PRINTED: 04/05/2019 FORM APPROVED OMB NO. 0938-0391

1, 7		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	' '	(X3) DATE SURVEY COMPLETED	
		555892	B. WING _			C 9/18/2018	
	ROVIDER OR SUPPLIER DNVALESCENT HOSPI	TAL		STREET ADDRESS, CITY, STATE, ZIP CODE 2108 STILLMAN SELMA, CA 93662	1 0	3/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS	S	F 0	00			
	severity of "C" for FAMENDED on 9/24/ 1. Immediate Jeopai 3:35 p.m. after onsiti implementation of in acceptable Action Pl 2. Exit date to the reto 9/18/18. AMENDED on 9/11/ 1. change scope and F584 and F908 2. Add F684 with scd 3. Edited Based On F908 to reflect chroridentifiers 4. For F584 edited Fassessment 5. edited CA005964 identified deficiency CA00596479: Subst deficiencies - refer to 6. The Centers for MRegional Office (CM deficient practices alpotential serious har serious actual harm Resident 12, Reside 27, and Resident 78 Jeopardy (IJ) situation District Office (DO) of telephone conference administrator. The Dadministrator an amendation of the content of the conference administrator an amendation of the conference and conference administrator and conference and conference administrator and conference and conference administrator and conference administrator and conference and confe	18 to reflect: rdy removed on 9/18/18 at e visit validated terventions listed on the lan. certification survey changed 18 to reflect: d severity to "L" (from "I") for ope and severity of "L" statements for F584 and hological order of Resident Resident 4 to include EMT 79: Substantiated with one - refer to F584 to state "FRI antiated with three identified o F584, F684 and F908. Redicare & Medicaid Services IS RO) reviewed the facility and determined the identified and to all residents and the to Resident 4, Resident 6, ant 15, Resident 24, Resident awarranted an Immediate on. An IJ was called by the on 9/11/18 at 11:10 a.m., via the with the facility and explained to the facility ended 2567/Statement of					
ADODATODY		be submitted to the facility to	DE	TITLE		(X6) DATE	

Electronically Signed 10/24/2018

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.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	AL		STREET ADDRESS, CITY, STATE, ZIP CODE 2108 STILLMAN SELMA, CA 93662		
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 000	reflect the IJ with sco F 584 and F 908; and practice at F 684 with would be added. A wi	e 1 pe and severity of L called at an additional deficient scope and severity of L itten Action Plan to address equested to be submitted.	F 00	00		
	Department of Public Certification, during a Representing the Cal Health, Licensing and	the findings of the California Health, Licensing and Recertification survey. ifornia Department of Public I Certification by federal ID: 795 RN, HFEN, 35737 RN,				
		ve Entity Reported Incident's ing the RECERTIFICATION				
	Substantiated with no FRI CA00596479: Su identified deficiencies F908.	CA00592856, CA00576373: deficiency identified. bstantiated with three - refer to F584, F684 and				
	COMPLAINT CA0058 Deficiency identified. Resident Rights/Exer CFR(s): 483.10(a)(1)(F 55	50		8/26/18

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		555892	B. WING			C 09/18/2018
	ROVIDER OR SUPPLIER ONVALESCENT HOSPIT	AL		STREET ADDRESS, CITY, STATE, ZIP CODE 2108 STILLMAN SELMA, CA 93662	I	03/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 550	self-determination, a access to persons are outside the facility, in this section. §483.10(a)(1) A facility with respect and digresident in a manner promotes maintenan her quality of life, recindividuality. The facility promote the rights of §483.10(a)(2) The faces to quality careseverity of condition, must establish and in practices regarding the provision of services residents regardless §483.10(b) Exercise The resident has the rights as a resident or resident of the Unit §483.10(b)(1) The face interference, coercion from the facility. §483.10(b)(2) The refree of interference, or reprisal from the facility and to be supposed.	Rights. ght to a dignified existence, and communication with and and services inside and cluding those specified in ty must treat each resident and in an environment that are or enhancement of his or ognizing each resident's lity must protect and the resident. cility must provide equal a regardless of diagnosis, or payment source. A facility maintain identical policies and ransfer, discharge, and the under the State plan for all of payment source. of Rights. right to exercise his or her f the facility and as a citizen	F 55			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		555892	B. WING		09/18/2018	
	ROVIDER OR SUPPLIER ONVALESCENT HOSPIT	AL		STREET ADDRESS, CITY, STATE, ZIP CODE 2108 STILLMAN SELMA, CA 93662		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 550	subpart. This REQUIREMENT by: Based on observation review, the facility fair residents (Resident 1 dignity and respect who peeling from the walls Resident 10's bed. This failure promoted the residents could indignified existence. Findings: On 7/23/18 at 9:35 and room 10, Resident 24's upper a shallow hand sized On 7/23/18 at 9:35 and room 10, Resident 10's on his left side facing the plastered wall. On 7/23/18 at 9:45 and concurrent intervoof Nurses (DON) state peeling from the walls been there for some knows." On 7/23/18 at 9:50 and concurrent record reviews as the side of the side facing from the walls been there for some knows."	is not met as evidenced on, interview, and record led to treat two of 25 0 and Resident 24) with when their room had plaster is and plaster fell and laid on I an environment in which ot exercise their right to a m., during an observation in laid asleep in loody laid directly across from hole in the plastered wall. m., during an observation in laid asleep in loody laid asleep in loody laid directly across from hole in the plastered wall. m., during an observation in laid asleep in loody laid asleep in loody laid directly across from hole in the plastered wall. m., during an observation wiew in room 10, the Director led she was aware of plaster s. The DON stated, "It had time, I think maintenance m., during an interview and wiew, the Director of Plant lated he was aware of peeling	F 55	1. Maintenance Director repaired the wall in room #10 immediately on 7/23/ 2. Maintenance Director inspected a other rooms in the facility on 7/23/18 a there were no additional findings. 3. Department Heads will inspect the assigned resident rooms daily during the room rounds. Department managers willog any needed repairs into the maintenance log, notify maintenance director and discuss the findings in the daily stand up meeting. On 8/17/18, all available staff was in-serviced on Quality of life-Home Like Environment and Communication via the Maintenance Log to notify maintenance director about any maintenance issues immediately and enter in maintenance available at nurses station. 4. Dept. Heads will visually inspect the rooms daily during room rounds, Maintenance Director will do monthly room inspections and present any trenidentified to the monthly QA meeting up the QA committee determines that further view is no longer necessary.	18. Il nd eir heir vill e he e s log ne ds ntil	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	COMPLETED		
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	ROVIDER OR SUPPLIER	TAL.		STREET ADDRESS, CITY, STATE, ZIP CODE 2108 STILLMAN SELMA, CA 93662	1 09/	10/2010
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F 550	and stated rooms wherequired repair were workload was prioritinesidents directly. The [peeling plaster] affects should have been fix. Review of document log" dated 6/2/18 three "6/7/18 Patch holes in #17." Resident 10 are omitted from the log. On 7/23/18 at 11:25 and concurrent intervas awake and laid and stated, "everythinare falling" and point in the west wall next. Resident 24's MDS A indicated Resident 2 which indicated the reasonable judgeme. On 7/23/18 at 11:25 Resident 10 was awaperpendicular to the rested on the east wand used his left indes shallow hole in the pand shavings fell on Resident 10's MDS A indicated Resident 1 which indicated the resident 10's MDS A indicated Resident 1 which indicated the resident 10's MDS A indicated Resident 1 which indicated the resident 10's MDS A indicated Resident 1 which indicated the resident 1 which indic	t titled, "Maintenance Log" sich had peeled plaster and listed. The DPO stated zed by issues which affected e DPO stated, "Absolutely it cts residents in that room ed." titled, "Selma Maintenance bugh 6/24 18, indicated in rooms #13, #11, #2, and Resident 24's room was a.m., during an observation view in room 10, Resident 24 in bed. Resident 24 grimaced ing is dirty even the walls ed using his chin to the hole to his bed. Assessment, dated 6/25/18, 4's BIMS score was 5 of 15 esident had severe in memory and ability to make ints. a.m., during an observation, ake and laid on his back bed. Resident 10's head all. Resident 10 reached over ex finger to pick at the lastered wall. Plastered dust Resident 10's bed. Assessment, dated 5/2/18, 0's BIMS score was 4 of 15	F 55	5. 18/26/2018		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
			7. BOILBIN	·		С	
		555892	B. WING	B. WING		9/18/2018	
	ROVIDER OR SUPPLIER DNVALESCENT HOSPIT	AL		STREET ADDRESS, CITY, STATE, ZIP CODE 2108 STILLMAN SELMA, CA 93662			
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F 550 F 577 SS=C	of Life- Homelike Envindicated, "Residents clean, comfortable, a 2. (a) Clean, sanitary The facility's docume [not dated], indicated to a dignified existence	nd procedure titled, "Quality vironment" dated 5/17, are provided with a safe, and homelike environment and orderly environment." Int titled, "Resident Rights", "Each resident has a right ce"	F 55			8/26/18	
	§483.10(g)(10) The r (i) Examine the result of the facility conduct surveyors and any pl respect to the facility; (ii) Receive informatic client advocates, and to contact these ager §483.10(g)(11) The fa (i) Post in a place rea and family members residents, the results the facility. (ii) Have reports with certifications, and cor respecting the facility years, and any plan of respect to the facility, to review upon reque (iii) Post notice of the areas of the facility the accessible to the pub	esident has the right to- ts of the most recent survey ed by Federal or State an of correction in effect with and on from agencies acting as I be afforded the opportunity ncies. acility must idily accessible to residents, and legal representatives of of the most recent survey of respect to any surveys, implaint investigations made during the 3 preceding of correction in effect with available for any individual st; and availability of such reports in inter a prominent and					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		555892	B. WING		C 09/18/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/10/2010	
SELMA CO	ONVALESCENT HOSPITA	AL		2108 STILLMAN SELMA, CA 93662		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 577	Continued From page	e 6	F 57	7		
	information about con This REQUIREMENT by: Based on observation review, the facility fail accessible to resident residents complaints investigating facility. This failure deprived to opportunity and the rithe facility. Findings: On 7/23/18 at 4:36 Pthe facility postings in there were no posted On 7/25/18 at 4:50 Pthe facility postings in the facility postings in th	Inplainants or residents. It is not met as evidenced In, interview, and record led to post in a place readily its and family members of investigations when no it in the Interview complaints for Interview complaint investigations. Interview in the Interview complaints interview c	F 57	1. Facility administrator printed out a entity reported incidents and complain from the EPOC site and placed the 2567 sinto the survey results binder located in the main entrance hallway immediately on 7/25/18, no residents affected by this finding. 2. Administrator inspected the surve results binder and there were no additional findings. 3. Administrator will update the surve binder with latest survey/ complaint investigation results at ongoing basis received. 4. Administrator will review the surve result binder monthly and present any trends identified to the monthly QA meeting until the QA committee determines that further review is no lo necessary. 5. 18/26/2018	were ey ey as	
F 584	The facility did not a procedure upon requessafe/Clean/Comfortal		F 58	4	9/20/18	

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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 584	Continued From page	e 7	F 5	84				
SS=L	CFR(s): 483.10(i)(1)-	(7)						
	§483.10(i) Safe Envir The resident has a rig comfortable and hom but not limited to rece supports for daily livir The facility must prov §483.10(i)(1) A safe, homelike environmentuse his or her person possible. (i) This includes ensureceive care and serve physical layout of the independence and do (ii) The facility shall ethe protection of the roor theft. §483.10(i)(2) Housek services necessary to and comfortable inter	ronment. ght to a safe, clean, relike environment, including giving treatment and ng safely. ride- clean, comfortable, and nt, allowing the resident to real belongings to the extent ring that the resident can rices safely and that the reacility maximizes resident rese not pose a safety risk. Exercise reasonable care for resident's property from loss reeping and maintenance or maintain a sanitary, orderly,						
	§483.10(i)(4) Private resident room, as spe	closet space in each ecified in §483.90 (e)(2)(iv);						
	§483.10(i)(5) Adequal levels in all areas;	ate and comfortable lighting						
	levels. Facilities initia	table and safe temperature lly certified after October 1, a temperature range of 71 to						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:		PLE CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED	
		555892	B. WING			C 09/18/2018	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		09/10/2010	
				2108 STILLMAN			
SELMA CO	ONVALESCENT HOSPITA	AL		SELMA, CA 93662			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 584	Continued From page	8	F 58	34			
	sound levels. This REQUIREMENT by: Based on observation review, the facility fail comfortable and hom 29 residents (Resident Resident 4, Resident 13, Resident 14, Resident 13, Resident 21, Resident 20, Resident 21, Resident 27, Resident 27, Resident 27, Resident 27, Resident 80) when the failed to work and resident after prolitemperatures above 8 [Cross reference F68] The failure to maintain ambient temperature symptoms of heat explication and required transfer The local fire department and determined the himself the prosidents were at risk temperatures and directions.	n a safe and comfortable in the facility led to cosure in 29 residents and in seven of the 29 residents 6, Resident 12, Resident dent 27, and Resident 78) to an acute care hospital.		1. Well motor was replaced which supplied water to facility the facility was in compliance comfortable temperatures by 7. Transfer agreement with 4 SN executed on 7/27/18. 2. On 9/11/18 project to conwater supply to the Chiller as a case of well pump failure was by the contracted vendor. Facility has purchased hand 2 coolers and multiple fans on 7 back up if temperatures becomange. 3. Maintenance Director or coinspect well pump function vis and document Monday throug Charge Nurse will inspect and on weekends. On 9/11/18 project to connect supply to the Chiller as a back of well pump failure was compontracted vendor.	r Chiller and with safe, rom. Fs were nect City a backup in completed water //21/18 as ne out of designee will ually daily h Friday, document City water up in case		
	residents were displa The Centers for Medi	ced for several hours. care & Medicaid Services		All staff has been in-serviced of switch over to city water supplements			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:		ULTIPLE CONSTRUCTION LDING		(X3) DATE SURVEY COMPLETED	
			A. BOILDI	_			С
		555892	B. WING			09/18/2018	
NAME OF PI	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE		7 10/2010
				2.	108 STILLMAN		
SELMA CO	ONVALESCENT HOSPITA	AL		s	ELMA, CA 93662		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PRÉFIX TAG	,	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 584	Continued From page	9	F:	584			
		S RO) reviewed the facility			well failure on 08/20/18 by DSD &		
		d determined the identified			Maintenance Director. Staff was able		
	T	n to all residents and the			return demonstrate on how to inspect in	f	
	1 -	o Resident 4, Resident 6,			chiller and well motor are functioning		
	I .	nt 15, Resident 24, Resident			properly by visual flow of water, audible	3	
	27, and Resident 78	warranted an Immediate			operation noise from chiller and noting		
	Jeopardy (IJ) situatio	n. An IJ was called by the			safe temperatures from temperature		
		n 9/11/18 at 11:10 a.m., via			gauges in the halls.		
	telephone conference						
		O explained to the facility			New DON started on 10/22/18 and wer		
	administrator an amended 2567/Statement of Deficiencies would be submitted to the facility to				through facility orientation that includes		
	I .	-			facility EOP, Incident Command System		
		pe and severity of L called at			changing over to water supply back-up	,	
		I an additional deficient scope and severity of L			inspecting well and chiller function etc.		
	1 -	ritten Action Plan to address			All staff has been in-serviced on follow	ina	
		equested to be submitted.			topics by DSD - Emergency Operations	-	
	line to citaation was re	squested to be odstrikted.			Plan, Incident Command Center,	•	
	An acceptable Action	Plan was received on			Evacuation Procedures, Communication	n	
	9/14/18 and commun				during a Disaster, Tracking Staff and		
		site visit was conducted on			Residents during Disaster, Resident		
	9/18/18 and validated	l implementation of			Safety and Safe Temperatures and		
	interventions meant to	o address the IJ. The IJ was			location of Disaster Binder (nurses		
	removed on 9/18/18 a				station); Started 8/2/18 and completed	on	
	communcated to the	facility Administrator.			8/22/18.		
	Findings:				On 8/14/18 Administrator in-serviced maintenance director on maintaining		
	On 7/26/18 at 9:54 a.	m., during an interview, the			equipment in working order, preventive	:	
		D - the facility Administrator)			maintenance, maintaining outside vend		
	,	text from the Director of			repairs and inspection records and		
	` '	1/18 at 7:40 a.m., which			inspecting well motor function visually		
	,	unit for the facility had			daily and keeping logs; to inspect Chille	er	
		ED stated the water pump			and Well pump for function daily and		
		unit) broke which caused			perform necessary preventive		
		. The ED stated, "We knew			maintenance.		
	_	ps [temperatures] were not					
	1	vere focused on repairs			On 8/14/18, all available staff was		
	i we knew it [pump] wa	as going to take a couple of	1		in-serviced to notify maintenance about	1	1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	IPLE CONSTRUCTION IG	. ,	(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	L	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP C	•	10/2010	
				2108 STILLMAN			
SELMA CO	ONVALESCENT HOS	PITAL		SELMA, CA 93662			
(X4) ID PREFIX TAG	(EACH DEFICI	SUMMARY STATEMENT OF DEFICIENCIES ID PRO (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH		PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 584	Continued From p	age 10	F 5	84			
	hours to fix." The and two large coo had not kept the facity] Fire Departm evacuation of the stated maintenancome and evaluat when it was deterpumped through to fail. The ED statook over and cooresidents to the hothe [name] church to the hospital, on family." The ED stevacuated by 5:48 stated he did not leave to the fire and two largest and the fire and the fire and the fire and the fire and two largest and the fire a	ED stated portable floor fans lers purchased by the facility acility cool and the [name of ent (FD) Chief ordered the residents on 7/21/18. The ED be staff had requested the FD et the facility's water supply mined water was not being the cooling unit, which caused it ted, "I was not there the FD redinated the transfer of pospital 20 [residents] went to across the street, seven went et o dialysis, and one went with atted all residents were of p.m. from the facility. The ED know why the FD came back to		any equipment failure immerenter in maintenance log an nurses station. Facility created an action provided in Conditioning Failure who of facility statements Emergency Operand included in Disaster Bistantian Plan Station Pla	lan to address sich is now part perations Plan nder. System Failure ally act as the vill immediately poon, Medical Director upon		
	the facility the afternoon of 7/21/18. On 7/26/18 at 11:25 a.m., during an interview, the Director of Staff Development (DSD) stated she was notified by the DON of the broken air conditioner and was called in to work on 7/21/18. The DSD stated, "We [meaning the DON and ED and herself] all arrived around the same time 4:30 p.m." The DSD also stated EMS (Emergency Medical Service) was at the facility evaluating residents for heat exhaustion (a heat related illness) when she arrived. On 7/26/18 at 3:55 p.m., during an interview, the Maintenance Supervisor (MS) stated he was called into the facility the morning of 7/21/18. The MS stated he arrived at 10:00 a.m. The MS stated the Director of Plant Operations (DPO) had contacted a heating, ventilation, and air conditioning (HVAC) company and had the air conditioning unit evaluated. The MS stated it was			any failure of the air-cooling Facility Administrator, Main Director and DON or Desig to the building after notifica with plan with in 1 hour. Up DON or designee will take Incident Commander. Incident Commander will in the following measures in pu Charge nurse will immedia triage residents for any chat base line. Triage will consist respiratory status, comfort signs, delirium, lethargy an status. Charge nurse will b residents at highest risk su with respiratory problems, high-risk medications such psychotropic medications,	Intenance Innee will report Intion to assist Intion to anges from their Intion to assessing Intion to assist the assessing Intion to as		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
							С
		555892	55892 B. WING				9/18/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SEL MA C	ONVALESCENT HOS	DITAL		2	108 STILLMAN		
SELIVIA C	UNVALESCENT HUSI	PIIAL		S	ELMA, CA 93662		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
F 584	Continued From page	age 11	F!	584			
	unit which caused	it to fail. The MS stated, "We			total dependent, non-verbal, etc.		
		oblem with the water supply so			Resident s status will be documented	in	
		department to see later we			their medical record following the triage	e.	
		e pump around 12:00 [p.m.]"					
	The MS stated the	y were unsure of how long it			Charge nurse will notify Medical Direct	or	
	would take to fix. 7	Γhe MS stated, "It was a			of the status of each resident. The Cha		
	· ·	lucky we could get it fixed." The			Nurse, with the Physician□s input, will		
		nance communicated with the			identify individuals with signs and		
	ED [Administrator] throughout the day to keep him informed of what was happening.				symptoms that might reflect fluid and		
	him informed of wh	nat was happening.			electrolyte imbalance or heat related		
	On 7/26/19 at 6:55	n m. during an interview, the			illness and determine further interventi	ons	
		5 p.m., during an interview, the DON should have			that may be needed at that time. Direct CNA s to dress their assigned		
		that day [7/21/18] if the			residents in lightweight, loose fitting		
		dents from the facility was			clothing.		
		SD stated the facility					
	· ·	arm when she arrived at the			Direct CNA□s to pass fresh water to e	ach	
	facility on 7/21/18	at around 4:30 p.m. The DSD			of their assigned residents. CNA□s w	ill	
	stated, "From wha	t I saw, the residents were hot."			check water every hour and refresh as		
		ed she had not taken a			needed. CNA□s should encourage 2		
	l :	facility environment nor had ts if they were hot. The DSD			glasses (16 ounces) of water every ho	ur.	
	stated her role on	7/21/18 was to assist with the			Direct Dietary Staff to set up hydration		
	evacuation only.				stations at the nurse□s station and in t	:he	
					activity room for residents, family and		
		p.m., during an interview,			staff.		
	_	Assistant (CNA) 12 stated she			Direct CNA s to provide assigned		
		6:10 a.m. on 7/21/18. CNA 12 environment felt hot and muggy			residents with cool, moist towels. Direct CNA sto provide and encourage	20	
		o the charge nurse. CNA 12			residents to eat popsicles between me	-	
		nurse had spoken to the			residents to eat populates between the	ais.	
	_	. CNA 12 stated, "I was			Instruct CNA⊡s to monitor their assign	ed	
		ing the residents started			residents□ vital signs every hour and i		
		ble after lunch time." CNA 12			verbal ask resident if they are		
		partment (FD) was at the facility			comfortable, then report results back to	э	
	1	gave direction to the nurse to			charge nurse.		
		t 2:00 p.m. if the temperatures					
	did not get better.				o Instruct CNA□s to monitor their assigned residents hourly for any adve	erse	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
						С	
		555892	B. WING _		0	9/18/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
SELMA CO	ONVALESCENT HOSPI	ΤΔΙ		2108 STILLMAN			
OLLINA O	ONVALLOGENT 110011			SELMA, CA 93662			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 584	6 stated, "It started to after lunch at 12:00 not sure how hot it gwater after breakfas passed at 10:00 a.m feeling uncomfortab stated she witnesse CNA 6 stated the material fans and residents of the stated she arrived 7/27/18 at 2:50 pt 5 stated she arrived 7/21/18. CNA 5 stated inside than outside. Conditioner] was brought of the complained that it wome to give him ice at CNA 5 also stated, "said the facility was approached me and us if we thought resident of the complained that it wome to give him ice at CNA 5 also stated, "said the facility was approached me and us if we thought resident of the complained that it wome to give him ice at CNA 5 also stated, "said the facility was approached me and us if we thought resident of the facility of the DON, and the vacuation. On 7/27/18 at 3:20 pt 3 stated on 7/21/18 nurse for the facility charge nurse (LN 5)	o.m., during an interview, CNA to get hot at 9:00 a.m. and p.m. it was really hot I am yot we started passing ice t and wet cold towels were hthe residents verbalized le and hot." CNA 6 also d the FD at the facility twice.	F 5		signee to lity eratures e and DN and signee to oling area and has lers will ntain safe		
	cooling measures for provided during the reported the FD had	r the residents had been day. LN 3 also stated LN 5 been called to the facility instructions to evacuate the		The DON as the Incident Commensure transfers are made appro	ocedures. ander will		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
			71. 5012511				С		
		555892	B. WING _			(09/18/2018		
NAME OF P	ROVIDER OR SUPPLIER	•		STE	REET ADDRESS, CITY, STATE, ZIP CODE				
				210	08 STILLMAN				
SELMA CO	ONVALESCENT HOSPIT	AL		SELMA, CA 93662					
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)		(X5) COMPLETION DATE		
F 584	Continued From pag	e 13	F 5	584					
	residents if ambient (temperatures in the f day. LN 3 stated the facility at 4:00 p.m. a the residents when th purchased and delive units to the facility. L reach church staff to evacuation of the res from the FD walked a church and had the o Resident 80 and Res the evacuation. LN 3 the scheduled 5:00 p (mechanical procedu fluid are filtered from stated Resident 2 wa Review of receipt fro provided by the facili stamped 7/21/18 at 1 p.m.), indicated two p were purchased afte initiated by the FD. On 7/26/18 at 3:45 p ED stated, "I didn't th evacuate residents b being completed I wanting to transfer re [name of DSD], [nam Director Plant Opera one was in any distre facility did not have a and the Pastor of the	surrounding environment) acility rose throughout the FD Chief returned to the nd ordered the evacuation of ne maintenance staff had not ered portable air conditioning N 3 stated she was unable to open the church and initiate cidents. LN 3 stated someone across the street to the church opened. LN 3 stated cident 2 were not included in stated Resident 80 left for			according to acuity as determined by triaging residents. Residents with a higher risk status as determined by the Charge Nurse assessment, will be evacuated as first priority then lower relower acuity residents will follow. Residents requiring a higher level of cas determined by the Charge Nurse assessment and consultation with DO and Medical Director, will be transferred by ambulance to the nearest acute cashospital. Residents that are stable as determined by the Charge Nurse assessment and consultation with DON and Medical Director will be transferred via facility (3 available with seating capacity of 1.8 1). On 7/27/18 facility executed transfer agreements for emergencies with 4 shoursing facilities and is also participated in Fresno Mutual Aid Compact MOU among 25 skilled nursing facilities in Fresno area as part of CAHF Disaster Preparedness initiative. Incident Commander will first contact following 4 skilled nursing facilities in which a transfer agreement for emergencies is in place to coordinate many beds are available and how ma residents they can accommodate.	isk, are N ed re ed van 4, 1 idled ing			
	facility for evacuation On 7/30/18 at 10:20	a.m., during a telephone			If contracted facilities can not accommodate all residents, the Incide	ent			

