STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055085	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Moraga Post Acute	348 Rheem Boulevard Moraga, CA 94556

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 1) was free from unnecessary drugs when:1. Interdisciplinary team (IDT-a group of professionals from different disciplines working together to provide the greatest benefit to the resident, which included the resident, the resident's family and/or representative, whenever possible, develops and implements approaches to care that are both clinically appropriate and person - centered.) did not address Resident 1's angry outbursts and hallucinations (perceptual experiences in the absence of real external sensory stimuli) and identify person-centered non-pharmacological/behavior approaches prior to administering Resident 1 Quetiapine Fumarate (Seroquel), an antipsychotic medication for vascular dementia (a general term to describe a group of symptoms related to loss of memory, judgment, language, complex motor skills, and other intellectual function, caused by the permanent damage or death of the brain's nerve cells, or neurons. There are many types and causes of dementia with varying symptoms and rates of progression. [Adapted from: About Dementia. Alzheimer's Foundation of America. 30]).2. Resident 1 was administered Seroquel for vascular dementia, an inadequate diagnosis for use. (Antipsychotic medications are drugs used to treat psychotic disorders such as schizophrenia and bipolar disorder, serious mental health conditions). 3. Prescribing physician did not obtain informed consent from Resident 1 and or Resident 1's representative prior to administration of Seroquel and Lorazepam (Ativan-antianxiety medication). 4. Facility did not address Resident 1's use of Seroquel and Ativan in Resident 1's care plan with appropriate interventions. These failures had the potential for Resident 1 to receive unnecessary medications and to suffer adverse side effects.During a review of Resident 1's admission Minimum Data Set (MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan), dated 1/12/26, the MDS indicated Resident 1's Basic Interview of Mental status (BIMS, a scoring system used to determine the resident's cognitive status regarding attention, orientation, and ability to register and recall information. A BIMS score of thirteen to fifteen is an indication of intact cognitive status), score was 08 and indicated moderately impaired mental status. The BIMS score indicated Resident 1 was unable to recall the correct year, month, and day of the week. MDS indicated Resident 1 was able to recall recent information with cueing. MDS indicated Resident 1 had no behavioral evidence of an acute change in mental status. MDS indicated Resident 1 had no potential indicator of psychosis, no hallucinations or delusions. MDS indicated Resident 1 had no physical, verbal, or other behavioral symptoms exhibited e.g., hitting, kicking, pushing, screaming, threatening, scratching, wandering or rejection of care. MDS indicated Resident 1's diagnoses included non-Alzheimer's dementia (memory loss) and anxiety disorder. During an observation on 2/25/26, at 10:25 a.m., in Resident 1's room, Resident 1 lay on her back in bed, awake and mumbling with incomprehensible sounds. Resident 1 had a swelling to the left side of forehead with dry lacerated area and no bleeding. Resident 1 had bluish black discoloration around the left eye area. During a review of Resident 1's Order Summary Report (OSR), dated 1/25/26, the OSR indicated Resident 1's physician prescribed Resident 1 Seroquel tablet 25 mg give one tablet by mouth two times a day for vascular dementia manifested by manic behaviors. During a review of Resident 1's (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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medical Progress Note Skilled Nursing Facility (MPN), dated 2/14/26, the MPN indicated Resident 1 exhibited progressively increasing aggressive outbursts and episodes of confusion as reported by both staff and family. A urinalysis was performed and returned positive (a positive urinalysis for urinary tract infection UTI typically shows elevated white blood cells or bacteria accompanied by symptoms like burning, frequency, or urgency). In response, Resident 1 was initiated on antibiotics for five days. Additionally, the patient's Seroquel dose was increased from 25 mg daily to 25 mg BID (twice a day). During a review of Resident 1's Psychotherapeutic Drug informed Consent Form (IC), for use of Seroquel dated 1/25/26, IC indicated that the prescriber/medical doctor (MD) did not document that informed consent was obtained from Resident 1's representative (RP) prior to Resident 1's use of Seroquel. During a