STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505085	A. Building B. Wing	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crescent Health Care	505 North 40th Avenue Yakima, WA 98908

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to identify and prevent an avoidable accident hazard in the resident's environment for 1 of 3 residents (Resident 1) that used both bed bolsters (a soft barrier along the edge of the bed that minimizes the risk of rolling off the bed) and required mechanical lift transfers. ˆ Resident 1 experienced harm when they slid out of the lift sling during two-staff assist transfer when the resident in the sling did not clear the top edge of the bolster there by lifting the lower left sling loop up off the lift hook due to no longer being taut and the loop disconnected from the lift. The fall resulted in pain, a forehead wound, and transfer to the hospital where they were diagnosed with an ankle fracture. This failure placed resident with mechanical lift transfers at risk for injury and a diminished quality of life. Findings included.Review of the medical record showed that Resident 1 was admitted to the facility on [DATE] with diagnoses to include Alzheimer's dementia (a degenerative brain disorder and the most common cause of dementia, characterized by progressive memory loss, cognitive decline, and behavioral changes that interfere with daily life), anxiety disorder (the mind and body's reaction to stressful, dangerous, or unfamiliar situations), and osteoarthritis (a long-term degenerative joint condition in which the joints gradually deteriorate, causing pain and stiff joints). ˆ Review of a [DATE] comprehensive assessment showed that Resident 1 had moderate impaired cognition, was dependent on staff for grooming, bed mobility, transfers and was at risk for falls. ˆ Record review of Resident 1's fall care plan dated [DATE] showed as a fall risk intervention the left side of their bed was positioned against the wall to help prevent falls/rolls out of bed.ˆ The care plan, reviewed on [DATE], showed no interventions that included a bolster. ˆ Review of a [DATE] at 6:35 AM progress note by Staff B, Director of Nursing, showed Resident 1 fell out of a mechanical lift sling during a transfer from their bed to the wheelchair.ˆ The resident was observed lying on the floor with left shoulder, arm, hip and foot on the mechanical lift leg. ˆThere was bleeding from a one centimeter (cm) by 0.5 cm laceration (a torn or jagged wound to the skin and soft tissue underneath) to the left side of forehead.ˆ The left arm had bruising developing to their left arm and elbow.ˆ There was also a two cm by one cm skin shearing (occurs when the skin remains relatively stationary while underlying tissues or bones move in opposite directions. This parallel force stretches and distorts deeper tissue layers, damaging blood vessels and separating skin layers beneath the surface) on the left ankle with bruising and swelling.ˆ Resident 1 was sent to the hospital for further evaluation. ˆ Review of a [DATE] at 1:00 PM progress note showed that Resident 1 returned from the hospital with a left ankle bone fracture that was supported by a leg splint and a shallow scalp laceration (a torn or jagged wound to the skin and soft tissue underneath).ˆ Resident 1 was yelling out in pain upon their return. ˆ On [DATE] at 2:50 PM Resident 1 was observed lying in a low bed, head of bed elevated, with the left side against the wall and a blue wedge-shaped bolster was along the right side of the bed.ˆ The top of the bolster was eight inches above the bed surface.ˆ Resident 1's eyes were closed and did not open with the door knock and announce visit from the investigator.ˆ There was a two cm by two cm bruised area to the left side of their forehead. ˆ On [DATE] at 3:10 PM, Staff C, Registered Nurse (RN)/ Restorative (continued on next page)

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

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Nurse, stated the nursing assistants (NA) staff present for Resident 1's transfer were Staff D, NA, and Staff E, NA.ˆ Staff B stated they had the NA's witness statements, and they told Staff C that while moving the resident in the sling, over the left side of the bed, the lower left sling loop somehow came off the lift hook and Resident 1 slid to the floor. ˆ On [DATE] at 3:15 PM, Staff B stated that they were at the medication cart near Resident 1's room when the NA came out to find a nurse.ˆ Staff B stated that when they entered the room, they saw the mechanical lift legs were parallel to the bed, [Resident 1] was on their left side on the floor, bleeding from the left side of their forehead and [Resident 1] was crying it hurts, it hurts.ˆ Upon assessment there was skin shearing, bruising and swelling to the resident's left ankle. ˆ On [DATE] at 3:44 PM, Staff G, NA, stated when they did mechanical lift transfers for residents with bed bolsters, they would release the bolster wedge and move it to the foot of the bed.ˆ Staff G stated, If you don't do that the sling can get caught on the bolster. ˆ On [DATE] at 4:30 PM, Staff C could not produce any mechanical lift policies or training that were documented. Staff C stated staff receive lift training all the time but not related to beds with bolsters stated and probably not documented. Staff C stated there were no written guidelines for staff to follow for mechanical lift transfers and or use of bolster wedges on resident's beds. ˆ On [DATE] at 4:50 PM, Resident 1 was observed lying in their bed, groaning and moving head from side to side.ˆ Resident Representative 1 (RR1) was seated at the resident's bedside.ˆ RR1 stated that it was the first time they had seen [Resident 1] since going to the hospital that day.ˆ RR1 stated in an upset tone this was clearly negligent and the facility was at fault. ˆ During a telephone interview on [DATE] at 5:22 PM, Staff E, NA, stated that they had assisted with mechanical lift transfers for [Resident 1] many times.ˆ They stated, Today, [Staff D] had [Resident 1] ready with the sling already hooked up to the lift when they came to assist. Staff D operated the lift remote while they were watching the resident's position in the sling. Staff E stated, It happened so fast when the loop came out of the lift hook. Looking back, the bed was too high, the bed only needed to be high enough to get the lift legs under the bed.ˆ Staff E stated that the bolster-wedge should have been removed before the transfer. ˆ On [DATE] at 11:45 AM, Resident 1 was observed in bed, with Resident Representative 2 (RR2) at the bedside.ˆ RR2 stated they were at the hospital that morning with Resident 1 and they were hollering out in pain.ˆ RR2 stated the wound on Resident 1's head did not need stiches, and they could not surgically repair the fractured ankle, so they were treated with a splint on lower left leg.ˆ RR2 stated, This was an accident that should not have happened.ˆ RR2 stated the bolster wedge had been on the bed for a couple of years and did not recall being informed of risks and benefits of its use. ˆ On [DATE] at 12:15 PM, Staff B, stated they did staff training last Fall on resident transfers using a picture board.ˆ Staff B provided the visual aid used for the training. Looking at the board, the instructions for mechanical lift showed residents should initially be lifted two inches off the surface to complete checks for safety and comfort and then slowly lift the residents as high as necessary to complete the transfer.ˆ Staff B stated, The staff should have been taking down the bolster wedge, and I had no idea the staff were not. ˆ On [DATE] at 12:30 PM, Staff D stated that they had provided care for [Resident1] many times. Yesterday morning they readied Resident 1 to transfer to their wheelchair.ˆ The bed was at working height to dress and place the full body sling under Resident 1. ˆThey stated that while operating the lift to transfer, they did not realize the sling got caught on the bolster.ˆ Then suddenly, Resident 1 slid out of the sling and was on the floor. ˆStaff D stated they had not removed the bolsters for mechanical lifts, No one told me to. ˆ On [DATE] at 12:50 PM, Staff C stated that they could not find a physician order, assessment, care plan, or representative consent for Resident 1's bolster. ˆ On [DATE] at 3:10 PM, Staff A, Administrator, stated that they were not aware the bolsters could be a hazard, acknowledged there were no policies for lifts and Staff A stated, The bolster should have been taken down.ˆ Reference: WAC 388-97-1060 (3)(g)