STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056266	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Keystone Post-Acute	3672 North First Street Fresno, CA 93726

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 - Minimal harm or potential for 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** Based on interview and record review, the facility failed to ensure residents were free from accidents for one of three sampled residents (Resident 1) when Resident 1 was not assessed for safe transfer, seating, and supervision needs prior to being transferred and Resident 1 was left unattended in wheelchair despite documented weakness and limited mobility on 4/17/26This failure resulted in Resident 1 experiencing an unwitnessed fall from a wheelchair on 4/21/26 onto the floor. After the fall Resident 1 experienced facial abrasions and busing and was sent to the general acute care hospital (GACH) for evaluation.Findings:During a review of Resident 1's admission Record (AR- a summary of important information regarding a patient which include patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 5/8/26, the AR indicated, Resident 1 was admitted to the facility on [DATE] for a five-day respite (temporary, short-term care provided to an individual to give their primary, unpaid family caregiver a break) hospice stay with a diagnosis of hemiplegia (muscle weakness) and hemiparesis (paralysis - no control over one side of the body) following cerebral infarction (stroke) affecting left non- dominant side, heart failure (conditions where the heart cannot pump enough blood to meet the body's needs for oxygen), and chronic obstructive pulmonary disease (COPD- on going lung disease caused by damage to the lungs).During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 4/17/26, the MDS section C indicated Resident 1 had a Brief Interview for Mental Status (BIMS -an evaluation of attention, orientation and memory recall on a scale of 1-15) score of 3 (a score of 0-7 severe cognitive impairment, 8-12 moderately impaired, 13-15 no cognitive impairment), indicating Resident 1 had severe cognitive impairment.During a record review of Resident 1's Hospice Nursing Clinical Notes (HCN) dated 4/17/26, the HCN indicated, under musculoskeletal/activities Resident 1 had weakness and limited mobility/range of motion. The HNC did not identify Resident 1's transfer status, did not indicate whether Resident 1 was bedbound or chair bound, and did not document assistive devices needed.During a record review of Resident 1's Hospice Physician Order dated 4/17/26, the Hospice Physician Orders indicated, under physician communication: respite care [for] 5 days effective at 1:30 pm 4/17/26, No [Physical Therapy], [Occupational Therapy], and [Speech Therapy] and hospitalization without.consultation, .contact hospice for any concerns or questions.During a concurrent interview and record review on 5/8/26 at 10:00 a.m. Director of Nursing (DON), Resident 1's Facility Progress notes Administration Assessment dated 5/8/26, indicated Resident 1 was admitted for respite care on 4/17/26. resident [1] is bed bound with left sided weakness. Further review did not identify documentation of mobility, transfer, seating, or wheelchair safety evaluation completed prior to Resident 1 being transferred into a wheelchair on 4/21/26.During an interview on 5/8/26 at 9:40 a.m. with the Occupational Therapy Assistant (OTA), the OTA explained that before any resident is transferred or a decision is made about which assistive device to use, the resident should first undergo an evaluation to determine their mobility, transfer needs, and the safest equipment for positioning. The OTA specifically stated this process is critical for residents (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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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	like Resident 1, who had documented weakness and limited mobility, as identified in both hospice and facility records. The OTA stated because Resident 1 demonstrated poor trunk control and was unable to sit upright from a stroke, the OTA stated that recliner or Geri chairs are often recommended for such individuals. The OTA stated the use of a Geri chair is important because it provides enhanced positioning and safety for residents who cannot safely sit upright in a standard wheelchair, helping to prevent falls and other accidents. The OTA stated in Resident 1's case, failure to complete a mobility and seating assessment resulted in staff transferring to a standard wheelchair without proper evaluation, ultimately contributing to an unwitnessed fall and injury.During a concurrent interview and record review on 5/8/26 at 10:00 a.m., with the DON, Resident 1's Electronic Medical Record (EMR), dated 5/8/26 was reviewed. The DON stated Resident 1 remained in bed during the respite stay until staff transferred Resident 1 into a wheelchair on 4/21/26 after repeated requests from Resident 1's daughter. The DON stated there was no documentation in Resident 1's EMR to indicate the transfer status or if Resident 1 was able to use a wheelchair. The DON confirmed Resident 1's EMR did not have documentation of communication from Resident 1's daughter to facility staff. The DON stated Resident 1 sustained an unwitnessed fall after being transferred into the wheelchair by staff on 4/21/26.During an interview on 5/8/26 at 10:28 a.