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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055475	A. BUILDING _____ B. WING _____	07/17/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health- Licensing and Certification during a RECERTIFICATION survey. Representing the California Department of Public Health- Licensing and Certification: Debbie Nolan, RN, HFEN; Luz Jamero RN, HFEN; Irene Thiabault RN, HFEN. Capacity: 99 Census: 84 Sample: 17 Random Residents: 3 Entity Reported Incident (ERI) Regulatory Groupings investigated for the following ERIs during the recertification survey: CA00303806: Substantiated, no regulatory violation CA00310271:Substantiated, no regulatory violation CA00311294: Substantiated, no regulatory violation CA00311289: Substantiated, no regulatory violation CA00311094: Substantiated, no regulatory violation CA00306625: Substantiated, no regulatory violation CA00306360: Substantiated, no regulatory violation CA00299568: Substantiated, no regulatory violation	F 000	POC ACCEPTABLE YES NO Reviewed By: [signature] HFEN Name Fax Original Facility Notified Name: Pam Powell DON Date: 8/13/12 Time: 11 am Notified By: [signature] HFEN Name	
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY	F 241		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mary E Baker — TITLE: Administrator — (X6) DATE: 8/9/12

RECEIVED
AUG 13 2012
DEPT OF HEALTH SERVICES
LICENSING & CERTIFICATION

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.

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F 241	Continued From page 1 The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, clinical record and administrative document review, the facility failed to ensure residents were treated with respect and dignity when: 1. Six of eight residents in group and 1 of 3 random residents (Resident 19) stated they were aggravated with recurrent screaming of residents at night. This failure had the potential to result in psychosocial distress. 2. Three of eight residents in group (Resident 6) and 1 of 3 random residents (Resident 19) were bothered with staff noise levels at night. This had the potential to result in mental and psychosocial distress. Findings: 1. On 7/9/12 at 3:00 p.m., during an interview, Resident 6 stated residents were screaming at night and it was hard for him to sleep. Stated he had told the staff about the screaming residents at night and the staff had told him that there was nothing they could do about it. The Comprehensive MDS dated 7/3/12 indicated Resident 6's cognitive level was 13 out of 15,	F 241	Will continue to try to place resident #9 in a facility more suitable for her diagnosis and behaviors. Resident #9 was sent to Saint Joseph's Behavioral Center on 7/19/12 for evaluation and medication review. Resident returned to Elness on 7/30/12 with new medication changes. Resident #9's behaviors have improved since recent medication changes and resident has not been screaming out. MD will continue to monitor closely resident #9 behaviors and mood and will provide recommendations and medication changes as needed.	7/30/12 & ongoing

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F 241	Continued From page 2 (with 15 indicating no cognitive loss). On 7/10/12 at 9:30 a.m., during group interview, a resident stated, "[We] have people who scream. We don't sleep at night. [We] were told they have their rights, what about us?..." Another resident stated, "[I] have told them [referring to facility staff]..." and said there was no response from the staff. The same resident shrugged his shoulder during the conversation. On 7/12/12 at 8:30 a.m. during an interview, Resident 12 stated there were residents who screamed at night "[And it] Happens almost every night... [I] can't sleep...[I] wake up tired... [the] other night, I just wanted to sleep... screaming from [resident's name]... I needed medication to calm my nerves... I felt awful..." Resident 12 rubbed her temple while recounting the incident and frowned. Resident 12 continued, "[resident's name] starts to yell, the other resident [another resident's name] starts to yell...sometimes it lasts all night long, even goes all day long [the] next day... [I] told everybody (nurses, CNAs - Certified Nurse Assistants, the DON - Director of Nurses, SSD - Social Service Director)... they say the same thing over and over...'It's their right'... I think to myself, what about me? It's my right to sleep at night too." A review of Resident 12's clinical record revealed that she took Ativan (an anti-anxiety medication) on a prn (as needed) basis every six hours. Her Medication Administration Record (MAR) for July 2012 contained documentation that she took doses on 7/4/12, 7/9/12 and 7/11/12 - in the a.m.).	F 241	Resident #12 used Ativan on 7/4, 7/12, 7/9, 7/11 and 7/12 prior to her dialysis appointment for feelings of nervousness. This resident uses this medication before all dialysis appointments. Resident has not voiced any complaints about the noise level in the facility making her nervous and is sleeping well at night. Nursing staff will be given in-servicing on how to communicate with schizophrenic and dementia residents, in-service will include new approaches and communication skills for staff as well as resident dignity and respect. In-service will be given on 8/9 and 8/14/12 with a make up in-service on 8/16/12. Also an in-service will be given by the Social Services Director on Behaviors and Communication to staff on 8/23 and 8/24.	7/20/12 & ongoing 8/24/12 & ongoing

