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	04/13/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview and record review, the facility failed to ensure it kept accurate records of controlled medications (medication with a potential for abuse) as evidenced by: 1. The facility failed to ensure, for residents (1-9), the scheduled (controlled medication, narcotic) medication system was complete (all documents available) and accurate (information matched). The record system included Shipping Manifests (pharmacy delivery receipt), Controlled Substance Accountability Sheets (CDR, Controlled Drug Record), Medication Administration Records (MAR, record of medication administration), and destruction logs. The facility records were incomplete. The facility records were inaccurate. These failures had the potential to result in undetected loss and diversion of scheduled medications. In addition, these failures had the potential to result in preventable medication errors (medication not given as ordered). 2. The facility failed to ensure, between 4/1/22-7/31/22, the Consultant Pharmacist identified the scheduled (controlled medication, narcotic) medication system was incomplete (all documents available) and inaccurate (information matched). The record system included Shipping Manifests (pharmacy delivery receipt), Controlled Substance Accountability Sheets (CDR, Controlled Drug Record), Medication Administration Records (MAR, record of medication administration), and destruction logs. The facility records were incomplete. The facility records were inaccurate. These failures had the potential to result in undetected loss and diversion of scheduled medications. In addition, these failures had the potential to result in preventable medication errors (medication not given as ordered).1. During an interview, on 3/19/26 at 11 a.m. the Director of Nursing (DON) and Medical Record Director (MRD) were asked to describe the scheduled medication record system. Their description included that scheduled medications were delivered by the pharmacy with a corresponding Shipping Manifest. The Shipping Manifest was the documentation that the scheduled medication was delivered to the facility. They further described that the Shipping Manifests were retained by the facility. They were requested to provide all the scheduled medication Shipping Manifests from 4/1/22 through 7/31/22, CDRs and Automated Dispensing Cabinet (ADC, device to store and dispense medications) dispense reports. During a concurrent observation and interview, on 3/19/26 at 11:40 a.m. Licensed Vocational Nurse (LVN 1) identified medication cart (stores medication) #1. LVN 1 was asked to describe the scheduled medication record system. Her description included scheduled medications were delivered with a Shipping Manifest and a corresponding CDR. The nurse reviewed the scheduled medication and Shipping Manifest for errors. The nurse signed the Shipping Manifest. The medication was locked in the medication cart. The CDR was filed at the medication cart. The CDR was used to document removal of patient medications. Administration of the medication was documented on the MAR. Completed CDRs were sent for retention. If there were scheduled medications remaining upon discontinuation, the remaining medication and the CDR were sent to the DON. Continuing the interview, LVN 1 was asked to describe the ADC (Automated Dispensing Cabinet) process. Her description included that the ADC did not provide a receipt for the scheduled medication dispensed. She further described that the ADC did not provide a CDR for the scheduled medication dispensed. During a concurrent observation and interview, on 3/19/26 at 11:55 a.m. at the nursing station, (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Licensed Vocational Nurse (LVN 2) was asked to describe the use of the Rx Now ADC. During her description she identified the ADC. The ACD was in a closet across from the nursing station. During a concurrent interview and record review, on 3/20/26 at 10:17 a.m. DON and MRD identified ARxIUM DT Usage (Begin Date: 4/1/2022 End Date: 7/31/2022) (ADC scheduled medication dispensed) report. Inspection of the report showed the following dispenses:Resident 1 6/23/2023 7:20 pm Hydrocodone (hydrocodone, narcotic pain reliever)-Acetaminophen (non-narcotic pain reliever) 10-325 mg (milligram) tab (tablet) #1.Resident 2 7/2/22 5:02 pm Hydrocodone (narcotic pain reliever) w/APAP (acetaminophen, non-narcotic pain reliever) 5/325 mg tab #1.DON and MRD confirmed the ADC dispenses listed above. They were requested to provide documentation that the scheduled medications were administered. They stated the medical records did not document administration, or destruction, of either scheduled