

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

Printed: 12/04/2024
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 09/05/2024
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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 27137 Based on observation, interview, and record review, the facility failed to ensure the Interdisciplinary Team (IDT- a group of professional individuals involved in the care of the resident) assessed one of 14 sampled resident (Resident 4) on the resident ' s ability to self-administer medications safely and accurately when Resident 4 did not take her six oral medications left by License Vocational Nurse (LVN) 3 at the bedside table. This failure had the potential to result of Resident 4 not receiving the correct dose of medications necessary to treat her condition or illness. Findings: During a review of Resident 4 ' s Admission Record (AR-documents that contained the resident ' s demographics and medical diagnosis), dated 9/6/24, the AR indicated Resident 4 was admitted to the facility in 2020, with diagnoses which included Alzheimer ' s Disease (a progressive disease affecting the brain, altering mood, judgement, and memory); and schizophrenia (mental disorder affecting perceptions of reality). During an observation on 9/5/24, at 12:02 p.m., in Resident 4 ' s room, Resident 4 was in bed with her eyes closed and six oral medications inside a small medication cup was on Resident 4 ' s bedside table. The medications were within Resident 4 ' s reached and there was no facility staff in the room. During a concurrent observation and interview on 9/5/24, at 12:05 p.m., with the Assistant Director of Nursing (ADON), in Resident 4 ' s room. Resident 4 was in bed with her eyes closed. The ADON confirmed the six oral medications inside a medicine cup on Resident 4 ' s bedside table. The ADON stated the medications should not have been left at the bedside table. The ADON stated the medication nurse should have ensured Resident 4 took her medications before leaving the room. (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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 9/5/24, at 12:10 p.m., with the Assistant Director of Nursing (ADON), and Licensed Vocational Nurse (LVN) 3, LVN 3 was preparing medications for residents. LVN 3 stated she was the medication nurse assigned to Resident 4. The ADON showed LVN 3 the medication cup with the six medications found in Resident 4 ' s bedside table. LVN 3 stated she recalled entering Resident 4 ' s room around 9 a.m. to give Resident 4 a total of ten prescribed medications, divided into two separate medication cups. LVN 3 stated she observed Resident 4 take the first medication cup and left the second cup at the bedside table and had no idea if Resident 4 took the second medication cup after she left the room. LVN 3 stated she should have not left the medications at Resident 4 ' s bedside table and should have ensure Resident 4 took the medications before she left the room. LVN 3 stated she did not follow the facility ' s policy and procedure for medication administration. During a concurrent interview and record review on 9/5/24, at 12:25 p.m., with the ADON, Resident 4 ' s clinical record was reviewed. The ADON stated Resident 4 should have an IDT assessment which indicates she is safe to self-administer medications. The ADON stated she was unable to find an IDT assessment for Resident 4 to self-medicate. The ADON stated the six oral medications left on Resident 4 ' s bedside table were one table Sodium Chloride (to replace water and salt), one tablet of Hydralazine (a medication used to treat high blood pressure) 25 milligrams (mg-unit of measurement), one tablet of Duloxetine (a medication used for nerve pain, depression and anxiety) 20 mg, one tablet of Gabapentin (a medication for nerve pain and prevent seizures) 300 mg and two tablets of Furosemide (a medication used to remove excess fluid) 20 mg. During a review of the facility ' s policy and procedure (P&P) titled LTC Facility Pharmacy Services and Procedures Manual -Policy #/Title: 6.0 General Dose Preparation and Medication Administration dated 4/30/24, the P&P indicated (2.8) Facility staff should not leave medications or chemicals unattended; (5.4) Administer medications within timeframes specified by facility policy or manufacturer ' s information; (5.9) Observe the resident ' s consumption of the medication(s). During a review of the facility ' s P&P titled Self- Administration of Medication- Procedure #591 dated 2008, the P&P indicated, (2) If the resident expresses a desire to self-administer their medications ., the facility will not allow the resident to self-administer meds until the following .a. A licensed nurse will complete the self-administration assessment review which includes the resident ' s physical and cognitive ability to safely administer and store their medications. b. The assessment will then be routed to the director of nursing/ designee to review with the interdisciplinary