STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055049	A. Building B. Wing	08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant Hill Post Acute	1625 Oak Park Boulevard Pleasant Hill, CA 94523

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, for six of 47 sampled residents (Resident 2, 4, 9, 16, 64, and 68), the facility failed to inform and provide information to the resident and/or resident representatives, the option to formulate an Advance Directive (AD, a legal document in which a person specifies what actions should be taken for their health if they are no longer able to make decisions for themselves because of illness or incapacity). This deficient practice had the potential to result in delayed treatment directions to healthcare providers regarding residents' medical care. 1. A review of Resident 2's admission Record, printed on 8/14/25, indicated resident was admitted to the facility on [DATE], with diagnoses that included hemiplegia (muscle weakness on one side of the body, complete paralysis) and hemiparesis (partial weakness), atrial fibrillation, (an irregular, often rapid heart rate that causes poor blood flow), and diabetes mellitus (high blood sugar). 2. A review of Resident 4's admission Record, printed on 8/14/25, indicated resident was admitted to the facility on [DATE], with diagnoses that included right lower leg fracture, chronic obstructive pulmonary disease (COPD, a lung condition caused by damage to the airways and other parts of the lungs), and chronic kidney disease. During a concurrent interview and record review on 8/14/25, at 3:20 p.m., with the Medical Records Director (MRD), Resident 2 and Resident 4's electronic records were reviewed. Both Resident 2 and Resident 14 showed no Advance Directives (AD) available in their charts. MRD stated both residents had no copies of AD on file. During a follow-up interview on 8/14/25, at 4:12 p.m., with the Operations Manager (OP), acting Social Services (SS), OP stated during resident's initial conference, OP stated MRD should ask the resident if there was an existing AD or MRD should provide an option to formulate an AD if the resident did not have one. OP stated the AD will help guide the facility in providing the residents their preferred plan of care when residents are no longer able to make decisions for themselves during an illness or incapacity. OP further stated the facility will abide whatever decision the residents may have indicated in their AD. 3. During a review of Resident 9’s admission Record, printed on 8/14/25, indicated Resident 9 was originally admitted to the facility on [DATE] and was re-admitted on [DATE] with multiple diagnoses that included congestive heart failure (when heart cannot pump enough blood to rest of the body) and degenerative disease of nervous system (progressive loss of nerve cells in the brain/spinal cord affecting movement, cognition, behavior). (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. During a review of Resident 16’s admission Record, printed on 8/14/25, indicated Resident 16 was admitted to the facility on [DATE] with multiple diagnoses that included acute and chronic respiratory failure with hypoxia (when lungs are not getting enough oxygen to the body) and chronic lymphocytic leukemia of b-cell (blood cancer). 5. During a review of Resident 64’s admission Record, printed on 8/14/25, indicated Resident 64 was admitted to the facility was originally admitted to the facility on [DATE] and was re-admitted on [DATE] with multiple diagnoses that included anoxic brain damage (caused by complete lack of oxygen to the brain) and personal history of malignant neoplasm of breast (breast cancer). 6. During a review of Resident 68’s admission Record, printed on 8/14/25, indicated Resident 68 was originally admitted to the facility on [DATE] and was re-admitted on [DATE] with multiple diagnoses that included traumatic subdural hemorrhage with loss of consciousness (brain injury). During a concurrent interview and record review on 8/14/25 at 4:14 p.m. with OP, OP stated, Residents 9, 16, 64 and 68 did not have Advance Directive in their medical record nor were they offered Advance Directive upon admission. OP further stated, without Advance Directive resident’s wishes and preferences regarding treatment and medical care may not be honored. During a review of the facility's policy and procedure (P&P) titled Advance Directives, dated 2022, the P&P indicated, “Determining Existence of Advance Directive 1. Prior to or upon admission of a resident, the social services director or designee inquires of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives.”

