STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A205	A. BUILDING _____ B. WING _____	07/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SELMA CONVALESCENT HOSPITAL	2108 STILLMAN SELMA, CA 93662

POC ACCEPTABLE YES NO
Reviewed By: V. Trautman HFES
Facility Notified
Name: Carolyn Norcross, Adm
Date: 7/26/12
Time: 0840
Notified By: V. Trautman HFES
Name

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS AMENDED 7/17/12 TO REFLECT CHANGE WITH THE CAPACITY TO 34 AND THE CENSUS TO 32 The following reflects the findings of the California Department of Public Health-Licensing and Certification during a RECERTIFICATION survey. Representing the California Department of Public Health: Sullivan Morris HFEN, Linda Friesen HFEN, and Irene Thibault HFEN. Capacity: 34 Census: 32 Sample: 10 Entity Report Incident (ERI) Regulatory Groupings investigated for the following ERI's during the Recertification survey: CA00309418: Substantiated, no regulatory violation. CA00311970: Substantiated, no regulatory violation. CA00313149: Substantiated, no regulatory violation. CA00313597: Substantiated, no regulatory violation. CA00314644: Substantiated, no regulatory violation.	F 000	Amended CN THIS PLAN OF CORRECTION CONSTTUTES OUR WRITTEN CREDIBLE ALLEGATION OF COMPLIANCE FOR DEFICIENCES NOTED The preparation and execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth and facts alleged and conclusions set forth in the Statement of Deficiencies. This Plan is prepared and executed solely because it is required by the provisions of Federal and State Law.	
F 164 SS=F	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.	F 164	F 164 483.10(e), 483.75(i)(4) **Personal Privacy/Confidentiality Records** 1. Resident records were removed from the unlocked shed by facility staff under supervision of administrator on July 5, 2012. The medical records staff cataloged each record on July 5 & July 6, 2012. Records which were able to be destroyed were then secured in a locked U-Haul truck until Monday July 9	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Carolyn Norcross — TITLE: Administrator — (X6) DATE: 7-26-12

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.

JUL 30 2012
DEPT OF PUBLIC HEALTH
LICENSING & CERTIFICATION - FRESNO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A205	A. BUILDING _____ B. WING _____	07/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SELMA CONVALESCENT HOSPITAL	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 164	Continued From page 1 Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and administrative document review the facility failed to ensure confidentiality of residents personal and clinical records when 99 boxes of personal information which included clinical records with private medical information were stored in an unsecured storage building. This failure exposed residents to a potential breach of health information and identity theft.	F 164	when they were shredded by a certified records shredding company. Resident records are currently stored in the nurse station, the medical records office and in the basement records storage room. 2. The administrator checked all other basement and storage closets on July 5, 2012 to identify if medical records were stored in any unlocked areas. None were found. Had any been found they would have been moved to the secure location, cataloged for possible shredding and labeled for easy retrieval if too soon to shred. 3. The secure locations identified for record storage in the facility are the nurse station, the medical record office, and the basement medical records storage room. The Medical Records consultant is scheduled to provide in-service training for facility staff on 08/02/2012 on the medical	

RECEIVED
JUL 30 2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A205	A. BUILDING _____ B. WING _____	07/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SELMA CONVALESCENT HOSPITAL	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 164	Continued From page 2 Findings: On 7/5/12 at 11 a.m., during the environmental observation 99 boxes of resident clinical records and personal information were observed strewn about in an unorganized manner and in an unsecured storage building behind the facility by an alleyway. On 7/5/12 at 2:45 p.m., during an interview the administrator confirmed the 99 boxes stored in the outside storage building contained resident clinical records and personal information. The administrator stated the records were not secure and they should be secured at all times. The administrator confirmed there were resident clinical records from 2003 contained in some of the boxes. The administrator stated, "I am appalled at the water or termite damage to the residents medical records." The Administrator stated, "This is a "complete mess." The undated facility policy and procedure titled, "Retention & Storage of Discharged Records" indicated, "Policy: "Records of discharged residents will be... stored in an organized manner for ease of retrieval by appropriate individuals and agencies. Confidentiality of resident information will be protected." "PROCEDURE... 2. Keep areas that contain the discharge record files locked at all times to ensure that information contained in the resident's record is kept confidential."	F 164	records storage policy. 4. Our monitoring process will be monthly that the MRD will review the areas where boxes are stored to verify that medical records are stored only in secured location at facility. If any medical records would be found outside the secured identified areas the administrator would be immediately notified and the records moved immediately to secured area. The MRD will report to the Quality Assessment and Assurance Committee on monthly basis for 3 months then quarterly for one year on the security of medical records storage for review and recommendations. 5. Completion date:	08-06-12
F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT	F 252	F 252 483.15(h)(1) **Safe/Clean Homelike Environment** 1. The hallway floor tiles are now being worked on by both the maintenance man	