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F 241	Continued From page 3 On 7/12/12 at 10:50 a.m., during an interview, Resident 13 stated there were residents who screamed at night. Resident 13 stated "...It bothers me. They [referring to the facility staff] won't do anything about it." Both residents identified as the ones who yelled at night were located at Station 2. Residents 11, 12 and 13 were all located at Station 3. On 7/16/12 at 12:40 p.m., during an interview, Resident 19, stated it "bothers" him when the residents yelled and screamed, especially during the night hours. Stated he told the nurses and they said they could not do anything about it. Resident 19 stated it made him feel angry and the screaming at night kept him from sleeping. On 7/16/12 at 1:08 p.m., during an interview, the DON stated that the facility was aware of the resident's screaming episodes that the other residents were complaining about. The DON stated that the facility had attempted "many approaches" to improve the resident's behavior which included adjustments to the medications, involvement of the Medical Director, transferred to a different facility (but resident had to return to this county), room transfer, and keeping resident up and active during the day. There was no documented evidence that facility staff explained to the concerned residents that certain measures were being taken by the facility to address this issue. On 7/16/12 at 1:40 p.m., during an interview, Licensed Nurse (LN) 1, a regular night shift nurse, stated, "[Resident 9] yells out at night.	F 241	DON will talk with residents daily regarding noise level from staff on evening and night shift. DON will follow up on complaints received from residents directly or from resident council meetings and report to QA committee for review weekly. Nursing staff will be in-serviced on noise level in the facility at night on 8/2, 8/9 and 8/14/12. Make up inservice will be given on 8/16/12. In-service will be given by DON/DSD. Staff will be educated on how noise levels affect the resident's psychosocial and mental well-being. Charge Nurse at each nurses station will be responsible to keep staff noise level down on pm and night shifts. Staff who continue to be loud during shift will be written up by the charge nurse, DON will review write up and will determine discipline for employee.	8/9/12 & ongoing 8/16/12 & ongoing 8/9/12 & ongoing

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F 241	Continued From page 4 [Her yelling] causes the resident next room to yell out... Alert residents complain... [We] talk to her, at times it calms her down... [Resident 9] at times yell out all night..." The facility's admission packet indicated, "ATTACHMENT F. RESIDENT BILL OF RIGHTS... California Code of Regulations Title 22. Section 72527. Skilled Nursing Facilities. (a) Patients have the rights enumerated in this section and the facility shall ensure that these rights are not violated... Patients shall have the right...(12) To be treated with consideration, respect and full recognition of dignity and individuality..." 2. On 7/9/12 at 3:00 p.m., during a resident interview, Resident 6 stated the night shift staff were noisy and he was unable to sleep. On 7/10/12 at 9:30 a.m., during a group interview, a resident stated "Night staff are loosely run... [they are] not disciplined... keeps on giggling... noisy... I find it disrespectful..." Two other residents in group concurred with this statement. On 7/16/12 at 12:40 p.m., during an interview, Resident 19 stated the night shift were noisy at night, especially around 11:00 p.m. Resident 19 stated the noise "disturbs" him. On 7/16/12 at 1:08 p.m., the DON stated during an interview that she was aware of the staff noise levels on the night shift. She stated that she had an in-service with the night shift to keep their voices down.	F 241	DON will talk with residents daily regarding noise level in the facility on pm and night shift, DON will follow up on resident complaints and will report to QA committee for review weekly.	8/9/12 ongoing
F 248	483.15(f)(1) ACTIVITIES MEET	F 248		

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F 248 SS=E	Continued From page 5 INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, clinical record and administrative document review, the facility failed to provide an ongoing program of activities designed to meet the interests and the mental and psychosocial well being of residents when: 1. Four of eight residents in group (Residents 11, 12, 13, and 14) stated activities were not appropriate to their cognitive level. 2. Five of eight residents in a group interview (Residents 1, 3) and 1 of 3 random residents (Resident 19) stated planned outings had been cancelled and not rescheduled. 3. Three of eight residents in group and 2 of 17 sampled residents (Residents 12 and 13) stated there was a lack of variety of activities provided. These failures had the potential to affect the psychosocial well being of the residents by failing to enhance and promote the residents' highest practicable level of cognitive and mental health. Findings:	F 248	Meeting held with Resident Council on 8/03/12. Activity Director and Activity Assistant were present. Residents were given an opportunity to express what type of activities they would like to add to current program. Residents # 4, 6, 9, 11, 12, 14, 18 were present at meeting. Activities these residents would be interested in are; Diner's Club once a month and residents will choose the theme for the evening and menu. More trips away from the facility such as a country drive, picnic at the park, movies and restaurants. Resident's #13 & 19 were interviewed on 8/3/12 individually because they were unable to attend Resident Council. The minutes from Resident Council were discussed and an opportunity was given for suggestions of activities they would like to add or change on the August Calendar. Two activities were suggested; Gin Rummy and Uno. Activity Director implemented the changes to August Activity Calendar. Resident #1 is non-verbal with ST and LT memory loss due to dx of Lewy Body Dementia and Dementia with Agitation.	8/3/12 8/3/12 & Ongoing 8/3/12 & Ongoing

