STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555190	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
English Oaks Convalescent & Rehabilitation Hospita	2633 West Rumble Rd 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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 43943 Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1), was accurately assessed for the use of a partial denture (fully removable dental inserts that replaced seven missing top teeth) and use of hearing aids. These failures resulted in staff not being aware when Resident 1 ' s partial denture and hearing aids were missing and the lack of consistent use could have contributed to Resident 1 ' s confusion and weight loss. Findings: During a review of Resident 1 ' s clinical record titled, ADMISSION RECORD (a document that contained Resident 1 ' s demographic information), indicated Resident 1 ' s diagnosis included the need for assistance with personal care. A review of Resident 1 ' s clinical record titled, NSG [nursing]: Admission Data Collection and Baseline Care Plan Tool (a personalized document that identified problems, goals, and interventions), dated 1/3/25, by Licensed Nurse (LN 1), indicated Resident 1 was oriented to person, place, date, and time. The record further indicated Resident 1 ' s use of a partial denture and hearing aids were not assessed. A review of Resident 1 ' s clinical record titled, MDS [Minimum Data Set - part of a comprehensive assessment] - Section B - Hearing, Speech, and Vision, dated 1/10/25, by the MDS nurse (MDS 1), indicted Resident 1 did not use hearing aids. During a review of Resident 1 ' s clinical record titled, Nutritional Comprehensive Assessment, dated 1/14/25, by the Registered Dietitian (RD), indicated Resident 1 had dentures. A review of Resident 1 ' s clinical record titled, Theft/Loss Monitoring Report, by the Housekeeping Director (HD), indicated Resident 1 ' s partial denture was found in the laundry area of the facility on 1/8/25, and on 1/24/25, FRIEND 1 reported the missing partial denture, and the partial denture was returned to Resident 1. A review of Resident 1 ' s clinical record titled, Patient ' s Clothes and Possessions, dated 1/29/25, indicated Resident 1 had two hearing aids. (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1 ' s clinical record titled, Weights and Vitals, dated 1/3/25 through 1/26/25, indicated Resident 1 lost 15 pounds (lbs.) while at the facility with the following weights recorded: 1/3/25 = 197 lbs. 1/5/25 - 194 lbs. 1/20/25 = 185 lbs. 1/26/25 - 182 lbs. During an interview on 2/6/25, at 1:55 p.m., with LN 2, LN 2 stated she was not aware that Resident 1 utilized a partial denture or hearing aids. LN 2 stated upon admission, the LN was supposed to assess Resident 1 ' s use of partial dentures or hearing aids. LN 2 stated Resident 1 had intermittent confusion while at the facility. During an interview on 2/6/25, at 2:05 p.m., Certified Nursing Assistant (CNA 1) stated she was not aware Resident 1 utilized a partial denture or hearing aids. CNA 1 stated Resident 1 had bouts of confusion. During a phone interview on 1/12/25, at 10 a.m., with Resident 1 ' s Family Member (FM 1), FM 1 stated Resident 1 ' s partial denture had been lost while at the facility. FM 1 stated when the denture was found, it was cracked and not able to be used. FM 1 stated after discharge from the facility, the partial denture was taken to a dentist for repair, however Resident 1 was not able to eat with the partial denture for over three weeks. FM 1 stated Resident 1 ' s hearing aids were lost for a few days but had been found. FM 1 stated the facility should have taken an accurate inventory assessment for Resident 1 ' s partial denture. During a phone interview on 1/12/25, at 12:34 p.m., Resident 1 ' s Friend (FRIEND 1) stated the facility had lost Resident 1 ' s partial denture soon after arriving at the facility. FRIEND 1 stated when the facility returned the partial denture to Resident, it was cracked. FRIEND 1 stated Resident 1 ' s hearing aids were also missing for a couple days at the facility. During a phone interview on 12/14/25, at 12:30 p.m., with Resident 1 ' s FM 2, FM 2 stated a family member had placed a sign above Resident 1 ' s bed that reminded staff to take out Resident 1 ' s partial dentures every night and soak them in cleaning solution and to charge Resident 1 ' s hearing aids each night. FM 2 stated the facility should have ensured the partial denture and hearing aids were accessible and properly cared for each day and that an inventory list and sensory assessment was accurately completed. FM 2 stated Resident 1 was confused while at the facility, which was not Resident 1 ' s