separation of wound edges] noted proximally to the 2nd toe incision, otherwise skin edges are coapted [joining the edges of a surgical wound to promote healing] well. No drainage, dehiscence, or ecchymosis [bruising]. +erythema [positive for redness] noted to dorsal midfoot [top surface of the middle part of the foot] with increased warmth. Skin maceration [occurs when skin is in contact with moisture for too long] noted. Assessment/Plan. Oral abx [antibiotics] prescribed for cellulitis [common, potentially serious bacterial (microorganisms) infection of the deeper layers of the skin and tissue]. The DON stated skin maceration was caused by moisture, but (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she was unsure if the resident's dressing had gotten wet or not. The DON stated Resident 1 was diagnosed with cellulitis at the appointment according to the POD's note. The DON reviewed Resident 1's care plans and stated there was no care plan entered for cellulitis or antibiotic use. The DON stated the physician's order should specify the type and location of infection according to the order sent from the doctor. The DON stated the expectation for the staff to keep a resident's extremity dressing dry during a shower would be to use plastic wrap around the dressing secured with tape. The DON reviewed Resident 1's electronic medical record and stated there was no order in place to monitor the dressing for cleanliness or dryness. During a review of Resident 1's Office Visit, dated 3/10/26, the note indicated, . Reason for Visit. Recheck. Post-Operative Note. two weeks and six days post right second, third, and fourth toe repair. He reports the forefoot dressing came off and the foot was soaked in water for an unknown period. He notes persistent swelling and burning between the lesser toes. taking [brand name of antibiotic] . Assessment & Plan. Finish [name of antibiotic] . The DON stated she did not have any documentation indicating the dressing had become wet in the facility shower, but stated Resident 1 was sometimes noncompliant with allowing the staff to check his dressing.During a telephone interview on 3/18/26 at 11:40 a.m. with the DON, the DON stated she was unable to locate a policy and procedure for following physician orders or professional standards of practice. The DON stated Resident 1's POD did not send the facility an order for the antibiotic directly and the facility did not get a copy of the POD's note the day of the visit, so Resident 1's antibiotic arrived to the facility directly from the pharmacy and was started on 3/4/26 after the PHY approved it.During a review of the facility's Job Description. Licensed Vocational Nurse (LVN), undated, the job description indicated, . The LVN implements the established plan of care of each assigned group of Resident's. ESSENTIAL JOB FUNCTIONS. Perform assigned resident care duties in a manner that provides for the physical, psycho-social, and spiritual needs. Correctly differentiates between normal and abnormal clinical findings and intervenes in accordance with clinical standards of practice per physicians orders.During a review of the facility's Job Description. Director of Nursing (DON), undated, the job description indicated, . The Director of Nursing . Manages facility employees in the provision of care and services according to professional standards of nursing practice.During a review of the facility's policy and procedure (P&P) titled Wound Care, dated 10/2010, the P&P indicated, . purpose of this procedure is to provide guidelines for the car of wounds to promote healing. Review the resident's care plan to assess for any special needs of the resident. Report other information in accordance with facility policy and professional standards of practice.During a review of professional reference from https://www.registerednursing.org/does-nurse-always-follow-doctors-orders/ titled, Does a Nurse Always Have to follow a Doctor's Orders? dated 1/30/24, the reference indicated, .nurses cannot just randomly decide which order to follow and which not to follow. Unless there is a safety concern or an order that conflicts with personal or religious beliefs, failing to carry out orders can be grounds for discipline by the employer as well as the board of nursing, as it could be deemed neglect .