review of Resident 1's Medication Administration Records (MARs), dated 1/25/26 to 2/15/26 indicated Resident 1 was administered Seroquel 25 mg two times a day for vascular dementia manifested by manic behavior. During an interview on 2/25/26, at 10:50 a.m., with Licensed Vocational Nurse (LVN 2), LVN 2 stated Resident 1 had dementia and was forgetful. During a review of Resident 1's OSR dated 1/8/26, OSR indicated Resident 1's physician prescribed Resident 1 to receive Ativan oral 0.5 mg by mouth nightly as needed (PRN) for anxiety. During a review of Resident 1's MARs dated 1/10/26 to 1/31/26 indicated Resident 1 was administered PRN Ativan tablet 0.5mg by mouth PRN nightly for anxiety on 1/10/26 twice on 1/11/26, 1/12/26, twice on 1/15/26 and 1/16/26 at night for anxiety. During a review of Resident 1's IC for use of Ativan, dated 1/17/26, the IC indicated that the prescriber/MD did not document that informed consent was obtained from Resident 1's RP prior to Resident 1's PRN use of Ativan. During an interview on 2/25/26, at 1:20 p.m., with Licensed Vocational Nurse (LVN 2), LVN 2 stated facility process was that when an order for psychotropic medication was received from the physician, licensed nurses will notify resident's family by calling the RP, explain the medication, uses and side effects and ask if it's OK to give resident the medication. If family agrees to administer psychotropic medication, then two nurses will complete and sign IC. If resident's family refused, the licensed nurse would notify the physician. During an interview on 2/25/26, at 1:37 p.m., with Resident 1's Physician (MD), MD stated she did not speak to Resident 1's RP directly regarding obtaining IC for Seroquel and Ativan. MD stated the way it was set up at the facility was for licensed nurses to discuss psychotropic medication order with Resident 1's family/RP and have Resident 1's family/RP sign IC. MD stated except when MD was at the facility, MD did not directly obtain IC from Resident 1/RP. MD stated that licensed nurses obtained IC from Resident 1's RP with option to call the physician if there was need for more clarification. During a concurrent interview and record review on 2/25/26, at 1:42 p.m., with Director of Nursing (DON), Resident 1's care plans, OSR, MARs, IC and PN were reviewed. DON could not provide IDT documentation and care plan that addressed Resident 1's angry outburst with person-centered non-pharmacological approach identified and implemented prior to administration of Seroquel. DON stated Resident 1 was treated for urinary tract infection (UTI) but continued with increased agitation. DON stated facility process for obtaining IC was to call physician and clarify behavior indication for psychotropic medication order when received. DON stated licensed nurse would call resident's representative, explain what the psychotropic medication was for and the side effects. DON stated mostly psychotropic medications were not administered until family verbalized understanding. If the resident representative needed more clarification, the physician would call the resident's family. According to the manufacturer, elderly patients with dementia-related psychosis treated with antipsychotic medication are at an increased risk of death. Seroquel was not approved for use in psychotic conditions related to dementia. Although causes of death varied, most of the deaths appeared to be related to cardiovascular (e.g., heart failure, sudden death). [Reference: https://dailymed.nlm.nih.gov/seroquel]. During a review of the facility's policy and procedure (P&P) titled, Behavioral Assessment, Intervention, and Monitoring, dated 2001, indicated, The IDT will thoroughly evaluate new or changing behavioral symptoms to identify underlying causes and address any modifiable factors that may have contributed to the resident's change in condition, including: (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	infection; fluid or electrolytes imbalance; pain or discomfort; constipation; change related to medications and or worsening of or complications related to others conditions. During a review of the facility's policy and procedure (P&P) titled, Psychoactive/Psychotropic Medication Use, dated 04/2025, the P&P indicated, Psychoactive (also known as Psychotropic) medications may be administered following federal and state regulations if the medication is necessary to treat a specifically diagnosed condition and is appropriately documented in the medical record. Additionally behavioral interventions, unless contraindicated, will be used to meet the individual needs of the resident. The prescribing clinician will obtain informed consent from the resident (or as appropriate, the resident representative) for use of a psychotropic medication.