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO	<u>). 0938-0391 </u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		555892	B. WING _				C 1 18/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	10/2010
TO UNIC OF T	TO VIDER OR OUT FEILER				108 STILLMAN		
SELMA CO	ONVALESCENT HOSPITA	AL			ELMA, CA 93662		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	Х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 584	nurse notified her of tunit on 7/21/18 at app DON stated she instructor contact maintenance water, cool wash rags. The DON also stated nurse to monitor their symptoms of heat extitold her to monitor for excessive sweating, it decreased level of constated the charge nurstaff had contacted a repairs to the air conditive temperature readings. DON stated their facility temperature stated she did not ambient temperature stated she did not know the monitor of the pool of the	ated the AM shift charge he broken air conditioning proximately 8:00 a.m. The acted the charge nurse to staff and distribute ice is, and fans to the residents. She instructed the charge residents for signs and paustion. The DON stated, "I mausea and vomiting, increased fatigue, [and] insciousness." The DON se told her maintenance service technician and ditioner were being done. In maintenance staff recorded and reported the indirectly to the ED. The intensity to the ED. The intensity is was on 7/21/18. The DON bow what the facility ave been in order to resident's but considered 89 as af e temperature. The intensity is a safe temperature. The incustion. The DON stated in vacuated when residents safe.	F	584	Commander will reach out to Fresno County Emergency Services Agency Coordinator/Medical Health Operationa Area Coordinator to facilitate transfer or residents to Fresno SNF S Mutual Aid Compact participating facilities (25 tota facilities) to coordinate available beds. (Contact information for these facilities also in the facility disaster binder) Charge Nurse or Designee will contact responsible party prior to transfer to inform them of the plan. Maintenance/ Upgrade of Air Condition System —— On 9/11/18 project to connect City water supply to the Chiller as a backup in cast of well pump failure was completed by contracted vendor Maintenance Supervisor and/or Design will complete daily inspections of the wand chiller system to ensure it is functioning properly by checking for was flow and checking blowing cool air. On 9/12/18 facility received CapEx proapproval to replace current chiller systewith a new HVAC system, OSHPD approval requested, IOR has been retained - 9/12/18.	of il is ing er se the nee ell ater ject	
	east hall, the west ha The log indicated tem be recorded hourly fro p.m. The log indicated	Ill, and the north/south hall. perature readings were to om 8:00 a.m. through 7:00 d omissions of recorded 00 a.m. to 11:00 a.m. The			OSHPD official conducted site visit on 09/13/18.		

first recorded temperature readings were at 12:00

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILDI	_		Ι,	С	
		555892	B. WING			1	18/2018	
NAME OF P	ROVIDER OR SUPPLIER		-	S	TREET ADDRESS, CITY, STATE, ZIP CODE	, , ,		
OELMA O	NIVAL FOOENT LIGORIT	A.I.		2	108 STILLMAN			
SELMA CO	ONVALESCENT HOSPITA	AL		s	ELMA, CA 93662			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	EFIX (EACH CORRECTIVE ACTION SHOULD BE COM			(X5) COMPLETION DATE	
F 584		ough room 20, including the	F	584	DSD has provided the following In-Service Training to all staff	vice		
	dining room, the east hall, the west hall, and the north/south hall with temperatures ranging from 77 degrees F. up to 79 degrees F. Temperature readings at 1:00 p.m. in the areas listed ranged				o A. Emergency Operations Plan, Incident Command Center, Evacuation Procedures, Communication during a			
	from 83 degrees F. to 84 degrees F. Temperature readings at 2:00 p.m. in the areas listed ranged from 85 degrees F. to 88 degrees F. Temperature				Disaster, Tracking Staff and Residents during Disaster, Resident Safety and S Temperatures. Started 8/2/18 and			
	readings at 3:00 p.m. in the areas listed ranged from 87 degrees F. to 88 degrees F. Temperature readings at 4:00 p.m. in the areas listed ranged				completed on 8/22/18. Maintenance Director provided the			
	_	o 89 degrees F. Temperature in the areas listed ranged 89 degrees F.			following In-Service Training to all staff o How to access and turn on back u			
		s noted dated 7/21/16 at			city water supply to Chiller in case of w			
	facility due to heat ex evacuated to church	"Resident evacuated from posure for safety. Resident across the street from facility			All staff In-service started on 9/12/18 a completed on 9/20/18.	na		
	"	2 potes detect 7/21/19 et			On 8/14/18 Administrator in-serviced maintenance director on maintaining			
		s notes dated 7/21/18 at "Resident was evacuated for safety. Resident			equipment in working order, preventive maintenance, maintaining outside veno repairs and inspection records and			
	evacuated to church	across the street." s notes dated 7/21/18 at			inspecting well motor function and keeping logs of those inspections, maintenance and repairs.			
		"Resident was evacuated			o Maintenance Director will immedia	itely		
	evacuated to church				report any problems to the Administrate and schedule any repair, corrections or	or		
	7:21 p.m., indicated,	s notes dated 7/21/18 at "Resident was evacuated			vendor visit necessary.			
	due to heat exposure evacuated to church	across the street."			Facility Wide Exercise was completed with Focus on Activation of EOP, Nursi Home Incident Command System and	_		
		ss notes dated 7/21/18 at "Resident was evacuated for safety. Resident			Evacuation Procedures on 8/30/18 with Supervision and feedback provided by Fire Department. Areas			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		555892	B. WING			C 09/18/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		00.10.20.10	
				2108 STILLMAN			
SELMA CO	ONVALESCENT HOSPITA	AL		SELMA, CA 93662			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	RECTION	(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)		COMPLETION DATE	
F 584	F 584 Continued From page 16		F 58	34			
	evacuated to church	across the street."		addressed included Emergend			
				Operations Plan, Nursing Hom			
		ss notes dated 7/21/18 at		Command System and Comm	unication		
		'Resident was evacuated		Plan.			
	due to heat exposure evacuated to church			Director of Staff Davidonment	will provide		
	evacuated to church	across the street.		Director of Staff Development facility staff with quarterly Disa			
	Resident 13's progres	ss notes dated 7/21/18 at		Preparedness training refresh			
	5:55 p.m., indicated, "Resident evacuated from facility due to heat." Resident 14's progress notes dated 7/21/18 at			updates. Quarterly/Ongoing	5.0 6.14		
				DSD will audit In-Service Trair	ning records		
	6:28 p.m., indicated, '	'Resident was evacuated		weekly until all staff has comp	leted the		
	due to heat exposure	•		In-Service Training.	Service Training.		
	evacuated to church	across the street."					
				Evidence of the In-Service Tra	•		
		ss notes dated 7/21/18 at		documented and submitted to	CDPH.		
	facility due to heat."	'Resident evacuated from		All new employees of the facili	ity will bo		
	lacility due to fleat.			provided with In Service training			
	Resident 17's progres	ss notes dated 7/21/18 at		DSD upon facility orientation for			
		'Resident was evacuated		following:			
	due to heat exposure			o A. Emergency Operation	s Plan,		
	evacuated to church	across the street."		Incident Command Center, Ev			
				Procedures, Communication of	•		
		ss notes dated 7/21/18 at		Disaster, Tracking Staff and R			
	-	'Resident was evacuated		during Disaster, Resident Safe	ety and Safe		
	due to heat exposure	•		Temperatures.			
	evacuated to church	across the street."		o How to access and turn o city water supply to Chiller in o	•		
	Resident 10's progres	ss notes dated 7/21/18 at		motor failure with return demo			
				motor failure with return demo	nonanon		
	6:08 p.m., indicated, "Resident was evacuated due to heat exposure for safety. Resident						
	evacuated to church			Monitoring □			
		ss notes dated 7/21/18 at		Director of Staff Development			
		'Resident was evacuated		monthly random checks of fac	•		
	due to heat exposure evacuated to church	· · · · · · · · · · · · · · · · · · ·		knowledge about Disaster Pro EOP and INC. Knowledge wil			
		20.000 110 011001.		and nao. Ithowicage will	. 20 20000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	\ \ \ \ \	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		555892	B. WING			C	
NAME OF D	ROVIDER OR SUPPLIER	333032	B. WIING	STREET ADDRESS, CITY, STATE, ZIP CODE	0	9/18/2018	
NAME OF T	NOVIDEN ON 3011 EIEN			, , ,			
SELMA CO	ONVALESCENT HOSPIT	AL		2108 STILLMAN			
				SELMA, CA 93662			
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 584	Continued From pag	e 17	F 58	4			
	dated 7/21/18 at 6:08 was evacuated due to Resident evacuated Resident 22's progref 5:45 p.m., indicated, facility due to heat." Resident 23's progref 6:29 p.m., indicated, due to heat exposure evacuated to church Resident 25's progref 5:58 p.m., indicated, due to heat exposure	ss notes dated 7/21/18 at "Resident was evacuated e for safety. Resident		on ability to answer random quereturn demonstration, which incomplete the control of the facility temperature 2. What area of the facility is designated cooling space? 3. How do we keep the reside hydrated? 4. How often are facility temperatured? 5. Show me how switch the consystem from well to city water? 6. Show me how to tell if the working? 7. Where can you find out who during a cooling failure if you for may also include	clude: es? a ents eratures chiller chiller is nat to do orgot?		
	Resident 26's progress notes dated 7/21/18 at 5:48 p.m., indicated, "Resident evacuated from facility due to heat." Resident 77's progress notes dated 7/21/18 at 5:46 p.m., indicated, "Resident evacuated from facility due to heat." Resident 79's progress notes dated 7/21/18 at 6:14 p.m., indicated, "Resident was evacuated due to heat exposure for safety. Resident evacuated to church across the street." Resident 80's progress notes dated 7/21/18 at 6:24 p.m., indicated, "Resident went to dialysis (a process used to remove toxins from the body) as			1. What do you monitor for hydrostatus and heat exposure? 2. What type of residents are a risk for heat related illness? 3. When should the DON and Administrator be notified during system failure? 4. When should assessments completed? On the spot refreshers will be postaff as necessary. Director of Supevelopment will provide in-set training refreshers and updates all-staff with quarterly on topics Preparedness, EOP Action Plant.	at a high g a cooling be provided to Staff rvices, s to facility of Disaster n and INC.		
		will be at dialysis center ation due to heat exposure for		The Administrator will present paction plan to the monthly QAP committee for further review an	1		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		555892	B. WING			09/·	18/2018
SELMA C	ROVIDER OR SUPPLIER ONVALESCENT HOSPITA	AL ATEMENT OF DEFICIENCIES	ID	STREET ADDRESS, CITY, STATE, ZIP CODE 2108 STILLMAN SELMA, CA 93662 PROVIDER'S PLAN OF COF		, <u>GG</u>	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		SHOULD BE		COMPLETION DATE
F 584	8 stated she worked of morning shift. CNA 8 ac [air conditioner] wain at 6:15 a.m the n it felt stuffy, no ven alert residents had co stated, "[Resident 19] seemed weaker than Resident 19's room a CNA 8 stated, "We of open windows, but it up old fans from down On 7/30/18 at 3:10 p. 5 stated she was the who reported the brown of the previous shift (night nurse) thought working properly. LN temperature felt warm contacted the DON. Ime to pass ice water LN 5 stated they pulle for the residents as the stated the maintenant additional fans. LN 5 complained of the heat the FD came to the fawas instructed to contemperatures rose green 5 stated maintenance the first time and was FD the second time. It consider the situation	m., during an interview, CNA on 7/21/18 during the stated, "It seemed like the is not working when I came curse told me it doesn't work tilation." CNA 8 also stated implained it was hot. CNA 8 looked dehydrated usual." CNA 8 stated ind room 20 were very hot. fered water and tried to was too hot we brought instairs." m., during an interview, LN AM charge nurse on 7/21/18 sen air conditioning unit at a. LN 5 stated the night nurse it told her in shift report she the air conditioner was not 5 stated the facility's iter than usual so she N stated, "She [DON] told to drink and cold towels." It did fans from different areas in eday progressed. LN 5 ce staff arrived later with stated Resident 78 at and felt hot. LN 5 stated she cact them [FD] if eater than 80 degrees F. LN staff had contacted the FD not sure who contacted the	F 54	QAPI determines further review longer necessary. The Director of Staff Developm present progress on staff educing responses to the QAPI monthly QAPI determines that further relonger necessary. End of Action Plan 4. Maintenance Director will documentation for inspections performed on the Chiller and Wand present any trends identification monthly QA meeting until the Committee determines that furtilis no longer necessary. 5. 9/20/2018	ment will cation & ly until the review is a keep loga or works Well pump ied to the QA	s &	

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		555892	B. WING			C 09/18/2018		
	ROVIDER OR SUPPLIER	ΓAL		STREET ADDRESS, CITY, STATE, ZIP CODE 2108 STILLMAN SELMA, CA 93662	<u>'</u>	00/10/2010		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
F 584	interviews, CNA 9 st and LN 4) worked or shift. CNA 9 stated for p.m. and the temperature. CNA 9 stated far night to cool down the was told during shift for heat exhaustion. The that had transferred evacuation returned (7/21/18) except for and Resident 80. On 7/31/18 at 4:00 plocal city FD Fire Chon the scene becaus trouble reaching any her I would assist in evacuation." The FD of residents was initite environmental temperature the residents. The Flin the facility were we cooling measures initineffective. The FD of was bobbing his heat out bedridden residents were transferred out had not spoken to the 4:00 p.m. Review of the Fire D dated 7/21/18, indicated 4:09 p.m. to the facility of the Fire D dated 7/21/18, indicated 7/21/18, indicated, "Temperature of the Fire D dated 7/21/18, indicated, "Temperature of th	in it.	F 5	84				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	PLE CONSTRUCTION G	, ,	DATE SURVEY COMPLETED	
		555892	B. WING			C 09/18/2018
	ROVIDER OR SUPPLIER ONVALESCENT HOSPI	TAL		STREET ADDRESS, CITY, STATE, ZIP CODE 2108 STILLMAN SELMA, CA 93662	l	00/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 584	[residents] suffering seven patients requ [by way of] ambuland Resident 4's progres 6:18 p.m., indicated facility due to heat evacuated to Hospit Resident 4's local filter record dated 7/21/8 [emergency medica patient sitting uprigh nursing facility]. Pt [inausea secondary to been at SNF with not afternoonPt reass longer nauseated Resident 4's acute of "After Visit Summard 1:41 a.m., indicated infection without her Resident 4's progres 2:54 a.m., indicated the facility from ER Resident 6's progres 6:07 p.m., indicated facility due to heat evacuated to Hospit Resident 6's acute of "Emergency Depart at 5:59 p.m., indicated to "Emergency Depart at 5:59 p.m., indicated to Hospit Resident 6's acute of "Emergency Depart at 5:59 p.m., indicated to Hospit Resident 6's acute of "Emergency Depart at 5:59 p.m., indicated to Hospit Resident 6's acute of "Emergency Depart at 5:59 p.m., indicated to Hospit Resident 6's acute of "Emergency Depart at 5:59 p.m., indicated to Hospit Resident 6's acute of "Emergency Depart at 5:59 p.m., indicated to Hospit Resident 6's acute of "Emergency Depart at 5:59 p.m., indicated to Hospit Resident 6's acute of "Emergency Depart at 5:59 p.m., indicated to Hospit Resident 6's acute of "Emergency Depart at 5:59 p.m., indicated to Hospit Resident 6's acute of "Emergency Depart at 5:59 p.m., indicated to Hospit Resident 6's acute of "Emergency Depart at 5:59 p.m., indicated to Hospit Resident 6's acute of "Emergency Depart at 5:59 p.m., indicated to Hospit Resident 6's acute of "Emergency Depart at 5:59 p.m., indicated to Hospit Resident 6's acute of "Emergency Depart at 5:59 p.m., indicated to Hospit Resident 6's acute of "Emergency Depart at 5:59 p.m., indicated to Hospit Resident 6's acute of "Emergency Depart at 5:59 p.m., indicated to Hospit Resident 6's acute of "Emergency Depart at 5:59 p.m., indicated to Hospit Resident 6's acute of "Emergency Depart at 5:59 p.m., indicated to Hospit Resident 6's acute of "Emergency Depart at 5:59 p.m., indicated to Hospit Resident 6's acute of	from heat related illnesses ired transport to hospital via ce." ss notes dated 7/21/18 at , "Resident evacuated from exposure for safety. Resident al; [name of hospital]." re department patient care at 4:47 p.m., indicated, "EMS I services] arrived to find at on the bed at SNF [skilled patient] is [complaining of] to heat exhaustion. Pt has a pair conditioning since this sessed in route and Pt is no " care hospital record titled, y Report" dated 7/22/18 at , "Diagnosis: Urinary Tract	F 5	34		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C			
		555892	B. WING		09/18/2018		
	ROVIDER OR SUPPLIER ONVALESCENT HOSPI	TAL		STREET ADDRESS, CITY, STATE, ZIP CODE 2108 STILLMAN SELMA, CA 93662	1 00/	10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUNDER CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED CORRECTION OF THE APPROPRIED C	JLD BE	(X5) COMPLETION DATE	
F 584	11:10 p.m., indicated facility at approximal hospital]." Resident 12's progre 6:29 p.m., indicated facility due to heat elevacuated to Hospit Review of Resident "Emergency Service dated 7/21/18 at 5:5 Diagnosis: Heat exhibiting the progression of the progress	ss notes dated 7/21/18 at d., "Resident returned to tely 10:15 PM from [name of ess notes dated 7/21/18 at "Resident evacuated from exposure for safety. Resident al; [name of hospital]." 12's record titled, es Discharge Instructions" 7 p.m., indicated, "Discharge austion." 12's progress notes dated in, indicated, "Resident exports approximately 10:55 PM tal] in stable condition." ess notes dated 7/21/18 at "Resident transferred to the om] due to facility evacuation. e of hospital) Visit Summary 18 at 9:38 p.m., indicated,	F 58	4			

. ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	LE CONSTRUCTION	(X3)	(X3) DATE SURVEY COMPLETED C		
		555892	B. WING			09/18/2018		
	ROVIDER OR SUPPLIER DNVALESCENT HOSP	ITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 2108 STILLMAN SELMA, CA 93662		00,10,2010		
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F 584		ge 22 24's record, titled, "(name of mary Report" dated 7/21/18 at	F 58	4				
	• •	ed, "Diagnosis: Heat						
	Review of Resident 24's progress notes dated 7/22/18 at 1:08 a.m., indicated, "Resident returned from hospital."							
	7:25 p.m., indicated facility due to heat	27's progress notes dated 7/21/18 at ., indicated, "Resident evacuated from the to heat exposure for safety. Resident ad to Hospital; [name of hospital]."						
	1:24 a.m., indicated of hospital] [name of this resident would [Intensive care unit Sepsis [infection], F	ress notes dated 7/22/18 at I, "Resident admitted to [name of hospital] nurse stated that be transferred to ICU [Admitting Dix [diagnosis] PENA [Pneumonia], and HERD sease; kidney disease]."						
	Resident 27's [name of hospital] Order requisition dated 7/25/18 at 10:24 a.m., indicated, "Discharge Diagnosis Sepsis, Pneumonia, End stage renal disease."							
		•						
	9:53 p.m., indicated hospital] called and admitted to acute constructive Pulmor	ress notes dated 7/21/18 at I, "Nurse from [name of stated that resident was being are for COPED [Chronic hary Disease; lung disease] onia; lung infection caused by						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		555892	B. WING	_		l	C
NAME OF P	ROVIDER OR SUPPLIER	333092	D. Willo	9	STREET ADDRESS, CITY, STATE, ZIP CODE	09/	18/2018
	DNVALESCENT HOSPITA	AL		2108 STILLMAN SELMA, CA 93662			
(X4) ID PREFIX TAG				ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD I TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE
F 584	Continued From page 23		F	584			
	repopulation on 7/21/ during an interview, L	returned to the facility after 18. On 7/30/18 at 3:10 p.m., N 5 stated Resident 78 was Skilled Nursing facility from					
	On 7/30/18 at 2:23 p.m., during an interview, Resident 3 stated, "It was very hot on Saturday [7/21/18] I felt fatigued. It got very hot by mid-morning and I was given oxygen because I could not breathe." Resident 3 also stated the Director of Social Services (DSS) sat him in front of a floor fan to cool off. Resident 3 stated, "A nurse checked my blood pressure and it was too high I felt sick until Monday I had difficulty breathing I was using oxygen off and on until today they offered ice water, towels wet with ice, but they didn't really work, I just felt bad."						
	3's Brief Interview for was 13 of 15 which in	/23/18, indicated Resident Mental Status (BIMS) score adicated the resident was regard to memory and					
	indicated Resident 3 Hypertension (high bl Intracranial Hemorrha	on Record, dated 12/19/17, had a history of Secondary lood pressure) and age (bleeding in the brainby high blood pressure).					
	regards to 7/21/18, R	m., during an interview in esident 14 stated, "It was in the morning the Fire d moved us."					
	Resident 14's MDS A	ssessment, dated 5/21/18,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER'SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED		
		555892	B. WING			C 09/18/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2108 STILLMAN SELMA, CA 93662	ı	03/10/2010
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F 584	which indicated the rewith regard to memore reasonable judgements. On 7/30/18 at 2:35 pregards to 7/21/18, Figetting really hot midsticky, muggy, and use Resident 11's MDS ABIMS score was 12 resident was moderaregard to memory argudgements. On 7/30/18 at 3:52 pregard to memory argudgements. Resident 1 stated, "I drank my shirt was all wet, journal which he stated he on Saturday, dated at told them [staff], wet. Resident 1's MDS A (Assessment referent indicated Resident 1 which indicated the lewith regard to memory reasonable judgement on 7/31/18 at 5:11 president 20 stated, air conditioner was redidn't see anyone ta	4's BIMS score was 15 of 15 resident was cognitively intact by and ability to make ints. a.m., during an interview in Resident 11 stated, "It started diafternoon really hot, incomfortable." Assessment, dated 7/23/18, of 15 which indicated the ately cognitively intact with and ability to make reasonable a.m., during an interview and the resident's journal, the was hot, it gave me a lice water. I was sweating, "Resident 1 pointed to his ted he kept for personal use. It made an entry in his journal r/21/18, which read, "Hot I clothes and pillow." Sesessment, with ARD ince date) of 6/25/18, "s BIMS score was 13 of 15 resident was cognitively intact by and ability to make ints. a.m., during an interview, "My room was very hot I king temperatures it started its a.m. I had a fan, but I	F 58	34		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER DNVALESCENT HOSPI			STREET ADDRESS, CITY, STATE, ZIP CODE 2108 STILLMAN SELMA, CA 93662		09/18/2018
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 584	Continued From pag	ge 25	F 58	4		
	indicated Resident 2 which indicated the	Assessment, dated 6/18/18, 20's BIMS score was 15 of 15 resident was cognitively intact bry and ability to make ents.				
	regarding 7/21/18, F to the church. The a here. I have a fan, th came back I was sweat. I was a little I complain. It started	getting hot about 12 noon. It checking the temperatures				
	indicated Resident 2 which indicated the	Assessment, dated 6/29/18, 25's BIMS score was 14 of 15 resident was cognitively intact bry and ability to make ents.				
	healthcare facilities: Department of Publi Certification dated 7 must implement recommeasures to keep in comfortable during a must have a conting with the loss of air composition when no air condition measures to ensure free from adverse con heat-related health of that facility administra conditions for flucture	c Health Licensing and /5/18, indicated, "Facilities ommended precautionary dividuals safe and extreme hot temperatures and ency plans in place to deal onditioning, or in the case ning is available, take patients and residents are onditions that may cause complications It is important rators monitor weather				

(X1) PROVIDER/SUPPLIER/CLIA

PRINTED: 04/05/2019 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G		(X3) DATE COMP	SURVEY PLETED
		555892	B. WING _			1	C 18/2018
	ROVIDER OR SUPPLIER DNVALESCENT HOSPITA	AL	STREET ADDRESS, CITY, STATE, ZIP CODE 2108 STILLMAN SELMA, CA 93662		DDE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIA		(X5) COMPLETION DATE
F 636 SS=D	well maintained and of Review of the facility "Quality of Life- Home 5/17, indicated, "Resisafe, clean, comfortal environment2. (h) of temperatures (71 deg F)." Review of [name of w 7/20/18 and 7/21/18 is temperatures in [area high of 105 degrees F 100 degrees F. on 7/2 Comprehensive Assection CFR(s): 483.20(b)(1) which shall be substituted as the facility must concare a comprehensive, accomprehensive, acc	r conditioning equipment is operating effectively." policy and procedure titled, elike Environment" dated dents are provided with a ble, and homelike Comfortable and safe grees F through 81 degrees reather service] forecast for indicated outside and the facility] reached a few of the facility] reached a few of the facility] reached a few of the facility and a high of 21/18. Issments & Timing (2)(i)(iii) Sessment duct initially and periodically curate, standardized ment of each resident's Pensive Assessment Instrument. As comprehensive dent's needs, strengths, preferences, using the instrument (RAI) specified the sement must include at least demographic information in the comprehensive demographic information in the comprehension of the comprehension	F 6				8/26/18

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
				_		(c
		555892	B. WING			09/	18/2018
	ROVIDER OR SUPPLIER DNVALESCENT HOSPITA	AL		21	TREET ADDRESS, CITY, STATE, ZIP CODE 108 STILLMAN ELMA, CA 93662		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 636	(ix) Continence. (x) Disease diagnosis (xi) Dental and nutritic (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatmen (xvi) Discharge plann (xvii) Documentation regarding the addition on the care areas trig the Minimum Data Se (xviii) Documentation assessment. The ass include direct observa with the resident, as v licensed and nonlicer members on all shifts §483.20(b)(2) When it timeframes prescribe chapter, a facility mus assessment of a resid timeframes specified through (iii) of this see prescribed in §413.34 apply to CAHs. (i) Within 14 calendar excluding readmissio significant change in mental condition. (Fo "readmission" means	or patterns. ell-being. ining and structural problems. and health conditions. chal status. Its and procedures. ing. of summary information nal assessment performed gered by the completion of et (MDS). of participation in sessment process must ation and communication well as communication with insed direct care staff . required. Subject to the d in §413.343(b) of this est conduct a comprehensive dent in accordance with the in paragraphs (b)(2)(i) ction. The timeframes (3(b) of this chapter do not and days after admission, and in which there is no the resident's physical or are purposes of this section, a return to the facility absence for hospitalization	F	336			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		E SURVEY IPLETED	
		555892	B. WING		0.0	C 09/18/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	•	7/10/2010	
				2108 STILLMAN			
SELMA C	ONVALESCENT HOSE	PITAL		SELMA, CA 93662			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETION DATE	
F 636	by: Based on interview facility failed to cor assessment Minime evaluation to deter functional abilities) residents (Resider admitted from an a and did not have a assessment complidays. This failure resulte needed services for Findings: On 7/30/18 at 10:2 record review, the stated Resident 77 when resident was stated,"I do the ME Assessment). MDS days of his admission completed." On 7/31/18 at 10:0 concurrent record Director (SSD) state was not completed acute care hospital assessment was swithin 14 days follows.	NT is not met as evidenced w, and record review, the implete an admission ium Data Set (MDS - an imine level of care and if or one of 29 sampled it 77) when Resident 77 was icute care hospital on 7/5/18 in MDS comprehensive leted within the required 14 d in the risk of not providing or the care of Resident 77. 3 a.m., during an interview and Director of Nursing (DON) is MDS was not complete is admitted on 7/5/18. The DON is of the Admission is is to be completed within 14 ion. The assessment is not 3 a.m., during an interview and review, the social services ted Admission Assessment I following his admission from I. The SSD stated the upposed to be completed owing his admission from the	F 63		ity have the nowever, after ds by the 18, no further ed as being and IDT was sining for MDS as on cal Operations. Complete a sements to eted timely as or Designee of past month as due in any trends ameeting until es that further		
	Comprehensive As	I. and procedure titled, "Facility seessments and the Care dated 2001, indicated "(2)		5. 18/26/2018			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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	201/1252 02 01/221/52	333032	B. Willo		TREET ADDRESS SITV STATE TID SODE	09/	18/2018
	ROVIDER OR SUPPLIER DNVALESCENT HOSPITA	AL		2	TREET ADDRESS, CITY, STATE, ZIP CODE 108 STILLMAN SELMA, CA 93662		
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F 636	Complete the Minimum Data Set within 14 days after admission."			636			0.0740
F 657	_		F	657			9/27/18
SS=D	be- (i) Developed within 7 the comprehensive as (ii) Prepared by an infincludes but is not lim (A) The attending phy (B) A registered nurse resident. (C) A nurse aide with resident. (D) A member of food (E) To the extent pract the resident and the r An explanation must medical record if the pand their resident rep not practicable for the resident's care plan. (F) Other appropriate disciplines as determined as requested by th (iii)Reviewed and reviteam after each asses comprehensive and gassessments. This REQUIREMENT by: Based on observatio review, the facility fail	ensive Care Plans prehensive care plan must I days after completion of essessment. Lerdisciplinary team, that lited to vicician. Le with responsibility for the I and nutrition services staff. Leticable, the participation of esident's representative(s). Leticable in a resident's coarticipation of the resident resentative is determined the development of the Staff or professionals in fined by the resident's needs the resident. Leticable in the participation of esident's representative(s). Leticable in the participation of the staff of professional in fined by the resident's needs the resident. Leticable in the participation of the staff or professionals in fined by the resident's needs the resident. Leticable in the participation of the staff or professionals in fined by the interdisciplinary the participation of the staff or professionals in the participation of the staff or professionals in the participation of the resident's needs the resident is needs to revise the care plans			F 657 🗆		
	for two of 25 sampled	residents (Resident 9 and			1. The care plans for Resident 9 and		
	Resident 22) when Re	esidents' care plans were			Resident 22 were updated on 7/30/18.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		555892	B. WING		C 09/18/2018	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/10/2010	
SELMA CO	ONVALESCENT HOSPITA	AL	I	2108 STILLMAN SELMA, CA 93662		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 657	not revised by the Inter Disciplinary Team (IDT) on a quarterly basis to show the care needed for the residents. These failures resulted in the risk of residents' needs not being met. Findings: Review of the care plans for Resident 9 and Resident 22 indicated the care plans were not updated on a quarterly basis. Resident 9's care plan was last revised on 4/20/18 and should have been updated on 7/20/18 and was not. Resident 22's care plan was last revised on 3/26/18 and should have been updated on 6/26/18 and was not. On 7/30/18 at 10:24 AM, during a concurrent interview and record review, the Director of Nurses (DON) stated Resident 9's care plan should have been updated on 7/20/18 and it was not. The DON stated Resident 22's care plan should have been updated on 6/26/18 and was not. No Policy and Procedure was provided for care plans which indicated how often care plans were to be updated.		F 657	 The Director of Nursing and IDT reviewed all residents care plans on 7/30/18 and there were no additional residents found to be affected. VP of Clinical Operations provided Director of Nursing and IDT with In Service training for Comprehensive Carlan Requirements, Revisions and Updates on 08/22/18. The Director of Nursing or Designee we complete a monthly audit of comprehensive care plans to ensure all have been completed, revised and updated as required. Any resident care plans found to need revisions will 	are ill	
F 684 SS=L			F 684	4. The Director of Nursing or Designa will present number of Care plan meeting and updated conducted in past month number of care plan due in upcoming month and present any trends identifies the monthly QA meeting until the QA committee determines that further reviews is no longer necessary. 5. 8/26/2018	ings and d to	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER DNVALESCENT HOSPIT	ΓAL	2	STREET ADDRESS, CITY, STATE, ZIP CODE 2108 STILLMAN SELMA, CA 93662	, 33.35233	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 684	Continued From pag	ne 31	F 684			
	facility residents. Base assessment of a residents received accordance with propractice, the comprescare plan, and the residents residents received failed to ensure that and treatment (a fundersidents to maintain level of physical, mewellbeing for 29 of 2 Resident 2, Resident 12, Resident 15, Resident 16, Resident 19, Resident 20, Resident 23, Resident 19, Resident 20, Resident 19, Resident 20, Resident 2	sed on the comprehensive ident, the facility must ensure e treatment and care in fessional standards of hensive person-centered esidents' choices. T is not met as evidenced and record review, the facility each resident received care damental principle) to enable in their highest practicable intal, and psychosocial 9 residents (Resident 1, tt 3, Resident 4, Resident 5, tt 9, Resident 10, Resident 11, int 13, Resident 14, Resident 17, Resident 18, int 20, Resident 21, Resident 25, int 27, Resident 25, int 27, Resident 27, Resident 25, int 27, Resident 27, Resident 27, Resident 28, int 29, When the facility of addressing the needs of acility was aware of the interpretative to climb ahrenheit (F). (Cross		F 684 □ 1. All residents of the facility were assessed for any injuries or complication from exposure to high temperatures up return to the facility on 7/21/18 and no injuries were noted. Facility created an action plan to addrest Air Conditioning Failure which is now proof facility □s Emergency Operations Planard included in Disaster Binder. 2. On 9/11/18 project to connect City water supply to the Chiller as a backup case of well pump failure was completed by the contracted vendor Facility has purchased hand 2 water coolers and multiple fans on 7/21/18 as back up if temperatures become out of range. 3. Maintenance Director or designee we inspect well pump function visually dail and document Monday through Friday (Attached).	ess eart an	
	24, Resident 27, and transfer to an acute	d Resident 78) and required care hospital. The local fire ergency services were called		On 9/11/18 project to connect City water supply to the Chiller as a backup in cast of well pump failure was completed by	se	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		555892	B. WING _			09/	18/2018	
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				2	108 STILLMAN			
SELMA CO	ONVALESCENT HOSPIT	AL		s	ELMA, CA 93662			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	FULL PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 684	Continued From page	e 32	F	684				
	· -	nment and determined the			contracted vendor			
		the residents were at risk due						
	_	mperatures and directed the			All staff has been in-serviced on how to	0		
		ate the residents to a nearby			switch over to city water supply in case	on		
	,	were displaced for several			well failure on 08/20/18 by DSD &			
	hours.	·			Maintenance Director. Staff was able			
					return demonstrate on how to inspect i	f		
	The Centers for Med	icare & Medicaid Services			chiller and well motor are functioning			
	Regional Office (CMS RO) reviewed the facility				properly by visual flow of water, audible	е		
	deficient practices and determined the identified				operation noise from chiller and noting			
	•	m to all residents and the			safe temperatures from temperature			
		to Resident 4, Resident 6,			gauges in the halls.			
		nt 15, Resident 24, Resident						
		warranted an Immediate			All staff has been in-serviced on follow	-		
		on. An IJ was called by the			topics by DSD - Emergency Operation	S		
		n 9/11/18 at 11:10 a.m., via			Plan, Incident Command Center,			
	telephone conference				Evacuation Procedures, Communication	n		
		O explained to the facility ended 2567/Statement of			during a Disaster, Tracking Staff and			
		e submitted to the facility to			Residents during Disaster, Resident Safety and Safe Temperatures and			
		ope and severity of L called at			location of Disaster Binder (nurses			
		d an additional deficient			station); Started 8/2/18 and completed	on		
		n scope and severity of L			8/22/18.	OH		
	•	ritten Action Plan to address			G/ZZ/10.			
		equested to be submitted.			On 8/14/18 Administrator in-serviced			
		- 4 3			maintenance director on maintaining			
	An acceptable Action	Plan was received on			equipment in working order, preventive	•		
	9/14/18 and commun				maintenance, maintaining outside vend			
	Administrator. An one	site visit was conducted on			repairs and inspection records and			
	9/18/18 and validated	d implementation of			inspecting well motor function visually			
		to address the IJ. The IJ was			daily and keeping logs; to inspect Chille	er		
	removed on 9/18/18	at 3:35 p.m. and			and Well pump for function daily and			
	communcated to the	facility Administrator.			perform necessary preventive maintenance.			
	Findings:				maintenance.			
	-				On 8/14/18, all available staff was			
	On 7/26/18 at 9:54 a	.m., during an interview, the			in-serviced to notify maintenance abou	it		
		D - the facility Administrator)			any equipment failure immediately and			
	stated he received a	text from the Director of			enter in maintenance log available at			

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				CIVID INC	7. 0936-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
							С
		555892	B. WING _			09/	18/2018
NAME OF P	ROVIDER OR SUPPLIER			S1	TREET ADDRESS, CITY, STATE, ZIP CODE		
SEL MA C	ONVALESCENT HOSPIT	ΓΔΙ		21	108 STILLMAN		
OLLINA O	ONVALEGOENT HOOFT			S	ELMA, CA 93662		
(X4) ID	I .	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
	•				22.10.2.10.1		
F 684	Continued From pag	e 33	F 6	684			
	Nurses (DON) on 7/2			nursesstation.			
		unit for the facility had					
	_	e ED stated the water pump			Facility created an action plan to addre	SS	
	for the chiller (cooling			Air Conditioning Failure which is now p			
	the cooling unit to fai			of facilitys Emergency Operations Plan			
	it was hot, taking tem			and included in Disaster Binder.			
	that important we						
		we knew it [pump] was going to take a couple of					
		stated portable floor fans			Responding to Air Cooling System Fail	ure	
	_	s purchased by the facility			Action Plan		
		lity cool and the [name of					
		t (FD) Chief ordered the			The Charge Nurse will initially act as the		
		evacuation of the residents on 7/21/18. The ED			Incident Commander and will immediate	•	
		staff had requested the FD			notify Facility Administrator, DON, Med		
		he facility's water supply			Director and Maintenance Director upo	n	
		ned water was not being			any failure of the air-cooling system.		
		cooling unit, which caused it d, "I was not there the FD			Facility Administrator, Maintenance		
	took over and coordi				Director and DON or Designee will rep	ort	
		oital 20 [residents] went to			to the building after notification to assis		
		cross the street, seven went			with plan with in 1 hour. Upon arrival, t		
		o dialysis, and one went with			DON or designee will take over as the		
	family." The ED state				Incident Commander.		
	1	.m. from the facility. The ED					
		ow why the FD came back to			Incident Commander will immediately p	out	
	the facility the afterno	oon of 7/21/18.			the following measures in place.		
		a.m., during an interview, the			Charge nurse will immediately begin to		
		elopment (DSD) stated she			triage residents for any changes from t		
	_	OON of the broken air			base line. Triage will consist of assessi	ng	
		called in to work on 7/21/18.			respiratory status, comfort level, vital		
		e [meaning the DON and ED			signs, delirium, lethargy and hydration		
	_	ed around the same time			status. Charge nurse will begin with	-4-	
	4:30 p.m." The DSD				residents at highest risk such as reside		
		Service) was at the facility			with respiratory problems, renal failure,		
	_	for heat exhaustion (a heat			high-risk medications such as diuretics		
	related illness) when	SHE AHIVEU.			psychotropic medications, those who a total dependent, non-verbal, etc.	ie	
	On 7/26/19 at 2:55 a	.m., during an interview, the			Residents status will be documented in		
	On 11201 to at 3.33 β	.m., during an interview, the	1		rasidents status will be abcamented if	ı	1

