

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555347	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/13/2024
NAME OF PROVIDER OR SUPPLIER North Starr Postacute Care		STREET ADDRESS, CITY, STATE, ZIP CODE 180 Starr Avenue 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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48739</p> <p>Based on observation, interview, and record review the facility failed to provide a clean, safe, and sanitary homelike environment for two of five sampled residents (Residents 16 and 22) when the west hall shower room remained accessible for use with missing floor tiles, and the existing floor tiles were black with yellow areas in the tile grout.</p> <p>This failure resulted in an unclean, unsafe, unsanitary and non-homelike environment for Residents 16 and 22.</p> <p>Findings:</p> <p>During a concurrent observation and interview on 9/12/24 at 9:15 a.m. with Resident 16 in Resident 16's room, Resident 16 was observed dressed, sitting in her wheelchair next to her roommate's bed. Resident 16 complained of the shower in her hallway of being dirty. Resident 16 stated she did not want to use the shower in the west hall. Resident 16 stated she had requested to go to another shower in the next hallway.</p> <p>During a review of Resident 16's Admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 9/12/24, the AR indicated Resident 16 was admitted from the acute care hospital on 7/31/24. Resident 16 was admitted with diagnoses of metabolic encephalopathy (a brain dysfunction caused by an underlying condition), severe sepsis (a serious condition in which the body responds improperly to an infection) with septic shock (a dramatic drop in blood pressure that can damage the lungs, kidneys, liver and other organs), Fournier disease (Fournier's gangrene, a very serious, sometimes fatal infection in the genital or anal area. It's a type of necrotizing fasciitis [flesh-eating disease] that develops quickly, and is often associated with general signs of sepsis, rapid tissue destruction, and a high fatality rate) of vagina and vulva, abnormalities of gait (walking) and mobility and generalized muscle weakness.</p> <p>During a review of Resident 16's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 8/5/24, the MDS section C indicated Resident 16 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of 13 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 16 was cognitively intact.</p> <p>(continued on next page)</p>

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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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent observation and interview on 9/12/24 at 9:16 a.m. with Resident 22 in Resident 22's room, Resident 22 was observed dressed in bed speaking with her roommate. Resident 22 stated the shower in her hallway (west hall) was always dirty. Resident 22 stated she did not want to use the shower in her hallway and had to request to use another shower in the next hallway.</p> <p>During a review of Resident 22's AR, dated, 9/12/24, the AR indicated Resident 22 was admitted from an acute care hospital on 12/7/22, with diagnoses of fracture of left femur (thigh bone), shortness of breath, muscle weakness, difficulty in walking and essential hypertension (high blood pressure).</p> <p>During a review of Resident 22's MDS, dated , 6/13/24, the MDS section C indicated Resident 22 had a BIMS score of 15, which indicated Resident 22 was cognitively intact.</p> <p>During a concurrent observation and interview on 9/12/24 at 11:18 a.m. with the Maintenance Staff (MAINS) in the west hallway shower room, black colored shower tile, missing shower tile and yellow shower tile grout were observed. The MAINS stated the tile in the shower was old. The MAINS stated the shower should not have missing tile. The MAINS stated the areas in the shower with missing tile could not be cleaned appropriately and could be a source of infection to the residents who used the shower.</p> <p>During a concurrent observation and interview on 9/12/24 at 4:15 p.m. with the Housekeeping Supervisor (HS) in the west hallway shower room, black colored shower tile, missing shower tile, and yellow shower tile grout were observed. The HS stated the shower tiles were stained. The HS stated she had asked MAINS to replace and repair the stained, broken, and missing tiles a while ago. The HS stated the stained and missing tiles in the west hallway shower were not a homelike environment for the residents.</p> <p>During an interview on 9/13/24 at 10:54 a.m. with the Director of Nursing (DON), the DON stated all the shower rooms should be clean. The DON stated the west hall shower should not have had missing tile. The DON stated the shower floor with the missing tile could cause injury to the residents who use the shower. The DON stated the stained tile and missing tiles on the west hall shower floor were not considered a homelike environment for the residents.</p> <p>During a review of the facility document titled, Job Description: Housekeeping Supervisor, dated, 10/19/15, the document indicated, . manages the Housekeeping Department to ensure the provision of a clean and safe environment for customers, visitors and staff . inspects the center on a regular basis to determine the effectiveness of the housekeeping function . takes immediate action on any observed deficiencies .</p> <p>During a review of the facility document titled, Job Description: Maintenance Director, dated 10/19/15, the document indicated, . the Maintenance Director . is responsible for performing repairs . performing regular daily, weekly and monthly maintenance checks . performs overall supervision of the Maintenance Department including hands-on performance of maintenance and repair work . maintains the building in good repair and free of hazards . maintains the building and grounds in compliance with Federal, State, and local laws .</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility's policy and procedure (P&P) titled, Homelike Environment, dated, [DATE], indicated, . residents are provided with a safe, lean, comfortable and homelike environment . facility staff and management maximized, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting . clean, sanitary and orderly environment .</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>44899</p> <p>Based on interview and record review, the facility failed to thoroughly investigate an allegation of abuse as per the facility's policy and procedure (P&P) titled, Abuse Investigation and Reporting policy for one resident (Resident 1), when Resident 1 had an unwitnessed fall with injury. In addition, the facility failed to report the results of the facility's investigation to the State Survey Agency within five working days of the alleged incident.