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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 adequate supervision was provided for one of three sampled residents (Resident 1) to prevent falls and sustained injuries when Resident 1, with history of unwitnessed falls, lost her balance while walking from her bed to room's doorway and fell forward to the ground. This failure resulted in Resident 1 sustaining a laceration to the left frontal part of the head with uncontrolled bleeding, transferred to Acute Care Hospital for follow up care and diagnosed with subarachnoid hemorrhage (a life-threatening condition caused by bleeding into the space surrounding the brain).During a review of Resident 1's admission Record (AR), printed on 2/23/26, AR indicated Resident 1 was admitted to the facility on [DATE], with diagnoses that included abnormalities of gait (a person's manner of walking) and mobility, age related physical debility, osteoarthritis, wedge compression fracture of first lumber vertebra (fractured back) and vascular dementia (memory loss). Dementia is a general term to describe a group of symptoms related to loss of memory, judgment, language, complex motor skills, and other intellectual function, caused by the permanent damage or death of the brain's nerve cells, or neurons. However, dementia is not a specific disease. There are many types and causes of dementia with varying symptoms and rates of progression. (Adapted from: About Dementia. Alzheimer's Foundation of America. 30). During a review of Resident 1's admission Minimum Data Set (MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan), dated 1/12/26, the MDS indicated Resident 1's ability to walk at least 10 feet in a room was not attempted due to medical condition or safety concerns. MDS indicated Resident 1 used a walker and wheelchair for mobility (ability to move, walk or change position easily and freely). MDS indicated Resident 1 had functional limitation in range of motion to lower extremity (hip, knee, ankle, foot) that placed Resident 1 at risk of injury. MDS indicated Resident 1 had a fall prior to admission to the facility. MDS indicated Resident 1's Basic Interview of Mental status (BIMS, a scoring system used to determine the resident's cognitive status regarding attention, orientation, and ability to register and recall information. A BIMS score of thirteen to fifteen is an indication of intact cognitive status.) score was 08 which indicated moderately impaired mental status. The BIMS score indicated Resident 1 was unable to recall the correct year, month, and day of the week. During an observation on 2/25/26, at 10:25 a.m., in Resident 1's room, Resident 1 lay on her back in bed, awake mumbling with incomprehensible sounds. Resident 1 had a swelling to the left side of forehead with dry lacerated area and no bleeding. Resident 1 had bluish black discoloration around the left eye area. Resident 1's bed was placed next to the wall; bed was in a lower position with floor mat placed on the right side of the bed. During a review of Resident 1's Progress Note (PN), dated 2/23/26, PN indicated that on 2/18/26 at approximately 11:30 a.m., another resident's family member saw Resident 1 ambulating from her bed to room's doorway. Per family member, Resident 1 lost balance and fell forward to the ground, and staff was called to assist Resident 1. Nurse found Resident 1 on the floor. Resident 1 was noted with laceration on left frontal forehead with uncontrolled bleeding. Resident 1 was sent to acute hospital for further evaluation. During a review of Resident 1's PN dated 1/25/26, PN indicated Director of Nursing (DON) asked Resident 1's Responsible Party (RP) if Resident 1's family could provide one on one sitter/caregiver for Resident 1 due to Resident 1 being a fall risk, trying to get out of bed to ambulate with agitation, aggression and hallucinations. According to Resident 1's RP, family cannot afford to hire anybody 24/7. Resident 1's RP stated they would try to come more often to sit with Resident 1 and redirect Resident 1. During a concurrent interview and record review on 2/25/26, at 1:42 p.m., with DON, Resident 1's Fall risk assessments and IDT (interdisciplinary team) progress notes were reviewed. The fall risk assessments dated 1/6/26, 1/15/26 and 1/22/26 had scores 28, 28 and 36 respectively, indicating Resident 1 was at high risk for falling. DON stated Resident 1's (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.	