

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

Printed: 08/01/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555240	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/26/2024
NAME OF PROVIDER OR SUPPLIER Turlock Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1111 E Tuolumne Road Turlock, CA 95380	
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. 27137 Based on interview and record review, the facility failed to provide treatment and care in accordance with professional standards of practice for one of three sampled residents (Resident 1) when Resident 1 was admitted in the facility on 10/3/24 for status post left hemiarthroplasty (a surgical procedure where half of the hip is replaced) and scheduled to have a follow-up appointment with Orthopedic Surgeon (OS- a physician who specialized in treating injuries and diseases of the bones) on 10/26/23. The Facility did not know of the appointment and did not perform a hip xray (a test used to create pictures inside of the body) for Resident 1 to bring for the appointment. This failure resulted for Resident 1 to arrive on his OS appointment without a hip x-ray result and was not assessed by the OS to ensure recovery was proceeding as expected and early detection of potential complications such as hip dislocation, infection, blood clots, and loosening of the joint. Findings: During an interview on 3/19/24, at 8:06 a.m. with the Family Member (FM), the FM stated Resident 1 recently had a surgery on his hip performed by OS and scheduled to have his first follow-up appointment with OS on 10/26/23. The FM stated she arrived at the facility on 10/26/23 to accompany Resident 1 to his orthopedic appointment. The FM stated the facility did not know of the OS appointment and only knew when she arrived and told them. The FM stated the facility did not arrange transportation services to the appointment and she ended up using her car to take Resident 1 to the appointment. The FM stated when they arrived at the orthopedic appointment the OS asked for the hip x-ray result. The FM stated the facility did not provide the hip x-ray result and OS would not assess Resident 1's hip without the x-ray result. The FM stated, It was a waste of time. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/26/24, at 2:55 p.m. with the Assistant of Staff Development (ASD), the ASD stated on 10/26/23 she was assigned for residents' appointment and transportation. The ASD stated on 10/26/23 FM arrived in the facility to accompany Resident 1 for his OS follow-up appointment. The ASD stated she did not know Resident 1 had an OS appointment she only knew of the appointment when FM told her. The ASD stated there was no transportation arranged and FM drove Resident 1 for his appointment using her own car. The ASD stated when Resident 1 arrived for his follow-up appointment the OS did not see Resident 1 because there was no hip x-ray result. The ASD stated the usual process was during resident admission in the facility, the admission staff normally provides me the residents appointment information to prepare residents for their appointments and it did not happen for Resident 1. The ASD stated the facility knew OS always wants an x-ray result for his patients to bring for follow-up appointment. The ASD stated a hip x-ray should have been performed prior to Resident 1 going to his follow-up appointment. During a concurrent interview and record review on 3/26/24 at 3:40 p.m. with the Director of Staff Development (DSD). Resident 1's Physician's Orders (PO), , dated 10/9/23, at 9:11 a.m. was reviewed. the PO indicated, .Follow up with [OS] on 10/26/23 at 11 AM . [OS address]. The order was received and signed by a facility licensed nurse on 10/9/23. The DSD confirmed the PO for the appointment. The DSD stated the PO did have an order for an x-ray and the licensed nurse should have obtained a physician's order for an x-ray. The DSD stated it was the standards of practice for Resident 1 to have an x-ray for his surgical left hip to bring to his first follow-up appointment with OS. During an interview on 4/2/24 at 9:45 AM, with Clinic Supervisor (CS) for OS, the CS stated OS always requires an x-ray for his patients to bring during the follow-up appointments and the facilities are aware of this. The CS stated most of the time the facility would provide the residents with a CD (Compact Disc-a digital storage medium) with the x-ray image to bring during the appointment. During a review of the professional reference from https://www.verywellhealth.com/follow-up-after-joint-replacement-surgery-4164748#:~:text=Some%20surgeons%20obtain%20these%20X,anything%20changes%20down%20the%20road. Titled Follow-Up Appointments After a Knee or Hip Replacement Surgery dated 7/2022 indicated, After undergoing a joint replacement, such as a hip replacement surgery . there will be a number of follow-up appointments with your orthopedic surgeon to ensure that your recovery is proceeding as anticipated . These follow up appointments may continue for years, or even decades . Follow-up appointments are critical time evaluation that can help ensure the recovery is proceeding as expected and can help detect any potential problems or complications that may required intervention . These visits are often called surveillance visits, and the X-rays obtained are called surveillance X-rays . Some surgeons will obtain X-rays every year, some every other year .		

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F 0774 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Help the resident with transportation to and from laboratory services outside of the facility. 27137 Based on interview and record review, the facility failed to assist in making transportation arrangements for one of three sampled residents (Resident 1), when Resident 1 was scheduled to have an orthopedic surgeon (OS- a physician who specialized in treating injuries and diseases of the bones) appointment on 10/26/23 and the facility did not know of the appointment and did not make prior transportation arrangements from the facility to the OS appointment. This failure resulted in Resident 1's family member (FM) to transport Resident 1 in her private vehicle at the last minute to the OS appointment. Findings: During an interview on 3/19/24, at 8:06 a.m. with the Family Member (FM), the FM stated Resident 1 recently had a surgery on his hip performed by OS and scheduled to have his first follow-up appointment with OS on 10/26/23. The FM stated she arrived at the facility on 10/26/23 to accompany Resident 1 to his orthopedic appointment. The FM stated the facility did not know of the OS appointment and only knew when she arrived and told them. The FM stated the facility did not arrange transportation services to the appointment and she ended up using her car to take Resident 1 to the appointment. During an interview on 3/26/24, at 2:55 p.m. with the Assistant of Staff Development (ASD), the ASD stated on 10/26/23 she was assigned for residents' appointment and transportation. The ASD stated on 10/26/23 FM arrived in the facility to accompany Resident 1 for his OS follow-up appointment. The ASD stated she did not know Resident 1 had an OS appointment she only knew of the appointment when FM told her. The ASD stated there was no transportation arranged and FM drove Resident 1 for his appointment using her own car. The ASD stated the usual process was during resident admission in the facility, the admission staff normally provides me the residents appointment information to prepare residents for their appointments and it did not happen for Resident 1. During a concurrent interview and record review on 3/26/24 at 3:40 p.m. with the Director of Staff Development (DSD). Resident 1's Physician's Orders (PO), , dated 10/9/23, at 9:11 a.m. was reviewed. the PO indicated, .Follow up with [OS] on 10/26/23 at 11 AM . [OS address]. The order was received and signed by a facility licensed nurse on 10/9/23. The DSD confirmed the PO for the appointment scheduled for 10/26/23. During a review of the Facility Handbook, undated, the Facility Handbook indicated Transportation: The facility is responsible for arranging transportation for our residents to medical appointments. When family assistance is not available, other transportation arrangements will be made.		