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete the tracking entry Minimum Data Set (MDS - a federally mandated assessment tool) within seven calendar days after re-entry for one of 47 sampled residents (Resident 64). This failure had the potential to delay care planning and delivery for Resident 64's care areas that would have been identified in the re-entry MDS.During a review of Resident 64's admission Record, printed on 8/15/25, indicated Resident 64 originally admitted to the facility on [DATE] and was re-admitted on [DATE] with multiple diagnoses that included anoxic brain damage (caused by complete lack of oxygen to the brain), acute respiratory failure with hypoxia (lung condition where lungs cannot provide enough oxygen to the body), malnutrition, contracture (stiff joint/body part and unable to move normally) of left and right knee, and personal history of malignant neoplasm of breast (breast cancer).During a review of Resident 64's Nursing Home and Swing Bed Tracking (NT/ST) MDS dated [DATE] indicated, Resident 64's assessment MDS was completed on 4/18/25.During a concurrent interview and record review on 8/15/25 at 12:11 p.m. with Minimum Data Set Coordinator (MDSC), MDSC revealed Resident 64's NT/ST MDS was due on 4/15/25. MDSC acknowledged she was late in assessment completion and stated she was responsible for making sure MDS assessments were completed timely. MDSC added, late completion of admission MDS assessment could have resulted in the delay of identifying Resident 64's care needs as well as delay in treatment.During a review of facility's policy and procedures (P&P) titled, MDS Completion and Submission Timeframes, dated 2023, indicated under policy statement: Our facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes. Under Policy Interpretation and Implementation: 1. Assessment coordinator or designee is responsible for ensuring resident assessments are submitted to CMS' Internet Quality Improvement Evaluation System (iQIES) in accordance with current federal and state guidelines.During a review of Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual CH 2: Assessments for the RAI, dated October 2024, indicated the completion assessment Reentry Tracking Form must be completed 7 days following date of event. {Reference: https://downloads.cms.gov/files}

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident’s assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, for one of 47 sampled residents (Resident 64), the facility failed to complete the quarterly Minimum Data Set (MDS - a federally mandated assessment tool) assessments. This failure had the potential to result in the delayed assessment of resident needs, goals of care and inability to monitor each resident's progress over time.During a review of Resident 64's admission Record, printed on 8/15/25, indicated Resident 64 originally admitted to the facility on [DATE] and was re-admitted on [DATE] with multiple diagnoses that included anoxic brain damage (caused by complete lack of oxygen to the brain), acute respiratory failure with hypoxia (lung condition where lungs cannot provide enough oxygen to the body), malnutrition, contracture (stiff joint/body part and unable to move normally) of left and right knee, and personal history of malignant neoplasm of breast (breast cancer).During a concurrent interview and record review on 8/15/25 at 12:11 p.m. with Minimum Data Set Coordinator (MDSC), the following MDS record reviews were not completed and transmitted within 14 days as follows:Review of Resident 64's Annual MDS dated [DATE], revealed assessment completed date, 1/18/24.Review of Resident 64's Quarterly MDS dated [DATE], revealed assessment completed date, 4/11/24.Review of Resident 64's Quarterly MDS dated [DATE], revealed assessment completed date,1/9/25.Review of Resident 64's Quarterly MDS dated [DATE], revealed assessment completed date, 4/10/25.MDSC stated, she was late in completing and transmitting the assessment. MDSC added, the expectation was to transmit completed MDS within 14 days after the assessment to be in compliance with the regulation.During a review of facility's policy and procedures (P&P) titled, MDS Completion and Submission Timeframes, dated 2023, indicated under policy statement: Our facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes. Under Policy Interpretation and Implementation: 1. Assessment coordinator or designee is responsible for ensuring resident assessments are submitted to CMS' Internet Quality Improvement Evaluation System (iQIES) in accordance with current federal and state guidelines.Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual CH 2: Assessments for the RAI, dated October 2024, indicated the quarterly assessment an OBRA non-comprehensive assessment for a resident that must be completed at least every 92 days following the previous OBRA assessment of any type. It is used to track a resident's status between comprehensive assessments to ensure critical indicators of gradual change in a resident's status are monitored. The MDS completion date must be no later than 14 days after the ARD (ARD + 14 calendar days).{Reference: https://downloads.cms.gov/files}

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide services to meet professional standards of quality for three of three sampled residents (Residents 64, 34, and 67) when the following were observed:1. Resident 64's Fiber source enteral feeding bag (food given through a feeding tube) and tubing were not labeled.2. Resident 34's Intravenous (IV - small flexible tube used to deliver medicine/fluids into a person's vein) secured by tegaderm (clear, waterproof medical device to secure IV line to a person's skin) was not labeled.3. Resident 67's IV line and tubing was not labeled.This failure had the potential to negatively impact the delivery of care services provided to Residents 64, 34 and 67.1. During a review of Resident 64's admission Record, printed on 8/15/25, indicated Resident 64 originally admitted to the facility on [DATE] and was re-admitted on [DATE] with multiple diagnoses which included malnutrition and dysphagia (difficulty swallowing).During a review of Resident 64's Baseline Care Plan (document that outline resident's care needs), dated 6/6/25, indicated under IV. Food and Nutrition Services A. Goals/Interventions for Care 1a. Diet Order: Enteral Feed.1c. Describe Resident Preferences based on Initial Screen: Enteral Feed.Under Nutritional Risks: .4. Dietary Interventions: Enteral Feed.During a concurrent observation and interview on 8/12/25 at 10:01 a.m. with Nursing Supervisor (NS), Resident 64 was observed receiving nutrition via enteral feeding. Resident 64's fiber source nutrition bag and the tubing were not labeled. NS stated the bag and the tubing were supposed to be labeled with date and time when it was prepared for Resident 64's safety. NS added, Resident 64 was at risk for complications. NS also added, the expectation for all licensed nurses was to label the nutrition bag and tubing immediately after hanging for infection control. 