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F 248	Continued From page 6 1. On 7/10/12 at 9:30 a.m., during group interview, 4 out of 8 residents concurred activities were "childish games." One resident stated, "[I'm] tired of the crap being offered" and felt they were "demeaning." On 7/12/12 at 8:30 a.m., during concurrent observation and interview, Resident 12 rolled her eyes and frowned when questioned about activities. Resident 12 said activities included working on puzzles of numbers 1-10, or passing a ball around a group of residents. Resident 12 stated "we're not kids... I feel offended... The Activity person [referring to AA 2] and [AD's name] treats us like kids... [AD's name] has a child and feels we need to be treated that way... [AD's name] picks things she wants and does not ask us what we want..."	F 248	An interview could not be obtained. Resident # 3 has ST and LT memory loss and Increased confusion due to dx of Dementia and Altered level of Consciousness. An interview could not be obtained. The Administrator will monitor the monthly Activity calendar and will be made aware of any changes that occurred. If the Activity Department has any more concerns about it's programming, the concerns will be brought to the Quality Assurance Committee for recommendations.	8/3/12 & ongoing 8/3/12 & ongoing
	Review of the Comprehensive MDS Assessment (Minimum Data Set - a resident assessment tool) dated 4/13/12 indicated Resident 12 had a cognitive score of 15/15, with 15 indicating no cognitive deficits. The Activity Care Planning Considerations dated 4/9/12 by the AD indicated Resident 12 needed "Promotion/ maintenance of cognitive functioning.." The Patient Care Plan dated 4/10/12 indicated Resident 12 "...needs mentally stimulating recreational and social act's [activities]..." On 7/12/12 at 10:00 a.m., during an interview, Resident 11 stated the activities they had there were for little children. Resident 11 she had owned a restaurant and had been a truck driver		An outing was scheduled for Tuesday June 19th 2012, but was cancelled due to the unavailablility of the bus driver. The maintenance supervisor who is our bus driver was on vacation from 6/15/12-7/2/12. An outing was rescheduled for 7/17/12 to the Stanislaus County Fair. In future outings that have been cancelled because of transportation issues will be rescheduled within 2 weeks.	8/3/12 & ongoing

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F 248	Continued From page 7 and did not like the "childish things they have here." On 7/12/12 at 10:50 a.m., during an interview, Resident 13 stated some activities were "childish...I don't need that..." Review of the Comprehensive MDS Assessment (Minimum Data Set - a resident assessment tool) dated 4/19/12 indicated Resident 12 had a cognitive score of 15/15, with 15 indicating no cognitive deficits. On 7/12/12 at 1:15 p.m.,. during an interview, Resident 14 stated he was going to participate in an activity after the interview called "Penny Ante", described it as a "childish" game but it was something to do during the day. Resident 14 stated many of the games offered at activities were "childish." On 7/12/12 at 10:00 a.m., during an interview, the Activity Director (AD) reviewed the July 2012 activity calender and verified there were very few activities that would appeal to an individual who was alert an oriented. On 7/16/12 at 3:55 p.m., during an interview, the Activities Assistant stated many of the activities were childish and were not appropriate for the group of residents in the facility who were alert and oriented. The AA stated it was hard to accommodate the large group of alert and oriented residents into activities. The AA stated it was a "work in progress." The AA stated the alert residents had been complaining that some of the less alert residents "take away from their time in activities."	F 248	Activities were reviewed at Resident Council meeting on 8/03/12. Residents would like Crossword every other Saturday. Residents would like a social hour added to activity calendar 2 saturdays a month. Activity Director will implement new changes on current August calendar. Residents will review monthly calendars each month at Resident Council with Activity Director and evaluate activity programing for every requested change. Administrator will also monitor activities that are offered on the weekend.	8/3/12 & ongoing 8/3/12 & ongoing

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F 248	Continued From page 8 The facility policy and procedure for activities titled "Daily Programming" indicated,..." Policy:...Provide meaningful activities appropriate to the Resident's cognitive, physical, and social abilities on a regular basis, to enhance their quality of life." 2. On 7/10/12 at 9:30 a.m., during a group interview, 5 of 8 residents stated planned outings were cancelled. Three of the 8 stated these cancelled activities were "supposed to" be rescheduled but were not. On 7/12/12 at 8:30 a.m., Resident 12 stated "We're supposed to have it [referring to outings] monthly... last was 2-3 months ago at a buffet..." Resident 12 added, "Lately [it has] been cancelled." On 7/12/12 at 10:50 a.m., during an interview, Resident 13 stated, "... [the] last time we went out, about 2-3 months ago, we went to hometown buffet, that's it." On 7/12/12 at 10:00 a.m., during an interview the AD verified the planned outing for the residents was cancelled last month and it was not rescheduled. On 7/16/12 at 12:40 p.m., during an interview, Resident 18 verified the planned outing for last month had been cancelled and it was not rescheduled. 3. On 7/10/12 at 9:30 a.m., during a group interview, 3 of 8 residents stated there was no variety in activities offered and there were not	F 248		