team (IDT) for approval. c. The IDT will reassess the resident to verify they are still able to self-administer medications quarterly. The resident will do a return demonstration to the IDT to show they are able to perform this task. (3) The decision to either approve or deny self-administration will be documented and the resident will be notified (4). If the IDT approves self-administration the following steps will be taken .: a. The resident physician will be contacted for approval. (5) The following steps . to monitor the residents and other residents ' safety and will be included on the care plan related to self-administration: c. The self-administration of the drug will be charted on the MAR by the licensed nurse (6) Quarterly the interdisciplinary team will reassess the resident to ensure they are still able to self-administer medication. The residents will do . to the IDT to show they are able to perform these tasks.		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 27137 Based on interview and record review, the facility failed to notify the Responsible Party (RP- the person who is responsible for paying the patient ' s account bills) of a change of condition for one of 14 sampled resident (Resident 3) when Resident 3 was diagnosed with Urinary Tract Infection (UTI- a bacterial infection that occurs when bacteria enter the urinary tract) and was started on antibiotics (a medication that kills bacteria). This failure resulted for the RP not aware of Resident 3 ' s UTI diagnosis and was not able to make informed decisions and participate with Resident 3 ' s care and treatment. Findings: During a review of review of Resident 3 ' s Admission Record (AR-documents that contained the resident ' s demographics and medical diagnosis), dated 9/6/24, the AR indicated, Resident 3 was admitted to the facility with diagnoses which included dementia (a progressive disease affecting the brain, memory, mood, and judgement) and Resident 3 ' s RP for Power of Attorney - Care (a legal document that allows someone to act on another person ' s behalf) was Family Member (FAM) 2. During a review of Resident 3 ' s Minimum Data Set (MDS- a comprehensive, standardized assessment tool used to assess resident ' s health and functional status), dated 8/31/24, the MDS indicated Resident 3 ' s Brief Interview for Mental Status (BIMS- an assessment tool used to identify resident ' s cognitive status) assessment score was 4 out of 15 (0-6 severe cognitive deficit, 7-12 moderate cognitive deficit, 13-15 no cognitive deficit) which indicated Resident 3 had severe cognitive impairment. During a review of Resident 3 ' s Progress Notes (PN), dated 9/3/24, at 8:49 a.m., the PN indicated Resident 3 ' s physician had reviewed a recent urine test and prescribed a one-time dose of the antibiotic ceftriaxone, one gram (unit of measurement), to be given via (by way) injection into a large muscle. The PN dated 9/3/24, at 9:52 p.m., indicated Resident 3 ' s physician ordered a second dose of ceftriaxone, one gram, to be given into a large muscle, antibiotic nitrofurantoin, 100 milligrams (unit of measurement), to be given twice daily for 7 days for UTI and laboratory analysis. There were no entries in the PN of Resident 3 ' s RP notified of the new diagnoses of UTI, antibiotic treatment, and laboratory analysis. During an interview on 9/5/24, at 11:28 a.m., with FAM 2, near Resident 3 ' s room, FAM 2 stated when he visited Resident 3 on 9/4/24, he saw a sign posted near Resident 3 ' s door and asked nursing staff about the sign. FAM 2 stated nursing staff told him the sign indicated Resident 3 had UTI and was on antibiotics. FAM 2 stated it was the first time he was notified of Resident 3 ' s diagnosis of UTI and antibiotic treatment. FAM 2 stated he was Resident 3 ' s RP and should have been notified of the UTI diagnosis and antibiotic treatment and was not. (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent record review and interview on 9/5/24, at 1:07 p.m., with the Assistant Director of Nursing (ADON), Resident 3 ' s clinical record was reviewed. The ADON stated Resident 3 ' s family was not notified of the change of condition identified by the facility on 9/3/24 until the next day when FAM 2 came to visit. The ADON stated FAM 2 should have been notified of Resident 3 ' s UTI diagnosis and antibiotic treatment. During an interview on 9/11/24, at 3:30 p.m., the ADON stated her expectation for license nurses was to notify resident ' s family member or RP for resident ' s change of condition. During a review of the facility ' s policy and procedure (P&P) titled, Change of Condition, dated 2016, the P&P indicated, Purpose - Basic Responsibility - Licensed Nurse[.] To appropriately assess, document and communicate changes of condition . Document assessment findings and communications as soon as practical[.] Notify physician and responsible party of assessment findings[.] Notify the Patient and/or responsible party of current status and subsequent actions/orders.		