2. During a review of Resident 34's admission Record, printed on 8/14/25, indicated Resident 34 was admitted to the facility on [DATE] with multiple diagnoses which included dysphagia (difficulty swallowing foods or liquids).During a review of Resident 34's Order Summary, dated 8/7/25, revealed an order for Sodium Chloride (sterile salt water) Intravenous Solution 0.9 percent.During a concurrent observation and interview on 8/12/25 at 10:50 a.m. with Director Of Nursing (DON), Resident 34 Tegaderm (transparent, sterile dressing) securing the IV line to Resident 34's skin and IV tubing was not labeled. DON stated, Resident 34's IV was not labeled therefore it was not known when the IV line was placed or changed. DON further added, this placed Resident 34 at risk for infection and complication.3. During a review of Resident 67's admission Record, printed on 8/12/25, indicated Resident 67 was admitted to the facility on [DATE] with multiple diagnoses which included metabolic encephalopathy (chemical imbalance that makes the brain work improperly).During a review of Resident 67's Order Summary Report, printed on 8/12/25, indicated Resident 67 had peripheral (close to skin surface, to the side) IV Line - Left hand (L).During a concurrent observation and interview on 8/12/25 at 11:05 a.m. with NS, Resident 67's Tegaderm securing the IV line to Resident 67's skin and IV tubing was not labeled. NS stated, Resident 67's IV was supposed to be labeled with date and time to prevent infection. During a review of facility's policy and procedure (P&P), titled, Enteral Tub Feeding via Continuous Pump, dated 11/2018, indicated under General Guidelines .3.c. Date and time formula was prepared. The P&P further indicated under, Initiate Feeding .5. On the formula label document initials, date and time the formula was hung/administered, and initial that the label was checked against the order.During a review of facility's P&P titled, Intravenous Therapy, dated 12/2024, indicated under Compliance Guidelines: .5. All IV tubing is to be labeled with date, time, and initials.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that one of three residents (Resident 57) received a thorough assessment and individualized activities program designed to meet his interests for almost two weeks.This failure resulted in Resident 57 feeling frustrated and placed him at risk for isolation. During a review of Resident 57's admission Record printed on 8/14/25, the record indicates Resident 57 was admitted to the facility on [DATE].During a review of Resident 57's Minimum Data Set (MDS-federally mandated resident assessment tool) assessment dated [DATE], the assessment indicated Resident 57 was able to understand others and was able to make himself understood. The assessment indicated it was very important for Resident 57 to listen to music he liked, to be around animals such as pets, to keep up with the news, and to do his favorite activities.During a concurrent observation and interview with Resident 57 on 8/12/25 at 10:12 a.m. in his room, Resident 57 was sitting up in bed watching television. Resident 57 stated he had a respiratory infection and was quarantined (isolation, not able to come out of the room and/or mingle with others). Resident 57 stated prior to his recent hospitalization, he enjoyed creating music at home and would like to have music-related activities to occupy his time while in the facility. Resident 57 stated that he had not been offered any activities and/or channels on the television that met his interests since his admission to the facility. Resident 57 stated being in isolation and not having an activity program made him feel frustrated.During a concurrent interview and record review on 8/14/25 at 10:49 a.m., with Activity Director (AD), Resident 57's Activity assessment dated [DATE], and Activity Program participation from 8/1/25 through 8/14/25 were reviewed. AD stated all newly admitted residents received an activities assessment within five days of admission. The assessment consisted of questions including the highest level of education, former occupation, whether the resident was part of any clubs or organizations, religious faiths, and any other interest. The AD stated all of these sections were left blank as she did not ask any of those questions when she assessed Resident 57 on 8/7/25. AD stated due to Resident 57's COVID-19 quarantine, he was primarily offered in-room activities such as television and newsletter. AD states that Resident 57 often declined these activities. The AD stated she spent about five to ten minutes with Resident 57 to encourage him to participate in newsletter activity, however Resident 57 was never interested in that. AD stated she did not document any notes when Resident 57 refused to participate in newsletter activity, rather documented as Resident 57 had participated in that activity. AD stated however, Resident 57's Activity record did not reflect accurate status of Resident 57's participation in the program. AD also stated she did not inform any other members of Resident 57's care team that Resident 57 was reluctant to participate in newsletter activity, and hence no alternative interventions were provided.During an interview with Director of Nursing (DON) on 8/14/25 at 2:14 p.m., the DON stated it was important to complete initial activity assessment thoroughly to identify personalized activities for the residents. The DON stated spending five to ten minutes was not enough to offer and encourage the residents to participate in activities of their interest. The DON stated it was unacceptable to document residents' activity participation inaccurately. The DON stated the activity program was important to promote healing and well-being of residents and lack of activities could slow the healing process.A review of the facility's policy and procedure titled Activity Programs dated 6/2018, indicated, Activity programs are designed to meet the interests and support the physical, mental, and psychosocial well-being of each resident.Activities offered are based on the comprehensive resident-centered assessment and the preferences of each resident.Individualized and group activities are provided that: reflect cultural and religious interests, hobbies, life experiences, and personal preferences of the residents.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure medication error rate was below five percent (%) when:1. Licensed Vocational Nurse (LVN) 2 administered three antihypertensive (medication to treat high blood pressure) medications to Resident 72 without checking vital signs prior to administering the medications.2. LVN 1 administered topical medication to Resident 45 without doctor's order.These deficient practices placed Residents 72 and 45 at risk of developing complications and adverse reaction related to error in medication administration. 