

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 01/16/2026
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 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on observation, interview, and record review, the facility failed to ensure the kitchen staff carried out proper dress code when dietary relief (DR) 1 did not wear a beard net properly exposing facial hair. This failure had the potential to expose residents to bacterial contamination, which could result in food borne illnesses for all residents who consumed food from the kitchen. The facility census was 167. Findings: During a concurrent observation and interview on 1/14/26, at 11:15 a.m., with registered dietitian (RD) 1, tray line (assembly line for food, commonly used in hospitals and nursing homes to prepare patient meals. Workers stand at stations, adding specific items-like hot food, drinks, or cutlery-to a moving tray as it passes) was observed. RD 1 verified DR 1 beard net was not covering all of his facial hair. RD 1 stated DR 1's beard net should have been covering his mustache. RD 1 also stated wearing hair and beard nets properly prevents physical contamination from entering the food being prepared to serve. During an interview on 1/15/26, at 8:30 a.m., with RD 2, RD 2 stated not wearing a beard net properly was a sanitation issue effecting quality of food and hair could also cause residents to choke. During a review of a facility policy and procedure (P&P) titled, DRESS CODE dated 2023, the P&P indicated, .personal hygiene and appropriate dress are a very important part of the total appearance of the Food & Nutrition Services Department. Hair net for hair. If applicable, bears and mustaches (any facial hair) must wear beard restraint.		

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

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 01/16/2026
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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. The facility failed to ensure safe pharmaceutical services with medication disposal, waste, and the accountability of delivered medications based on standards of practice for a resident census of 167 when: 1. Pharmaceutical waste (discontinued or no longer needed drugs) including prescription and over the counter (drugs sold directly to consumers without needing a prescription) medications were not rendered unusable when disposed in the pharmaceutical waste bin (also known as a drug waste bucket) and were accessible with hand retrieval from the waste bin; and, 2. Medication delivery slips and manifests from the pharmacy provider were not consistently signed and dated by licensed staff upon receipt from delivery courier for accuracy and accountability of prescription medication received. These failures could result in unsafe disposal of the discontinued prescription medications and the risk of drug diversion (illegal use of drugs). Findings: 1. During a concurrent observation and interview on 1/14/26, at 11:13 a.m., Licensed Nurse (LN) 8 confirmed that the pharmaceutical waste bin located in the Medication Room at the South Nurse Station was observed with the lid left open. Prescription and over-the counter medications were present in the bin and had not been rendered unusable, making them accessible to any individual with access to the medication room. LN 8 described the facility's process for disposal of non-controlled medications, stating that licensed nurses on the night shift were responsible for medication disposal. LN 8 stated process included removing resident identification stickers from the medication packaging, documenting the medication name and quantity in the non-narcotic medication destruction log maintained in the medication room, and disposing of the medications in the pharmaceutical waste bin. LN 8 added the facility policy required two licensed nurses to sign the medication destruction log. LN 8 further acknowledged that, when medications were not rendered unusable and the pharmaceutical waste bin lid was left open, there was a risk that medications could be accessed or removed by individuals with keys to the medication room, creating potential for diversion of medications. During a concurrent observation and interview on 1/14/26, at 1:40 p.m., Infection Control Nurse (IP) at the west nurses' station medication room confirmed that the pharmaceutical waste bin was observed to be open and that medications inside the bin were accessible and had not been rendered unusable. IP stated that, as safety precautions, medications should be crushed or dissolved in the approved solution prior to placement in the pharmaceutical waste bin to ensure destruction. IP further stated that nurses were required to don gloves, remove medication labels, and document the medication name and quantity in the non-narcotic medication destruction log located in the medication room, and the log must be signed by two licensed nurses in accordance with facility protocol. IP stated that leaving medications usable and accessible in the medication room posed a potential for medication diversion. IP indicated that her expectation of licensed nurses was to properly dispose of medications by following the established procedures to ensure medications were rendered non-retrievable and in compliance with regulatory requirements. The IP further stated that this expectation was not met. During an interview on 1/15/26, at 9:48 p.m., LN 10 stated that night shift nurses were responsible for destroying medications located in the medication rooms at the nurses' stations. LN 10 stated that medications