| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 05A024 | A. Building<br>B. Wing | 05/02/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Crestwood Manor | 1400 Celeste Dr.<br>Modesto, CA 95355 |

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<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47298<br><br>Based on observation, interview and record review, the facility failed to ensure adequate supervision was provided to prevent accidents for one of three sampled residents (Resident 1) when Resident 1 was assessed to be a high risk for falls and had a history of falls and effective interventions were not implemented to prevent a fall on [DATE]. Resident 1 was assessed to have an unsteady gait, educated on the need to call for assistance, had falls on [DATE], [DATE], [DATE]and fell on [DATE]. On [DATE], Resident 1 went to the bathroom unassisted, staff became aware of her presence in the bathroom alone, did not assist her with toileting, left her alone in the bathroom and Resident 1 fell and injured her right ankle.<br><br>These failures resulted in Resident 1 not being provided with the level of assistance and supervision needed to prevent a fall, suffered an ankle injury requiring emergency transport to an acute care hospital for care and services and diagnosed with a fracture to the distal fibula [the lower, outer ankle area] and medial malleolus [the lower, inner ankle area]. Resident 1 was provided with a stabilizing splint, sent back to the Skilled Nursing Facility (SNF) with pain medication, new use of a Hoyer lift (an assistive device used to lift patients to transfer between a bed, chair or similar resting place) for transferring and required surgery on [DATE] in order to provide Resident 1 with the chance to walk again.<br><br>Findings:<br><br>During a review of Resident 1 ' s Admission Record (AR- a document that provides resident contact details, a brief medical history), dated [DATE], the AR indicated, Resident 1 had diagnoses which included . SCHIZOAFFECTIVE DISORDER, BIPOLAR TYPE [a mental illness which can affect thoughts, mood and behavior] .METABOLIC ENCEPHALOPATHY [a change in how the brain works due to a chemical imbalance in the blood which causes confusion, memory loss and loss of consciousness] .DIFFICULTY IN WALKING . UNSTEADINESS ON FEET .ABNORMAL POSTURE .REPEATED FALLS .VERTIGO OF CENTRAL ORIGIN [spinning sensation or dizziness caused by problems within the brain] .<br><br>(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<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During a review of Resident 1's Minimum Data Set (MDS- a standardized assessment and care screening tool), dated [DATE], the MDS indicated, Resident 1's Brief Interview for Mental Status (BIMS- an evaluation of attention, orientation and memory recall) indicated a score of 10 (,d+[DATE] severe cognitive impairment (an intense inability to think, remember, use judgement and make decisions), ,d+[DATE] moderate cognitive impairment (lessened ability to think, remember, use judgement and make decisions), ,d+[DATE] no cognitive impairment), which indicated Resident 1 had moderate cognitive impairment.<br><br>During a concurrent observation and interview on [DATE] at 10:15 a.m. with Resident 1 in the Administrator ' s (ADM) office, Resident 1 was sitting on top of a Hoyer sling in her wheelchair and had a splint (a rigid material used for supporting a broken bone) with a tan bandage wrapped around her right ankle. Resident 1 stated, she fell in her bathroom alone the other day and broke her ankle badly. Resident 1 stated, she called out in a loud voice for help because she needed assistance using the bathroom. Resident 1 stated, staff did not respond in a prompt manner, so she used her wheelchair to go to the bathroom. Resident 1 stated, she used a wheelchair to ambulate because she is usually unsteady and shakes when walking. Resident 1 stated, there was a pressure alarm to her wheelchair which sounded an alarm noise when she stood up from her wheelchair. Resident 1 stated, she did not remember if the alarm went off when she stood up from her wheelchair to use the bathroom. Resident 1 stated, she slipped, hit a rail in the bathroom with her ankle, screamed in pain and fell down.