1. During concurrent medication administration observation and interview on 8/14/25, at 9:18 a.m. with LVN 2, LVN 2 was doing morning medication pass. LVN 2 administered Bumetanide 2mg 1 tablet, Carvedilol 6.25mg 1 tablet, and Losartan 100mg 1 tablet by mouth to Resident 72 without checking vital signs.LVN 2 stated she did not check Resident 72's vital signs because she relied on Certified Nursing Assistants (CNA - unlicensed direct care giver) to check Resident 72's vital signs. During a review of Resident 72's admission record printed on 8/14/25, indicated Resident 72 was originally admitted to the facility on [DATE] and was re-admitted on [DATE] with multiple diagnoses that included essential primary hypertension (high blood pressure), congestive heart failure (CHF-when heart cannot pump enough blood) and presence of cardiac pacemaker (device implanted in the chest to help regulate irregular heartbeat).2. During a concurrent interview and medication administration observation on 8/14/25 at 9:47 a. m. with LVN 1, LVN 1 applied Biofreeze (topical pain reliever) gel on Resident 45's left and right knee. During a review of Resident 45's admission record printed on 8/14/25, indicated Resident 45 was originally admitted to the facility on [DATE] and was re-admitted on [DATE] with multiple diagnoses that included, disorder involving the immune mechanism (when body's defense system is malfunctioning making it vulnerable to frequent, prolonged, and severe infections).During a concurrent interview record review on 8/14/25 at 10:18 a.m. with LVN 1, Resident 45's medical record was reviewed. LVN 1 confirmed there was no doctor's order for Resident 45 to receive topical pain reliever. LVN 1 stated, I did not check for doctor's order, that's my mistake, it is a medication error I admit it.During an interview on 8/14/25 at 10:49 a.m. with the Director Of Nursing (DON), DON stated, LVN 2 did not administer Resident 72's antihypertensive and diuretic medications in a safe manner because LVN 2 did not check Resident 72's vital signs prior to giving the medications. DON added, LVN 2 did not have recent blood pressure reading to follow parameters required for administering antihypertensive medications. DON also added, Resident 72's diuretic medication can cause sudden drop in blood pressure. During a concurrent interview record review on 8/14/25 at 10:53 a.m. with DON, DON confirmed Resident 45 did not have doctor's order to receive topical pain reliever. DON added, LVN 1 applied the treatment to Resident 45 without doctor's order. DON also added, Resident 45 could have had allergic adverse reaction to the treatment.During a review of facility's policy and procedures (P&P) titled, Administering Medications, dated 4/2019, indicated, Medications are administered in a safe and timely manner, and as prescribed. The P&P also indicated, .11. The following information is checked/verified for each resident prior to administering medications: .b. Vital signs.During a review of facility's P&P titled, Adverse Consequences and Medication Errors, dated 2/2023, indicated under Adverse Consequences: 1. An 'adverse consequence' refers to an unwanted, uncomfortable or dangerous effect that a drug may have, such as a decline in mental or physical condition, or functional or psychosocial status. An adverse consequence may include: a. Adverse drug/medication reaction; b. Side effect.2. The staff and practitioner strive to minimize adverse consequences by: .c. Determining that the resident: (1) Has no known allergies to a medication;.(3) Has no condition, history, or sensitivities that would preclude use of that medication. The P&P also indicated under Medication Errors: 1. A 'medication error' is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services. 2. Examples of medication errors include: .b. Unauthorized drug - a drug is administered without a physician's order.

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one resident of 27 (Resident 72) sampled residents observed during medication administration pass was free from significant medication error when Licensed Vocational Nurse (LVN) 2 administered the following medications without checking Resident 72's vital signs (clinical measurements that tells the state of essential body functions).1. Bumetanide (a powerful water-pill that can lower blood pressure) 2 milligrams (mg - unit of measurement)2. Carvedilol (antihypertensive - medication to treat high blood pressure)3. Losartan (antihypertensive- to treat high blood pressure)This deficient practice had the potential for dangerous drop in blood pressure, possible for stroke and increased risk of death.During a review of Resident 72's admission record printed on 8/14/25, indicated Resident 72 was originally admitted to the facility on [DATE] and was re-admitted on [DATE] with multiple diagnoses that included essential primary hypertension (high blood pressure), congestive heart failure (CHF-when heart cannot pump enough blood) and presence of cardiac pace maker (device implanted in the chest to help regulate irregular heartbeat).During a concurrent observation and interview on 8/14/25 at 9:18 a. m. with LVN 2, LVN 2 administered Bumetanide 2mg 1 tablet, Carvedilol 6.25 mg 1 tablet, and Losartan 100mg by mouth without checking Resident 72's blood pressure. LVN 2 stated, she did not check Resident 72's blood pressure prior to giving antihypertensive medications because the Certified Nursing Assistants checked the vitals signs at 7:30am. When asked how did she determine the vital signs taken by another staff was accurate, LVN 2 stated, it may not be accurate. LVN 2 acknowledged it was unsafe to give Resident 72 antihypertensive medications without first checking blood pressure.During an interview on 8/14/25 at 10:49 a. m. with the Director Of Nursing (DON), DON stated, LVN 2 did not administer Resident 72's antihypertensive and diuretic medications in a safe manner because LVN 2 did not check Resident 72's vital signs prior to giving the medications. DON added, LVN 2 did not have recent blood pressure reading to follow parameters required for administering antihypertensive medications. DON also added, Resident 72's diuretic medication can cause sudden drop in blood pressure. During a review of Resident 72's Order Summary Report, dated 8/14/25, indicated the following physician order for Resident 72:1. Bumetanide Oral Tablet 2 mg (Bumetanide) Give one tablet by mouth in the morning for CHF,2. Carvedilol Oral ablet 6.25 mg (Carvedilol) Give one tablet by mouth in the morning for Hypertension Hold for systolic blood pressure (SBP-pressure when heart beats) less than 110 (parameters - measuring factor whether to give medications or not for safety) or heart rate (HR) less than 60 (parameters) and, 3. Losartan Potassium Oral Tablet 100mg (Losartan Potassium) Give one tablet by mouth in the morning for Hypertension Hold for SBP less than 110. During a review of Resident 72's care plan (a written document that outlines the specific patient needs) dated 8/12/25, indicated Resident 72 required antihypertensive medication related to hypertension and one of the interventions is Adhere to parameters for holding medication as ordered.During a review of facility's policy and procedures (P&P) titled, Administering Medications, dated 4/2019, indicated, Medications are administered in a safe and timely manner, and as prescribed. The P&P also indicated, .11. The following information is checked/verified for each resident prior to administering medications: .b. Vital signs.

