

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05A024	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/15/2024
NAME OF PROVIDER OR SUPPLIER Crestwood Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 1400 Celeste Dr. 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)
<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>46258</p> <p>Based on observation, interview, record review, facility document review, and facility policy review, the facility failed to ensure a written consent was obtained for in-room camera monitoring for 2 (Resident #103 and Resident #124) of 2 sampled residents reviewed for privacy.</p> <p>Findings included:</p> <p>An undated facility document titled, Consent for Identification Photograph, specified, [Facility name] may utilize audio or video recording and telecommunication if face-to-face services are not available and/or if the treatment team determines this to be an appropriate form of communication.</p> <p>A facility policy titled, Resident Rights, revised 10/2012, specified, 11. To be treated with consideration, respect and full recognition of dignity and individuality, including privacy in treatment and in care of personal needs.</p> <p>1. An Admission Record revealed the facility admitted Resident #103 on 10/12/2017. According to the Admission Record, the resident had a medical history that included diagnoses of schizophrenia and adverse effects of unspecified antipsychotics and neuroleptics.</p> <p>A significant change in status Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/20/2024, revealed Resident #103 had a Staff Assessment for Mental Status (SAMS), which indicated the resident had moderately impaired cognitive skills for daily decision making. The MDS indicated the resident had one fall since admission or the prior assessment.</p> <p>Resident #104's care plan, included a focus revised 08/07/2024, that indicated the resident had a potential for falls and/or injuries related to falls.</p> <p>On 08/12/2024 at 12:35 PM, a monitor was observed outside of Resident #103's room.</p> <p>During an interview on 08/12/2024 at 12:36 PM, Certified Nursing Assistant #10 stated the monitor was for Resident #103.</p> <p>On 08/13/2024 at 10:46 AM, a monitor was observed in use outside of Resident #103's room.</p> <p>(continued on next page)</p>

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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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. An Admission Record revealed the facility admitted Resident #124 on 05/16/2022. According to the Admission Record, the resident had a medical history that included diagnoses of delusional disorders, mild cognitive impairment, and other specified disorders of bone density and structure.</p> <p>A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/27/2024, revealed Resident #124 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated the resident had not had any falls since admission or the prior assessment.</p> <p>Resident #124's care plan included a focus initiated 07/04/2024, that indicated the resident was a moderate risk for falls.</p> <p>On 08/12/2024 at 12:47 PM, a monitor was observed outside Resident #124's room.</p> <p>During an interview on 08/12/2024 at 12:48 PM, Certified Nursing Assistant #11 stated the monitor was for Resident #124 so that staff could watch the resident for falls.</p> <p>On 08/12/2024 at 12:59 PM, the surveyor attempted an interview with Resident #124; however, the resident told the surveyor to leave their room.</p> <p>On 08/13/2024 at 10:46 AM, a monitor was observed in use outside of Resident #124's room.</p> <p>During an interview on 08/13/2024 at 3:16 PM, the Administrator stated the facility did not have a consent for the cameras (monitor). The Administrator stated the cameras were used to prevent falls.</p> <p>During an interview on 08/15/2024 at 12:46 PM with the Director of Nursing and the Administrator, the Administrator stated there needed to be a written consent for the use of the camera for the residents' privacy.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>46258</p> <p>Based on observation, interview, record review, and facility policy review, the facility failed to ensure a care plan was implemented for in-room camera monitoring for 2 (Resident #103 and Resident #124) of 2 sampled residents reviewed for privacy.</p> <p>Findings included:</p> <p>A facility policy titled, Care Planning, revised 10/28/2017, specified, Policy A person-centered care plan to meet the individual needs of residents/clients is prepared by an Interdisciplinary Team, which is periodically reviewed and revised after subsequent assessments.</p> <p>1. An Admission Record revealed the facility admitted Resident #103 on 10/12/2017. According to the Admission Record, the resident had a medical history that included diagnoses of schizophrenia and adverse effects of unspecified antipsychotics and neuroleptics.</p> <p>A significant change in status Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/20/2024, revealed Resident #103 had a Staff Assessment for Mental Status (SAMS), which indicated the resident had moderately impaired cognitive skills for daily decision making. The MDS indicated the resident had one fall since admission or the prior assessment.</p> <p>Resident #104's care plan, included a focus revised 08/07/2024, that indicated the resident had a potential for falls and/or injuries related to falls. There was no documented intervention for the use a camera monitor.</p> <p>On 08/12/2024 at 12:35 PM, a monitor was observed outside of Resident #103's room.</p> <p>During an interview on 08/12/2024 at 12:36 PM, Certified Nursing Assistant #10 stated the monitor was for Resident #103.</p> <p>On 08/13/2024 at 10:46 AM, a monitor was observed in use outside of Resident #103's room.