_		NIEDIO/ ND OEITVIOEO					2. 0000 0001
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMF	SURVEY
			A. BOILDI	_		,	С
		555892	B. WING			09/	18/2018
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SELMA CO	ONVALESCENT HOSPITA	ΔΙ		2	108 STILLMAN		
022	, , , , , , , , , , , , , , , , , , ,			S	ELMA, CA 93662		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	called into the facility MS stated he arrived stated the Director of contacted a heating, conditioning (HVAC) conditioning unit eval determined water was unit which caused it to thought it was a probout we called the fire depfound out it was the property to the MS stated they would take to fix. The Saturday we're luc	sor (MS) stated he was the morning of 7/21/18. The at 10:00 a.m. The MS Plant Operations (DPO) had ventilation, and air company and had the air uated. The MS stated it was s not being supplied to the of fail. The MS stated, "We em with the water supply so artment to see later we ump around 12:00 [p.m.]" vere unsure of how long it MS stated, "It was a ky we could get it fixed." The	F	684	their medical record following the triage Charge nurse will notify Medical Direct of the status of each resident. The Charge nurse, with the Physicians input, will identify individuals with signs and symptoms that might reflect fluid and electrolyte imbalance or heat related illness and determine further intervention that may be needed at that time. Direct CNAs to dress their assigned residents in lightweight, loose fitting clothing. Direct CNAs to pass fresh water to each control of the control	or urge ons	
	ED [Administrator] the him informed of what	ce communicated with the roughout the day to keep was happening. m., during an interview, the			of their assigned residents. CNAs will check water every hour and refresh as needed. CNAs should encourage 2 glasses (16 ounces) of water every hou		
	DSD stated the ED of determined earlier that evacuation of resident necessary. The DSD temperature felt warm facility on 7/21/18 at a stated, "From what I stated the DSD also stated."	the DON should have at day [7/21/18] if the ts from the facility was stated the facility when she arrived at the around 4:30 p.m. The DSD saw, the residents were hot."			Direct Dietary Staff to set up hydration stations at the nurses station and in the activity room for residents, family and staff. Direct CNAs to provide assigned residents with cool, moist towels. Direct CNAs to provide and encourage residents to eat popsicles between me		
	she asked residents i stated her role on 7/2 evacuation only. On 7/27/18 at 1:50 p. Certified Nursing Ass arrived to work at 6:1 stated the facility env	f they were hot. The DSD 1/18 was to assist with the m., during an interview, istant (CNA) 12 stated she 0 a.m. on 7/21/18. CNA 12 ironment felt hot and muggy he charge nurse. CNA 12			Instruct CNAs to monitor their assigned residentsvital signs every hour and if verbal ask resident if they are comfortable, then report results back to charge nurse. o Instruct CNAs to monitor their assigned residents hourly for any advechanges in resident condition that can heat related and immediately report ba	rse be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		555892	B. WING _			C 9/18/2018	
NAME OF PR	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COD	•	3/10/2010	
				2108 STILLMAN			
SELMA CO	ONVALESCENT HOSP	ITAL		SELMA, CA 93662			
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	REFIX (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION DATE	
F 684	Continued From pa	_	F 6	84			
	maintenance staff. sweating just walking feeling uncomfortal stated the Fire Dep at 11:30 a.m. and go call the FD back at did not get better. On 7/27/18 at 2:20 6 stated, "It started after lunch at 12:00 not sure how hot it water after breakfarpassed at 10:00 a.m. feeling uncomfortal stated she witnessed CNA 6 stated the man fans and residents On 7/27/18 at 2:50 5 stated she arrived 7/21/18. CNA 5 stated she arrived 7/21/18. CNA 5 stated than outside Conditioner] was benot checked the the "[Resident 3] looked drowsy with eyes how complained that it was approached me and us if we thought responded noas stresponded	CNA 12 stated, "I was ng the residents started ble after lunch time." CNA 12 artment (FD) was at the facility ave direction to the nurse to 2:00 p.m. if the temperatures p.m., during an interview, CNA to get hot at 9:00 a.m. and p.m. it was really hot I am got we started passing ice st and wet cold towels were mthe residents verbalized ble and hot." CNA 6 also led the FD at the facility twice.		to the charge nurse changes ¿ Unconsciousness ¿ Dizziness, Nausea and o ¿ Red, hot and dry skin ¿ Rapid, strong pulse ¿ Headache ¿ Muscle cramps, weaknes ¿ Paleness, tiredness Instruct Maintenance Staff or immediately start monitoring temperatures every hour. Ter will be placed in log for refere relayed to the Charge Nurse, Administrator. Instruct Maintenance Staff or set up Activity Room as the d cooling area. The designated is equipped with window AC ucapacity to hold 34 residents. Additional 2 Portable Water Cobe placed in cooling room to temperatures. Evacuation/Transfer If facility temperatures continuan unsafe level for residents a determined by consultation we Medical Director, DON, Admin Charge Nurse the facility will implement facility evacuation	Designee to facility inperatures ence and DON and Designee to esignated cooling area unit and has Coolers will maintain safe ue to rise to as ith the inistrator and proceed to		
	ED, the DON, and evacuation.	the DSD arrived during the p.m., during an interview, LN		The DON as the Incident Cor ensure transfers are made ap according to acuity as determ triaging residents. Residents	ppropriately nined by		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			7 50125	_				
		555892	B. WING _			09/	18/2018	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
SELMA CO	ONVALESCENT HOSPITA	ΔΙ		2	108 STILLMAN			
022				S	ELMA, CA 93662			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 684	nurse for the facility. I charge nurse (LN 5) r staff) the facility's air cooling measures for provided during the d reported the FD had I twice and had given i residents if ambient (stemperatures in the facility at 4:00 p.m. ar the residents when the purchased and delivered units to the facility. LN reach church staff to evacuation of the resifrom the FD walked a church and had the concept the evacuation. LN 3 the scheduled 5:00 p. (mechanical procedur fluid are filtered from	the was the PM shift charge LN 3 stated the AM shift reported (to the nursing conditioner was broken and the residents had been ay. LN 3 also stated LN 5 been called to the facility instructions to evacuate the surrounding environment) acility rose throughout the FD Chief returned to the and ordered the evacuation of the maintenance staff had not the portable air conditioning N 3 stated she was unable to topen the church and initiate didents. LN 3 stated someone the cross the street to the thurch opened. LN 3 stated dident 2 were not included in stated Resident 80 left for	F	384	higher risk status as determined by the Charge Nurse assessment, will be evacuated as first priority then lower ris lower acuity residents will follow. Residents requiring a higher level of cast determined by the Charge Nurse assessment and consultation with DON and Medical Director, will be transferred by ambulance to the nearest acute care hospital. Residents that are stable as determine by the Charge Nurse assessment and consultation with DON and Medical Director will be transferred via facility of (3 available with seating capacity of 14 & 1). On 7/27/18 facility executed transfer agreements for emergencies with 4 skinursing facilities and is also participating in Fresno Mutual Aid Compact MOU among 25 skilled nursing facilities in Fresno area as part of CAHF Disaster Preparedness initiative.	sk, ire I d e d an , 1		
	provided by the facilit stamped 7/21/18 at 1 p.m.), indicated two p were purchased after initiated by the FD.	n the local hardware store y staff dated and time 635 (military time for 4:35 ortable evaporator coolers the facility evacuation was			Incident Commander will first contact the following 4 skilled nursing facilities in which a transfer agreement for emergencies is in place to coordinate he many beds are available and how man residents they can accommodate.	IOW		
	ED stated, "I didn't the evacuate residents be being completed I wanting to transfer re	m., during an interview, the ink it was necessary to ecause repairs were close to base my decision on not sidents [name of DON], e of MS], and [name of			If contracted facilities can not accommodate all residents, the Incider Commander will reach out to Fresno County Emergency Services Agency	ıt		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			71. 501251	_			С
		555892	B. WING			1	/18/2018
NAME OF P	ROVIDER OR SUPPLIER		I	S	TREET ADDRESS, CITY, STATE, ZIP CODE		7.10.20.10
				2	108 STILLMAN		
SELMA C	ONVALESCENT HOSPITA	AL		S	ELMA, CA 93662		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 684	Continued From page	e 37	F	684			
	Director Plant Operat	ions-Maintenance] said no			Coordinator/Medical Health Operations	al	
	· -	ss." The ED also stated the			Area Coordinator to facilitate transfer of		
	_	n agreement with the church			residents to Fresno SNFs Mutual Aid		
		church. The ED stated, "We			Compact participating facilities (25 total	.I	
	don't have any transf	er agreements with any			facilities) to coordinate available beds.		
	facility for evacuation				(Contact information for these facilities	is	
					also in the facility disaster binder)		
	On 7/30/18 at 10:20 a	a.m., during a telephone					
	I .	tated the AM shift charge			Charge Nurse or Designee will contact		
	I .	he broken air conditioning			responsible party prior to transfer to		
		proximately 8:00 a.m. The			inform them of the plan.		
		ucted the charge nurse to					
		staff and distribute ice			Maintenance/ Upgrade of Air Condition	ıng	
	_	s, and fans to the residents.			System		
		she instructed the charge			On 0/11/19 project to connect City water	or	
		residents for signs and haustion. The DON stated, "I			On 9/11/18 project to connect City water supply to the Chiller as a backup in case		
		nausea and vomiting,			of well pump failure was completed by		
	I .	ncreased fatigue, [and]			contracted vendor	uic	
		nsciousness." The DON					
		se told her maintenance			Maintenance Supervisor and/or Desigr	iee	
	_	service technician and			will complete daily inspections of the w		
	repairs to the air cond	ditioner were being done.			and chiller system to ensure it is		
	1 -	maintenance staff recorded			functioning properly by checking for wa	ıter	
	facility temperatures	and reported the			flow and checking blowing cool air.		
	temperature readings	directly to the ED. The					
	I .	not know what the facility's			On 9/12/18 facility received CapEx pro	-	
		was on 7/21/18. The DON			approval to replace current chiller syste	∍m	
	stated she did not kno				with a new HVAC system, OSHPD		
	temperature should h				approval requested, IOR has been		
		esident's but considered 89			retained - 9/12/18.		
		F) a safe temperature. The			OCUED official constructed site of the		
		notified by the PM nurse the			OSHPD official conducted site visit on		
		acuation. The DON stated evacuated when residents			09/13/18.		
	were in distress or un				In Service Training		
	Review of facility doc	ument titled, "Daily			DSD has provided the following In-Ser	vice	
	Inspection Records"	dated 7/21/18, indicated an			Training to all staff		

CENTER	S FOR MEDICARE &	WEDICAID SERVICES				OIVID INC	J. 0930-039 i
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	2) MULTIPLE CONSTRUCTION BUILDING			SURVEY PLETED
							С
		555892	B. WING _			09/	/18/2018
NAME OF P	ROVIDER OR SUPPLIER			S1	TREET ADDRESS, CITY, STATE, ZIP CODE		
SELMA C	ONVALESCENT HOSPIT	·A1		21	108 STILLMAN		
OLLINA O	ONVALLOGENT NOOF IT	AL .		SI	ELMA, CA 93662		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page	e 38	F 6	84			
		ature readings for 20 facility			o A. Emergency Operations Plan,		
		ding the dining room, the			Incident Command Center, Evacuation	Į.	
		all, and the north/south hall.			Procedures, Communication during a		
	_	nperature readings were to			Disaster, Tracking Staff and Residents		
		om 8:00 a.m. through 7:00			during Disaster, Resident Safety and S	ate	
		ed omissions of recorded			Temperatures. Started 8/2/18 and		
		:00 a.m. to 11:00 a.m. The			completed on 8/22/18.		
	· ·	rature readings were at 12:00 rough room 20, including the			Maintenance Director provided the		
		t hall, the west hall, and the			following In-Service Training to all staff	;	
		temperatures ranging from			lollowing in-octvice training to all stan		
		79 degrees F. Temperature			o How to access and turn on back u	n	
		in the areas listed ranged			city water supply to Chiller in case of w		
		o 84 degrees F. Temperature			motor failure with return demonstration		
	_	. in the areas listed ranged			All staff In-service started on 9/12/18 a		
		o 88 degrees F. Temperature			completed on 9/20/18.		
		. in the areas listed ranged			·		
	from 87 degrees F. to	o 88 degrees F. Temperature			On 8/14/18 Administrator in-serviced		
	readings at 4:00 p.m.	. in the areas listed ranged			maintenance director on maintaining		
	_	o 89 degrees F. Temperature			equipment in working order, preventive	<u>;</u>	
		. in the areas listed ranged			maintenance, maintaining outside vend	lor	
	from 84 degrees F to	89 degrees F.			repairs and inspection records and		
					inspecting well motor function and		
		s noted dated 7/21/16 at			keeping logs of those inspections,		
		"Resident evacuated from			maintenance and repairs.		
		oposure for safety. Resident			Maria Branchi de Company		
		across the street from facility			o Maintenance Director will immedia	-	
	"				report any problems to the Administrate		
	Pecident 3's progress	s notes dated 7/21/18 at			and schedule any repair, corrections or vendor visit necessary.	r.	
		"Resident was evacuated			vendor visit necessary.		
	due to heat exposure				Facility Wide Exercise was completed		
	evacuated to church				with Focus on Activation of EOP, Nursi	ina	
	Svacaaled to church	adiood the offeet.			Home Incident Command System and	٠ ن	
	Resident 5's progress	s notes dated 7/21/18 at			Evacuation Procedures on 8/30/18 with	า	
		"Resident was evacuated			Supervision and feedback provided by		
	due to heat exposure				Fire Department. Areas		
	evacuated to church				addressed included Emergency		
					Operations Plan, Nursing Home Incide	nt	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		555892	B. WING _				C 18/2018
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	10/2010
					108 STILLMAN		
SELMA CO	ONVALESCENT HOSPITA	AL			ELMA, CA 93662		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page	: 39	F 6	84			
	7:21 p.m., indicated, 'due to heat exposure				Command System and Communication Plan.	1	
	evacuated to church a	across the street."			Director of Staff Development will provi facility staff with quarterly Disaster	de	
		•			Preparedness training refreshers and updates. Quarterly/Ongoing		
		s notes dated 7/21/18 at Resident was evacuated for safety. Resident			DSD will audit In-Service Training reco weekly until all staff has completed the In-Service Training.		
	evacuated to church a				Evidence of the In-Service Training will documented and submitted to CDPH.	be	
		s notes dated 7/21/18 at Resident evacuated from			All new employees of the facility will be provided with In Service training by the DSD upon facility orientation for the		
					following: o A. Emergency Operations Plan, Incident Command Center, Evacuation Procedures, Communication during a Disaster, Tracking Staff and Residents		
	5:48 p.m., indicated, 'facility due to heat."	s notes dated 7/21/18 at Resident evacuated from			during Disaster, Resident Safety and S Temperatures. o How to access and turn on back u city water supply to Chiller in case of w	p ell	
	. •	s notes dated 7/21/18 at Resident was evacuated for safety. Resident			motor failure with return demonstration		
	evacuated to church a	•			Monitoring		
	6:11 p.m., indicated, "due to heat exposure evacuated to church a				Director of Staff Development will do 5 monthly random checks of facility staffsknowledge about Disaster Procedures, EOP and INC. Knowledge will be based on ability to answer randoquestions and return demonstration,	e	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		ILTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		555892	B. WING _				C 18/2018
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	10.2010
				21	108 STILLMAN		
SELMA CO	ONVALESCENT HOSPIT	AL		s	ELMA, CA 93662		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page	e 40	F 6	84			
	6:08 p.m., indicated,	"Resident was evacuated			which include:		
	due to heat exposure	for safety. Resident			What are safe temperatures?		
	evacuated to church	across the street."			2. What area of the facility is a		
					designated cooling space?		
		ss notes dated 7/21/18 at			How do we keep the residents		
		"Resident was evacuated			hydrated?		
	due to heat exposure evacuated to church				4. How often are facility temperatures monitored?	3	
	evacuated to church	across the street."			5. Show me how switch the chiller		
	Resident 21 and Res	sident's 1's progress notes			system from well to city water?		
		5 p.m., indicated, "Resident			6. Show me how to tell if the chiller is	•	
		o heat exposure for safety.			working?	•	
		to church across the street."			7. Where can you find out what to do)	
					during a cooling failure if you forgot?		
	Resident 22's progre	ss notes dated 7/21/18 at					
		"Resident evacuated from			Additional random questions for nurses	3	
	facility due to heat."				may also include		
	Resident 23's progre	ss notes dated 7/21/18 at			What do you monitor for hydration		
		"Resident was evacuated			status and heat exposure?		
	due to heat exposure	for safety. Resident			2. What type of residents are at a high	I	
	evacuated to church	across the street."			risk for heat related illness?		
					3. When should the DON and		
		ss notes dated 7/21/18 at			Administrator be notified during a cooli	ng	
		"Resident was evacuated			system failure?		
	evacuated to church	e for safety. Resident			4. When should assessments be completed?		
	evacuated to church	across the street.			completed?		
	Resident 26's progre	ss notes dated 7/21/18 at			On the spot refreshers will be provided	to	
		"Resident evacuated from			staff as necessary. Director of Staff		
	facility due to heat."				Development will provide in-services,		
					training refreshers and updates to facil		
		ss notes dated 7/21/18 at			all-staff with quarterly on topics of Disa		
	facility due to heat."	"Resident evacuated from			Preparedness, EOP Action Plan and IN	1C.	
	racility due to fiedt.				The Administrator will present progress	s of	
	Resident 79's progre	ss notes dated 7/21/18 at			action plan to the monthly QAPI	, OI	
		"Resident was evacuated			committee for further review and until t	he	
	due to heat exposure				QAPI determines further review is no		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		555892	B. WING_				C 18/2018
	ROVIDER OR SUPPLIER DNVALESCENT HOSPITA	AL		21	TREET ADDRESS, CITY, STATE, ZIP CODE 108 STILLMAN ELMA, CA 93662	1 03/	10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	6:24 p.m., indicated, process used to remoscheduled. Resident during facility evacuar safety" On 7/30/18 at 3:05 p. 8 stated she worked of morning shift. CNA 8 ac [air conditioner] wain at 6:15 a.m the n it felt stuffy, no ven alert residents had costated, "[Resident 19] seemed weaker than Resident 19's room a CNA 8 stated, "We of open windows, but it up old fans from down On 7/30/18 at 3:10 p. 5 stated she was the who reported the brol 7:40 a.m. to the DON from the previous shift (night nurse) thought working properly. LN temperature felt warm	across the street." as notes dated 7/21/18 at 'Resident went to dialysis (a ove toxins from the body) as will be at dialysis center tion due to heat exposure for m., during an interview, CNA on 7/21/18 during the stated, "It seemed like the as not working when I came urse told me it doesn't work tilation." CNA 8 also stated implained it was hot. CNA 8 I looked dehydrated usual." CNA 8 stated nd room 20 were very hot. fered water and tried to was too hot we brought instairs." m., during an interview, LN AM charge nurse on 7/21/18 ken air conditioning unit at . LN 5 stated the night nurse fit told her in shift report she the air conditioner was not 5 stated the facility's	F	584	Ionger necessary. The Director of Staff Development will present progress on staff education & responses to the QAPI monthly until th QAPI determines that further review is longer necessary. End of Action Plan 4. Maintenance Director will keep logs documentation for inspections or works performed on the Chiller and Well pum and present any trends identified to the monthly QA meeting until the QA committee determines that further revie is no longer necessary. The Director of Staff Development will present progress of 5 random checks, staff participation and response to the monthly QA meeting. QA committee wi review the trends of staff performance until the QA committee determines that further review is no longer necessary. 5. 9/20/2018	& & & & & & & & & & & & & & & & & & &	
	LN 5 stated they pulle for the residents as the stated the maintenan- additional fans. LN 5 complained of the hea	to drink and cold towels." ed fans from different areas ne day progressed. LN 5 ce staff arrived later with stated Resident 78 at and felt hot. LN 5 stated ncility twice. LN 5 stated she					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE COMP	SURVEY LETED
		555892	B. WING _			l	C 18/2018
	ROVIDER OR SUPPLIER DNVALESCENT HOSPITA	AL		STREET ADDRESS, CITY, STATE 2108 STILLMAN SELMA, CA 93662	, ZIP CODE		10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	X (EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION 'E ACTION SHOULD BE D TO THE APPROPRIA CIENCY)		(X5) COMPLETION DATE
F 684	5 stated maintenance the first time and was FD the second time. I consider the situation they were working on On 7/31/18 at 6:40 a. interviews, CNA 9 stated th p.m. and the tempera hot. CNA 9 stated fan night to cool down the was told during shift r	tact them [FD] if eater than 80 degrees F. LN e staff had contacted the FD not sure who contacted the	F	584			
	evacuation returned to (7/21/18) except for Found Resident 80. On 7/31/18 at 4:00 p. local city FD Fire Chie on the scene because trouble reaching any ther I would assist in gevacuation." The FD of residents was initial environmental tempet the residents. The FD in the facility were we cooling measures initianeffective. The FD C was bobbing his head out bedridden residents.	o the hospital during the o the facility that night desident 78, Resident 27, m., during an interview, the ef stated, "I was the contact the the nurse was having of her supervisors I told giving her direction as to Chief stated the evacuation at the distance on the facility's rature and potential risk to the Chief stated temperatures all above 81 degrees F. and diated by the facility were the hief stated, "One resident of like he was going to pass the stated the seed [Administrator] prior to					

NAME OF PROVIDER OR SUPPLIER SELMA CONVALESCENT HOSPITAL SELMA, CA 93662 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	(X3)) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER SELMA CONVALESCENT HOSPITAL SELMA, CA 93662 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) STREET ADDRESS, CITY, STATE, ZIP CODE 2108 STILLMAN SELMA, CA 93662 ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM CROSS-REFERENCED TO THE APPROPRIATE			555892	B. WING _			C 09/18/2018
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE			ITAL		2108 STILLMAN		03/10/2010
	PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A	SHOULD BE	(X5) COMPLETION DATE
F 684 Continued From page 43 F 684	F 684	μ.	•	F 6	84		
Review of the Fire Department Incident Report dated 7/21/18, indicated the FD was dispatched at 4:09 p.m. to the facility to assist in the removal of 29 convalescent residents after the mechanical breakdown of an HVAC unit. The report also indicated, "Temperature inside the facility exceeded 80 plus degrees with multiple patients [residents] suffering from hear related illnesses seven patients required transport to hospital via [by way of] ambulance." Resident 4's progress notes dated 7/21/18 at 6:18 p.m., indicated, "Resident evacuated from facility due to heat exposure for safety. Resident evacuated to Hospital;" Resident 4's local fire department patient care record dated 7/21/8 at 4:47 p.m., indicated, "EMS [emergency medical services] arrived to find patient sitting upright on the bed at SNF [skilled nursing facility). Pt patient jis [complaining of] nausea secondary to heat exhaustion. Pt has been at SNF with no air conditioning since this afternoonPt reassessed in route and Pt is no longer nauseated" Resident 4's acute care hospital record titled, "After Visit Summary Report" dated 7/22/18 at 1:41 a.m., indicated, "Diagnosis: Urinary Tract infection without hematuria." Resident 4's progress notes dated 7/22/18 at 2:54 a.m., indicated, "Resident arrived back to the facility from ER [Emergency Room]." Resident 6's progress notes dated 7/21/18 at 6:07 p.m., indicated, "Resident evacuated from		dated 7/21/18, indicated 4:09 p.m. to the for 29 convalescent breakdown of an H' indicated, "Tempera exceeded 80 plus of [residents] suffering seven patients requested by way of ambular Resident 4's progres 6:18 p.m., indicated facility due to heat of evacuated to Hospi Resident 4's local firecord dated 7/21/8 [emergency medicated patient sitting uprignursing facility]. Pt nausea secondary been at SNF with nafternoonPt reas longer nauseated Resident 4's acute "After Visit Summai 1:41 a.m., indicated infection without he Resident 4's progres 2:54 a.m., indicated the facility from ER	cated the FD was dispatched facility to assist in the removal residents after the mechanical VAC unit. The report also ature inside the facility degrees with multiple patients of from heat related illnesses uired transport to hospital via nee." The sess notes dated 7/21/18 at d., "Resident evacuated from exposure for safety. Resident tal; [name of hospital]." The department patient care at 4:47 p.m., indicated, "EMS al services] arrived to find the on the bed at SNF [skilled (patient)] is [complaining of] to heat exhaustion. Pt has on air conditioning since this sessed in route and Pt is no The care hospital record titled, by Report dated 7/22/18 at d., "Diagnosis: Urinary Tract maturia." The ses notes dated 7/22/18 at d., "Resident arrived back to [Emergency Room]."				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) A. BU		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		555892	B. WING		09/18/2018
	ROVIDER OR SUPPLIER ONVALESCENT HOSPI	TAL	:	STREET ADDRESS, CITY, STATE, ZIP CODE 2108 STILLMAN SELMA, CA 93662	, 30.10.2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION
F 684	Resident 6's acute of "Emergency Depart at 5:59 p.m., indicate Heat exhaustion; Hypressure)." Resident 6's progres 11:10 p.m., indicate facility at approximation hospital]." Resident 12's progres 6:29 p.m., indicated facility due to heat evacuated to Hospital Review of Resident "Emergency Service dated 7/21/18 at 5:50 Diagnosis: Heat exhaustrand to facility a from [name of hospital] Resident 15's progres 4:32 p.m., indicated ER [Emergency Room MD ordered."	care hospital records titled, ment Reports" dated 7/21/18 ed, "Discharge Diagnosis: pertension (high blood es notes dated 7/21/18 at d, "Resident returned to tely 10:15 PM from [name of ess notes dated 7/21/18 at et], "Resident evacuated from exposure for safety. Resident exp	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		555892	B. WING				C 40/0040
NAME OF D	ROVIDER OR SUPPLIER	333092	D. Willo		STREET ADDRESS, CITY, STATE, ZIP CODE	09/	18/2018
	DNVALESCENT HOSPITA	AL		2	2108 STILLMAN SELMA, CA 93662		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page hospital."	<u>.</u> 45	F	684			
	7/21/18 at 6:12 p.m., evacuated from facilit	4's progress notes dated indicated, "Resident y due to heat exposure for uated to Hospital; [name of					
		4's record, titled, "(name of ary Report" dated 7/21/18 at "Diagnosis: Heat					
	Review of Resident 2 7/22/18 at 1:08 a.m., returned from hospita						
	7:25 p.m., indicated, '	rss notes dated 7/21/18 at 'Resident evacuated from posure for safety. Resident l; [name of hospital]."					
	1:24 a.m., indicated, 'of hospital].[name of I this resident would be [Intensive care unit]. A Sepsis [infection], PE	rs notes dated 7/22/18 at l'Resident admitted to [name nospital] nurse stated that e transferred to ICU Admitting Dix [diagnosis] NA [Pneumonia], and HERD ase; kidney disease]."					
	dated 7/25/18 at 10:2	of hospital] Order requisition 4 a.m., indicated, Sepsis, Pneumonia, End					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG			LETED
		555892	B. WING _			l	C 18/2018
	ROVIDER OR SUPPLIER ONVALESCENT HOSPITA	AL		STREET ADDRESS, CITY, STATE, ZIP CO 2108 STILLMAN SELMA, CA 93662	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF C ((EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIA		(X5) COMPLETION DATE
F 684	9:53 p.m., indicated, hospital] called and s admitted to acute car Obstructive Pulmona and PENA [Pneumon germs]." Resident 78 had not repopulation on 7/21/during an interview, L admitted to another Sthe hospital. On 7/30/18 at 2:23 p. Resident 3 stated, "It [7/21/18] I felt fatigumid-morning and I was could not breathe." R Director of Social Ser of a floor fan to cool on urse checked my blo high I felt sick until breathing I was us today they offered ice, but they didn't reach they didn't reach sessment, dated 7 3's Brief Interview for was 13 of 15 which in cognitively intact with ability to make reason Resident 3's Admission indicated Resident 3 Hypertension (high bill)	is notes dated 7/21/18 at "Nurse from [name of tated that resident was being e for COPED [Chronic ry Disease; lung disease] ia; lung infection caused by returned to the facility after 18. On 7/30/18 at 3:10 p.m., N 5 stated Resident 78 was skilled Nursing facility from m., during an interview, was very hot on Saturday red. It got very hot by as given oxygen because I esident 3 also stated the rvices (DSS) sat him in front off. Resident 3 stated, "A rood pressure and it was too Monday I had difficulty ing oxygen off and on until ice water, towels wet with ally work, I just felt bad." In Data Set (MDS) //23/18, indicated Resident Mental Status (BIMS) score redicated the resident was regard to memory and hable judgements. In Record, dated 12/19/17, had a history of Secondary	F	584			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		555892	B. WING				C 18/2018
	ROVIDER OR SUPPLIER ONVALESCENT HOSPITA	AL	1	2	STREET ADDRESS, CITY, STATE, ZIP CODE 2108 STILLMAN SELMA, CA 93662		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	On 7/30/18 at 2:31 p. regards to 7/21/18, R very hot by 11 o'clock Department came an Resident 14's MDS A indicated Resident 12 which indicated the rewith regard to memor reasonable judgement On 7/30/18 at 2:35 p. regards to 7/21/18, R getting really hot midsticky, muggy, and ur Resident 11's MDS A BIMS score was 12 or resident was moderar regard to memory and judgements. On 7/30/18 at 3:52 p. concurrent review of Resident 1 stated, "It headache I drank i my shirt was all wet." journal which he stated Resident 1 stated he on Saturday, dated 7 told them [staff], wet on Resident 1's MDS As (Assessment reference indicated Resident 1's manual reference indicated Resident 1's m	m., during an interview in esident 14 stated, "It was a in the morning the Fire d moved us." assessment, dated 5/21/18, It's BIMS score was 15 of 15 esident was cognitively intact by and ability to make nts. m., during an interview in esident 11 stated, "It started eafternoon really hot, incomfortable." assessment, dated 7/23/18, if 15 which indicated the tely cognitively intact with diability to make reasonable m., during an interview and the resident's journal, was hot, it gave me a ce water. I was sweating, Resident 1 pointed to his ed he kept for personal use. made an entry in his journal /21/18, which read, "Hot I clothes and pillow." sessment, with ARD ce date) of 6/25/18, is BIMS score was 13 of 15 esident was cognitively intact	F	684			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	, ,	CX3) DATE SURVEY COMPLETED C		
		555892	B. WING			09/18/2018	
	ROVIDER OR SUPPLIER	ITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 2108 STILLMAN SELMA, CA 93662	1	23.13.2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 684	Resident 20 stated, air conditioner was didn't see anyone to getting hot about 10 didn't think about us. Resident 20's MDS indicated Resident which indicated the with regard to mem reasonable judgem. On 7/31/ at 5:00 p.r regarding 7/21/18, I to the church. The abere. I have a fan, to came back I was sweat. I was a little complain. It started was [name of staff] he didn't tell me how Resident 25's MDS indicated Resident which indicated the	ents. p.m., during an interview, "My room was very hot the running but it was very hot I aking temperatures it started 0:30 a.m. I had a fan, but I sing it." Assessment, dated 6/18/18, 20's BIMS score was 15 of 15 resident was cognitively intact ory and ability to make ents. m., during an interview Resident 25 stated, "We went air conditioner wasn't working they turned it on for me when I sweating to death, I never light headed, I didn't getting hot about 12 noon. It checking the temperatures	F 68	,			
	healthcare facilities Department of Publ Certification dated 7 must implement rec measures to keep in comfortable during	ies Letter (AFL 18-28) sent to from the California ic Health Licensing and 7/5/18, indicated, "Facilities commended precautionary					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		555892	B. WING		C 09/18/2018		
	ROVIDER OR SUPPLIER DNVALESCENT HOSPITA	AL		2	TREET ADDRESS, CITY, STATE, ZIP CODE 108 STILLMAN ELMA, CA 93662		10.2010
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	when no air condition measures to ensure presented from adverse conheat-related health conthat facility administration conditions for fluctuate temperatures and takensure appropriate air well maintained and continuous of the facility "Quality of Life- Home 5/17, indicated, "Resistafe, clean, comfortal environment2. (h) of the facility environment2.	nditioning, or in the case ing is available, take patients and residents are nditions that may cause emplications It is important ators monitor weather ions in extreme e extra precautions to r conditioning equipment is operating effectively." policy and procedure titled, elike Environment" dated dents are provided with a	F	684			
F 741 SS=E	7/20/18 and 7/21/18 it temperatures in [area high of 105 degrees F 100 degrees F. on 7/2 Sufficient/Competent CFR(s): 483.40(a)(1): \$483.40(a) The facilit who provide direct se appropriate competer provide nursing and resident safety and at practicable physical, well-being of each resident assessments and considering the resident and sometimes are sident assessments and considering the resident assessments.	of the facility] reached a F. on 7/20/18 and a high of 21/18. Staff-Behav Health Needs (2) y must have sufficient staff rvices to residents with the noies and skills sets to elated services to assure ttain or maintain the highest mental and psychosocial sident, as determined by a and individual plans of care number, acuity and ity's resident population in	F.	741			9/27/18