<br><br>During an interview on [DATE] at 10:23 a.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated, Resident 1 required one staff member to assist her with Activities of Daily Living (ADLs- activities such as bathing, dressing, and toileting a person performs daily). CNA 1 stated, Resident 1 experienced shakiness which required two staff members to assist Resident 1 with ADLs. CNA 1 stated, Resident 1 had fallen in the facility before and was a known fall risk resident. CNA 1 stated, there were stars next to Resident 1 ' s name tag outside Resident 1 ' s room so staff were aware Resident 1 was a fall risk. CNA 1 stated, Resident 1 had an alarm on her bed and wheelchair to alert staff when she attempted to get up.<br><br>During an observation on [DATE] at 10:47 a.m. in Resident 1 ' s bathroom, an emergency call button was observed on the wall next to the toilet with the words Push For Help on the button.<br><br>During an interview on [DATE] at 10:54 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated, she was alerted by staff Resident 1 was on the floor. LVN 1 stated, Resident 1 told LVN 1 she fell when she was attempting to pull up her pants. LVN 1 stated, Resident 1 screamed her ankle hurt badly. LVN 1 stated, Resident 1 ' s ankle visually looked broken, when assessed by LVN 1. LVN 1 stated, Resident 1 ' s physician was called and a call for an ambulance was made. LVN 1 stated, it was important to provide residents with adequate supervision to prevent accidents because Resident 1 ' s safety was the staff ' s priority, and she should have had access to the help she needed.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During an interview on [DATE] at 11:12 a.m. with CNA 2, CNA 2 stated, on [DATE], she heard Resident 1 was found on the floor so she went to Resident 1 ' s bathroom to help. CNA 2 stated, she heard Resident 1 say, Ouch! Ouch! and saw Resident 1 ' s ankle was damaged. CNA 2 stated, prior to the fall, the AM[CE1] (daytime shift) Program Manager (AMPM) had responded to Resident 1 ' s wheelchair alarm ringing. CNA 2 stated, Resident 1 declined help from the AMPM so the AMPM left Resident 1 in the bathroom. CNA 2 stated, the AMPM returned to Resident 1 and found Resident 1 on the floor. CNA 2 stated, the AMPM should have pushed the emergency call light in the bathroom and stayed with Resident 1 until another staff member arrived to help. CNA 2 stated, Resident 1 had fallen in the past. CNA 2 stated, she reminded Resident 1 to use the call light because staff did not want Resident 1 to fall and get hurt causing unnecessary pain.<br><br>During an interview on [DATE] at 11:40 a.m. with the AMPM, the AMPM stated, on [DATE], she had checked on Resident 1 because she heard Resident 1 ' s wheelchair alarm going off. The AMPM stated, Resident 1 was using the bathroom and declined help from the AMPM. The AMPM stated, she left Resident 1 on the toilet, turned off the wheelchair alarm, and went back to her office. The AMPM stated, she did not notify any other staff member Resident 1 was still on the toilet. The AMPM stated, she heard Resident 1 yell out shortly after, went to check on Resident 1 and found her on the floor.<br><br>During a concurrent interview and record review on [DATE] at 11:53 a.m. with the Director of Nursing (DON), Resident 1 ' s Care Plan Report (CPR), dated [DATE], and Resident 1 ' s MORSE FALL SCALE [CE2] (MFS-An assessment tool that predicts the likelihood that a resident will fall), dated [DATE] were reviewed. The CPR indicated, .[Resident 1] is a high fall risk [as evidenced by] .Repeated falls .Unsteadiness on feet . Abnormal posture .Difficulty in walking .Psychoactive [affecting the mind] drug use .Vertigo of central origin . age related osteoporosis [weak and brittle bones due to lack of calcium and Vitamin D] .right ankle fracture [DATE] due to fall XXX[DATE] Witnessed fall with [Head Injury Protocol (HIP)- facility protocol in which staff assesses and monitors the resident after a suspected or identified head injury] .Fall with HIP [DATE] . Unwitnessed Fall [DATE] without HIP, [DATE] with no HIP .Interventions XXX[DATE]: intervention will be to educate staff and resident about assisting