medication. During a concurrent interview and record review, on 3/20/26 at 10:25 a.m. DON and MRD identified Resident 3's Shipping Manifest dated 5/1/22 Rx# 3964597 Oxycodone/APAP 5/325 mg tab #90. They stated the facility found CDRs to account for 60, out of 90, tablets. They acknowledged the facility did not have a CDR to account for 30 tablets. During a concurrent interview and medical record review, on 3/20/26 at 10:29 a.m. DON identified the following Shipping Manifests.Resident 1, manifest date 6/23/22, Rx# 4159127 Hydrocodone/APAP 10/325 mg tab #34Resident 4, manifest date 4/1/22, Rx# 3853803 Hydrocodone/APAP 5-325 mg tab #30Resident 5, manifest date 4/16/22, Rx# 3910274 Oxycodone (narcotic pain reliever) 5 mg tab #18Resident 6, manifest date 7/15/22, Rx# 4243475 Oxycodone/APAP 5/325 mg tab #26DON was requested to provide the CDRs for the above Shipping Manifests. She stated that the facility did not have a corresponding CDR for the above shipping manifests. During a concurrent interview and medical record review, on 3/20/26 at 10:43 a.m. DON identified Resident 7's RX# 3954045 Hydrocodone/APAP 5/325 mg tablet #28 CDR. She compared the CDR medication removal against the MAR. DON acknowledged the CDR removal did not have a corresponding MAR administration on 5/10/22 2103. During a concurrent interview and medical record review on 3/20/26 at 10:45 a.m., DON identified Resident 8's RX# 4036730 Hydrocodone/APAP 10/325 mg tablet #28 CDR. She compared the CDR medication removal against the MAR. DON acknowledged the CDR removals did not have a corresponding MAR administration on the dates and times listed below.5/27/22 0600, 01456/1/22 5016/5/22 1600 During a concurrent interview and medical record review on 3/20/26 at 10:50 a.m., DON identified Resident 9's RX# 4019103 Hydrocodone/APAP 5/325 mg tablet #16 CDR. She compared the CDR medication removal against the MAR. DON acknowledged the CDR removal did not have a corresponding MAR administration on 5/17/22 2022. During an interview on 3/20/26 at 11:10 a.m., DON acknowledged the facility did not have the Shipping Manifests and CDRs as documented above. She further acknowledged that information was inaccurate between CDRs and corresponding MARs as documented above. She stated that it was the facility's expectation that all documents were to be complete and accurate. During a concurrent interview and document review on 3/20/26 at 11:15 a.m., DON identified the Policy for Controlled Substances (Revision Date November 2022). She reviewed the policy and acknowledged it required the documentation (Shipping Manifests, CDRs and MARs) to be accurate (monitored and reconciled). An administrative record review, of the Policy for Controlled Substances (Revision Date November 2022) showed, Dispensing and Reconciling Controlled Substances, 1. Controlled substance inventory is monitored and reconciled (complete and accurate) to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow-up.2. The system of reconciling the receipt, dispensing and disposition of controlled substances includes the following: a. Records of personnel access and usage; b. Medication administration records; c. Declining inventory records. 2. During an interview on 3/19/26 at 11 a.m., the Director of Nursing (DON) and Medical Record Director (MRD) were asked to describe the scheduled medication record system. Their description included that scheduled medications were delivered by the pharmacy with a corresponding Shipping Manifest. The Shipping Manifest was the documentation that the scheduled medication was delivered to the facility. They (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	further described that the Shipping Manifests were retained by the facility. They were requested to provide all the scheduled medication Shipping Manifests from 4/1/22 through 7/31/22, CDRs and Automated Dispensing Cabinet (ADC, device to store and dispense medications) dispense reports. During a concurrent observation and interview on 3/19/26 at 11:40 a.m., Licensed Vocational Nurse (LVN 1) identified medication cart (stores medication) #1. LVN 1 was asked to describe the scheduled medication record system. Her description included scheduled medications were delivered with a Shipping Manifest and a corresponding CDR. The nurse reviewed the scheduled medication and Shipping Manifest for errors. The nurse signed the Shipping Manifest. The medication was locked in the medication cart. The CDR was filed at the medication cart. The CDR was used to document removal of patient medications. Administration of the medication was documented on the MAR. Completed CDRs were sent for retention. If there were scheduled medications remaining upon discontinuation, the remaining medication and the CDR were sent to the DON. Continuing