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		555892	B. WING			C 18/2018	
	ROVIDER OR SUPPLIER	AL		2	STREET ADDRESS, CITY, STATE, ZIP CODE 1108 STILLMAN SELMA, CA 93662		10,2010
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 741	limited to, knowledge and supervision for: §483.40(a)(1) Caring and psychosocial diswith a history of traunstress disorder, that it facility assessment con §483.70(e), and [as linked to history of post-traumatic stress implemented beginning (Phase 3)]. §483.40(a)(2) Implementer interventions. This REQUIREMENT by: Based on interview at failed to ensure the series idents (Resident 78, Resident 27, Resident 79, Resident 79, Resident 79, Resident 23, Resident 13, Resident 23, Resident 23, Resident 17, Resident 25, Resident 17, Resident 26, Resident 17, Resident 27, Resident 17, Resident 28, Resident 29, Resident 17, Resident 29, Resident 17, Resident 29, Resident 17, Resident 29, Resident 29, Resident 20, Resid	ills sets include, but are not of and appropriate training for residents with mental orders, as well as residents in and/or post-traumatic in ave been identified in the conducted pursuant to f trauma and/or disorder, will be ing November 28, 2019 menting non-pharmacological is not met as evidenced and record review, the facility afety of 29 of 29 sampled 15, Resident 14, Resident ident 4, Resident 16, in 21, Resident 18, in 11, Resident 19, Resident 18, in 11, Resident 19, Resident ident 3, Resident 26, in 10, Resident 20, Resident 14, Resident 14, Resident 15, Resident 24, in the solution of an appropriate training on ate Disaster Preparedness	F	741	F 741 – 1. All residents of the facility were assessed for any injuries or complicating from exposure to high temperatures up return to the facility on 7/21/18 and no injuries were noted. 2. Disaster Preparedness training with focus on multiple types of disasters (Fit Earthquake, Extreme Weather Conditions, etc), Emergency Operation Plan, Incident Command Center & Commander and Safe temperatures was provided to staff on 08/02/18 by the Administrator and Director of Staff Development and completion of all employees was accomplished on 8/30/ Staff unable to attend were taken off schedule until able to come in for	oon th re, ons as	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		555892	B. WING		C	
NAME OF D	ROVIDER OR SUPPLIER	00002		STREET ADDRESS, CITY, STATE, ZIP CODE	09/18/2018	
NAME OF T	NOVIDER OR SOLT LIER					
SELMA CONVALESCENT HOSPITAL			2108 STILLMAN SELMA, CA 93662			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 741	Continued From page	e 51	F 741			
	Findings:			in-service and training.		
	On 7/26/18 at 9:54 a. Executive Director (E stated the air condition on 7/21/18 which results 29 (Resident 15, Results 27, Resident 27, Resident 21, Results Resident 11, Results Resident 13, Resident 2, Resident 10, Resident 22, Resident 22, Resident 25, Resident 80) resident 15, Resident 16, Resident 17, Resident 18, Resident 19, Resident 19, Resident 19, Resident 21, Resident 22, Resident 25, Resident 80) resident 19, Resident 19, Resident 19, Resident 19, Resident 21, Resident 19, Resident 19, Resident 21, Resident 19, Resident 19, Resident 19, Resident 19, Resident 19, Resident 19, Resident 21, Resident 19, Resident 21, Resident 22, Resident 19, Resident 21, Resident 21, Resident 22, Resident 21, Resident 22, Resident 23, Resident 24, Resident 25, Resident 26, Resident 26, Resident 27, Resident 27, Resident 28, Resident 29, Resident 29, Resident 20, Resident 2	at 6, Resident 18, Resident dent 19, Resident 23, at 3, Resident 26, Resident dent 20, Resident 17, at 12, Resident 24, Resident dents; seven residents were ospitals. The ED stated, artment (FD) took over and		All new employees of the facility will be provided with In Service training for Disaster Preparednessby the DSD up facility orientation. 3. Director of Staff Development wi 5 monthly random checks of facility sknowledge about Disaster Procedure EOP and INC. Staff will be required to answer all questions correctly on the questionnaires and perform return demonstrations, on the spot refreshed will be provided to staff as necessary Director of Staff Development will profacility staff with quarterly Disaster Preparedness, EOP and INC training	oon II do taffs s, to rs .	
	regarding evacuation 7/21/18, Certified Nur stated she was in-ser Development (DSD) of emergency only. On 7/30/18 at 11:40 at Housekeeper (HSK) often in-services are sknow which ones are remember emergency. On 7/30/18 at 1:35 pr Licensed Nurse (LN) evacuation drill was not stated he watched and during his new hire or	m., during an interview procedures conducted on raing Assistant (CNA) 12 viced by the Director of Staff on how to respond to a fire a.m., during an interview, 1 stated, "I'm unsure of how supposed to be I don't mandatory I can't y evacuation training." m, during an interview, 1 stated an emergency not done at the facility. LN 1 emergency training video rientation in 2017. LN 1 ring orientation to use the		refreshers and updates. 4. The Director of Staff Developmer present progress of random checks, participation and response to the mor QA meeting. QA committee will review trends of staff performance until the Committee determines that further revision longer necessary. 5. 8/30/2018	staff hthly w the QA	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION B	(X3) DATE SURVEY COMPLETED	
		555892	B. WING		C 09/18/2018
	ROVIDER OR SUPPLIER ONVALESCENT HOSPI	TAL		STREET ADDRESS, CITY, STATE, ZIP CODE 2108 STILLMAN SELMA, CA 93662	1 00/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETION
F 741	evacuation site in the 1 stated, "I don't know is located for the Charles of the	treet from the facility as an e event of an emergency. LN ow where the [phone] number urch." o.m., during an interview, CNA ery little training the Director of (DSD) hardly does any talk about it [Emergency we don't practice." o.m., during an interview, CNA receive training on extreme (such as hot weather alerts). a.m., during an interview, CNA know who to notify I'm 1 I think the emergency is station." a.m., during an interview, LN regency preparedness fire we did it on orientation actice evacuation." o.m., during an interview, the ster Preparedness In-service in facility's employees. The not discussed Disaster	F 74		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		555892	B. WING		C 09/18/2018	
	ROVIDER OR SUPPLIER ONVALESCENT HOSPIT	AL		STREET ADDRESS, CITY, STATE, ZIP CODE 2108 STILLMAN SELMA, CA 93662	1 03/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 741	Continued From page	e 53	F 74	11		
	Development Progral "10. The following i are mandatory g. F Preparedness."	nd procedure titled, "Staff m" dated 12/09, indicated, n-service training classes ire Safety and Disaster				
F 759 SS=D	Free of Medication E CFR(s): 483.45(f)(1)	rror Rts 5 Prcnt or More	F 75	59	9/27/18	
	§483.45(f) Medication The facility must ensi					
	percent or greater;	tion error rates are not 5				
	Based an observation	on interview and record led to ensure its medication less when:		F 759 – 1. Resident 77 Physician was not 7/25/18 and no new orders were given		
	7/24/18 two of 27 opposition of the physician of the phys	n pass at 8:07 a.m. on portunities observed did not orders for the administration ese errors represented a		2. All residents of the facility rece medications have the potential of b affected, however, no other residentave been identified as being affect this time.	iving eing its	
		ng medication and/or the ootential for adverse effects		The Director of Nursing and/or designee has completed a Medicat Administration competency assess for current licensed nurses on 08/2-	ion ment	
	and observation, LN orders poured Panto (milligrams) (unit of n	M, during a medication pass 3 after review of physicians prazole one tablet 40 mg neasurement) in a paper		and will complete a Medication Administration competency assess for all newly hired licensed nurses of the orientation process and will upo Medication Administration compete assessments annually.	ment during date	
		ted, Pantoprazole tablet 40 y mouth A.D. (before meals)		The Director of Nursing and/or desi	gnee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,			(X3) DATE SURVEY COMPLETED	
		555892	B. WING		no	C 9/18/2018	
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP C	•	710/2010	
				2108 STILLMAN			
SELMA C	ONVALESCENT HOS	PITAL		SELMA, CA 93662			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 759	Continued From p	-	F 75	59 will do 1 random monthly m	nedication		
	On 7/24/18 at 8:06 and observation L tablet from the bot Administration Revitamin with miner daily into the pape Pantoprazole and at 8 a.m. LN 3 adr Resident 77. On 7/24/18 at 8:10 was asked what the Pantoprazole order if he had breakfast had breakfast in the checked the vitame "It's fine to give the range from when thour after the resident and observations of the part of th	AM, during a medication pass N 3 poured multiple vitamin one title, the Medication cord (MAR) indicated Multiple rals P.O. (by mouth) 1 tablet or cup along with the the eight other medication due ministered the medications to DAM, LN 3, during an interview, ne A.D. indicated on the er. LN 3 then asked Resident 77 tt. Resident stated "I already ne dinning room." LN 3 also in bottle and order. LN 3 stated, e Pantoprazole; there is an hour the medication is ordered or an indent could have their stated the vitamins were ok		administration observation nurse per month to ensure are administered as ordere updated counseling/training. The Director of Nursing and will complete a weekly aud to ensure that medications ordered times, such as beforevide updated counseling needed. 4. The Director of Nursing progress, or any trends ide QA meeting monthly until the committee determines that is no longer necessary. 5. 8/26/18	on 1 licensed medications and and provide g as needed. d/or designee it of the eMAR are given at ore meals and g/training as g will present intified to the ne QA		
	Director of staff Delast Inservice we hand procedures. Vinurses on checkin pass for check for patient, right meditime before adminion On 7/25/18 at 3:20 conference room, stated the nurses rights when passin wright medication,	D PM, during an interview, the evelopment (DSD) stated the nad was on pharmacy policy Ve (DON, DSD) Inservice the g medication on medication the 5 rights, right dose, right cation, right route and the right istering it to the resident. D PM, during an interview in the the Director of Nursing (DON) are expected to follow the five ng medication, right route and the amin with minerals should not					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
					С		
		555892	B. WING			09/	18/2018
	ROVIDER OR SUPPLIER DNVALESCENT HOSPITA	AL		2	TREET ADDRESS, CITY, STATE, ZIP CODE 108 STILLMAN ELMA, CA 93662		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 759	has minerals the other as the order says. The facility Policy and titled,"Administering Mindicated "3. Medical in accordance with the required time frame. Administered within or prescribed time, unless example, before and individual administeric check the label THRE right resident, right metime and right method before giving the medius Meet Resident CFR(s): 483.60(c)(1)-\$483.60(c) Menus and Menus must-\$483.60(c)(1) Meet the residents in accordant guidelines.; \$483.60(c)(2) Be pressed \$483.60(c)(3) Be follows \$483.60(c)(4) Reflect reasonable efforts, the	I Procedure Medications" dated 2001 ations must be administered e orders, including any Medications must be ne (1) hour of their se otherwise specified (for after meal orders)7. The ng the medication must EE (3) times to verify the edication right dosage, right I (route) of administration lication" It Nds/Prep in Adv/Followed (7) Id nutritional adequacy. The nutritional needs of ce with established national coared in advance; The wed; The population, as well as esidents and resident		759			9/27/18

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE 2108 STILLMAN SELMA, CA 93662		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
F 803	Continued From page	e 56	F 803	3		
	professional for nutrit	cally qualified nutrition				
	construed to limit the personal dietary choice. This REQUIREMENT by:	resident's right to make ces. is not met as evidenced				
	review, the facility fail cornbread prepared a residents (Resident 1 Resident 79, Resider 77, Resident 6, Resident			F 803 □ 1. Dietary staff on duty was provided with immediate in-servicing for portion sizes on 7/25/18 by the Dietary Supervisor.		
	13, Resident 3, Resident Resident 10, Resident 22, Resident 12, Res	at 20, Resident 17, Resident ident 24, Resident 25) when e cornbread did not match		2. All residents of the facility with ora diets have the potential to be affected. However, after a random meal observation by the DON and Dietary Supervisor on 8/22/18 and 8/24/18 no other residents have been identified as		
	-	otential to negatively affect food served to residents.		being affected. 3. In Service training was provided to		
	Findings:			dietary staff by the Dietary Supervisor following Menus and Portion Sizes for	for	
	concurrent interview, Dining room, cornbre were wrapped in plas during the lunch mea	o.m., during an observation, and record review in the ad squares of various sizes tic wrap and were served I service. The cornbread		meals on 08/22/18. Dietary Supervisor will do weekly rando observations of food preparation to ensure menus and portions are being	om	
	Cook 1 stated, "I cut of portions they are cut squares I eyeball it. servings I don't follo	e not cut the same size. regular pieces, [for] small in half I don't measure the menu is for 48-98 ow that I don't have that		followed. 4. The Dietary Supervisor will preser progress and any trends identified to the		
		ow that I don't have that Dietary Supervisor (DS)		progress and any trends identified to the monthly QA meeting until the QA	ne	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		· ·	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	AL		STREET ADDRESS, CITY, STATE, ZIP CODE 2108 STILLMAN SELMA, CA 93662			
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F 803	stated, "Serving sizes should be followed to what they need." The equipment was not us cornbread. On 7/31/18 at 2:00 p. RD stated cooks show portion sizes. The RD not followed, it may be nutrition I do my cal residents] based on pshould be followed." On 8/1/18 at 9:45 a.m RD stated she review sizes and was unable cornbread squares we of residents to be serviced to the [name] requested clarification. The facility policy and Service Management 565", dated 2014, ind the size portions State 12 X 20 X 2 se 36 (one each) [cut inches." The facility policy and Service Management 570", dated 2014, ind use a production she amounts of each items	make sure residents get DS stated measuring sed to prepare the m., during an interview, the ald be following recipes and a stated, "When portions are e robbing residents of culations [calorie counts for ortions they [menus] a., during an interview, the ed the menus and portion to determine what sizes the ere to be cut for the amount yed. The RD stated she menu service and a. procedure titled, "Food Portion Control policy No. icated, "The menus specify andard portion control pan rvings [each serving total] measurement] 2 X 3 procedure titled, "Food Portion Control policy No. icated, "Best practice is to et for each meal stating the to prepare. Dietary staff will is listed on the production	F 80	committee determines that furth is no longer necessary. 5. 8/26/18	er review		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION NUMBER: A. BUILDING				(X3) DATE SURVEY COMPLETED	
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		555892	B. WING _			09/18/2018	
	ROVIDER OR SUPPLIER DNVALESCENT HOSPITA	AL		STREET ADDRESS, CITY, STATE, ZIP COL 2108 STILLMAN SELMA, CA 93662	ΣE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 803	Therapeutic Spreads indicated, "2281 Corr Food Procurement, St) Cycle 2 2018 (4WK) heet" dated 7/25/18, ibread one each." tore/Prepare/Serve-Sanitary		803		9/27/18	
SS=E	812 Food Procurement, Store/Prepare/Serve-Sanitary			F 812 □ 1. Dietary Supervisor discastored in damaged container on 7/23/18. Dietary Supervisor discarded cereal immediately on 7/23/1 Dietary aide re-washed and a metal pans the pans in quest 7/23/18.	immediately I the dry 8. air dried the 4		

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NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/10/2010
				2108 STILLMAN	
SELMA CO	ONVALESCENT HOSPIT	AL		SELMA, CA 93662	
(X4) ID	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX TAG			PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	
F 812	Continued From pag	e 59	F 812	2	
	3. Two half-gallon me	etal pans and two		Portable Air cooler was placed in dry	
		pans were stored wet,		storage area to used during hot	
		cked instead of air-dried.		temperatures exceeding 81 degrees 7/23/18.	on
	4. The temperature of	of a dry food storage room			
	registered 84 degree	s Fahrenheit (F)) a scale of		Maintenance Director cleaned the Fo	od
	temperature) instead	of maintaining the room		Service Dumbwaiter immediately on	
	temperature betweer	n 50 and 70 degrees (F).		7/23/18.	
	5. A foods service du	ımbwaiter (a small elevator		Counseling and education for hand	
		uch as food and dishes		hygiene was immediately provided to	
	between floors) was	visibly dirty while in use.		Cook 2 by the Dietary Supervisor on 7/23/18.	
	6. Cook 2 did not per	form hand hygiene during			
	food preparation.			Director of Staff Development immed provided counseling and education to	
	7. A Certified Nursing Resident 24's meal to	g Assistant (CNA) blew on o cool the food.		CNA staff on Assisting Residents with Meals on 08/02/18.	1
	These failures placed				
	foodborne illness and	d food contamination.		0 411 1 1 611 6 334 34	
	Findings:			All residents of the facility with or diets have the potential to be affected	
		5 a.m., during an observation view in the kitchen, one			
		dated 7/19/18, was stored in		3. Dietary Staff was provided with in	,
		ntainer on the second shelf of		Dietary Staff was provided with it service training by the Dietary Superviser.	
	-	as white, dry and cracked.		for Food Storage, Temperature Monit	
		sor (DS) stated the pie had		and Labeling/Dating Foods on 08/22/	
		ir dries the food product) and		and Laboling, Dating 1 0003 on 00/22/	
	should be thrown aw	• • •		Dietary Staff was provided with in ser	vice
		,-		training by the Dietary Supervisor for	
	On 7/30/18 at 9:20 a	.m., during an interview, the		Cleaning and Storage of Equipment a	
		elopment (DSD) stated		Utensils on 07/27/18.	-
		ause foods to taste bad. The			
		with freezer burn would not		Dietary Staff was provided with in ser	vice
	i i	sty or appetizing) for the		training by the Dietary Supervisor for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		555892	B. WING		C 09/18/2018	
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 09/10/2010	
TO THE OT TH	TO VIDEIX OIX OOI I EIEIX			, , ,		
SELMA CO	ONVALESCENT HOSPITA	AL		2108 STILLMAN		
				SELMA, CA 93662		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 812	Continued From page	e 60	F 812	2		
	residents."			Hand Hygiene on 07/27/18.		
	On 7/31/18 at 9:08 a. Registered Dietician (freezer burn tastes ba and should be tossed burn altered the taste could have affected the nutrition of the reside items stored in damage the quality and safety. The facility's policy are Receiving and Storage When food is delivered inspected for safe transpected for safe transp	and procedure titled, "Food e" dated 7/14, indicated, "4. ed to the facility it will be ensport and quality before a.m., during an observation iew in the kitchen, one ainer filled with dry cereal ored on a shelf. The DS		Director of Staff Development provided service training to the CNA solve for Assisting Residents with Meals on 08/02/18. Dietary Supervisor and/or Designee we complete daily inspections to ensure a items are cleaned, stored, dated and labeled according to policy and that the dumbwaiter is clean. Dietary Supervisor and/or Designee we do daily temperature checks of the dry storage room, log the results and immediately notify maintenance staff of temperatures that are out of range and deploy portable air conditioner as intervention. Dietary Supervisor will maintain a log of the conditioner as intervention.	III II II If	
	DS stated the purpose make sure stored foo	hould have been dated. The e of dated containers was to ds were safe to eat and not Everything should be dated		daily dumbwaiter inspections and cleanings. The Director of Staff Development will	do	
	On 7/31/18 at 9:08 a. RD stated it was important follow food storag stated, "When you take container to store, you date the purpose of	m., during an interview, the ortant to date all food items ge guidelines. The RD we foods out of the original u lose the original expiration labeling food with dates		random weekly observations of breakf lunch and dinner to ensure residents a properly assessed with meals and pro- re-education to staff as needed.	ast, re	
	RD stated foods store	as not stored too long." The ed on a shelf for long periods o longer fresh or pleasant to (germs).		 The Dietary Super will present progress and any trends identified to the monthly QA meeting until the QA committee determines that further revision no longer necessary. 		