resident fully when resident is using the restroom and ensure their safety when transferring .Anticipate and meet [Resident 1] ' s needs .Follow facility fall protocol .Interventions is to communicate with [Resident 1], encourage her to ask for assistance when attempting to ambulate, utilize the call lights, and make sure her wheelchair is locked before attempting to sit in or get out of it . The MFS indicated, .Score: 50 .High Risk for Falling .Has the Resident ever fallen before? .Yes . The DON stated, on [DATE], Resident 1 ' s wheelchair alarm was going off so the AMPM went to help Resident 1. The DON stated, Resident 1 declined help from the AMPM, the AMPM left and did not notify patient care staff Resident 1 was in the bathroom. The DON stated, Resident 1 fell after the AMPM had left Resident 1 in the bathroom. The DON stated, Resident 1 was not being actively supervised every time she went to the bathroom. The DON stated, Resident 1 ' s CPR included the intervention to educate staff and Resident 1 about assisting Resident 1 fully when Resident 1 used the restroom and ensured her safety when transferring. The DON stated, Resident 1 ' s MFS indicated she was a high risk for falls with a score of 50. The DON stated, Resident 1 was in the Falling Star Program (a program where staff could identify and intervene for residents who have had a fall within the last 30 days). The DON stated, Resident 1 had stars next to her name tag by her room doorway which alerted staff she was in the Falling Star Program. The DON stated the AMPM knew Resident 1 was a high risk for falls. The DON stated, it was important to provide Resident 1 with adequate supervision to prevent accidents to avoid any risk of falls and injuries.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During a concurrent phone interview and record review on [DATE] at 1:37 p.m. with the Assistant Director of Nursing (ADON), Resident 1 ' s MDS Section GG- Functional Status (MDSGG), dated [DATE] was reviewed. The MDSGG indicated, .Self-Care .Coding: .Supervision or touching assistance- Helper provides verbal cues and/or touching/steading and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently .[Resident 1] .Toileting hygiene: The ability to maintain perineal [area between the genitals and anus] hygiene, adjust clothes before and after voiding or having a bowel movement Signed .on [March] 4, 2025 .Supervision or touching assistance . The ADON stated, according to the MDS Section GG, Resident 1 required supervision or touching assistance with toileting. The ADON stated, this meant Resident 1 required assistance with cleaning or help with anything else while toileting. The ADON stated, a staff member responded to Resident 1 ' s wheelchair alarm ringing and found Resident 1 using the bathroom. The ADON stated the staff member left Resident 1 alone in the bathroom then Resident 1 had an unwitnessed fall. The ADON stated, Resident 1 was sent to the emergency room because her ankle was misaligned and was screaming. The ADON stated, Resident 1 was diagnosed with a right ankle fracture at the emergency department [ED]. The ADON stated the staff member who responded to Resident 1 should have pushed the emergency call button in the bathroom to alert more staff to come to assist the resident instead of leaving Resident 1 unassisted in the bathroom. The ADON stated Resident 1 ' s care plan indicated to educate staff and Resident 1 about calling for staff assistance and to ensure safety when transferring. The ADON stated, Resident 1 needed constant reminders for safety and had a history of falls. The ADON stated, Resident 1 had prior falls on [DATE], [DATE] and [DATE]. The ADON stated, Resident 1 was on the Falling Star program which meant there were stars on the name tag by Resident 1 ' s room door so all staff recognized Resident 1 had a fall within the last 30 days. The ADON stated, it was important to provide Resident 1 with adequate supervision to prevent falls.<br><br>During a phone interview on [DATE] at 10:45 a.m. with the DON, the DON stated, Resident 1 ' s fall was avoidable.