the interview, LVN 1 was asked to describe the ADC process. Her description included that the ADC did not provide a receipt for the scheduled medication dispensed. She further described that the ADC did not provide a CDR for the scheduled medication dispensed. During a concurrent observation and interview on 3/19/26 at 11:55 a.m., at the nursing station, Licensed Vocational Nurse (LVN 2) was asked to describe the use of the Rx Now ADC. During her description she identified the ADC. The ACD was in a closet across from the nursing station. During a concurrent interview and record review on 3/20/26 at 10:17 a.m., DON and MRD identified ARxIUM DT Usage (Begin Date: 4/1/2022 End Date: 7/31/2022) (ADC scheduled medication dispensed) report. Inspection of the report showed the following dispenses:Resident 1 6/23/2023 7:20 pm Hydrocodone (hydrocodone, narcotic pain reliever)-Acetaminophen (non-narcotic pain reliever) 10-325 mg (milligram) tab (tablet) #1.Resident 2 7/2/22 5:02 p.m. Hydrocodone (narcotic pain reliever) w/APAP (acetaminophen, non-narcotic pain reliever) 5/325 mg tab #1.DON and MRD confirmed the ADC dispenses listed above. They were requested to provide documentation that the scheduled medications were administered. They stated the medical records did not document administration, or destruction, of either scheduled medication. During a concurrent interview and record review on 3/20/26 at 10:25 a.m., DON and MRD identified Resident 3 Shipping Manifest date 5/1/22 Rx# 3964597 Oxycodone/APAP 5/325 mg tab #90. They stated the facility found CDRs to account for 60, out of 90, tablets. They acknowledged the facility did not have a CDR to account for 30 tablets. During a concurrent interview and medical record review, on 3/20/26 at 10:29 am, DON identified the following Shipping Manifests.Resident 1, manifest date 6/23/22, Rx# 4159127 Hydrocodone/APAP 10/325 mg tab #34Resident 4, manifest date 4/1/22, Rx# 3853803 Hydrocodone/APAP 5-325 mg tab #30Resident 5, manifest date 4/16/22, Rx# 3910274 Oxycodone (narcotic pain reliever) 5 mg tab #18Resident 6, manifest date 7/15/22, Rx# 4243475 Oxycodone/APAP 5/325 mg tab #26DON was requested to provide the CDRs for the above Shipping Manifests. She stated that the facility did not have a corresponding CDR for the above shipping manifests. During a concurrent interview and medical record review on 3/20/26 at 10:43 a.m., DON identified Resident 7's RX# 3954045 Hydrocodone/APAP 5/325 mg tablet #28 CDR. She compared the CDR medication removal against the MAR. DON acknowledged the CDR removal did not have a corresponding MAR administration on 5/10/22 2103. During a concurrent interview and medical record review on 3/20/26 at 10:45 a.m., DON identified Resident 8's RX# 4036730 Hydrocodone/APAP 10/325 mg tablet #28 CDR. She compared the CDR medication removal against the MAR. DON acknowledged the CDR removals did not have a corresponding MAR administration on the dates and times listed below.5/27/22 0600, 01456/1/22 5016/5/22 1600 During a concurrent interview and medical record review on 3/20/26 at 10:50 a.m., DON identified Resident 9's RX# 4019103 Hydrocodone/APAP 5/325 mg tablet #16 CDR. She compared the CDR medication removal against the MAR. DON acknowledged the CDR removal did not have a corresponding MAR administration on 5/17/22 2022. During an interview, on 3/20/26 at 11:10 a.m., DON acknowledged the facility did not have the Shipping Manifests and CDRs as documented above. She further acknowledged that (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	information was inaccurate between CDRs and corresponding MARs as documented above. She stated that it was the facility's expectation that all documents were to be complete and accurate. During a concurrent interview and document review on 3/20/26 at 11:15 a.m., DON identified the Policy for Controlled Substances (Revision Date November 2022). She reviewed the policy and acknowledged it required the documentation (Shipping Manifests, CDRs and MARs) to be accurate (monitored and reconciled). During a concurrent interview and record review on 3/20/26 at 11:15 a.m., DON was requested to provide the Pharmacist inspection reports for 4/1/22 through 7/31/22. DON identified the Pharmacist's Medication Regimen Review & Report, Monthly Pharmacy Inspection Report, 5/4/22 and 6/10/22. She inspected the reports and stated they did not document issues with incomplete or inaccurate scheduled medication records. During a concurrent interview and record review on 3/20/26 at 11:15 a.m., DON identified the Policy for Pharmacy Services-Role of the Consultant Pharmacist (Revision Date April 2019). She reviewed the policy and stated that it was the facility's expectation that issues with scheduled medications should have been identified. An administrative record review, of the Policy for Controlled Substances (Revision Date November 2022) showed, Dispensing and Reconciling Controlled Substances, 1. Controlled substance inventory is monitored and reconciled (complete and accurate) to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow-up.2. The system of reconciling the receipt, dispensing and disposition of controlled substances includes the following: a. Records of personnel access and usage; b. Medication administration records; c. Declining inventory records. An administrative record review, of the Policy for Pharmacy Services-Role of the Consultant Pharmacist (Revision Date April 2019) showed, Policy Interpretation and Implementation, 3. The consultant pharmacist shall provide consultation on all aspects of pharmacy services in the facility, and collaborate with the facility and medical director to:, a. develop, implement, evaluate, and revise (as necessary) the procedures for the provision of all aspects of pharmacy services.

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. Based on observation, interview and record review, the facility failed to ensure the social services department was directed and supervised by a qualified social worker according to State regulation for more than 9 years.This failure resulted in all residents receiving social services care from unqualified staff.During an interview on 3/24/26 at 9:45 a.m. with the Social Services Director (SSD), the SSD stated they were the only staff member in the facility's social services department and had worked there for more than 9 years as the social services director. The SSD stated they did not have a bachelor's degree in any field and that their training for the position consisted of a certificate course they completed in 1997. The SSD further stated they had not received any continuing education or additional training since obtaining the certificate in 1997.During a concurrent interview and record review on 3/24/26 at 10:00 a.m. with the Operations Manager (OM), two job descriptions for the SSD, dated 7/2022 and 12/2025, were reviewed. Both job descriptions were signed by the SSD. The job description dated 7/2022 indicated under Qualifications.Education that the position required a Bachelor of Science in Social Work, two years of experience, and noted that an MSW (Master's in Social Work) was preferred. The job description dated 12/2025 indicated under Preferred Qualifications.Education that a Bachelor of Science in Social Work and two years of experience were preferred, and an MSW was also preferred. OM stated the two job descriptions were for the Social Services Director and that the facility removed the education and experience requirements from the newer job description. After reviewing the 12/2025 job description, OM stated there was no minimum education or experience needed for the Social Services Director position.During a concurrent interview and record review on 3/24/26 at 10:15 a.m. with the OM, the SSD's resume dated 1997 was reviewed. The SSD's resume indicated that the highest level of education completed was high school.During a phone interview on 3/24/26 at 11:54 a.m. with the Administrator (ADM), the ADM stated that the SSD was the only staff member in the social services department. The ADM stated there was no qualified social worker who supervised or directed the department. The ADM was aware that the SSD's qualifications did not indicate they were a qualified social worker.During a review of facility policy and procedure (P&P) titled, Social Services, dated 2/2024, the P&P indicated the facility's director of social services was a qualified social worker.During a review of facility's facility assessment titled, [Facility] Facility Assessment, dated 12/27/25, the facility assessment indicated a staffing plan which included Total Number Needed or Average or Range.Social Worker.FULL-TIME on AM and PM shift.During a review of California state regulation titled, Title 22 S72433, the state regulation indicated 'Social Work Service' means those services which assist.a patient and a patient's family to understand and cope with.personal, emotional and related health and environmental problems.During a review of California state regulation titled, Title 22 S72105, the state regulation indicated a Clinical Social Worker means a person who is a licensed clinical social worker by the Board of Behavioral Sciences.During a review of California state regulation titled, Title 22 S72437, the state regulation indicated Social Work Service Unit-Staff.the social work service unit shall be organized, directed and supervised by a social worker, who is responsible for supervision of other social work staff, including social work assistants.