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	055049	A. Building B. Wing	08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant Hill Post Acute	1625 Oak Park Boulevard Pleasant Hill, CA 94523

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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. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure food was stored, prepared, and served in a safe and sanitary manner when:1. Two dietary staff members did not have their hair fully covered with a hairnet. 2. Plate covers and plate bases used were worn out and damaged. 3. A ladle spoon was found stored dirty and in poor condition. 4. Kitchen storage cabinet doors for storing food and cooking equipment were either missing or in poor condition. These failures had the potential to result in contamination of food and foodborne illness for 46 residents who received food from the kitchen out of a facility census of 47. 1. During a concurrent observation and interview on 8/13/25, at 12:40 p.m., with [NAME] 1 and Dietary Aide 1, both dietary staff members did not have their hair fully secured with a hairnet. [NAME] 1's hair to the back of her neck was not fully covered with the hairnet. Dietary Aide 1 was also noted with some hair to both sides of her neck that were not fully secured to the hairnet. [NAME] 1 stated she was aware she has a lot of hair and acknowledged her hair had tendency to stick out of the hairnet. [NAME] 1 further stated hair must be prevented from dropping into the residents' food at all times, especially during food preparation and tray line. A review of the facility policy and procedure (P&P) titled, Hairnet Use Policy, undated, indicated, All staff, contractors, and visitors entering the kitchen or food preparation areas must wear an approved hairnet that fully covers the hair. Before entering the kitchen: Ensure hair is restrained by a clean hairnet .While in the kitchen: Hairnets must remain securely in place at all times . 2. During the concurrent initial kitchen observation and interview, on 8/12/25, at 9:34 a.m., with the Dietary Manager (DM) and Registered Dietitian (RD), several piles of black-colored plastic plate covers and plate bases were stacked and stored on top of the steam table island. Majority of the insulated plastic domes and plate bases were worn out, damaged, and noted with shallow scratches on both interior and exterior surfaces, and could be potential sources of harmful chemical exposure. DM stated 12 of the 50 pairs of lids and bases had been replaced due to missing covers. DM also stated the lids and bases no longer had its shine, were overused, and could cause cross contamination. During a concurrent follow-up observation and interview on 8/13/25, at 12:40 p.m., with [NAME] 1, [NAME] 1 stated most of the plate covers, lids, and bases were scratched and had lost its shine which was not good for the residents' food. 3. During the concurrent kitchen observation and interview, on 8/12/25, at 9:40 a.m., with the Dietary Manager (DM) and Registered Dietitian (RD), a cooking utensil (ladle/basting spoon) was noted to have lost its gloss, was tarnished, and with dried food debris. This is a form of corrosion that occurred when metals were exposed to substances like cleaning solutions. DM stated it should be discarded and replaced.4. During the concurrent kitchen observation and interview, on 8/12/25, at 9:50 a.m., with the Dietary Manager (DM) and Registered Dietitian (RD), noted were three cabinet doors that were not in good repair. The low cabinet to the right side of the stove had a missing door panel which exposed piles of white ceramic bowls stacked in the bottom shelf and boxes of plastic storage bags on the top shelf of the cabinet. DM, stated the report was not documented on the Maintenance Log but was reported verbally to Maintenance & Housekeeping Director (MHD) yesterday. Another cabinet door panel located on top of the double sink was not in good repair. The cabinet door had a missing latch so that the door did not fully close when pushed. Inside the cabinet were two recipe binders, a gallon container of cooking wine, a container of Lea & [NAME] Sauce, and other seasonings. Another kitchen cabinet door below the microwave oven had a broken side hinge that would not close evenly. DM stated cabinet doors should be in good operating condition and MHD should be informed immediately. During a concurrent follow-up observation and interview on 8/13/25, at 12:50 p.m., with [NAME] 1, [NAME] 1 stated dietary staff usually gave verbal report to Maintenance when there was something that needed to be fixed in the kitchen. [NAME] 1 stated the broken cabinet doors were not reported. A review of the facility policy and procedure (P&P) titled, Kitchen Equipment and Supplies, review date 1/2025, indicated, It is the policy of the facility to maintain all kitchen equipment and supplies in a clean, sanitary, and operable condition, and to ensure adequate quantities are available to safely prepare, serve, and store food, in compliance with California Code of Regulations Title 22, Sections72331 and 72333 .All kitchen equipment shall be maintained in good repair and operating condition, free of breaks, corrosion, and defects .Preventative maintenance schedules shall be established and documented. Any defective or nonfunctioning equipment shall be tagged, removed from service, and reported immediately to the Dietary Supervisor and Maintenance Department .Damaged, chipped, or cracked dishes and utensils shall be discarded or replaced immediately .Staff shall report any

