

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 08/15/2024
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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 28196 Based on interview, record review, and facility policy review, the facility failed to report an allegation of abuse for 1 (Resident #15) of 1 sampled resident reviewed for abuse. Findings included: A facility policy titled, Abuse Prevention, Intervention, Investigation & Crime Reporting Policy, revised November 2016, indicated, In response to allegations of abuse, neglect exploitation or mistreatment, the facility will: Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury; or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury; to the administrator of the facility and to other officials in accordance with State law. An Admission Record revealed the facility admitted Resident #15 on 10/27/2020. According to the Admission Record, the resident had a medical history that included diagnoses of Alzheimer's disease, anxiety disorder, somatoform disorder (one or more chronic physical symptoms that coincide with excessive and maladaptive thoughts, emotions, and behaviors connected to those symptoms), and depression. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/20/2024, revealed Resident #15 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. During an interview on 08/09/2024 at 9:58 AM, Resident #15 reported they got on the wrong side of the Activities Manager a while back when they were in another room with a resident who was on hospice. The resident stated the facility was not providing care to their roommate, and they told the Activities Manager about it, who told them to keep their mouth shut and mind their own business. Resident #15 stated the Activities Manager told them she could rid of someone and there would no evidence of what happened to them and there would be no prosecution due to a lack of evidence. Resident #15 stated they felt this was a threat against them and it made them uncomfortable as they had to live with the threat for the last two years. Resident #15 stated they reported this to the Director of Social Service (DSS), but nothing was ever done about it. (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 555240	Facility ID: 555240 If continuation sheet Page 1 of 21

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 08/09/2024 at 1:02 PM, the DSS stated Resident #15 did report to her that they did not want them here, someone took away their TV channels, and they felt as though they were being poisoned. The DSS stated she did not report the resident's concerns as an allegation of abuse because after she and the Director of Staff Development (DSD) met with resident, they explained to the resident they were not being poisoned. During an interview on 08/09/2024 at 1:14 PM, the DSD stated the DSS asked her to talk with Resident #15 as the resident voiced they felt as though someone was tried to poison them. The DSD stated while she and the DSS spoke with Resident #15, the resident was very tearful and stated they felt as though someone tried to poison them. The DS denied reporting this to anyone because she thought it was just a conversation with the resident and the DSS. The DSD stated she knew if a resident reported an allegation of abuse, it must be reported immediately. During a telephone interview on 08/09/2024 at 1:52 PM, the Executive Director (ED) said she expected her staff to report an allegation of abuse received from a resident immediately. The ED denied receiving any allegation of abuse regarding Resident #15. During an interview on 08/09/2024 at 3:21 PM, the Director of Nursing (DON) said she expected that when staff became aware of a resident making an allegation of abuse that they report it immediately. During an interview on 08/09/2024 at 3:49 PM, the Activities Manager stated she would immediately let the Administrator know of an allegation of abuse if a resident informed her of an allegation of abuse. The Activities Manager stated she never told the resident to keep their mouth shut, stay out of other residents' business, or that she could rid of someone without leaving any evidence.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 42192 Based on observation, record review, interview, and review of the Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, the facility failed to accurately code a Minimum Data Set (MDS) assessment for 1 (Resident #277) of 33 residents for whom MDS assessments were reviewed. Specifically, the facility failed to ensure Resident #277's 08/02/2024 admission MDS assessment reflected the presence of a nephrostomy tube. Findings included: The CMS Long-Term Care Facility RAI 3.0 User's Manual, revised in 10/2023, revealed, H0100: Appliances, Steps for Assessment: 1. Examine the resident to note the presence of any urinary or bowel appliances. 2. Review the medical record, including bladder and bowel records, for documentation of current or past use of urinary or bowel appliances. Coding Instructions Check next to each appliance that was used at any time in the past 7 days. Select none of the above if none of the appliances A-D were used in the past 7 days. -H0100A, indwelling catheter (including suprapubic catheter and nephrostomy tube) -H0100B, external catheter -H0100C, ostomy (including urostomy, ileostomy, and colostomy) -H0100D, intermittent catheterization -H0100Z, none of the above. The section titled, Coding Tips and Special Populations specified, -Suprapubic catheters and nephrostomy tubes should be coded as an indwelling catheter (H0100A) only and not as an ostomy (H0100C). An Admission Record indicated the facility admitted Resident #277 on 07/26/2024. According to the Admission Record, the resident had a medical history that included diagnoses of acute kidney failure, hydronephrosis (swelling of one or both kidneys due to a backup of urine), type two diabetes mellitus, obstructive and reflux uropathy (obstruction of urine flow), and other artificial openings of the urinary tract status. Resident #277's care plan included a focus area, initiated on 07/29/2024, that indicated the resident had a nephrostomy tube to their left, lower back. An admission MDS, with an Assessment Reference Date (ARD) of 08/02/2024, revealed Resident #277 had a BIMS score of 11, indicating the resident had moderate cognitive impairment. Section H0100 was coded as