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F 248	Continued From page 9 enough activities on weekends. One resident stated "Sunday... was the most boring [day with] absolutely nothing [to do]." On 7/12/12 at 8:30 a.m., during an interview, Resident 12 stated they had the "same activities over and over... [AD] picks things she wants and does not ask us what we want..." Resident 12 stated they only played bingo on Saturday afternoon and there was nothing else to do all day. On 7/12/12 at 10:00 a.m. during an interview, the AD verified the activities on the weekends were always the same activities with no variety from week to week. The AD stated she was aware of the residents' "boredom" on weekends but had made no changes. The facility policy and procedure for activities titled," Daily Programming", undated, indicated,..." Procedures:...The activity Supervisor/Staff will...Provide programs which promote cognitive, physical and emotional health" The facility activity calendar for June and July 2012 indicated the activities scheduled every Saturday were: " 9:30 Coffee, Coco, & Tea ; 10:00 Crosswords; 1:15 Dominos; 2:30 BINGO." The activities scheduled every Sunday during the months of June and July 2012 were religious services at 9:30 a.m. and 2:00 p.m., and an activity called "Remember When." An activity called "Fancy Nails" was scheduled every other Sunday at 2:30 p.m. The March 2012 through May 2012 activities calendar indicated that 11 out of 13 Saturdays had the same activities scheduled.	F 248		

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F 248	Continued From page 10 On 7/12/12 at 10:50 a.m., during an interview, Resident 13 stated there are no activities on weekends... there's nothing to do, we just sit there [referring to the day room] and watch people go by.	F 248		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and administrative document review, the facility failed to maintain housekeeping services necessary to sustain a sanitary environment when two soiled shower chairs were parked and co-mingled with other clean shower chairs in the hallway. This failure had the potential to expose residents, staff and the public to health hazards. Findings: On 7/10/12 at 11:20 a.m., during an observation, four shower chairs were parked in the hallway in front of the shower equipment room, adjacent to the resident dining room. Two of the four shower chairs had substances streaked along the seats. One shower chair had a brown substance and hair smeared around the seat. Another shower chair had a black line, about 1-2 centimeters (cm) in width around the ring of the seat. Several residents, staff and visitors had walked past the shower chairs.	F 253	All shower equipment has been inspected by the DSD on 7/30/12. Shower chairs will be kept in the clean equipment room on women's wing and men's wing. No shower chairs will be left in hallways by staff. C.N.A.'S will be inserviced on 8/9 and 8/14/12 by the DSD regarding proper cleaning, sanitation and storage of shower chairs in the facility. Shower chairs will be monitored for proper cleaning, sanitation and storage by the DSD daily. Any concerns re housekeeping and maintenance services will be brought to the QA committee meeting weekly.	7/30/12 7/30/12 + ongoing 8/14/12 + ongoing 7/30/12 + ongoing 8/3/12 + ongoing

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F 253	Continued From page 11 On 7/10/12 at 11:25 a.m., during a concurrent observation and interview, Certified Nurse Assistant (CNA) 1 stated the shower chairs were "usually" stored in the shower equipment room. CNA 1 stated CNAs had to clean the chairs after use. CNA 1 stated the brown substance on one shower chair was bowel movement (BM). CNA 1 was unable to identify what the black substance was on the other shower chair. The facility policy and procedure titled, "Cleaning Resident Rooms and Equipment" revised on 4/09 indicated, "...POLICY: Resident rooms and equipment shall be maintained in a clean and sanitary condition..."	F 253		
F 258 SS=E	483.15(h)(7) MAINTENANCE OF COMFORTABLE SOUND LEVELS The facility must provide for the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, the facility failed to maintain comfortable sound levels when: 1. Five of eight residents in group, (Residents 6, 12, 13) and 1 out of 3 random residents (Resident 19), stated they were disturbed by screaming residents at night. 2. Three out of eight residents during group, 1 out of 3 sampled resident (Resident 6) and 1 out of 3 random residents (Resident 19) were disturbed by staff noise levels at night.	F 258		

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F 258	Continued From page 12 This failure had the potential to affect the residents mental and psychosocial well being and comfort levels. Findings: 1. On 7/9/12 at 3:00 p.m., during the Resident Interview, Resident 6 stated residents are screaming at night and it was hard for him to sleep. Stated he had told the staff about the screaming residents at night and the staff had told him that there is nothing they can do about it. On 7/10/12 at 9:30 a.m., during group interview, a resident stated, "[We] have people who scream. We don't sleep at night. [We] were told they have their rights, what about us?..." Another resident stated, "[I] have told them [referring to facility staff]..." and said there was no response from the staff. The same resident shrugged his shoulder during the conversation. On 7/10/12 at 9:30 a.m., during group interview, a resident stated, "[We] have people who scream. We don't sleep at night. [We] were told they have their rights, what about us?..." Another resident stated, "[I] have told them [referring to facility staff]..." and said there was no response from the staff. The same resident shrugged his shoulder during the conversation. On 7/16/12 at 12:40 p.m., during an interview, Resident 19, stated it "bothers" him when the residents are yelling and screaming, especially during the night hours. Stated he told the nurses but they said they could not do anything about it. Resident 19 stated it makes him feel angry and	F 258	Will continue to try to place resident #9 in a facility more suitable for her diagnosis and behaviors. Resident #9 was sent to Saint Joseph's Behavioral Center on 7/19/12 for evaluation and medication review. Resident returned to Elness on 7/30/12 with new medication changes. Resident #9's behaviors have improved since recent medication changes and resident has not been screaming out. MD will continue to monitor closely resident #9 behaviors and mood and will provide recommendations and medication changes as needed.	7/30/12 & ongoing