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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 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure resident's food items brought from outside and stored in the residents' refrigerator located in the Conference Room, were labeled and stored appropriately for one of 47 sampled residents (Resident 19).These failures had the potential to cause food contamination and foodborne illnesses.A review of Resident 19's admission Minimum Data Set (MDS, a resident assessment tool used to provide care), dated 6/13/25, indicated resident was admitted to the facility on [DATE], with a therapeutic diet (a meal plan) order.During a concurrent observation, interview, and record review, on 8/13/25, at 3:15 p.m., with the Infection Preventionist (IP) and Dietary manager (DM), in the conference room, contents of the facility's refrigerator and freezer designated for residents' food brought from outside were checked. Items found were Resident 19's liquid food Items that were stored in the refrigerator, with no received date, open date, use-by date, or expiration date:1. A carton of Lactose-Free 2% Reduced Fat Milk, less than a quarter full, had no open date, with an expiration date of 9/10/25.2. Three plastic bags with various sealed single-packed creamers (taken out from original packaging) were undated, without received date, use-by date, or expiration date.IP stated food items brought in by family/visitors that are left with the resident to consume later are labeled with the resident's name, the item, and the use by date. IP further stated nursing staff will discard perishable food items on or before the use-by date and for non-perishables, tossed after three days or follow the expiration date. DM stated dietary staff checked the refrigerator/freezer daily for temperature log. IP stated she checked the contents of the refrigerator daily from Mondays thru Fridays and another nursing staff member checked the refrigerator during weekends. IP claimed she last checked the refrigerator this morning and stated she must have missed the missing open date and use-by date on the milk carton and the expiration date on the creamers. A review of the facility policy and procedure (P&P) titled, Foods Brought by Family/Visitors, dated 5/28/2025, indicated, .Facility will strive to balance resident choice and a homelike environment with the nutritional and safety needs of the residents .Foods brought by family/visitors that is left with the resident to consume later is labeled and stored in a manner that is clearly distinguishable from facility-prepared food .Containers are labeled with the resident's name, the item and the use by date. The nursing staff will discard perishable foods on or before the use by date .A review of the facility P&P titled, Food Receiving and Storage, dated July 2025, indicated, Foods shall be received and stored in a manner that complies with safe food handling practices .Food items and snacks kept on the nursing units must be maintained as indicated below:a. All foods .must be placed in the refrigerator located at the nurses' station and labeled with a use by date.b. All foods belonging to residents must be labeled with the resident's name, the item and the use by date .d. Beverages must be dated when opened and discarded after twenty-four (24) hours.e. Other opened containers must be dated and sealed or covered during storage .

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow infection control practices when following were noted:1. Doors of four out of five sampled rooms designated for COVID-19 (a disease caused by coronavirus that spreads through the air when an infected person coughs, sneezes, or talks. It can cause fever, cough, tiredness, and trouble breathing, and can be more serious in older adults or people with health problems) residents were left open.2. Certified Nursing Assistant (CNA) 1 did not perform hand hygiene after touching resident care areas and prior to serving food to Resident 51.3. Resident 57 did not have hand hygiene supplies readily available and within easy reach, to clean his hands after coughing up phlegm (yellow thick mucus).4. Oxygen tubing (a clear flexible hose that delivers oxygen from tank) for one of two sampled residents (Resident 16) was not labeled and was kept off the floor. 1. During a concurrent interview and record review on 8/12/25, at 11:50 a.m., with Infection Control and Preventionist (IP), the facility's COVID-19 Line List (a table used to track and monitor cases during an infection outbreak) initiated on 8/1/25 was reviewed. The line list indicated Resident 51,11, 47, and 22 were tested positive for COVID-19. The Line List indicated facility had a total of 12 residents and two facility staff were tested positive for COVID-19 between 8/1/25 through 8/8/25. During an observation on 8/12/25 9:34 a.m., the doors of four rooms designated for Residents 11, 51, 22, and 47 were left wide open. A signage was posted on each of these doors indicating residents in these rooms were on enhanced airborne precautions (safety steps used to stop germs, like Covid-19, from spreading through the air. These steps include keeping the resident’s door closed, staff wearing N95 masks or other special respirators, and using extra protective equipment when entering the room). During an observation on 8/12/25 9:40 a.m., Resident 47’s room door was left open for five minutes and had Enhanced Airborne Precautions signage. Certified Nursing Assistant (CNA) 2 came and closed the door. CNA 2 stated the door should be kept closed at all times to prevent the spread of COVID-19. During a concurrent observation and interview on 8/12/25, at 10:34 a.m., with CNA 1, doors of Resident 11 and Resident 51 rooms were left open. CNA 1 closed the door for Resident 51 and