STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555421	A. Building B. Wing	03/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stonebrook Post Acute	4367 Concord Boulevard Concord, CA 94521

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 Note: The nursing home is disputing this citation.	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 ensure one of three sampled Residents' (Resident 1) was free from accidents during incontinence care (the management and support for individuals with involuntary urine or stool leakage, aiming to maintain hygiene, skin health, dignity, and quality of life).This failure resulted in Resident 1 falling out of bed and sustaining a bruise (discolored skin on the body, caused by a blow or impact rupturing underlying blood vessels) to the forehead, perinasal hematoma (accumulation of blood within the nasal septum, which is the wall of cartilage and bone that divides the two nostrils), right elbow abrasion (a superficial, minor injury where the top layer of skin is scraped or rubbed away), and right femoral fracture (a serious, high-impact break in the longest, strongest bone in the leg, usually caused by severe trauma like car accidents or falls). During a review of Resident 1's admission Record, printed on 2/5/26, the admission Record indicated Resident 1 was admitted in December 2025.During a review of Resident 1's Minimum Data Set (MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan), dated 12/17/25, the MDS indicated Resident 1's Brief Interview for Mental Status (BIMS, a scoring system used to determine the resident's cognitive status in regard to attention, orientation, and ability to register and recall information) score was 3 out of 15, indicating Resident 1's cognition was severely impaired. MDS Section GG Functional Abilities indicated Resident 1 was dependent (helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) in toileting hygiene (the ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement).During a review of Resident 1's Baseline Care Plan, dated 12/12/25, the care plan indicated Resident 1's personal hygiene: support provided, two persons physical assist.bed mobility: support provided, two persons assist.During a review of Resident 1's Potential for Falls Care Plan Report, initiated 12/12/25, the care plan indicated Floor mats on both side of bed.Keep bed in low position. Monitor resident frequently when in bed or chair. The ?Goals' within the care plan indicated, No fall daily in 90 days.During a review of Resident 1's Skilled Charting, dated 12/31/2025, Skilled Charting indicated, Functional Status: does not bear weight, unsteady gait requiring supervision, impaired balance, weakness, paralysis.Late loss ADL's (activity of daily living; which are essential self-care tasks such as eating, bathing, dressing, toileting): requires assistance with transfers, requires assistance with toilet use.Bladder function: incontinent of urine.Skin/Wound: no new changes to skin integrity noted.During a review of Resident 1's Change of Condition, dated 1/2/26, at 4:21 p.m., the Change in Condition indicated Resident 1 had a fall out of bed and identified Fall risk factors.impaired balance.During a review of Resident 1's Post Fall Evaluation, dated 1/2/26, at 4:38 p.m., the Post Fall Evaluation indicated the date, time and location of the fall was on 1/2/26 at 12:00 p.m. in Resident 1's room. Factors involved in the fall indicated poor balance. The incident summary indicated, Patient 77 y/o (year old) female with hemiplegia and hemiparesis (weakness or partial paralysis [loss of voluntary movement] affecting one entire side of the body) following cerebral infarction affecting left dominant side. Patient is (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 Note: The nursing home is disputing this citation.	confused, but able to move herself towards her left side and fell on the floor from her bed. Patient sustained a skin tear on her forehead and right face right below periorbital area, also complaining of left arm pain 6/10 (on a scale of 0 to 10, with 6 representing moderate to severe pain). Patient transported to Hospital in Concord for medical evaluation.During a review of Resident 1's Rehab Post Fall Review, dated 1/8/26, at 3:02 p.m., the review indicated date, time and location of event was 1/2/26 at 12 p.m. in Resident 1's bedroom from bed. Circumstances of Event indicated Certified Nursing Assistant (CNA) was beginning to change resident, CNA left room to get supplies and assistance. Bed was at working height, not lowered when CNA left the room, air mattress adjusted and slid the pt (patient) out of bed. Pt was found on the floor when CNA returned. Listed interventions included Post Fall IDT interventions: floor mats.During an interview with Certified Nurse Assistant (CNA) 1 on 3/23/26, at 11:23 a.m., CNA 1 stated was informed by Resident 1's family that Resident 1 needed incontinence care. CNA 1 stated went into Resident 1's room alone to ensure Resident was incontinent and gain consent for a shower. CNA 1 stated the family stepped out for privacy and CNA 1 elevated the bed, and turned resident to assess brief and confirmed resident was soiled in stool. CNA 1 stated lowered the bed a little and went outside of Resident 1's room to gather gloves and request assistance from another staff member. CNA 1 stated moments later Resident 