AND DUAN OF CORRECTION IDENTIFICATION NUMBER		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		555892	B. WING		C 09/18/2018
	ROVIDER OR SUPPLIER ONVALESCENT HOSPIT	TAL		STREET ADDRESS, CITY, STATE, ZIP CODE 2108 STILLMAN SELMA, CA 93662	03/16/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 812	Receiving and Storage Dry foods that are stored original packing date)." 3. On 7/23/18 at 7:48 and concurrent intervential parts were stored upside downwest on a metal storage should not be like this bacteria [germs] to go On 7/30/18 at 9:25 at DSD stated contained be stored upside downwest of the kitchen is hot at potential for waterbour grow in water and cancent and the stored upside downwest of the kitchen is hot at potential for waterbour grow in water and cancent and the stored upside downwest of the stor	d procedure titled, "Food ge" dated 7/14, indicated, "6. ored in bins will be removed I, labeled and dated ("use by" a.m., during an observation view in the kitchen, two is and two quarter-gallon red upside down stacked and ge shelf. The DS stated, "It is, the moisture can cause row." .m., during an interview, the rs in the kitchen should not wn wet. The DSD stated, and humid there is a rne bacteria (germs that tuse infection) when if wet it increases the and sickness." The DSD a higher risk of getting sick mune systems (cells that in infection). .m., during an interview, the build not be stored wet." The grow bacteria and food can be RD stated contaminated ents sick. Administration 2017 Food ed, "Storing 4-903.11 (A) Cleaned equipment the stored: (1) In a clean, dry they are not exposed to	F 812	5. 8/26/18	

1, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,			(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	ΓAL		STREET ADDRESS, CITY, STATE, ZIP CODE 2108 STILLMAN SELMA, CA 93662	I	03/10/2010		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 812	as specified in parag (1) In a self storing p and (2) Covered or in 4. On 7/23/18 at 8:12 and concurrent intenthe room temperature a thermometer (instratemperature) located. The DS stated, "The 81 degrees (F)." On 7/24/18 at 7:50 a and concurrent intentroom, the room temperature in the room was not checked the temperature in the kept below 80 degrees F. Cook 2 stated temperoom was not checked the temperature in the kept below 80 degrees the growth of Cook 1 also stated, 'circulate air so we do can develop in stores small worm] in the form on 7/30/18 at 9:30 a DSD stated temperature were too hot for the consultation of the store maintained at a temperature of the store maintained at a temperature for long temperatures for long the store of the store	graph (A) and shall be stored: dosition that allows air drying; inverted." If a.m., during an observation view in the dry storage room, are registered 84 degrees F on ument used to measure if on the dry storage shelf, aroom should be kept below in the dry storage observation views in the dry storage observation views in the dry storage observation in the dry storage observation of the dry storage room should observe for the dry storage for the floor to on't get weevils [pest which dry food] or maggots [a very bod." In.m., during an interview, the stures over 80 degrees (F) dry food storage room. The large room should have been observed the pests (insects). The DSD obsolied when stored at high greinds of time.	F 81					
	RD stated warm tem	.m., during an interview, the peratures in the food storage eria and bring pests or flies						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 812	the facility should had Guidelines posted in A facility document tit Storage" dated 7/14, Storage areas will be temperature 50 deg Fahrenheit." 5. On 7/23/18 at 8:25 and concurrent intervisiticky residue was or service dumbwaiter. sticky residue on the was missed when it viccoks and dietary aid cleaning and sanitizing after each meal servitiwas on the dumbwait with a rope used to lit packet of crackers, a on the floor beneath stated Maintenance vicleaning the dumbwait of the cleaning scheol on 7/24/18 at 8:50 at and concurrent intervidumbwaiter, the Main stated, "I can see it's The MS stated the dimaintenance to clear dumbwaiter but it [cle MS stated there was maintenance request	te the food. The RD stated of followed Dry Food Storage the kitchen. Ided, "Food receiving and indicated, "Procedure well ventilated with an ideal grees through 70 degrees a.m., during an observation riew in the kitchen, a thick of the bottom shelf of the food The DS confirmed the thick shelf and stated the shelf was cleaned. The DS stated les were responsible for ring the dumbwaiter's shelves ce. A thick black residue for she the dumbwaiter. The DS was responsible for deep of the dumbwaiter. The DS was responsible for deep of the dumbwaiter. The DS was responsible for deep of the dumbwaiter of the dumbwaiter of the dumbwaiter. The DS was responsible for deep of the dumbwaiter of t	F 81			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 2108 STILLMAN SELMA, CA 93662		9/10/2010	
(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 C ((EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 812	RD stated the dumbwunclean during a pass stated she had notified requested the dumbw stated, "I told her [DS be like that it [duml growth, bring insects RD stated the food sedumbwaiter was not proposed to the facility policy and cleaning was requested but not proceed to the facility policy and cleaning was requested but not proceed to the facility policy and cleaning was requested with gloved hands during the oven and prepare food. Cook 2 my gloves and wash because of germs." The should have washed in between tasks, the germs from the oven contamination." On 7/31/18 at 9:10 a. RD stated appropriate kitchen was especiall the risk for cross contamination contamination contamination.	m., during an interview, the vaiter was identified as takitchen inspection. The RD and the DS of her findings and vaiter to be cleaned. The RD of it [dumbwaiter] shouldn't cowaiter] can cause bacterial or bring rodents [rats]." The ervice through a dirty sanitary (clean). In procedure on dumbwaiter ed but not provided. It procedure on dumbwaiter ed but not provided. O a.m., during an current interview in the need the oven handrail twice ring food preparation. Hand formed by Cook 2 after deprior to going back to stated, "I forgot to change my hands I should have the DS stated, "She [Cook 2] thands and changed gloves re is a risk for transferring	F8				

PRINTED: 04/05/2019 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		555892	B. WING			l	C
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	09/	18/2018
SELMA C	ONVALESCENT HOSPITA	AL			108 STILLMAN ELMA, CA 93662		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 812	CNA 1 fed Resident 2 with ground cooked for stated the temperature too hot. CNA 1 held at to her mouth and blev 24 the food. CNA 1 st down for the resident. On 7/24/18 at 2:15 p. DSD stated meals sh heat and cool foods. The resident of the properties of the prope	8 p.m., during an current interview in room 10, 24 his pureed (a paste made bod) meal. Resident 24 re of the pureed food was a spoonful of pureed food up w on it. CNA 1 fed Resident tated, "I blew on it to cool it so he can eat." m., during an interview, the ould be stirred to disperse The DSD stated, "definitely resident food] it [blowing] it [blowing] is an infection m., during an interview, the should ever blow or fan easure for foods that were be stirred and left to cool red blowing on food was an eand could spread germs. m., during an interview, the on food is definitely not stated spit (saliva droplets) of food and germs spread. an infection control issue. Ship Requirements		812			9/27/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI IDENTIFICATION NUMBER: A. BUILDIN		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		555892	B. WING		C 09/18/2018
	ROVIDER OR SUPPLIER DNVALESCENT HOSPI	ΓAL	:	STREET ADDRESS, CITY, STATE, ZIP CODE 2108 STILLMAN SELMA, CA 93662	1 00/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 844	licensing the facility change occurs in- (i) Persons with an of as defined in §§420. chapter; (ii) The officers, dire employees; (iii) The corporation, company responsible facility; or (iv) The facility's administry and facility and facility and facility; or (iv) The facility's administry and facility	gency responsible for at the time of change, if a swnership or control interest, 201 and 455.101 of this ctors, agents, or managing association, or other e for the management of the ministrator or director of cotice specified in paragraph must include the identity of or company. T is not met as evidenced on, interview, and record illed to comply with State law less of Facility Name Change W) when the facility new name prior to having entralized Applications Unit	F 844	F 844 □ The clinical records for resident 15, 2 and 27 was reviewed and name updato licensed name was made. All residents of the facility have the potential to be affected. After IDT revof resident records on 9/26/18 no other residents have been noted to be affected. On 9/26/18 the VP of Clinical Operation provided an in-service training to facility.	view er cted. ons ity
	Executive Director (I under new ownershi new name. The new accommodation for after 6/1/18 under the	a.m., during an interview, the ED) stated the facility was p and was not advertising the name was there for those residents who came e new company name. The by business license was		staff on the change of ownership produced and using licensed name until change ownership process has been complet and approved. DSD will educate staff on Facility Narchange when the facility name changoccurs in future. Administrator will ma	e of ed ne e

IDENTIFICATION NUMBER:			1, ,	(X3) DATE SURVEY COMPLETED	
	A. BOILDII	<u> </u>		С	
555892	B. WING _		1 ,	09/18/2018	
	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COL		0.10.2010	
NI		2108 STILLMAN			
AL.		SELMA, CA 93662			
/ MUST BE PRECEDED BY FULL	ID PREFIX TAG	((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
e facility advertised. The ED what the status was illity license name change. The Change of Ownership was at the attorney's office. The stated the CHOW had usually takes 6 months to 1 the owner of the facility remation regarding the off Name (CHON). He stated apany had filed for the He stated, "I do not have a have any paperwork." The many paperwork." The during an interview, the stated operations are a CHOW was same time the new cility operations. The O at handled the healthcare of the CHOW. The O stated wing the status of the application is not kept on the master copy. The facility Detail Pop Up" of the facility was licensed state approved of 7/6/18, indicated the electronic file titled, "Facility ed 7/6/18, indicated the	F	name change a QAPI Perform improvement project when not happens. DSD will complete 3 random interviews with staff in various departments, about "Facility I will provide updated education as needed. DSD will present progress of and education to the QAPI exfort further review until the QAPI.	weekly s Name". DSD on on the spot monitoring very month		
	IDENTIFICATION NUMBER:	AL ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) B 667 Be facility advertised. The ED W what the status was Bility license name change. Be Change of Ownership Was at the attorney's office. Be tood that until the change of oved, the new ownership We stated the CHOW had Usually takes 6 months to 1 We off Name (CHON). He stated Depany had filed for the We have any paperwork. In m., during an interview, the We stated, "I do not have We have any paperwork." In m., during an interview, the We stated, the facility was We and "assumed operations We are the chow. The O We at handled the healthcare We detect the chow of the master copy. Internet public information We deficitly operation is not kept on We facility Detail Pop Up" We defined the facility was licensed We densed State approved We facility was licensed We for the chow of the state of the s	STREET ADDRESS, CITY, STATE, ZIP COE 2108 STILLMAN SELMA, CA 93662 AL STEMENT OF DEFICIENCIES (MAUST BE PRECEDED BY PULL SCIDENTIFYING INFORMATION) 2 67 e facility advertised. The ED w what the status was sillity license name change. He Change of Ownership was at the attorney's office. Good that until the change of wed, the new ownership He stated the CHOW had usually takes 6 months to 1 the owner of the facility remainer (CHON). He stated propry had filed for the He stated, "I do not have I have any paperwork." m., during an interview, the ty stated, the facility was same time the new cility operations. The O at handled the healthcare dithe CHOW. The O stated wing the status of the application is not kept on the master copy. Internet public information dFacility do 7/6/18, indicated the bilications were received, on for Change of Indirect STREET ADDRESS, CITY, STATE, ZIP COE 2109 STILLMAN SELMA, CA 93662 PROVIDERS PLAN OF CE (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) TAG STREET ADDRESS, CITY, STATE, ZIP COE 2109 STILLMAN SELMA, CA 93662 PROVIDERS PLAN OF CE (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) F 844 In ame change a QAPI Perform improvement project when not happens. DSD will complete 3 random interviews with staff in various departments, about "Facility will provide updated education as needed. DSD will present progress of and education to the QAPI en for further review until the QA committee determines further longer necessary. DSD will present progress of and education to the QAPI en for further review until the QA committee determines further longer necessary. DSD will present progress of and education to the QAPI en for further review until the QA committee determines further longer necessary.	STREET ADDRESS, CITY, STATE, ZIP CODE 2108 STILLMAN SELMA, CA 33662 AL TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FUILL, SC IDENTIFYING INFORMATION) B. 677 B. 678 B. 677 B. 687 B.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
			7 50.25				С
		555892	B. WING			09/	18/2018
	ROVIDER OR SUPPLIER DNVALESCENT HOSPITA	AL		2108 STIL	DDRESS, CITY, STATE, ZIP CODE LMAN CA 93662		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 844	On 7/31/18 at 9:28 a the letter sent out from responsible party and change in ownership facility. Review of clinical record Resident 24 and Resident 24 and Resident of the facility.	ras "Pending Assignment." .m. ED produced a copy of methe facility to inform for family member of the with the new name of the	F	344			
F 880 SS=E	CFR(s): 483.80(a)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)	ntrol blish and maintain an and control program asafe, sanitary and bent and to help prevent the asmission of communicable as. brevention and control blish an infection prevention and infection prevention and infection prevention are preventing, identifying, and controlling infections aseases for all residents, bors, and other individuals and contractual by the facility assessment and controlling infections are preventing, identifying, and controlling infections and controlling infections are preventing, identifying, and controlling infections are preventing infe	F	380			9/27/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDIN	G		c	
		555892	B. WING _			8/2018	
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP COD	· · · · · · · · · · · · · · · · · · ·	0/2010	
CEL MA C	ONVALESCENT LIGERIT	Al		2108 STILLMAN			
SELIVIA CO	ONVALESCENT HOSPIT	AL		SELMA, CA 93662			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 880	Continued From page	e 69	F8	80			
	procedures for the property but are not limited to: (i) A system of surveit possible communical infections before they persons in the facility (ii) When and to who communicable diseast reported; (iii) Standard and trait to be followed to previously when and how is resident; including but (A) The type and durice depending upon the involved, and (B) A requirement that least restrictive possicircumstances. (v) The circumstance must prohibit employ disease or infected secontact with residents contact will transmit to (vi)The hand hygiene by staff involved in disease of the factoric disease of the factoric disease. §483.80(a)(4) A system of the factoric disease. Personnel must hand	Illance designed to identify ble diseases or can spread to other c; m possible incidents of se or infections should be ensmission-based precautions went spread of infections; blation should be used for a set not limited to: ation of the isolation, infectious agent or organism at the isolation should be the ble for the resident under the ses under which the facility ees with a communicable kin lesions from direct so or their food, if direct the disease; and a procedures to be followed rect resident contact.					

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	COMPLETED
		555892	B. WING		C 09/18/2018
	ROVIDER OR SUPPLIER DNVALESCENT HOSPIT	AL		STREET ADDRESS, CITY, STATE, ZIP CODE 2108 STILLMAN SELMA, CA 93662	09/16/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	D.4TE
F 880	IPCP and update the This REQUIREMENT by: Based on observation review, the facility fail control program designs anitary environment. 1. Resident 22's cathone nebulizer mask was a used urinal laid on the second of the resident and there was no significated and there was no significated and the entrance of the resident 25's foley uncovered and his unnext to the bed. 4. Resident 1's urinated feeding bag had an effecting bag had an effective for the second of the resident and the second of the second of the resident and the second of the se	view. Ict an annual review of its ir program, as necessary. It is not met as evidenced in, interview, and record led to maintain an infection gned to provide a safe and when: eter was uncovered, unmarked, uncovered and a le floor next to the bed. It is gen tube was unmarked in for 'No Smoking' posted at from. I laid on the floor and his expired date. Sistant (CNA) 7 fed Resident ler hands. I rector (SSD) fed Resident ler hands. I a brown crusted particles ler room floor on the main	F 880	1. On 7/23/18 Resident 22□'s Foley catheter was covered with a dignity bay the nebulizer was cleaned, and a new mask was labeled and placed in a cover and the urinal was discarded. On 7/23/18 the oxygen tubing for Residus 15 was changed and dated and a no smoking sign was placed at the entrant to the room. On 7/23/18 Resident 25□'s Foley cathed bag was placed in a dignity bag and his urinal was discarded. Resident 1'□s urinal and feeding bag was immediately discarded on 7/23/18. CNA 7, SSD and DSD was educated be the VP of Clinical Operations on handwashing 7/23/18. The white towel was immediately picked up and removed from the shower room 7/23/18.	dent ce eter s vas
		aff Development did not ching her nose and helping		potential to be affected. 3. The Director of Staff Development provided facility staff with in service	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		555892	B. WING _				C 18/2018
NAME OF P	ROVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, STATE, ZIP CODE	1 00/	10/2010
SELMA CO	ONVALESCENT HOSPITA	ΔL		210	08 STILLMAN		
				SE	ELMA, CA 93662		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	Continued From page	÷71	F 8	80			
		residents at risk for cross ection and result in health			training for Infection Control: Safe and Sanitary Environment/ Hand Hygiene c 08/02/18.	on	
	Resident 22's room, Foley catheter hung from with approximately 30 in the bag. The nebuted with the mask untop of the machine. On 7/23/18 at 8:30 Afficoncurrent interview, mask should be labeled plastic bag when not we want to make sure (germs-bacteria). 2. On 7/23/18 at 7:45 room 3b and concurrent Resident 15 was on consal canula. The oxy and there was no significant room announcing	O AM, during initial tour in Resident laid in bed her om the bed rail uncovered to cc of amber colored urine lizer machine laid on the marked and uncovered on M, during initial tour and DSD stated the nebulizer ed and covered with a in use. It's infection control, e nothing gets passed on AM, during initial tour in ent interview with the DSD, exygen running at 3 L/M via a roted at the entrance of oxygen was in use. There is No Smoking. DSD stated			The Director of Staff Development will provide in service training to facility star on "infection control" topics such as har hygiene, clean environment, cross contamination prevention, using PPE e every quarter. The Director of Staff Development and Director of Nursing and/or Designee wire complete daily infection control rounds/observations and address any noted issues immediately, and re-educate staff on the spot as needed. 4. The Director of Staff Development present progress and any trends identified to the monthly QA meeting until the QA committee determines that further reviews is no longer necessary. 5. 8/26/18	nd tc. /or II ate will fied	
	nobody is going to be the policy is on postin On 7/25/18 at 3:20 Pt conference room, DO No Smoking) on the conference room, DO On 7/23/18 at 08:25 at the conference room,	smoking, I'm not sure what g signs." M, during an Interview in the N stated the sign (meaning loor should be put up. at AM, during an interview in DSD stated nobody sure what the policy is but I'll					

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		555892	B. WING		C 09/18/2018
	ROVIDER OR SUPPLIER	PITAL	2	STREET ADDRESS, CITY, STATE, ZIP CODE 2108 STILLMAN SELMA, CA 93662	1 03/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 880	Administration" dat Equipment and Sequipment and supperforming this pro Smoking/Oxygen in 3. On 7/23/18 at 7 room 5, Resident 2 uncovered and the next to the bed. Th put it (urinal) there bag." On 7/23/18 at 07:5 DSD stated, "The uplastic bag. I'm not them. 4. On 7/23/18 at 8: room 6 with the D laid on the floor bebag hung from the DSD stated, "The fevery 24 hours, daneeds to be change the bed side; they so the DON, she stated changed daily, usu	nd procedure titled," Oxygen ed 2001, indicated suppliesThe following splies will be necessary when cedure4. "No n Use" signs; 50 AM, during an initial tour in 5's foley catheter bag was urinal hung on her trash can e resident stated, "They (staff) after they empty my catheter 1 AM, during an interview, the rinals should be placed in a sure how often they change 05 AM, during an initial tour in SD, Resident 1's used urinal side the bed. A used feeding feeding pole dated 7/21/18. eeding bags are changed y shift changes them. That ed. The urinals usually are at should be marked." PM, during an interview with ed the feeding bags should be ally on the day shift.	F 880	,	
	urinals were stored should always be v Urinals were transp in clear trash bags	PM, DSD stated resident on the floor under tables , wrapped with clear trash bags. Ported to community restrooms by CNAs. CNAs were to wear a hand hygiene/ sanitizing after			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		555892	B. WING				C 18/2018
	ROVIDER OR SUPPLIER DNVALESCENT HOSPITA	AL	•	2	STREET ADDRESS, CITY, STATE, ZIP CODE 2108 STILLMAN SELMA, CA 93662		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	by day shift or done so Urinals are to remain prevention of spills/ in 5. On 7/23/18 at 12:1 and interview in the dup a chair then placed proceeded to feed Rehandled the cups, play without washing or sa 6. On 7/23/18 at 12:3 and interview in the dobserved feeding Restrays and setting up rowashing her hands on On 7/23/18 at 12:28 for supposed to wash out feeding residents. Chowashed my hands for prevention. The gern (Residents) sick." On 7/24/18 at 2:15 Placed regarding good hand stated hand washing tasks, when visibly so stick glucose and after should wash hands bot touching residents. If there is a risk for cross stated sanitizing with when touching trays or resident/staff safety, for said the said of t	als changed every Monday sooner if visibly soiled. in clear trash bags for affection control. O PM, during an observation inning room, CNA 7 picked did at the table sat down and esident 18. CNA 7 then attes and fed the resident anitizing her hands. 7 PM, during an observation inning room the SSD was sident 21 after passing out esidents without first rusing hand sanitizer. PM CNA 7 stated we are r hands before we start IA 7 stated, "I should have r cross contamination	F	880			

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) AN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		' '	X3) DATE SURVEY COMPLETED		
		555892	B. WING			C 09/18/2018
	ROVIDER OR SUPPLIER	ΓAL		STREET ADDRESS, CITY, STATE, ZIP CODE 2108 STILLMAN SELMA, CA 93662		03/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 880	and concurrent interroom, a white towel particles was found in 2 stated the shower unsure of how long the floor. CNA 2 stated, because of germs residents from our state towel in a clear plast clear bag was used in infectly into the linear ground, ever that is is an infection control every staff person with maintaining infection. On 8/1/18 at 6:45 a. Housekeeping Supel linear should not be leplaced into the white The HKS stated linear to the area where it is placed in the bags a was an infection con HKS stated, "It can stand fall." The HKS stated, "It can stand fall." The HKS stated infection con the facility policy and and Bedding, Soiled Soiled laundry and be contaminated with, materials must be had a solice in the bags and the facility policy and and Bedding, Soiled Soiled laundry and be contaminated with, materials must be had a solice in the bags and the facility policy and and Bedding, Soiled Soiled laundry and be contaminated with, materials must be had a solice in the bags and the facility policy and and Bedding, Soiled Soiled laundry and be contaminated with, materials must be had a solice in the bags and the facility policy and the facility policy and and Bedding, Soiled Soiled laundry and be contaminated with, materials must be had a solice in the shower of the facility policy and the facility poli	5 a.m., during an observation view in the main shower with dry crusted brown in stall one on the floor. CNA had not been used and was he towel had been on the "It can't be left on the floor we can spread germs to noes." CNA 2 placed the fic bag. CNA 2 stated the for soiled linens. 1.m., during an interview, the nen and towels should go a bag and not touch the sa risk for contamination it of issue." The DSD stated as responsible for a control. 1.m., during an interview, the risk for any floor and should be a bags immediately after use. In bags should be transported was used so linen could be fiter use. The HKS stated it trol and safety issue. The spread germs or someone tated it was everyone's berly handle linens and ontrol. In the difference of the main should be greated it was everyone's berly handle linens and ontrol. In the difference of the main should be greated it was everyone's berly handle linens and ontrol. In the difference of the main should be greated it was everyone's berly handle linens and ontrol.	F 8	80		