that were placed into the pharmaceutical waste bin should be rendered unusable. LN 10 further stated that an approved dissolving solution was available in the medication carts for the nurses to use to dissolve medications prior to disposal of non-narcotic medications. LN 10 further added that failure to properly dispose of medications had a risk that individuals with access to the medication room could remove medications from the pharmaceutical waste bin, creating potential for diversion. During a phone interview on 1/15/25, at 2:00 p.m., the Pharmacy Consultant (PC) stated that licensed nurses were expected to dispose of non-narcotic medications with verification by two nurses, in accordance with the facility policy, and to ensure medications were placed into an approved pharmaceutical waste bin with the lid securely closed so that medications were not accessible. Review of the facility provided (continued on next page)		

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 01/16/2026
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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	policy and procedure (P&P) titled Discarding and Destroying Medications, revised in June 2025 indicated, . Medications that cannot be returned to the dispensing pharmacy are disposed of in accordance with federal, state, and local regulations governing management of non-hazardous pharmaceuticals, hazardous waste, and controlled substances. 3. Non-controlled. are disposed of in accordance with state regulations and federal guidelines. 2. Review of the facility documents titled Packing Slip, located in a delivery manifests binder in the south nurses' station, between 1/1/26 through 1/13/26, indicated, Deliver to: [facility name] . By signing below, you acknowledge that the items above have been received. Discrepancies must be reported to the pharmacy within 4 hrs of delivery. Nurse Signature Date Time. The review revealed that the documents were incomplete, as they were not consistently signed, dated, and timed by licensed nursing staff as required. During a concurrent interview and record review on 1/14/26 10:47 a.m., with LN 8 at the south nurses' station, pharmacy medication delivery manifests/slips dated from 1/01/26 through 1/13/26 were reviewed. The review revealed that medication delivery slips were not consistently signed and dated by licensed nursing staff. Delivery slips on 1/7/26, 1/10/26, and 1/11/26 were found to be missing required signatures and/or dates and times. LN 8 confirmed these findings. LN 8 stated that delivery manifest binders were located at each nurses' station and were available for nursing staff to file the delivery slips after they were properly signed and dated upon receipt of medications from the pharmacy provider. LN 8 stated that upon medication delivery, nurses were responsible for verifying that the medications received match the information documented on the delivery slips, including medication name, dosage, and quantity. LN 8 emphasized the importance of signing and dating medication delivery slips, stating that this process assisted in identifying potential medication errors related to medication name, dosage, or quantity. LN 8 further stated that without properly signed and dated delivery slips, the facility was unable to accurately track missing medications or determine which staff member received the medications and the date and time the medications were received. During an interview on 1/14/2026, at 12:30 p.m., LN 13 stated that pharmacy deliveries were primarily received during the night shift. LN 13 further stated that the nurse who received the medications was responsible for verifying the delivery for accuracy and discrepancies and ensuring that the medication delivery manifest/slip was signed and dated upon receipt. During an interview on 1/15/2026, at 9:36 a.m., LN 14 described the facility's process for receiving medications from the pharmacy provider, stating that the receiving nurse was required to sign both copies of the delivery manifest/slip. LN 14 stated one signed copy was retained in the facility's medication manifest binder. LN 14 emphasized that the receiving nurse was responsible to document signature, date, and time of receipt to ensure accurate tracking, verification of medication receipt, and compliance with insurance purposes. During a phone interview on 1/15/2026, at 2:00 p.m., PC stated that nurses were expected to sign and date medication delivery manifests/slips at the time medications were received from the pharmacy and to maintain a signed copy in the facility. PC further stated that all discrepancies should be noted upon receipt and reported to the pharmacy. PC indicated that to prevent the possibility of medication diversion, medication manifests/slips should be properly signed and dated. During an interview on 1/15/26, at 3:40 p.m., the DON stated that medications from the pharmacy provider were primarily received by the night shift nurses. The DON further stated that licensed nursing staff were expected to reconcile medications with the medication delivery manifests/slips and to sign and date the receipts at the time of delivery. Review of the facility provided P&P titled Pharmacy Services Overview, revised on April 2019 indicated, . Policy Interpretation and Implementation. 9. The consultant pharmacist, in collaboration with the dispensing pharmacy and the facility, oversees the development of procedures related to pharmacy services, including. (1) receipt. (4) facility staff roles and responsibilities during the receipt and storage of medication.		