</p> <p>This failure had the potential to place Resident 1 and other vulnerable residents at increased risk of abuse.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record (AR- a document that provides resident contact details, a brief medical history, level of functioning, preferences, and wishes), dated 9/11/24, the AR indicated, Resident 1 was admitted from the acute hospital on 4/16/24 to the facility with diagnoses including Displaced Fracture of Surgical Neck of Left Humerus (bone in the upper arm, between elbow and shoulder), Pneumonia (lung infection caused by bacteria), Chronic Obstructive Pulmonary Disease (COPD - is a chronic inflammatory lung disease that causes obstructed airflow of the lungs), Hypertension (high blood pressure), and Major Depressive Disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest).</p> <p>During a review of Resident 1's Minimum Data Set (MDS, an assessment tool which indicates physical, medical, and cognitive abilities), dated 8/8/24, the MDS indicated Resident 1's Brief Interview for Mental Status (BIMS) score was 8 out of 15 (0-7 indicated severe cognitive impairment [memory loss, poor decision making-skills], 8-12 moderate cognitive impairment, 13-15 cognitively intact).</p> <p>During a concurrent observation and interview on 9/11/24, at 10:57 a.m., with Resident 1 in the activity room, Resident 1 was observed sitting in her wheelchair and wearing a black shoulder sling on her left arm. Resident 1 stated she was pushed by someone several days ago, which resulted to an injury on her left arm and shoulder. Resident 1 was unable to give further details about the incident. Resident 1 reported having pain on her left arm and the pain level was between 6 and 8, on a scale of 0 to 10 (0 = no pain, 10 = severe pain).</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 9/13/24, at 9:40 a.m., with Licensed Vocational Nurse (LVN) 2, Resident 1's Nursing Progress Note (PN) was reviewed. LVN 2 confirmed that she worked on 8/13/24, from 11:00 p.m. to 7:00 a.m. and was the Charge Nurse when Resident 1 had an unwitnessed fall. The PN indicated, . Resident had an unwitnessed fall. Certified Nurse Assistant notified [Charge] Nurse that resident [Resident 1] was on the floor in the bathroom . Nurse assessed resident and during assessment resident stated she was having pain to her left arm . when nurse asked resident to move the left upper extremity [arm] resident was unable to move it without assistance . [Ambulance] arrived at 0422 [4:22 a.m.] and left the building with resident at 0435 [4:35 a.m.] . Resident came from [Acute Hospital] at 10:40 a.m. [8/13/24] . came back with diagnosis of humeral fracture of left arm . Resident has swelling and discoloration on left upper arm. Resident has sling on her left arm . LVN 2 stated she does not recall completing an incident report and submitting the report to the California Department of Public Health (CDPH - State survey agency) and the Ombudsman office (assist residents in long-term care facilities with issues related to resident's safety such as resident rights, physical, verbal, mental, or financial abuse). LVN 2 stated she did not complete the SOC 341 form (a form used to report a suspected dependent adult/elder abuse to the Ombudsman and State survey agency).</p> <p>During a concurrent interview and record review on 9/13/24, at 11:42 a.m., with LVN 1, Resident 1's PN and Interdisciplinary Team (IDT - staff members from various disciplines and responsible for the assessment, development, implementation, and evaluation of the treatment plan for facility residents) note were reviewed. LVN 1 stated she was unable to find documentation that the unwitnessed fall with injury was reported to CDPH and the Ombudsman office. LVN 1 stated Licensed Nurses were supposed to prepare an incident report and submit a copy to CDPH and to the Ombudsman office. LVN 1 stated, If we don't submit a copy of the incident report, it looks like were hiding something. Our Director of Nursing (DON) is pretty good about reporting incident to CDPH and to the Ombudsman office.</p> <p>During a concurrent interview and record review on 9/13/24, at 12:34 p.m., with the DON, Residents 1's IDT note was reviewed. The IDT note indicated, . Interventions . Resident was assessed by the charge nurse, vital signs were taken, neuro checks were started. [Attending] was notified via phone and the resident was sent out to ER [emergency room] as MD [Physician] order for further evaluation. RP [Responsible Party] was also called but was unable to reach . The DON stated there was no record of the fall incident being reported to CDPH and to the Ombudsman office. The DON stated she does not think Resident 1's unwitnessed fall with injury was a reportable incident to CDPH and to the Ombudsman office. The DON stated there was no investigation report prepared and submitted to CDPH within five working days after the alleged incident.</p> <p>During a review of Resident 1's emergency room Record, dated 8/13/24, the record indicated, . brought in by ambulance from [Facility Name] for an unwitnessed ground-level fall . Findings: Left shoulder humeral fracture . Patient placed on sling . Hydrocodone for pain .</p> <p>During a review of the facility's document titled, Job Description: Licensed Vocational Nurse (LVN), dated 10/15, the document indicated, . the Licensed Vocational Nurse delivers efficient and effective nursing care . He/she operates within the scope of practice defined by the State Nurse Practice Act .</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's document titled, Job Description: Director of Nursing, dated 10/15, the document indicated, . The Director of Nursing has 24-hour accountability and is responsible for the delivery of high-quality and cost-effective health care while achieving positive clinical outcomes . 5.5 Ensures that patient's accidents/incident, adverse event and grievances/concerns are fully documented, investigated, reported and addressed in accordance with [Facility Name] policies and procedures and the Federal/State rules and regulations .</p> <p>During a review of the facility's policy and procedure (P&P) titled Abuse Investigation and Reporting dated 2/24, the P&P indicated, . All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknow source (abuse) shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported . 5. The administrator, or his/her designee, will provide the appropriate agencies or individual listed above with written report of the findings of the investigation withing five (5) working days of the occurrence of the incident .</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44899</p> <p>Based on observation, interview, and record review, the facility failed to develop and implement comprehensive person-centered care plans (CP - a detailed approach to care customized to an individual resident's needs) for three of 16 sampled residents (Residents 1, 6, 10) when:</p> <ol style="list-style-type: none"> 1. Resident 1's care plan was not developed to reflect interventions to address her use of a left shoulder sling after an unwitnessed fall with injury. <p>This failure had the potential for Resident 1's left upper arm's injury to worsen.</p> <ol style="list-style-type: none"> 2. Resident 10's care plan was not developed to reflect interventions to address her refusal of medications. <p>This failure had the potential for Resident 10's medical needs to not be met.</p> <ol style="list-style-type: none"> 3. Facility failed to implement the care plan for monitoring and assisting Resident 6 during meals. <p>This failure resulted in Resident 6's monitoring and assessment needs to not be met and had the potential for aspiration.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During a review of Resident 1's Admission Record (AR- a document that provides resident contact details, a brief medical history, level of functioning, preferences, and wishes), dated 9/11/24, the AR indicated, Resident 1 was admitted from the acute hospital on 4/16/24 to the facility with diagnoses including Displaced Fracture of Surgical Neck of Left Humerus (bone in the upper arm, between elbow and shoulder), Pneumonia (lung infection caused by bacteria), Chronic Obstructive Pulmonary Disease (COPD - is a chronic inflammatory lung disease that causes obstructed airflow of the lungs), Hypertension (high blood pressure), and Major Depressive Disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). <p>During a review of Resident 1's Minimum Data Set (MDS, an assessment tool which indicates physical, medical, and cognitive abilities), dated 8/8/24, the MDS indicated Resident 1's Brief Interview for Mental Status (BIMS) score was 8 out of 15 (0-7 indicated severe cognitive impairment [memory loss, poor decision making-skills], 8-12 moderate cognitive impairment, 13-15 cognitively intact).</p> <p>During a concurrent observation and interview on 9/11/24, at 10:57 a.m., with Resident 1 in the activity room, Resident 1 was observed sitting in her wheelchair and wearing a black shoulder sling on her left arm. Resident 1 stated she was pushed by someone several days ago, which resulted to an injury on her left arm and shoulder. Resident 1 was unable to give further details about the incident. Resident 1 reported having pain on her left arm and the pain level was between 6 and 8, on a scale of 0 to 10 (0 = no pain, 10 = severe pain).</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review on 9/13/24, at 9:40 a.m., with Licensed Vocational Nurse (LVN) 2, Resident 1's Nursing Progress Note (PN), Physician Order Summary (POS), and Care Plan (CP) were reviewed. LVN 2 confirmed that she worked on 8/13/24, from 11:00 p.m. to 7:00 a.m. and was the Charge Nurse when Resident 1 had an unwitnessed fall. The PN indicated, . Resident had an unwitnessed fall. Certified Nurse Assistant notified [Charge] Nurse that resident [Resident 1] was on the floor in the bathroom . Nurse assessed resident and during assessment resident stated she was having pain to her left arm . when nurse asked resident to move the left upper extremity [arm] resident was unable to move it without assistance . [Ambulance] arrived at 0422 [4:22 a.m.] and left the building with resident at 0435 [4:35 a.m.] . Resident came from [Acute Hospital] at 10:40 a.m. [8/13/24] . came back with diagnosis of humeral fracture of left arm . Resident has swelling and discoloration on left upper arm. Resident has sling on her left arm . LVN 2 reviewed Resident 1's POS and stated she was unable to find a Physician Order written for the use of left shoulder sling. LVN 2 reviewed Resident 1's care plan and stated there was no care plan intervention created for Resident 1's use of shoulder sling. LVN 2 stated nurses were supposed to create a Resident specific care plan interventions and it was not done. LVN 2 stated Resident 1's left shoulder fracture could worsen if the sling was improperly use or not assess every shift.</p> <p>During a concurrent interview and record review on 9/13/24, at 12:30 p.m., with the Director of Nursing (DON), Residents 1's nursing care plan was reviewed. The DON stated Residents 1's care plan should have been resident-specific and it was not. The DON stated the care plan drove resident care to ensure resident's care and wishes were being met. The DON stated the facility failed to follow its policy and procedures related to care planning process. The DON stated the failure could potentially result to Resident 1's left upper arm bone fracture to worsen and limit her mobility.</p> <p>During a review of the facility's document titled, Job Description: Licensed Vocational Nurse (LVN), dated 10/15, the document indicated, . The LVN contributes to the nursing assessments and care planning, provides direct patient care . 3.1 Administers medications and performs treatment per physician orders .</p> <p>During a review of the facility's policy and procedure (P&P) titled Care Plans, Comprehensive Person-Centered, dated 1/18, the P&P indicated, . A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for reach resident . The comprehensive, person-centered care plan will: a. include measurable objectives and timeframes; b. describe the services that are to be furnished to attain or maintain resident's highest practicable physical, mental, and psychosocial well-being .</p> <p>2. During a review of Resident 10's AR, dated 9/13/24, the AR indicated, Resident 10 was admitted from the acute hospital on 7/22/24 to the facility, with diagnoses including COPD, Hypertension, Muscle Weakness, and Congestive Heart Failure (CHF - weakness in the heart where fluid accumulates in the lungs).</p> <p>During a review of Resident 10's MDS, dated [DATE], the MDS indicated Resident 10's Brief Interview for Mental Status (BIMS) score was 15 out of 15 (0-7 indicated severe cognitive impairment [memory loss, poor decision making-skills], 8-12 moderate cognitive impairment, 13-15 cognitively intact).