POC ACCEPTABLE YES NO

Reviewed By: [redacted] Name

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/06/2013
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055475	A. BUILDING _____ B. WING _____	07/26/2013

Fax: [redacted] Original
Facility Notified
Name: [redacted]
Date: [redacted]
Time: [redacted]
Notified By: [redacted] Name

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELNESS CONVALESCENT HOSPITAL	812 WEST MAIN STREET TURLOCK, CA 95380

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health-Licensing and Certification during a RECERTIFICATION survey. Representing the California Department of Public Health: 31279 HFEN, 32306 HFEN, 32055 HFEN, 31267 HFEN Capacity: 99 Census: 97 Sample: 21	F 000	The preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of truth of the facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. The plan of correction constitutes my written credible allegation of compliance for the deficiencies noted.	
F281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and administrative document review the facility failed to provide services in accordance with professional standards of quality when 1 of 20 sampled residents, (Resident 13) when medication was not administered as ordered by the physician. This failure placed residents at risk of medical complications and risk of developing thrush, (a yeast infection in the mouth and throat.) Findings: On 07/25/13 at 8:40 a.m.. during the Medication Pass observation, licensed nurse 1 (LN) administered Advair 100/50, an anti-asthma	F 281	F281 483.20 (k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS Amended 8/23/13 **Medications administered as ordered by physicians** **Corrective Action:** Licensed nurse 1 received an inservice during inspection regarding Specific Medication Administration Procedures [including inhalers]. Resident 13 was assessed without negative outcome for administration of inhaler procedure. Resident 13 continues to reside at the facility. **Residents Affected:** All residents, who have physician's orders for inhaler administration, have the potential to be affected.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Don Weseloh — TITLE: Administrator — (X6) DATE: Amended 8/26/13

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AUG 26 2013
CA DEPT. OF PUBLIC HEALTH
LICENSING & CERTIFICATION - FRESNO

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.

POC ACCEPTABLE YES NO
Reviewed By: Judy Wilson RN
Date:
Fax
Original

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055475	A. Facility Verified Date: 8/23/13 Time: 8:45 AM Initials: JW B. Initials:	07/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELNESS CONVALESCENT HOSPITAL	812 WEST MAIN STREET TURLOCK, CA 95380

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE | TITLE | (X6) DATE

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AUG 27 2013
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055475	A. BUILDING _____ B. WING	07/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELNESS CONVALESCENT HOSPITAL	B12 WEST MAIN STREET TURLOCK, CA 95380

(X4) ID PREFIX FULL TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE
F281	Continued From page 1 medication. The Advair was administered to Resident 13 through an inhaler. After completing the inhalation Resident 13 took a sip water from the drinking glass and swallowed the water. Resident 13 did not rinse the mouth or spit out the water as written in the physician order. Resident 13's Physician Orders 04/19/13, indicated "FLUTICASONE/SALMETEROL(ADVAIR HFA) 100/50...1 PUFF VIA INHALER...**RINSE MOUTH AFTER ADMINISTRATION**..." The prescribing information for Advair reviewed 07/25/13, indicated "Risks and Side Effects...Overview and important information...Thrush in the mouth and throat may occur. It is important to rinse your mouth with water or brush your teeth after using your Advair..." On 07/25/13 at 10:26 a.m., during an interview, LN 1 stated, "I did not instruct [Resident 13] to rinse her mouth and spit out the rinse water...! should have done that." The facility's undated policy and procedure, titled "Oral Inhalation Administration " indicated, "...correct administration of oral inhalers to residents...have resident rinse his/her mouth and spit out the rinse water..."	F281	**Systemic Changes:** The Director of Nursing will inservice Licensed Staff on Specific Medication Administration Procedures, including inhalers, to ensure medications administered according to physician's orders. This inservice will cover both the Correct Equipment Required, as well as Correct Procedures Demonstrated. **Monitoring:** The Director of Nursing will validate a return demonstration of at least two licensed staff weekly for Oral Inhalation Administration to ensure ongoing compliance [and document observations of Special Administration Procedures on the Oral Inhalation Administration tool]. The outcome of this monitoring will be reported to the quarterly QAPI meeting for further review and possible action. **Alleged compliance: 8/26/2013**	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to	F 323	F323 483.25(h) FREE OF ACCIDENT HAZARDS /SUPERVISION/DEVICES	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055475	A. BUILDING _____ B. WING	07/26/2013