Resident 11. CNA 1 stated the doors should remain closed to prevent the spread of infection. During an interview on 8/13/25, at 9:17a.m., with IP, IP stated she knew that keeping the doors, especially the ones in the main hallway open, had potential to spread infection to more people. IP stated the facility was keeping residents who were tested positive for Covid-19 on enhanced airborne precautions, which required resident room doors to remain closed at all times except when staff are entering or exiting. During a review of the facility’s Policy and Procedure (P&P), titled “Covid-19 Infection Prevention and Control Measures” revised on a 5/2023, the P&P indicated, “the facility follows infection prevention and control practices recommended by the Centers for Disease Control (CDC) and Prevention to prevent the transmission of Covid-19 within the facility.” (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of CDC infection control guidance updated as of 5/8/23 indicated, for infection prevention and control in healthcare settings, place suspected or confirmed COVID-19 residents in private rooms with the door closed. 2. During an observation on 8/12/25, at 12:48 p.m., CNA 1 put on a yellow colored disposable personal protective gown and touched Resident 51’s doorknob (this room designated for residents who tested COVID-19). CNA 1 then knocked on the door with right bare hand. Without performing hand hygiene, CNA 1 put on gloves, grabbed a bag of food, opened the door, and closed the door to the room wearing the same gloved hands. There were no hand hygiene supplies available outside the room. During an interview on 8/12/25 12:51 p.m., CNA 1 stated she served the bag of food to Resident 51. CNA 1 stated she should not have touched any surfaces once she had the gloves on, for infection control purposes. During an interview on 8/15/25, at 11:21 a.m., IP stated staff was expected to perform hand hygiene before and after donning (putting on)/doffing (removing) gloves to prevent spread of infection. During a review of the facility's policy and procedure (P&P), titled Handwashing/Hand Hygiene, dated 10/2023, the P&P indicated, This facility considers hand hygiene the primary means to prevent the spread of healthcare- associated infections .” Under Applying and Removing Gloves – “1. Perform hand hygiene before applying non sterile gloves. 3. During an observation on 8/12/25, at 10:08 a.m., Resident 57 was laying in bed. Resident 57 stated he was positive for COVID-19, had hoarse voice, and was coughing up phlegm. Resident 57 grabbed a Kleenex tissue from the bedside table, coughed up phlegm in the tissue, wiped off his face, and threw the contaminated tissue into the trash can. Resident 57 did not have hand hygiene supplies available by his bedside. During a concurrent observation and interview on 8/13/25, at 3:51 p.m., with Registered Nurse (RN 1), RN 1 stated Resident 57 did not have any hand hygiene supplies at his bedside. RN 1 stated he had not seen Resident 57 coughing up phlegm, however if he did, he should have supplies available for him to clean his hands afterwards. RN 1 stated Resident 57 had a hand sanitizer available on the wall in his room, which was about 12 feet far from Resident 57. RN 1 stated they did not expect Resident 57 to get out of bed and walk up to the sanitizer to perform hand hygiene. During an interview on 8/15/25, at 1:30 p.m., with the Director of Nursing (DON), the DON stated if resident is coughing up phlegm, even if the resident is already sick, they should be performing hand hygiene because that is the primary way to prevent spread of the infections. 4. Based on observation, interview, and record review, the facility failed to observe infection control measures for one of two sampled (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	residents (Resident 16) when oxygen tubing (a clear flexible hose that delivers oxygen from tank) was not labeled and kept off the floor. During a review of Resident 16’s admission Record printed on 8/14/25, indicated Resident 16 was admitted to the facility on [DATE] with multiple diagnoses that included acute and chronic respiratory failure (a condition that occurs when the lungs are unable to get enough oxygen into the blood or remove enough carbon dioxide from the blood) with hypoxia (a condition that occurs when the body's tissues, blood, or cells don't have enough oxygen to function normally), Chronic Obstructive Pulmonary Disease (COPD – ongoing lung condition caused by damage to lungs), and shortness of breath. During a concurrent observation and interview on 8/12/25 at 10:13 a.m. with Licensed Vocational Nurse (LVN) 2, in Resident 16’s room while receiving supplemental oxygen therapy, Resident 16’s oxygen tubing was on the floor, kinked and stuck under Resident 16’s garbage can. LVN 2 acknowledged the oxygen tubing was not labeled and removed the oxygen tubing from being stuck under garbage can. LVN 2 stated the tubing on the floor placed Resident 16 at risk for infection. LVN 2 added, the tubing was too long that was why it always ended up on the floor. During an interview on 8/12/25 at 10:50 a.m. with the Director Of Nursing (DON), DON stated oxygen tubing should not be touching the floor, must be secured to Resident 16’s bed, and if too long, must be wrapped in a clear bag. DON further added, infection control issues present when the oxygen tubing is touching the floor and tubing not labeled with date it was changed. During a review of facility’s policy and procedure (P&P) titled, “Oxygen Administration,” dated 10/2010, indicated under Steps in the Procedure …”7. Check the tubing connected to the oxygen cylinder to assure that it is free of kinks.”

