

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

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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 12/12/2024
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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 27137 Based on interview and record review, the facility failed to: 1. Ensure the rights of 1 of 3 sampled residents (Resident 11) were respected and honored when one Certified Nursing Assistant (CNA 9) displayed an obscene finger gesture toward Resident 11. This failure had the potential for Resident 11 to experience a negative effect to his psychosocial well-being, and, 2. Honor the rights of an unknown number of resident rights by ensuring staff followed their policy and procedure and spoke only English in the facility. This failure had the potential for resident rights to not be honored when an unknown number of residents heard staff speaking a non-English language, and possibly thinking staff were speaking about them. Findings: 1. During a review of the facility document titled, Verification of Incident Investigation / Administrative Summary (VIAS) , dated 11/25/24, the VIAS indicated, On 11/21/24 at approximately 4 pm an Admissions staff member reported that she witnessed male CNA flip off [Resident 11] with his middle finger. [Director of Staff Development, or DSD] was notified and the CNA was identified as [CNA 9] and was immediately pulled off the floor and suspended pending investigation. [CNA 9] stated he was preparing [Resident 12, who was Resident 11's roommate] for a shower & bumped into [Resident 11's] bed. At this time, [Resident 11] began using foul language and calling [CNA 9] names. [CNA 9] states that on his way out of the room, [Resident 11] kicked at him and continued cursing him and flipping him off. When [CNA 9] left the room with [Resident 12], he states he turned and flipped [Resident 11] off twice because he was frustrated and felt he did not do anything to deserve such treatment from [Resident 11]. [I]t was agreed upon to terminate [CNA 9] involved in the event. During a review of the facility document titled, Notice to Employee as to change in Relationship (Notice) , dated 11/25/24, the Notice indicated, On 11/25/24 [CNA 9's] employment status change/will change as follows: Involuntarily terminated for misconduct. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 1's Progress Notes (PN) , dated 11/21/24, at 5 pm, the PN indicated, [At 4 pm], Called by [Charge Nurse, or CN] regarding abuse [to Resident 1] by staff member. as per Admission staff member, she saw staff member flipping off the resident, this nurse and the DSD immediately removed the staff member from the floor. [H]ead to toe skin inspection done by CN no physical injury noted and no emotional distress noted, vital signs stable. During a review of Resident 11's Care Plan (CP) , dated 11/22/24, the CP indicated, Resident 1 was assessed for a Risk for decline in psychosocial well being related to: staff to resident non-physical abuse[.] During an interview on 12/3/24, at 12:45 pm, with the Administrator, the Administrator stated, We terminated [CNA 9]. He admitted to doing this and we terminated him. [Resident 11] can be difficult at times, but he can't be treated like that. During an interview on 12/3/24, at 1 pm, with the Admissions Staff Member (ASM), the ASM stated she witnessed the event between Resident 11 and CNA 9 on 11/21/24 at 4 pm. The ASM stated she was near Resident 11 and Resident 12's room when she saw Resident 11 and CNA 9 talking, and stated, Words were exchanged, not angry, then I saw [CNA 9] flip [Resident 11] off. Then, [CNA 9] flipped him off again. [Resident 11] looked at me, we made eye contact, he stated to me: ' Did you see that?' I said: ' Yes I did.' You can't do that to a resident. During an interview on 12/3/24, at 1:35 pm, with Resident 11, Resident 11 stated, I don't ever recall being flipped off by anybody. During an interview on 12/5/24, at 5 pm, with CNA 9, CNA 9 stated that on 11/21/24, he was transporting Resident 12, who was Resident 11's roommate, in his wheelchair when he accidentally bumped Resident 11's bed. CNA 9 stated Resident 11 then began cussing at him, kicked him in the leg, and, gave me the middle finger. CNA 9 stated that he then gave Resident 12 a shower, and upon his return to Resident 11 and Resident 12's shared room, Resident 11 flipped me off again. I flipped him off. The resident did it first, this is why I did it, to let him know this is not ok. During a review of the facility Policy & Procedure (P&P) titled, Abuse Prevention, Intervention, Investigation & Crime Reporting Policy , dated 11/16, the P&P indicated, Definitions[:] Verbal Abuse is defined as the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, agility to comprehend or disability. 