

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05A340	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/25/2025
NAME OF PROVIDER OR SUPPLIER Crestwood Manor - 104		STREET ADDRESS, CITY, STATE, ZIP CODE 1130 Monaco Court Stockton, CA 95207	

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 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50925</p> <p>Based on interview, and record review, the facility failed to ensure 4 of 39 sampled residents (Resident 119, Resident 19, Resident 106 and Resident 80) had their rights related to treatment choices known and protected when:</p> <ol style="list-style-type: none"> 1. Resident 119's signed Advance Directive (a legal document indicating resident preference on end-of-life treatment decisions) documentation was not found in the chart; 2. Resident 19 wanted to formulate an Advance Directive and no follow-up documentation was found in the chart; 3. Resident 106's chart did not contain documentation regarding Advance Directive discussion; and 4. Resident 80's code status (a medical directive that specifies what actions medical professionals should take in the event of a life-threatening emergency) was not found in both the electronic health record (EHR) and physical chart. <p>These failures had the potential to result in not determining and/or honoring the residents' wishes related to the provision of medical treatment and health care services when the residents were unable to make decisions for themselves, and had the potential for Resident 80's wishes regarding emergency treatment would not be followed.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. A review of Resident 119's medical record titled, ADMISSION RECORD, indicated Resident 119 was admitted to the facility in 2023. <p>A review of Resident 119's EHR progress notes by Social Services, dated [DATE], indicated .Initial Social Service Note: .Resident sign advanced directives . and another note dated [DATE], indicated .Resident did not sign advanced directives at this time stating she was in pain and had difficulty at the time of interview .</p> <p>A review of Resident 119's physical chart at the Station 2 nurses station on [DATE], at 9:38 a.m., no copy of Advance Directive acknowledgement or forms were found in the chart.</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 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review on [DATE], at 10:16 a.m., with the Social Services (SS), the SS stated that the Advance Directive paperwork should be located in Resident 119's physical chart. The SS reviewed both Resident 119's physical chart and EHR at the Station 2 nurses station and stated he found documentation on Resident 119's EHR, per the admission initial SS notes on [DATE], Resident 119 was given copies of resident's rights and resident signed advance directives.</p> <p>During an interview on [DATE], at 11:43 a.m., with Resident 119, Resident 119 stated that she does not really remember about having an Advance Directive because all her items were in her old home in probate. Resident 119 further stated she thinks she does not have an Advance Directive but was not sure at this time and might change her mind.</p> <p>During a concurrent interview and record review on [DATE], at 8:47 a.m, the SS stated that the process of obtaining the Advance Directive was during the admission timeframe when the SS would interview the resident usually the same day of admission or the day after. The SS stated that the initial SS assessment packet included a form which had information regarding the Advance Directive where it asked if resident had an Advance Directive or whether they would like to formulate one. The SS further stated that if the resident wanted to formulate an Advance Directive, the SS would notify the conservator to start the process. The SS stated that Resident 119 was previously at Station 3 during the initial admission and then had surgery at the hospital and when she returned to the facility, she was then transferred to Station 2. The SS stated that the note from [DATE] was made during the time of Resident 119's initial admission from Station 3, so the physical records from Resident 119's old chart from Station 3 would not be in the chart at Station 2 anymore. The SS stated that whenever a resident got transferred to another station, the resident's chart got closed out and then placed in storage.</p> <p>During an interview on [DATE] at 9:07 a.m., the Unit Clerk (UC) stated that she could not find the copy of Resident 119's Advance Directive documentation in the facility's storage area for old charts. The UC verified that the Advance Directive documentation should be in Resident 119's chart. The UC stated that it was important to have the forms to acknowledge whether the Advance Directive was done and if the resident wanted to formulate one.</p> <p>During a concurrent interview and record review on [DATE], at 11:46 a.m., with the Director of Nursing (DON), the DON reviewed Resident 119's SS note dated [DATE] and stated it was her expectation for the Advance Directive documentation to be in Resident 119's chart. The DON stated that the facility's process during admission of a resident includes SS checking in with the resident about Advance Directive. The DON further stated that it was also her expectation for the SS to note the discussion with residents or conservators in the EHR about Advance Directives. The DON stated that it was important to have the Advance Directive copy in the chart to respect Resident 119's wants and needs, and if something happened to make sure that the facility would respect his wishes.</p> <p>2. A review of Resident 19's medical record titled, ADMISSION RECORD, indicated Resident 19 was admitted to the facility in 2015.</p> <p>A review of Resident 19's EHR SS notes dated [DATE], indicated .Initial Social Service Note: .Resident signed advanced directives and checked yes that he would like to formulate one. Called conservator and left her a vm [voicemail] informing her that resident would like to formulate an advanced directive .</p> <p>(continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident 19's physical chart at Station 2 nurses station on [DATE], at 9:34 a.m., Resident 19's Advance Directive acknowledgement paperwork was not found in the physical chart.</p> <p>During an interview on [DATE], at 11:49, with Resident 19, Resident 19 stated he was interested in formulating an Advance Directive. Resident 19 stated he did not recall if the Advance Directive was offered at this facility.</p> <p>During an interview on [DATE], at 8:58 a.m., with the SS, the SS stated he reviewed Resident 19's physical chart and verified no notes or documentation back in 2015 regarding any follow-up about the Advance Directive were found. The SS verified that he did not find a copy or acknowledgement form in Resident 19's physical chart at Station 2. The SS stated he would check the facility's storage for overflow chart records to verify. The SS verified that a follow-up should have been done since Resident 19 specified that he wanted to formulate an Advance Directive. The SS further stated that it was important to keep the Advance Directive documentation in Resident 19's chart to ensure it was available and accessible.</p> <p>During an interview on [DATE], at 10:32 a.m., with the Director of Medical Records (DMR), the DMR stated that Resident 19's physical chart was sent to storage because he had been at this facility for a long time. The DMR verified that the Advance Directive documentation should be in the Resident 19's chart.</p> <p>During a concurrent interview and record review on [DATE], at 11:46 a.m., with the DON, the DON verified the SS note dated [DATE], during Resident 19's admission that Resident 19 wanted to formulate an Advance Directive. The DON stated it was her expectation for the SS to have documented and followed up regarding Resident 19's Advance Directive in both the EHR and physical chart. The DON further stated the importance of having the Advance Directive or offering the option of the Advance Directive was to respect Resident 19's wants and needs, and if something happens to ensure that the facility respects Resident 19's wishes.</p> <p>3. A review of Resident 106's medical record titled, ADMISSION RECORD, indicated Resident 106 was admitted to the facility in late 2021.</p> <p>A review of Resident 106's physical chart at Station 2 nurses station on [DATE], at 9:17 a.m., indicated Resident 106's POLST form dated [DATE] section D for no Advance Directive box was marked.</p> <p>During a concurrent interview and record review on [DATE], at 9:23 a.m., with the UC, the UC checked Resident 106's physical chart and verified there was no Advance Directive documentation found in the chart.</p> <p>During an interview on [DATE], at 11:03 a.m., with the SS, the SS stated on [DATE] Resident 106 refused the initial SS assessment during the admission timeframe. The SS stated that Resident 106 kept saying I don't know during that time of the assessment. The SS verified that there was no documentation of Advance Directive follow-up found and stated that the documentation should have been done. The SS verified that Resident 106 did not have an Advance Directive acknowledgement form found in the chart.</p> <p>(continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident 106's social services notes, dated [DATE], indicated .Resident was oriented to situation, place and new room. Resident was very anxious and agreed to have formal Initial Social Services Assessment at another time .Social Services assessment and Primary Assessment will be done when resident is less anxious .</p> <p>During an interview on [DATE], at 11:46 a.m., with the DON, the DON stated that the SS would check in with the resident about Advance Directive during the admission process. The DON stated that it was her expectation to have the Advance Directive documentation and follow-up in both Resident 106's EHR and physical chart. The DON further stated that it was important to offer the option of formulating an Advance Directive to respect Resident 106's wants and needs, and to respect their wishes if something happened.</p> <p>A review of the facility document, titled, .ADVANCE DIRECTIVES, . dated [DATE], indicated .POLICY .The facility respects each resident/client right to participate in his/her life sustaining treatment decisions . PROCEDURE .2. When admitted , the resident/client is asked if he or she has executed an Advance Directive. If the answer is yes, a copy of the Advance Directive is obtained and placed in the clinical record . 3. Residents who are competent and who have not previously executed an Advance Directive are asked if they would like one prepared .4. Social Services may provide information on preparing Advance Directive and contact the local Ombudsman for assistance. Social Services may also ensure a copy of any existing directive is obtained for the clinical record .</p> <p>4. A review of Resident 80's medical record titled, ADMISSION RECORD, indicated Resident 80 was admitted to the facility in late 2015.</p> <p>A review of Resident 80's EHR on [DATE], at 12:32 p.m., indicated Resident 80 did not have a copy of the Physician Orders for Life-Sustaining Treatment (POLST - a form that contains written medical orders for healthcare professionals regarding specific medical treatments that can or cannot be done at the end-of life) form or a physician's order for the code status on the order list.</p> <p>A review of Resident 80's physical chart at Station 2 nurses station on [DATE], at 9:47 a.m., Resident 80's face sheet was found without a code status listed.</p> <p>During a concurrent interview and record review on [DATE], at 9:54 a.m., with Licensed Nurse (LN) 9, LN 9 reviewed Resident 80's EHR and verified there was no code status listed upon pulling up Resident 80's chart. LN 9 stated that the EHR normally had the code status listed and verified Resident 80's code status was missing in the EHR. LN 9 checked Resident 80's physical chart and verified that Resident 80's face sheet did not have the code status listed. LN 9 stated that if she could not find the code status on EHR, she would then check the resident's physical chart to verify the resident's code status. LN 9 stated that it was important to have the code status both in Resident 80's EHR and physical chart to respect his wishes and to know what the code status would be.