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F 258	Continued From page 13 that the screaming at night keeps him from sleeping. On 7/16/12 at 1:00 p.m., during an interview, the DON (Director of Nursing) stated there is one particular resident who screams and yells loudly through out the day and night. The Don verified the facility had been unable to control the resident's behaviors. On 7/10/12 at 9:30 a.m., during group interview, a resident stated, "[We] have people who scream. We don't sleep at night. [We] were told they have their rights, what about us?..." Another resident stated, "[I] have told them [referring to facility staff]..." and said there was no response from the staff. The same resident shrugged his shoulder during the conversation. On 7/12/12 at 8:30 a.m. during an interview, Resident 12 stated there are residents who scream at night "[And it] Happens almost every night... [I] can't sleep...[I] wake up tired... [the] other night, I just wanted to sleep... screaming from [stated a resident's name from another hall]... I needed medication to calm my nerves... I felt awful..." Resident 12 rubbed her temple while recounting the incident and frowned. Resident 12 continued, [Resident 9's name] starts to yell, the other resident [stated another resident's name] starts to yell... sometimes it lasts all night long, even goes all day long [the] next day... [I] told everybody [nurses, CNA - Certified Nurse Assistants, the DON - Director of Nurses, stated SSD - Social Service Director's name)... they say the same thing over and over..."It's their right... I think to myself, what about me? It's my right to sleep at night too."	F 258	Resident #12 used Ativan on 7/4, 7/12, 7/9, 7/11 and 7/12 prior to her dialysis appointment for feelings of nervousness. This resident uses this medication before all dialysis appointments. Resident has not voiced any complaints about the noise level in the facility making her nervous and is sleeping well at night. Nursing staff will be given in-servicing on how to communicate with schizophrenic and dementia residents, in-service will include new approaches and communication skills for staff as well as resident dignity and respect. In-service will be given on 8/9 and 8/14/12 with a make up in-service on 8/16/12. Also an in-service will be given bv the Social Services Director on Behaviors and Communication to staff on 8/23 and 8/24.	8/9/12 & ongoing 8/16/12 & ongoing 8/24/12 & ongoing

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F 258	Continued From page 14 On 7/12/12 at 10:50 a.m., during an interview, Resident 13 stated there were residents who screamed at night. Resident 13 stated "...It bothers me. They [referring to the facility staff] won't do anything about it." Both residents identified to yell at night are at Station 2. Residents 11, 12 and 13 are all at Station 3. On 7/16/12 at 12:40 p.m., during an interview, Resident 19, stated it "bothers" him when the residents are yelling and screaming, especially during the night hours. Stated he told the nurses and they said they could not do anything about it. Resident 19 stated it makes him feel angry. Resident 19 stated the screaming at night keeps him from sleeping. On 7/16/12 at 1:00 p.m., during an interview, the DON (Director of Nursing) stated there is one particular resident who screams and yells loudly through out the day and night. The Don verified the facility had been unable to control the resident's behaviors. On 7/16/12 at 1:40 p.m., during an interview, Licensed Nurse (LN) 1, a regular night shift nurse, stated, "[Resident 9's name] yells out at night. [Her yelling] causes the resident next room to yell out... Alert residents complain... [We] talk to her, at times it calms her down... [Resident 9's name] at times yell out all night..." The facility's admission packet indicated, "ATTACHMENT F. RESIDENT BILL OF RIGHTS... Calofornia Code of regulations Title	F 258	DON will talk with residents daily regarding noise level from staff on evening and night shift. DON will follow up on complaints received from residents directly or from resident council meetings and report to QA committee for review weekly. Nursing staff will be in-serviced on noise level in the facility at night on 8/2, 8/9 and 8/14/12. Make up inservice will be given on 8/16/12. In-service will be given by DON/DSD. Staff will be educated on how noise levels affect the resident's psychosocial and mental well-being.	8/3/12 & ongoing 8/16/12 & ongoing

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F 258	Continued From page 15 22. Section 72527. SKilled Nursing Facilities. (a) Patients have the rights enumerated in this section and the facility shall ensure that these rights are not violated... Patients shall have the right...(12) To be treated with consideration, respect and full recognition of dignity and individuality..." 2. On 7/9/12 at 3:00 p.m., during a Resident Interview, Resident 6 stated the night shift staff were noisy and he was unable to sleep. On 7/10/12 at 9:30 a.m., during a group interview, 1 resident stated "Night staff are loosely run... [they are] not disciplined... keeps on giggling... noisy... I find it disrespectful..." Two other residents in group concurred with this statement.	F 258	Charge Nurse at each nurses station will be responsible to keep staff noise level down on pm and night shifts. Staff who continue to be loud during shift will be written up by the charge nurse, DON will review write up and will determine discipline for DON will talk with residents daily regarding noise level in the facility on pm and night shift, DON will follow up on resident complaints and will report to QA committee for review weekly.	8/1/12 T ongoing 8/3/12 T ongoing
F 314 SS=D	On 7/10/12 at 9:30 a.m., during a group interview, 1 resident stated "Night staff are loosely run... [they are] not disciplined... keeps on giggling... noisy... I find it disrespectful..." Two other residents in group concurred with this statement. On 7/16/12 at 12:40 p.m., during an interview, Resident 19 stated the night shift are noisy at night, especially around 11:00 p.m. Resident 19 stated the noise "disturbs" him. 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that	F 314		