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 01/16/2026
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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that staff treated three of 33 sampled residents with dignity and respect when,1. The infection preventionist (IP) referred to Resident 193 as a feeder (a derogatory term sometimes used by nursing staff when a resident needs total staff assistance with feeding) which labelled Resident 193 by her care needs rather than as an individual.2. Staff posted signage in Resident 22's room identifying the resident as a 1:1 feeder (one staff member assists one resident at a time with feeding) which publicly disclosed Resident 22's care needs and placed the resident at risk for diminished dignity.3. The urinary catheter bag (a urine drainage bag that collects urine via a catheter- plastic tube inserted into the bladder) of Resident 6 was left uncovered and without a privacy cover (a cover placed over the urine collection bag so that the urine in the bag cannot be seen). This failure had the potential to negatively impact the residents' dignity, self-worth, and right to be treated with respect.Findings: 1.During a concurrent observation and Interview on 1/14/25 at 9:54 AM with the Infection Preventionist (IP) at Resident 193's bedside, the IP stated Resident 193 was on aspiration precautions (intervention that prevent food, liquid, or saliva from entering the airway) and was a feeder. Review of Resident 193's care plan, (a document that contains the resident's problems, goals, and interventions) the document indicated, .At risk for altered nutritional status.poor oral intake.dysphagia [difficulty swallowing] .Aspiration Precautions: Sitting upright.1:1 feeding. Review of the facility's policy titled, Dignity, dated 2/21, indicated, .Each resident shall be cared for in a manner that promotes and enhances.feeling of self-worth and self-esteem.treated with dignity and respect at all times.Staff speak respectfully to residents at all times.and not 'labelling' or referring to the resident by.care needs. 2.Review of Resident 22's admission RECORD, (a document that contains the resident's demographic information) indicated Resident 22 was admitted to the facility with multiple diagnoses, including dysphagia (difficulty swallowing caused by problems in the mouth or throat) and protein-calorie malnutrition (a condition in which a person does not receive enough protein and calories to meet nutritional needs). During an observation on 1/13/26 at 10:05 a.m., signage was observed posted on Resident 22's communication board (a board that contains pictures, symbols, or letters&mdash;that help residents with speech, language, or cognitive challenges) indicated, Assist pt [patient] with all meals 1:1 feeder, which publicly disclosed Resident 22's care needs. The Department took a photograph of the signage for documentation and interview purposes. During an interview on 1/13/26 at 2:20 p.m. with the Certified Nursing Assistant (CNA 6), CNA 6 stated that Resident 22 should not have been labeled as a feeder. CNA 6 stated that Resident 22 was not a baby and when Resident 22 was publicly identified as a feeder it was disrespectful and could have negatively affected Resident 22's dignity. During a concurrent interview and record review on 1/13/26 at 2:25 p.m. with the Licensed Nurse (LN 12), LN 12 stated that when Resident 22 was identified as a feeder, it was inappropriate. LN 12 (continued on next page)		

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 01/16/2026
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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reviewed the photograph of the signage posted on Resident 22's communication board and confirmed that the signage was not acceptable as it could have compromised Resident 22's dignity and psychosocial well-being. During an interview on 1/13/26 at 2:42 p.m. with the Administrator (ADM) inside Resident 22's room, the Department showed the ADM the signage posted on Resident 22's communication board that indicated, Assist pt with all meals 1:1 feeder. The ADM stated that the signage was not acceptable and was not in accordance with the facility's policy. The ADM further stated that when Resident 22 was labeled in this manner, it could have negatively impacted Resident 22's psychosocial well-being and dignity. A review of the facility policy titled, Dignity, dated 2/21, indicated, .Each resident shall be cared for in a manner that promotes feelings of self-worth and self-esteem.8. Staff speak respectfully to residents at all times, including addressing the resident by his or her name of choice and not 'labeling' or referring to the resident by his or her room number, diagnosis, or care needs. 