baseline. During a phone interview on 2/17/25, at 5:14 p.m., with Resident 1, Resident 1 stated his partial dentures (upper) was lost at the facility. Resident 1 stated he looked all over for the partial and reported the loss to the staff, but staff stated the facility did not have a lost and found department. Resident 1 stated after approximately three weeks, the partial denture was returned to him, and it was cracked. Resident 1 stated his hearing aids were lost for a couple of days while he was at the facility. Resident 1 stated he was confused during his stay at the facility. (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview on 2/20/25, at 11 a.m., with MDS 2, MDS 2 stated if the LN was unable to assess Resident 1 ' s hearing and dental status upon admission, the LN should have reassessed at a later date. MDS 2 stated the admission assessment problems and concerns generated Resident 1 ' s care plan and because hearing and dental was not assessed, there was not a careplan for hearing aids or partial dentures. MDS 2 stated Resident 1 ' s inventory list should have been updated with the partial denture when the dentures were found and returned to Resident 1. MDS 2 stated it was important to have identified if dentures were used because food modifications may have needed to be made. During phone interview on 2/20/25, at 11:05 a.m., with the RD, the RD stated Resident 1 reported to her that Resident 1 had dentures. The RD stated she had not asked Resident 1 to open his mouth and show RD his dentures. The RD stated she would have noticed if Resident 1 had seven missing front teeth. During a joint phone interview on 1/20/25, at 11:10 a.m., with the Administrator (ADM) and Director of Nursing (DON), the ADM and DON acknowelged that the LN should have reassessed Resident 1 ' s dental and hearing status which would have generated a hearing and dental care plan. During a concurrent phone interview, review of Resident 1 ' s clinical record, and review of the facility ' s policy and procedure (P&P), on 2/20/25, at 12:20 p.m., with the DON, the P&P titled, Resident Assessment/Care Plan Coordinator (MDS), dated 2003, was reviewed. The P&P indicated, .Ensures that all assessments are completed . Works with the Interdisciplinary Care Plan Team in developing a comprehensive resident assessment and care plan for each resident . Evaluate each resident ' s condition and pertinent medical data to determine any need for special assessment activities or a need to amend the admission assessment . The DON acknowelged the LN did not reassess Resident 1 ' s use of hearing aids or partial denture. The DON acknowelged the P&P was not followed.

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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 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. 43943 Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1) had a care plan (a document that identified Resident 1 ' s problems, goals, and interventions) in place that addressed Resident 1 ' s use of a partial denture (fully removable dental inserts that replaced seven missing top teeth) and hearing aids. These failures resulted in a lack of knowledge by nursing staff of Resident 1 ' s use of a partial denture and hearing aids, lack of care of the partial denture and hearing aids, and could have contributed to Resident 1 ' s confusion and 15-pound weight loss while at the facility. Findings: During a review of Resident 1 ' s clinical record titled, ADMISSION RECORD, (a document that contained Resident 1 ' s demographic information), indicated Resident 1 ' s diagnosis included the need for assistance with personal care. A review of Resident 1 ' s clinical record titled, NSG [nursing]: Admission Data Collection and Baseline Care Plan Tool (an individualized plan of care that identified Resident 1 ' s problems, goals, and interventions), dated 1/3/25, by Licensed Nurse (LN 1), indicated Resident 1 was oriented to person, place, date, and time. The record further indicated Resident 1 ' s use of a partial denture and hearing aids were not assessed. During a review of Resident 1 ' s clinical record titled, Nutritional Comprehensive Assessment, dated 1/14/25, by the Registered Dietitian (RD) indicated Resident 1 had dentures. A review of Resident 1 ' s clinical record titled, Theft/Loss Monitoring Report, indicated Resident 1 ' s partial denture was found in the laundry area of the facility on 1/8/25 and on 1/24/25, FRIEND 1 reported the missing partial denture, and the partial denture was returned to Resident 1. A review of Resident 1 ' s clinical record titled, Weights and Vitals, dated 1/3/25 through 1/26/25, indicated Resident 1 lost 15 pounds while at the facility with the following weights recorded: 1/3/25 = 197 lbs. 1/5/25 - 194 lbs. 1/20/25 = 185 lbs. 1/26/25 - 182 lbs. A review of Resident 1 ' s clinical record titled, Patient ' s Clothes and Possessions, dated 1/29/25, indicted Resident 1 had two hearing aids. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/6/25, at 1:55 p.m., with LN 2, LN 2 stated she was not aware that Resident 1 utilized a partial denture or hearing aids. LN 2 stated upon admission, the LN was supposed to assess Resident 1 ' s use of partial dentures or hearing aids. LN 2 stated Resident 1 had intermittent confusion while at the facility. During a phone interview on 1/12/25, at 10 a.m., with Resident 1 ' s Family Member (FM 1), FM 1 stated Resident 1 ' s partial denture (7 false teeth on the top of the mouth) had been lost while at the facility. FM 1 stated when the denture were found, it was cracked and not able to be used. FM 1 stated after discharge from the facility, the partial denture was taken to a dentist for repair, however Resident 1 was not able to eat with the partial denture for over three weeks. FM 1 stated Resident 1 ' s hearing aids were missing for a few days but had been found. During a phone interview on 1/12/25, at 12:34 p.m., Resident 1 ' s Friend (FRIEND 1), FRIEND 1 stated the facility had lost Resident 1 ' s partial denture soon after arriving at the facility. FRIEND 1 stated when the facility returned the partial denture to Resident 1. FRIEND 1 stated Resident 1 ' s hearing aids were lost for a couple of days at the facility. During a phone interview on 12/14/25, at 12:30 p.m., with Resident 1 ' s FM 2, FM 2 stated a family member had placed a sign above Resident 1 ' s bed that reminded staff to take out Resident 1 ' s partial denture every night and soak them in cleaning solution and to charge Resident 1 ' s hearing aids each night. FM 2 stated the facility should have ensured the partial denture and hearing aids were accessible and properly cared for each day and that an inventory list and sensory assessment was accurately completed. FM 2 stated Resident 1 was confused while at the facility, which was not Resident 1 ' s baseline. During a phone interview on 2/17/25, at 5:14 p.m., with Resident 1, Resident 1 stated his partial denture (upper) was lost at the facility. Resident 1 stated he looked all over for the partial and reported the loss to the staff, but the staff stated the facility did not have a lost and found department. Resident 1 stated after approximately three weeks, the partial denture was returned to him, and it was cracked. Resident 1 stated his hearing aids were lost for a couple of days while at the facility. During a phone interview on 2/20/25, at 11 a.m., with MDS 2, MDS 2 stated if the LN was unable to assess Resident 1 ' s hearing and dental status upon admission, the LN should have reassessed at a later date. MDS 2 stated the admission assessment problems and concerns generated Resident 1 ' s care plan and because hearing and dental was not assessed, there was not a care plan created for Resident 1 to include hearing aids or partial dentures. MDS 2 stated it was important to have identified if dentures were used because food modifications may have needed to be made. During phone interview on 2/20/25, at 11:05 a.m., with the RD, the RD stated Resident 1 reported to her that Resident 1 had dentures. During a joint phone interview on 1/20/25, at 11:10 a.m., with the Administrator (ADM) and Director of Nursing (DON), the ADM and DON acknowelged that the LN should have reassessed Resident 1 ' s dental and hearing status which would have generated a hearing and dental care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent phone interview and review of facility policies on 2/20/25, at 12:20 p.m., with the DON, the facility ' s policy and procedures (P&Ps) titled, Care planning - Interdisciplinary Team, dated 3/22, and Care Plans, Comprehensive Person-Centered, dated 3/22, were reviewed. The P&P titled Care planning - Interdisciplinary Team, indicated, . Comprehensive, Person-centered care plans are based on resident assessments and developed by an interdisciplinary team (IDT) . The P&P titled, Care Plans, Comprehensive Person-Centered, indicated, .The care plan interventions are derived from a through analysis of the information gathered as part of the comprehensive assessment .The compressive, person-centered care plan .describes the services that are to be furnished to attain or maintain the resident ' s highest physical, mental, and psychosocial well-being . The DON acknowelged when Resident 1 ' s initial hearing and dental needs were not reassessed by the LN, the hearing and dental care plans were not generated. The DON acknowelged the P&Ps were not followed.