</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent observation and interview, on 9/10/24, at 2:30 p.m., with Licensed Vocational Nurse (LVN) 1, in front of the nurse station, LVN 1 was observed holding Resident 10's Fluticasone-Salmeterol inhaler. LVN 1 stated the inhaler opened date was 7/31/24 with 18 doses left in the container. LVN 1 stated the physician order was to administer twice a day and if given as ordered, there should be no remaining doses left in the inhaler that was opened on 7/31/24.</p> <p>During a concurrent interview and record review on 9/10/24, at 2:41 p.m., with LVN 1, Resident 10's August 2024 and September 2024 Medication Administration Record (MAR), Nursing Progress Note, and Nursing Care Plan were reviewed. LVN 1 stated Resident 10 has a history of refusing her Fluticasone-Salmeterol inhaler. LVN 1 stated she was unable to find any nursing documentation that Resident 10's attending physician was notified of multiple refusals. LVN 1 stated licensed nurses were supposed to notify the physician after multiple episodes of medication refusal and it was not done. LVN 1 stated licensed nurses were supposed to document medication refusals and it was not done. LVN 1 reviewed Resident 1's care plan and stated there was no care plan developed and no interventions were implemented to address Resident 10's medication refusal. LVN 1 stated nurses were supposed to create a care plan for medication refusal and it was not done. LVN 1 stated Resident 10's Chronic Obstructive Pulmonary Disease could worsen and potentially result to hospitalization .</p> <p>During a concurrent interview and record review on 9/13/24, at 12:15 p.m., with the DON, Residents 10's nursing care plan was reviewed. The DON stated she was unable to find a nursing care plan related to Resident 10's medication refusal. The DON stated Residents 10's care plan should have been resident-specific and it was not. The DON stated the care plan drove resident care to ensure resident's care and wishes were being met. The DON stated the facility failed to follow its policy and procedures related to care planning process. The DON stated the failure could potentially result to Resident 10's COPD to worsen.</p> <p>During a review of the facility's document titled, Job Description: Licensed Vocational Nurse (LVN), dated 10/15, the document indicated, . The LVN contributes to the nursing assessments and care planning, provides direct patient care . 3.1 Administers medications and performs treatment per physician orders .</p> <p>During a review of the facility's policy and procedure (P&P) titled Care Plans, Comprehensive Person-Centered, dated 1/18, the P&P indicated, . A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for reach resident . The comprehensive, person-centered care plan will: a. include measurable objectives and timeframes; b. describe the services that are to be furnished to attain or maintain resident's highest practicable physical, mental, and psychosocial well-being .</p> <p>48739</p> <p>3. Facility failed to implement the care plan for monitoring and assisting Resident 6 during meals.</p> <p>This failure resulted in Resident 6's monitoring and assessment needs to not be met and had the potential for aspiration.</p> <p>Findings: (continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. During a review of Resident 6's AR, dated 9/12/24, the AR indicated, Resident 6 was admitted from the acute hospital on 6/22/20, with the diagnoses of dysphagia (difficulty swallowing), and gastro-esophageal reflux disease (a condition in which stomach acid repeatedly flows back up into the tube connecting the mouth and stomach called the esophagus), and heart failure (a condition when the heart muscle doesn't pump enough blood to meet the body's needs which can cause fatigue and shortness of breath).</p> <p>During a review of Resident 6's MDS, dated , 6/17/24, the MDS section C indicated, Resident 6 had a BIMS score of six, which indicated Resident 6 had severe cognitive impairment.</p> <p>During a concurrent observation and interview on 9/10/24 at 12:07 p.m. with Resident 6 in Resident 6's room, Resident 6 was observed sitting up in her bed reading. Resident 6 stated she had not received her lunch tray. Observed the meal tray cart in the hallway with no staff nearby. Observed residents in the next room eating their meal.</p> <p>During an interview on 9/10/24 at 12:10 p.m. with Certified Nursing Assistant (CNA) 6, CNA 6 stated Resident 6's meal tray was not in the meal tray cart. CNA 6 stated she would ask the kitchen staff for Resident 6's meal tray.</p> <p>During a concurrent observation and interview on 9/10/24 at 12:15 p.m. with LVN 1 in Resident 6's room, LVN 1 was observed setting Resident 6's meal tray on the bedside table. LVN 1 stated Resident 6 had a pureed texture diet and required supervision during meals. LVN 1 was observed leaving Resident 6's room after setting up Resident 6's meal tray. Resident 6 was observed eating her pureed meal without supervision from staff.</p> <p>During a concurrent interview and record review on 9/11/24 at 4:35 p.m. with the Infection Preventionist (IP), Resident 6's CP, undated was reviewed. The CP indicated, . on 6/23/24, RD (Registered Dietician) recommended nursing to provide 1:1 feeding assistance to promote max PO intake . monitor/document/report PRN (as needed) any s/sx (signs or symptoms) of dysphagia: pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusing to eat, appears concerned during meals . The IP stated Resident 6 had a CP for assistance with feeding 1:1. The IP stated somebody should have been with Resident 6 while she ate. The IP stated if Resident 6 was left alone with no assistance while eating, Resident 6's CP was not being followed. The IP stated if Resident 6 was not receiving assistance during mealtime, Resident 6 could have lost weight and Resident 6 could have declined. The IP stated Resident 6 had dysphasia and could have choked or aspirated food if Resident 6 was not being assisted or supervised while she ate.</p> <p>During a concurrent interview and record review on 9/13/24 at 10:36 a.m. with LVN 1, Resident 6's Nursing Progress Notes and CP, undated were reviewed. LVN 1 stated Resident 6 had some episodes of choking during her meals when she was admitted in June 2022. LVN 1 reviewed Resident 6's CP with the RD's recommendation for assistance and monitoring of Resident 6 during meals. LVN 1 stated if Resident 6's care plan was not followed, Resident 6 was at risk for choking. LVN 1 stated staff were to follow resident's care plans to prevent things from happening and to meet the resident's needs. LVN 1 stated Resident 6's care plans should have been followed by the staff to meet Resident 6's needs.