</p> <p>(continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review on [DATE], at 10:02 a.m., with Quality Control Manager (QCM) 1, QCM 1 stated to confirm a resident's code status the nurse needed to check the resident's EHR or the resident's physical chart for the POLST form which would indicate the resident's code status. QCM 1 verified that there was no code status order found in Resident 80's EHR list of orders. QCM 1 verified both Resident 80's physical chart and EHR did not have the code status listed. QCM 1 further stated that another way to determine the code status was by looking at the resident's physical chart label on the spine of the binder, if the label was white then the resident would be considered full code (healthcare professionals will do everything possible to keep a patient alive if their heart stops or they stop breathing) and a red label would be considered DNR (Do Not Resuscitate- a medical order written by a doctor to instruct health care providers NOT to do cardiopulmonary resuscitation [CPR] if breathing stops or the heart stops beating). QCM 1 verified Resident 80's physical chart had a white label and would be considered full code. QCM 1 stated it was admissions who was responsible to have ensured the code status was entered in Resident 80's chart. QCM 1 stated that it was important to have the code status in both Resident 80's physical chart and EHR to respect his wishes whether he wanted CPR or not.</p> <p>During an interview on [DATE], at 2:26 p.m., with QCM 2, QCM 2 stated that each nurses station would have a designated QCM who did the admissions. QCM 2 stated during the admissions process, the code status had to be entered and the EHR system would automatically add the code status as an order on the resident's order list. QCM 2 stated if a resident's EHR and physical chart did not have the code status listed, another way to check would be to check the resident's physical chart's spine label color and to check the POLST form if available. QCM 2 stated if the resident's physical chart label was white, it meant the resident's code status would be full code and red label would be for DNR status. QCM 2 stated the code status would also be reviewed and brought up during the quarterly IDT (a group of healthcare professionals with different areas of expertise [like nurses, therapists, and social workers] working together to create a personalized care plan for each resident) meetings. QCM 2 further stated that the nursing staff could also verify the code status with the resident or their conservator. QCM 2 stated it was important to be able to find Resident 80's code status in an event of an emergency to be able to administer the appropriate medical intervention and to respect his wishes.</p> <p>During an interview on [DATE], at 12:31 p.m., with the RP, the RP verified Resident 80's code status was full code and there had been no changes to his code status. The RP further stated there were no discussions or concerns about changing the code status for Resident 80 with the facility.</p> <p>During an interview on [DATE], at 11:46 a.m., with the DON, the DON stated it was her expectation for Resident 80's code status to have been in both Resident 80's EHR and physical chart. The DON stated that the staff should verify a resident's code status by asking the resident directly or by confirming with the resident's conservator and once determined, the staff should notify the MD to obtain the order to be added to the resident's chart. The DON stated the nurse doing the admission process would be responsible in ensuring the resident's code status to have been entered in the chart for new admissions. The DON stated it was important to have the code status available in case of an emergency for the staff to have known whether to provide or not to provide care if Resident 80 was unresponsive and to respect his wishes.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>40903</p> <p>47368</p> <p>Based on interview and record review, the facility failed to ensure services provided met professional standards when facility did not provide drug information resources as reference for nursing staff.</p> <p>This failure could contribute to unsafe use of medication and nursing ability to provide quality care to the residents.</p> <p>Findings:</p> <p>During an interview and concurrent record review on 4/24/25, at 1:54 p.m., Licensed Nurse (LN) 2 stated they did not have drug information resources (a drug book or in computer) to look up how to administer Linzess medication (a prescription medication used to treat complicated constipation). LN 2 further stated she was not aware of manufacturer specification to give Linzess on empty stomach 30 minutes before meals. LN 2 stated she was not aware of a drug information book or online drug information via internet that was used in the facility.</p> <p>During an interview on 4/24/25, at 2:03 p.m., Licensed Psychiatric Technician (LPT) 1 stated it would have been nice if MAR (Medication Administration Record, a record that listed drugs to be administered) had information for Linzess to be taken on an empty stomach. LPT 1 further stated there was no drug information book for reference in the medication cart or medication room.</p> <p>During an interview on 4/24/25, at 2:12 p.m., Registered Nurse Supervisor (RN) 1 stated she could not locate a drug information book for nurses to use if needed. RN 1 further stated she was not aware of any online drug reference guide for the nurses.</p> <p>During an interview on 4/25/25, at 12:04 p.m., the Director of Nursing (DON) confirmed that the facility did not have printed and online drug resources for nursing staff and she was working on getting the resources for use by the staff.</p> <p>Review of the facility policy titled, 1.4 Medication Reference Sources and Texts, dated 10/31/16, indicated, . This Policy 1.4 sets forth procedures relating to medication reference sources and texts that should be maintained at Facility and accessible to staff . Facility should obtain medication reference sources for each nursing station .</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>40583</p> <p>Based on interview and record review, the facility failed to ensure one resident (Resident 39), in a sample of 39 residents, received accurate post fall and comprehensive fall assessments.</p> <p>This failure potentially resulted in Resident 39's subsequent fall 14 days later, negatively impacting Resident 39's health and well-being.</p> <p>Findings:</p> <p>A review of Resident 39's clinical record titled, ADMISSION RECORD, indicated Resident 39 was admitted to the facility with diagnoses which included convulsions (a sudden, involuntary contraction or series of contractions of the muscles, often involving shaking or jerking movements).</p> <p>During a concurrent interview and record review of Resident 39's clinical record, with Licensed Nurse (LN) 3, on 4/25/25, at 9:30 AM, LN 3 confirmed the following clinical documents were filled out incorrectly for Resident 39:</p> <p>Fall Risk Assessment, dated 11/8/24, indicated, in Section H, . PREDISPOSING FACTORS . Seizures . NONE PRESENT . contrary to Resident 39's ADMISSION RECORD, which indicated Resident 39 did have a history of seizures.</p> <p>Fall Risk Assessment, dated 11/22/24, indicated, in Section H, . PREDISPOSING FACTORS . Seizures . NONE PRESENT .</p> <p>Fall Risk Assessment, dated 12/30/24, indicated, in Section G, . MEDICATIONS . Antiseizure . Psychotropics (drugs that affect mental processes and behavior) . NONE of these medications were taken within the last 7 days, Section H, . PREDISPOSING FACTORS . Seizures . NONE PRESENT .</p> <p>A review of Resident 39's clinical document titled, Medication Administration Record, (MAR - contains physicians order with start dates and times of administration), dated 4/1/25 through 4/30/25, indicated Resident 39 was taking the following medications for the following diagnoses:</p> <p>Kepra (a seizure medication) to treat convulsions, with a start date of 8/15/16;</p> <p>Olanzapine (a medication used to treat mental health condition) for delusions (a disease characterized with a false belief or judgment about external reality), with a start date of 12/11/24.</p> <p>LN 3 confirmed the above Fall Risk Assessment, inaccuracies. LN 3 stated the importance of the above documents was to determine Resident 39's fall risk. LN 3 explained it was important for nursing to be able to review the fall assessments and know what medications the resident was taking that may contribute to their fall risk. LN 3 further explained the fall assessments contained relevant diagnoses which could contribute to residents fall risk. LN 3 stated if the fall risk assessments were not filled out accurately there was a risk the resident may fall and sustain an injury.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the Director of Nursing (DON), on 4/25/25, at 10:03 AM, the DON stated the importance of the fall assessment was to have an accurate picture of the resident's fall risk and interventions that were in place for the resident's plan of care. The DON explained it would affect the resident's safety if the fall risk assessment was not accurate and the facility would not be able to develop a personalized fall prevention plan for the resident.</p> <p>During a follow-up interview with the DON, on 4/25/25, at 12 PM, the DON explained the risk of having inaccurate post fall assessments, reflected in the Fall Assessment[s], dated 11/8/24, 11/22/24, and 12/30/24, would be subsequent falls for that resident.</p> <p>A review of the facility policy titled, FALL PREVENTION & MANAGEMENT, revised 4/3/20, 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 . Fall details, assessment findings, interventions, & notifications are to be documented in resident's clinical record & care plan updated accordingly .</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41838</p> <p>Based on observation, interview, and record review, the facility failed to maintain a healthy nutrition status for two residents (Resident 140 and Resident 126) when:</p> <ol style="list-style-type: none"> 1. Resident 140's weight was not maintained when an 8 pound (#)/5.8% weight loss occurred in one month; and, 2. Resident 126 was not offered a replacement lunch meal in a timely manner. <p>These failures had the potential for leading to malnutrition, nutrient deficiencies, loss of muscle mass and independence, and increased susceptibility to illness for Resident 140, and had the potential for Resident 126 to experience food insecurity, negatively affecting Resident 126's health and well-being.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During an observation of the lunch meal service on 4/23/25 at 12:17 p.m. with the Dietary Supervisor (DS), Resident 140's meal tray was noted to contain both a shake and an oral supplemental drink, in addition to pureed food. The DS stated resident 140 had a history of poor intake and meal refusals with the nursing staff reporting that the resident had been pocketing food and spitting it out. When asked about a speech therapy evaluation, the DS stated the facility did not have a therapy department. <p>Food pocketing is the accumulation of food between the cheeks and gums during chewing or swallowing. It's often associated with dysphagia (difficulty swallowing). Causes include weakened muscles, inability to feel what is going on inside of the mouth, or medical conditions such as a stroke or tumor. A speech therapist can evaluate swallowing function and recommend strategies for improving swallowing.</p> <p>Review of Resident 140's medical record on 4/24/25 at 10:47 am, showed that resident 140's diagnosis included hypothyroidism (low activity of the thyroid gland leading to metabolic changes), anxiety, depression, pain, and pneumonia (as of 4/9/25).</p> <p>Review of weights for Resident 140 indicated the following: 4/19/25=129# (pounds, a unit a measure), 3/15/25=137. This is a loss of 8# or 5.8% of body weight over a month, is considered severe weight loss by the Centers for Medicare/Medicaid.</p> <p>Review of Resident 140's orders included shakes (started on 4/7/25), oral supplemental drink (started on 4/14/25), an appetite stimulant (started on 4/7/25), and a pureed diet (smooth, blended, easy to swallow foods similar to baby food was started 4/22/25).</p> <p>(continued on next page)</p>

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Registered Dietitian (RD) consult note for weight loss from 4/8/25 indicated that significant weight loss had occurred related to an issue with swallowing. Recommendations included an appetite stimulant and the addition of supplemental nutrition drinks.</p> <p>Review of nursing note from 4/12/25 indicated the resident was watched during mealtime and had pocketing of food with poor intake. Resident was offered alternatives but refused and spat out food.</p> <p>Review of nursing note on 4/13/25 indicated that meal refusals continued.</p> <p>Review of nursing note from 4/21/25 indicated that a trial of mac and cheese was offered. Resident did not eat, only drank fluids. Continued pocketing food. Resident does not want pureed foods.</p> <p>Interdisciplinary Team meeting notes from 4/22/25 regarding nutrition changes indicated that a pureed diet was ordered as of 4/22/25. Resident had been pocketing food and not eating.</p> <p>Interventions included ice cream, supplemental nutrition drinks, and an appetite stimulant.</p> <p>Observation of lunch intake on 4/24/25 at 12:32 p.m., showed Resident 140 had left her lunch tray on the dining table. Pureed foods had not been eaten. Supplemental drink had been opened with 1/3 of container (approximately 2 1/3 ounces) left, no other liquids had been drunk. The intake of the supplemental drink provided approximately 145 calories and 6 grams of protein for the 2/3rds consumed.</p> <p>Review of the facility provided Nutrition at a Glance ([NAME] Corporate Dietitians, 2025) indicated that the lunch provided on 4/24/25 would provide 1,015 calories and 36 grams of protein.</p> <p>During a telephone interview with the Registered Dietitian (RD) on 4/24/25 at 2:31 p.m., the RD confirmed that no referral had been made to a speech therapist but could occur if the physician were to order a speech therapy consult.</p> <p>Review of Registered Dietitian (RD) Job Description (Dietary Directions, Inc./Nutrition Therapy Essentials, Inc. Food Service Policy & Procedures Manual 2018) indicated the RD 1. Evaluates the nutrition needs of residents/patients and documents in the nutritional record. 2. Interprets, evaluates and utilizes current research relating to nutritional care.</p> <p>Review of Policy & Procedure titled Nutrition Care-Significant Weight Changes (Dietary Directions, Inc. /Nutrition Therapy Essentials, Inc. Food Service Policy & Procedures Manual 2018) indicated Residents/patients experiencing significant weight changes will be identified and assessed in a timely manner in order to minimize further unplanned significant weight changes by identifying the underlying causes and contributing factors, and intervening as appropriate to resolve the problem .</p> <p>40583</p> <p>2. A review of Resident 126's clinical document titled, ADMISSION RECORD, indicated Resident 126 was admitted to the facility with diagnoses which included diabetes (problems with blood sugar control).</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation, on 4/22/25, between 12:10 PM and 12:20 PM, in the hallway, between the Station 1 dining room and the Station 1 Television/Activities (TV/Act) room, Resident 126 was observed stating she did not want to enter the TV/Act room with that (expletive) person. Staff members were observed trying to calm Resident 126. Staff were observed rolling Resident 126, in her wheelchair (w/c), into the TV/Act room. Resident 126 was observed yelling at staff, repeatedly, to get her out of the TV/Act room. Resident 126, at 12:20 PM, to be seated away from the table, Resident 126's lunch tray was placed on the table, and she was rolled up to the table to eat. Resident 126 was then observed to be yelling and tapping her plastic fork on her tray, and then Resident 126 purposefully spilled all the items on her lunch tray onto the table, spilling liquid all on the table where other residents were eating.</p> <p>During an interview with Resident 126, in Resident 126's room, on 4/22/25, at 1:24 PM, Resident 126 stated she was tired of being in the facility. Resident 126 explained they do not feed her, and she needed to eat.</p> <p>During an interview with licensed nurse (LN) 1, on 4/22/25, at 1:30 PM, LN 1 stated Resident 126 threw her plate during lunch and asked to go back to her room. LN 1 explained when a resident refuses to eat lunch staff were supposed to check on Resident 126 every 15 minutes, three times to see if she wanted a tray.</p> <p>During an interview with certified nursing assistant (CNA) 1, on 4/22/25, at 1:33 PM (I), CNA 1 stated Resident 126 returned to her room around 12:30 PM. CNA 1 explained she asked Resident 1 at 12:45 PM if she wanted a lunch tray and Resident 126 declined. CNA 1 further explained she did not ask Resident 126 again if she wanted a lunch tray and she should have.</p> <p>During an interview with the Director of Nursing (DON), on 4/24/25, at 3:16 PM, the DON stated Resident 126 should have been offered a replacement lunch meal directly following the initial incident. The DON explained when Resident 126 returned to her room a replacement meal should have been offered at least twice and it was not.</p> <p>A review of the facility policy titled, NUTRITION & MEALS, ASSISTING THE RESIDENT / CLIENT, effective 9/1/13, indicated, .It is the policy of this facility to assist resident with meal intake according to individual needs in a safe and dignified manner . Ensure residents dine in designated preferred locations . Offer meal replacement and/or substitution as appropriate if the resident refuses an item, or consumes 75% or less .</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>51285</p> <p>Based on observation, interview, and record review, the facility failed to provide adequate pain management, and develop and implement a resident centered care plan (tool that outlines the plan of action that will be implemented during a resident's care) for 1 of 39 sampled residents (Resident 22) when:</p> <ol style="list-style-type: none"> 1. The pain management services was not adequately provided to Resident 22; and, 2. The facility did not develop and implement a comprehensive person-centered care plan for pain for resident 22. <p>These failures led to Resident 22 experiencing unnecessary pain that potentially affected his physical and psychosocial well-being.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. A review of Resident 22's clinical record, ADMISSION RECORD, indicated Resident was admitted to the facility with diagnoses including, but not limited to, chronic embolism and thrombosis (long-standing blood clots in the deep veins of the legs, often causing leg pain and swelling) of unspecified deep veins of lower extremity, bilateral. <p>During an interview in Resident 22's room, on 4/22/25 11:37 a.m., and again on 04/23/25 09:16 a.m., Resident 22 stated that had pain fluctuating from 5 to 8 out of 10 on pain scale (a common tool used to quantify the intensity of pain. It typically ranges from 0, no pain to 10, worst possible pain,) to the bilateral anterior thigh radiating to lower extremities. Resident 22 added, pain was ongoing and did not relieve with current pain medication which was acetaminophen. Resident 22 further stated that pain affected his routine activities, and he was unable to attend group activities and any social events 2 weeks ago due to pain. Resident 22 stated it was hard to wake up with pain every day.</p> <p>During an interview in the hallway near Resident 22's room on 4/24/25 at 10:15 a.m., Certified Nursing Assistant (CNA) 2 stated Resident 22 had pain on daily basis in the morning around breakfast time and requested pain medication.</p> <p>Review of Resident 22's clinical record, Order Summary Report indicated, . Acetaminophen Tablet 325 MG Give 2 tablet by mouth every 4 hours PRN (as needed) for pain .</p> <p>Review of Resident 22's clinical record, MEDICATION ADMINISTRATION RECORD dated 2/1/2025-2/28/2025 in comparison to 4/1/2025-4/24/2025 were reviewed. Review of records indicated, the frequency of taking PRN acetaminophen for pain management had increased from 4 doses in the month of February to 28 doses in the month of April with the severity of pain fluctuating from 5 to 8 out of 10 on pain scale which for 11 days were administered in the mornings anytime between 5:31 a.m., to 8:10 a.m.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 22's clinical record, Activity Participation Note dated 4/12/25 indicated, .resident said, hurting because of body pain. Resident didn't attend any group today. Resident didn't attend any special events this week .</p> <p>Review of Resident 22's clinical record, Interdisciplinary Team Progress Note dated 4/16/25 indicated, .Pain: The resident is at risk for pain r/t arthritis, osteopenia, and degenerative disease .</p> <p>During a concurrent interview and record review in the nurse station 1 on 4/24/25 at 10:27 a.m., with Licensed Nurse (LN) 8 Resident 22's clinical record, MEDICATION ADMINISTRATION RECORD dated 4/1/25-4/24/25 was reviewed. LN 8 confirmed that frequency of taking PRN (as need arises) pain medication, acetaminophen has been significantly increased. Further LN 8 confirmed that in February PRN pain medication was administered 4 doses, and from April 1, 25 to April 24,25 Resident 22 received 28 doses of PRN pain medication. LN 8 stated that review indicated, Resident 22's PRN pain medication was not effective. LN 8 added Resident 22 requested specific pain medication. However, LN 8 was not able to recall the name of the medication and the date that Resident 22 requested the medication.</p> <p>During a concurrent interview and record review in the Director of Nursing (DON) office on 4/24/25 at 11:57 a. m., Resident 22's clinical records, MEDICATION ADMINISTRATION RECORD dated 2/1/25-2/28/25 and 4/1/25-4/24/25, and Activity Participation Note dated 4/12/25 were reviewed with the DON. The DON confirmed that frequency of taking PRN pain medication, acetaminophen had been significantly increased from February to April 2025. The DON stated increase in frequency indicated, pain medication was not effective. The DON stated her expectation from licensed nurses was to notify the Medical Director (MD)1 about increased in frequency of PRN pain medication. Further the review of Activity Participation Note dated 4/12/25 indicated that .pain affected Resident 22's daily activity. The DON stated that Resident 22's pain affected his daily activities, and there was a risk for Resident 22's to be declined in physical and mental well-being. Review of facility policy and procedure (P&P), PAIN MANAGEMENT dated 9/1/13 with the DON indicated, .the policy of this facility to promote physical comfort and psychosocial well-being through the identification and treatment of pain, as expressed by cognitively intact, or cognitively impaired, residents. PROCEDURE .10 .when a resident's medication regimen is ineffective at alleviating pain, or if pain is frequently severe in nature, the physician is to be notified for orders. If pain is consistent and exhibits noticeable patterns, and only PRN medications are ordered, then routine pain management should be considered and pursued with the physician . The DON acknowledged that the facility P&P was not followed.</p> <p>During a phone interview with MD 1 on 4/24/25 at 12:48 p.m., MD 1 stated his expectation from licensed nurses was to notify him when Resident 22's pain management was not effective and affected his daily activities. MD 1 further stated licensed nurses did not follow his expectation.</p> <p>2. During a concurrent interview and record review in nurse station 1 with Licensed Nurse (LN) 8 Resident 22's care plans were reviewed. LN 8 confirmed that Resident 22 did not have a care plan for pain. LN 8 stated the risk of not having a care plan for residents on a pain medication was missing the measures to manage the pain/discomfort. LN 8 further stated that Resident 22's needs to control pain/discomfort had not been met by the facility.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review in the Director of Nursing (DON) office on 4/24/25 at 11:57 a. m., Resident 22's care plans were reviewed. The DON confirmed that Resident 22 did not have a care plan for pain medication. The DON stated that care plans and its related interventions were tools for nursing staff to implement to eliminate Resident 22's pain/discomfort. The DON stated that not having a care plan for residents receiving pain medications would lead to not identifying and addressing residents' concerns about pain/discomfort and would affect residents' activities of daily living. The DON stated her expectation was that Resident 22 who was prescribed pain medication had a care plan for pain. The DON stated there was a risk for Resident 22 to decline in physical and mental health and his needs not being met. The facility policy and procedure (P&P) titled, PAIN MANAGEMENT dated 9/1/13 was reviewed with the DON. The facility P&P for PAIN MANAGEMENT indicated, .POLICY .the policy of this facility to promote physical comfort and psychosocial well-being through the identification and treatment of pain, as expressed by cognitively intact, or cognitively impaired, residents .PROCEDURE .4. Each resident who has active pain symptoms or are high risk for experiencing pain (diagnosis related or situational), will have a plan of care encompassing the use of medication .Plans of care should be specific to the location and type of pain the resident experiences, clinical manifestation of non-verbal or cognitively impaired residents, and measurable objectives . The DON acknowledged that the facility P&P was not followed.</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40903</p> <p>Based on interview and record review the facility failed to ensure safe medication use practices in three out of 39 sampled residents (Resident 134, Resident 19 and Resident 160) when:</p> <ol style="list-style-type: none"> 1. Resident 134's long term use of a medication called Protonix (or pantoprazole, belongs to a class of drugs called Proton Pump Inhibitor [PPI], a type of medication that reduces the amount of acid stomach produces) was not re-assessed or evaluated for continued use based on standards of practice and Food and Drug Administration's (FDA, a federal agency responsible for protecting the public health by assuring the safety, efficacy, and security of drugs) risk warnings on long term use of PPI's. 2. Resident 19's and 160's diabetic (a disease of unregulated blood sugar) medication including insulin (medication given as injection under skin to control high blood sugar) use did not have safe monitoring parameters for blood sugar levels changes. <p>These failed practices had potential to contribute to unsafe medication use and affect health and safety of the residents.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During a review of Resident 134's electronic medical record, titled Admission Record, dated 4/25/25, the record indicated Resident 134 was admitted into the facility on [DATE] with diagnosis including mental health issues, allergies, heartburn and GERD (stands for Gastro-Esophageal Reflux Disease, a condition where stomach acid frequently flows back up into the esophagus, the tube that carries food from your mouth to your stomach, and this backflow, called acid reflux, can irritate the lining of the esophagus and cause symptoms like heartburn) among others. The record did not indicate any history of recent or current intestinal (stomach) bleeding. <p>During a review of Resident 134's electronic medical record, titled Medication Administration Record (or MAR, a record that listed doctor's order and medications nurses give on daily basis), dated 4/2025, the record indicated Resident 134 had been receiving Protonix on daily basis since 9/30/21 for GERD.</p> <p>During a review of Resident 134's electronic medical record, under nursing plan of care, dated 10/4/21, the care plan which was updated on 3/25/25, indicated Resident will be free from discomfort or complication related to alteration in gastrointestinal through review date . The resident should avoid overeating. Provide small frequent meals rather than 3 large ones. Encourage the resident to take time eating and to alternate food with sips of fluids. Date Initiated: 10/04/2021</p> <p>Review of Resident 134's medical record, titled Physician Progress Notes, for year 2025, the record written by Medical Doctor 1 (MD 1), did not address continued need for use of Protonix or any issues related to resident's GERD diagnosis.</p> <p>(continued on next page)</p>

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In a concurrent telephone interview with facility's Consultant Pharmacist (CP) and the record review of Resident 134's medication list, on 4/24/25, at 11:49 AM, the CP's monthly Drug Regimen Review (DRR, it's the monthly review of drugs resident was taking and assess for risks and appropriateness by a pharmacist) was reviewed, and the CP confirmed no recommendation provided to the facility or the medical doctor to re-assess the use of long term Protonix. The CP stated she was aware of the FDA warnings regarding long term use of Protonix and other PPI.</p> <p>In a phone interview with MD 1, on 4/25/25, at 10:53 AM, MD 1 stated he did not recall getting any recommendation to address the long-term use of Protonix. MD 1 stated he heard about long term risks. MD 1 stated he did not see any active issues regarding resident's GERD or heartburn. MD 1 stated there were alternative and safer medication available if needed to treat the resident. MD 1 stated he was planning to reduce the dose and eventually discontinue if indicated.</p> <p>In an interview with the Director of Nursing (DON), in her office, on 4/25/25, at 12:22 PM, the DON stated the long-term use of Protonix should have been re-assessed since there was no compliant of stomach issues and she relied on the pharmacy and doctors to address it.</p> <p>Review of drug alert warning by FDA on long term use of Proton Pump Inhibitors (PPIs, i.e. Protonix), with date range of 5/25/2010, 2/8/2012, and 8/4/2017, the FDA had issued warnings about the potential risks associated with long-term use of PPI, including increased risk of fractures, hypomagnesemia (low magnesium level; Magnesium, a vital mineral that plays a crucial role in various bodily functions, including nerve and muscle function, bone health, and maintaining a steady heartbeat), and certain infections like Clostridium difficile (or C. Diff, a stomach infection that can lead to severe diarrhea). The FDA links were accessed on 4/29/25 via 1. https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/fda-drug-safety-communication-possible-increased-risk-fractures-hip-wrist-and-spine-use-proton-pump , 2. https://www.fda.gov/drugs/drug-safety-and-availability/fda-drug-safety-communication-clostridium-difficile-associated-diarrhea-can-be-associated-stomach#:~:text=pump%20inhibitors%20(PPIs)-,FDA%20Drug%20Safety%20Communication:%20Clostridium%20difficile%20associated%20diarrhea%20can%20be,as%20proton%20pump%20inhibitors%20(PPIs)&text=%5B02%2D08%2D2012%5D,diarrhea%20that%20does%20not%20improve.&text=Marketed%20under%20various%20brand%20and,used%20to%20treat%20frequent%20heartburn , and 3. https://www.fda.gov/drugs/drug-safety-and-availability/fda-drug-safety-communication-low-magnesium-levels-can-be-associated-long-term-use-proton-pump#:~:text=Data%20Summary-,Safety%20Announcement,PPI%20had%20to%20be%20discontinued.</p> <p>2A. Review of Resident 19's electronic medical record, titled admission Records, dated 4/25/25, indicated Resident 19 was admitted on [DATE] to the facility with diagnosis of mental health issues, diabetes and obesity among others.</p> <p>Review of Resident 19's electronic MAR, dated 4/2025, indicated resident 19 was on three different medications to treat the diabetes, an order to check blood sugar four times a day, and order for a reversal agent called Glucagon (a drug that reverse very low blood sugar) as follow:</p> <p>a. Basaglar . (Insulin Glargine, a long-acting insulin); Inject 14 unit (a measure of the dosage) subcutaneously (shot under the skin) one time a day; For FBS (Fingerstick Blood Sugar) Reduce further by 2 units for each occurrence if AM FBS (morning blood sugar) is <70 mg/dl and stay at the lower dose thereafter; Active since 3/2/25</p> <p>b. Insulin Lispro . (Insulin Lispro, is a short acting with quick onset insulin)</p> <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Inject 4 unit subcutaneously three times a day for DM2 (Diabetes disease); Active since 6/14/24</p> <p>c. Glucophage Tablet (or metformin, pill form of a drug to treat diabetes): Give 1000 mg (mg is milligram; a unit of measure) by mouth two times a day .; Active since:12/21/21</p> <p>d. FBS (Fingerstick Blood Sugar) QID or four times per day for FBS monitoring; Order date: 5/30/22</p> <p>e. Glucagon Inject 0.2 ml (ml is milliliter a measure of volume) subcutaneously as needed for S/S (Sign and Symptoms) Hypoglycemia (low blood sugar) for a blood glucose value less than 50, when the individual is unresponsive or unable to take an oral glucose replacement .; Order Date 9/29/22</p> <p>The orders did not give guideline or parameters to the nursing staff what to do if blood sugar was very high and what was considered high or low before residents becoming unresponsive.</p> <p>In a telephone interview with the Consultant Pharmacist (CP), on 4/24/25, at 11:37 AM, the CP stated she did not notice Resident 19's insulin and blood sugar measurement orders not having parameters. The CP stated she did not ask the nursing or the doctor to provide parameters for use of insulin and four times a day blood sugar measurement. The CP stated having a reversal agent order and Residents 19's good blood sugar results were an indication that parameters were not needed.</p> <p>In a concurrent interview and record review of the Resident 19, with the Director of Nursing (DON), in her office, on 4/25/25, at 12:22 PM, the DON stated the short acting insulin and blood sugar measurement orders did not have parameters to address variation and extremes in blood sugar number. The DON agreed it was a safe thing to have parameters. The DON acknowledged hyperglycemia (high blood sugar) was as important as hypoglycemia (low blood sugar) in the setting of many mental health drugs used in the facility that could result in higher blood sugar level.</p> <p>2B. Review of Resident 160's electronic medical record, titled admission Records, dated 4/25/25, indicated Resident 160 was admitted on [DATE] to the facility with diagnosis of mental health issues, diabetes and blood pressure among others.</p> <p>Review of Resident 160's electronic MAR, dated 4/2025, indicated resident 160 was on four different medications to treat the diabetes, an order to check blood sugar three times a day, and an order for a reversal agent called Glucagon (a drug that reversed a very low blood sugar) as follow:</p> <p>a. Insulin Degludec (or Tresiba, a long-acting insulin) 22 units subcutaneously one time a day for DM2; Increase by 2 units every week, if Average FBS (in the previous 6 days) is over 110 (the 110 number is blood sugar level), May go up to 30 units; Start date 3/3/25</p> <p>b. Novolin R . Insulin Regular (human) [a short acting insulin with quick onset]; Inject 3 unit subcutaneously three times a day for DM2 (Diabetes disease) After meals; Active since 3/4/24</p> <p>c. Glucophage Tablet (or metformin, pill form of a drug to treat diabetes): Give 1000 mg (mg is milligram; a unit of measure) by mouth two times a day .; Active since:5/24</p> <p>d. Ozempic (drug used to treat blood sugar) 1 mg Subcutaneous . once a week on Tuesday's for DM2 (Diabetes); Start Date: 11/2025</p> <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>e. FBS (Fingerstick Blood Sugar) TID AC (same as Three Times per day before meals); Order date: 12/24</p> <p>f. Glucagon Inject 0.2 ml subcutaneously as needed for S/S (Sign and Symptoms) Hypoglycemia (low blood sugar) for a blood glucose value less than 50, when the individual is unresponsive or unable to take an oral glucose replacement .; Order Date 6/24.</p> <p>The orders did not give guideline to the nursing staff what to do if blood sugar was very high and what blood sugar number was considered high or low before residents becoming unresponsive. The order for dose adjustment of insulin degludec (or Tresiba) based on 6 days average of blood sugar was not documented in the MAR.</p> <p>During a medication administration observations, with Licensed Nurse 6 (LN 6), at station 2 hallway, on 4/22/25, at 8:57 AM, LN 6 administered two insulins to Resident 160. LN 6 administered 3 units of insulin Novolin (a short acting with fast onset insulin) into the left side of abdominal area and injected 22 units of Insulin Degludec (or Tresiba, a long-acting insulin) into the right side of the abdominal area. The two orders did not have any parameters for nursing staff and the blood sugar number was documented as 81 (Normal blood sugar in adults 70 to 100 mg/dL or milligram per deciliter, a measure of sugar in blood).</p> <p>In an interview with Licensed Nurse 6 (LN 6) , at the nursing station 2, on 4/24/25, at 10:55 AM, LN 6 stated the parameters for hold to call MD or making interventions most of the times were included in the MAR. LN 6 stated the parameters were a safety alert to go beyond her nursing instincts and it would give directive from the doctor on what to do to prevent an event before actually happening.</p> <p>In a telephone interview with MD 1, on 4/25/25, at 10:53 AM, MD 1 stated he asked the facility to remind him of weekly blood sugar numbers. The MD 1 stated sometimes the facility continued the same orders from previous admission or hospital. MD 1 stated in the future we could write orders for nursing to review insulin orders. MD 1 stated moving forward he would make sure the safety parameters would be part of the order and implemented.</p> <p>In a concurrent interview and record review of the Resident 160's MAR, with Director of Nursing (DON), in her office, on 4/25/25, at 12:22 PM, the DON stated the short acting insulin and blood sugar measurement orders did not have parameters to address variation and extremes in blood sugar number. The DON agreed it was a safe thing to have parameters on when to call the doctor. The DON acknowledged hyperglycemia (high blood sugar) was as important as hypoglycemia (low blood sugar) in the setting of many mental health drugs used in the facility that could result in higher blood sugar level.</p> <p>Review of the facility's policy, titled Blood Glucose Testing, dated 9/1/13, the policy on section 7 indicated If the blood sugar result is abnormal or beyond the established ranges ordered by the physician: a. Notify the physician for further orders . Notify the physician and initiate treatment symptomatic of hypoglycemia or blood glucose value less than 60 mg/dL or as ordered by the physician .</p>		

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NAME OF PROVIDER OR SUPPLIER Crestwood Manor - 104		STREET ADDRESS, CITY, STATE, ZIP CODE 1130 Monaco Court Stockton, CA 95207	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>40903</p> <p>47368</p> <p>Based on observation, interview, and record review, the facility failed to ensure safe medication administration practices when medication error rate was more than 5% (% or percentage- number or ratio that expressed as a fraction of 100) with resident census of 176. Medication administration observations were conducted over multiple days, at varied times, in random locations throughout the facility. The facility had a total of three errors out of 32 opportunities which resulted in a facility wide medication error rate of 9.37% in 3 out of 13 residents (Resident 111, Resident 21 and Resident 163) observed for medication administration as follow:</p> <ol style="list-style-type: none"> 1. Resident 111's eye drop administration did not follow standards of practice on ophthalmic (eye) drug medication administration. 2. Resident 21's Linzess (a medication used to treat bowel motility and promotion of bowel movement) was given after morning breakfast against manufacturer specification to be given before meal and on an empty stomach. 3. Resident 163's Blood Pressure (BP, the force of blood pushing against the walls of arteries as heart pumps blood throughout your body) medication called Metoprolol (lower the blood pressure and heart rate) was documented in the Medication Administration Record (MAR, a legal document that listed doctor's orders and nursing administration of drugs) as given when it was held due to low BP. <p>These failures may result in unsafe medications use affecting residents' health and well-being.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During a medication administration observation, on 4/22/25, at 1:14 p.m., Licensed Psychiatric Technician (LPT) 2 administered eye drop to Resident 111's right and left eye. LPT 2 handed Resident 111 a piece of tissue paper which Resident 111 used to squeeze the eyeball and wiped the eye drops from both her eyes immediately after eye drop was administered. <p>During an interview with LPT 2 outside Resident 111's Room, on 4/22/25 at 1:20 p.m., LPT 2 stated that she also noticed Resident 111 wiped her eye drops from her eyes while squeezing her eyeballs with the tissue. LPT 2 further stated that Resident 111 should not have wiped eye drops from her eyes using the piece of tissue paper.</p> <p>Review of Nursing Journal-2025, last accessed on 4/30/25 via https://journals.lww.com/nursing/citation/2007/05000/administering_eyedrops.14.aspx, the article titled Administering Eyedrops: Clinical Do's and Don'ts, indicated using proper technique helps ensure that the patient benefits from his medication. The document further indicated . Ask the patient to tilt his head slightly back and to look toward the ceiling . Instill the prescribed number of drops into the center of the conjunctiva sac . Ask him to gently close his eyes and move them while closed to help distribute the solution. Tell him not to rub his eyes or squeeze them shut . Use a tissue to remove excess medication that has escaped from the conjunctiva sac . on to the cheeks.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. During a medication administration observation, on 4/23/25, at 8:50 a.m., Licensed Nurse (LN) 2 administered one capsule of Linzess mixed with apple sauce by mouth to Resident 21.</p> <p>During a concurrent interview with LN 2, and record review, on 4/24/25, at 1:54 p.m., LN 2 stated Linzess was ordered to be given at 8:00 a.m. and she administered it within the timeframe prescribed around 8:50 AM. LN 2 further stated breakfast was served to Residents 21 between 7:30 a.m. to 8.00 a.m. LN 2 stated there was no drug information resource available to look up Linzess and how it should have been administered.</p> <p>During an interview on 4/24/25, at 2:03 p.m., with Licensed Psychiatric Technician (LPT) 1, LPT 1 stated it would have been nice if instruction for Linzess to be administered on an empty stomach was entered on the MAR.</p> <p>During a concurrent interview with LN 2, on 4/24/25, at 1:54 p.m., and record review of resident 21's MAR, dated 4/2025, the MAR indicated the order for Linzess as follow: .Give 1 capsule by mouth one time a day for constipation . LN 2 confirmed the MAR order did not specify to be taken on empty stomach or before meal.</p> <p>Review of the DailyMed, a drug information database (a comprehensive, searchable online database providing access to drug labeling information submitted to the Food and Drug Administration (FDA) by pharmaceutical companies) on Linzess (or generic name of linaclotide), updated on 6/12/23, was last accessed on 4/30/25, via https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=09beda19-56d6-4a56-afdc-9a77b70b2ef3, the drug information under Preparation and Administration Instruction indicated Take LINZESS on an empty stomach, at least 30 minutes prior to a meal, at approximately the same time each day.</p> <p>3. During a medication administration observation, on 4/23/25, at 9:04 a.m., LN 2 measured Resident 163's blood pressure (the force of blood pushing against the walls of the arteries as it circulates throughout the body) and entered in the medical record. LN 2 stated the blood pressure medication called metoprolol needed to be held due to low blood pressure. LN 2 did not administer the metoprolol to Resident 163.</p> <p>During a review of Resident 163's electronic MAR, on 4/23/25, at 2:15 p.m., the MAR indicated the order for metoprolol as follow: .Give 50mg (a unit of measurement used to express the weight) .Hold if . SBP < 110 (systolic blood pressure less than 110) . The MAR further indicated the dose held on 4/23/25 at 9 a.m. was marked as given.</p> <p>During a concurrent interview with LN 2, and Resident 163's MAR review, on 4/24/25, at 2:06 p.m., LN 2 stated metoprolol was held because Resident 163's systolic blood pressure was low and was below the parameters ordered by the doctor. LN 2 further stated there was no documentation indicating metoprolol was held on 4/23/25 at 9 a.m.</p> <p>During an interview on 4/24/25, at 12:04 p.m., with the Director of Nursing (DON), the DON stated the licensed nurse should have prompted the resident not to squeeze out the eye drop with tissue. The DON further agreed that facility should have followed manufacturer's specification and asked for guidance from pharmacy on how to administer Linzess medication. The DON stated the nurse should have accurately documented in the electronic medical record when a medication was being held.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's policy, titled General Dose Preparation and Medication Administration, dated 1/1/22, the policy on section 5 indicated During medication administration, facility staff should take all measures required by facility policy and applicable law, including but not limited to the following: . Position the resident properly if necessary . Administer medication within time frame specified by facility policy or manufacturer's information . Provide residents with any instructions.</p> <p>Review of the facility's policy, titled Med Pass, Medication Administration Essentials, dated 12/28/18, the policy on section B indicated Whenever a medication is held for any reason, it must be indicated on the Electronic Medication Administration Record (EMAR) by the licensed nurse. The licensed nurse shall document on the Electronic Medication Administration Record (EMAR), noting the time and reason for medication was held.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40903</p> <p>Based on observation, interview, and record review the facility failed to ensure safe medication storage and labeling practices in three out of three medication rooms and one out of 4 medication carts when:</p> <ol style="list-style-type: none"> 1. Unlabeled and discontinued medications were stored in active storage areas in the medication rooms at Station 2 and Station 3. 2. Hazardous (drugs known to pose a health risk to healthcare workers due to their toxic properties upon skin contact) liquid medication with spills on the outer body of the medication bottle was stored in medication cart A at Station 3. 3. The pre-pour medication bins were observed to have sticky looking brownish spills in the top drawer of medication cart B at Station 1. 4. Supplies and discontinued medications were stored under the sink in medication rooms at station 1 and Station 2. 5. The refrigerator temperature upon inspection was above the temperature range listed on the temperature log for Station 2. <p>These failed practices could contribute to unsafe medication use, medication error and risk of contaminated or spoiled product or supplies.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During a concurrent interview and inspection of facility's medication room at Station 2, on [DATE], at 9:40 AM, accompanied by Licensed Nurse 4 (LN 4), the bucket holding supplies of Linzess (a prescription medication used to treat and prevent chronic constipation and required to be kept in original manufacturer container) contained two bottles of medications with no pharmacy label with only a small label on the bottle cap. LN 4 was not sure why the unopened bottles did not have provider pharmacy label like other bottles in the same bucket. <p>During a concurrent interview and inspection of facility's medication room at Station 2, on [DATE], at 9:40 AM, accompanied by LN 4, the cabinets stored bottles of a medication called Gavilyte-G (or GoLYTELY, a laxative powder containing medicine to help clean the gut prior to a surgery or procedure), dated [DATE] was stored in the active storage areas. LN 4 stated these were for one time use and should have been discarded.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and inspection of facility's medication room at Station 3, on [DATE], at 10:11 AM, accompanied by LN 5 and LN 6, the Linzess prescription container did not have pharmacy label with full dispensing information as required for a prescription medication. LN 5 stated the bottles had not been opened and it was sent to the facility with a small label on the cap of the container.</p> <p>During a concurrent interview and inspection of facility's medication room at Station 3, on [DATE], at 10:15 AM, accompanied by LN 5 and LN 6, the cabinets stored bottles of a medication called Gavilyte-G, dated [DATE] and [DATE] was stored in the active storage areas. LN 5 stated these unused discontinued medications should have been discarded.</p> <p>In an interview with the Director of Nursing (DON), in her office, on [DATE], at 3:26 PM, the DON stated she expected the pharmacy to provide full label upon dispensing with information on use and handling of drugs such as Linzess. The DON stated the discontinued or one time use medications, such as Golytely, should have been removed from active spaces even though they were not used unless there was an active order for them.</p> <p>2. During a concurrent interview and inspection of facility's medication cart A at Station 3, on [DATE] at 10:42 AM, accompanied by Licensed Psychiatric Technician 2 (LPT 2), the liquid form of a hazardous medication called Valproic Acid (drug in liquid form used to treat mood and help in controlling seizure [unusual brain activity]) had reddish color spills on the outer surface of the opened bottle inside the bottom drawer of the medication cart. LPT 2 stated they used glove to administer the medication but touching the bottle without gloves could have happened inadvertently when trying to find other liquid medications.</p> <p>In an interview with the DON, in her office, on [DATE], at 3:26 PM, the DON stated she expected nursing staff to use glove when handling the hazardous medication and any spill or contamination could have been contained if it was stored inside a Ziplock bag to prevent inadvertent skin contact.</p> <p>3. During a concurrent interview and inspection of facility's medication cart B at Station 1, on [DATE] at 1:52 PM, accompanied by LN 7, the top drawer had pre-pour medication bins with traces of residues, sticky looking brownish spills and broken sections. LN 7 stated she was not sure what was the brownish sticky spills and residues and needed to be replaced or cleaned.</p> <p>In an interview with Director of Nursing (DON), in her office, on [DATE], at 3:26 PM, the DON stated she was not aware of the condition of the pre-pour container in the medication cart and the nursing staff should have cleaned any spills or contamination in the medication workspaces.</p> <p>4. During a concurrent interview and inspection of facility's medication room at Station 2, on [DATE], at 9:40 AM, accompanied by LN 4, the cabinet underneath the sink stored multiple items including discontinued medication. LN 4 stated she was not sure why they were stored there.</p> <p>During a concurrent interview and inspection of facility's medication room at Station 1, on [DATE], at 1:49 PM, accompanied by LN 7, the cabinet underneath the sink stored multiple items including discontinued medication and cleaning supplies. LN 7 stated they have used the space for a while for storage.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview with the DON, in her office, on [DATE], at 3:26 PM, the DON stated the stored items placed under the sink could get soiled or contaminated for handling and use.</p> <p>5. During a concurrent interview and inspection of facility's medication room at Station 2, on [DATE], at 9:40 AM, accompanied by LN 4, the digital thermometer inside the medication refrigerator was located on top of the narcotic box and the temperature was recorded as 43-degree Fahrenheit (a temperature scale). LN 4 stated the temperature were recorded twice daily by nursing staff.</p> <p>The review of the temperature log sheet located on the refrigerator door, dated [DATE], the record indicated the temperature range for the morning and afternoon temperatures were between 36-to-41-degree Fahrenheit.</p> <p>During a concurrent interview and inspection of the facility's medication room at Station 3, on [DATE], at 11:20 AM, accompanied by LN 5 and LPT 4, the digital thermometer inside the medication refrigerator had a reading of 33.3 Fahrenheit. LN 5 and LPT 4 both confirmed that the temperature of the medication refrigerator was below the accepted range of 36-to-41-degree F. LPT 4 stated that bottles of eye drops, insulin (A hormone in the body that controls the amount of sugar in the blood by moving it into the cells, where it can be used by the body for energy) pens, bottles of Risperidone (A drug used to treat certain mental disorders), and vials of Ativan (a calming effect on the brain and nerves, which helps to reduce anxiety symptoms and treat seizures) were located inside the refrigerator. LPT 4 further stated that the efficacy of medications inside the refrigerator could be affected and that the medicines could freeze if the temperature continued to be below the accepted range.</p> <p>During an interview on [DATE] at 10:10 AM with the Director of Staff Development (DSD), the DSD stated that medicines that needed to be refrigerated should be between the 36-to-41-degree F range. The DSD also stated that medications would not be as effective if stored at incorrect temperatures. The DSD further stated that medications would not have the intended effect that they should.</p> <p>During an interview on [DATE] at 2:40 PM, the DON stated she wanted medications that were refrigerated to be in the proper temperature range. The DON also stated that medications could be diminished or not work as effectively if they were not in the proper temperature range.</p> <p>Review of the facility's policy titled, Storage and Expiration Dating of Medications ., last revised on [DATE], indicated Facility should ensure that medications and biologicals are stored at their appropriate temperature according to the United States Pharmacopeia guidelines for temperature ranges . Refrigeration: 36-to-46-degree Fahrenheit</p> <p>Review of the facility's policy titled, Storage and Expiration Dating of Medications ., last revised on [DATE], the policy on section ,d+[DATE] indicated The facility should ensure that medication and biological for expired or discharged or hospitalized residents are stored separately, away from use, until destroy or return to provider. Facility should destroy or return all discontinued, outdated, expired or deteriorated medication or biologicals in accordance with pharmacy return/destruction guidelines and other applicable law . Facility personnel should inspect nursing station storage area for proper storage compliance on a regularly scheduled basis. Facility should request that pharmacy perform routine nursing unit inspection for each nursing station in the in the facility to assist Facility in complying with its obligation pursuant to applicable law relating to the proper storage, labeling, security and accountability of medications and biologicals.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's policy titled, NIOSH (National Institute for Occupational Safety and Health, a federal agency within the Centers for Disease Control and Prevention (CDC) that focuses on occupational safety and health research) Hazardous Drugs/Chemicals and Safety Data Sheets ., last revised on [DATE], the policy on section 7 indicated Any equipment in the preparation of NIOSH hazardous drugs should be cleaned after each use with disposable wipes containing hypochlorite[same as bleach] .</p>

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41838</p> <p>Based on observation, interview and record review, the facility failed to provide a vegetarian (a person who does not eat meat, and sometimes other animal products) menu for the four residents for which a vegetarian diet had been ordered (Residents 30, 99, 129, and 165).</p> <p>This failure had the potential for leading to weight loss and nutrient deficiencies for those residents avoiding animal products.</p> <p>Findings:</p> <p>During an interview with the Dietary Assistant Supervisor (DAS) on 4/22/25 at 8:24 a.m., in the kitchen, facility offered diets were discussed. The DAS stated that the facility did not offer a vegetarian menu, and that they would serve fruit and cottage cheese to those avoiding animal products.</p> <p>During a concurrent observation and interview in the kitchen during the lunch preparation on 4/23/25 at 10:18 a.m., [NAME] 1 stated that residents on a vegetarian diet would get the Manicotti that day since the main entree was without meat, but fruit and cottage cheese would be provided for other meals when meat was on the menu.</p> <p>Review of Week 5 Menu indicated 16 out of 21 meals contained meat products.</p> <p>During an observation of the lunch meal plating on 4/23/25 at 12:03, the Dietary Supervisor (DS) stated they do not have a vegetarian menu, as many residents claim to be vegetarian but will eat the regular entree.</p> <p>Review of lunch tickets indicated that the facility had four residents on the vegetarian diet, Residents 30, 99, 129, and 165.</p> <p>Review of medical chart for Resident 30 indicated an order for a vegetarian diet since admission earlier in the month.</p> <p>Review of medical chart for Resident 99 indicated vegetarian diet orders had been in effect since September of 2014.</p> <p>Review of medical chart for Resident 129 indicated a preference for vegetarian meals as of 10/1/24.</p> <p>Review of medical chart for Resident 165 indicated a vegetarian diet was ordered as of 5/26/24.</p> <p>During an observation of lunch on 4/24/25 at 12:18 p.m., Resident 99 received pureed peas, mashed potatoes, a pureed roll, and a serving of pureed cookie for lunch. No source of protein was on the meal tray.</p> <p>During an observation of lunch on 4/24/25 at 12:41 p.m., Resident 165 was noted to have received a fruit and cottage cheese plate with 2 packages of crackers and cookie bar.</p> <p>(continued on next page)</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 4/24/25 at 12:56 p.m., Certified Nursing Assistant (CNA) 1 (who had worked at the facility for 8 years) stated those on vegetarian diets received fruit and cottage instead of the main entree.</p> <p>During an observation on 4/24/25 at 1:14 p.m., Resident 30 received a fruit and cottage plate with 2 packages of crackers, and a cookie bar.</p> <p>During an observation on 4/24/25 at 1:25 p.m., Resident 129 received meatloaf, mashed potatoes, peas, a roll and a cookie bar.</p> <p>Review of the facility provided Nutrition at a Glance ([NAME] Corporate Dietitians, 2025) indicated that the lunch provided on 4/24/25 would provide 1,015 calories and 36 grams of protein.</p> <p>Nutrition analysis of a fruit and cottage cheese plate (containing 1 cup of mixed fruit, 6 ounces of 4% fat cottage cheese, and 4 crackers) would provide approximately 280 calories and 9 grams of protein. This is 28% of the calories, and 25% of the protein provided by the regular meal.</p> <p>During a telephone interview with the Registered Dietitian (RD) on 4/24/25 at 2:31 p.m., the RD concurred that the fruit and cottage cheese plate with crackers would not provide the same nutrition as the regular diet. The RD further stated that the menu company the facility used had a vegetarian option but was unsure as to why it was not being used.</p> <p>Review of the RD Job Duties provided by the facility (Dietary Directions, Inc./Nutrition Therapy Essentials, Inc. Food Service Policy & Procedures Manual 2018) indicated that the RD, .1. Evaluates the nutrition needs of residents/patients and documents in the nutritional record .2. Interprets, evaluates and utilizes current research relating to nutritional care .3. Coordinates, implements, and evaluates the facility menus for nutritional adequacy .6. Evaluates and monitors the food service department to assure that the department is providing adequate, acceptable quality food .</p> <p>Review of the facility provided Dietary Manual section on Vegetarian Preferences ([NAME] Corporate Dietitians, revised 2/19) indicated, .The request for a vegetarian preference may come from a resident wishing to avoid foods that come from animals.Vegetarian meal plans can be well balance and meet the DRI's (Dietary Reference Intakes, a set of reference values for nutrient intake used to assess healthy diets) but may pose a challenge in providing all essential nutrients without the use of additional supplementation. Meeting adequate protein and calories for individuals on vegetarian preferences is essential. Include a wide variety of nutrient dense and fortified foods .</p> <p>Review of Senate [NAME] 1138 was signed into California law by Governor [NAME] in September 2018. It requires, .prisons, hospitals, nursing homes, and other state-operated facilities to offer plant-based meals . The law defines plant-based meals as entire meals that contain no animal products or byproducts, including meat, poultry, fish, dairy, or eggs.</p>		