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTITUTION OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTITUTION NUMBER: A. BUILDING		IPLE CONSTRUCTION IG		(3) DATE SURVEY COMPLETED	
		555892	B. WING _			C 09/18/2018
	ROVIDER OR SUPPLIER ONVALESCENT HOSPIT	TAL .		STREET ADDRESS, CITY, STATE, ZIP CODE 2108 STILLMAN SELMA, CA 93662	'	00/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 880	container at the local The facility policy and Control Guidelines for dated 2005, indicated general infection control residents1. Standal in the care of all residents observation and control assisted Resident 10 scratched her nose with grabbed a disposable 10. Hand hygiene was baddent of the care	d procedure titled," Infection or all Nursing Procedures" edTo provide guidelines for other of the procedures will be used dents" 26 p.m., during an current interview in the dining of Staff Development (DSD) of with his meal. The DSD with her bare hand then be cup by the rim for Resident as not performed after the cose. The DSD confirmed ed hand hygiene and stated, ched it [disposable cup] with ch us not to grab cups at the shave germs." p.m., during an observation wiew in the Dining room, the rvices (DSS) served and with their meals in the Dining dled the residents' food trays, with bare hands. Hand formed by the DSS in the DSS stated, "I know they hands before serving meals een every resident it [hand]	F8			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		555892	B. WING _		C 09/18/2018
	ROVIDER OR SUPPLIER ONVALESCENT HOSPITA	AL		STREET ADDRESS, CITY, STATE, ZIP CODE 2108 STILLMAN SELMA, CA 93662	1 00/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 880	RD stated hand sanit when residents were equipment or utensils tasks were changed. hygiene in between a in cross contaminatio. On 7/25/18 at 3:25 p. Director of Nurses (D person was expected trays were served, be when hands were vis hand hygiene was pathere was a possibility.	m., during an interview, the izing must be performed assisted with meals, after were handled and when The RD stated poor hand ssisting residents can result	F 8		
F 908 SS=L	S483.90(d)(2) S483.90(d)(2) Mainta and patient care equi condition. This REQUIREMENT by: Based on observatio review, the facility fail and electrical facility o operating condition for (Resident 1, Resident Resident 11, Resident Resident 15, Res Resident 18, Resident 21, Resident 22, Res Resident 25, Resident	Safe Operating Condition in all mechanical, electrical, pment in safe operating is not met as evidenced n, interview, and record ed to maintain mechanical equipment in a safe	F9	F 908 1. Fan provided to Resident 19 was discarded on 7/23/18. On 7/21/18 well motor was replaced, a facility was in compliance with safe, comfortable temperatures by 7pm. On 7/27/18 the air filters were change and dated by the Maintenance Supervision	and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		555892	B. WING		C 09/18/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	09/10/2010
				2108 STILLMAN	
SELMA C	ONVALESCENT HOSPIT	AL		SELMA, CA 93662	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLETION
F 908	heating, ventilation, a unit (HVAC system) was maintained and failed 2. A fan in disrepair ventilation was desident 19. The failure to monitor mechanical and election the breakdown of the the need to evacuate [cross reference F58 to seven residents (Find Resident 24, Resident 24, Resident 6, Resident 12) being hospital. The local fire emergency services residents and determenvironment for their evacuation to a nearly displaced for several for Resident 19 their a fan in disrepair and potential harm for injustice (CMS deficient practices are potential serious harm serious actual harm to Resident 12, Resident 27, and Resident 78 Jeopardy (IJ) situation in the sident 18 for Resident 19 their serious actual harm to Resident 19 t	water into the facility's and air conditioning chiller was not monitored, not at to work on 7/21/18. was provided for use to r and maintain facility trical equipment resulted in facility HVAC system and 29 residents from the facility 4 and F 684]; and directly led desident 15, Resident 78, at 27, Resident 4, Resident 19 transferred to an acute care to department and assessed the safety of the sined an unsafe temperature esidents and ordered the by church; the residents were hours. failure resulted in the use of placed Resident 19 at	F 903	2. All residents were found to be affected by this finding. 3. Facility completed project on 9/ to connect City water supply to the G as a backup in case of Well pump far On 08/14/18 Administrator provided service training to the Maintenance Supervisor for Maintaining Equipme Proper Working Condition and Maintaining Inspections and Vendor Records. On 8/14/18, all available staff was in-serviced to notify maintenance at any equipment failure immediately a enter in maintenance log available a nurses station. Maintenance Supervisor and/or Deswill complete daily inspections of the and chiller system to ensure it is functioning properly. Maintenance Supervisor will inspect equipment prior to residents use to dit is functioning properly and safe to Facility created an action plan to address Air Conditioning Failure whow part of facility semergency Operations Plan and included in Dis Binder.	Chiller ailure. in ent in cout and at signee e well tensure use.

AND DI AN OF CORRECTION INFORMATION NUMBER:		1		(X3) DATE SURVEY COMPLETED
	555892	B. WING		C 09/18/2018
ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/10/2010
ONVALESCENT HOSPITA	AL			
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDERICIENCY)	D BE COMPLETION
Continued From page	e 78	F 90	8	
Deficiencies would be reflect the IJ with sco F 584 and F 908; and practice at F 684 with would be added. A with e IJ situation was real An acceptable Action 9/14/18 and commun Administrator. An one 9/18/18 and validated interventions meant to removed on 9/18/18 as	e submitted to the facility to pe and severity of L called at I an additional deficient a scope and severity of L ritten Action Plan to address equested to be submitted. Plan was received on icated to the facility site visit was conducted on I implementation of a address the IJ. The IJ was at 3:35 p.m. and		Responding to Air Cooling System F Action Plan The Charge Nurse will initially act as Incident Commander and will immed notify Facility Administrator, DON, N Director and Maintenance Director u any failure of the air-cooling system Facility Administrator, Maintenance Director and DON or Designee will r to the building after notification to as with plan with in 1 hour. Upon arriva DON or designee will take over as the	s the diately fledical upon . report ssist al, the
the Executive Director stated the water pumbroke on 7/21/18 at 7 air conditioning coolin "It just went out, there The ED stated the war maintained and was a monthly routine inspendent of the ED stated water pump a major of the ED stated water pump a major of T/26/18 at 3:55 p. with the Maintenance Director of Plant Ope stated he was called 7/21/18 and arrived at 12:00 p.m. it was considered.	or (ED - facility Administrator) p for the chiller (HVAC unit) 1:40 a.m. which caused the ng unit to fail. The ED stated, was no way of checking it." after pump had not been not part of maintenance's ection. The ED stated, "My ng how to maintain the d he had not considered the repair. m., during a group interview a Supervisor (MS) and the rations (DPO), the MS to the facility the morning of the 10:00 a.m. The MS stated letermined that the water		Incident Commander will immediate the following measures in place. Charge nurse will immediately begin triage residents for any changes from base line. Triage will consist of asserespiratory status, comfort level, vital signs, delirium, lethargy and hydratic status. Charge nurse will begin with residents at highest risk such as reswith respiratory problems, renal failt high-risk medications such as diured psychotropic medications, those who total dependent, non-verbal, etc. Resident status will be document their medical record following the trice. Charge nurse will notify Medical Direct of the status of each resident. The Course, with the Physician sinput, widentify individuals with signs and symptoms that might reflect fluid and	n to m their essing al on idents ure, on ics, o are eed in age. ector Charge vill
	CORRECTION ROVIDER OR SUPPLIER SUMMARY ST. (EACH DEFICIENC REGULATORY OR I Continued From page administrator an ame Deficiencies would be reflect the IJ with sco F 584 and F 908; and practice at F 684 with would be added. A with the IJ situation was reflect the IJ with sco F 584 and commun Administrator. An ons 9/18/18 and validated interventions meant to removed on 9/18/18 acommuncated to the Findings: 1. On 7/26/18 at 9:54 the Executive Director stated the water pumbroke on 7/21/18 at 7 air conditioning coolin "It just went out, there The ED stated the water monthly routine inspendent of the ED stated the water pumbroke on 7/21/18 at 7 air conditioning coolin "It just went out, there The ED stated the water pumbroke on 7/21/18 at 3:55 p. with the Maintenance Director of Plant Ope stated he was called 7/21/18 and arrived a at 12:00 p.m. it was depump which fed water pump w	CORRECTION 555892 ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 78 administrator an amended 2567/Statement of Deficiencies would be submitted to the facility to reflect the IJ with scope and severity of L called at F 584 and F 908; and an additional deficient practice at F 684 with scope and severity of L would be added. A written Action Plan to address the IJ situation was requested to be submitted. An acceptable Action Plan was received on 9/14/18 and communicated to the facility Administrator. An onsite visit was conducted on 9/18/18 and validated implementation of interventions meant to address the IJ. The IJ was removed on 9/18/18 at 3:35 p.m. and communicated to the facility Administrator.	CORRECTION DENTIFICATION NUMBER: A. BUILDING	TONDALESCENT HOSPITAL SUMMARY STATEMENT OF DEFICIENCIES (FACH DEPICIENCY MISS BE PRECEDED BY PULL (FEGULATORY OR ISC DENTIFYMS INFORMATION) COntinued From page 78 administrator an amended 2567/Statement of Deficiencies would be submitted to the facility to reflect the IJ with scope and severity of L would be added. A written Action Plan to address the IJ situation was requested to be submitted. An acceptable Action Plan was received on 9714/18 and communicated to the facility Administrator. An onsite visit was conducted on 9714/18 and validated implementation of interventions meant to address the IJ. The IJ was removed on 9718/18 at 3:35 p.m. and communicated to the facility Administrator. Findings: 1. On 7/26/18 at 9:54 a.m., during an interview, the Executive Director (ED - facility Administrator) stated the water pump for the chiller (HVAC unit) broke on 7/21/18 at 7:40 a.m. which caused the air conditioning cooling unit to fail. The ED stated, "It just went out, there was no way of checking it." The ED stated he water pump had not been maintained and was not part of maintenance's monthly routine inspection. The ED stated, "It just went out, there was no way of checking it." The ED stated he water pump had not been maintained and was not part of maintenance's monthly routine inspection. The ED stated, "It just went out, there was no way of checking it." The ED stated he had not considered the water pump a major repair. On 7/26/18 at 3:55 p.m., during a group interview with the Maintenance Supervisor (MS) and the Director of Plant Operations (DPO), the MS stated he was called to the facility the morning of 7/21/18 and arrived at 10:00 a.m. The MS stated at 12:00 p.m. it was determined that the water pump which fed water into the chiller was broken.

	DF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
				_		(C	
		555892	B. WING			09/	18/2018	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
SELMA CO	ONVALESCENT HOSPITA	ΔΙ		2	108 STILLMAN			
SELIVIA CO	ONVALLOCENT HOSFIII		SELMA, CA 93662		ELMA, CA 93662			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 908	contacted a company MS also stated, "They was an emergency are fixed right away." The located a pump and hon 7/21/18. The MS is how long it would take was a Saturday we fixed." The MS stated communicated with the keep the ED informed. The DPO stated, "On service technician dia flowing through the clawater was present but water." The DPO also maintenance to the water was present but water." The DPO also maintenance to the water of 7/21/18. The lone pump which is sufficient to assess." On 7/26/18, at 3:55 p concurrent interview of box stood next to the stated the metal box water pump. The DPO can tell if the pump is stated no type of maintenance to face the control box. On 7/26/18 at 6:55 p. Director of Staff Deve ED or the Director of determined earlier that residents from the face.	so we called the Fire ee." The MS stated he had to evaluate the pump. The y [company] felt the pump and it [water pump] had to get MS stated the company and it replaced by 5:00 p.m. stated they were unsure of the to fix. The MS stated, "It the maintenance staff the ED throughout the day to dof what was happening. Saturday [7/21/18] the tignosed water was not niller the pump was bad the pump did not pump to stated no type of the pump was performed DPO stated, "There is only tibmerged in water was outside the facility, a metal water pump unit. The DPO was the control box for the D stated, "The control box disconnected" The DPO intenance had been done to outside the facility of the pump the control box disconnected" The DPO intenance had been done to outside the vacuation of the pump t	F	908	illness and determine further intervention that may be needed at that time. Direct CNA□s to dress their assigned residents in lightweight, loose fitting clothing. Direct CNA□s to pass fresh water to early of their assigned residents. CNA□s will check water every hour and refresh as needed. CNA□s should encourage 2 glasses (16 ounces) of water every hour distributions at the nurse□s station and in the activity room for residents, family and staff. Direct CNA□s to provide assigned residents with cool, moist towels. Direct CNA□s to provide and encourage residents to eat popsicles between meaning the provide in the provide ask residents if they are comfortable, then report results back to charge nurse. o Instruct CNA□s to monitor their assigned residents □ vital signs every hour and if verbal ask resident if they are comfortable, then report results back to charge nurse. o Instruct CNA□s to monitor their assigned residents hourly for any advectionages in resident condition that can be heat related and immediately report back to the charge nurse changes such as: ¿ Unconsciousness ¿ Dizziness, Nausea and confusion ¿ Red, hot and dry skin ¿ Rapid, strong pulse ¿ Headache Muscle eremas averal assigned.	ach II Ir. ne le als. ed		
	DSD stated the facility	y temperature felt warm I at the facility on 7/21/18 at			i Muscle cramps, weakness i Paleness, tiredness			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		555892	B. WING			C 9/18/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		13/10/2010
				2108 STILLMAN		
SELMA CO	ONVALESCENT HOSPIT	AL		SELMA, CA 93662		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 908	Continued From page	e 80	F 90	8		
		tated, "From what I saw, the				
	residents were hot."	rated, 110111 what 13aw, the		Instruct Maintenance Staff or	Designee to	
	rooldonto word not.			immediately start monitoring	-	
	On 7/27/18 at 1:50 p.	m., during an interview,		temperatures every hour. Ter		
		istant 12 (CNA 12) stated		will be placed in log for refere		
		t 6:10 a.m. on 7/21/18. CNA		relayed to the Charge Nurse,	DON and	
	12 stated the facility	environment felt hot and		Administrator.		
		d it to the charge nurse.				
		arge nurse had spoken to		Instruct Maintenance Staff or	J	
		2 stated, "I was sweating just		set up Activity Room as the d		
	walking the resider			cooling area. The designated		
	uncomfortable after lu	unch time."		is equipped with window AC u		
	On 7/27/19 at 2:50 n	m during an interview CNA		capacity to hold 34 residents. Additional 2 Portable Water 0		
		.m., during an interview, CNA o work at 2:15 p.m. on		be placed in cooling room to		
		d, "It [the facility] felt hotter		temperatures.	maintain saic	
		they told me the AC [air		temperatares.		
		ke." CNA 5 stated she had				
	-	nostats. CNA 5 stated,		Evacuation/Transfer □		
		dehydrated he looked				
	drowsy with eyes hal	f opened and shut and he		If facility temperatures continu	ue to rise to	
	complained that it wa	is really hot the nurse [LN		an unsafe level for residents	as	
		ice and sit him in front of a		determined by consultation w		
		the FD [fire department]		Medical Director, DON, Admi		
		id the facility was too hot		Charge Nurse the facility will		
		ned me and two other CNAs		implement facility evacuation	procedures.	
		and asked us if we thought		TI DON		
		nere. We all responded no		The DON as the Incident Cor		
		em we started evacuation stated the ED, the DON, and		ensure transfers are made ap according to acuity as determ		
	the DSD arrived during			triaging residents. Residents	•	
	and DOD annived dulii	ig the evacuation.		higher risk status as determin		
	On 7/27/18 at 3:20 P	M, during an interview,		Charge Nurse assessment, w	•	
		N 3) stated on 7/21/18 she		evacuated as first priority the		
	,	rge nurse for the facility. LN		lower acuity residents will follow		
	3 stated the AM shift	-				
		air conditioner was broken		Residents requiring a higher l	evel of care	
	and cooling measure	s for the residents had been		as determined by the Charge	Nurse	
	provided during the d	lav. LN 3 also stated LN 5		assessment and consultation	with DON	

NAME OF PROVIDER OR SUPPLIER SELMA CONVALESCENT HOSPITAL (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) SELMA CONVALESCENT HOSPITAL STREET ADDRESS, CITY, STATE, ZIP CODE 2108 STILLMAN SELMA, CA 93662 (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE DEFICIENCY)	
NAME OF PROVIDER OR SUPPLIER SELMA CONVALESCENT HOSPITAL SELMA, CA 93662 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETED ACTION SHOULD BE COMPLETED ACTION SHOULD BE COMPLETED ACTION SHOULD BE DATE COMPLET	
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(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE SELMA, CA 93662 (X5) PROVIDER'S PLAN OF CORRECTION (X5) COMPLE TAG CROSS-REFERENCED TO THE APPROPRIATE	
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	ETION
F 908 Continued From page 81 F 908	
reported the FD had been called to the facility and Medical Director, will be transferred	
twice and had given instructions to evacuate the by ambulance to the nearest acute care	
residents if ambient (surrounding environment) hospital.	
temperatures in the facility rose throughout the	
day. LN 3 stated the FD Chief returned to the Residents that are stable as determined	
facility at 4:00 p.m. and ordered the evacuation of by the Charge Nurse assessment and	
the residents when Maintenance [staff] had not consultation with DON and Medical	
purchased and delivered portable air conditioning Director will be transferred via facility van	
units to the facility. (3 available).	
On 7/31/18 at 4:00 p.m., during an interview, the On 7/27/18 facility executed transfer	
(local) FD Fire Chief stated, "I was the contact on agreements for emergencies with 4 skilled	
the scene because the nurse [LN 5] was having nursing facilities and is also participating	
trouble reaching any of her supervisors I told in Fresno Mutual Aid Compact MOU	
her I would assist in giving her direction as to among 25 skilled nursing facilities in	
evacuation." The FD Chief stated the evacuation Fresno area as part of CAHF Disaster	
of residents was initiated based on the facility's Preparedness initiative.	
environment and a potential for harm to the residents. The FD Chief stated temperatures in Incident Commander will first contact the	
the facility were well above 81 degrees following 4 skilled nursing facilities in	
Fahrenheit (F) and cooling measures initiated by which a transfer agreement for	
the facility were ineffective. The FD Chief stated, emergencies is in place to coordinate how	
"One resident was bobbing his head like he was many beds are available and how many	
going to pass outbedridden residents with residents they can accommodate.	
multiple issues were transferred out." The (local	
fire department) FD Chief stated he had not o Facility 1	
spoken to the ED prior to 4:00 p.m. when the ED arrived during the facility's evacuation. o Facility 2	
arrived during the facility's evacuation. O Facility 2 in Fresno.	
On 7/30/18 at 10:20 a.m., during a telephone	
interview, the DON stated the AM shift charge	
nurse (LN 5) notified her of the broken air o Facility 4	
conditioning unit on 7/21/18 at 8:00 a.m. The	
DON stated she instructed the charge nurse to	
contact the Maintenance Department staff and If above contracted facilities can not	
distribute ice water, cool wash rags, and fans to accommodate all residents, the Incident	
the residents. The DON also stated she Commander will reach out to Fresno County Emergancy Son income Agency	
instructed the charge nurse to monitor the County Emergency Services Agency residents for signs and symptoms of heat Coordinator/Medical Health Operational	