RECEIVED
JUL 30 2012
DEPT. OF HEALTH SERVICES
LICENSING & CERTIFICATION PROGRAMS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A205	A. BUILDING _____ B. WING _____	07/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SELMA CONVALESCENT HOSPITAL	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 252	Continued From page 3 The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure cracked and chipped floor tiles were replaced. This failure contributed to a potentially unsafe environment for all residents residing in the facility. Findings: On 7/2/12 at 9:30 a.m., during an environmental tour of the facility, cracked, chipped and broken floor tiles were noted throughout the halls and 14 of 20 residents rooms. On 7/5/12 at 10 a.m., during a concurrent observation and interview the Maintenance Supervisor (MS) stated, "I've worked on the tiles about 3 hours a day for two months. I don't have enough time to do it. It takes too long. I have to do one half of the hall at a time, then the other half. They should hire someone to do this all at once." On 7/5/12 at 11 a.m., the Administrator (Adm) stated, "Since I have been spending more time at this facility, I keep the MS busy. He has had to redo some of the work he did on the tiles due to unlevel flooring underneath and it's a slow process." On 7/5/12 at 1:30 p.m., the Adm stated she was	F 252	and a helper. This 2 person process began on Monday July 16, 2012. 2. The administrator walked through the resident rooms on July 17, 2012 with the DON to assess which resident rooms had cracked tiles. List of those rooms placed on schedule for after hallways complete. 3. The Maintenance man and the helper will work on the floor tile project steadily until the hallway floors are complete. Then the room schedule for tile repair will be done at a rate of two per week until the 14 rooms are complete. 4. Monthly rounds by the maintenance man will be done to inspect the tile in the rooms and hallways. Report of the rounds will be used to schedule any future tile repairs and a copy will be submitted to the administrator. Reports of the floor tile inspection from the monthly maintenance rounds report	

RECEIVED
JUL 30 2012
DEPT. OF HEALTH SERVICES
LICENSING & CERTIFICATION - FRESNO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A205	A. BUILDING _____ B. WING _____	07/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SELMA CONVALESCENT HOSPITAL	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 252	Continued From page 4 aware the broken tiles had been present for the last year and had not yet been repaired.	F 252	will be presented to the Quality Assessment and Assurance committee on a quarterly basis by the administrator for review and recommendations. 5. Completion date:	08-06-12
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on staff interview, and clinical record review, the facility failed to conduct a comprehensive assessment for 1 of 10 sampled residents (Resident 6), when the quarterly Minimum Data Set (MDS) assessment contained information a decline in more than two areas of health had occurred. This failure placed Resident 6 at risk for health care based on an inaccurate assessment. Findings: On 7/3/12 at 2:25 p.m., a comparative review of Resident 6's quarterly MDS assessments dated 12/16/11 and 3/14/12 was done. The data that	F 274	F 274 483.20(b)(2)(ii) **Comprehensive Assessment after Significant Change** 1. The change of condition MDS assessment for resident #6 was scheduled by the DON on 07/03/12. And was completed and submitted on 7-18-12. 2. Since July 2, 2012 The DON is reviewing the MDS assessments for the current facility residents one by one to identify any other residents with declines/improvement so that change of condition MDS assessments could be completed for them. She is anticipating being complete with the identification	

RECEIVED
JUL 30 2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A205	A. BUILDING _____ B. WING _____	07/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SELMA CONVALESCENT HOSPITAL	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 274	Continued From page 5 demonstrated Resident 6's decline was: MDS Items 12/16/11 3/14/12 Result Cognitive 13/15* 7/15* decline Mood 0/27* 7/27* decline Dressing 1/1* 3/2* decline *13/15 = thirteen cognitive indicator points out of a possible 15 points. *7/15 = seven cognitive indicator points out of a possible 15 points. *0/27 = no mood indicator points out of a possible 27 points. *7/27 = seven mood indicator points out of a possible 27 points. *1/1 = supervision-oversight, encouragement or cueing *3/2 = extensive assist- resident involved in activity, staff provide weight-bearing support. On 7/3/12 at 2:25 p.m., during an interview, the MDS Coordinator stated she should have done a significant change comprehensive assessment on 3/14/12, instead of a quarterly assessment. The MDS Coordinator confirmed these had been areas of significant decline for Resident 6 prior to the quarterly MDS done on 3/14/12.	F 274	process by 8-6-2012. Her process is to immediately open a full assessment for any which were found. 3. Starting on July 2, 2012 The DON will refer to the prior MDS during the process of completion of the next scheduled MDS. Declines noted will then be addressed by completing the change of condition MDS instead of a quarterly MDS. The Medical Records Consultant will provide in-service training on the MDS change of condition for licensed staff and the MRD on August 2, 2012. 4. The monitoring process will be that the Medical Records Consultant will review completed MDS during his monthly consultation visit to further note any MDS with decline/improvement which should be completed as full or change of condition MDS assessment. Report of his visit findings will be submitted in his visit report to DON,MRD & ADM. If	
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		