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F 314	Continued From page 16 they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record and administrative document review, the facility failed to ensure 1 of 17 sampled residents (Resident 2) received appropriate interventions and treatment to an existing pressure ulcer as indicated in the resident's care plan and the facility's policy on Wound and Skin management. This failure had the potential to result in delayed wound healing and increased predisposition to infections. Findings: The facility Policy and Procedure (P&P) titled, "WOUND AND SKIN MANAGEMENT" reviewed 1/12 indicated, "...It is the policy of this facility that... Any resident who has pressure sores will receive the necessary treatment and services to promote healing, prevent infections, prevent new ulcers/ sores from developing... INTERVENTION... In the event of a Stage II lesion [an ulcer that presents as an abrasion, blister or a shallow crater], IDT (interdisciplinary team) and licensed nurse will implement the following... Request for high protein supplements if this has not already been done. Request order for multivitamins/ mineral supplement if deficiencies are suspected if this has not already been done..." The Weekly Skin Condition Progress Report	F 314	Resident #2 was started on Vitimin C 500mg and Zinc Sulfate 222mg for 30days on 7/11/2012. RD reviewed resident nutritional status on 7/11/12 and recommendations were carried out by staff on 7/11/12. Resident's with pressure ulcer Stage 2 or higher were reviewed by the DON on 8/2 and 8/3/12 to ensure request for high protein supplements and vitamin supplements had been ordered and given per policy and procedure. IDT will continue to review all resident's with pressure ulcers care plans at care plan meetings and make recommendations as needed and document in resident chart. RD will monitor weekly.	7/11/12 8/3/12 + ongoing 8/3/12 + ongoing

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F 314	Continued From page 17 dated 6/19/12 indicated Resident 2 had a Stage II pressure ulcer to the left (L) inner buttock and to the right buttock. Resident 2's care plan dated 6/10/12 indicated the need to "utilize protein supplement" as a care approach to the identified Stage II pressure ulcers. There was no documented evidence of a protein supplement in the resident's diet or to the medication regimen in both June and July 2012 physician's orders. There was no documented evidence that the Registered Dietician (RD) had evaluated the resident's nutritional status after identification of the Stage II pressure ulcers on 6/19/12. The comprehensive MDS (Minimum Data Set - a resident assessment tool) dated 6/29/12 indicated Resident 2 had an unhealed, worsening Stage PU pressure ulcer. Resident 2's Care Plan Conference Summary by the Interdisciplinary Team (IDT) dated 6/29/12 indicated the current diet and the identified Stage II pressure ulcer. There was no documented evidence the IDT evaluated or recommended fortification of the resident's diet as indicated in the facility P&P. There was no documented evidence the IDT evaluated the resident's need for any supplements for wound healing. On 7/11/12 at 11:45 a.m., during an interview, Licensed Nurse (LN) 2, a treatment nurse, stated the treatment protocol for Stage II pressure ulcers included adding multivitamins or minerals for wound healing, as well as fortification of the resident's diet. LN 2 was unable to comment on Resident 2's lack of interventions contrary to the	F 314	DON will review all residents with pressure ulcers Stage 2 and above weekly, review log will be kept in the DON office and monitored by the Administrator weekly. QA committee will review weekly skin sheet and DON weekly pressure ulcer log book. QA committee will evaluate effectiveness of plan monthly and make any new recommendations, new skin issues will be brought to the QA committee meetings.	8/3/12 ongoing 8/3/12 ongoing 8/3/12 ongoing

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F 314	Continued From page 18 resident's care plan and the facility's wound management P&P.	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, the facility failed to ensure that the resident environment was free of accident hazards when wheelchairs in use by 1 of 17 residents (Resident 14) and 2 of 3 random residents residents (Residents 18, 20) had torn arm rests and a torn head rest. This failure put the residents at risk for injuries. Findings: On 7/9/12 at 9:30 a.m., during an observation in the hallway of the facility, Resident 14 was sitting in a wheelchair that had torn areas on the bottom areas of the head rest and torn areas on the right arm rest, exposing the foam under the top layer of black vinyl. Resident 14 verified these areas were torn. Resident 14 was unable to say the length of time these areas had been torn. On 7/9/12 at 1:40 p.m., during an observation in the hallway of the facility, Resident 20 was sitting	F 323	All wheel chair armrests were repaired throughout facility on 7-31-2012 by the facility maintenance staff. Resident #14,18, and 20 armrests and head rest have been repaired and replaced. The facility will conduct monthly steam cleaning of wheel chairs and repairs will be made to damaged items as needed by the facility maintenance staff.	7/31/12 7/31/12 & ongoing

