STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555118	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Almond Vista Healthcare	2030 Evergreen Avenue Modesto, CA 95350

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** 49884 Based on observation, interview and record review, the facility failed to ensure one of five residents (Resident 1) was free from accident hazards, when Resident 1 was assessed to be a high risk for falls, had a history of falls on 5/9/24, and 7/28/24, and had a physician order for a floor mat to prevent injury in the event of fall and the floor mat was not placed beside the bed. Nursing staff failed to implement the Care Plan intervention for use of the floor mat to prevent injury. These failures resulted in Resident 1 experiencing a fall from her bed on 1/11/25 and suffering an avoidable injury, pain and being sent to the acute care hospital for higher level of care. Resident 1 was diagnosed with a broken left hip and required administration of fentanyl (a medication for severe pain) to control the pain. Resident 1 experienced discomfort and decreased mobility where was no longer able to turn herself from side to side because of the left hip fracture. Resident 1's Physicians did not recommend surgery for Resident 1, and she was placed on hospice care. Findings: During a review of Resident 1's facility Progress Notes (PN), dated 1/11/25 at 6 p.m., the PN indicated, . [Resident 1] was found on the floor next to her bed lying on her right side. There was a skin tear on her left forearm. A bruise noted on her right hip. The resident was c/o [complain/of] left leg pain. Staff assisted the resident back into bed. The skin tear was cleansed with NS [normal saline- a mixture of water and salt] and a dressing was applied. Neuro checks [neurological checks - a physical exam to assess the brain and nerves] were started. MD [Medical Doctor] was notified of the fall and an order was received for bilateral [both] hips and pelvis [bones between the lower abdomen and upper thighs that connect to the spine and legs] x-ray. Family member [name] was notified of the unwitnessed fall . (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	During a review of Resident 1's acute hospital record ED (Emergency Department) Provider Notes (EDPN), dated 1/12/25, the EDPN indicated, Resident 1 arrived in the ED from the facility for evaluation after an unwitnessed [by facility staff] ground level fall on 1/11/25. The EDPN indicated, . On exam . did appear to have discomfort upon pushing on her lateral [outside] aspect of left hip. However, she refused to straighten the extremity [leg] and pushed me away mid [in the middle of] exam. XR [x-ray] pelvis with questionable displaced [not lined up] left femur [thigh bone] fracture [broken bone] but difficult to interpret due to positioning. After discussion with daughter, she was agreeable for repeat imaging of XR pelvis with treatment of her pain and agitation . Repeat image does show evidence of impacted[the ends of the bone are jammed together] left femoral neck [narrow bridge of bone connecting the rounded top of thigh bone to the long straight section of thigh bone] fracture . discussed case with (orthopedic [doctors who specialize in surgery of bones, joints and muscles] physician) who does not recommend surgery given it would not be considered helpful as patient is non-ambulatory/bed bound [does not walk/remains in bed] . Daughter chose against surgery and was agreeable to pursue hospice care [end of life care] . Plan and Disposition: . Discharge . Care Timeline . Arrived 1100 [11 a.m.] . discharged 2002 [8:02 p.m.] . During a review of Resident 1's acute hospital record, Images, dated 1/12/25, the Images indicated, Resident 1 received an x-ray of the pelvis for injury and was found to have a basicervical intertrochanteric left femoral fracture (a specific type of hip fracture where the break is at the bottom of the bone that connects the hip joint to the thigh bone, right where it meets the wider part of the thigh bone). During a review of Resident 1's acute hospital record ED Provider Notes Meds (medications) Administered, dated 1/12/25, the ED Provider Notes Meds Administered indicated on 1/12/25 at 3:06 p.m. Resident 1 was administered 50 mcg (micrograms a unit of measurement) fentanyl (a medication for severe pain) intravenously (a way to deliver medicine directly into a vein using a needle or plastic tube) for pain. During a review of Resident 1's Admission Record (AR-a summary of important information regarding a patient which include patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 1/13/25, the AR indicated, Resident 1 was admitted on [DATE] with a diagnoses which included senile degeneration of brain (a group of symptoms causing a decline in thinking, reasoning, remembering, imagining, learning words, and using language), syncope and collapse (passing out falling down), fall on same level, dysarthria (difficulty speaking due to the muscles used for speech being weak) and anarthria (condition causing a person to completely lose their ability to speak). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool used to identify resident cognitive [mental processes of thinking, learning, remembering and understanding] and physical function), assessment dated [DATE], Resident 1's MDS assessment indicated, Resident 1's Brief Interview for Mental Status (BIMS -assessment of cognitive status for memory and judgment) assessment score was 03 out of 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment). The BIMS assessment indicated, Resident 1 had a severe cognitive impairment (a person that has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's Care Plan (CP - a detailed document that outlines a patient's specific healthcare needs, goals and nursing interventions required to meet those goals), dated 1/15/23, the CP indicated, . Focus . The resident at risk for fall r/t [related/to] Confusion, weakness, and impaired mobility . per staff resident has been trying to get up to the w/c [wheelchair] on her own . Date initiated: 5/30/24 . Created On: 1/15/23 . Revision on: 7/29/24 . Intervention for 7/28/24 Staff to monitor patient's position while in bed . Place floor mats [a soft mat that lays beside a bed to prevent an injury] on floor next to bed Date initiated: 1/30/23 . Revision on: 7/29/24 . Staff will look for another room where floor mats can be utilized . During a concurrent observation and interview on 1/16/25 at 10:55 a.m. with Resident 2 in Resident 2's room. Resident 2 was observed lying on her back, her bed at a 30-degree angle, with her eyes open. Resident 2 was Resident 1's roommate and was in the first bed closest to the door (A bed). Resident 2 stated, she had been Resident 1's roommate since August 2024 and was present when Resident 1 fell off her bed onto the floor on 1/11/25. Resident 2 stated, Resident 1 was trying to walk when she fell , Resident 2 stated, Resident 1 does not walk or get out of bed to a wheelchair, but she was able to sit up without help. Resident 2 stated, no fall mats were present when Resident 1 fell , and the bed was lower now than when Resident 1 fell . Resident 2 stated, the bed was replaced yesterday. Resident 2 stated, the day of the fall a Certified Nursing Assistant (CNA) was in their room changing a resident in the third bed (C- bed) and the curtain was closed around C bed. Resident 2 stated, Resident 1 sat up and moved to the edge of the bed then fell to the floor. Resident 2 stated, Resident 1 landed onto the floor between Resident 1 and Resident 2's beds. Resident 2 stated, she called out to the CNA in their room saying Resident 1 fell and was on the floor. Resident 2 stated an X-ray was done on Resident 1 in the room. Resident 2 stated, Resident 1 calls out in pain when staff were changing her clothing or her brief (absorbent undergarments that can help with bladder or bowel leakage) since the fall. During a review of Resident 2's AR, dated 1/16/25, the AR indicated, Resident 2 was admitted on [DATE]. During a review of Resident 2's MDS assessment dated [DATE], Resident 2's MDS assessment indicated, Resident 2's BIMS assessment score was 10 out of 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment). During a concurrent observation and interview on 1/16/25 at 11:10 a.m. with Resident 1 in Resident 1's room, the three beds in the room were against the left wall and Resident 1 was in the center bed (B-bed). Resident 1 did not answer verbally when greeted, but waved hello and nodded her head indicating yes when asked her name. Resident 1 shook her head indicating no, when asked if she remembered when she fell . During an interview on 1/16/25 at 11:11 a.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated she was familiar with Resident 1. LVN 2 stated, Resident 1 was a high fall risk. LVN 2 stated, Resident 1 had fallen from her bed multiple times. LVN 2 stated, Resident 1 now had fall mats in place, to prevent further injury due to falls. LVN 2 stated, Resident 1 used to have fall mats in place. LVN 2 stated, she did not know why they were removed. LVN 2 stated, Resident 1 was a total care patient and was completely dependent (unable to perform activities of daily living without assistance) on staff. LVN 2 stated, she did not know who decided the type of fall interventions residents were assigned. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of Interdisciplinary Progress Notes (IPN), dated 5/10/24, the IPN indicated, . IDT [Interdisciplinary Team - a group of individuals with unique knowledge that work together to address complex issues] meeting for incident on 5/9/24: Resident had an unwitnessed fall in room, was found on floor next to bed, Resident is confused and could not state what happened. Apparently, Resident rolled out of bed, no injury noted, no c/o pain . will provide floor mats to sides of bed . During a review of IPN, dated 5/13/24, the IPN indicated, . IDT meeting for incident on 5/9/24: Resident had an unwitnessed fall in room, was found on floor left side next to bed . During a review of Resident 1's Post Fall Evaluation (PFE), dated 7/28/24 at 1:30 p.m., the PFE indicated, . Fall Details: Date/ Time of Fall: 07/28/2024 1:30 PM Fall was not witnessed. Fall occurred in the Resident's room. Resident was attempting to self-toilet at time of fall . Floor mat was on floor: No . During a review of Interdisciplinary Progress Notes (IPN), dated 7/29/24, the IPN indicated, . IDT fall . Resident had a fall on 7/28/24 when she was found on the floor in her room . Risk factors . Senile Degeneration of the Brain . Dysarthria/anarthria [slurred sleech/inability to speak . Weakness . Hx [history] of falls . Previous Interventions: Floor mats, increased monitoring . IDT recommendations . Staff to monitor patient's positioning in bed . IDT Attendees . Admin [Administrator], DON [Director of Nursing], DSD [Director of Staff Development] . During an interview on 1/16/25 at 11:34 a.m. with Certified Nursing Assistant (CNA) 2, the CNA stated, she has been working with Resident 1 since the Resident was admitted in 2023. CNA 2 stated, she was not working at the time of Resident 1's fall. CNA 2 stated, she had witnessed Resident 1 sit at the side of the bed and re-oriented Resident 1 to sit back in the bed to prevent a fall. CNA 2 stated, Resident 1 had fall mats in place sometime in the past, but they had been removed until yesterday (1/15/25). CNA 2 stated, she did not know why the fall mats were removed. CNA 2 stated, she believed the mats were important to prevent injury. CNA 2 stated, if Resident 1 were to stand and fall the mats would soften the fall. During an interview on 1/16/25 at 2:58 p.m. with CNA 1, CNA 1 stated, she was the CNA responsible for Resident 1's care when Resident 1 fell on [DATE]. CNA 1 stated, she was changing a Resident in the last bed furthest from the door and the privacy curtain was closed, so could not see Resident 1. CNA 1 stated, Resident 1 was in her bed when she passed by her to change the Resident in C bed. CNA 1 stated, Resident 2 called out to her Resident 1 fell and was on the floor. CNA 1 stated, Resident 1 fell out of the bed on the right side onto the floor. CNA 1 stated Resident 1 would sit up then attempt to walk, but her legs could not hold her weight. CNA 1 stated, she had never seen the fall mats in the room before. CNA 1 stated since Resident 1's injury her mobility had decreased, and she no longer turned herself. CNA 1 stated, Resident 1's care was changed due to her hip fracture and since Resident 1 cannot have surgery, she must be moved slowly to prevent pain. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 1/16/25 at 3:06 p.m. with LVN 1, LVN 1 stated, she was the nurse responsible for Resident 1 at the time of the fall on 1/11/25. LVN 1 stated, Resident 1 had fallen before and was a high fall risk. LVN 1 stated, CNA 1 came to her at the nurse's station around 5:30 p.m. and told her Resident 1 was on the floor. LVN 1 stated, Resident 1 was lying on the floor between A and B bed on her right side. LVN 1 stated Resident 1 had a skin tear on left forearm and complained of pain everywhere. LVN 1 stated, Resident 1 turned to her back, and there was a small bruise on her right hip. LVN 1 stated, Resident 1 had her legs up with knees bent and would not extend her legs. LVN 1 stated the physician was called for an x-Ray order. LVN 1 stated if a fall mat was in place, it could have lessened the impact of the fall. During a review of Resident 1's PFE, dated 1/11/25 at 5:25 p.m., the PFE indicated, . Fall Details: Date/ Time of Fall: 01/11/2025 5:25 PM Fall was not witnessed. Fall occurred in the Resident's room. Activity at the time of fall: Attempting to walk Reason for the fall was evident. Reason for fall: Trying to get out of bed unassisted Did an injury occur as a result of the fall: Yes . The resident was c/o left leg pain . Floor mat was on floor: No . During a review of IPN, dated 1/13/25, the IPN indicated, . Met to discuss fall that resident