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 9/13/24 at 10:54 a.m. with the DON, the DON stated staff should have been following Resident 6's CP. The DON stated if resident's CPs were not followed, staff could miss providing appropriate resident care. The DON stated her expectation was that the CP should have been completed and followed. The DON stated the CP should be individualized to each resident.</p> <p>During a review of the facility's document titled, Job description: Certified Nursing Assistant (CNA), dated 10/19/2015, the document indicated, . under the direction of a licensed nurse, the CNA . participates in the care planning process and implements care according to care plan . feeds or assists patients with meals and provides additional nourishment and hydration per care plan .</p> <p>During a review of the facility's P&P titled, Assisting the Impaired Resident with In-Room Meals, dated 1/2018, the P&P indicated . the purpose of this procedure is to provide appropriate support for residents who need assistance with eating . review the resident's care plan and provide for any special needs of the resident .</p> <p>During a review of the facility's P&P titled, Care Plans, Comprehensive Person-Centered, dated 1/2018, indicated, . a comprehensive, person-centered care plan . is developed and implemented for each resident . the comprehensive, person-centered care plan will . describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . incorporate risk factors associated with identified problems . developing interventions that are targeted and meaningful to the resident .</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>44899</p> <p>Based on interview and record review, the facility failed to provide services which met professional standards of practice for one of 16 sampled residents (Residents 10) when the facility failed to notify the Attending Physician of Resident 10's ongoing refusal of Fluticasone-Salmeterol (medication to prevent inflammation and narrowing of airway) inhaler.</p> <p>This failure had the potential to place Resident 10 at risk of not receive appropriate care and attain her highest well-being.</p> <p>Findings:</p> <p>During a review of Resident 10's Admission Record (AR- a document that provides resident contact details, a brief medical history, level of functioning, preferences, and wishes), dated 9/13/24, the AR indicated, Resident 10 was admitted from the acute hospital on 7/22/24 to the facility, with diagnoses including Chronic Obstructive Pulmonary Disease (COPD - is a chronic inflammatory lung disease that causes obstructed airflow of the lungs), Hypertension (high blood pressure), Muscle Weakness, and Congestive Heart Failure (CHF - weakness in the heart where fluid accumulates in the lungs).</p> <p>During a concurrent observation and interview, on 9/10/24, at 2:30 p.m., with Licensed Vocational Nurse (LVN) 1, in front of the nurse station, LVN 1 was observed holding Resident 10's Fluticasone-Salmeterol inhaler. LVN 1 stated the inhaler opened date was 7/31/24 with 18 doses left in the container. LVN 1 stated the physician order was to administer twice a day and if given as ordered, there should be no remaining doses left in the inhaler that was opened on 7/31/24.</p> <p>During a concurrent interview and record review on 9/10/24, at 2:41 p.m., with LVN 1, Resident 10's August 2024 and September 2024 Medication Administration Record (MAR) and Nursing Progress Note were reviewed. LVN 1 stated Resident 10 has a history of refusing her Fluticasone-Salmeterol inhaler. The MAR indicated Resident 10 received her inhaler twice a day from 7/31/24 to 9/19/24 and there was no record of refusal. LVN 1 stated she was unable to find any nursing documentation that Resident 10 refused her inhaler and her attending physician was not notified of refusals. LVN 1 stated licensed nurses were supposed to document medication refusals and it was not done. LVN 1 stated licensed nurses were supposed to notify the physician after multiple episodes of medication refusal and it was not done. LVN 1 stated Resident 10's Chronic Obstructive Pulmonary Disease could worsen and potentially result to hospitalization .</p> <p>During an interview on 9/13/24, at 12:15 a.m. with the Director of Nursing (DON), the DON stated licensed nurses were supposed to notify the Attending Physician after three or more episodes of medication refusal. The DON stated her expectation was for the licensed nurses to document any refusal of medications and to report multiple episodes of medication refusal to the attending physician for further guidance. The DON stated licensed nurses failed to follow the facility's P&P related to refusing and/or discontinuing care or treatment. The DON stated the lack of follow-up and communication between the licensed nurses and the attending physician could result to Resident 10's COPD to worsen.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 10's Physician Order Summary(POS), dated 9/13/24, the POS indicated, . Fluticasone-Salmeterol Inhalation Aerosol Powder Breath Activated 100-50 Micro Grams Actuator (MCG/ACT - unit of measurement) . Order date 7/29/24 .</p> <p>During a review of the facility's document titled, Job Description: Licensed Vocational Nurse (LVN), dated 10/15, the document indicated, . The LVN contributes to the nursing assessments and care planning, provides direct patient care . 3.1 Administers medications and performs treatment per physician orders .</p> <p>During a review of the facility's policy and procedure (P&P) titled, Administering Medications, dated 1/18, the P&P indicated . Medications shall be administered in a safe and timely manner, and as prescribed . 19. The individual administering the medication must initial the resident's MAR after giving each medication .</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44899</p> <p>Based on observation, interview, and record review, the facility failed to maintain a safe environment for two of nine sampled residents (Residents 20 and 22) when Residents 20 and 22's wheelchairs wheel locks were loose and not locking properly.</p> <p>This failure had the potential to put Resident 20 and Resident 22's safety at risk.