3.A review of Resident 6's admission RECORD, (a document that contains the resident's demographic information) indicated Resident 6 was admitted to the facility on [DATE] with a diagnosis that included a urinary tract infection (an infection of the bladder or kidneys). During an observation on 1/13/26 at 2:45 p.m. in Resident 6's room, Resident 6's urinary catheter bag was not covered with a privacy cover. During a concurrent observation and interview on 1/13/26 at 4:24 p.m. with the certified nursing assistant (CNA) 6, CNA 6 confirmed Resident 6 urinary catheter bag did not have a privacy cover. CNA 6 further stated a privacy cover should have been placed over Resident 6's urinary catheter bag for dignity purposes. During an interview on 1/16/26 at 9:35 a.m. with the Director of Staff Development (DSD), the DSD stated it was her expectation that urinary catheter bags would have had a privacy cover. The DSD further stated it was important for Resident 6's dignity and self-respect. During a review of the facility's policy and procedure (P&P) titled Dignity, dated 2001, the P&P indicated, .Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents, . helping the resident to keep urinary catheter bags covered.		

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 01/16/2026
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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, interview, and record review, the facility failed to ensure that staff protected the residents' personal privacy and confidentiality for one out of 33 sampled residents (Resident 4) and one unsampled resident (Resident 19) when:1.The Respiratory Therapist (RT) performed tracheostomy care (care provided to keep a breathing tube and the opening in the neck clean and functioning to help a person breathe safely) for Resident 4 without closing the resident's room door, exposing the resident to other staff, residents, and/or visitors during a personal medical procedure; and,2.Resident 19's confidential electronic medical record (EMR, a confidential electronic medical record that details the residents' health, treatment, demographic information, and payment source) was left opened on a laptop computer in a common hallway of the facility.These failures had the potential to result in compromised resident dignity, emotional distress, and unauthorized disclosure of protected health information. Findings: Findings: 1.Review of Resident 4's admission RECORD, (a document that contains the resident's demographic information) indicated Resident 4 was admitted to the facility with multiple diagnoses, which included dysphagia (difficulty swallowing caused by problems in the mouth or throat), and aphasia (a condition that affects a resident's ability to speak, understand speech, read, or write due to damage to the brain). During a concurrent observation and interview conducted on 1/15/26 at 2:57 p.m. with the Respiratory Therapist (RT) in Resident 4's room, the RT performed tracheostomy care while Resident 4's bedroom door remained open. The RT confirmed that the door remained open throughout the medical procedure, which allowed visibility into the room by staff, residents, and/or visitors from the hallway. The RT stated that he should have ensured privacy by closing the door or pulling the privacy curtains (curtains that close around a bed to provide privacy). The RT acknowledged the bedroom door was left open and was an oversight on his part. The RT stated that he should have protected Resident 4's privacy and dignity during the provision of care. During a concurrent interview and record review on 1/15/26 at 3:34 p.m. with the Administrator (ADM), the facility's policy and procedure (P&P) titled, Dignity, dated 2/21, was reviewed. The P&P indicated, .Each resident shall be cared for in a manner that promotes feelings of self-worth and self-esteem.11. Staff promote, maintain, and protect resident privacy, including bodily privacy, during assistance with personal care and during treatment procedures. The ADM verified that the RT had not followed the facility's policy when he had not provided privacy for Resident 4 when the RT administered tracheostomy care. The ADM stated that she expected the staff to provide privacy during all treatments and procedures. The ADM further acknowledged that when privacy was not provided during treatment, Resident 4's dignity may have been negatively impacted. 