<br><br>During a phone interview on [DATE] at 2:37 p.m. with the DON, the DON stated, Resident 1 returned from the hospital ED with an oxycodone/acetaminophen (pain medication) prescription to alleviate her pain. The DON stated, Resident 1 had an open reduction internal fixation (ORIF) surgery (surgical procedure used to repair broken bones) of the right ankle on [DATE].<br><br>During a review of Resident 1 ' s Progress Notes (PN), dated [DATE], the PN indicated, .At [1:25 p.m.], Staff alerted me that [Resident 1] was on the floor in her bathroom. Upon arrival to resident ' s bathroom, I was informed that this was an unwitnessed fall and that [Resident 1] did not hit her head. [Resident 1] reported having pain in her right foot, and upon assessment, [Resident 1] ankle appeared to be displaced. I asked another nurse to assist with contacting [ambulance company name] to send [Resident 1] to the hospital [Resident 1] claimed that her pain was ,d+[DATE] [a numerical pain scale assessment tool used to quantify the intensity of pain by having an individual rate their pain on a numbered scale, with ,d+[DATE] typically representing mild pain, ,d+[DATE] moderate pain, and ,d+[DATE] severe pain] . [Resident 1] stated that she was trying to pull up her pants and transfer herself back to her wheelchair, but the wheels were not locked, and she fell . Initially, [Resident 1] stated that only her Right Foot/leg area were in pain, but when [ambulance company name] showed up at [1:45 p.m.], She told them that her back was also hurt during the fall. [Ambulance company name] splinted her Right Ankle/Foot with a pillow .Author: [LVN] .<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During a review of Resident 1 ' s Post Fall Assessment (PFA), dated [DATE], the PFA indicated, .Date and Time of Fall: [DATE] [1:25 p.m.] .Where was the resident when they fell ? Residents ' bathroom .What was the resident doing when they fell ? Transferring from toilet to wheelchair .[wheelchair] brakes were unlocked . [Resident 1] stated that she was trying to pull up her pants and transfer herself back to her wheelchair but the wheels were not locked and she fell .Was this fall observed? No .possible ankle fracture .Sent to acute facility .Date of most recent prior fall XXX[DATE] .<br><br>During a review of Resident 1 ' s PN, dated [DATE], the PN indicated, .[7:00 p.m.] [Resident 1] returned from acute [diagnosis] right ankle [fracture] .Right ankle in splint. [Resident] able to move toes on right foot with . complaints of discomfort .Reports pain level ,d+[DATE] [severe pain according to the numerical pain scale assessment tool] to right ankle .<br><br>During a review of Resident 1 ' s Hospital Patient Education & Visit Summary (PEVS), dated [DATE], the PEVS indicated, .[Resident 1] .[brought in by ambulance] from [Skilled Nursing Facility (SNF) facility] reporting unwitnessed [ground level fall] .right ankle deformity observed upon arrival .Patient Diagnosis . Ankle fracture, right .PATIENT EDUCATION INSTRUCTIONS .After an ankle fracture, you can lose ankle mobility and muscle strength and endurance .<br><br>During a review of Resident 1 ' s Hospital Orthopedic [pertaining to the bones and muscles] Consultation Note (OCN), dated [DATE], the OCN indicated, REASON FOR CONSULTATION: Right ankle fracture . presents to the emergency department via ambulance from [facility] status post [after] unwitnessed ground-level fall .on the ground after an unwitnessed fall, complained of right ankle pain and was noted to have a deformity of the right ankle .ED workup revealed right ankle fracture and orthopedic surgery was consulted .ground level fall with closed right bimalleolar ankle fracture [type of fracture where both the inner and outer ankle are fractured] .leave splint in place until [follow up (f/u)] .closed reduction [a procedure to realign a fractured bone by manipulating it back into its correct position without surgery] and splinting performed in the ED .Patient is stable for discharge home from an orthopedic standpoint with outpatient follow up .in ,d+[DATE] days .[X-RAY (XR)- a form of medical imaging to take pictures of the inside of the body] Ankle Complete .Right .IMPRESSION .Acute [sudden onset] displaced [to move from the original position] fractures [breaks] of the distal fibula and medial malleolus .Orthopedic surgery consultation recommended .