</p> <p>Findings:</p> <p>During a review of Resident 20's Admission Record (AR- a document that provides resident contact details, a brief medical history, level of functioning, preferences, and wishes), dated 9/11/24, the AR indicated, Resident 20 was admitted from the acute hospital on 8/5/24 to the facility with diagnoses including , Aftercare Following Joint Replacement surgery (a procedure that replaces a damaged joint with an artificial part, such as plastic, metal or ceramic), Morbid Obesity (overweight), Hypertension (high blood pressure), Muscle Weakness and Anxiety Disorder (a mental health illness characterized by a sudden feeling of panic and fear, restlessness, and uneasiness).</p> <p>During a review of Resident 20's Minimum Data Set (MDS, an assessment tool which indicates physical, medical, and cognitive abilities), dated 8/10/24, the MDS indicated Resident 20's Brief Interview for Mental Status (BIMS) score was 15 out of 15 (0-7 indicated severe cognitive impairment [memory loss, poor decision making-skills], 8-12 moderate cognitive impairment, 13-15 cognitively intact).</p> <p>During a review of the Resident 20's document titled, History and Physical, dated 8/5/24, the document indicated, . DATE OF SURGERY: 7/31/24 . PROCEDURE: Right knee robotic-assisted total knee arthroplasty (a procedure that replaces a damaged joint with an artificial part) .</p> <p>During a concurrent observation and interview on 9/10/24, at 10:51 a.m., with Resident 20 in the activity room, Resident 20 was observed sitting in her wheelchair and trying to lock the wheel lock on the right side of her wheelchair. Resident 20 stated the wheel lock was loose for two weeks and she wanted it [wheel lock] to be fixed as soon as possible. Resident 20 stated the wheelchair was not safe to use. Resident 20 stated she recently had a knee surgery, requiring the use of wheelchair for mobility.</p> <p>During a review of Resident 22's AR, dated 9/11/24, the AR indicated, Resident 22 was admitted from the acute hospital on 12/7/22 to the facility with diagnoses including Fracture of Left Femur (thigh bone), Hypertension, Muscle Weakness, Difficulty Walking, and Unspecified Pain.</p> <p>During a review of Resident 22's MDS, dated [DATE], the MDS indicated Resident 22's Brief Interview for Mental Status (BIMS) score was 15 out of 15.</p> <p>During a review of the Resident 20's document titled, History and Physical, dated 12/8/22, the document indicated, . DISCHARGE DIAGNOSES AND PLAN . 2. Intertrochanteric Fracture (fracture that occurs in the upper part of the thigh bone) of left hip .</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent observation and interview on 9/10/24, at 10:57 a.m., with Resident 22 in the activity room, Resident 22 was observed sitting in her wheelchair, next to Resident 20. Resident 22 stated the left wheel lock of her wheelchair was loose for several weeks and she wanted it [wheel lock] to be fixed as soon as possible. Resident 22 stated the staff knew that her wheelchair was not working but they did not do anything about it. Resident 22 stated she had a hip surgery couple of years ago, was unable to ambulate on her own, and used her wheelchair to go places.</p> <p>During a concurrent observation and interview on 9/10/24, at 10:59 a.m., with Certified Nurse Assistant (CNA) 1 in the activity room, CNA 1 checked Resident 20's wheelchair and stated Resident 20's right wheel lock was loosed and not locking properly. CNA 1 checked Resident 22's wheelchair and stated Resident 22's left wheel lock was loose. CNA 1 stated staff should report any equipment issues to the maintenance staff. CNA 1 stated loose wheel locks can allow the wheelchair to move, which can increase the risk of injury to Resident 20 and Resident 22.</p> <p>During a concurrent observation and interview on 9/10/24, at 11:06 a.m., with the Maintenance Supervisor (MAINS) in the activity room, MAINS checked Resident 20's wheelchair and stated Resident 20's right wheel lock was loosed and not locking properly. MAINS checked Resident 22's wheelchair and stated Resident 22's left wheel lock was loose. MAINS stated staff should report any equipment issue by completing the maintenance log. MAINS stated staff could also call him for issues requiring immediate attention such as wheel locks malfunction. MAINS stated loose wheel locks could cause fall or injury to Resident 20 and Resident 22.</p> <p>During a concurrent interview and record review on 9/10/24, at 4:00 p.m., with the MAINS, the facility's document titled Maintenance Log, undated, was reviewed. The log indicated, . Maintenance Needs . 9/3/24 . room [ROOM NUMBER]A . Bed remote not work [working] . MAINS stated the most recent maintenance request was related to bed remote not working. MAINS stated there were no documented request related to Resident 20 and Resident 22's loose wheelchair wheel locks. MAINS stated he cleans and inspects wheelchair once a month for any issues and perform repairs as needed. MAINS stated all staff were responsible in reporting any issues related to equipment malfunctions. MAINS stated loose wheel locks might result to a fall or injury to facility residents.</p> <p>During an interview on 9/13/24, at 12:49 p.m., with the Director of Nursing (DON), the DON stated licensed and unlicensed staff were responsible for reporting non-emergent equipment issues by completing the maintenance log. The DON stated for issues requiring immediate attention, staff should call the maintenance supervisor. The DON stated loose wheelchair wheel locks could cause injury to facility residents. The DON stated staff failed to follow the policy and procedure related to reporting equipment malfunction.</p> <p>During a review of the facility's document titled, Certified Nurse Aide (CNA) Job Description, dated 10/15, the document indicated, . 1. Provides patient care in a manner conducive to safety and comfort . 1.3 Assists patients with ambulation and transfers . 15. Reports changes in patient's condition, patient/family concerns or complaints to charge nurse/or supervisor .</p> <p>During a review of the facility's document titled, Job Description: Licensed Vocational Nurse (LVN), dated 10/15, the document indicated, . the Licensed Vocational Nurse delivers efficient and effective nursing care . He/she operates within the scope of practice defined by the State Nurse Practice Act . 13. Promotes a culture of safety to ensure a healthy practice and living environment .</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility's document titled, Maintenance Director Job Description, dated 10/15, the document indicated, . The Maintenance Director is responsible for the overall maintenance operation of the center, and he/she is responsible for performing repairs and maintenance on equipment . 