2. During an observation on 1/15/26 at 9:08 AM in the [NAME] Station Unit, (a nurses' station in the facility) an open laptop computer was left on top of a medication cart (a mobile unit on wheels used to organize, transport, and dispense medications, in healthcare facilities) which exposed Resident 19's personal and medical information to anyone who walked by the laptop computer. During an interview on 1/15/26 at 9:11 AM with the Licensed Nurse (LN) 5, LN 5 confirmed she used the medication cart with the laptop and stated she stepped away from the computer and gave a medication to a resident and had forgotten to lock the computer screen (pushing the lock button hides the computer information). LN 5 stated the facility required the staff to protect the resident's information and that she should have locked the computer screen when she stepped away from it. LN (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 01/16/2026
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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5 stated it was important to lock the computer screen so other residents or visitors who walked by the computer could not visualize Resident 19's confidential personal information. During an interview on 1/15/26 at 9:29 AM with LN 1, LN 1 stated the expectation was when nursing staff walked away from their computers, the nursing staff were to lock the computer screens. LN 1 stated when the computer screen was left open with Resident 19's information it, it was considered a HIPPA violation (HIPPA -Health Insurance Portability and Accountability Act -a United States law that sets national standards to protect sensitive patient health information). LN 1 stated the risk to Resident 19 was exposure of their protected health information to others who did not have authority to access it. During an interview on 1/15/26 at 10:24 AM with the Administrator (ADM), the ADM stated it was important to protect residents' medical information because of HIPPA laws. The ADM further stated it was her expectation that when staff walked away from their computer, they logged off (locked the computer) so no resident's information could be seen. Review of a facility provided policy and procedure (P&P) titled, Computer Terminals/Workstations, dated 4/14, indicated, .Computer terminals and workstations will be positioned/shielded to ensure that protected health information (PHI).is protected from public view or unauthorized access.A user may not leave his/her workstation or terminal unattended unless the terminal screen is cleared and the user is logged off.		

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 01/16/2026
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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, interview, and record review, the facility failed to provide necessary care and services necessary as per professional standards of practice for one of 33 sampled residents (Resident 3) when Resident 3's physician orders for constipation were not followed in a timely manner. This failure placed Resident 3 at risk for constipation-related complications such as abdominal pain, nausea, vomiting, hemorrhoids (painful swollen veins in the rectum), fecal impaction (hard stool blocking the colon requiring medical removal). Findings: Review of Resident 3's admission RECORD (a document that contains the resident's demographic information) indicated Resident 3 had aphasia (a language disorder that makes it hard to communicate), dementia (a condition that causes decline in thinking, memory, and reasoning), Alzheimer's (a disease that slowly affects memory, thinking and daily functioning), and gastrostomy (a tube that goes into the stomach through the belly to give food and fluids) among other diagnoses. During an interview on 1/14/26 at 9:26 AM, with the Infection Preventionist (IP), the IP stated that Resident 3 was non-verbal (not able to talk). During a phone interview on 1/14/26 at 11:26 AM, with Resident 3's daughter (DTR), the DTR stated that she asked the nurse when Resident 3's last bowel movement occurred and was told that it was four days ago, and that this was the only time staff acted on the situation. Review of Resident 3's bowel elimination record for the month of January 2026 indicated Resident 3 did not have a bowel movement from 1/4/26 through 1/8/26. Review of Resident 3's Medication Administration Record (MAR) for the month of January 2026, indicated, . Milk of magnesia (MOM) suspension [medication for constipation] .as needed for constipation give 1 dose on evening shift IF NO BM [bowel movement] after 3 DAYS. If no results, see Dulcolax Suppository [medication used for constipation] Order Dulcolax suppository . insert 1 suppository