

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555190	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/20/2025
NAME OF PROVIDER OR SUPPLIER English Oaks Convalescent & Rehabilitation Hospita		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to protect the residents' right to be free from physical abuse (intentional act of causing injury or trauma to another person through bodily contact) for one of four sampled residents (Resident 1) when on 9/8/25, Resident 2 who was known by the facility staff to have abusive behavior, approached Resident 1 and hit her on the hand and attempted to kick Resident 1. This failure resulted in a bruised right hand on Resident 1. In addition, this failure left Resident 1 feeling upset, uncomfortable, and unsafe. Findings: A review of Resident 1's admission RECORD, indicated Resident 1 was admitted to the facility with diagnoses which included: need for assistance with personal care, other abnormalities of gait (walking) and mobility (ability to move around freely), and depression (a common mental health condition with continuous feelings of sadness, hopelessness, and loss of interest in activities that were once enjoyable). A review of Resident 1's minimum data set (MDS - a resident assessment and screening tool which identifies care needs) dated 8/18/25, under the section titled, .Section C: Cognitive Patterns, - (an assessment of the mental abilities and functions the brain uses to think, learn, remember, pay attention, process information and solve problems) indicated Resident 1's Brief Interview for Mental Status (BIMS - a screening tool used in long-term care to assess a resident's cognitive function [the mental processes like thinking, memory, and perception, that a person uses to understand and respond to their environment] Scoring = 13-15 indicates normal intact cognitive function, 8-12 moderate cognitive impairment, 0-7 signifies severe cognitive impairment) was 14 out of 15 which indicated Resident 1 had normal intact cognitive function. A review of Resident 2's admission RECORD, indicated Resident 2 was admitted to the facility with diagnoses which included: dementia (a decline in cognitive functions such as memory, language, attention and problem-solving abilities that interfere with daily life) with agitation (a behavioral syndrome [a group of symptoms which consistently occur together] characterized by excessive restlessness, verbal outbursts, and/or physical aggression) and dementia with behavioral disturbance (the presence of a range of behavioral symptoms in a person with dementia such as aggression and agitation which interfere with daily life). A review of Resident 2's MDS dated [DATE], under the section titled, .Section C: Cognitive Patterns, indicated Resident 2's BIMS was 99 which indicated Resident 2 was unable to complete the interview. A review of Resident 2's MDS dated [DATE], under the section titled, .Section E: Behavior, indicated that during the review period Resident 2 had, .A. Physical behavioral symptoms directed towards others (e.g. [for example], hitting, kicking, pushing, scratching, grabbing, abusing others sexually). Behavior of this type occurred 1 to 3 days. Impact on others. A. Put others at significant risk for physical injury?. 1. Yes. B. Significantly intrude on the privacy or activity of others?. 1. Yes. During a concurrent interview and observation on 9/23/25, at 3:39 PM, in Resident 1's room, Resident 1 stated on 9/8/25 she was attacked by Resident 2, while sitting in a wheelchair in front of her room. Resident 1 explained her room was at the end of a long hallway and there was glass door where she could see outside. Resident 1 further explained, when she saw Resident 2 coming toward the end of the hallway, she tried to move out of the way since there was not a lot of room in the hallway. Resident 1 stated as Resident 2 approached her she said hello and then Resident 2 reached out and struck her on her hand with his hand. Resident 1 stated Resident 2 also attempted to kick her, but Resident 1 was able to use her legs to back her wheelchair into her room to avoid being kicked. Resident 1 stated no one was in the hallway when he hit and attempted to kick her, so she yelled out. Resident 1 further stated she felt upset because she was not expecting to get hit by Resident 2. Resident 1 explained she felt uncomfortable and unsafe to get into her wheelchair and roam the facility because Resident 2 frequented the hallways near her path. The end of the hallway was observed where Resident 1's room and the physical abuse incident occurred and was noted to not be visible from the nurses station. During an interview on 9/23/25, at 3:15 PM, Licensed Nurse (LN) 1 confirmed while working on 9/8/25 she was alerted by Certified Nursing Assistant (CNA) 3 of the physical abuse that occurred between Resident 1 and Resident 2. LN 1 stated CNA 3 reported to her that she heard yelling while CNA 3 was in a room and went to check on it. LN 1 further stated when Resident 1 explained what happened, LN 1 checked Resident 1 for injuries and observed Resident 1 had redness on her right hand. LN 1 explained Resident 1 was upset and told LN 1 that she did not want to see Resident 2 again. LN 1 further explained Resident 2 was known to become easily agitated, angry, moody and sometimes not approachable. LN 1 stated that Resident 2 had a history of hitting staff during care. LN 1 further stated because Resident 2 was known to have these</p>		