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F 323	Continued From page 19 in a wheelchair with torn areas on the left arm rest of the wheelchair. On 7/9/12 at 1:42 p.m., during an interview, LN5 verified Resident 20's wheelchair had torn areas on the left arm rest. LN5 stated it is the responsibility of the maintenance staff to repair torn areas on the wheelchairs. On 7/9/12 at 1:36 p.m., during an interview, the MA (Maintenance Assistant) verified that the maintenance department is responsible for repairing or replacing parts on the wheelchairs. MA stated the maintenace supervisor had ordered new wheelchair arm rests. On 7/16/12 at 1:45 p.m., during an interview, the DON (Director of Nursing) stated the facility staff should be monitoring the condition of resident equipment and reporting issues to the maintenance department. On 7/10/12 at 2:20 p.m., during an observation in the dayroom of the facility, Resident 18 was sittting in a wheelchair that had torn areas on the right and left arm rest. The left arm rest was partially wrapped with gray duct tape.	F 323	Staff will be in-serviced by the DSD to document torn or damaged equipment on the maintenance repair logs located at each nurses station. The repair log will be reviewed daily by the maintenance department and repairs will be completed in a timely manner. Items that pose a threat shall be tagged by staff and removed from the building to the maintenance department. The DON/DSD and Maintenance Supervisor will monitor weekly.	8/16/12 & ongoing 8/3/12 & ongoing
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		

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F 371	Continued From page 20 This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and administrative document review, the facility failed to label, date and time four ice cream cups stored in freezers. this failure had the potential to expose residents to potentially hazardous foods. Findings: On 7/9/12 at 10:15 a.m., during an observation in the kitchen on the initial tour, two 118 milliliter cups of ice cream were stored in the door of freezer number one that were not dated or labeled. In freezer number two, there were two 118 milliliter cups of ice cream that were not dated or labeled. On 7/9/12 at 10:20 a.m., during an interview, the Dietary Supervisor stated the ice cream cups in freezers one and two should have been labeled and dated. The facility policy and procedure titled "Food Storage" dated 2010, indicated in section 15, subsection g that " All foods should be covered, labeled and dated."	F 371	The dietary staff will no longer remove ice cream cups from original packaging boxes and place them in the stand up freezers without placing a date and time on them. To ensure that this practice is being followed the Dietary Supervisor will monitor the freezers on a weekly basis to ensure there are no ice cream cups inside without dates and times. This corrective action has been implemented as of July 30, 2012. Dietitian will monitor the dietary department on her bi-monthly visits to ensure policy and procedures are being followed. Any concerns about procedures not being followed will be brought to the attention of the QA team for review.	7/30/12 & ongoing 7/30/12 & ongoing
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission	F 441		

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F 441	Continued From page 21 of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and administrative document review, the facility failed to ensure infection control was maintained during	F 441	In-service by the DON/DSD will be given on 8/9 and 8/14/12 on maintaining infection control during medication pass, In-service will include eye drop administration to residents. Make up in-service will be given on 8/16/12. Eye drop medication pass was reviewed with LN 3 on 7/12/12 with the DON. Medication pass will be observed by the DON bi-monthly and prn to ensure LN are maintaining proper infection control standards during medication pass. Any concerns regarding infection control during medication pass will be brought to the QA committee meeting.	8/16/12 & ongoing 7/12/12 8/16/12 & ongoing 8/16/12 & ongoing

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F 441	Continued From page 22 medication pass when a Licensed Nurse (LN) touched the tip of the eye drop bottle prior to eye drop administration. This failure had the potential to expose the resident to health hazards. Findings: On 7/11/12 at 9:37 a.m., during medication pass observation, LN 3 donned non-sterile gloves, took the cover off the eye drop bottle, touched the cart, touched the tip of the eye drop bottle and proceeded to administer the eye drops to both eyes of a resident. On 7/11/12 at 9:42 a.m., during an interview, LN 3 touching the tip of the eye drop bottle would potentially lead to infection. LN 3 was unable to answer why she touched the tip of the eye drop bottle prior to medication administration. The undated facility Policy and Procedure titled, "EYE DROP ADMINISTRATION" indicated, "...Remove the cap, taking care to avoid touching the dropper tip..." Review of the article "How to Use Eye Drops Properly" by American Society of Health-System Pharmacists (ASHP) from www.safemedication.com indicated, "...Avoid touching the dropper tip against your eye or anything else - eyedrops and droppers must be kept clean..."	F 441		
F 458 SS=E	483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms.	F 458		

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	055475	A. BUILDING _____ B. WING _____	07/17/2012

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

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F 458	Continued From page 23	F 458		

This REQUIREMENT is not met as evidenced by:
*Waiver based on observation, resident, staff interview and administrative document review during the survey period 7/9/12 to 7/17/12, the facility failed to maintain rooms that measured at least 80 square feet per resident in 17 of 43 rooms. this placed residents and families at risk of not having enough usable space to meet their care needs, comfort and privacy needs.