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		(X3) DATE SURVEY COMPLETED		
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		555892	B. WING) 18/2018
NAME OF PI	ROVIDER OR SUPPLIER		_	S	TREET ADDRESS, CITY, STATE, ZIP CODE	, 00,	10/2010
				2	108 STILLMAN		
SELMA CO	ONVALESCENT HOSPIT	AL		s	ELMA, CA 93662		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 908	Continued From page	e 82	F:	908			
	exhaustion. The DON	N stated. "I told her to			Area Coordinator to facilitate transfer o	f	
		nd vomiting, excessive			residents to Fresno SNF□s Mutual Aid		
		fatigue, [and] decreased			Compact participating facilities (25 tota	I	
	level of consciousnes	ss." The DON stated the			facilities) to coordinate available beds.		
	charge nurse told her	maintenance had contacted			(Contact information for these facilities	is	
	a service technician a				also in the facility disaster binder)		
		ng done. The DON stated					
		d facility temperatures and			Charge Nurse or Designee will contact		
	reported the temperature readings directly to the				responsible party prior to transfer to		
		she did not know what the			inform them of the plan.		
		perature was on 7/21/18.			Maintanance/ Ungrade of Air Condition	ina	
		she did not know what hould have been to minimize			Maintenance/ Upgrade of Air Condition System □	irig	
		considered 89 degrees F. a			System =		
		e DON stated she was			On 9/11/18 project to connect City water	er.	
		urse (LN 3) the FD mandated			supply to the Chiller as a backup in case		
	-	DON stated nurses should			of well pump failure was completed by		
	have evacuated where	n residents were in distress			contracted vendor		
	or unsafe.						
					Maintenance Supervisor and/or Desigr	ee	
	Review of facility doc				will complete daily inspections of the w	ell	
		dated 7/21/18, indicated an			and chiller system to ensure it is		
	, , , ,	ture readings for 20 facility			functioning properly by checking for wa	.ter	
		ling the dining room, the			flow and checking blowing cool air.		
	l	ill, and the north/south hall.			On 0/42/40 facility reactived Confly are	:4	
		nperature readings were to om 8:00 a.m. through 7:00			On 9/12/18 facility received CapEx pro		
	-	eratures from 8:00 a.m. to			approval to replace current chiller systemith a new HVAC system, OSHPD	2111	
		ted from the log. The first			approval requested, IOR has been		
		e readings were at 12:00			retained - 9/12/18.		
		ough room 20, including the					
		hall, the west hall, and the			OSHPD official conducted site visit on		
	_	temperatures ranging from			09/13/18.		
	77 degrees F. up to 7	9 degrees F. Temperature					
		in the areas listed ranged			In Service Training □		
		84 degrees F. Temperature					
		in the areas listed ranged			DSD has provided the following In-Serv	/ice	
	_	88 degrees F. Temperature			Training to all staff		
	readings at 3:00 p.m.	in the areas listed ranged			o A. Emergency Operations Plan.		1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		555892	B. WING _				C 1 18/2018
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	10/2010
				21	108 STILLMAN		
SELMA CO	ONVALESCENT HOSPITA	AL			ELMA, CA 93662		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	BE PRECEDED BY FULL PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 908	Continued From page	e 83	F 9	908			
	readings at 4:00 p.m. from 86 degrees F. to readings at 5:00 p.m. from 84 degrees F to	ould have been maintained			Incident Command Center, Evacuation Procedures, Communication during a Disaster, Tracking Staff and Residents during Disaster, Resident Safety and S Temperatures. Started 8/2/18 and completed on 8/22/18. Maintenance Director provided the		
	Resident 3 stated, "It I felt fatigued. It got vom was given oxygen between Resident 3 also stated Services (DSS) sat his cool off. Resident 3 siblood pressure and it until Monday I had using oxygen off and ice water, towels wet really work, I just felt in Resident 3's Minimum Assessment, dated 7 3's Brief Interview for was 13 of 15 which in				following In-Service Training to all staff o How to access and turn on back u city water supply to Chiller in case of w motor failure with return demonstration All staff In-service started on 9/12/18 a completed on 9/20/18. On 8/14/18 Administrator in-serviced maintenance director on maintaining equipment in working order, preventive maintenance, maintaining outside veno repairs and inspection records and inspecting well motor function and keeping logs of those inspections, maintenance and repairs. o Maintenance Director will immedia	p ell nd	
	ability to make reasor On 7/30/18 at 2:35 p. regards to 7/21/18, R getting really hot mid- sticky, muggy, and ur Resident 11's MDS A BIMS score was 12 o resident was moderat	nable judgements. m., during an interview in esident 11 stated, "It started afternoon really hot,			report any problems to the Administrate and schedule any repair, corrections of vendor visit necessary. Facility Wide Exercise was completed with Focus on Activation of EOP, Nursi Home Incident Command System and Evacuation Procedures on 8/30/18 with Supervision and feedback provided by Selma Fire Department. Areas addressed included Emergency Operations Plan, Nursing Home Incide Command System and Communication	ng n	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		555892	B. WING		C 09/18/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/10/2010
				2108 STILLMAN	
SELMA CO	ONVALESCENT HOSPIT	ΓAL	:	SELMA, CA 93662	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX TAG			PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 908	Continued From pag	ne 84	F 908		
		ess notes dated 7/21/18 at "Resident was evacuated		Plan.	
	due to heat exposure	e for safety. Resident		Director of Staff Development will prov	vide
	evacuated to church	across the street."		facility staff with quarterly Disaster	
				Preparedness training refreshers and	
		ess notes dated 7/21/18 at		updates. Quarterly/Ongoing	
	-	"Resident evacuated from			
	facility due to heat."				
				DSD will audit In-Service Training reco	
		ess notes dated 7/21/18 at		weekly until all staff has completed the	9
		"Resident was evacuated		In-Service Training.	
	evacuated to church	e for safety. Resident		Evidence of the In-Service Training wi	II ho
	evacuated to church	across the street.		documented and submitted to CDPH.	ii be
	Resident 21's progre	ess notes dated 7/21/18 at		documented and submitted to ODI 11.	
		"Resident was evacuated		All new employees of the facility will be	<u>a</u>
		e for safety. Resident		provided with In Service training by the	
	evacuated to church			DSD upon facility orientation for the	
				following:	
	Resident 1's progres	ss notes dated 7/21/18 at		o A. Emergency Operations Plan,	
		"Resident was evacuated		Incident Command Center, Evacuation	า
		e for safety. Resident		Procedures, Communication during a	
	evacuated to church	across the street."		Disaster, Tracking Staff and Residents	
	D .: 1 . (6)	1 1 1 7 2 4 4 2 4		during Disaster, Resident Safety and S	Safe
		ss notes dated 7/21/18 at		Temperatures.	
		"Resident was evacuated		o How to access and turn on back u	
	evacuated to church	e for safety. Resident		city water supply to Chiller in case of v	
	evacuated to church	across the street.		motor failure with return demonstration	1
	Resident 77's progre	ess notes dated 7/21/18 at			
		"Resident evacuated from		Monitoring □	
	facility due to heat."				
	·			Director of Staff Development will do	
	Resident 18's progre	ess notes dated 7/21/18 at		monthly random checks of facility staff	·s 🗆
		"Resident was evacuated		knowledge about Disaster Procedures	
		e for safety. Resident		EOP and INC. Knowledge will be bas	
	evacuated to church	across the street."		on ability to answer random questions	and
				return demonstration, which include:	
	Resident 5's progres	s notes dated 7/21/18 at		1. What are safe temperatures?	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION		(X3) DATE SUR\ COMPLETE	
		555892	B. WING			C 09/18/2	018
NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COD	<u>_</u>)E	03/10/2	010
				2108 STILLMAN			
SELMA CO	ONVALESCENT HOSPIT	AL		SELMA, CA 93662			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIAT		(X5) MPLETION DATE
F 908	Continued From pag	e 85	F 90	8			
	6:17 p.m., indicated,	"Resident was evacuated		2. What area of the facility i	is a		
	due to heat exposure			designated cooling space?			
	evacuated to church	across the street."		3. How do we keep the resi hydrated?	dents		
	Resident 11's progre	ss notes dated 7/21/18 at		How often are facility ten	nperatures		
		"Resident was evacuated		monitored?			
	due to heat exposure	<u> </u>		5. Show me how switch the			
	evacuated to church	across the street."		system from well to city water			
	D i - i t - 401			6. Show me how to tell if the	e chiller is		
		ss notes dated 7/21/18 at "Resident was evacuated		working? 7. Where can you find out v	what to do		
	due to heat exposure			during a cooling failure if you			
	evacuated to church			during a cooming famore if you	lorgot:		
				Additional random questions	for nurses		
	Resident 23's progre	ss notes dated 7/21/18 at		may also include			
		"Resident was evacuated					
	due to heat exposure			What do you monitor for h	ydration		
	evacuated to church	across the street."		status and heat exposure?			
	D			2. What type of residents are	at a high		
		ss notes dated 7/21/18 at		risk for heat related illness?	_1		
	facility due to heat."	"Resident evacuated from		When should the DON and Administrator be notified during		~	
	lacility due to fleat.			system failure?	ig a cooliii	9	
	Resident 3's progres	s notes dated 7/21/18 at		4. When should assessment	s he		
		"Resident was evacuated		completed?			
	I .	e for safety. Resident		, , , , , , , , , , , , , , , , , , ,			
	evacuated to church	-		On the spot refreshers will be	provided t	ю О	
				staff as necessary. Director o	f Staff		
		ss notes dated 7/21/18 at		Development will provide in-s			
		"Resident evacuated from		training refreshers and update		-	
	facility due to heat."			all-staff with quarterly on topic			
	Dooldont 10's are	on notes dated 7/04/40 at		Preparedness, EOP Action P	ian and IN	∵ .	
		ss notes dated 7/21/18 at "Resident was evacuated		The Administrator will present	t progress	of	
	due to heat exposure			action plan to the monthly QA	. •	Oi	
	evacuated to church			committee for further review a		e	
		40.000 the off out.		QAPI determines further review		<u> </u>	
	Resident 20's progre	ss notes dated 7/21/18 at		longer necessary.			
		"Resident was evacuated					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3	3) DATE SURVEY COMPLETED
		555892	B. WING			C 09/18/2018
	ROVIDER OR SUPPLIER	AL		STREET ADDRESS, CITY, STATE, ZIP COI 2108 STILLMAN SELMA, CA 93662	DE	03/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 908	6:13 p.m., indicated, due to heat exposure evacuated to church a Resident 22's progres 5:45 p.m., indicated, facility due to heat." Resident 25's progres 5:58 p.m., indicated, due to heat exposure evacuated to church a due to heat exposure evacuated to church at 4:09 p.m. to the factor of 29 convalescent rebreakdown of an HVA indicated, "Temperatuexceeded 80 plus deg [residents] suffering fi seven patients require [by way of] ambulance. Resident 15's progres 4:32 p.m., indicated, ER [Emergency Roor MD ordered." Resident 15's "(name Report" dated 7/21/18" "Diagnosis: Heat expersident 15's progres 15's progres 15's progres 15's progres 15's "(name Report" dated 7/21/18" "Diagnosis: Heat expersident 15's progres 15's progre	for safety. Resident across the street." Is notes dated 7/21/18 at 'Resident was evacuated for safety. Resident across the street." Is notes dated 7/21/18 at 'Resident evacuated from as notes dated 7/21/18 at 'Resident was evacuated for safety. Resident across the street." Is partment Incident Report ted the FD was dispatched cility to assist in the removal sidents after the mechanical accunit. The report also are inside the facility grees with multiple patients from heat related illnesses and transport to hospital via the et across dated 7/21/18 at 'Resident transferred to the inj due to facility evacuation. In of hospital) Visit Summary 8 at 9:38 p.m., indicated,	F 90	The Director of Staff Develop present progress on staff eduresponses to the QAPI mont QAPI determines that further longer necessary. End of Action Plan 4. Maintenance Director widocumentation for inspection performed on the Chiller and and present any trends ident monthly QA meeting until the committee determines that furis no longer necessary. 5. 9/20/2018	ucation & hly until the r review is no ill keep logs & ns or works I Well pump tified to the e QA	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		555892	B. WING		C
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2108 STILLMAN SELMA, CA 93662	09/18/2018
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 908	5:56 p.m., indicated, [name of hospital] divia ambulance." Resident 78's progreg 9:53 p.m., indicated, hospital] called and admitted to acute care Obstructive Pulmona and PNA [Pneumoningerms]." Resident 78 had not 7/30/18 at 3:10 p.m. stated Resident 78 facility from the hospitality from the hospitality due to heat evacuated to Hospitality due to heat evacuated to Hospitality from the hospitality due to heat evacuated to Hospitality from the hospitality due to heat evacuated to Hospitality from the hospitality due to heat evacuated to Hospitality from the hospitality due to heat evacuated to Hospitality from the hospitality due to heat evacuated to Hospitality from the hospitality due to heat evacuated to Hospitality from the hospitality from the hospitality due to heat evacuated to Hospitality from the hospitality from the hospitality due to heat evacuated to Hospitality from the hospitality from	ess notes dated 7/21/18 at "Residents transferred to theat exposure transferred ess notes dated 7/21/18 at "Nurse from [name of stated that resident was being re for COPD [Chronic ary Disease; lung disease] a; lung infection caused by returned to the facility. On , during an interview, LN 5 vas admitted to another oital. ess notes dated 7/21/18 at "Resident evacuated from exposure for safety. Resident al; [name of hospital]." ess notes dated 7/22/18 at "Resident admitted to [name fospital] nurse stated that the transferred to ICU Admitting dx [diagnosis] NA [Pneumonia], and ESRD tease; kidney disease]." e of hospital] Order requisition 24 a.m., indicated, its Sepsis, Pneumonia, End	F 908	3	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
						С	
		555892	B. WING			09/	18/2018
	ROVIDER OR SUPPLIER ONVALESCENT HOSPITA	AL		2	TREET ADDRESS, CITY, STATE, ZIP CODE 108 STILLMAN SELMA, CA 93662		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 908	facility due to heat exevacuated to Hospital Resident 4's (name of Report dated 7/22/18 "Diagnosis: Urinary Thematuria [blood in undersident 4's progress 2:54 a.m., indicated, the facility from ER [ERESIDENT FOR THE FOR TH	"Resident evacuated from posure for safety. Resident I; [name of hospital]." If hospital) Visit Summary at 1:41 a.m., indicated ract infection without rine]." Is notes dated 7/22/18 at "Resident arrived back to Emergency Room]. Is notes dated 7/21/18 at "Resident evacuated from posure for safety. Resident I; [name of hospital]." Incomposite the example of the	F	908			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		555892	B. WING			C 09/18/2018
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 2108 STILLMAN SELMA, CA 93662		09/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 908	facility at approximate hospital] in stable of Resident 24's progression of 12 p.m., indicated facility due to heat devacuated to Hospital Resident 24's "(name Report" dated 7/21/"Diagnosis: Heat extended to the chiller of 1:08 a.m., indicated hospital On 7/26/18 at 3:55 and concurrent interpolity cooling unit which fachiller was located Air filters were not of the chiller were covered substance and were below. The pans we and a green-black for top of the liquid. Murair duct were secure foam was used to secure foam was used to secure of 1:00 progression of 1:0	d, "Resident returned to ately 10:55 PM from [name of condition." less notes dated 7/21/18 at l., "Resident evacuated from exposure for safety. Resident tal; [name of hospital]." me of hospital) Visit Summary 18 at 10:47 p.m., indicated	F 9	,		
	referred to as comp grease. The MS sta on the chiller one w changed it [filters] is to date filters so y done." The MS stat	ressors were covered in black ated he had changed the filters eek ago. The MS stated, "I I didn't date it the process you know when it was last ed the crystal like substance or pipes was condensation and a drippings from the				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		555892	B. WING			C 09/18/2018	
	ROVIDER OR SUPPLIER			s 2	TREET ADDRESS, CITY, STATE, ZIP CODE 108 STILLMAN SELMA, CA 93662	1 09/	10/2010
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 908	the chiller are dead be decided by Director of Plant Ope chiller was the only of the DPO stated the beand thought the chiller unit. The DPO stated chiller unit. Review of an estimate company] dated 7/23 repairs Replace state size and amps, replace and pressure) services replace oil replace leaking replace leaking replace there wire and settings remains through December 20 omissions for January log had an "X" entere chiller filters maintain who performed the mathedate and time the performed. Review of All Facilities for Department of Public Certification dated 7/5 must implement recommeasures to keep indicomfortable during exmust have a continger must have a continger in the chiller filters maintain who performed.	S also stated, "The wires on ut we need to fix that." The rations (DPO) stated the poling unit for the facility. Soliding was built in 1949 for was the original cooling he had no blue prints for the rater overload to the correct ce all safety controllers (oil to both compressors and filter drier on circuit#2 that's ramostat control Electrical frigerant R-417C" provided by the MS titled, Records" dated 2018, were to be done January of 18. The log contained by through June 2018. The din a box labeled July; itemed. The document omitted aintenance on the unit and maintenance was s Letter (AFL 18-28) sent to om the California Health Licensing and 5/18, indicated, "Facilities mended precautionary lividuals safe and carey plans in place to deal anditioning, or in the case	F	908			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		555892	B. WING				C 40/0040
NAME OF P	ROVIDER OR SUPPLIER	333032			STREET ADDRESS, CITY, STATE, ZIP CODE	09/	18/2018
SELMA C	ONVALESCENT HOSPIT	AL		2	108 STILLMAN SELMA, CA 93662		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 908	free from adverse collection heat-related health or important that facility weather conditions for temperatures and takensure appropriate a well maintained and of the collection of the collect	catients and residents are nditions that may cause omplications It is administrators monitor or fluctuations in extreme se extra precautions to ir conditioning equipment is operating effectively." 3 a.m., during an 19, a desk fan with two control switches sat on r drawer. The missing wo finger sized holes on the e base of the fan. The fan wall and was on. Resident facing the fan. 4.m., during an interview, the isor (MS) stated the broken his work room in the to Resident 19. The MS sed to cool Resident 19's r (air conditioning cooling g on 7/21/18 and Resident of the MS stated, "It should due to risk for injury to the outtons were missing and the cuttons were was nine of the resident was moderately in regard to memory and mable judgements.	F	908			

AND DI AN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		555	892	B. WING		C 09/18/2018
	ROVIDER OR SUPPLIER	AL			STREET ADDRESS, CITY, STATE, ZIP CODE 2108 STILLMAN SELMA, CA 93662	33/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIEN Y MUST BE PRECEDED LSC IDENTIFYING INFO	D BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 908 F 912 SS=C	8/06, indicated, "Whe canes, etc. are maint Bedrooms Measure at CFR(s): 483.90(e)(1) (ii) Mea per resident in multip least 100 square feet This REQUIREMENT by: Surveyor: Rodarte, II Based on observation 7/23/18 through 8/1/1 provide the minimum resident in a multi-resident in a multi-resident of privacy. Cl were adequate. Beds There was sufficient in resident to ambulate. facilities were access of the residents will not this waiver. Room number	elchairs, walkers, ained by our facilitat Least 80 Sq Ft/f(ii) sure at least 80 sq le resident bedrood in single resident is not met as evolutional and during the surve 8, the facility faile square footage	ty" Resident quare feet oms, and at rooms; idenced y period of d to or each able e space evailable. eare and toilet nd safety	F 96		d as icient and sident nee f table uest or onitor
	8 117	7.64 2			monthly for review and recommenda	ion.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		555892		B. WING			C 18/2018
	ROVIDER OR SUPPLIER DNVALESCENT HOSPITA	AL		2	TREET ADDRESS, CITY, STATE, ZIP CODE 108 STILLMAN SELMA, CA 93662	, ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE
F 912	14 112 16 119 18 129 19 96 20 96 We recommend continue Health Facility Evaluate Request for a continue Facility Administrator Safe/Functional/Sanit CFR(s): 483.90(i) §483.90(i) Other Envi The facility must provious anitary, and comfortate residents, staff and the This REQUIREMENT by: Based on observation review, the facility failure in the second content of the second	2.61 2 2.44 2 2.44 2 2.77 2 2.58 2 2.31 2 2.88 1 2.88 1 2.89 1 2.99 1 2.99 1 2.99 1 2.99 1 2.99 1 2.99 2 2.	Date	F 912	5. 8/26/18 F 921 □		9/27/18
		ent for two of 25 residents ident 24) when wall plaster nt's bed.			Maintenance Director repaired the walls of Room 10 on 7/23/18.		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	MULTIPLE CONSTRUCTION JILDING		(X3) DATE SURVEY COMPLETED	
		555892	B. WING			C	
NAME OF PROVID	DER OR SUPPLIER	00002		STREET ADDRESS, CITY, STATE, ZIP COI	I	09/18/2018	
				2108 STILLMAN			
SELMA CONVA	ALESCENT HOSPITA	AL		SELMA, CA 93662			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
This the con high fine con high fine con set Res a sill on roo set on the con the con	residents could nonfortable homelike thest practicable with the practica	an environment in which of exercise their right to a existence and reach their ell being. m., during an observation in laid asleep in bed which swest wall. The right side of body laid directly across from hole in the plastered wall. m., during an observation in laid asleep in bed which seast wall. Resident 10 laid a shallow hand sized hole in m., during an observation iew in room 10, the Director ed she was aware of plaster s. The DON stated, "It had time, I think maintenance m., during an interview and riew, the Director of Plant ated he was aware peeling he facility. The DPO to titled, "Maintenance Log" ich had peeled plaster and listed. The DPO stated are de by issues which effected are DPO stated, "Absolutely it ets residents in that room	F 92	2. All residents of the facility potential of being affected. A review by the IDT no further have been affected. 3. On 8/23/18 Director of S Development conducted instraining with facility staff on O life-Home Like Environment Communication via the Main Department Managers have assigned rooms for daily rou Department managers will lo repairs into the maintenance discuss the findings in the dameeting. Maintenance Director will reviating maintenance log daily and mappropriate repairs within 48 4. Dept. Heads will visually rooms daily during room rour Maintenance Director will do room inspections of each roopresent any trends of repairs identified to the monthly QAF until the QAPI committee defurther review is no longer new 5. 8/26/18	After further residents Staff ervice Quality of and tenance Log. been nds. g any needed log and hily stand up view ake hours. vinspect the nds. monthly on and or items PI meeting termines that		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED		
		555892	B. WING _			C 09/18/2018	
	ROVIDER OR SUPPLIER ONVALESCENT HOSPIT	TAL		STREET ADDRESS, CITY, STATE, ZIP CODE 2108 STILLMAN SELMA, CA 93662		03/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 921	F 921 Continued From page 95		F 9	21			
	log" dated 6/2/18 thro "6/7/18 Patch holes i #17." Resident 10 an omitted (left out) from On 7/23/18 at 11:25 and concurrent interv	titled, "Selma Maintenance bugh 6/24 18, indicated in rooms #13, #11, #2, and Resident 24's room was in the log. a.m., during an observation view in room 10, Resident 24 in bed. Resident 24 grimaced					
	and stated, "Everythi	ng [is] dirty the walls are ising his chin to the hole in					
	indicated Resident 24 which indicated the re	memory and ability to make					
	Resident 10 was awa perpendicular to the rested on the east wa and used his left inde	a.m., during an observation, ake and laid on his back bed. Resident 10's head all. Resident 10 reach over ex finger to pick at the lastered wall. Plastered dust Resident 10's bed.					
	indicated Resident 10 which indicated the re	memory and ability to make					
	Life- Homelike Environments indicated, "Residents clean, comfortable, a	procedure titled, "Quality of onment" dated 5/17, s are provided with a safe, and homelike environment					

PRINTED: 04/05/2019 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		555892	B. WING _			l	C 18/2018
NAME OF PROVIDER OR SUPPLIER					TREET ADDRESS, CITY, STATE, ZIP CODE	<u> 09/</u>	10/2010
SELMA CONVALESCENT HOSPITAL					108 STILLMAN SELMA, CA 93662		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 943 F 943 SS=D	In addition to the free and exploitation requifacilities must also prothat at a minimum edical state of that at a minimum edical state of the tast at a minimum edical state of tast a	exploitation Training (3) glect, and exploitation. dom from abuse, neglect, rements in § 483.12, ovide training to their staff ucates staff on- es that constitute abuse, and misappropriation of set forth at § 483.12. ures for reporting incidents cloitation, or the esident property tia management and intion. is not met as evidenced and record review, the facility effective abuse training ght employees (Licensed Nursing Assistant 3)when s not tracked and implete the required training and report abuse to meet lents. sidents at risk for abuse,		943	F 943 1. The Director of Staff Development provided in service training for Abuse a Dementia Care to LN 2 on 8/25/18 and CNA 3 is no longer employed at Facility 2. All Residents of the facility have th potential to be affected, however no residents have been noted to be affected. 3. DSD has completed an audit of all	and /. e ed.	9/28/18
	Findings:	m during a consumant			employee training records on 8/13/18 a there were no additional findings.		
	interview and record in Development (DSD) s	m., during a concurrent review, the Director of Staff stated Abuse and Dementia Nurse (LN) 2, hired on			DSD will maintain a training log that is reviewed and updated monthly to track required employee trainings and sched		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		555892	B. WING			C	
NAME OF D	DOVIDED OD GUDDUED	333632	B. WING_	CTDEET ADDRESS CITY STATE 71D CO		09/18/2018	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE		
SELMA CO	ONVALESCENT HOSPITA	AL		2108 STILLMAN			
				SELMA, CA 93662			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	(X5) COMPLETION DATE		
F 943	Continued From page 97		F 94	43			
	records indicated LN	Review of personnel training 2 last completed abuse and 5/29/13		the required in services acco	ordingly.		
	interview and record of Abuse training for Ce (CNA) 3, hired on of personnel training completed abuse and 1/3/17. On 7/31/18 at 8:01 a. DSD stated she was orientation and all instending the facility. The DSD her audit of employees employees required a stated a log of completin-services for each in kept. The DSD stated track and make up indirector of Nurses (Daware of the expired Abuse, Dementia and were required at minimustated most competer hire during staff orientraining and competer address the needs of The DON stated emp	m., during a concurrent review, the DSD stated rtified Nursing Assistant was expired. Review records indicated CNA 3 last I dementia training on m., during an interview, the responsible for the new hire service training required by stated she did not complete charts to identify which additional training. The DSD reted competencies and adividual employee was not I she relied on employees to reservices when missed. Infection Control training mum annually. The DON stated I Infection Control training mum annually. The DON recies should be done upon tation. The DON stated their resident population. loyee's skill set helped resignments and provide		4. The Director of Staff Depresent the training records meeting monthly to ensure a are trained until the QAPI codetermines that further revienecessary. 5. 8/26/18	to QAPI III employees mmittee		
	Participation: Facility	titled, "Requirements of Assessment" indicated, es Topic Abuse All staff					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		555892	B. WING			C 09/18/2018	
NAME OF PROVIDER OR SUPPLIER SELMA CONVALESCENT HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 2108 STILLMAN SELMA, CA 93662	I	03/10/2010	
(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 CORREC ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)		(X5) COMPLETION DATE	
F 943	upon hire, annually, I The facility's policy a Development Progra	oi-annually at a minimum." nd procedure titled, "Staff m" dated 12/09, indicated, in-service training classes	F 94	13			