</p> <p>2. An Admission Record revealed the facility admitted Resident #124 on 05/16/2022. According to the Admission Record, the resident had a medical history that included diagnoses of delusional disorders, mild cognitive impairment, and other specified disorders of bone density and structure.</p> <p>A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/27/2024, revealed Resident #124 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated the resident had not had any falls since admission or the prior assessment.</p> <p>Resident #124's care plan included a focus initiated 07/04/2024, that indicated the resident was a moderate risk for falls. There was no documented intervention for the use a camera monitor.</p> <p>On 08/12/2024 at 12:47 PM, a monitor was observed outside Resident #124's room.</p> <p>(continued on next page)</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 08/12/2024 at 12:48 PM, Certified Nursing Assistant #11 stated the monitor was for Resident #124 so that staff could watch the resident for falls.</p> <p>On 08/12/2024 at 12:59 PM, the surveyor attempted an interview with Resident #124; however, the resident told the surveyor to leave their room.</p> <p>On 08/13/2024 at 10:46 AM, a monitor was observed in use outside of Resident #124's room.</p> <p>During an interview on 08/14/2024 at 10:57 AM, the Administrator stated there were no care plans for the use of the cameras for Resident #103 and Resident #124.</p> <p>During an interview on 08/14/2024 at 1:58 PM, the Assistant Director of Nursing (ADON) stated care plans were in place to inform the staff what the resident's plan of care was. The ADON stated there were no care plans for the cameras that monitored Resident #103 and Resident #124.</p> <p>During an interview on 08/14/2024 at 2:10 PM, the Director of Nursing (DON) stated the cameras were put in place to monitor the residents for falls and safety.</p> <p>During an interview on 08/15/2024 at 12:46 PM with the DON and the Administrator, the DON stated there needed to a care plan for the use of the cameras for Resident #103 and Resident #124.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>40141</p> <p>Based on observation, interview, record review, and facility policy review, the facility failed to ensure staff implemented enhanced barrier precautions when they performed wound care for 1 (Resident #113) of 1 sampled resident reviewed for pressure ulcer/injury.</p> <p>Findings included:</p> <p>A facility policy titled, Enhanced Barrier Precautions, revised 05/21/2024, indicated, 1. Identify residents at high risk for MDRO [multiple-drug resistant organisms] colonization and transmission. Use ESP [Enhanced Standard Precautions], primarily gowns and gloves for specific high contact care activities, based on the resident's characteristics that are associated with a high risk of MDRO colonization and transmission. *Presence of indwelling devices *Wounds or presence of pressure ulcer (unhealed).</p> <p>An Admission Record indicated the facility admitted Resident #113 on 02/25/2020. According to the Admission Record, the resident had a medical history that included diagnoses of urinary incontinence and non-pressure chronic ulcer of the right ankle.</p> <p>A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/13/2024, revealed Resident #113 had a Staff Assessment for Mental Status (SAMS), which indicated the resident had severely impaired cognitive skills for daily decision making. The MDS indicated the resident had one stage 2 pressure ulcer.</p> <p>Resident #113s care plan included a focus area revised 07/02/2024 that indicated the resident had impaired skin integrity as described as a stage 2 pressure ulcer to their left gluteal cleft. Interventions directed staff to clean the open area to the left gluteal cleft with normal saline, pat dry, then apply hydrogel and cover with a waterproof dressing daily (initiated 07/23/2024).</p> <p>Resident #113's Order Summary Report, with active orders as of 08/15/2024, contained an order dated 08/08/2024 that directed staff to clean the open area to left gluteal cleft with normal saline, apply hydrogel, and cover with waterproof dressing daily for 14 days.</p> <p>During an observation on 08/15/2024 at 10:13 AM, Certified Nursing Assistant (CNA) #6 and Licensed Vocational Nurse (LVN) #1 provided wound care for Resident #113. The CNA and the LVN did not implement enhanced barrier precaution (EBP) and wore only gloves and masks during the provision of wound care.</p> <p>During an interview on 08/15/2024 at 10:30 AM, LVN #1 stated staff were to use a gown, gloves, and a mask as EBP for resident safety and during wound care for any resident who had an opened area. LVN #1 stated Resident #113 had an opened area and that she should have worn a gown when she provided wound care to prevent the spread of infection.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 08/15/2024 at 12:55 PM, the Infection Preventionist (IP) stated EBPs included the use of a gown and gloves should be worn to provide care for a resident with MDRO, open wounds, or indwelling medical devices. The IP stated EBPs were used to prevent the spread of anything like germs, parasites, or fungus to a resident. The IP stated that based on EBP criteria, CNA #6 and LVN #1 should have worn all personal protective equipment (PPE) to provide wound care to Resident #113.</p> <p>During an interview on 08/15/2024 at 1:11 PM, the Director of Nursing stated she expected for staff to be aware of EBPs, and if it was not understood, they were to receive more training. The DON stated she expected EBP to be utilized for resident safety. The DON stated she expected staff to wear the appropriate PPE if the resident required EBPs.</p> <p>During an interview on 08/15/2024 at 1:18 PM, the Administrator stated the facility would in-service staff on the requirements for EBPs and to use EBP when required.</p>		