2. During an interview on 12/10/24, at 8:13 a.m., with the Ombudsman (a government official that advocates for the rights of the residents), the Ombudsman stated she was aware of facility residents complaining of English not being spoken in the facility. During a review of the facility's Resident Council - Meeting Minutes (RCMM) , dated 9/24/24, the RCMM indicated the meeting was attended by seven residents. The RCMM indicated, Shift speaking different language other than English[.] Improvement Recommended . During an interview on 12/10/24, at 12:55 p.m., with Resident 8, Resident 8 stated, Staff talk in a non-English language loudly in the hallways. This bothers me. (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/11/24, at 1:45 p.m., with Certified Nursing Assistant (CNA) 2, CNA 2 stated, Sometimes I do hear staff talking at work in their own language. Some residents think they are talking about them. This doesn't happen every day. We tell the staff this is not allowed. During an interview on 12/11/24, at 1:52 p.m., with CNA 3, CNA 3 stated, Sometimes I hear non-English language spoken in the hallways. Those staff should be more professional. The residents think we are talking about them. During an interview on 12/12/24, at 10:25 a.m., with the Director of Nursing (DON), the DON stated, Speaking only English on duty is still an ongoing issue. We remind each other that only English is to be spoken to each other on duty. We re-emphasize this during our monthly meetings. If I was a resident, if I heard staff speaking in a language I didn't understand, I would think that too - that they were speaking about me. During a review of the facility Policy and Procedure (P&P), titled English the Official Language , dated 5/15, the P&P indicated, It is the policy of [the facility] to establish English as the official spoken and written language of [the facility]. This policy applies to all employees. Residents have the right to be fully informed of their medical condition. To ensure that right, English is established as the official language used at [the facility]. When employees are in resident care or living areas, they must speak English.		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 27137 Based on interview and record review, the facility failed to ensure timely responses to 2 of 5 residents (Resident 6, Resident 7) requests for pain relief when they had to wait over 30 minutes for a nurse to bring them their prescribed pain medication. This failure had the potential for Resident 6 and Resident 7 to have their pain poorly managed, potentially resulting in prolonged pain and discomfort. Findings: 1. During a concurrent observation and interview on 12/10/24, at 12:42 p.m., with Resident 6, in his room, Resident 6 stated he takes Norco (a strong narcotic pain reliever) for his painful right elbow. Resident 6's right elbow was observed, it was noted to be swollen and red. Resident 6 stated, Sometimes it takes two to three hours to answer my call light. I laid awake all night last night from the pain in my elbow. Last night I was hurting so bad. I got my Norco at 7:30 a.m. this morning. Resident 6 then produced his personal notebook that indicated his handwritten note, indicating he received Norco at 7:30 a.m. that day. During a review of Resident 6's Admission Record (AR) , dated 12/12/24, Resident 6 had a medical diagnosis dated 11/12/24 of bursitis, a painful swelling of fluid filled sacs in a joint, such as the elbow. During a review of Resident 6's Order Summary Report (OSR) , dated 12/12/24, the OSR indicated he had a physician's order for Norco, dated 12/1/24, to be given every four hours as needed for pain. During a review of Resident 6's Minimum Data Sheet (MDS, a comprehensive, standardized assessment tool) , dated 9/24/24, the MDS indicated at Question C0500 a score of 15 out of a possible 15, which indicated Resident 6 was cognitively intact (having sufficient judgment, planning, organization, self-control, and the persistence needed to manage the normal demands of the resident's environment). During a review of Resident 6's Care Plan, dated 8/23/23, the Care Plan indicated Resident 6 has acute pain . The Care Plan indicated as an intervention, dated 8/25/21, Anticipate the resident's need for pain relief and respond immediately to any complaint of pain. During a review of Resident 6's Controlled Drug Record (CDR) dated 12/3/24, the CDR indicated Resident 6 was given Norco on 12/9/24, at 2 p.m., and then the next dose was given on 12/10/24, at 7:30 a.m. The CDR indicated no doses of Norco were administered between those times. 2. During a review of Resident 7's Progress Notes (PN) , dated 12/4/24, at 3:10 p.m., the PN indicated Resident 7 had a Brief Interview for Mental Status (BIMS) score of 14 out of a possible 15, which indicated Resident 7 was cognitively intact. The PN dated 12/13/24 indicated Resident 7 had a medical diagnosis of Pain in right hip. (continued on next page)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 7's Medication Administration Record (MAR) , the MAR indicated she had a physician's order for Norco, dated 11/28/24, to be given every 6 hours as needed for pain. The MAR indicated Resident 7 received Norco eight times from 12/1/24 to 12/12/24. During an interview on 12/12/24, at 10 a.m., with Resident 7, in her room, Resident 7 stated she takes pain medication for pain. Resident 7 stated it takes about 30 minutes on average to get her pain medication but at times takes one hour. Resident 7 stated this did not make her feel good. During an interview on 12/12/24, at 10:25 a.m., with the Director of Nursing (DON), the DON stated that 30 minutes to medicate a resident for pain is too long. 60 minutes is too long, that is my expectation. If a resident has to wait that long, that is too long. The [Registered Nurse] supervisor we have on duty at night should be able to help. The RN supervisor is not assigned any residents, they can help. That's why we don't assign the RN supervisor a cart at night. During an interview on 12/12/24, at 12:06 p.m., with the Medical Director (MD), the MD stated it was his expectation that resident should not have to wait more than 30 minutes for their prescribed pain medication. During a review of the facility's policy and procedure (P&P), titled, Pain Management , undated, the P&P indicated, The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.		