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NAME OF PROVIDER OR SUPPLIER Crestwood Manor - 104		STREET ADDRESS, CITY, STATE, ZIP CODE 1130 Monaco Court Stockton, CA 95207	
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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50778</p> <p>Based on observation, interview, and record review the facility failed to ensure foods were stored, prepared, and served in accordance with professional standards for food service for 176 residents who ate facility prepared meals when:</p> <ol style="list-style-type: none"> 1. Red onions were found to have mold (a type of fungus that grows in moist environments); and 2. Food products lacked an open date, complete labeling, and/or expiration dates on labels; and 3. Walk-in freezer found with ice buildup; and 4. Washed items were stacked and stored wet; and 5. Fixed can opener had visible food particles and metal worn off the cutting tip, had worn/missing metal on the base, and metal shavings were located on ledge behind the cutting tip; and 6. Coffee cups and pitchers found to be discolored and/or deglazed (no longer having a finished surface), and cutting boards found with deep gouges on both sides; and 7. Fruit and vegetable preparation sink and ice machine lacked an air gap (backflow prevention system that prevents contaminated water from re-entering the sink or ice machine). <p>These failures had the potential to put residents at risk for foodborne illnesses (an illness resulting from eating contaminated food or beverages).</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During a concurrent observation and interview during the initial kitchen tour, on [DATE], at 8:24 a.m., with the Dietary Assistant Supervisor (DAS), in the walk-in refrigerator, a box of red onions was found to have mold on one onion and another onion that was cracked, bruised, and discolored. The DAS confirmed the observation and stated it was not acceptable to have molded food in a container with non-molded food which would cause them to go bad faster. <p>A review of The US Food and Drug Administration (FDA-a federal agency responsible for protecting public health by ensuring the safety and security of food, drugs, and other products) 2022 Food Code (US FDA 2022 Food Code), version [DATE], indicated, .Section ,d+[DATE].15 .Washing Fruits and Vegetables . Pathogenic microorganisms [organisms, like bacteria, viruses, and fungi, that can cause disease or illness], such as Salmonella ssp. [a group of bacteria that can cause diarrhea illness] .and chemicals such as pesticides [substances used to control or kill unwanted organisms], may be present on the exterior surfaces of raw fruits and vegetables .Infiltration [to enter or become established gradually] of microorganisms can occur through stem scars, cracks, cuts or bruises in certain fruits and vegetables .Once internalized, bacterial pathogens cannot be removed .</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>2. During a concurrent observation and interview during the initial kitchen tour, on [DATE], between 8:37 a.m. and 8:44 a.m., in the walk-in refrigerator, with the DAS, green onions were in a bag with no expiration date (ED). The DAS confirmed the observation and stated sometimes the staff forgets to write an ED on packages of food the facility had received.</p> <p>During a concurrent observation and interview during the initial kitchen tour, on [DATE] at 9:13 a.m., with the DAS, there was a plastic storage container in the kitchen refrigerator with a red lid that contained an undated bag of whipping cream. The sticker on the red lid was dated ,d+[DATE] and did not include the year. Additionally, several items in the kitchen did not include a complete open date (OD) and/or were not labeled correctly as follows:</p> <ul style="list-style-type: none"> a. A tray of milk in cups with lids contained a label with Date poured ,d+[DATE], and did not include the year; b. An open carton of Potato Pearls without an OD; c. Food rack containing loaves of bread dated pulled out ,d+[DATE] and Exp [expired] ,d+[DATE] and did not include the year; d. Opened box of corn starch was not sealed and was without an OD; e. Opened container of ground cloves was without an OD; f. Opened box of baking soda was not sealed and was without an OD; g. Container of Greek yogurt with an OD ,d+[DATE] and ED ,d+[DATE] and did not include the year; h. Box of powdered sugar was opened, not sealed and undated; and i. Round container of baking powder with a plastic lid had an unreadable OD on the lid. <p>The DAS confirmed the above observations and stated the potential problem of not writing an OD or the date on food items with the month/day/year would be that staff would not know when to throw the item out, when the item expired, and/or when the item needed to be discarded.</p> <p>During a telephone interview on [DATE] at 3:31 p.m. with the Registered Dietician (RD), the RD stated, her expectation was that items must have an OD and use by date, and the required elements of dated food included month/day/year.</p> <p>During an interview on [DATE] at 8:55 a.m., with the Dietary Supervisor (DS), the DS stated staff should use correct expiration dates including the year, as expired items can lead to foodborne illness.</p> <p>During a review of the facility's policy and procedure (P&P) titled, FOOD RECEIVING AND STORAGE OF COLD FOODS, dated 2018, the P&P indicated, .All perishable [food likely to go bad quickly] food items .will be stored properly .will have an open date and use-by-date .</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>A review of the US FDA 2022 Food Code, version [DATE], indicated, .Section ,d+[DATE].17 (A) (B) (C) (D) . required food labeling and dating .the day the original container is opened in the food establishment shall be counted as Day 1 .The date marked shall not exceed a manufacturer's use-by date .mark the date or day of preparation, with a procedure to discard the food on or before the last date or day .</p> <p>3. During a concurrent observation and interview on [DATE] at 8:50 a.m., with the DAS during the initial kitchen tour, in the walk-in freezer, there was ice buildup on the ceiling, as well as covering ,d+[DATE] of the right side of the door (approximately ,d+[DATE]-,d+[DATE] inches thick), the entire top of the freezer door, the top 6 inches of the left side of the door, and plugging the vent on the door. The walk-in freezer door would not shut or latch completely due to ice buildup. The DAS acknowledged the above observation and stated he would report the issue to maintenance.</p> <p>During an interview on [DATE] at 8:20 a.m., the PMS confirmed ice buildup was on and around the door of the walk-in freezer, and the door did not latch securely. The PMS stated the problem was the hinges on the door needed to be replaced which resulted in the door not latching. The PMS further stated when the door is unable to close, freezer temperatures would not be maintained, ice would continue to build up around the door, and the food would not freeze properly.</p> <p>A review of the US FDA 2022 Food Code, version [DATE], indicated, .Section ,d+[DATE].11 .Packaged and Unpackaged Food - Protection Separation, Packaging, and Segregation .The freezer equipment should be designed and maintained to keep foods in the frozen state XXX,d+[DATE].11 Good Repair and Proper Adjustment .Proper maintenance of equipment to manufacturer specifications helps ensure that it will continue to operate as designed .</p> <p>4. During an observation on [DATE] at 9:40 a.m., in the kitchen, [NAME] 2 was working on the clean side of the dishwashing area. [NAME] 2 stacked trays before they were dry (wet stacked-the act of stacking or putting away kitchen items without allowing them to air dry completely), placed wet bowls and coffee cups on wet trays without a drying mat (a mesh mat that permits air to flow under dishes allowing them to dry completely), and placed a plate with a brown substance (possibly food residue) in the stack of clean plates.</p> <p>During an interview on [DATE] at 12:22 p.m., the DS confirmed the above observations and stated plates should be clean when stacked, and clean bowls and coffee cups should be allowed to air dry before stacking or being placed on trays with a drying mat. The DS stated the problem with placing a dirty plate with clean plates and when wet stacking clean bowls and coffee mugs could be bacteria growth causing illness to residents.</p> <p>During a telephone interview on [DATE] at 2:31 p.m., the RD stated, kitchen items should not be put away when still wet and should be left on a rack to air dry. The RD stated, the problem would be water collected in/on dishes could cause odors and bacterial growth and could make residents sick.</p> <p>A review of the US FDA 2022 Food Code, version [DATE], indicated, .Section ,d+[DATE].11 .Equipment and Utensils, Air-Drying Required . Items must be allowed to drain and to air-dry before being stacked or stored. Stacking wet items such as pans prevents them from drying and may allow an environment where microorganisms can begin to grow .</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>5. During an observation on [DATE] at 9:50 a.m., in the kitchen, the metal cutting tip on the fixed can opener had food particles stuck to it and had missing metal. Additionally, there was missing metal around the shaft, and metal shards were visible on the ledge behind the metal cutting tip.</p> <p>During a telephone interview on [DATE] at 2:31 p.m., the RD stated, when conducting a monthly kitchen inspection, she would check to see if the can opener was clean and without residual food on it. The RD stated, she was unaware of missing metal on the cutting tip and shaft. The RD further stated, if metal was chipping, metal could go into the food and become a safety issue.</p> <p>During an interview on [DATE] at 8:55 a.m., the DS confirmed the above observation and stated, the can opener does not meet his expectations.</p> <p>During a review of the facility's policy and procedure (P&P) titled, CLEANING SMALL APPLIANCES AND EQUIPMENT, dated 2018, indicated, .Equipment will be cleaned and sanitized to prevent food borne illness . Can openers will be cleaned after each use and sanitized daily .</p> <p>A review of the US FDA 2022 Food Code, version [DATE], indicated, .Section ,d+[DATE].11 .Good Repair and Proper Adjustment .(C) cutting or piercing parts of can openers shall be kept sharp to minimize the creation of metal fragments that can contaminate food when the container is opened .