2. Maintains the building in good repair and free of hazards .</p> <p>During a review of the facility's policy and procedure (P&P) titled Assisted Devices and Equipment, dated 1/18, the P&P indicated, . Our facility provides, maintains, trains and supervises the use of assistive devices and equipment for residents . Devices and equipment that assist with resident mobility, safety and independence are provided for residents. These include, but are not limited to: a. Wheelchairs .</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>44899</p> <p>Based on observation, interview, and record review, the facility failed to follow their policy and procedure titled Medication Storage in the Facility when the medication room and medication refrigerator temperature which stored drugs and biologicals were not monitored and documented on 9/8/24 and 9/9/24.</p> <p>This failure had the potential for drugs and biologicals stored inside the medication room and medication refrigerator to decrease their effectiveness.</p> <p>Findings:</p> <p>During a concurrent observation and interview, on 9/10/24, at 11:52 a.m., with the Director of Nursing (DON), inside the medication room, the DON was observed reviewing the temperature log of the medication room and the medication refrigerator. The DON stated the medication room and the medication refrigerator temperature were not documented from 9/8/24 to 9/9/24. The medication room stored over-the-counter medications such as Multivitamins (supplement), Vitamin C (use for wound healing), Vitamin B-12 (use to prevent anemia), Zinc (use for wound healing), Ferrous Gluconate (iron supplement), Ibuprofen (use to relieve pain or fever), Acetaminophen (use to relieve pain or fever), Docusate Sodium (stool softener), Sennosides (stool softener), Milk of Magnesia (use to relieve constipation), and Melatonin (use to relieve sleeplessness). The medication refrigerator contained one vial of pneumovax vaccine (fights bacteria against pneumonia, blood infections, and bacterial meningitis-infection in the brain), two Tuberculin test (a tool for screening tuberculosis), two vials of regular insulin (a short acting insulin used to lower blood sugar level), two insulin glargine pen (a long acting insulin used to lower blood sugar) and the emergency kit which contained insulins (e-kit - emergency medications supplied by pharmacy that was stocked with 4-10-day supply of the most common medications used).</p> <p>During an interview on 9/10/24, at 12:28 p.m., with the DON, the DON stated the medications can go bad if the temperature of the medication room and medication refrigerator gets too hot or too cold. The DON stated Licensed Nurses (LNs) were responsible for checking the medication room and medication refrigerator temperature and document on the temperature log right away.</p> <p>During a review of a facility's document titled, Medication Storage Room Temperature Log, undated, the log indicated, . Month: September . Year: 2024 . 9/7/24 Temperature 78 degrees F . 9/8/24 Temperature [blank] . 9/9/24 Temperature [blank] .</p> <p>During a review of a facility's document titled, Refrigerator Temperature Log, undated, the log indicated, . Month: September . Year: 2024 . 9/7/24 Temperature 38 degrees F . 9/8/24 Temperature [blank] . 9/9/24 Temperature [blank] .</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During a review of the facility's policy and procedure (P&P) titled, Medication Storage in the Facility, undated, the P&P indicated, . Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier . J. Medications requiring storage at room temperature are kept at temperatures ranging from 59 degrees Fahrenheit (F - unit of measurement) to 86 F degrees . K. Medication requiring refrigeration or temperatures between 36 degrees F and 46 degrees F are kept in a refrigerator with a thermometer to allow temperature monitoring .</p>		

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<p>F 0912</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44899</p> <p>Based on observation during the survey period of 9/10/24 to 9/13/24, the facility failed to provide the minimum of at least 80 square feet per resident in 15 out of 16 rooms (Rooms 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15 and 16).</p> <p>This failure had the potential for residents in Rooms 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15 and 16 to not have reasonable privacy or adequate space.</p> <p>Findings:</p> <p>During an observation on 9/12/24, at 4:33 p.m., an environment tour was conducted with the maintenance supervisor, the inspection indicated the following rooms did not meet the minimum square footage as required by regulation. These rooms were as follows:</p> <table border="0"> <thead> <tr> <th>Room Number</th> <th>Square Feet</th> <th>Number of Residents</th> </tr> </thead> <tbody> <tr><td>room [ROOM NUMBER]</td><td>144</td><td>2</td></tr> <tr><td>room [ROOM NUMBER]</td><td>144</td><td>2</td></tr> <tr><td>room [ROOM NUMBER]</td><td>144</td><td>2</td></tr> <tr><td>room [ROOM NUMBER]</td><td>144</td><td>2</td></tr> <tr><td>room [ROOM NUMBER]</td><td>144</td><td>2</td></tr> <tr><td>room [ROOM NUMBER]</td><td>144</td><td>2</td></tr> <tr><td>room [ROOM NUMBER]</td><td>144</td><td>2</td></tr> <tr><td>room [ROOM NUMBER]</td><td>144</td><td>2</td></tr> <tr><td>room [ROOM NUMBER]</td><td>143</td><td>2</td></tr> <tr><td>room [ROOM NUMBER]</td><td>143</td><td>2</td></tr> <tr><td>room [ROOM NUMBER]</td><td>143</td><td>2</td></tr> <tr><td>room [ROOM NUMBER]</td><td>143</td><td>2</td></tr> <tr><td>room [ROOM NUMBER]</td><td>144</td><td>2</td></tr> <tr><td>room [ROOM NUMBER]</td><td>144</td><td>2</td></tr> <tr><td>room [ROOM NUMBER]</td><td>143</td><td>2</td></tr> </tbody> </table> <p>(continued on next page)</p>	Room Number	Square Feet	Number of Residents	room [ROOM NUMBER]	144	2	room [ROOM NUMBER]	144	2	room [ROOM NUMBER]	144	2	room [ROOM NUMBER]	144	2	room [ROOM NUMBER]	144	2	room [ROOM NUMBER]	144	2	room [ROOM NUMBER]	144	2	room [ROOM NUMBER]	144	2	room [ROOM NUMBER]	143	2	room [ROOM NUMBER]	143	2	room [ROOM NUMBER]	143	2	room [ROOM NUMBER]	143	2	room [ROOM NUMBER]	144	2	room [ROOM NUMBER]	144	2	room [ROOM NUMBER]	143	2
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555347	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/13/2024
NAME OF PROVIDER OR SUPPLIER North Starr Postacute Care		STREET ADDRESS, CITY, STATE, ZIP CODE 180 Starr Avenue 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)		