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F 323	Continued From page 2 prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record and administrative document review, the facility failed to ensure each resident received adequate supervision to prevent accidents when Care Plans were not updated and interventions not implemented for 1 of 20 sampled residents (Residents 5 and 9.) This failure placed residents at risk of injury or death. Findings: Resident 5's Minimum Data Set, (MOS, an assessment of functional and cognitive ability,) dated 05/29/13 indicated Resident 5 was totally dependent on staff for transfers and was unable to walk. Resident 5 used a wheelchair for mobility in and out of the facility. Resident 5's Care Plan dated 05/24/13 indicated, Resident 5 was at risk for falls related to multiple concerns/problems including... Neuropathy, cognitive deficits, weakness, impaired mobility, impaired vision, and balance problems. Resident 5 had a history of falls. Approaches listed included assist with transfers and frequent visual checks, (every 15 minutes.) The care plan did not have a stop date for the checks. There were no new interventions entered on the care plans after Resident 5's documented falls. Resident 5's falls check list that is completed after a fall has entries to indicate falls on	F 323	Amended 8/23/13 **Adequate supervision and assistance devices** **Corrective Action:** Nursing staff were inserviced 7/23/13 regarding resident monitoring, including visual checks when initiated for resident safety. Charge nurses will be accountable [and document] each shift to ensure aides conduct and document these visual checks. Nursing managers and/or designee will monitor and endorse daily to ensure compliance and safety of residents. Following this inservice, there were no further deficient practices identified. Residents 5 and 9 continue to reside at the facility. **Residents Affected:** All residents, who at risk for falls and/or have visual checks implemented for safety, have the potential to be affected. Nursing staff were inserviced on resident monitoring, and nursing managers conduct daily audits to ensure safety and compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X11 PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055475	A. BUILDING _____ B. WING	07/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELNESS CONVALESCENT HOSPITAL	812 WEST MAIN STREET TURLOCK, CA 95380

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 3 06/06/13, 07/11/13, and 07/13/13. Documentation on 06/06/13, indicated Resident 5 was found on the floor after falling. On 07/11/13, Resident 5 was found on his abdomen under the bed after falling and again on 07/13/13, Resident 5 was found on the floor after falling. Resident 5's visual check list dated 06/06/13, has entries documenting Resident 5 was checked every 30 minutes instead of the 15 minute checks documented on the care plan. The checks only occurred for 1 day for a 24 hour period, then stopped. Resident 5's visual check list dated 07/11/13, has entries documenting Resident 5 was checked every 30 minutes instead of the 15 minutes on the care plan. This again only occurred during a 24 hour period. The visual check list dated 07/12/13, indicated Resident 5 was checked every 15 minutes but only for 2 days. There was no documentation Resident 5 was checked at all for a period of 5 and a half hours between 2:30 p.m., and 8 p.m., when Resident 5 fell again. On 07/23/13 at 2:30 p.m., the director of nursing, (DON,) reviewed the visual check documentation. The DON stated, "The 15 minutes visual check was not implemented on 07/12/13 as recommended by the IDT. The DON stated she would expect a CNA to go to the resident's room and visually check the resident as the care plan directed. The facility's policy and procedure, effective date 4/06, titled "Fall Prevention Program" indicated "...any residents identified at risk for falls shall have an individual care plan that includes interventions to prevent falls from occurring...licensed nurse will enter problems,	F 323	**Systemic Changes:** The Director Staff Development and/or designee inserviced nursing staff Resident Monitoring 7/23/13, including charge nurse, and nurse manager, monitoring and endorsement of resident visual checks and documentation by nursing aides. **Monitoring:** The Director of Nursing and/or designee will monitor weekly to ensure safety of residents of residents on visual checks to ensure ongoing compliance, endorsing that the Resident Monitoring protocols are followed. The outcome of this monitoring will be reported to the quarterly QAPI meeting for further review and possible action. **Alleged compliance: 7/23/2013**	