None of the above instead of as indwelling catheter to reflect the presence of a nephrostomy tube. During a concurrent observation and interview on 08/05/2024 at 1:23 PM, a urinary drainage bag was observed at Resident #277's bedside. Resident #277's emergency contact stated the resident had a nephrostomy tube site located on their back that was placed while the resident was in the hospital. During an interview on 08/12/2024 at 9:55 AM, MDS Coordinator #38 stated the presence of a nephrostomy tube should be reflected on the MDS. She stated she reviewed orders and hospital documentation to determine what appliances, including nephrostomy tubes, a resident had. MDS Coordinator #38 reviewed Resident #277's MDS and confirmed it did not reflect the presence of a nephrostomy tube, and after reviewing the resident's record, confirmed, the resident's MDS should have reflected the presence of a nephrostomy tube. MDS Coordinator #38 stated she was responsible for reviewing MDS assessments for accuracy. (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/12/2024 at 4:09 PM, the Director of Nursing (DON) stated MDS assessments should be accurate. She stated Resident #277 did have a nephrostomy tube, and it should have been reflected on their MDS.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 43648 Based on record review, interview, and facility policy review, the facility failed to complete Abnormal Involuntary Movement Scale (AIMS) assessments every six months in accordance with a care planned intervention for 1 (Resident #81) of 5 residents reviewed for unnecessary medications. Findings included: A facility policy titled, Care Plan, Comprehensive, dated 12/2017, indicated the purpose was To support and guide resident and IDT [interdisciplinary team] collaboration to achieve and maintain optimal resident health, function and quality of life. The Procedure specified, 1. Care Plans are individualized through the identification of resident concerns, unique characteristics, strengths, and individual needs. 2. Care Plans are based on fundamental information gathered by the MDS [Minimum Data Set], CAA's [Care Area Assessments] and information gathered through observation and evaluation. 3. Care Plans become a comprehensive tool for the IDT to utilize as a reference for identified concerns and approaches to establish guidance for meeting resident individual needs. 4, Resident progress is regularly evaluated, and approaches revised or updated as appropriate. 5. Each plan should include measurable goals and associated time-frames and responsibility. An Admission Record indicated the facility admitted Resident #81 on 12/07/2021. According to the Admission Record, the resident had a medical history that including a diagnoses of unspecified psychosis, schizophrenia, and other specified persistent mood disorders. A quarterly MDS, with an Assessment Reference Date (ARD) of 04/30/2024, revealed Resident #81 had a Brief Interview for Mental Status (BIMS) score of 6, which indicated the resident had severe cognitive impairment. According to the MDS, the resident had verbal behavioral symptoms directed towards others and other behavioral symptoms not directed towards others during one to three days of the assessment look-back period and received antipsychotic medications in the seven days prior to the assessment. Resident #81's care plan included a focus area, initiated on 10/06/2022, that indicated the resident displayed manipulative behaviors that were disruptive, insensitive, and/or disrespectful to staff and peers related to a psychiatric disorder. This focus area included an intervention dated 10/06/2022 that directed staff to complete an Abnormal Involuntary Movement Scale (AIMS) every six months and with each increase in dose of antipsychotic medication. A focus area, initiated on 12/14/2022, indicated the resident had behavioral disturbances related to acute psychosis, schizophrenia, attention seeking behavior [of] rolling out of bed, constantly calling out profanities, screaming, crying out, disruptive sounds [and] delusions. This focus area included an intervention dated 12/08/2021 that directed staff to complete an AIMS every six months and with each increase in dose of antipsychotic medication. Resident #81's physician's order history revealed the resident had orders to receive quetiapine fumarate (an atypical antipsychotic) dating back to 12/28/2022. Per the physician's order history, the resident received quetiapine fumarate from 12/28/2022 until the time of the survey, with their most recent order started on 05/09/2024 for quetiapine fumarate 100 milligrams (mg) twice daily. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #81's medical record revealed an AIMS was completed on 12/08/2021, 06/15/2023, 07/31/2024, and 08/11/2024. During a phone interview on 08/08/2024 at 11:35 AM, the Pharmacy Consultant stated an AIMS should be completed every six months to monitor for tardive dyskinesia (a movement disorder), a possible side effect from quetiapine fumarate. During an interview on 08/09/2024 at 11:32 AM, the Director of Nursing (DON) stated the facility did not have a policy related to the completion of AIMS assessments but indicated an AIMS should be completed every six months and as needed. During a follow-up interview on 08/10/2024 at 4:12 PM, the DON said she expected care plans to be followed. During an interview on 08/15/2024 at 8:00 AM, Licensed Vocational Nurse (LVN) #49 stated care plans included interventions specific to what should be done for each resident. LVN #49 stated it was important for staff to review care plans to determine when the interventions should be completed.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 43648 Based on record review, interview, and facility policy review, the facility failed to follow physician's orders requesting psychiatric evaluations for 2 (Residents #81 and Resident #9) of 5 residents reviewed for unnecessary medications. Findings included: 1. An Admission Record indicated the facility admitted Resident #81 on 12/07/2021. According to the Admission Record, the resident had a medical history that included diagnoses of unspecified psychosis, schizophrenia, and other specified persistent mood disorders. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/30/2024, revealed Resident #81 had a Brief Interview for Mental Status (BIMS) score of 6, which indicated the resident had severe cognitive impairment. According to the MDS, the resident had verbal behavioral symptoms directed towards others and other behavioral symptoms not directed towards others during one to three days of the assessment look-back period and received antipsychotic, antidepressant, and antianxiety medications in the seven days prior to the assessment. Resident #81's care plan included a focus area, initiated on 10/06/2022, that indicated the resident displayed manipulative behaviors that were disruptive, insensitive, and/or disrespectful to staff and peers related to a psychiatric disorder. This focus area included an intervention dated 10/06/2022 for psychiatric evaluation and treatment as necessary. A focus area, initiated on 12/14/2022, indicated the resident had behavioral disturbances related to acute psychosis, schizophrenia, attention seeking behavior [of] rolling out of bed, constantly calling out profanities, screaming, crying out, disruptive sounds [and] delusions. This focus area included an intervention dated 05/09/2024 directing staff to provide psychiatric services as ordered. A pharmacy Consultation Report, dated 04/04/2024, revealed Resident #8's medications were reviewed, and the pharmacist asked the physician to consider that some of the resident's medications may contribute to falls. The Medical Director (MD) responded on 04/17/2024 with a request for a psych [psychiatric provider] eval [evaluation] [of] psych [psychiatric] med [medication] and adjust as needed. A General Note, dated 04/17/2024, revealed the MD gave an order for a psychiatric provider to evaluate Resident #81's psychiatric medications and adjust them as needed. Per the note, the order was noted and carried out. Resident #81's Order Summary Report, listing active orders as of 08/08/2024, revealed an order dated 04/17/2024 for, psych eval, psych med and adjust as needed. A Social Services note, dated 04/18/2024, revealed the Director Social Services (DSS) left a message with Resident #81's Power of Attorney (POA) per the resident's request regarding the order for a psychiatric evaluation and medication adjustment. Per the note, the DSS was awaiting a call back to confirm the POA's permission to proceed. (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An IDT [interdisciplinary team] Walking Round Addendum note, dated 05/09/2024, revealed the note was a Late Entry for Quarterly 04/30/2024. Per the note, Resident #81's POA gave permission for the facility's in-house psychiatric provider to evaluate Resident #81 and their medications. The note indicated the DSS would add the resident to the list to be seen by Psychiatric Physician #34 via a telemedicine visit in May 2024. Resident #81's medical record revealed no documented evidence the resident was evaluated by Psychiatric Physician #34 in May 2024. The MD was interviewed on 08/08/2024 at 1:13 PM. The MD stated he expected facility staff to follow through with all orders for psychiatric referrals. The Interim Executive Director (IED) was interviewed on 08/12/2024 at 1:24 PM. The IED stated all physician's orders should be followed, including orders for psychiatric evaluations. During an interview on 08/12/2024 at 3:33 PM, the DSS stated Resident #81's last psychiatric visit was in 10/2023. The DSS said Resident #81's POA agreed for the resident to be seen by the facility's psychiatric provider in 04/2024 but indicated the facility had been unable to get a psychiatric provider to come to the facility or conduct telemedicine visits until now. The DSS said a psychiatric appointment was not scheduled for the resident when one was ordered in 04/2024. During an interview on 08/09/2024 at 11:32 AM, the Director of Nursing (DON) stated the facility did not have a policy related to following physician's orders. She stated it was a standard of practice to follow the physician's orders. 42192 2. An Admission Record indicated the facility admitted Resident #9 on 10/20/2021. According to the Admission Record, the resident had a medical history that included diagnoses of depression and anxiety disorder. A five-day Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/03/2024, revealed Resident #9 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated the resident displayed other behaviors not directed towards others one to three days during the assessment period. The MDS indicated the resident received antianxiety and antidepressant medications during the assessment period. Resident #9's care plan revealed a focus area initiated 08/06/2024 that indicated the resident had anxiety as manifested by restlessness. Interventions directed staff to administer medications as ordered and monitor for effectiveness and side effects. The care plan revealed a focus area initiated 08/06/2024 that indicated the resident had depression related to admission to the facility. Interventions directed staff to administer medications as ordered and monitor for effectiveness and side effects. A Order Recap Report for the timeframe from 10/01/2023 through 08/07/2024 revealed an order dated 05/16/2024 for psych (psychiatric service provider) evaluation and treatment as ordered. (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/07/2024 at 1:57 PM, the Director Social Services (DSS) stated she was able to provide the resident's psychiatric evaluations dated 07/26/2023 and 09/13/2023 but had no other evaluations for Resident #9. During an interview on 08/08/2024 at 1:12 PM, the MD stated that usually the facility staff would make the call to psychiatry to schedule an evaluation and the resident would be added to the list and seen. He stated the psychotropic team, consisting of the Director of Nursing (DON), DSS, and Pharmacist, should follow through with recommendations and scheduling needs. During an interview on 08/09/2024 at 11:32 AM, the DON stated the facility did not have a policy related to following physician orders. She stated it was a standard of practice to follow the physician's orders.