<p>F 0912</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>room [ROOM NUMBER] 143 2</p> <p>However, variations were in accordance with the particular needs of the residents. The residents had a reasonable amount of privacy. Closets and storage space were adequate. Bedside stands were available. There was sufficient room for nursing care and for residents to ambulate. Wheelchairs and toilet facilities were accessible. The waiver will not adversely affect the health and safety of residents.</p> <p>Recommend waiver be continue in effect.</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0943</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation.</p> <p>44899</p> <p>Based on interview and record review, the facility failed to follow the policy and procedure titled Staff Development Program to ensure Licensed Nurses (LNs), Certified Nursing Assistants (CNAs) and ancillary (additional) support staff received and demonstrated competency to prevent and recognize resident abuse and had the necessary skills and techniques necessary to care for residents who were identified as high risk for fall when:</p> <ol style="list-style-type: none"> 11 of 28 facility staff had not attended and completed the 2024 annual mandatory in-service training for Abuse Prevention. 16 of 28 facility staff had not attended and completed the 2024 annual mandatory in-service training for Fall Prevention. <p>These failures had the potential to place residents at risk for care not being provided in a safe and competent manner.</p> <p>Findings:</p> <p>During a concurrent interview and record review on 9/12/24, at 10:41 a.m., with the Director of Staff Development (DSD), the in-service training titled Abuse Prevention, dated 3/20/24 was reviewed. The DSD stated they have 28 employees providing direct and indirect care to facility residents. The document indicated 11 of 28 facility staff had not attended the mandatory training. The DSD stated she did not offer a remedial class for staff who was not present on 3/20/24 mandatory in-service. The DSD stated without the training, staff would not have the proper knowledge on recognizing and preventing resident abuse.</p> <p>During a concurrent interview and record review on 9/12/24 at 2:57 p.m. with the DSD, the in-service training for Fall Prevention dated 6/21/24 was reviewed. The DSD stated, they have 28 employees providing direct and indirect care to facility residents. The document indicated 16 of 28 facility staff had not attended the mandatory training. The DSD stated she did not offer a remedial class for staff who was not present on 6/21/24 mandatory in-service. The DSD stated, without the training, staff would not have the proper knowledge on preventing residents from falling.</p> <p>During a concurrent interview and record review on 9/12/24 at 3:15 p.m. with the Director of Nursing (DON), the 2024 In-service Training Calendar was reviewed. The DON stated, the trainings for Abuse Prevention and Fall Prevention were mandatory trainings and should be completed annually. The DON stated, in-service training should be attended by Licensed Nurses, Certified Nurse Aides, and support staff to provide proper care to facility residents.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Staff Development Program, dated 1/18, the P&P indicated, . All personnel must participate in initial orientation and regularly scheduled in-service training classes . 10. The following in-service training classes are mandatory . e. Resident Rights; f. Resident Abuse .</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555347	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/13/2024
NAME OF PROVIDER OR SUPPLIER North Starr Postacute Care		STREET ADDRESS, CITY, STATE, ZIP CODE 180 Starr Avenue Turlock, CA 95380	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0943</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During a review of the facility's P&P titled, Abuse Prevention Program, dated 1/18, the P&P indicated, . Our residents have the right to be free from abuse, neglect . 4. Require staff training/orientation programs that include such topics as abuse prevention, identification and reporting of abuse .</p> <p>During a professional reference of document titled Center for Clinical Standards and Quality/Survey & Certification Group, dated 9/14/12, indicated The Affordable Care Act: Section 6121 requires the Centers for Medicare & Medicaid Services (CMS) to ensure that nurse aides receive regular training on caring for residents with dementia and on preventing abuse. CMS created this training program to address the requirement for annual nurse aides training on these important topics.</p> <p>During a professional reference review retrieved from https://www.nursinghomeabuse.org/articles/nursing-home-abuse-training/ titled, Abuse and Neglect Training in Nursing Homes, dated 3/31/21, the professional reference indicated, .Nursing home abuse and neglect is unfortunately still a problem in nursing homes across the country. Nursing homes can significantly reduce the incidence of abuse and neglect in their facilities by investing in training and prevention. Nursing home facilities that do offer training have shown to have fewer cases of abuse and neglect .</p> <p>During a review of the facility's document titled, Licensed Vocational Nurse (LVN) Job Description, dated 10/15, the document indicated, . delivers efficient and effective nursing care . 11. Enhances nursing practice by attending all mandated in-service programs .</p> <p>During a review of the facility's document titled, Certified Nurse Aide Job Description, dated 10/15, the document indicated, . 1. Provides patient care in a manner conducive to safety and comfort . Must attend a minimum of 12 hours continuing education programs provided by the center in order to maintain certification .</p> <p>During a review of the facility's document titled, Maintenance Director Job Description, dated 10/15, the document indicated, . 2. Maintains the building in good repair and free of hazards . 9. Participates in and plans in-service programs .</p> <p>During a review of the facility's document titled, Staff Developer Job Description, dated 10/15, the document indicated, . the LVN Staff Developer functions as a practioner, consultant, educator and facilitator for all nursing staff focusing on the following areas . Nurse Education and in-service training . 2.6 Develops an annual nursing education calendar to include State/Federal Mandatory in-services .</p>		