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F 323	Continued From page 4 goals and interventions in the care plan, update the CNA of any new interventions needed due to the incident...interventions are to include preventative measures. IDT will...make recommendations and assure the carnelian is updated."	F 323		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and administrative document review, the facility failed to store food properly when a container of a mashed potato powdered mix was opened for use and was stored undated. This failure had the potential for improperly stored and contaminated opened food items to be served to residents. Findings: On 07/24/13 at 10:30 a.m., during a tour and observation of the kitchen, an undated, 2.61 kilogram white colored plastic container of Sysco mashed potato without milk was observed. The container was stored open and ready for use.	F 371	F371 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE – SANITARY **Proper Food Storage** Amended 8/23/13 **Corrective Action:** The identified item was correctly dated upon identification of deficient practice. On 7/24/13 dietary staff were inserviced on the proper dating and storage to comply with open-dating regulations. No residents were affected. **Residents Affected:** All residents have the potential to be affected. Dietary staff were inserviced, and dietary manager will monitor daily for ongoing compliance. **Systemic Changes:** The Dietary Manager and/or designee inserviced dietary staff 7/24/13 on proper dating and storage of opened items within the kitchen. The dietary cook and manager will inspect daily to ensure compliance open-dating protocols.	

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	055475	A. BUILDING _____ B. WING	07/26/2013

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ELNESS CONVALESCENT HOSPITAL	812 WEST MAIN STREET TURLOCK, CA 95380

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F 371	Continued From page 5 On 07/24/13 at 10: 35 a.m., during an interview, the PM (evening) Cook stated, she opened and used the mashed potato products during the lunch meal the day before, on 07/23/13. The PM Cook stated, "I should have dated the food container after opening it" On 07/24/13 at 10:45 p.m., during an interview, the Dietary supervisor stated "The opened food item [referring to the mashed potatoes] should have been dated for proper storage." The facility's policy and procedure dated 2010, titled "Food Storage" indicated "...Food is stored...by methods designed to prevent contamination or cross contamination...Plastic containers with tight fitting covers must be used...Food should be dated an it is placed on the shelves..."	F 371	**Monitoring:** The Dietary Manager and/or designee will monitor daily to ensure ongoing compliance, documenting on the "monitoring of open items for dates." The outcome of this monitoring will be reported to the quarterly QAPI meeting for further review and possible action. **Alleged compliance: 7/24/13**	
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation	F425	F425 483.60(A)(B) PHARMACEUTICAL SVC – ACCURATE PROCEDURES, RPH **Providing Pharmaceutical Services** Amended 8/23/13 **Corrective Action:** Licensed nurse 3 called the pharmacy and arranged delivery of treatment supplies and medication prior to next scheduled treatment for resident 5. Resident 5 did not miss the next scheduled treatment, as the supplies arrived prior to scheduled treatment. Resident 5 continues to reside at the facility.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENT1F!CAT10N NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055475	A. BUILDING _____ B. WING	07/26/2013

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F 425	Continued From page 6 on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, clinical record and administrative document review, the facility failed to request and obtain a prescribed medication for 1 of 20 residents (Resident 5), when necessary treatment solution was not available. This failure placed Resident 5 at risk of the wound worsening relating to delayed treatment. Findings: The clinical record review was conducted on 07/24/13. Resident 5 was admitted with diagnosis including right heel blister, Diabetes mellitus, Peripheral neuropathy, chronic pain and anemia. Resident 5 is dependent on staff for grooming, hygiene, transfers and bed mobility. Resident 5's physician order dated 07/15/13 at 1:30 p.m., indicated "Clean wound on the posterior right heel with Di-Dok-Sol solution and cover with calcium alginate twice a day and cover with a foam dressing. Cleanse the wound top of right foot with Di-Dok-Sol solution and cover with calcium alginate daily and as needed. Cover with foam dressing. Cleanse the wound right medial heal with Di-Dok-Sol and cover with calcium alginate and foam dressing two times daily." Resident 5's Physician's Progress Notes dated 07/24/13, indicated Resident 5 was being	F 425	**Residents Affected:** All residents, who have prescribed medication ad/or supplies for treatments, have the potential to be affected. Nursing staff were inserviced 7/24/13 with form developed by Medical Records for daily communication on ordering treatment supplies. **Systemic Change:** The Medical Records Director developed a reordering form, based on facility formulary, for treatment supplies. The Director of Nursing and/or designee inserviced licensed staff 7/24/13 on protocol for ordering treatment supplies. **Monitoring:** The Medical Records Director and/or designee will monitor weekly to ensure supplies ordered, and resident treatments have the necessary medications and supplies available for those physician ordered treatments. The MR will document order dates, and supplies received dates on Wound Care order form to validate. The outcome of this monitoring will be reported to the quarterly QAPI meeting for further review and possible action. **Alleged compliance: 7/24/2013**	

