Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 04/30/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555446	A. Building B. Wing	01/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rossmoor Post Acute	1226 Rossmoor Parkway Walnut Creek, CA 94595

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 - Minimal harm or potential for 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. 36087 Based on observation, interview, and record review, the facility failed to provide appropriate safety measures and adequate supervision to prevent one of three residents (Resident 1) from rolling out of bed and falling on the floor during after-shower care. The failure to provide sufficient staff or adequate measures to prevent a dependent resident from rolling off the bed during Activities of Daily Living (ADL, the basic self-care tasks an individual does on a day-to-day basis) care/after-shower care, resulted in Resident 1 being transported to the emergency department for evaluation after the fall, caused a seven centimeter (cm) laceration to the right forehead, a brief loss of consciousness, and a contusion (a bruise or skin discoloration due to injury to soft tissue) of right ankle. Findings: A review of Resident 1's Admission Record, printed 12/19/24, indicated Resident 1 was admitted to the facility in 2019 with diagnoses of morbid obesity (having too much body fat), cerebrovascular accident (CVA, a stroke or loss of blood flow to the brain), and Schizophrenia (a serious mental condition that affects how people think, feel, and behave). A review of Resident 1's Minimum Data Set (MDS, resident assessment tool used to provide care), dated 9/24/24, indicated Resident 1 had clear speech, was understood, and was able to understand others. The MDS indicated Resident 1 was dependent (helper does all the effort. Resident does none of the effort to complete the activity. Or the assistance of two or more helpers is required for the resident to complete the activity) on most ADLs including toileting hygiene, shower/bathe self and lower body dressing. The MDS also indicated resident required substantial/maximal assistance (the helper does more than half the effort of lifting or holding trunk or limbs) when rolling from lying on back to left and right side and return to lying on back on the bed. The MDS further indicated Resident 1 was incontinent (no voluntary control of urine or feces) on both bladder (urination) and bowel (defecation). A review of Resident 1's Care Plan titled, ADL Self-care Deficit related to (r/t) CVA and Physical Limitations, revision date 7/6/20, indicated a goal, Will receive assistance necessary to meet ADL needs, and interventions/tasks that included, ADL Assist: Transfer with mechanical lift with double extra-large (XXL) size sling .Encourage and or assist to reposition frequently . (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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NAME OF PROVIDER OR SUPPLIER Rossmoor Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1226 Rossmoor Parkway Walnut Creek, CA 94595	

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A review of Resident 1's clinical record titled, Situation, Background, Appearance, Review and Notify (SBAR) Communication Form, dated 11/12/24, indicated resident had a fall, obtained a laceration with bleeding to the forehead, with increased confusion or disorientation, and a Physician Order (PO) to send resident to the emergency room (ER) for evaluation and testing. During an interview on 12/19/24, at 1:02 p.m., with Resident 1, inside her room, Resident 1 stated three staff members, a male Restorative Nursing Assistant 1 (RNA 1), a male Certified Nursing Assistant 2 (CNA 2) and a female CNA 1 (CNA 1) were present in the room and assisted the resident with after-shower care. Resident 1 stated during the resident's final turn to complete the incontinent brief application, while RNA 1 and CNA 2 were standing next to resident's left side and CNA 1 to resident's right side (to secure the tape to resident's brief), as resident was turned by the two male staff from her left to the right side, Resident 1 claimed CNA 1 pushed her real hard toward the right side of the bed, which made resident slip from the bed and fall, hit her right forehead on something, and landed face down onto the floor. Resident 1 stated there was blood all over the floor and people came running when resident somewhat lost her consciousness. Resident 1 stated she was taken to the hospital where they took X-rays (X-radiation, a quick, painless test to create images of the inside of the body) to several parts of her whole body. At this time during the interview, Resident 1 started crying as she continued with her recollection of the incident. Resident 1 stated she feared she was going to go to surgery. During an interview on 12/19/24, at 1:10 p.m., with RNA 1, RNA 1 stated Resident 1 was a three to four (3-4) person assist with transfers using the Hoyer Lift (an electric lift designed to transfer patients between two surfaces), turning, and repositioning. RNA 1 stated during Resident 1's after-shower care that day, only three staff members, RNA 1 (male), CNA 2 (male), and CNA 3 (female) were available to assist the resident. During an interview on 12/19/24, at 2:16 p.m., with the Director of Staff Development (DSD), DSD stated CNA 1 was from registry (an agency that provided certified nursing assistant services to facilities as needed) and the CNA's first time being assigned to take care of Resident 1 on the day the fall incident happened. DSD stated the facility's licensed nurses and seasoned CNAs provided quick orientation to registry staff during the times registry services were called to report for work at the facility. During a telephone interview on 12/23/24, at 12:45 p.m., with CNA 1, CNA 1 stated during Resident 1's final turn to complete the after-shower care/incontinent brief application, CNA 1 stood next to resident's right lower side of the bed to secure and stick the tape to the incontinent brief. CNA 1 stated as RNA 1 and CNA 2 turned and pushed resident to the right side towards CNA 1, the locked bed jerked and moved a bit due to resident's dead, heavy weight, and Resident 1 fell on to the floor and hit her head on something, towards the wall where there was a bedside table in the corner, about two feet away from the bed, and started bleeding from the forehead. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During a telephone interview on 12/23/24, at 12:45 p.m., with CNA 2, CNA 2 stated both RNA 1 and CNA 2 knew Resident 1 so well that staff had to follow resident's preferences/directions regarding provisions of the resident care. CNA 2 stated Resident 1 required 3-4 person assist, with usually four people to help when a fourth person was available. CNA 2 stated on the day of the incident, RNA 1 and CNA 2 assisted CNA 1 with Resident 1's after-shower care. CNA 2 further stated CNA 1 stood at the right side of the resident, next to the mid-lower part of the bed and it was unfortunate that CNA 1 was unable to control the force of gravity and weight of the resident during the turn, enough to cause Resident 1 to fall off the bed, upper body first, onto the floor. CNA 2 stated Resident 1 had severe bleeding to the forehead and was sent to the emergency room for evaluation. A review of Resident 1's clinical record titled, Emergency Department (ED) Provider Notes, dated 11/12/24, indicated resident obtained ED procedures and critical care that included plastic surgery consultation, large right forehead laceration (seven cm long) repair, minor head injury, and trauma (tenderness and swelling likely component of sprain and contusion) to the right ankle on the resident's old site of chronic deformity. A review of the facility's policy and procedure (P&P) titled, Falls and Fall Risk, Managing, revision date March 2018, indicated, .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 .A fall is defined as: Unintentionally coming to rest on the ground, floor, or other lower level, but not as a result of an overwhelming external force .An episode where a resident lost his or her balance and would have fallen, if not for another person or if he or she had not caught him/herself, is considered, a fall. A fall without injury is still a fall. Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred .