STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A427	A. Building B. Wing	04/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crestwood Manor - Fremont	4303 Stevenson Boulevard Fremont, CA 94538

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 51749 Based on interview, record review, facility document review, and facility policy review, the facility failed to protect a resident's right to be free from abuse perpetrated by staff for 1 (Resident #103) of 1 sampled resident reviewed for abuse. Findings included: A facility policy titled, Elder and Dependent Adult Abuse/Suspicion of a Crime, revised 01/10/2019, indicated, First and foremost, [facility name] believes every person served, or resident has the right to be free of: a) Physical abuse, neglect, financial abuse, abandonment, isolation, abduction, exploitation, or other treatment with resulting physical harm or pain or mental suffering. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. b) Deprivation of goods or services that is necessary to avoid physical harm or mental suffering. An Admission Record indicated the facility admitted Resident #103 on 04/04/2024. According to the Admission Record, the resident had a medical history that included diagnoses of schizoaffective disorder and type 2 diabetes. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/09/2024, revealed Resident #103 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. Resident #103's Care Plan Report included a focus area initiated 04/04/2024, that indicated the resident had a history of assaultive behavior and was easily upset or frustrated related to their diagnoses and poor impulse control. Interventions directed staff to place a stop sign at the resident's door (initiated 04/18/2024) and encourage attendance in special treatment program (STP) groups and activities that encouraged impulse control and development of social skills (initiated 04/04/2024). (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #103's Progress Notes, dated 11/18/2024 at 11:35 AM and electronically signed by Registered Nurse (RN) #4, revealed that an incident took place at lunch time in the community center/dining room. The note indicated that a CNA reached for Resident #103's cup of juice, and the resident picked up the cup and threw it at the CNA. Per the note, a program staff entered the dining room and attempted to de-escalate the situation and wheel the resident back to their room. The note indicated that the CNA approached Resident #103 with a disinfectant spray bottle, aimed at the resident, then stated something along the lines of Do you think I'm afraid of you? The note indicated that a program staff and RN #4 notified their supervisor of the incident. A Report of Suspected Dependent Adult/Elder Abuse report form, dated 11/18/2024, indicated that on 11/18/2024 at 11:40 AM, Resident #103 threw juice on CNA #3 when the CNA took the juice off the resident's meal tray. The report indicated that CNA #3 then threw juice on the resident from the same cup. The report indicated that the CNA gestured with a spray bottle as if she was going to spray the resident and said, I am not afraid of you. Per the report, the CNA did not deny the incident. The report indicated CNA #3 was suspended pending the investigation and their employment would be terminated pending the results. An untitled handwritten document, dated 11/18/2024, provided as part of the facility's investigation indicated that CNA #3 did not deny what happened and stated that there may have been juice in the cup. The document indicated that CNA #3 apologized and stated that they lost their temper. A handwritten statement, dated 11/18/2024 and signed by the Director of Nursing (DON), indicated that the resident was interviewed about the incident and stated that they attacked a staff member, and the staff member pointed a spray bottle at them. A handwritten statement, dated 11/18/2024 and signed by RN #4, indicated that she was waiting for Resident #103 to finish their meal when a CNA grabbed a cup of juice the resident had on their table. The statement indicated the resident got upset with the CNA for touching their juice and threw the juice at the CNA. The statement indicated that a program staff member came to deescalate the situation and as they wheeled the resident back to their room, the CNA walked up to the resident holding a cleaning spray bottle, aimed it at the resident, and asked, Do you think I'm afraid of you? A typed statement, dated 11/18/2024 by Special Treatment Program Counselor (STPC) #5, indicated that at 11:35 AM, he entered the community center and upon entering, he heard a resident having a verbal disagreement with a CNA. The statement indicated that he witnessed the CNA throw juice on the resident. Per the statement, when he began to wheel the resident out of the community center, the CNA walked up to them holding a cleaning bottle, aimed it at the resident, and gestured as if she was going to squeeze the trigger and spray the cleaner on the resident. The statement indicated that the CNA stated, I'm not afraid of you! (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/15/2025 at 1:36 PM, RN #4 stated that she had been watching dining, and Resident #103 was the last resident in the room to finish their meal. She stated CNA #3 grabbed Resident #103's food, which made the resident get agitated and start yelling, eventually throwing juice in a cup at the CNA. She stated that she told CNA #3 that she would handle the situation and attempted to de-escalate when the CNA and Resident #103 started to argue. She stated that a program staff member walked into the room and attempted to calm Resident #103. She stated that the program staff started to wheel the resident out of the door to go back to the resident's room when CNA #3 pointed a cleaning bottle at Resident #103. She stated that Resident #103 was removed to their room and RN #4 reported the incident immediately to the CNA supervisor, the DON, and the Administrator. She stated that she wrote out a statement. She stated Resident #103 did not suffer any injuries and had no changes in behavior after the incident. She stated that she was not aware of any prior history between CNA #3 and Resident #103. She stated that she had never witnessed CNA #3 being inappropriate with other residents. During an interview on 04/15/2025 at 1:16 PM, STPC #5 stated that he walked through the dining room and witnessed the incident. He stated that Resident #103 was the last person in the dining room, and other staff in the room included RN #4 and CNA #3. He stated he noticed Resident #103 and CNA #3 were arguing and when he went to intervene, CNA #3 made a motion like she was going to throw juice from a cup on Resident #103, but he did not actually see any liquid. He stated he tried to wheel the resident back to their room through the right door, since CNA #3 was on the left side of the room. STPC #5 stated CNA #3 came to the right side of the room and made a motion like she was going to spray Resident #103 with a yellow bleach spray bottle. He stated he got Resident #103 safely to their room and then reported to the nurse and the Administrator. He stated that CNA #3 was serious and was mad. He stated CNA #3 spoke with a raised voice and said, You think I'm scared of you? STPC #5 stated Resident #103 did not have any injuries, and no juice or bleach actually got on the resident. He stated that he did not notice any changes in behavior for the resident. He stated that there was no history between CNA #3 or Resident #103 that he was aware of. During an interview on 04/15/2025 at 1:59 PM, the Assistant Administrator, who investigated the incident, stated she was notified of the allegation of abuse by STPC #5 immediately after it happened. She stated CNA #3 was put in a separate room to protect the alleged victim. She stated CNA #3 was called to the front office and was suspended immediately. She stated CNA #3 admitted to committing the abuse. She stated what was reported to her was that STPC #5 said that Resident #103 threw juice on CNA #3, then CNA #3 tossed the same glass contents on Resident #103, then pointed a spray bottle at the resident as a threat. The Assistant Administrator stated they notified the nursing board, local police department, the Ombudsman, and the state survey agency. During an interview on 04/15/2025 at 2:28 PM, the Administrator stated that the administration staff was notified of the alleged abuse within minutes of it happening. She stated CNA #3, the alleged perpetrator, was suspended and taken off the premises immediately.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 51749 Based on interview, record review, facility document review, and facility policy review, the facility failed to implement their policy to complete a thorough investigation, which affected 1 (Resident #103) of 1 sampled resident reviewed for abuse. Specifically, the facility failed to interview additional cognitively intact residents to determine if there was a history of inappropriate behaviors by Certified Nursing Assistant (CNA) #3 or other staff following an incident of abuse which involved CNA #3 and Resident #103. Findings included: A facility policy titled, Elder and Dependent Adult Abuse/Suspicion of a Crime, revised 01/10/2019, indicated, II. Investigation & Protection A. All incidents require a thorough investigation in an attempt to determine what occurred and to make changes, as needed, to prevent reoccurrence. A thorough investigation is a systemic (consistent and ordered) collection of information (evidence) that describes and explains an event or a series of events. The policy specified, (g) Interview other cognitively alert persons served to determine if there is a possible history of inappropriate staff behavior toward persons served. An Admission Record indicated the facility admitted Resident #103 on 04/04/2024. According to the Admission Record, the resident had a medical history that included diagnoses of schizoaffective disorder and type 2 diabetes. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/09/2024, revealed Resident #103 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. Resident #103's Care Plan Report included a focus area initiated 04/04/2024, that indicated the resident had a history of assaultive behavior and was easily upset or frustrated related to their diagnoses and poor impulse control. Interventions directed staff to place a stop sign at the resident's door (initiated 04/18/2024) and encourage attendance in special treatment program (STP) groups and activities that encouraged impulse control and development of social skills (initiated 04/04/2024). Resident #103's Progress Notes dated 11/18/2024 at 11:35 AM and electronically signed by Registered Nurse (RN) #4, revealed that an incident took place at lunch time in the community center/dining room. The note indicated that a CNA reached for Resident #103's cup of juice, and the resident picked up the cup and threw it at the CNA. Per the note, a program staff entered the dining room and attempted to de-escalate the situation and wheel the resident back to their room. The note indicated that the CNA approached Resident #103 with a disinfectant spray bottle, aimed at the resident, then stated something along the lines of Do you think I'm afraid of you? The note indicated that a program staff and RN #4 notified their supervisor of the incident. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Report of Suspected Dependent Adult/Elder Abuse report form, dated 11/18/2024, indicated that on 11/18/2024 at 11:40 AM, Resident #103 threw juice on CNA #3 when the CNA took the juice off the resident's meal tray. The report indicated that CNA #3 then threw juice on the resident from the same cup. The report indicated that the CNA gestured with a spray bottle as if she was going to spray the resident and said, I am not afraid of you. Per the report, the CNA did not deny the incident. The report indicated CNA #3 was suspended pending the investigation and their employment would be terminated pending the results. During an interview on 04/15/2025 at 11:49 AM, the Administrator provided the file of the facility's investigation of the incident and stated that no resident interviews had been completed because CNA #3 was well liked by residents and did not have any history of abuse and had worked at the facility for a long time. During an interview on 04/15/2025 at 1:59 PM, the Assistant Administrator stated she was unsure if any other potentially affected residents were interviewed. She stated the Director of Nursing (DON) would have been the one to do so. During an interview on 04/15/2025 at 2:21 PM, the DON stated that she interviewed the alleged victim and reported the incident to the resident's doctor, Conservator, and to the local police department. The DON stated she did not interview any other residents because Resident #103 was the only resident in the dining room at the time. The DON stated she did not interview any residents on the unit that CNA #3 may have had contact with.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 51749 Based on interview, record review, facility document review, and facility policy review, the facility failed to report an allegation of misappropriation of resident property to the state survey agency for one (Resident #93) of 22 sampled residents. The facility further failed to timely report an allegation of abuse to the state survey agency and submit the results of the investigation to the state survey agency for 1 (Resident #103) of 1 sampled resident reviewed for abuse. Findings included: A facility policy titled, Elder and Dependent Adult Abuse/Suspicion of a Crime, revised 01/10/2019, indicated, If the alleged violation involves abuse OR results in serious bodily injury: Immediately but no later than 2 hours to the State & local police. The policy specified, Results of all investigations of allegation violations: Within 5 working days of the incident. 1. An Admission Record revealed the facility admitted Resident #93 on 03/06/2024. According to the Admission Record, the resident had a medical history that included a diagnosis of schizoaffective disorder. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/13/2025, revealed Resident #93 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. Resident #93's Progress Notes, dated 03/07/2024 at 8:56 AM and electronically signed by Social Services (SS) #27, revealed Resident #93 accused SS #27 of stealing $1,400.00. During an interview on 04/17/2025 at 11:48 AM, the Administrator stated they did not have any self-reports made to the state survey agency for Resident #93. She stated that she did not report to the state because there was no actual property missing. During a follow-up interview on 04/17/2025 at 12:40 PM, the Administrator stated that by talking to other staff that, she found that Resident #93 alleged previously that social services staff stole $1,400. She stated that her process when an allegation of abuse was reported to her was to immediately report to the state agency. She stated that during the timeframe when they had to report to the state agency, she verified through interviews and gathering information to determine if in fact abuse/misappropriation of property occurred. During an interview 04/17/2025 at 2:41 PM, SS #27 stated that upon admission, Resident #93 reported they were missing a $1,400 check. She stated that she talked to other staff about if the resident had a check. She stated that because there was no evidence, she felt no need to proceed with reporting misappropriation to the Administrator. She stated that if there had been evidence Resident #93 had a check, she would have gone to the Administrator and notified the Conservator. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/18/2025 at 9:04 AM, the Director of Nursing (DON) stated that she had not been notified of an allegation of misappropriation of property in March 2024 from Resident #93. The DON stated that she expected staff to report the allegation of theft to her or the Administrator, who was the Abuse Coordinator, and she would need to do a full investigation. The DON stated she would verify it first with social services staff if the resident really had money but then would report to the state agency after verifying that the resident had money. During an interview on 04/18/2025 at 10:49 AM, the Assistant Administrator stated that she did not recall if the allegation of misappropriation of funds on 03/07/2024 had been reported to her, but SS #27 was trained to notify her of allegations. 