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 42192 Based on interview, record review, and review of the National Pressure Ulcer Advisory Panel (NPUAP) document titled Pressure Injury Stages, the facility failed to ensure Nurse Practitioner (NP) #37 followed professional standards of practice for wound staging for 1 (Resident #278) of 5 residents reviewed for pressure ulcers/injury. Specifically, NP #37 reverse staged Resident #278's Stage 4 right heel pressure injury to a Stage 3. Findings included: An NPUAP document titled, Pressure Injury Stages, dated 2018, revealed, Do not Reverse Stage: NPUAP pressure injury staging describes the depth of tissue damage due to pressure. It does not describe healing tissue. Do not reverse stage using NPUAP pressure injury staging. (i.e. [id est; that is]- a Stage 4 pressure injury cannot become a Stage 3, Stage 2, and/or subsequently Stage 1. When a Stage 4 injury has healed it should be classified as a healed Stage 4 pressure injury. An Admission Record indicated the facility admitted Resident #278 on 04/26/2024. According to the Admission Record, the resident had a medical history that included diagnoses of pressure ulcer of the right heel Stage 4 (onset date 07/29/2024) and pressure ulcer of the right heel Stage 3 (onset date 08/05/2024). A five-day Admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/30/2024, revealed Resident #278 had a Brief Interview for Mental Status (BIMS) score of 7, which indicated the resident had severe cognitive impairment. The MDS revealed the resident was at risk of developing pressure ulcers/injuries and had no unhealed pressure ulcers/injuries or other ulcers. The MDS indicated the resident was provided a pressure reducing device for their bed. Resident #278's care plan indicated a focus area revised 08/06/2024, that indicated the resident had an actual pressure ulcer. The focus area revealed the resident had a facility acquired Stage 3 pressure ulcer to their right heel. The focus area revealed the resident required extensive assistance with turning and repositioning. Interventions directed staff to use heel protector as ordered, treatment as ordered, provide off-loading of ulcer site, and encourage the resident to reposition as able. Resident #278's Wound Assessment performed by the Wound Physician's Assistant (WPA) dated 06/13/2024 indicated the resident had a pressure injury to the right heel with mild localized edema and was Unstageable. The WPA performed debridement of the right heel wound uncovering fascia, fat, and muscle tissues. Resident #278's Wound Assessment performed by the WPA dated 06/20/2024, 07/11/2024, 07/18/2024, 07/25/2024, and 08/01/2024 indicated the resident had a pressure injury to the right heel. The WPA indicated the wound stage was Stage 4. (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Skin/Wound Note dated 08/05/2024 at 12:34 PM, revealed Licensed Vocational Nurse (LVN) #4 documented that NP #37 was at the facility and assessed Resident #278 skin and wounds with the treatment nurse and reclassified the resident's wound to the right heel from a Stage 4 to a Stage 3 pressure wound and noted that the wound was improving. During an interview on 08/08/2024 at 11:24 AM, LVN #49 stated Resident #278's right heel wound was currently a Stage 3. She stated the wound was reclassified to Stage 3 by NP #37. During an interview on 08/08/2024 at 1:12 PM, the Medical Director (MD) stated they had a wound team consisting of LVN #4 and the WPA, who was in the facility weekly on Tuesdays or Thursdays. He stated the wound team notified him if there was improvement to the wound and he would be involved if wounds became infected. The MD stated he was aware of Resident #278's wound and that it was improving. He stated he was unsure why NP #37 reviewed the stage of the wound and deferred staging information to the wound team since they were the specialists. During a telephone interview on 08/08/2024 at 1:40 PM, the WPA stated he was in the facility weekly on Thursdays. He stated a Stage 4 wound revealed muscle or bone. He stated Resident #278's right heel wound was initially necrotic tissue, and as it was removed, he got down to the muscle, tendon, and to bone. He stated heel skin was thin, so it did not take much to get to a Stage 4 wound. He stated he was the one who staged the wound, and the facility had all his notes. He stated he was unaware of the facility's reasoning for downstaging (reverse staging) the wound. He stated a wound could not be down staged to a lower level and was unaware of NP #37's restaging of the wound. During an interview on 08/09/2024 at 9:44 AM, NP #37 stated the facility had a wound team but if a wound needed to be seen they would ask her to review them. She stated if the resident had a chronic wound that was not healing or progressing and staging needed to be changed up or down, she would do that. She stated she reviewed treatments as well. She stated if the wound was healing and there was no discharge or smell and the edges were not raw, it was healing from its previous stage and could be downgraded, especially if there was no visible bone or discharge. She stated Resident #278's wound was healing, had no discharge or smell, and had no raw edges. She stated she saw no visible bone and it was not deep, so it was a Stage 3. She stated the wound team did the staging and evaluations since they were the specialists. She stated she was unaware that wounds could not be down staged and since the wound was improving, she felt she could restage it. During an interview on 08/09/2024 at 12:09 PM, the Director of Nursing (DON) stated she expected LVN #4 and the WPA to provide documentation about advancing wounds and changing stages. She stated she was unaware that wounds could not be down staged from a higher stage. She stated NP #37 restaged Resident #278's wound. She stated NP #37 said the residents wound looked better and was now a Stage 3.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 43648 Based on observation, interview, record review, and facility policy review, the facility failed to ensure proper incontinence care was provided for 1 (Resident #58) of 3 residents observed during incontinence care. Findings included: A facility policy titled, Perineal Care, dated 2006, revealed the section titled Procedure indicated 11. Female perineal care f. Use one gloved hand to stabilize and separate the labia, with other hand wash from front to back. Rinse and pat dry with towel. An Admission Record revealed the facility admitted Resident #58 on 06/12/2024. According to the Admission Record, the resident had a medical history that included diagnoses of peripheral vascular disease (PVD) and palliative care. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/19/2024, revealed Resident #58 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated the resident had moderate cognitive impairment. The MDS indicated Resident #58 was dependent on staff for toileting and bed mobility and was always incontinent of bowel and bladder. Resident #58's care plan included a focus area initiated 06/13/2024 that indicated Resident #58 had incontinence of bowel and bladder related to impaired mobility, weakness, PVD, and received hospice services related to PVD. Interventions directed staff to check and change the resident during personal care and to assist with toileting (initiated 06/13/2024). During an observation on 08/09/2024 at 9:43 AM, two Certified Nursing Assistants (CNAs), CNA #12 and CNA #11, were observed providing incontinence care to Resident #58. CNA #11 and CNA #12 donned gloves. The resident's bed was made flat, and the resident's brief was undone and pulled down. CNA #12 took a wipe and cleaned the perineal area, from front to back, wiping straight down the center of the perineum. CNA #12 did not spread the labia and clean the sides to the left and right. CNA #12 used three wipes to go down the center of the perineum. The resident was rolled to their left side and CNA #12 began to clean the resident's bottom, which was visibly soiled with stool. During an interview on 08/09/2024 at 9:51 AM, CNA #12 stated she was nervous, but she should have cleaned both sides of the perineum. During an interview on 08/09/2024 at 10:15 AM, the Director Staff Development (DSD) stated this was incorrect incontinence care. She stated that when providing incontinence care for a female resident the CNA should open the labia and clean both sides and always front to back. During an interview on 08/09/2024 at 11:17 AM, the Infection Preventionist (IP) stated the CNA should be getting a visual and cleaning on both sides of the labia from front to back. (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Nursing (DON) on 08/10/2024 at 4:15 PM, she stated cleaning of the perineum should include spreading apart the area and cleaning on both sides of the labia with a different wipe from front to back.		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 28196 Based on observation, record review, interview, and facility policy review, the facility failed to reevaluate the appropriateness of continued use of bed rails after a resident attempted to climb over their bed rails and sustained a fall. This deficient practice affected 1 (Resident #23) of 8 residents reviewed for accidents. Findings included: A facility policy titled, Proper Use of Bed Rails, dated 10/2022, revealed, Policy: It is the policy of this facility to utilize a person-centered approach when determining the use of bed rails. The policy further indicated, 3. Assess Resident's risk from using bed rails. Examples of the potential risks with the use of bed rails include: a. Accident hazards (e.g. [exempli gratia, for example], falls, entrapment, and other injuries sustained from attempts to climb over, around, between, or through the rails, or over the footboard) and 15. Responsibilities of ongoing monitoring and supervision are specified as follows: a. Direct care staff will be responsible for care and treatment in accordance with the plan of care b. A nurse assigned to the resident will complete reassessments in accordance with the facility's assessment schedule, but not less than quarterly, upon a significant change in status, or a change in the type of bed/mattress/rail c. The interdisciplinary team will make decisions regarding when the bed rail will be used or discontinued, or when to revise the care plan to address any residual effects of the bed rail. An Admission Record revealed the facility admitted Resident #23 on 10/17/2022. According to the Admission Record, the resident had a medical history that included diagnoses of senile degeneration of the brain, anxiety disorder, restlessness and agitation, and generalized muscle weakness. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/24/2024, revealed Resident #23 had a Brief Interview for Mental Status (BIMS) score of 4, which indicated the resident had severe cognitive impairment. Resident #23's Order Summary Report, listing active orders as of 08/08/2024, revealed an order dated 10/17/2022 for half-length side rails on both sides of the bed to aid in mobility and transfers. Resident #23's care plan included a focus area, initiated on 10/18/2022, that indicated the resident had self-care deficits as evidenced by the need for extensive assistance with activities of daily living (ADLs). An intervention dated 10/18/2022 indicated the resident used half-length side rails on each side of their bed for bed mobility and transfers. The intervention directed staff to observe for injury or entrapment related to side rail use. An SBAR [situation, background, assessment, and recommendation]- Fall Report of Incident, dated 05/25/2024 at 10:30 PM, revealed that while in the hallway, Licensed Vocational Nurse (LVN) #44 saw Resident #23 crawling over the bed rail on the left side of the resident's bed facing the door, and the resident fell to their bottom onto the floor padding. (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #23's record revealed a bed rail safety assessment was not completed after the fall until a routine, quarterly Bed Rails - Safety Assessment was completed on 06/24/2024. On 08/06/2024 at 9:51 AM, Resident #23 was observed in bed; their bed was in the low position with half-length bed rails up on both sides. On 08/08/2024 at 9:53 AM, Resident #23 was observed in bed; their bed was in the low position with half-length bed rails up on both sides. During an interview on 08/12/2024 at 8:44 AM, the Assistant Director of Nurses (ADON) stated that she completed the SBAR note for the incident in which Resident #23 fell while attempting to crawl over their bed rails. The ADON confirmed a bed rail safety assessment was not conducted after the fall and indicated one should have been done prior to the one completed in 06/2024. The ADON said a bed rail safety assessment should be completed within 24 hours of an incident involving bed rails. During an interview on 08/12/2024 at 1:03 PM, the Director of Nursing (DON) stated a new bed rail safety assessment should be completed after any incident or fall involving bed rails. She indicated that one should have been completed for Resident #23 after the fall involving the bed rail in May 2024, before the quarterly one was completed in June 2024. During a follow-up interview on 08/15/2024 at 8:20 AM, the DON said LVN #49 was the staff member who would have been responsible for completing a new bed rail safety assessment after Resident #23's fall in 05/2024. During an interview on 08/15/2024 at 8:29 AM, LVN #49 stated that a bed rail safety assessments should be completed when bed rails were first initiated, then quarterly, and annually. She stated that one should also be completed after any incidents involving the use of bed rails; however, LVN #49 denied knowledge of Resident #23 attempting to climb over their bed rails.