<br><br>During a review of Resident 1 ' s PN, dated [DATE], the PN indicated, .I accompanied [Resident 1] to her . [orthopedic] appointment today .After reviewing the notes from her [emergency room (ER)] visit on [DATE] and the x-ray images taken that day, [Orthopedic Surgery Doctor of Medicine (OSMD)] asked [Resident 1] if she ' [wanted] to be able to walk again ' , to which [Resident 1] replied that she want the option to try walking again. [OSMD] then explained that she would need surgery if she wanted the opportunity to walk and that is she did not care to walk again, then nothing needed to be done other than to let her ankle heal naturally. [Resident 1] then stated her desire for surgery and agreed with [OSMD] ' s Plan of Care. [OSMD] then stated that [Resident 1] ' s surgery would be ' next Thursday ' .<br><br>During a review of Resident 1 ' s PN, dated [DATE], the PN indicated, .Resident returned from surgery .with Orthopedics. Resident had an Open- Reduction- Internal- Fixation of Right Ankle and a Popliteal Nerve block [a technique used to numb the leg, foot, and ankle for procedures like surgery] .<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During a review of Resident 1 ' s Hospital Encounter Summary (ES), dated [DATE], the ES indicated, . Diagnoses .RIGHT ANKLE BIMALLEOLAR FRACTURE XXX[DATE] .Surgery .RIGHT ANKLE OPEN REDUCTION INTERNAL FIXATION .Medications at Time of Discharge .HYDROcodone/acetaminophen [pain medication] .10 [milligrams- unit of measurement (mg)]/325mg [tablet (tab)] .Take one Tab by mouth every 6 hours as needed .Indications: Closed displaced bimalleolar fracture of right ankle .HISTORY OF PRESENT ILLNESS: [Resident 1] .presents today with right ankle fracture .She reports sustaining the injury in the bathroom. Reduction was done .on [DATE]. She reports pain and rates the pain at ,d+[DATE] [severe pain according to the numerical pain scale assessment tool] .After discussion, she is interested in proceeding with surgical intervention .<br><br>During a review of the facility ' s policy and procedure (P&P) titled, FALL PREVENTION & MANAGEMENT, dated [DATE], the P&P indicated, .It is the goal of this facility to prevent or reduce the occurrence of falls and severity of fall-related injuries while improving the quality of life for our residents and clients .Upon admission, each resident is assessed using a Fall Risk Assessment tool to determine possible risk for sustaining a fall . Residents scoring high per the risk assessment process, have strategies implemented to reduce the potential for falls outlined in their plan of care .Resident who have actively sustained a fall, will be placed on the facility ' s heightened awareness program (i.e., Falling Star), designed to alert staff of a resident who has actively fell in the presence of standard fall prevention interventions .Visual identifiers will be used to identify residents on the program. Those identifiers may be placed on the nameplate outside the resident ' s room .<br><br>During a professional reference review retrieved from https://rn-journal. com/journal-of-nursing/preventing-falls-in-the-elderly-long-term-care-facilities, titled Preventing Falls in the Elderly Long Term Care Facilities, undated, .The elderly long-term care population is at increased risk for falls and fall related injuries. The implementation of a fall prevention program is important for ensuring resident safety. Systematically assessing residents ' risk for falls and implementing appropriate fall prevention interventions can reduce the number of falls in the elderly long-term care residents .Falls can cause serious injuries and accidental death, in older people .The elderly in long-term care facilities are predisposed to falling and may fall for a variety of reasons. Predisposing factors include, unsteady gait [a person ' s manner of walking] and balance, weak muscles .Staff should be educated about predisposing [to give a tendency to beforehand] and precipitating [to bring something on] factors for falls and related prevention strategies and interventions . Staff needs to understand the different interventions available to them, in order to apply them when caring for patients . |