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated she transferred Resident 1 into a facility wheelchair on 4/21/26. CNA 1 stated she transferred Resident 1 on 4/21/26 at approximately 2:00 p.m., after receiving a request from Resident 1's daughter to have the resident sitting up. CNA 1 stated Resident 1 was moved using a hoyer lift (a mechanical device used to safely transfer individuals with limited mobility) and was placed into a standard facility wheelchair. CNA 1 stated Resident 1's personal wheelchair from home was not present in the facility. CNA 1 stated after she completed the transfer, she left Resident 1 unattended in the wheelchair. CNA 1 stated she was alerted by the hospice social worker, who was making a visit to Resident 1 and discovered Resident 1 was face down on the floor with facial bleeding. CNA 1 stated she did not receive specific instructions or information regarding mobility tolerance for Resident 1. CNA 1 stated she did not know where to locate that information in Resident 1's chart. During an interview on 5/8/26 at 10:55 a.m., Licensed Vocational Nurse (LVN) 1 stated Resident 1 was extensively dependent on staff for mobility and positioning. LVN 1 stated Resident 1 was transferred into a wheelchair by CNA 1, following repeated requests from Resident 1's daughter, even though there was no documentation regarding wheelchair use or a therapy evaluation. LVN 1 was not present during the transfer of Resident 1 by CNA 1 but later observed Resident 1 seated upright in the wheelchair, leaning slightly left. LVN 1 reported Resident 1 was left unattended for less than 15 minutes. LVN 1 was alerted by a hospice staff member that Resident 1 was found face down on the floor with facial bleeding. LVN 1 stated neither Resident 1 nor his roommate could provide details about what had happened. LVN 1 emphasized that Resident 1's mobility baseline required extensive assistance, as he was unable to reposition himself or independently transfer.During an interview on 5/8/26 at 11:23 a.m., with the Restorative Nursing Assistant (RNA), the RNA explained that hospice residents typically use reclining chairs after an evaluation is completed, due to poor trunk control, comfort needs, and positioning requirements. The RNA stated that performing assessments is essential before determining seating or transfer equipment, especially for residents with impaired trunk stability or limited mobility. The RNA stated the use of a reclining chair, such as a Geri chair, provided critical support and enhanced safety for those who cannot sit upright in a standard wheelchair, ultimately helping to prevent falls and injuries. The RNA stated facility practice involved evaluating each resident's individual needs prior to mobility and equipment decisions, underscoring the facility's responsibility to ensure resident safety through proper assessments and interventions.During a concurrent interview and record review on 5/8/26 at 2:00 p.m. with the Administrator (ADM), the facility document titled internal investigation dated 4/21/26 was reviewed, the internal investigation indicated Resident 1 was last observed seated upright in the wheelchair after transfer by CNA 1 on 4/21/26. The facility internal investigation indicated Resident 1 had an (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	unwitnessed fall. The internal investigation indicated Resident 1 was found face down on the floor with facial bleeding. The internal investigation indicated CNA 1 left Resident 1 unattended after transfer into the wheelchair.During an interview on 5/8/26 at 2:20 p.m., with DON, the DON stated all residents should be evaluated prior to transfer and mobility changes; however, no evaluation was completed for Resident 1 prior to transfer into wheelchair. The DON stated staff should not have relied on information provided by Resident 1's daughter regarding Resident 1's use of assistive devices such as a wheelchair. The DON stated the facility should have followed up with hospice to confirm Resident 1's needs.During a record review of Review of Resident 1's general acute care hospital (GACH) emergency department records dated 4/21/26, the emergency department records, indicated Resident 1 sustained facial abrasions and bruising after an unwitnessed fall.During a review of the facilities Policy and Procedure (P&P) titled, Providing End of Life Care, dated 9/2/22, the P&P indicated, .providing the needed care and services to those residents at or approaching end of life in accordance with the residents preferences. to promote their highest practicable physical, mental, and psychosocial well-being. The facility will complete a comprehensive assessment to provide direction for the development of the residence care plan to address choices and preferences. the assessment will include.v. Level of activities desired and psychosocial needs vi. Functional/ ADL status.During a review of the facility P&P titled, Accident and Supervision, dated 9/22/22, the P&P indicated, The resident environment will remain as free of accident hazards as is possible. Each resident will receive adequate supervision and assistive devices to prevent accidents'.the facility should make a reasonable effort to identify the hazards and risk factors for each resident' . implementing interventions to reduce a resident's risk from hazards in the environment . Ensuring that the interventions are put into action . Monitoring and modification processes include. evaluating the effectiveness of interventions. modifying or replacing interventions as needed . adequacy of supervision . based on the individual resident's assessed needs and identified hazards in the resident environment.During a review of the facility P&P titled, Coordination of Hospice Services, dated 11/1/23, the policy indicated, The facility retains primary responsibility for implementing those aspects of care that are not related to the duties of the hospice . The care plan and any related forms shall be revised and updated as necessary to reflect the resident's current status . The facility will monitor and evaluate the resident's response to the hospice care plans . All residents receiving hospice will continue to receive the same facility services.including. ongoing monitoring or resident conditions.