STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555240	A. Building B. Wing	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Turlock Nursing & Rehabilitation Center	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.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of six sampled residents (Resident 1's) family member (FM 1) was notified of a significant change of condition when Resident 1 returned to the facility after a seven-day stay in a nearby hospital, and facility staff noted Resident 1 had new areas of skin breakdown, was refusing further skin assessment of this new breakdown, was refusing antibiotics (medication used to treat infections), and refusing to have a blood test as ordered by her physician. This failure resulted in Resident 1's family being unaware of Resident 1's changes in condition upon her return to the facility from the hospital. Findings: During a review of Resident 1's admission Record (AR) , dated 6/16/25, the AR indicated she was a [AGE] year-old female admitted to the facility on [DATE], with diagnoses that included Congestive Heart Failure (chronic condition where the heart doesn't pump blood as efficiently as it should, leading to a buildup of fluid in the body), Chronic Obstructive Pulmonary Disease (a progressive lung disease that makes it difficult to breathe), Diabetes (condition where body cannot regulate sugar in the blood, affecting all body systems), End Stage Renal Disease (condition where kidneys have permanently lost most of their function of filtering blood), Morbid Severe Obesity (overweight), Muscle Wasting and Atrophy (a decrease in muscle mass and strength, often resulting in reduced function), Dependence on Renal Dialysis (requiring the blood to be filtered through a machine three times a week), Dependence On Other Enabling Machines and Devices, and Noncompliance with Other Medical Treatment and Regimen. During a review of Resident 1's Minimum Data Sheet (MDS, a comprehensive, standardized assessment tool) , dated 4/9/24, the MDS indicated at Question C0500 a score of 15 out of a possible 15, which indicated Resident 1 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 1's Skin Inspection Assessment ([NAME]) , dated 4/9/24, at 8:18 a.m., the [NAME] indicated Resident 1's skin was clear [,] No new skin concerns at this time. During a review of Resident 1's Progress Notes (PN) , dated 4/15/24, at 11:35 p.m., the PN indicated Resident 1 was noted to have a skin excoriation [excoriation is the act of scratching or rubbing the skin, resulting in the removal of the surface layer of the skin, creating superficial wounds or scratches] to right buttock . [Resident 1's primary care physician, MD 1] made aware. (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 review of Resident 1's [NAME] dated 4/16/24, at 1:32 p.m., the [NAME] indicated a Right buttock skin excoriation . During a review of Resident 1's PN dated 4/16/24, at 11:57 a.m., the PN indicated, Resident continues to note with MASD [Moisture Associated Skin Damage, a skin condition caused by prolonged exposure to moisture, like sweat] to abdominal folds and skin excoriation to right buttock. Resident allowed staff to complete skin assessment and change dressing. Resident was cleaned and skin dried then [Resident 1] was dressed and . encouraged to reposition and float heels at this time but resident continues to state she is unable to breathe if she repositions. Risks and benefits explained. During a review of Resident 1's PN dated 4/16/24, at 1:34 p.m., the PN indicated Resident 1 was transferred from the facility to a local acute care hospital by ambulance due to the resident complaining of being short of breath. The PN indicated, MD [1] in house and got order to send [Resident 1] to ER [emergency room or Department] for further eval[uation] and treat[ment], called [Family Member 1] and made aware. During a review of Resident 1's History and Physical/admission Notes (H&P) , from the local acute care hospital, dated 4/16/25, at 8:39 p.m., the H&P indicated Resident 1 had been brought into the Emergency Department by ambulance for increasing [shortness of breath, patient] found to be in atrial flutter [a condition where a portion of the heart is beating to quickly] by [emergency medical services]. Assessment/Plan: 1. Acute on chronic respiratory failure [occurs when a patient with a pre-existing chronic respiratory condition experiences a sudden, worsening of their respiratory status] 2. Cellulitis of right groin [a common bacterial infection of the skin and the tissues beneath it] 3. Metabolic acidosis [a condition where there's too much acid in the body fluids] 4. Atrial flutter. Admit to telemetry [a specialized unit where patients receive continuous remote monitoring of their vital signs, primarily heart rhythms, using specialized equipment] . During a review of Resident 1's Discharge Summary (DS) , from the local acute care hospital, dated 4/23/25, at 2:06 p.m., the DS indicated Resident 1 had a urinary tract infection (UTI, a bacterial infection that affects any part of the urinary system, and is usually treated with antibiotic medication) and was to be discharged back to the facility with antibiotics as continuing treatment. The DS also indicated Resident 1 has several wounds, wound care was consulted. Patient is non-compliant. Refusing most of the medication during hospitalization. During a review of Resident 1's Printable Discharge Form (PDF) document, from the local acute care hospital, dated 4/23/24, at 1:22 p.m., the PDF indicated, Physical Exam: The patient has pressure wounds under her pannus[, a condition where there is an excess of skin and fat tissue that hangs over the lower abdomen] the patient appears weak [,] morbidly obese with large pannus[.] Wounds – pressure wounds from patient's obese tissue laying on her other skin . Wound – suggest offloading and keeping clean and dry. Resident 1 was also to continue her antibiotics for her UTI at the facility. During a review of Resident 1's PN dated 4/23/24, at 11:36 p.m., the PN indicated Resident 1 had returned to the facility, and indicated, .she is to receive [antibiotic medication] tomorrow at [2 p.m.]