

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055839	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/12/2025
NAME OF PROVIDER OR SUPPLIER San Luis Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 709 N Street Newman, CA 95360	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689 Level of Harm - Actual harm Residents Affected - Few	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility nursing staff failed to use the proper turning technique and ensure one of three sampled residents (Resident 1), received adequate supervision and assistance during pericare (cleaning a patient's genital and anal areas) to prevent falls when Resident 1 who was deemed fully dependent for toileting hygiene, experienced a fall on 9/7/25. The certified nursing assistant did not ensure implementation of effective intervention as the use of a draw sheet (sheet placed underneath a patient to assist with repositioning and transferring in a healthcare setting) or proper technique and positioning without draw sheet for Resident 1 in accordance with facility competency, training consistent with Resident 1's care's need. This failure resulted in Resident 1 sustaining an avoidable fall during pericare leading to a scalp laceration (cut or tear in the scalp, the outer layer of the head), traumatic brain injury (TBI - an injury to the brain caused by an external force) with Intracranial Hemorrhage (ICH- bleeding within the brain cavity), left rib fracture (broken rib), left pneumothorax (collapsed lung), and a manubrial fracture (break in the upper part of sternum, breast bone) requiring urgent transfer to an acute care hospital and admission to the Intensive Care Unit (ICU - unit in hospitals that provides round-the-clock monitoring and treatment for people with serious illnesses or injuries). During a review of Resident 1's 60-Day Physician recertification of Terminal illness, document signed by physician on 6/21/25, the document indicated Resident 1 was a [AGE] year-old female with primary hospice (comprehensive care program for terminally ill patients, focusing on comfort, quality of life, and symptom management rather than cure) diagnosis of Parkinson's (progressive disorder that affects movement, balance and coordination disease with comorbidities (medical condition that is simultaneously present with another disease or other conditions in a patient), conditions of hypothyroidism (a condition in which the thyroid gland does not produce enough thyroid hormones, hormones essential for regulating metabolism, growth, and other bodily functions), hyperlipidemia (high level of fat in blood), depression (mental health condition characterized by persistent feelings of sadness, loss of interest, and other symptoms that can significantly impact daily life), dysphagia (difficulty swallowing food or liquids), Coronary Artery Disease (CAD - condition where the arteries that supply the heart with blood become narrowed or blocked, usually due to the buildup of fat) and pacemaker (implanted electronic device that sends electrical impulses to the heart to help it beat at a steady and appropriate rate). During a review of Resident 1's hospice note (HN) titled, [Skilled Nursing (SN)] For Routine Visit Summary, dated 8/28/25, the HN indicated, . [Resident 1] requires [one to one (1:1- one caretaker to one patient care model)] assist with meals . dependent in bathing, dressing, toileting, transferring, repositioning, and feeding. Patient bedridden [inability to get out of bed due to illness]. Requires changing and repositioning every two hours. Patient incontinent [unable to control your bladder or bowels, leading to leakage of urine or feces] of urine and feces. Contracture [permanent tightening and shortening of muscles leading to restricted movement in a joint] to right hand, and to [Bilateral (both) lower extremity] . Facility responsible for the 24-hour custodial care [assistance with daily activities like bathing, dressing, and eating, provided to individuals who cannot perform these tasks themselves] for the patient and will notify [company name] Hospice of changes in patient condition. During a review of the facility's document titled, COMPETENCY CHECK-MOVING A RESIDENT IN BED, dated January 2025, the document indicated, . Performance Criteria . MOVING RESIDENT TO SIDE OF BED . Stands on same side of bed to where resident will be moved . With a draw sheet: Rolls draw sheet up and grasps draw sheet with palms up. Puts one hand at resident's shoulders and the other at resident's hips. Applies on knee against side of bed, leans back, and pulls draw sheet and resident on the count of three. Without a draw sheet: Slides hands under head and shoulders and moves toward self. Slides hands under midsection and moves toward self. Slides hands under hips and legs and moves toward self . During a review of the document titled, [Emergency Medical Services (EMS)] Patient Care Report (3.5)x, dated 9/7/25, the document indicated, . Response Mode to Scene: Emergent (immediate response) . Lights and Sirens . Unit Arrived On Scene . 9/7/25 at 21:58 . unit left the Scene: 9/7/25 at 22:13 . Patient arrived at destination . 9/7/25 at 22:50 . arrived . patient laying supine on the linoleum floor with two pillows under her head, both saturated with blood. Per facility staff [unknown], [Certified Nursing Assistant (CNA- a healthcare professional who provides basic patient care, such as assisting with daily activities, vital signs, and hygiene, under the supervision of a licensed nurse)] 's had patient in a standing position next to the bed when she slipped, fell, and hit her head causing a deep/ open head laceration [cut] approximately 2 inches. unit of</p>		