

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

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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 06/17/2026
NAME OF PROVIDER OR SUPPLIER Turlock Nursing and 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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure 1 of 3 sampled residents (Resident 1) were safe from physical abuse when Resident 2 struck Resident 1 with a call light (device used to summon staff for assistance, consisting of a long insulated electrical cord with a 1/4 inch metal headphone-type jack on one end, and a bulbous handheld activator button on the other, with a metal clasp to attach to linens or clothing) several times on the head, face, hand, and forearm. This failure resulted in lacerations (cuts in the skin) to the scalp, forehead, cheek, left forearm, and left hand; pain, and bleeding. During a review of Resident 1's admission Record (AR) dated 6/18/26, the AR indicated Resident 1 was a [AGE] year-old male admitted to the facility about three months earlier. During a review of Resident 1's Minimum Data Sheet (MDS, a comprehensive, standardized assessment tool), dated 6/8/26, the MDS indicated at Question C0500 a score of 13 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 Progress Notes (PN), dated 6/15/26, at 7:02 p.m., the PN indicated .called by [Certified Nursing Assistant, or CNA] that [Resident 1] has blood all over his face. This nurse went to resident room, assess[ed] resident. Resident has laceration [cut in skin] on his head that [is] 4 [cm, or centimeters] long, laceration on forehead 0.5 cm, laceration on left cheek 0.5 cm, skin tear on top of left hand [no measurement], skin tear to left forearm 3.5 cm. Resident [1] stated he [was] hit by his roommate [Resident 2] with call light while going to bathroom. The PN was written by Licensed Vocational Nurse (LVN) 3. During a concurrent observation and interview on 6/17/26, at 1:55 p.m., with Resident 1, he stated There were two of us in here, and both in our wheelchairs, me and that numbskull [Resident 2] was trying to get into the bathroom. [Resident 2] pulled his call light out of the wall and just started hitting me with it, on my face, on the top of my head. I raised up my left arm to protect myself and he started hitting that. Afterwards, I got back into bed and was looking down toward my lap and saw something dripping down onto the sheet, it was blood! It really hurt. Lacerations as documented were noted to scalp under hair, forehead, cheek, with skin tears noted to left arm and wrist. During an interview on 6/17/26, at 2:35 p.m., with the Administrator, the Administrator stated Resident 2 is now in a private room for resident safety. During a concurrent observation and interview on 6/17/26, at 2:40 p.m., with the Assistant Director of Nursing (ADON), room [ROOM NUMBER] was observed. The ADON stated this was the room where the incident between Resident 1 and Resident 2 had occurred (both had been since moved to different rooms). The ADON stated the call light device attached to the wall was likely the same one used in the assault on Resident 1. The call light was noted to be a long insulated electrical cord with a 1/4 inch metal headphone-type jack on one end, and a bulbous handheld activator button on the other, with a metal clasp used to attach to clothing or bed linens. The ADON stated this call light device could have caused the type of injuries on Resident 1. During an interview on 6/24/26, at 2:10 p.m., with CNA 3, CNA 3 stated that on 6/15/26, I was in the hallway [near room [ROOM NUMBER]] and I saw the call light on in [Resident 1's] room [ROOM NUMBER], so I went to answer it and saw (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the door was closed. I opened it and saw [Resident 1] sitting on the A bed [the bed closest to the door] with a very, very bloody face. He asked me 'am I bloody?' and I told him 'yes'. He said his roommate [Resident 2] hit him with the call light. He said he had been trying to go to the bathroom in his wheelchair. He is independent, and able to transfer himself from his bed to the wheelchair and back again. I went and got the nurse [LVN 3]. During an interview on 6/24/26, at 2:30 p.m., with LVN 3, LVN 3 stated that on 6/15/26 [CNA 3] came and got me, for room [ROOM NUMBER]. When I entered room [ROOM NUMBER], I saw blood all over [Resident 1's] face. I asked him 'what happened?' He told me his roommate [Resident 2] had hit him with his call light. [Resident 2's] call light was unplugged from the wall and on the floor. During a review of Resident 2's admission Record (AR) dated 6/18/26, the AR indicated Resident 2 was a [AGE] year-old male admitted to the facility about six months earlier. During a review of Resident 2's MDS, dated 4/17/26, the MDS indicated at Question C0500 a score of 13 out of a possible 15, which indicated Resident 2 was cognitively intact. The MDS indicated at Question E200 A, a score of 1, which indicated Resident 2 was assessed to have demonstrated Physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing other sexually). During a review of the facility document titled Verification of Incident Investigation / Administrative Summary (VIAS), dated 6/19/26, the VIAS indicated, On 6/15/26, at approximately 7 pm, CNA [3] notified [LVN 3] that [Resident 1], had blood on his face. [LVN 3] went to resident room to assess him & found a laceration on his head 4 cm long, laceration on his forehead 0.5 cm, laceration on left cheek 0.5 cm, skin tear to top of left hand and a skin tear to left forearm 3.5 cm. [Resident 1] told [LVN 3] that his roommate, [Resident 2] hit him with a call light while he was trying to get to the restroom. he stated that he was on his way to the shared restroom and [Resident 2] was near the bathroom door. As [Resident 1] got closer, [Resident 2] began swinging his call light over his head and hitting him with it and then left the room. When staff came into his room, [Resident 1] shared what had happened. Upon review of all interviews, assessments, and statements, the facility believes the reported event is substantiated. The document was signed by the Administrator and ADON. During a review of the facility's Policy and Procedure (P&P) titled, Reporting Alleged Violations of Abuse, Neglect, Exploitation or Mistreatment, dated 4/25, the P&P indicated, It is the policy of this Facility that each resident has the right to be free from abuse. Residents must not be subjected to abuse by anyone, including, but not limited to . other residents. Abuse is willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish.		