1 fell out of bed and was seen on the floor. CNA 1 stated was unsure if floor mats were in place at the time of fall. CNA 1 stated was aware that Resident 1 needed a two person assist for incontinence care, but wanted to confirm resident was soiled and consented to a shower first. CNA 1 stated it was important to use two person assist for dependent residents so they are not alone and to ensure safety.During a concurrent interview and record review on 3/11/26, at 3:11 p.m., with Assistant Director of Nursing (ADON) and Director of Nursing (DON), Resident 1's Potential for Falls care plan and Rehab Post Fall Review were reviewed. Resident 1's Potential for Falls care plan, initiated 12/12/2025, indicated Floor mats on both side of bed, keep bed in low position, monitor Resident frequently when in bed or chair. DON stated based on documentation within Rehab Post Fall Review, dated 1/8/26, which indicated Post fall IDT intervention: floor mats, it could be assumed there were no floor mats in place at time of fall. DON stated CNA 1 should not have left Resident 1 with side rails down and bed elevated before exited room. DON stated CNA 1 should have gathered necessary supplies and requested assistance from another staff member before entering Resident 1's room for incontinence care. DON stated due to Resident 1's limited cognition and one-sided, partial mobility, Resident 1 was able to shift self-off of bed onto floor. DON stated dependent, total care residents always warranted a two person assist for incontinence care, and residents should not be left alone in the middle of incontinence care. DON stated CNA 1 should have stayed at Resident 1's bedside and used call light system to alert staff for additional help and supplies. DON stated it was important to implement fall precautions and utilize two staff members during incontinence care of dependent residents to prevent accidents and ensure resident safety.During a review of the hospital Emergency Department (ED) Provider Notes, dated 1/2/26 at 3:40 p.m., the ?Chief Complaint and Triage Note' indicated, Brought in by ambulance from SNF. Pt had unwitnessed fall from bed. Pt seen 15 minutes prior to being discovered on floor. Pt has lac (laceration) between eyes, beneath L (left) eye, abrasion to R (right) elbow, shortening to R leg. The History and Present Illness note indicated, Patient is a 77 y.o. female brought in from skilled nursing facility. Patient had unwitnessed fall from bed. Patient was seen 15 minutes prior to her fall and discovered on the floor. Patient states that she heard a pop in her right lower extremity. Patient has abrasion to face abrasion to right elbow as well. Patient has some shortening to the right leg.During a review of the Hospitalist History and Physical (H&P) note dated 1/2/2026 at 6:06 p.m., the H&P indicated, Patient is a [AGE] year-old female with left sided hemiparesis presenting after an unwitnessed fall at her SNF. The patient was found on the floor by nursing staff after they briefly left the room to obtain supplies. The exact circumstances of the fall are unknown. She was noted to have significant pain and bruising on her forehead concerning for trauma. She underwent a full trauma workup in the ER. Head CT (computed tomography scan; a (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	noninvasive, rapid diagnostic imaging test that uses a rotating X-ray machine and computers to create detailed, cross-sectional slices of the brain, skull, sinuses, and blood vessels) was unremarkable. Pelvis x-ray (a noninvasive medical imaging test that uses a small amount of electromagnetic radiation to produce images of the body's internal structures) was unremarkable, but femur x-ray revealed a distal femur fracture. Physical exam within record indicated, Skin: obvious bruising on forehead with dried blood extending to bridge of nose and left eye.During a review of Resident 1's CT head, dated 1/2/26 at 2:03 p.m., indicated frontal/perinasal hematoma (accumulation of blood within the nasal septum, which is the wall of cartilage and bone that divides the two nostrils),.During a review of Resident 1's x-ray of right femur dated 1/2/26 at 2:35 p.m., indicated, comminuted distal femoral fracture (a severe, high-energy injury where the lower end of the thigh bone (femur) breaks into three or more pieces just above the knee joint).During a review of the facility's policy and procedure (P&P) titled, Falls - Clinical Protocol and Prevention, dated March 2018, the P&P indicated, The staff and practitioner will review each resident's risk factors for falling and document in the medical record. Examples of risk factors for falling include musculoskeletal abnormalities (disorders affecting muscles, bones, joints and ligaments, causing pain, inflammation and reduced mobility), peripheral neuropathy (nerve damage causing numbness, tingling, burning pain, or weakness), gait and balance disorders, cognitive impairment, weakness, environmental hazards, confusion. Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address the risks of clinically significant consequences of falling. During a review of the facility's P&P titled, Compliance Risks - Resident Quality of Care and Quality of Life, dated January 2025, indicated, Residents are provided with a safe, clean, and comfortable environment that is free of accident hazards, and adequately supervised.