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 43648 Based on observation, interview, record review, facility document review, and facility policy review, the facility failed to ensure enhanced barrier precautions (EBP) were followed while providing direct care for 1 (Resident #91) of 6 residents reviewed for pressure ulcers and 1 (Resident #54) of 1 resident reviewed for dialysis. The facility also failed to ensure staff washed their hands and changed soiled gloves when providing incontinence care, which affected 1 (Resident #58) of 3 residents observed during incontinence care. Findings included: 1. A facility policy titled, Infection Prevention Manual for Long Term Care, revised 10/2022, indicated, Enhanced Standard Precautions, It is facility policy to adopt a comprehensive strategy to prevent, contain, and mitigate multidrug-resistant organisms (MDRO) in the facility. Enhanced Standard Precautions (ESP) is a core component of this strategy, both during the prevention and mitigation phases. The policy revealed, Identify residents at high risk for MDRO colonization and transmission: the use of ESP, primarily the use of gowns and gloves for specific high contact care activities, based on the resident's characteristics that are associated with a high risk of MDRO colonization and transmission: Presence of indwelling devices (e.g. [exempli gratia; for example], urinary catheter, feeding tube, endotracheal or tracheostomy tube, vascular catheters). Wounds or presence of pressure ulcer (unhealed). The policy revealed, Wear gowns and gloves while performing the following high-contact tasks associated with the greatest risk for MDRO and contamination of HCP [healthcare professional] hands, clothes, and the environment: including Morning and evening care, and Any care activity where close contact with the resident is expected to occur such as bathing, peri-[perineal]care, assisting with toileting, changing incontinence briefs, respiratory care. An undated Centers for Disease Control and Prevention (CDC) Enhanced Barrier Precautions document used by facility staff on resident room doors who were on EBP revealed, Everyone Must: Clean their hands, including before entering and when leaving the room. Providers And Staff Must Also: Wear gloves and a gown for the following High-Contact Resident Care Activities, to include Dressing Providing Hygiene and Changing briefs or assisting with toileting. An Admission Record revealed the facility admitted Resident #54 on 05/23/2024. According to the Admission Record, the resident had a medical history that included diagnoses of end stage renal disease, local infection due to central venous catheter, and dependence on renal dialysis. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/28/2024, revealed Resident #54 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. The MDS indicated Resident #54 required partial to moderate assistance with sitting to standing, lying to sitting on the side of the bed, chair/bed-to-chair transferring, toileting hygiene, upper body dressing, and substantial to maximum assistance with lower body dressing. Resident #54's care plan included a focus area initiated 05/30/2024, that indicated the resident was receiving hemodialysis related to end stage renal failure. Interventions indicated that the resident had dialysis three times a week via a right upper chest hemodialysis catheter. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 08/07/2024 at 8:39 AM, Resident #54's room did not have any enhanced barrier precaution signage and there was no personal protective equipment (PPE) cart at the door. During an observation on 08/09/2024 at 8:14 AM, a certified nursing assistant (CNA) entered Resident #54's room and pulled the curtain between the residents and assisted Resident #54 in getting dressed. The CNA was wearing gloves and a surgical mask. No gown was worn. There was no EBP signage on the resident's room door and no PPE cart was observed at the resident's door. During an interview on 08/09/2024 at 8:24 AM, CNA #15 stated Resident #54 required assistance with upper and lower body dressing and putting on their shoes. CNA #15 stated the resident was incontinent and wore a brief. She stated she was unaware of any precautions for Resident #54 and did not wear a gown when providing care to the resident. During an interview on 08/09/2024 at 8:32 AM, Resident #54 stated the staff wore only gloves and a mask when providing care to them and did not wear gowns. Resident #54 further stated that when the CNA provided incontinence care before assisting them with getting dressed, they did not wear a gown. During an interview on 08/09/2024 at 8:35 AM, the Infection Preventionist (IP) stated Resident #54 should be on EBP because the resident had a dialysis catheter for dialysis. The IP stated she would place EBP signage and a PPE cart at the resident's door. During an interview on 08/10/2024 at 4:17 PM, the Director of Nursing (DON) stated it would be expected that EBP be followed since the resident had a hemodialysis catheter for dialysis. 2. A facility policy titled, Incontinence Care, dated 08/2014, revealed the section titled Procedure included 10. Place soiled linen and briefs in designated receptacles, 11. Remove gloves, and 12. Wash hands. An Admission Record revealed the facility admitted Resident #58 on 06/12/2024. According to the Admission Record, the resident had a medical history that included diagnoses of peripheral vascular disease (PVD) and palliative care. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/19/2024, revealed Resident #58 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated the resident had moderate cognitive impairment. The MDS indicated Resident #58 was dependent on staff for toileting and bed mobility and was always incontinent of bowel and bladder. Resident #58's care plan included a focus area initiated 06/13/2024 that indicated Resident #58 had incontinence of bowel and bladder related to impaired mobility, weakness, PVD, and received hospice services related to PVD. Interventions directed staff to check and change the resident during personal care and to assist with toileting (initiated 06/13/2024). (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 08/09/2024 at 9:43 AM, two certified nursing assistants (CNAs), CNA #11 and CNA #12, were observed providing incontinence care to Resident #58. CNA #11 and CNA #12 donned gloves. CNA #12 took a wipe and cleaned the perineal area, from front to back, wiping straight down the center of the perineum. CNA #12 used three wipes to go down the center of the perineum. CNA #12 handed each of the soiled wipes across the resident to CNA #11, who was assisting and standing on the opposite side of the bed, placing the soiled wipes into the trash can. The resident was then rolled to their left side and CNA #12 began to clean the resident's bottom, which was visibly soiled with stool. CNA #12 handed each soiled wipe over the resident to CNA #11. CNA #12 used approximately 12 wipes, and as she handed the soiled wipes to CNA #11, the wipes were placed in the trash can. Following placing the soiled wipes in the trash can with her gloved right hand, CNA #11 then rested her gloved hands onto the bed siderails. Following incontinence care, both CNAs made the resident comfortable by placing a pillow under the resident's knees, fluffing their pillow and adjusting the bed linens to cover the resident. CNA #11 and CNA #12 removed their gloves, and they washed their hands following making the resident comfortable. During an interview on 08/09/2024 at 9:51 AM, CNA #12 stated she was nervous, but she should not have handed soiled wipes over the resident to CNA #11. She stated she should have had a trash bag next to her and placed all soiled wipes into the trash bag. CNA #12 further stated she should have washed her hands and changed her gloves prior to making the resident comfortable and adjusting their linens after providing the incontinence care. During an interview on 08/09/2024 at 9:59 AM, CNA #11 stated she did not realize when the other CNA was handing her the soiled wipes, including the wipes visible with stool, that after placing the wipes into the trash can she was then holding onto the bed rail with the glove that had handled the soiled wipes. She stated there should have been a trash bag on the other side of the bed where CNA #12 was providing care to the resident. CNA #11 stated she should not have touched the bed rail, and she should have changed her gloves prior to adjusting the resident's pillow and blanket. During an interview on 08/09/2024 at 10:15 AM, the Director Staff Development (DSD) stated staff should not hand soiled wipes to someone else to be placed in the trash. She stated the soiled wipes should be bagged on the side where the CNA providing the incontinence care was standing. She stated that the bed rail should not be touched with a soiled glove. Per the DSD, the CNAs should have changed their gloves prior to making the resident comfortable, fluffing pillows, and adjusting bed linens. During an interview on 08/09/2024 at 11:17 AM, the Infection Preventionist (IP) stated the CNA providing incontinence care should have placed the soiled wipes into the trash bag, not handed over the resident to another CNA. She stated the CNA should not have touched the bed rail with the glove she held the soiled wipes in. She then stated both CNAs should have changed their gloves prior to getting the resident settled after care and touching the pillows and blankets. During an interview on 08/10/2024 at 4:15 PM, the Director of Nursing (DON) stated she expected the CNA providing the incontinence care to place a plastic trash bag next to her and place the soiled wipes in the bag and not hand the soiled wipes to the other CNA across the bed. She stated that the CNA should have changed her gloves after providing incontinence care and then repositioned the resident, fluffed pillows, or adjusted the linens. She stated that staff should always change gloves between dirty and clean tasks. Per the DON, the CNA handling the soiled wipes on the opposite side of the bed should not have been receiving those wipes, then she would not be in the position to have placed her gloved hand used in handling those wipes back onto the bed rail. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow-up interview on 08/10/2024 at 5:28 PM, the IP stated the facility policies did not specifically address placing a soiled glove on the bed rails but stated it should never occur. She stated that staff should remove soiled gloves before touching any surface. 28196 3. A facility policy titled, Infection Prevention Manual for Long Term Care, revised 10/2022, indicated, Enhanced Standard Precautions, It is facility policy to adopt a comprehensive strategy to prevent, contain, and mitigate multidrug-resistant organisms (MDRO) in the facility. Enhanced Standard Precautions (ESP) is a core component of this strategy, both during the prevention and mitigation phases. The policy revealed, Identify residents at high risk for MDRO colonization and transmission: the use of ESP, primarily the use of gowns and gloves for specific high contact care activities, based on the resident's characteristics that are associated with a high risk of MDRO colonization and transmission: Presence of indwelling devices (e.g. [exempli gratia; for example], urinary catheter, feeding tube, endotracheal or tracheostomy tube, vascular catheters). Wounds or presence of pressure ulcer (unhealed). The policy revealed, Wear gowns and gloves while performing the following high-contact tasks associated with the greatest risk for MDRO and contamination of HCP [healthcare professional] hands, clothes, and the environment: including Morning and evening care, and Any care activity where close contact with the resident is expected to occur such as bathing, peri-[perineal]care, assisting with toileting, changing incontinence briefs, respiratory care. An undated Centers for Disease Control and Prevention (CDC) Enhanced Barrier Precautions document used by facility staff on resident room doors who were on EBP revealed, Everyone Must: Clean their hands, including before entering and when leaving the room. Providers And Staff Must Also: Wear gloves and a gown for the following High-Contact Resident Care Activities, to include Wound Care: any skin opening requiring a dressing. An Admission Record revealed the facility admitted Resident #91 on 01/16/2024. According to the Admission Record, the resident had a medical history that included acute kidney failure, rhabdomyolysis (muscle breakdown that released muscle tissue into the blood), urinary tract infection, and sepsis. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/18/2024, revealed Resident #91 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. The MDS indicated Resident #91 had a Stage 4 pressure ulcer that was present upon admission/entry or reentry and received application of ointments/medications to skin and ulcer/injury for treatment. Resident #91's care plan included a focus area initiated 01/18/2024, that indicated the resident had an actual Stage 4 pressure ulcer to their sacral coccyx extending to the left and right buttock. Interventions directed staff to assess the pressure ulcer weekly by a licensed nurse (initiated 01/18/2024). The care plan also included a focus area initiated 03/18/2024, that indicated the resident had a documented pressure ulcer. Interventions directed staff to provide wound care per the treatment order (initiated 03/18/2024). (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #91's Order Summary Report, for active orders as of 08/06/2024, revealed an order dated 07/07/2024 for the resident's Stage 4 pressure ulcer to their sacral coccyx extending to their left and right buttock that directed staff to cleanse the wound with normal saline, pat dry, apply collagen and a triple antibiotic, pack with a topical antiseptic and cover with a foam dressing once a day, every day shift, until resolved. The Order Summary Report revealed an order dated 08/06/2024 for the resident's Stage 4 pressure ulcer to their sacral coccyx extending to their left and right buttock that directed staff to cleanse the wound with normal saline, pat dry, pack with hydrogel and cover with a foam dressing daily, every evening shift, until resolved. During an observation on 08/05/2024 at 11:59 AM, Resident #91's room did not have any signage indicating the resident was on EBP and there was no personal protective equipment (PPE) cart at the door. During an observation on 08/06/2024 at 10:37 AM, Resident #91 was observed in their room. Licensed Vocational Nurse (LVN) #4 provided wound care to the resident's wound on their sacrum. LVN #4 was wearing a surgical mask and gloves but was not wearing a gown during the procedure. Resident #91's door did not have any signage indicating the resident was on EBP nor was there a PPE cart at the door. During an interview on 08/06/2024 at 11:19 AM, LVN #4 stated residents that should be on EBP included residents with intravenous (IV) lines, indwelling catheters, infections that required contact precautions, and any wound with moderate to heavy drainage. She also stated that she was made aware of residents that were on EBP by signage on the resident's door, checking the resident's medical chart, or asking the nurses, supervisors, or the Infection Preventionist (IP). She stated that Resident #91 was on EBP when they had an indwelling catheter but that was discontinued and the EBP was also discontinued at that time. She stated that the drainage on the resident's wound was only light to mild drainage. After reviewing an EBP sign on another resident's door, she stated that after reading it, it looked like Resident #91 should be on EBP since it stated EBP requirements included residents with any skin opening requiring a dressing. She stated that EBP including washing and disinfecting her hands, wearing gloves, and wearing a gown. She stated that she did not wear a gown when she provided care to the resident. During an interview on 08/07/2024 at 7:40 AM, the IP stated that residents who were on EBP received extra care while receiving assistance with activities of daily living (ADLs), wound care, indwelling catheter care, IV treatments, and tube feedings. She stated that she made sure the staff were aware of residents who were on EBP through periodic staff trainings and communication every shift and as needed by her and the nurses. She also stated that she usually communicated with the charge nurses and registered nurses (RNs) in charge of receiving orders regarding EBP. The IP stated an EBP sign should be outside the resident's door and should be addressed on a guide used by direct caregivers outlining each resident's care needs and should also be on the resident's care plan. She stated that Resident #91 was initially on EBP for an indwelling catheter that was recently removed as a recommendation from the physician. Per the IP, the resident was removed from EBP when their indwelling catheter was removed. She stated that the resident should have remained on EBP since the resident still had an open wound. She stated the importance of ensuring that residents who should be on EBP were on it was to stop the spread of infections. (continued on next page)		

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 08/15/2024
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/07/2024 at 11:52 AM, the Director of Nursing (DON) stated residents that should be on EBP were residents with indwelling catheters, open wounds, had IV lines, and infections that were colonized with MDRO. She said that Resident #91 should have been on EBP but according to the IP, Resident #91 was overlooked because EBP was new to the facility staff. She stated that staff should be wearing gloves and a gown and practicing hand hygiene while providing care to those residents. Per the DON, after providing the care, the PPE they were wearing were to be removed and discarded in garbage cans directly outside the resident's room. She stated that there should also be a sign outside the room to alert staff on what they were to do and the PPE to wear when providing direct care to that resident. She stated the PPE should be available in a cart directly outside the resident's room. She stated that her expectation was for staff to adhere to the protocols for a resident on EBP while providing direct care to them.		