rectally as needed for constipation. Give if no result from MOM on NOC [night] shift . If no results, see Fleet enema [medication used for constipation] order . Insert 1 unit rectally as needed for constipation . Give if no results from Dulcolax Suppository. Further review of the MAR indicated none of the constipation medications as ordered were given from 1/4/26 through 1/7/26 and suppository was administered on 1/8/25 at 9:00 PM. During a concurrent interview and record review on 1/15/26 at 5:09 PM, with the Director of Nursing (DON), Resident 3's bowel elimination record, physician orders, MAR, and care plans were reviewed. The DON confirmed Resident 3 did not have a bowel movement for 5 days from 1/4/26 through 1/8/26. The DON verified Resident 3's physician orders were not followed when he was not given constipation medications as ordered after 3 days of no bowel movement. The DON stated she expected staff to follow residents' physician orders for bowel care. During an interview with Licensed Nurse (LN) 2 on 1/16/26 at 7:42 AM, LN 2 stated that if a resident did not have a bowel movement for more than three days, it could cause increased confusion in a bedbound resident. LN 2 stated nurses should consistently monitor resident's bowel elimination record and should follow physician orders for bowel care. During a phone interview with the Facility Doctor (FAD) on 1/16/26 at 1:50 PM, the FAD stated that if a resident did not have a bowel movement for two days, the facility should start the bowel care orders. Resident 3's Care plan, dated 9/16/25, indicated, . Problem .At risk for constipation .Goal .Will report continuous satisfactory bowel movements every 2 to 3 days .Interventions . Administer medications for constipation prevention as ordered by the Physician.		

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 01/16/2026
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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review the facility failed to provide respiratory care consistent with professional standards of practice for one of 33 sampled residents (Resident 2) when: 1. Resident 2 did not receive oxygen therapy as prescribed by the physician; and 2. Nursing staff did not follow the identified oxygen therapy interventions as outlined in Resident 2's care plans (a document that contains the resident's problems, goals, and interventions). These deficient practices had the potential to place Resident 2 at risk for health decline and respiratory distress. Findings: 1. Review of Resident 2's admission Record, (a document that contains the resident's demographic information) the document indicated Resident 2 was originally admitted to the facility 9/23, and then readmitted in 9/25, with diagnoses which included acute respiratory failure with hypoxia (a life threatening condition where the lungs can't get enough oxygen into the blood, causing low blood oxygen, and severe shortness of breath), chronic systolic congestive heart failure (a weak heart can't pump blood effectively over a long period of time, causing fluid backup in the body, leading to symptoms like shortness of breath, fatigue, and swelling), and pleural effusion (abnormal buildup of excess fluid in the thin gap between the lungs and chest wall causing symptoms of shortness of breath). During a concurrent observation and interview on 1/13/26 at 9:16 a.m. with Resident 2, Resident 2 was observed in bed in a sitting position and connected to an oxygen concentrator (oxygen delivery device) set at three liters (L, unit of measurement) per (l) minute (min). Resident 2 stated that he routinely received oxygen therapy while in bed via an oxygen concentrator and while seated in his wheelchair via a portable oxygen tank. Review of Resident 2's orders for oxygen, dated 9/2/25, indicated, Oxygen: At 3 Liters/Min via Nasal Cannula [a lightweight, flexible tube with two prongs that fit into the nostrils to deliver supplemental oxygen, connecting to an oxygen source like a tank or an oxygen concentrator] Every Shift for hypoxia [low oxygen in the blood]/shortness of breath. Goal is to maintain oxygen saturations [the percentage of red blood cells, carrying oxygen, indicating how well lungs oxygenate body and supply tissues] above 90%. During an observation on 1/15/26 at 2:45 p.m., Resident 2 sat in his wheelchair in the hallway near the south nurse station and was connected to a portable oxygen tank; however, the oxygen tank was turned off. During a concurrent observation and interview on 1/15/26 at 2:46 p.m. with the Respiratory Therapist (RT), the RT confirmed Resident 2 was connected to an oxygen tank