. The PN did not indicate FM 1 had been notified of Resident 1's return to the facility. (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 review of Resident 1's [NAME] dated 4/23/24, at 11:40 p.m., the [NAME] indicated Resident 1 had the following new skin issues: bruising and redness on lower back [,] bruising on left lower arm [,] bruising on left upper thigh [,] bruising on right lower leg [,] bruising on all over abdomen and two open wounds on right side of [abdominal] fold 5 cm x 2 cm, two open wounds on left side of [abdomen] 6 cm x 2 cm, abdomen fold on left side is brusied and is hard to touch [,] excoriation on right and left buttocks 2 cm x 2 cm [,] open wound on right sides of the hip [,] open wound and bruising under right breast [,] redness n right armpit [, and] left big toe nail has scab[.] During a review of Resident 1's PN , dated 4/24/24, at 8:38 a.m., the PN indicated, [Treatment] nurse attempted skin and wound inspection and assessment but resident states she is going to dialysis early and would like skin inspection at later time. Risks and benefits explained at this time. During a review of Resident 1's PN , dated 4/24/24, at 8:21 p.m., the PN indicated Resident 1 had refused her antibiotic medication after three attempts. The PN indicated, Explained to resident the risks of not taking [the prescribed antibiotic medication] and the importance of taking this medication. Resident stated she does not want to take the medication and that the hospital should have taken care of all the antibiotic there before sending her back. she continued to refuse stating she does not want the medication and she stated ' I don't really think it's important.' Resident stated understanding of teaching and continued to refuse. During a review of Resident 1's PN dated 4/25/24, at 11:50 a.m., the PN indicated Resident 1 refused a blood withdrawal [when blood is taken from a vein and sent to a laboratory for study] . During a review of Resident 1's Change in Condition (CIC) , dated 4/25/24, at 2:40 p.m., the CIC indicated MD 1 was informed of Resident 1 not feeling well and look tired. Vital Signs checked and stable. No complaints of pain, shortness of breath, and chest pain. The CIC indicated MD 1 ordered Resident 1 to be sent to an Emergency Department for further evaluation. The CIC indicated FM 1 was bedside. During an interview on 6/17/25, at 3:22 p.m., with FM 1, FM 1 stated the facility never notified her of Resident 1's arrival to the facility on 4/23/24, the assessment showing new wounds, her refusal of antibiotics, or refusal of blood withdrawal. FM 1 stated she did visit Resident 1 on the next day, 4/24/24. During a concurrent interview and record review on 6/18/25, at 2:18 p.m., with the Director of Nursing (DON), Resident 1's clinical record from April 2024 was reviewed. The DON was unable to find documentation that FM 1 was notified of Resident 1's return to the facility on 4/23/24 after a seven-day stay in a local hospital, the multiple new wounds noted upon her return, her refusal of antibiotics, or her refusal of a blood withdrawal. The DON stated the facility did not notify FM 1 about Resident 1's return to the facility and the wounds because we assumed [FM 1] already knew about her return here and the wounds due to her visits to the [hospital]. During a review of the facility's Policy and Procedure (P&P), titled Condition Change of the Resident , dated 2006, the P&P indicated, in part, Purpose – To observe, record and report any condition change [,] Assess the resident and notify the attending physician of the resident's condition. Notify the resident's responsible party.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement their policy on resident possessions when it failed to return belongings to the family of one of five sampled residents (Resident 1) when a 42-inch television belonging the Resident 1 was not returned to her family when Resident 1 was discharged from the facility. This failure resulted in Resident 1's family not receiving Resident 1's 42-inch television upon Resident 1's discharge. Findings: During a review of Resident 1's admission Record (AR) , dated 6/16/25, the AR indicated she was a [AGE] year-old female admitted to the facility on [DATE]. The AR indicated Resident 1 was discharged on 5/2/24. During an interview on 6/17/25, at 3:22 p.m., with Family Member (FM) 1, FM 1 stated Resident 1's family had purchased her a 42-inch television to use while in the facility. FM 1 stated that when Resident 1 was discharged from the facility in May 2025, the 42-inch television was never returned. During an interview on 6/18/25, at 12:35 p.m., with the Social Services Director (SSD), the SSD recalled Resident 1's family bringing her a television. The SSD stated, We just looked through the inventory of personal belongings, it was never put on the inventory. But I do know it was her personal TV. The facility did not buy her the TV. No TV is listed on her inventory, so it's not on her discharge inventory list, that's why it was not returned to her. Staff should have noticed the appearance of a 42-inch TV and added it to her inventory list. I know that our maintenance staff mounted this TV on her wall for her. The SSD stated the TV may still be in Resident 1's former room. During a concurrent interview and record review on 6/18/25, at 12:40 p.m., with the SSD, the facility's Grievance / Theft & Loss Tracking Log (GTLTL) , dated 11/23/23, was reviewed. The GTLTL indicated Resident 1 had a Missing TV on 11/23/23 but was found on 12/8/23. The SSD stated during this time, Resident 1 went out to the hospital for a few days, and it was during this time the facility's maintenance staff mounted the TV on the wall of Resident 1's room. The SSD stated when Resident 1 returned to the facility, she mistakenly thought her TV was missing because it was not on a wooden table as she left it. The SSD stated the GTLTL is the only facility documentation of Resident 1 having a TV. During a review of the facility's Policy and Procedure (P&P), titled Resident Personal Belongings , undated, the P&P indicated, It is the policy of this facility to protect the resident's right to possess personal belongings, such as clothing and furnishings, for their use while in the facility. The facility will ensure that personal belongings and/or possessions are rightfully returned to the resident, or to the resident's representative, in the event of the resident's death or discharge from the facility. Additional possessions brought in during the duration of the individual's stay shall be added to the existing personal belongings inventory listing. Inventories of all items are to be reviewed and examined by the Social Services designee and the resident's representative. Recipients of such personal items at the time of discharge or death shall sign off with their legal signature, acknowledging receipt of all personal belongings presented.