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F 425	Continued From page 7 considered for an above the knee amputation to the right leg. On 07/24/13 at 10:30 a.m., during an observation of Resident 5's wound treatment by Licensed Nurse 3 (LN), no Di-Dok-Sol was available for use in the treatment cart. LN 3 went to the Supply Room twice but was unable to find any of the Di-Dok-Sol cleansing solution prescribed for Resident 5. On 07/24/13 at 10:40 a.m., during an interview, LN 3 stated, LN 2 was responsible for ordering the cleansing solution from the pharmacy before the solution was used up. On 0/24/13 at 1:20 p.m., during a telephone interview, LN 2 stated she had forgotten to order the solution from the pharmacy. On 0/24/13 at 1:25 p.m., during an interview, the Director of Nursing stated, LN 2 should have ordered the solution before the solution was all used up. The reordering for treatment solutions is ordered the same as the pharmacy would be ordered. The facility policy and procedure, undated, titled "Medication ordering and receiving..." indicated "...reorder...after the earliest refill date to assure an adequate supply is on hand."	F 425		
F 458 SS=E	483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms.	F 458	F458 483.70(d)(1) BEDROOMS MEASURE AT LEAST 80 SQ FT / RESIDENT **Room Waiver Request Continued**	

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F 458	Continued From page 8 This REQUIREMENT is not met as evidenced by: *WAIVER* Based on observation and administrative document review, during the survey period, 7/22/13 - 7/25/13, the facility failed to ensure multiple bedrooms measured at least 80 square feet per resident in 17 of 43 resident rooms. Findings: On 07/24/13 the facility's resident rooms were measured by the MS and documented on the CDPH 709 form, measurements verified to be correct by MS. The following resident rooms did not provide the minimum square footage as required by the regulation. Although they did not provide the minimum square footage, variations were in accordance with the needs of the residents in these rooms. Residents had a reasonable amount of privacy, adequate closet and storage space and bedside stands were accessible. Wheelchairs and toilet facilities were readily accessible. Residents were able to move about in the rooms and there was sufficient space for nursing care to be delivered to the residents. The health and safety of the residents will not be adversely affected by the waiver.	F 458	**Monitoring:** The Administrator and/or designee will continue to monitor resident outcomes and satisfaction in identified resident rooms that do not meet the required area. The outcome of this monitoring will be reported to the quarterly QAPI meeting for further review and possible action. Facility administrator endorsed request for waiver to continue in effect 8/16/2013	

Rm #	SQ. FT.	Number of Residents
6	231.25	3
7	231.25	3
8	231.25	3
9	231.25	3

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F 458	Continued From page 9	F 458		

10	231.25	3
11	231.25	3
17	231.25	3
18	231.25	3
19	231.25	3
20	231.25	3
21	231.25	3
22	231.25	3
23	231.25	3
24	231.25	3
25	231.25	3
26	231.25	3
27	231.25	3

We recommend a waiver for the below minimum

square footage reforms' DTV HFE3 UC; 10

(Facilities Evaluator Supervisor Date

Request waiver continue in effect. Amanda

Don Wessels 8/26/13

Facility Administrator Date

RECEIVED
AUG 29 2013
CA DEPT. OF PUBLIC HEALTH
LICENSING & CERTIFICATION - FRESNO