that was not turned on. The RT assessed the resident's measured oxygen saturation using a pulse oximeter (a small, non-invasive device clipped onto a fingertip to measure blood oxygen saturation) which initially measured 90%, and within 30 seconds of receiving oxygen at 3 liters per minute (L/min), the oxygen saturation increased to 97%. The RT stated that Resident 2 had diagnoses of congestive heart failure and hypoxia, and that failure to receive prescribed oxygen therapy could have placed stress on the heart and led to symptoms such as syncope (fainting or passing out), and dizziness, thereby placing Resident 2's health at risk. The RT further stated that he was unable to determine how long Resident 2 had been without oxygen while seated in his wheelchair in the hallway. The RT stated that his expectation of the nursing staff was to ensure that Resident 2 remained on continuous oxygen therapy as ordered by physician. The RT further added that when Resident 2 was transferred to the wheelchair, nursing staff should have ensured the oxygen tank was turned on and delivered oxygen at the prescribed rate. The RT stated that this expectation was not met by the nursing staff. During an interview on 1/15/26 at 2:58 p.m. with the Licensed Vocational Nurse (LN) 9, LN 9 stated that Resident 2 was ordered continuous oxygen therapy 3 L/min via nasal cannula. LN 9 stated nurses were responsible for transitioning the oxygen source from the concentrator to a portable oxygen tank when Resident 2 was transferred from bed to a wheelchair. LN 9 further stated that nursing staff were expected to ensure the oxygen was turned on at the same flow rate as ordered by the physician. LN 9 further added the failure to properly receive oxygen could have placed Resident 2 at risk for respiratory distress and hypoxia. 2. A review of Resident 2's care plan for congestive heart failure, (continued on next page)		

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 01/16/2026
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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dated 9/13/25, indicated, . Interventions/Tasks. Oxygen Setting: O2 [oxygen] via (nasal cannula) @ [at] (3)L (continuously)., and a review of Resident 2's care plan for at risk for hypoxia [low oxygen in the blood], dated 9/10/25, indicated, . Interventions/Tasks. Administer oxygen as ordered and observe oxygen precautions. Review of the care plans revealed that the facility did not ensure the identified interventions were implemented as care planned.A Review of Resident 2's orders for oxygen, dated 9/2/25, indicated, Oxygen: At 3 Liters/Min via Nasal Cannula Every Shift for hypoxia/shortness of breath.During an interview on 1/15/26 at 2:58 p.m. with LN 9, LN 9 stated that Resident 2 had diagnoses of congestive heart failure and hypoxia and was ordered continuous oxygen therapy at 3 L/min via nasal cannula. LN 9 further stated that oxygen administration was addressed in Resident 2's care plan interventions and that nursing staff were responsible for reviewing and implementing the identified interventions. LN 9 also stated that failure to properly administer oxygen therapy and follow the care plans interventions for oxygen therapy placed Resident 2 at risk for respiratory distress and worsening hypoxia.During a concurrent interview and record review on 1/15/26 at 3:40 p.m. with the Director of Nursing (DON), all of Resident 2's active medication orders and active care plans were reviewed. The DON confirmed that Resident 2 had an active order for oxygen 3 L/min to be administered continuously via nasal cannula, using an oxygen concentrator while in bed and a portable oxygen tank when transferred from bed to wheelchair. During a review of the care plans the DON confirmed that Resident 2 had care plans addressing the identified interventions for oxygen administration as ordered by the physician. The DON further stated that her expectation from nursing staff was to ensure Resident 2 remained on oxygen therapy while seated in the wheelchair and that the portable oxygen tank remained on. The [NAME] stated that this expectation was not met.Review of the facility provided policy and procedure (P&P) titled, Oxygen Administration, revised 10/10, indicated, . The purpose of this procedure is to provide guidelines for safe oxygen administration. Preparation 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. 2. Review the resident's care plan to assess for any special needs of the resident. Steps in the Procedure. 4. Turn on the oxygen. 9. Observe the resident upon and periodically thereafter to be sure oxygen is being tolerated.		