</p> <p>6. During the initial kitchen tour on [DATE] at 10:00 a.m., food service items were observed in the following condition:</p> <p>a. Coffee mugs were found to be deglazed and had dark brown stains inside;</p> <p>b. Pitchers for water and other liquids intended for residents were found to be stained a tan to dark brown color and did not have an appealing appearance;</p> <p>c. Colored cutting boards in the food preparation area had visible, deep grooves on both sides: one red (typically used for meat products), one green (typically used for fruits and vegetables) and one white (typically used for dairy or bread products); and</p> <p>d. Colored cutting boards in the cook's station had visible deep grooves on both sides: two yellow (typically used for poultry) and a second green board.</p> <p>During an interview on [DATE] at 8:55 a.m., the DS confirmed the above observations and stated the cutting boards had too many deep grooves. The DS stated the problem was that bacteria could stay in the grooves and cause residents to contract food borne illnesses. The DS further stated, the pitchers used to serve residents were stained in a brownish color, resulting in an unappealing look which could cause the contents in them to be mistaken. The DS also stated the pitcher lids were cracked and looked old.</p> <p>During a review of the facility's P&P titled, TRAY ASSEMBLY, dated 2018, indicated, .Plates and serving equipment; plates, cups, silverware, special feeding devices, that are chipped or unsightly will be discarded .</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>A review of the US FDA 2022 Food Code, version [DATE], indicated, .Section ,d+[DATE].11 .Multiuse FOOD-CONTACT SURFACES shall be .Smooth . Free of breaks, open seams, cracks, chips, inclusions, pits, and similar imperfections . Free of sharp internal angles, corners, and crevices .</p> <p>7. During a concurrent observation and interview on [DATE] at 10:47 a.m., in the main dining room, with the PMS and the PMA, the PMS confirmed the ice machine lacked an adequate air gap of ,d+[DATE] inches and a second line was inserted into the body of the air gap. The PMA stated, he did not know that air gaps were required and confirmed the presence of the second plumbing line coming from the ice machine and was inserted into the body of the air gap.</p> <p>During a concurrent observation and interview on [DATE] at 10:55 a.m., in the kitchen, with the PMS and the PMA, both confirmed the fruit/vegetable wash sink lacked an air gap, as the black plumbing pipe from the ground was directly connected to the sink's water outlet. The PMS and PMA further stated they had never heard of this requirement before.</p> <p>A review of the US FDA 2022 Food Code, version [DATE], indicated, XXX,d+[DATE].13 Backflow Prevention, Air Gap .An air gap between the water supply inlet and the flood level rim of the PLUMBING FIXTURE, EQUIPMENT, or nonFOOD EQUIPMENT shall be at least twice the diameter of the water supply inlet and may not be less than 25 mm [millimeter, a unit of measure] (1 inch) .</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>40911</p> <p>Based on observation, interview, and record review, the facility failed to ensure proper and safe infection prevention practices were implemented and followed for a resident census of 176 when:</p> <ol style="list-style-type: none"> 1. There was no separation between clean area and dirty area in three of three utility rooms observed. 2. A bucket stocked with clean supplies, used for insulin (a drug used to treat blood sugar disease) administration and blood sugar measurement, were taken inside residents' room without consideration for risk of contamination. 3. Drug administration platform inside the medicine cart was not cleaned with brownish residues. 4. The pill cutter stored in medication cart had white powder-like residue inside the lid. 5. Kitchen swamp cooler vent covers had peeling paint with dust and debris above food preparation areas. <p>These failures had the potential to place the residents at risk for developing an infection and the potential to result in transmission of infection in the facility.</p> <p>Findings:</p> <p>1a. During a concurrent observation and interview on 4/23/25, at 4:13 p.m. with the Infection Preventionist (IP) and the Interim Infection Preventionist (IIP) in the utility room at Station 2, the utility room was noted to have a hopper (a flushing-rim sink used for disposal of blood or body fluids which is not the same as a hand-washing sink). In the utility room were also a stack of clean gloves mounted on the wall, a clean paper towel dispenser, and two bottles of eye wash mounted on the wall next to the hopper. There were other clean supplies in the utility room with the hopper such as staffs' N95 masks (respiratory protective device designed to filter out at least 95% of airborne particulate matter), blood pressure apparatus, wound care supplies, and residents' supplies in the cabinets next to the hopper. There was no clear delineation between the hopper and the clean supplies. The IP confirmed the hopper was being used and clean items should not be next to the hopper.</p> <p>1b. During a concurrent observation and interview on 4/23/25, at 4:23 p.m. with the IP and IIP in the utility room at Station 3, a hopper was noted. Above the hopper was a box of clean gloves and to the side of the hopper was a clean paper towel dispenser and an eyewash kit both mounted on the wall next to each other. There were other clean supplies kept in this utility room such as a blood pressure apparatus, staffs' personal N95 masks, laptop computers, and weighing scale. The IP confirmed the hopper was being used.</p> <p>1c. During a concurrent observation and interview on 4/23/25, at 4:27 p.m. with the IP and IIP in the utility room at Station 1, a hopper was noted. And next to the hopper was a weighing scale. There were other clean supplies noted such as personal items for oral care and personal trays for the residents. The IP confirmed the hopper was being used at times.</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 - Some</p>	<p>The IP stated the hopper and clean supplies in close proximity had the potential for possible contamination of the clean supplies and the contaminated supplies could had been used for residents' care, and there could be risk of spreading germs causing illnesses.</p> <p>A review of the facility's document titled, INFECTION CONTROL PROGRAM, dated 10/1/92, indicated, .The facility will establish and maintain an infection control Program designed to provide a safe, sanitary, and comfortable environment for residents and staff and to help prevent the development of transmission of disease and infection .</p> <p>40903</p> <p>2. During a medication pass observation, in the facility's Station 2 hallway, on 4/22/25, at 9:55AM, Licensed Nurse (LN) 4 took, along with insulin (drug in injection or shot form used to treat blood sugar disease) medications, a black plastic bucket containing supplies, into Resident 160's room to administer two insulin products. LN 4 placed the bucket at the bedside table and used the alcohol wipes to clean the injection sites for insulin administration. The black bucket stored supply of additional insulin needles, alcohol wipes and supplies to poke the finger. LN 4 returned the black bucket back to the bottom drawer of the medication cart without any cleaning or sanitizing.</p> <p>In an interview with LN 6, at facility's station 2 station, on 4/24/25, at 10:55 AM, LN 6 stated the facility trained them to use the bucket into the room when measuring blood sugar or giving insulin to have all supplies needed. LN 6 stated by taking the whole supply bucket into the room, there would be chances of contamination that could spread the germs.</p> <p>In an interview with the Director of Nursing (DON), in her office, on 4/23/25, at 3:26 PM, the DON stated the facility created the buckets with supplies for insulin and blood sugar measurement for nurses to take into the room so to reduce the number of times the nurse had to go in and out of the room to get supplies. The DON stated the practice could cause contamination of the supplies shared with other residents.</p> <p>Review of the facility's policy, titled Blood Glucose Testing, dated 9/1/13, the policy indicated Blood glucose (sugar) finger sticks will be done in a safe and comfortable manner within the standards of infection control, nursing practice and manufacturer's guidelines, .</p> <p>3. During a concurrent interview and inspection of facility's medication cart B at Station 1, on 4/22/25 at 1:52 PM, accompanied by Licensed Nurse 7 (LN 7), the top drawer had pre-pour medication bins with traces of dark residue, sticky looking brownish spills and broken sections. LN 7 stated she was not sure what was the brownish sticky spills and residues and needed to be replaced or cleaned.</p> <p>In an interview with the DON, in her office, on 4/23/25, at 3:26 PM, the DON stated she was not aware of the condition of the pre-pour container in the medication cart and the nursing staff should have cleaned any spills or contamination in the medication workspaces.</p> <p>4. During a concurrent interview and inspection of facility's medication cart B at Station 1, on 4/22/25 at 1:52 PM, accompanied by Licensed Nurse 7 (LN 7), the pill cutter (a device used to split pills in half) stored in the top drawer of medication cart had white powder like residue inside. LN 7 acknowledged and stated it should have been cleaned after use.</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 - Some</p>	<p>In an interview with the DON, in her office, on 4/23/25, at 3:26 PM, the DON stated the pill cutter should be cleaned after each use to reduce risk of cross contamination. The DON stated the pharmacy provider should send medications in a size or dose that reduces nursing to cut pills.</p> <p>Review of the facility's policy, titled General Dose Preparation and Medication Administration, dated 1/1/22, the policy indicated Prior to preparing or administering medication, authorize and competent facility staff should follow facilities infection control policy . Dose Preparation: Facility should take all measures required by facility policy and applicable law, .</p> <p>50778</p> <p>5. During an observation on 4/23/25 at 9:52 a.m., in the kitchen, there were three drop-down vent units on the ceiling in the kitchen. Each square unit had visible rusted areas, plus flaking, peeling, and/or missing paint on all four sides. The three vents were in a straight line and directly above the cooking and food preparation areas.</p> <p>During a concurrent observation and interview on 4/25/25 at 8:20 a.m., in the kitchen, the Plant Maintenance Supervisor (PMS) stated the three vents on the ceiling were for the facility swamp cooler and the vent covers on each unit were taken down monthly to be cleaned, and it was documented on a log. The PMS confirmed the presence of rusted areas, and/or flaking, peeling, or missing paint on all four sides of each vent. The PMS stated it was the responsibility of the kitchen staff to notify maintenance when problems were noticed, and the maintenance department would then scrub and paint them [the vents]. The PMS further stated, the risk was that the metal particles could fall on the food and once in the food, could harm residents, make them sick, or they could get stuck in the resident's throat.</p> <p>During an interview on 4/25/25 at 8:55 a.m., the Dietary Supervisor (DS) stated the rusted, flaking, peeling, and/or missing paint on the ceiling vents did not meet expectations and needed to be cleaned better, as it could lead to food borne illness.</p> <p>A review of The US Food and Drug Administration (FDA-a federal agency responsible for protecting public health by ensuring the safety and security of food, drugs, and other products) 2022 Food Code (US FDA 2022 Food Code), version 1/18/23, indicated, .Section 6-501 Premises, Structures, Attachments, and Fixtures .605.11 Repairing .PHYSICAL FACILITIES shall be maintained in good repair .Cleaning, Frequency and Restrictions .PHYSICAL FACILITIES shall be cleaned as often as necessary to keep them clean . Cleaning Ventilation Systems .Intake and exhaust air ducts shall be cleaned and filters changed so they are not a source of contamination by dust, dirt, and other materials .</p>		