RECEIVED
JUL 30 2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A205	A. BUILDING _____ B. WING _____	07/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SELMA CONVALESCENT HOSPITAL	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview, the facility failed to protect residents from potential harm when unprotected steam type heating radiators in 17 of 20 resident rooms and in common areas were used for the heat source were accessible to the residents with a potential for serious harm to the residents. Findings: On 7/2/12 at 9:30 a.m., during a facility tour, it was observed in 17 of 20 resident rooms and in common areas, unprotected steam type of radiators which could be used to heat the building. There was no shield to cover the radiators which did not afford protection from the heat source. On 7/5/12 at 10:30 a.m., during an interview, the Maintenance Supervisor (MS) stated "we use them (radiators) in the winter to heat." The MS stated the radiators were controlled by a thermostat downstairs. The MS stated, "...I set the heat to 120° F (Fahrenheit) in the winter. It can go as high at 240° F if someone accidentally turned the controls to that."	F 323	any were found to be needing the change of condition MDS they would be scheduled by the DON for that MDS within 24 hours of identification. A report on the status of review of past MDS for decline and thus needing a full or change of condition MDS will be provided to the Quality Assessment and Assurance committee on a monthly basis by DON for review and recommendations for 3 months then quarterly for one year. 5. Completion date:	08/06/2012
F 458 SS=D	483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms.	F 458	F 323 483.25(h) **Free Of Accident Hazards** 1. The steam radiator system is turned off. It has been off since Jan 16, 2012. 2. The facility staff will continue to be using the portable electric heaters for warming resident areas, thus	

RECEIVED
JUL 30 2012
DEPT OF HEALTH SERVICES
LICENSING & CERTIFICATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A205	A. BUILDING _____ B. WING _____	07/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SELMA CONVALESCENT HOSPITAL	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 458	Continued From page 7 This REQUIREMENT is not met as evidenced by: WAIVER- Based on observation during the survey period July 2, 2012, to July 7, 2012, the facility failed to provide and maintain minimum square footage for each resident in 17 of 20 rooms. Findings: On July 5, 2012 during the environmental tour, the following rooms failed to provide the minimum square footage as required by regulation. However, variations were in accordance with the particular needs of the residents for all rooms. The residents had a reasonable amount of privacy. Bedside stands were available. There was sufficient room for nursing care and for resident ambulation in 17 of 20 rooms that did not meet the square footage requirement. Wheelchairs and toilet facilities were accessible. The waiver did not adversely affect the health and safety of residents in 17 of 20 resident rooms. Rm# SQ. FT. Number of Residents 1 118.61 2 2 118.61 2 3 119.58 2 4 119.58 2 5 96.88 1 6 176.47 3 7 96. 88 1 8 117.63 2 9 119.58 2 10 120.43 2 11 118.61 2 12 120.43 2 14 112.77 2	F 458	the steam system will not be used. 3. The facility has requested plumbing/AC companies to submit bids to alter the heating system to eliminate the steam heat. One local vendor viewed the system on July 11, 2012 and the other two will do the same and submit bids before 8-6-2012. 4. The monitoring of the process will be administrator reviewing the status reports of bids provided by the outside vendors to the maintenance man on weekly basis. The maintenance man will submit status reports and bids to the Quality Assessment and Assurance committee regarding conversion of the heating system to eliminate a steam system for review and recommendations on a monthly basis until conversion complete. 5. Completion date:	08-06-2012