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to provide at least 80 square feet for each resident in multiple resident bedrooms: Rooms 14, 15, 12, 16, 17, 18, 19, 20, 21, and 22.This failure had the potential to result in a lack of sufficient space for facility staff to provide proper care and increased the risk of not having enough room to store resident belongings at their bedside.During random interviews and observations of care and services from 8/12/25 to 8/15/25, there were adequate space for residents' belongings and for caregivers to provide care in all of the rooms listed. There were no complaints from residents or staff regarding the room space.During a record review of the Client Accommodations Analysis, dated 8/12/25, the following multiple resident rooms were identified having below the required 80 square feet requirement per resident:room [ROOM NUMBER] had 4 beds and 68.5 sq.ft./bedroom [ROOM NUMBER] had 4 beds and 68.5 sq.ft. /bedroom [ROOM NUMBER] had 2 beds and 49.5 sq.ft./bedroom [ROOM NUMBER] had 2 beds and 70 sq.ft. /bedroom [ROOM NUMBER] had 2 beds and 70 sq.ft./bedroom [ROOM NUMBER] had 2 beds and 70 sq.ft. /bedroom [ROOM NUMBER] had 2 beds and 70 sq.ft./bedroom [ROOM NUMBER] had 2 beds and 70 sq.ft. /bedroom [ROOM NUMBER] had 2 beds and 70 sq.ft./bedroom [ROOM NUMBER] had 2 beds and 70 sq.ft. /bed

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. (continued on next page)

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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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that Resident 57's call bell was answered in a timely manner. Resident 57's call system consisted of a standalone call bell, not connected to the call light monitoring panel situated at the nursing station. The call bell did not activate a visual signal outside the room and did not allow tracking of response times. Staff did not respond to Resident 57's call promptly on multiple occasions.This failure resulted in Resident 57 feeling frustrated and placed him at risk for unmet care needs while he was already quarantined for COVID-19 infection. During a review of Resident 57's admission Record printed on 8/14/25, the record indicated Resident 57 was admitted to the facility on [DATE].During a review of Resident 57's Minimum Data Set (MDS-an assessment tool used to direct resident care) assessment dated [DATE], the assessment indicated Resident 57 was able to understand others and was able to make himself understood. During a concurrent interview and observation with Resident 57 on 8/12/25 at 10:08 a.m., Resident 57's room had a signage posted at the door indicating Keep door closed at ALL times except to enter/exit and the door was closed. Upon entering the room, Resident 57 was sitting up in his bed and had a call button tied to the bed rail. Resident 57 stated staff responses to his call system were often delayed. Resident 57 stated he pushed the button five (5) times at a five-minute intervals the night before as his incontinent brief needed to be changed. Resident 57 stated after waiting for about 25-30 minutes, he finally used his personal cell phone to call the front desk to get help. Resident 57 stated delay in call bell response made him feel frustrated. Resident 57 stated he had been using that call bell since he was moved to the current room more than a week ago. The call bell that was tied to Resident 57's bed rail was a wireless button that resembled a car like key fob. Pushing the button emitted one bell type of audible sound into the hallway. Resident 57 pushed his call button to gauge staff response time. After 25 minutes of time, no response to the call bell was delivered by facility staff.During an observation on 8/13/25 at 2:07 p.m., in Resident 57's room, Resident 57 pushed the call bell to test staff response time. No facility staff responded to the call bell until 2:17 p.m During a concurrent interview and observation with Registered Nurse (RN) 1 on 8/13/25 at 3:30 p.m., RN 1 stated he was the charge nurse assigned for Resident 57 on that day. RN 1 stated Resident 57's call bell emitted a loud sound into the hall and whoever is nearby should answer it, but could not explain how it was addressed if staff were busy when the bell was activated as there was no way of tracking when call bell was pushed. RN 1 stated failure to answer the bell in a timely manner posed a risk for not meeting care needs, injuries from trying to get up on his own and could pose a serious risk such as complications due to his COVID-19 diagnosis. RN 1 stated that call lights were answered in the most efficient way possible, ideally within five minutes. RN 1 stated there was no way of monitoring Resident 57's call bell response time. During an observation accompanied by RN 1 on 8/13/25 at 3:37 p.m., Resident 57 activated the call bell in his room. There was no response to Resident 57's call bell until 3:50 p.m. During an interview with Receptionist (REC) and Activity Director (AD) on 8/13/25 at 3:53 p.m. at the reception desk, REC stated she was the designated receptionist for the facility and was stationed at facility's nursing station, situated across from the main entrance. REC stated she at times answered the call bell for Resident 57 as she could hear it at the nursing station but did not hear the bell activated at 3:37 p.m. The AD also stated she did not hear Resident 57's call bell sound, as she was down the hall at the time. During an interview with Nursing Supervisor (NS), on 8/13/25 at 3:55 p.m. in the nurses' office, right next to the nursing station, NS stated she could sometimes hear the bell from the nurses' room but did not hear the bell pushed earlier at 3:37 p.m. A record review of facility's policy and procedure titled, Answering the Call Light revised September 2022, indicated that the facility will answer the resident call system immediately.If the resident needs assistance, indicate the approximate time it will take you to respond.complete the task within five minutes, if possible.