STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056103	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crown Bay Nursing and Rehabilitation Center	508 Westline Drive Alameda, CA 94501

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46658 Based on observation, interview and record review the facility failed to ensure one of three sampled residents (Resident 1) had at least two staff members to assist Resident 1 when Certified Nursing Assistant 1 (CNA 1) performed incontinence care by themselves which resulted in Resident 1 falling from their bed. This failure resulted in Resident 1 falling from their bed sustaining a left arm and left leg fracture. Resident 1 was not suitable for surgery to repair the fractures and had to enter hospice care due to the injuries sustained in the fall. Findings: A review of Resident 1 ' s admission record, dated 2/13/25, indicated Resident 1 was admitted to the facility for dementia (a loss of brain function that occurs with certain diseases, affecting one or more brain functions such as memory, thinking, language, judgment, or behavior), morbid obesity, osteoarthritis (inflammation of bone tissue leading to impaired function and pain) of the knees, and osteoporosis (reduction of bone density leading to increased risk of fracture). The admission record indicated Resident 1 was roomed with Resident 2 and 3. During a record review of Resident 1 ' s minimum data set (MDS, an assessment tool to guide resident care), dated 12/17/24, the MDS indicated Resident 1 had functional impairment in both legs, was completely dependent (indicating resident does none of the effort to complete the activity or the assistance of two or more helpers is required to complete the activity) on staff for toileting hygiene and needed maximum assistance (helper lifts or holds trunk or limbs and provides more than half the effort) to roll left and right in bed. The MDS also indicated Resident 1 was not able to stand or walk and needed a wheelchair for locomotion. During a record review of Resident 1 ' s vital signs record titled, Resident Vital Sign Report, dated 2/13/25, the record indicated, on 12/2/24, Resident 1 had a weight of 321 pounds (lbs. unit of weight measurement) A review of Resident 2 ' s admission record, dated 2/13/25, indicated Resident 2 was admitted to the facility for chronic heart failure (condition of reduced heart function), muscle atrophy (loss of muscle tissue) and hypertension (high blood pressure). The admission record indicated Resident 2 was roomed with Resident 1 and 3. (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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NAME OF PROVIDER OR SUPPLIER: Crown Bay Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 508 Westline Drive, Alameda, CA 94501	

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a record review of Resident 2 ' s MDS, dated [DATE], the MDS indicated Resident 2 had Brief Interview for Mental Status score of 15 (BIMS, is a scoring system used to determine the resident ' s cognitive status in regard to attention, orientation, and ability to register and recall information. A BIMS score of thirteen to fifteen is an indication of intact cognitive status.) The MDS indicated Resident 2 had impaired vision (able to see large print, but not regular print in books). A record review of Resident 2 ' s nursing note titled, Nursing Weekly Summary, dated 1/2/25, indicated Resident 2 wear eye glasses .in bed watching television. A review of Resident 3 ' s admission record, dated 2/13/25, indicated Resident 3 was admitted to the facility for rehabilitation after a hip fracture. The admission record indicated Resident 3 was roomed with Resident 1 and 2. During a record review of Resident 3 ' s MDS, dated [DATE], the MDS indicated Resident 3 had a BIMS score of 15, had adequate vision and hearing. A record review of Resident 3 ' s nursing note titled, Nursing Weekly Summary, dated 1/2/25, indicated Resident 3 had no complaint of visual problem .alert and verbally responsive. During a concurrent observation and interview on 1/21/25, at 3:20 p.m., with Resident 2 and Resident 3, Resident 2 was in bed. Resident 3 was in a wheelchair next to their own bed. Resident 2 and 3 stated Resident 1 was in the bed in the middle of the room and both were able to recall Resident 1 ' s fall on 1/3/25. Resident 2 stated it was around 9:00 a.m. and CNA 1 had come in to change Resident 1 ' s brief. Resident 2 saw CNA 1 leave the room to find help but CNA 1 returned alone, unable to get help. CNA 1 then started to clean Resident 1. CNA 1 rolled Resident 1 on their side and then Resident 1 fell off the bed. Both Resident 2 and 3 stated CNA 1 should have waited because they knew Resident 1 was unable to safely hold onto the bed rail. Both Resident 2 and 3 stated they had observed Resident 1 needing two or more people to assist during care. Resident 3 stated they saw Resident 1 on the floor between Resident 1 and Resident 3 ' s bed. Resident 3 stated Resident 1 was assessed by staff before being transported out to the hospital. During a phone interview on 2/14/25, at 12:08 p.m., with CNA 1, CNA 1 stated on 1/3/25 at around 9:00 a.m., he was in Resident 1 ' s room to change Resident 1 ' s brief. CNA 1 had not worked with Resident 1 before but knew Resident 1 needed at least two staff for assistance. CNA 1 did not get report from the previous shift or the charge nurse about the level of assistance Resident 1 required. CNA 1 looked down two nearby hallways to find help but could not find anyone. CNA 1 then started to perform incontinence care for Resident 1. Resident 1 was in bed, and CNA 1 rolled Resident 1 on their left side. CNA 1 instructed Resident 1 to hold themselves up using the bed rail, and it seemed like Resident 1 was able to comply. CNA 1 looked away to grab a cleaning wipe at the end of the bed and saw Resident 1 sliding off the bed. CNA 1 attempted to hold on to Resident 1 but was unable to prevent them from falling to the ground. CNA 1 then went out to get help. LVN 1 came in to assess Resident 1, and Resident 1 was transported to a hospital. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a record review of Resident 1 ' s change in condition note titled, Clinical Note Entry Change in Condition, dated 1/3/25, by Licensed Vocational Nurse 1 (LVN 1), the note indicated writer was notified by CNA that resident had witnessed fall. Writer noticed resident lying on the floor with her front belly side on the floor at 9:15 a.m .CNA stated he was cleaning (sic) up the resident around her back, had resident holding on to railing turned towards left side, resident legs slide down and fell on her legs first and the body. During an interview on 2/14/25, at 12:49 p.m., with LVN 1, LVN 1 stated on 1/3/25, they were the charge nurse for Resident 1 on that day. While LVN 1 was performing a medication pass, CNA 1 came up to report a fall. LVN 1 entered Resident 1 ' s room and found Resident 1 on the floor on their chest. LVN 1 stated for activities of daily living (ADL, life activities such as eating, hygiene, toileting and ambulation) care such as turning and repositioning, Resident 1 needed two staff to assist to prevent falls and injury. LVN 1 stated Resident 1 was over 300 lbs., had poor upper body strength and did not have enough strength or coordination to hold herself on her side. LVN 1 stated CNA 1 did not ask about how much assistance Resident 1 needed before starting care. During a concurrent interview and record review on 2/14/25, at 1:30 p.m., with Director of Staff Development (DSD), CNA 1 ' s in-service record titled, Facility Class Attendance Record, dated 1/3/25, was reviewed. The DSD stated CNA 1 completed a one on one in-service with the DSD after Resident 1 ' s fall. The DSD stated they had reinforced expectations to have two staff or more assist any residents which appeared heavier than 200 lbs. The DSD stated Resident 1 ' s weight indicated they required two staff to assist during care. During a concurrent interview and record review on 2/14/25, at 2:45 p.m., with the Assistant Director of Nursing (ADON), Resident 1 ' s fall assessment titled, Fall Risk Assessment, dated 12/31/24, was reviewed. The ADON stated the assessment indicated Resident 1 had a fall assessment score of 10 which indicated Resident 1 was at high risk for falls. The ADON stated Resident 1 required two staff for all ADL care because of her weight. The ADON stated at the beginning of the shift, nurses were expected to inform CNAs the ADL needs for each resident and CNAs were expected to endorse resident needs to the next shift. During a record review of Resident 1 ' s assessment of bowel and bladder function titled, Bowel and Bladder Assessment, dated 12/31/24, the assessment indicated Resident 1 was always incontinent of bowel and urine .no motivation to participate .2 or more person assist with transfer/ambulation. During a record review of Resident 1 ' s hospital history and physical assessment note titled, [Facility] Hospital Medicine History & Physical, dated 1/3/25, the note indicated on 1/3/25, Resident 1 accidentally rolled out of bed and onto the floor .found to have L humeral fx (left upper arm fracture) and L femoral neck fx (left leg fracture at the top thigh bone). During a record review of Resident 1 ' s hospital record titled, Specialty Palliative Care: Follow up Consult, dated 1/15/25, the record indicated per orthopedic surgery consult, no benefit from surgical management . plan for discharge to board and care with hospice. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of facility policy and procedure (P&P) titled, Falls - Clinical Protocol, dated 4/2013, the P&P indicated, nurse shall assess and document/report .musculoskeletal function .neurological status .staff will document risk factors for falling in the resident ' s record and discuss resident ' s fall risk .staff and physician will monitor and document individual ' s response to interventions intended to reduce falling.