family was asked to provide a sitter due to high risk for fall. IDT progress notes indicated that Resident 1 had the following documented falls:On 1/15/26 at 0820 (8:20 a.m.), staff heard screaming which came from Resident 1's room. Staff found Resident 1 on the floor sitting down. Resident 1 could not recall what happened.On 1/22/26 at 1910 (7:10 p.m.), Resident 1 had an unwitnessed fall; a staff member passed by Resident 1's room and heard Resident 1 calling out for help. Licensed Nurse found Resident 1 on the floor. The fall was unwitnessed. Resident 1 stated she struck her head on the floor. On 2/18/26 at 11:30 a.m., family member of another resident saw Resident 1 ambulate from bed to room's doorway, lose her balance and fall forward to the ground. Family member called staff to assist Resident 1. Resident 1 had a laceration on the left frontal scalp/forehead with uncontrolled bleeding. During an interview on 2/25/26, at 11:26 a.m., with Certified Nursing Assistant (CNA 1), CNA 1 stated she was Resident 1's care giver during the morning shift on 2/18/26. CNA 1 stated Resident 1 was at high risk for fall and frequently tried to get out of bed without assistance. CNA 1 stated she frequently checked on Resident 1. CNA 1 stated she was out on lunch break when Resident 1 fell and transferred to hospital. CNA 1 stated before she went on break, she asked CNA 2 to cover (step in to handle duties and responsibilities during their absence) for CNA 1. CNA 1 stated she also informed Licensed Vocational Nurse (LVN 1) that she was going on break. During an interview on 2/25/26, at 11:38 a.m., with LVN 1, LVN 1 stated she was the charge nurse when Resident 1 fell on 2/18/26. LVN 1 stated Resident 1 was asleep at the start of the shift. LVN 1 stated she assumed Resident 1 tried to walk by herself. LVN 1 stated Resident 1 had a high risk for falling. During an interview on 2/25/26, at 12:05 p.m., with CNA 2, CNA 2 stated she did not know the specific details of what happened with Resident 1's fall incident on 2/18/26. CNA 2 stated CNA 1 informed CNA 2 that CNA 1 was going on lunch break and that CNA 2 would cover for CNA 1. CNA 2 stated CNA 2 provided care in another room transferring a resident from wheelchair to bed and did not hear anything. CNA 2 stated by the time CNA 2 completed care with another resident, an ambulance was already at the facility to take Resident 1 to the hospital. During a concurrent interview and record review on 2/25/26, at 1:42 p.m., with DON, Resident 1's fall care plans were reviewed. Fall care plan initiated 1/6/26, indicated Resident 1 was at risk for falls with or without injury related to altered balance while standing and or walking, decreased muscular coordination, history of falls, unsteady gait, hearing and visual impairment. The interventions included to anticipate and meet needs, educate, and remind Resident 1 to call for assistance, keep bed in low position with brakes locked, keep call light within reach and keep personal items frequently used within reach. Further review of fall care plans dated 1/15/26 and 2/15/26, indicated Resident 1 had unwitnessed falls and was at risk for injury and recurring falls, and care plans were not updated with new interventions. Fall care plan dated 2/18/26 indicated Resident 1 had an unwitnessed fall and was transferred to ED (emergency department) for further evaluation. DON stated nursing staff checked Resident 1 every hour for safety and reminded Resident 1 to call for assistance. DON stated facility discussed 24/7 (at all times), one on one sitter with Resident 1's RP. DON stated Resident 1's RP indicated Resident 1's family could not afford the expense. During an interview on 3/12/26, at 10:45 a.m., with Administrator (Admin) and DON, DON stated facility does not provide one on one sitter/caregiver to watch or monitor fall risk residents. Admin stated facility would negotiate with the family of residents with fall risks to provide a sitter prior to admission. During a review of Resident 1's Hospital Discharge Summary (DS), dated 2/22/26, the DS indicated, Resident 1 presented to the hospital after a fall at the nursing facility. Resident 1 was found to have subarachnoid hemorrhage. During a review of the facility's policy and procedure (P&P) titled, Falls and Fall Risk, Managing, revised March 2018, the P&P indicated, 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.