had on the evening of 1/11 /25 when she was found on the floor on her right side, next to her bed. She c/o pain to left hip. MD was notified and received order for x-Ray. The results came back on 1/12/25 with a nondisplaced left femur fx [fracture] and MD was notified and gave order to send to ER for evaluation. Resident later returned from ER, no surgery recommended and suggested possible hospice referral. Resident was initially placed on q [every] 15 min monitoring x [for] 24 hrs [hours] but was extended to 72 hrs after fracture dx [diagnosis]. Floor mats were placed after fall. Staff was attempting to make a room change to an A bed, but the family prefers she stays where she is. Resident has dx [diagnosis] of senile degeneration of the brain and is confused . During an interview on 1/16/25 at 3:37 p.m. with the Director of Nursing (DON), the DON stated Resident 1 had a physician order for fall mats ordered on 1/31/23. The DON stated the order was never discontinued. The DON stated a new order was requested from the physician for fall mats on 1/13/25. The DON stated a new order was not necessary. The DON did not know why the fall mats were not in place for Resident 1 at the time of the fall on 1/11/25. The DON stated her expectation was for nursing staff to know what interventions were in place and follow the interventions. The DON stated her expectation was for the fall mat to be in place for the safety of Resident 1. During a review of Resident 1's Physician Order (PO), dated 1/31/23, the PO indicated, . Order Summary . Floor Mat Due to Fall Risk . Supply Last Order Date . 01/31/23 . During a concurrent interview and record review on 1/21/25 at 11:15 a.m., Resident 1's Fall Risk Evaluation (FRE),, dated 12/16/24, was reviewed. The FRE indicated, . [Resident 1] . History of falls (past 3 months) . 1-2 falls in past 3 months . Level of consciousness / mental status . disoriented x 3 at all times . Ambulation/elimination status . Bedbound [unable to move around safely]/incontinent [having no control over urination or bowels] . The DON stated, Resident 1's fall risk score was 14, and a 14 was considered a high fall risk. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review on 1/25/25 at 11:20 a.m. with the DON, Resident 1's CP, dated 1/16/25, was reviewed. The CP indicated . Place floor mats on floor next to bed Date initiated: 1/30/23 . Revision on: 7/29/24 . Staff will look for another room where floor mats can be utilized . The DON stated, Resident 1's fall mats were just never put back when Resident 1's roommates changed, and the fall mats could have been utilized again. The DON stated, the fall mats should have been put back in place. During a review of the facility's policy and procedure (P&P) titled, Falls and Fall Risk, Managing, dated March 2018, the P&P indicated, .Policy Statement: Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling . Unintentional change in position coming to rest on the ground , floor or onto the next lower surface . or identified when a resident is found on the floor or ground . Fall Risk Factors: . Resident conditions that may contribute to the risk of falls include: . delirium [a mental state of confusion, and difficulty thinking or remembering] and other cognitive impairment . pain . lower extremity weakness . functional impairments . Based on observation, interview and record review, the facility failed to ensure one of five residents (Resident 1) was free from accident hazards, when Resident 1 was assessed to be a high risk for falls, had a history of falls on 5/9/24, and 7/28/24, and had a physician order for a floor mat to prevent injury in the event of fall and the floor mat was not placed beside the bed. Nursing staff failed to implement the Care Plan intervention for use of the floor mat to prevent injury. These failures resulted in Resident 1 experiencing a fall from her bed on 1/11/25 and suffering an avoidable injury, pain and being sent to the acute care hospital for higher level of care. Resident 1 was diagnosed with a broken left hip and required administration of fentanyl (a medication for severe pain) to control the pain. Resident 1 experienced discomfort and decreased mobility where was no longer able to turn herself from side to side because of the left hip fracture. Resident 1's Physicians did not recommend surgery for Resident 1, and she was placed on hospice care. Findings: During a review of Resident 1's facility Progress Notes (PN), dated 1/11/25 at 6 p.m., the PN indicated, . [Resident 1] was found on the floor next to her bed lying on her right side. There was a skin tear on her left forearm. A bruise noted on her right hip. The resident was c/o [complain/of] left leg pain. Staff assisted the resident back into bed. The skin tear was cleansed with NS [normal saline- a mixture of water and salt] and a dressing was applied. Neuro checks [neurological checks - a physical exam to assess the brain and nerves] were started. MD [Medical Doctor] was notified of the fall and an order was received for bilateral [both] hips and pelvis [bones between the lower abdomen and upper thighs that connect to the spine and legs] x-ray. Family member [name] was notified of the unwitnessed fall . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's Care Plan (CP - a detailed document that outlines a patient's specific healthcare needs, goals and nursing interventions required to meet those goals) , dated 1/15/23, the CP indicated, . Focus . The resident at risk for fall r/t [related/to] Confusion, weakness, and impaired mobility . per staff resident has been trying to get up to the w/c [wheelchair] on her own . Date initiated: 5/30/24 . Created On: 1/15/23 . Revision on: 7/29/24 . Intervention for 7/28/24 Staff to monitor patient's position while in bed . Place floor mats [a soft mat that lays beside a bed to prevent an injury] on floor next to bed Date initiated: 1/30/23 . Revision on: 7/29/24 . Staff will look for another room where floor mats can be utilized . During a concurrent observation and interview on 1/16/25 at 10:55 a.m. with Resident 2 in Resident 2's room. Resident 2 was observed lying on her back, her bed at a 30-degree angle, with her eyes open. Resident 2 was Resident 1's roommate and was in the first bed closest to the door (A bed). Resident 2 stated, she had been Resident 1's roommate since August 2024 and was present when Resident 1 fell off her bed onto the floor on 1/11/25. Resident 2 stated, Resident 1 was trying to walk when she fell , Resident 2 stated, Resident 1 does not walk or get out of bed to a wheelchair, but she was able to sit up without help. Resident 2 stated, no fall mats were present when Resident 1 fell , and the bed was lower now than when Resident 1 fell . Resident 2 stated, the bed was replaced yesterday. Resident 2 stated, the day of the fall a Certified Nursing Assistant (CNA) was in their room changing a resident in the third bed (C- bed) and the curtain was closed around C bed. Resident 2 stated, Resident 1 sat up and moved to the edge of the bed then fell to the floor. Resident 2 stated, Resident 1 landed onto the floor between Resident 1 and Resident 2's beds. Resident 2 stated, she called out to the CNA in their room saying Resident 1 fell and was on the floor. Resident 2 stated an X-ray was done on Resident 1 in the room. Resident 2 stated, Resident 1 calls out in pain when staff were changing her clothing or her brief (absorbent undergarments that can help with bladder or bowel leakage) since the fall. During a review of Resident 2's AR, dated 1/16/25, the AR indicated, Resident 2 was admitted on [DATE]. During a review of Resident 2's MDS assessment dated [DATE], Resident 2's MDS assessment indicated, Resident 2's BIMS assessment score was 10 out of 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment). During a concurrent observation and interview on 1/16/25 at 11:10 a.m. with Resident 1 in Resident 1's room, the three beds in the room were against the left wall and Resident 1 was in the center bed (B-bed). Resident 1 did not answer verbally when greeted, but waved hello and nodded her head indicating yes when asked her name. Resident 1 shook her head indicating no, when asked if she remembered when she fell . During an interview on 1/16/25 at 11:11 a.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated she was familiar with Resident 1. LVN 2 stated, Resident 1 was a high fall risk. LVN 2 stated, Resident 1 had fallen from her bed multiple times. LVN 2 stated, Resident 1 now had fall mats in place, to prevent further injury due to falls. LVN 2 stated, Resident 1 used to have fall mats in place. LVN 2 stated, she did not know why they were removed. LVN 2 stated, Resident 1 was a total care patient and was completely dependent (unable to perform activities of daily living without assistance) on staff. LVN 2 stated, she did not know who decided the type of fall interventions residents were assigned. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555118	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Almond Vista Healthcare	2030 Evergreen Avenue Modesto, CA 95350