RECEIVED
JUL 30 2012
DEPT OF HEALTH SERVICES
LICENSING & CERTIFICATION - FRESNO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A205	A. BUILDING _____ B. WING _____	07/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SELMA CONVALESCENT HOSPITAL	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 458	Continued From page 8 16 119.58 2 18 129.30 2 19 96.88 1 20 96.88 1 Recommend waiver continue in effect for 17 rooms. Jay Carrington HFES 7/12/12 Health Facilities Evaluator Nurse Date Request waiver continue in effect. Carolyn Norcross 7-26-12 Facility Administrator Date	F 458	F 458 483.70(d)(1)(ii) **Bedrooms measure at Least 80 SQ FT/Resident** 1. The residents in smaller rooms have not voiced any concern over room size. 2. The SSD and the nursing LVN and C.N.A. are attentive to resident concerns over room size and if voiced SSD would attempt a room change as soon as possible. 3. The DSD will present an in-service to the facility staff on 08-01-2012 regarding communication of room size concerns to SSD for room changes. 4. The SSD will report on monthly basis to the Quality Assessment and Assurance Committee on any resident concerns over room size for review and recommendations. 5. Completion Date	08-06-2012
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide a safe and functional environment when a storage building was in disrepair and multiple boxes and various equipment were stored in an unsafe manner. These failures placed staff at risk of injury and potential health related dangers.	F 465		

RECEIVED
JUL 30 2012
DEPT. OF HEALTH SERVICES
LICENSING & CERTIFICATION - FRESNO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A205	A. BUILDING _____ B. WING _____	07/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SELMA CONVALESCENT HOSPITAL	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 9	F 465		

Findings:

On 7/5/12 at 11 a.m., during the environmental observation a storage building, the size of a five car garage located in back of the facility by an alleyway, was observed to contain hundreds of boxes of paper documents. These boxes were strewn about the floor and many contained water damage. Also observed were gardening equipment which included a garden rake, laying on the floor, with 16 sharp metal tines. The tines were pointed upward and presented a safety hazard if stepped on. Also contained in the building were two lawn mowers and a one gallon gas container that contained one quarter of a gallon of gasoline. Multiple mattresses and other miscellaneous bed and wheelchair items were also stored.

On 7/5/12 at 11 a.m., during the environmental observation when an attempt was made to enter the building the Administrator stated, "Don't go in there it's dangerous."

On 7/5/12 at 1:10 p.m., during an observation the Administrator had purchased gloves and instructed Staff Member 1, Staff Member 2, and the Maintenance Supervisor to put on gloves and to tape their pant legs closed prior to entering the storage building to protect from insect or spider bites.

F 465
483.70(h)
Safe/Functional/Sanitary/Comfortable Environment

1. The shed has been partially emptied on July 5, 2012 and a lock and hasp have been installed on July 5, 2012 to secure the door. The lock on the 1st gate was secured and a key provided to administrator on July 5, 2012 and the hinges on the 2nd gate have been repaired by the maintenance man on July 6, 2012 to provide security. Medical records will not be stored in the shed.
2. The items to be discarded will be arranged to be hauled away after the pest control service treatment. The shed will have stored items organized and will have pallets to keep some items off the floor. The pest control company was called on July 25, 2012 to confirm

RECEIVED
JUL 30 2012
DEPT. OF HEALTH SERVICES
LICENSING & CERTIFICATION - FRESNO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A205	A. BUILDING _____ B. WING _____	07/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SELMA CONVALESCENT HOSPITAL	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 9 Findings: On 7/5/12 at 11 a.m., during the environmental observation a storage building, the size of a five car garage located in back of the facility by an alleyway, was observed to contain hundreds of boxes of paper documents. These boxes were strewn about the floor and many contained water damage. Also observed were gardening equipment which included a garden rake, laying on the floor, with 16 sharp metal tines. The tines were pointed upward and presented a safety hazard if stepped on. Also contained in the building were two lawn mowers and a one gallon gas container that contained one quarter of a gallon of gasoline. Multiple mattresses and other miscellaneous bed and wheelchair items were also stored. On 7/5/12 at 11 a.m., during the environmental observation when an attempt was made to enter the building the Administrator stated, "Don't go in there it's dangerous." On 7/5/12 at 1:10 p.m., during an observation the Administrator had purchased gloves and instructed Staff Member 1, Staff Member 2, and the Maintenance Supervisor to put on gloves and to tape their pant legs closed prior to entering the storage building to protect from insect or spider bites.	F 465	service of the shed will be completed by July 27, 2012. 3. The DSD will provide an in-service for facility staff on 08-02-2012 regarding safety in the work place. 4. The monitoring process will be that the administrator will inspect the shed on a monthly basis to review storage. The administrator will report to the Quality Assessment and Assurance Committee on the results of the shed inspection monthly for review and recommendations. 5. Completion date	08-06-2012

RECEIVED
JUL 30 2012
DEPARTMENT OF HEALTH SERVICES