2. An Admission Record indicated the facility admitted Resident #103 on 04/04/2024. According to the Admission Record, the resident had a medical history that included diagnoses of schizoaffective disorder and type 2 diabetes. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/09/2024, revealed Resident #103 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. Resident #103's Care Plan Report included a focus area initiated 04/04/2024, that indicated the resident had a history of assaultive behavior and was easily upset or frustrated related to their diagnoses and poor impulse control. Interventions directed staff to place a stop sign at the resident's door (initiated 04/18/2024) and encourage attendance in special treatment program (STP) groups and activities that encouraged impulse control and development of social skills (initiated 04/04/2024). Resident #103's Progress Notes, dated 11/18/2024 at 11:35 AM and electronically signed by Registered Nurse (RN) #4, revealed that an incident took place at lunch time in the community center/dining room. The note indicated that a CNA reached for Resident #103's cup of juice, and the resident picked up the cup and threw it at the CNA. Per the note, a program staff entered the dining room and attempted to de-escalate the situation and wheel the resident back to their room. The note indicated that the CNA approached Resident #103 with a disinfectant spray bottle, aimed at the resident, then stated something along the lines of Do you think I'm afraid of you? The note indicated that a program staff and RN #4 notified their supervisor of the incident. A Report of Suspected Dependent Adult/Elder Abuse report form, dated 11/18/2024, indicated that on 11/18/2024 at 11:40 AM, Resident #103 threw juice on CNA #3 when the CNA took the juice off the resident's meal tray. The report indicated that CNA #3 then threw juice on the resident from the same cup. The report indicated that the CNA gestured with a spray bottle as if she was going to spray the resident and said, I am not afraid of you. Per the report, the CNA did not deny the incident. The report indicated CNA #3 was suspended pending the investigation and their employment would be terminated pending the results. An email from the Administrator, who was the Assistant Administrator at the time of the incident, to the state survey agency, dated 11/18/2024, indicated the facility notified the state survey agency of the abuse allegation on 11/18/2024 at 3:39 PM. The facility's investigation revealed no evidence that the facility submitted the required five-day investigation report to the state agency. (continued on next page)

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	05A427	A. Building B. Wing	04/18/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/15/2025 at 1:59 PM, the Assistant Administrator, who was the Administrator at the time of the incident and who investigated the incident, stated she was notified of the allegation of abuse immediately after it happened. The Assistant Administrator stated they notified the nursing board, police, Ombudsman, and the state survey agency. She stated that she could not recall if they submitted a five-day final report to the state survey agency. During an interview on 04/16/2025 at 11:21 AM, the Administrator stated abuse should be reported as soon as possible. She stated that Resident #103's incident did not get reported within two hours because there was not an injury.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49044 Based on observation, interview, facility document review, and facility policy review, the facility failed to ensure the temperature of the [NAME] Hall nourishment refrigerator was maintained at 41 degrees Fahrenheit (F) or below and food items in the nourishment refrigerator were dated and labeled for the 64 of the 111 residents who resided on the [NAME] Hall. Findings included: A facility policy titled, Labeling and Dating of Foods, dated 2023, revealed, Policy: All food items in the storeroom, refrigerator, and freezer need to be labeled and dated. The policy specified, Leftovers will be covered, labeled, and dated. A facility policy titled, Cold Storage Temperature Monitoring and Record Keeping dated 2023, revealed, Policy: Food & Nutrition Services staff shall review and record temperatures of all refrigerators and freezers to ensure they are at the correct temperature for food storage and handling. The policy specified, 3. If temperatures are not within standards, Food & Nutrition Services staff will notify the FNS [Food Nutrition Services] Director. In the Director's absence, notify both Maintenance and the Administrator. Refrigerator temperature standards are less or equal to 41 [degrees] F. The goal is to keep the temperature at 34 [degrees] F - 39 [degrees] F. This will allow for a 2 [degrees] rise in temperature when the door is opened throughout the day. This will also keep food at less than 41 [degrees] F. The [NAME] Hall Refrigerator/Freezer Temperature Log, for 03/2025, revealed staff documented the refrigerator temperature as the following: - On 03/01/2025, 42 degrees F during the night shift, 44 degrees F during the ante meridiem (AM, before midday) shift, and 45 degrees during the post meridiem (PM, after midday) shift. - On 03/02/2025, 42 degrees F during the AM shift. - On 03/04/2025, 42 degrees F during the AM shift and 43 degrees F during the PM shift. - On 03/05/2025, 43 degrees during the night shift. - On 03/07/2025, 46 degrees F during the PM shift. - On 03/08/2025, 42 degrees F during the AM shift. - On 03/11/2025, 45 degrees F during the PM shift. - On 03/12/2025, 45 degrees F during the night shift and 42 degrees F during the PM shift. - On 03/13/2025, 42 degrees F during the AM and PM shift. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On 03/14/2025, 42 degrees F during the AM shift. - On 03/15/2025, 42 degrees F during the night, AM, and PM shift. - On 03/17/2025, 42 degrees F during the night shift. - On 03/18/2025, 42 degrees F during the AM shift. - On 03/21/2025, 42 degrees F during the PM shift. - On 03/25/2025, 42 degrees F during the AM shift and 44 degrees F during the PM shift. - On 03/26/2025, 44 degrees F during the night shift, 42 degrees F during the AM shift, and 46 degrees F during the PM shift. - On 03/27/2025, 42 degrees F during the night shift. - On 03/30/2025, 42 degrees F during the PM shift. - On 03/31/2025, 46 degrees F during the night shift and 42 degrees F during the AM and PM shift. The [NAME] Hall Refrigerator/Freezer Temperature Log, for 04/2025, revealed staff documented the refrigerator temperature as the following: - On 04/02/2025, 48 degrees F during the PM shift. - On 04/03/2025, 44 degrees F during the night shift and 46 degrees F during the PM shift. - On 04/06/2025, 42 degrees F during the night shift. - On 04/07/2025, 46 degrees F during the PM shift. - On 04/08/2025, 46 degrees F during the night and PM shift. - On 04/09/2025, 46 degrees F during the night, AM, and PM shift. - On 04/10/2025, 46 degrees F during the night, AM, and PM shift. - On 04/11/2025, 46 degrees F during the night shift and 44 degrees F during the AM and PM shift. - On 04/12/2025, 44 degrees F during the night shift, 43 degrees F during the AM shift, and 46 degrees F during the PM shift. - On 04/13/2025, 46 degrees F during the night shift and 44 degrees F during the AM shift. - On 04/14/2025, 46 degrees F during the night and PM shift. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On 04/15/2025, 46 degrees F during the night shift, 45 degrees F during the AM shift, and 46 degrees F during the PM shift. - On 04/16/2025, 44 degrees F during the night, AM, and PM shift. - On 04/17/2025, 42 degrees F during the night shift. During a concurrent interview and observation of the [NAME] Hall nourishment refrigerator on 04/17/2025, at 8:52 AM, the temperature was recorded as 47 degrees F and there was a half-eaten black carton of spaghetti that was not labeled or dated. Licensed Vocational Nurse (LVN) #1 stated all items in refrigerator should be dated and labeled and she did not believe the food belonged to the staff. During an interview on 04/17/2025, at 10:32 AM, LVN #1 stated the temperature of the refrigerator should be between 36 degrees F and 46 degrees F. LVN #1 stated she did not know the temperature should be below 41 degrees F. Per LVN #1, she was not sure who the spaghetti belonged to and anything in the refrigerator should be dated and labeled. During an interview on 04/17/2025, at 1:52 PM, the Dietary Manager (DM) stated she did not monitor the nourishment refrigerators or the temperature of the nourishment refrigerators on the nursing units. The DM stated the temperature of the nourishment refrigerator should be below 41 degrees F. According to the DM, when staff placed food items in the nourishment refrigerator, they should label and date the item. The DM confirmed that if there was no date or label on the spaghetti found in the [NAME] Hall nourishment refrigerator, there would be no way to determine who the food item belonged to. During an interview on 04/17/2025, at 4:35 PM, Registered Nurse (RN) #2 stated she worked on both the East and [NAME] Halls as an RN during the 3:00 PM - 11:00 PM shift. RN #2 stated as part of a nurse's daily routine when they came on shift, the nurses were to check the temperatures of the refrigerators on the nursing units. RN #2 stated the temperature of the refrigerator should be between 36 degrees F and 48 degrees F and if it was outside of those parameters, maintenance should be notified. RN #2 acknowledged she was not aware of the regulation that specified what the temperature of the refrigerator should be. RN #2 stated the nourishment refrigerator was only for resident food items and when someone placed a food item in the refrigerator it should be dated and labeled. During an interview on 04/18/2025, at 10:02 AM, the Maintenance Supervisor (MS) stated prior to 04/17/2025, no one had notified him about the high temperatures on the [NAME] Hall nourishment refrigerator or that the temperature was not below 41 degrees F. Per the MS, the DM informed him on 04/17/2025 that the refrigerator temperatures were high on the [NAME] Hall. The MS stated he monitored the refrigerator temperature monthly and his last recorded temperature of the nourishment refrigerator was 38 degrees F on 03/25/2025. During an interview on 04/18/2025, at 10:50 AM, the Administrator stated the refrigerator temperature should be 41 degrees F or below. During a follow-up interview on 04/18/2025, at 11:55 AM, the Administrator stated she expected all staff to label and date any food items stored in the nourishment refrigerator. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A427	A. Building B. Wing	04/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crestwood Manor - Fremont	4303 Stevenson Boulevard Fremont, CA 94538

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/18/2025, at 11:59 AM, the Director of Nursing stated she expected the temperature of the refrigerator to be within range and food items in the refrigerator should be dated and labeled.