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	During a review of Interdisciplinary Progress Notes (IPN), dated 5/10/24, the IPN indicated, . IDT [Interdisciplinary Team - a group of individuals with unique knowledge that work together to address complex issues] meeting for incident on 5/9/24: Resident had an unwitnessed fall in room, was found on floor next to bed, Resident is confused and could not state what happened. Apparently, Resident rolled out of bed, no injury noted, no c/o pain . will provide floor mats to sides of bed . During a review of IPN, dated 5/13/24, the IPN indicated, . IDT meeting for incident on 5/9/24: Resident had an unwitnessed fall in room, was found on floor left side next to bed . During a review of Resident 1's Post Fall Evaluation (PFE), dated 7/28/24 at 1:30 p.m., the PFE indicated, . Fall Details: Date/ Time of Fall: 07/28/2024 1:30 PM Fall was not witnessed. Fall occurred in the Resident's room. Resident was attempting to self-toilet at time of fall . Floor mat was on floor: No . During a review of Interdisciplinary Progress Notes (IPN), dated 7/29/24, the IPN indicated, . IDT fall . Resident had a fall on 7/28/24 when she was found on the floor in her room . Risk factors . Senile Degeneration of the Brain . Dysarthria/anarthria [slurred sleech/inability to speak . Weakness . Hx [history] of falls . Previous Interventions: Floor mats, increased monitoring . IDT recommendations . Staff to monitor patient's positioning in bed . IDT Attendees . Admin [Administrator], DON [Director of Nursing], DSD [Director of Staff Development] . During an interview on 1/16/25 at 11:34 a.m. with Certified Nursing Assistant (CNA) 2, the CNA stated, she has been working with Resident 1 since the Resident was admitted in 2023. CNA 2 stated, she was not working at the time of Resident 1's fall. CNA 2 stated, she had witnessed Resident 1 sit at the side of the bed and re-oriented Resident 1 to sit back in the bed to prevent a fall. CNA 2 stated, Resident 1 had fall mats in place sometime in the past, but they had been removed until yesterday (1/15/25). CNA 2 stated, she did not know why the fall mats were removed. CNA 2 stated, she believed the mats were important to prevent injury. CNA 2 stated, if Resident 1 were to stand and fall the mats would soften the fall. During an interview on 1/16/25 at 2:58 p.m. with CNA 1, CNA 1 stated, she was the CNA responsible for Resident 1's care when Resident 1 fell on [DATE]. CNA 1 stated, she was changing a Resident in the last bed furthest from the door and the privacy curtain was closed, so could not see Resident 1. CNA 1 stated, Resident 1 was in her bed when she passed by her to change the Resident in C bed. CNA 1 stated, Resident 2 called out to her Resident 1 fell and was on the floor. CNA 1 stated, Resident 1 fell out of the bed on the right side onto the floor. CNA 1 stated Resident 1 would sit up then attempt to walk, but her legs could not hold her weight. CNA 1 stated, she had never seen the fall mats in the room before. CNA 1 stated since Resident 1's injury her mobility had decreased, and she no longer turned herself. CNA 1 stated, Resident 1's care was changed due to her hip fracture and since Resident 1 cannot have surgery, she must be moved slowly to prevent pain. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555118	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Almond Vista Healthcare	2030 Evergreen Avenue Modesto, CA 95350

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 1/16/25 at 3:06 p.m. with LVN 1, LVN 1 stated, she was the nurse responsible for Resident 1 at the time of the fall on 1/11/25. LVN 1 stated, Resident 1 had fallen before and was a high fall risk. LVN 1 stated, CNA 1 came to her at the nurse's station around 5:30 p.m. and told her Resident 1 was on the floor. LVN 1 stated, Resident 1 was lying on the floor between A and B bed on her right side. LVN 1 stated Resident 1 had a skin tear on left forearm and complained of pain everywhere . LVN 1 stated, Resident 1 turned to her back, and there was a small bruise on her right hip. LVN 1 stated, Resident 1 had her legs up with knees bent and would not extend her legs. LVN 1 stated the physician was called for an x-Ray order. LVN 1 stated if a fall mat was in place, it could have lessened the impact of the fall. During a review of Resident 1's PFE, dated 1/11/25 at 5:25 p.m., the PFE indicated, . Fall Details: Date/ Time of Fall: 01/11/2025 5:25 PM Fall was not witnessed. Fall occurred in the Resident's room. Activity at the time of fall: Attempting to walk Reason for the fall was evident. Reason for fall: Trying to get out of bed unassisted Did an injury occur as a result of the fall: Yes . The resident was c/o left leg pain . Floor mat was on floor: No . During a review of IPN, dated 1/13/25, the IPN indicated, . Met to discuss fall that resident had on the evening of 1/11 /25 when she was fou [TRUNCATED]