Findings:

On 7/9/12 the facility's resident rooms were measured by the MS and and documented on the CDPH 709 form, measurements verified to be correct by MS. The following rooms did not provide the minimum square footage as required by the Federal regulations:

Rm#	SQ FT.	Number of residents
6	235.6	3
7	234.6	3
8	233.9	3
9	233.9	3
10	233.9	3
11	233.9	3
17	230	3
18	234.5	3
19	234.5	3
20	235.1	3
21	235.5	3
22	235.5	3
23	234.5	3
24	234.5	3

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F 458	Continued From page 24 25 234.5 3 26 232.8 3 27 227.8 3 On 7/12/12 at 9:30 a.m., during an observation in room 11,there was a Hoyer lift (patient care eqipment used to transfer individuals from surface to surface) between bed A and bed B. Bed B had been moved approximately 3 feet towards bed C to accomodate the Hoyer lift. Resident 14 was sitting in his wheelchair at the foot of bed A and a Certified Nurse Assistant (CNA 4) was overheard saying to Resident 14, "It's tight in here." On 7/12/12 at 9:32 a.m., during an interview CNA 4 stated space is "tight" and "not enough space" in the 3 bed rooms. CNA 4 stated she often has to move beds in the 3 bed rooms to accomodate resident's assisstive devices. CNA 4 stated, " We do what we can to accomodate." On 7/12/12 at 1:15 p.m., during the Resident Interview, Resident 14 stated it was difficult to move his wheelchair around in his room because there was not enough space. On 7/12/12 at 3:20 p.m., during an interview CNA 5 stated she moves beds often in the 3 bed rooms when using resident care equipment because of the limited space. CNA 5 stated that she has asked residents to leave the room to provide care to another resident in the room.	F 458		

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F 458	Continued From page 25 Do not recommend a waiver for the below minimum square footage rooms. 7/27/12 Health Facilities Evaluator Supervisor Date Request waiver continue in effect. Facility Administrator Date	F 458		
F 518 SS=D	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and administrative document review, the facility failed to insure that all employees were trained and knowlegeable in emergency procedures. This failure had the potential to put the residents and staff's safety in jeopardy. Findings:	F 518	Mandatory In-service on Disaster and Emergency Preparedness review will be given by DSD to all staff on 8/9 and 8/14/2012 and make up on 8/16/2012. A Disaster and Emergency Preparedness in-service will be given to all staff on 8/13 and 8/15/2012 by the DSD. Make up will be given 8/28 and 8/29/12.	8/16/12 + ongoing 8/29/12 + ongoing

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F 518	Continued From page 26 On 7/10/12 at 1:30 p.m., during an interview on Disaster and Emergency Preparedness, Certified Nursing Assistant (CNA 3) stated she did not know the location of the emergency shut-off valve. CNA 3 stated she has been working in the facility since October 2010. There was no documented evidence of CNA 3's attendance in the Attendance sign-in record for Mandatory In-services on Disaster Preparedness dated 3/15/12, 3/16/12, 3/26/12, 3/29/12, 4/5/12 and 4/6/12. The employee records indicate CNA 3 did not attend Emergency Preparedness training during her general orientation. On 7/11/12 at 5:30 p.m., during an interview on Disaster and Emergency Preparedness, Certified Nurse Assistant (CNA 2) stated she did not know where the facility's emergency power shut-off was located . CNA 2 stated she had been working in facility for 3 years. There was no documented evidence of CNA 2's attendance in the Attendance sign-in record for Mandatory In-services on Disaster Preparedness dated 3/15/12, 3/16/12, 3/26/12, 4/6/12 and 4/7/12. On 7/12/12 at 10:30 a.m., during an interview on Disaster and Emergency Preparedness, Licensed Nurse (LN) 4 stated she did not know how to use a fire extinguisher. LN 4 stated she had been working in the facility for 3 years. The facility administrative document titled, "FIRE AND INTERNAL DISASTER" revised June 2011	F 518	New policy for mandatory in-services has been written and in-serviced to staff on 8/9 and 8/14/12. Staff who miss the mandatory in-service or make up in-service will not be on the working schedule until the employee has completed the in-service with the DSD. DSD will report to QA committee monthly list of mandatory in-services and any employee that has not attended mandatory in-service or make up in-service. Any concerns regarding mandatory in-service follow through by staff will be brought to the weekly QA meeting. c.n.a. #2 has attended one inservice on disaster preparedness with outside contractor who does our fire and disaster drills. c.n.a. #2 will attend the mandatory inservice on 8/13/12. DON and Administrator will monitory monthly.	8/14/12 8/14/12 & ongoing 8/13/12 8/14/12 & ongoing

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F 518	Continued From page 27 indicated, "...The facility's emergency procedures are outlined below... Know all fire, emergency, disaster and safety procedures... PREPARING FOR FIRES. The following are general instructions for all staff members: 1 Attend all classes in fire prevention and participate in all fire and emergency drills. 2. Learn the location of... fire alarms and fire extingushes (sic), and how to use them..."	F 518		