STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055150	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Diablo Valley Post Acute	3806 Clayton Road Concord, CA 94521

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43771 Based on interview and record review, the facility failed to report an allegation of abuse, within required expected timeframe, to the State Survey Agency and Adult Protective Services (APS), for one of two sampled residents (Resident 1). This failure had the potential to not ensure additional protection of Resident 1 and other residents from abuse. Findings: During record review of Resident 1 ' s Face Sheet (FS), the FS indicated Resident 1 is an [AGE] year old resident admitted to the facility in 2024. FS indicated Resident 1 had a responsible party (RP 1) for emergency contact and financial decisions. FS also indicated Resident 1 ' s diagnoses included Cognitive Communication Deficit (reduced awareness and ability to initiate and effectively communicate needs), Intermittent Explosive Disorder (a mental health condition that causes sudden and impulsive episodes of anger and aggression), and Senile Degeneration of Brain (mental deterioration [loss of intellectual ability] that is associated with the characteristics of old age). During an interview on 12/17/2024, at 12:59 p.m., with Assistant Director of Nursing (ADON) 1, ADON 1 stated she received an alleged abuse allegation report on 11/19/24 at around 6:30 a.m., from a Clinical Supervisor that involved a Licensed Vocational Nurse (LVN) slapping Resident 1 on the face, during care received on the night of 11/17/24. ADON 1 stated she reported the alleged abuse incident to the Director of Nursing (DON), in the morning of 11/19/24. ADON 1 also stated the alleged abuse incident was reported to the Administrator (ADM) the same morning, on 11/19/24. During a record review on 12/17/2024 at 1:55 p.m., the facility ' s SOC 341 (Report of Suspected Dependent Adult-Elder Abuse), faxed to California Department of Public Health (CDPH), involving the alleged abuse incident towards Resident 1, indicated transmittal on 11/19/24 at 10:38 a.m Further review of the SOC 341, indicated, 12/17/2024 as date completed. The SOC 341 report had no contact name, telephone number, date, and time, the alleged abuse incident was reported to Law Enforcement and the Local Ombudsman. During an interview on 11/19/2024 at 1:50 p.m., with ADM, ADM could not provide law enforcement badge number or case number when requested. ADM further stated that he does not have a proof of the fax. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of facility ' s policy and procedure (P&P), titled, Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, dated 2001, the P&P indicated, All reports of resident abuse (including injuries of unknown origin), exploitation, or theft/misappropriation of residents property are reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported . Policy Interpretation and Implementation . 3. Immediately is defined as: a. within two hours of an allegation involving abuse or result in serious bodily injury; or b. within 24 hours of an allegation that does not involve abuse or result in serious bodily injury . 9. The investigator notifies the ombudsman that an abuse investigation is being conducted. The ombudsman is invited to participate in the review process.

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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** 43771 Based on observation, interview and record review, the facility staff failed to implement their infection prevention and control program when: 1. Personal clothing and belongings were not stored in a clean and sanitary manner for one of three sampled residents (Resident 2). 2. Housekeeper (HK) 1 did not perform hand hygiene after removal of soiled gloves. 3. Certified Nursing Assistant (CNA) 1 did not properly handle and transport soiled linens. These failures have the potential to cause cross contamination and not prevent the development and spread of infections among residents, staff, and visitors. Findings: 1.During record review of Resident 2 ' s Face Sheet (FS), the FS indicated Resident 2 is an [AGE] year old female admitted to the facility in 2024. FS indicated Resident 2 had diagnoses that included Urinary Tract Infection (a condition in which bacteria [germs] enters and grow in the urinary tract, kidneys, ureters, bladder, and urethra), Irritable Bowel Syndrome (condition that leads to belly pain and problems with bowel movements [constipation, diarrhea, or both]), and Type 2 Diabetes Mellitus (a long-term condition in which the body has trouble controlling blood sugar and using it for energy) with Diabetic Polyneuropathy (type of nerve damage). During an observation on 12/17/2024 at 3:50 p.m., in Resident 2 ' s room, Resident 2 ' s personal belongings, clothes, and diapers were tied in a clear bag, and found on the floor next to the head of Resident 2 ' s bed. During an interview on 12/17/2024 at 3:52 p.m., with Resident 2, Resident 2 stated she did not know why her belongings were on the floor, and did not appreciate that her belongings were on the floor. Resident 2 further stated she did not store her personal belongings on the floor at her home. Resident 2 stated she did not know the reason the facility stored her belongings on the floor. During an observation and interview on 12/17/2024 at 4:05 p.m., with the License Vocational Nurse 1 (LVN) 1, LVN 1 stated resident ' s belongings were not supposed to be stored on the floor. LVN 1 stated Resident 2 ' s belongings had to be stored in the closet. LVN 1 took Resident 2 ' s belongings that were on the floor and placed them in Resident 2 ' s designated closet. During an interview on 12/17/2024 at 4:10 p.m., with the Director of Nursing (DON), DON stated it was not a good thing to leave residents ' personal belongings on the floor for infection control purposes. DON stated she did not know why Resident 2 ' s belongings were placed on the floor. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/16/2025 at 2:55 p.m., with the Infection Preventionist (IP), IP stated residents ' belongings must be placed inside the closet and the bag [containing resident ' s belongings] should not be left open. IP further stated staff were trained to store clean linens in the closet and not on the floor. 2. During an observation on 1/16/2025 at 3:18 p.m., in the hallway outside Resident 2 ' s room, Housekeeper (HK) 1 was transporting soiled linens into the soiled utility room. HK 1 took gloves out of his pocket, donned the gloves and emptied the soiled linens in the soiled bin located in the utility room. HK 1 then removed soiled gloves worn without hand sanitizing, left the soiled utility room, and headed down the hallway into the 100 Unit patient area. There were no glove supplies (glove supply or dispensers mounted?) and hand sanitizers inside the soiled utility room. There were no hand sanitizers outside of, and near the location of the utility room. During an interview on 1/16/2025 at 3:20 p.m., with HK, HK stated he does not speak or understand English, he is Spanish speaking only. 3. During an observation on 1/16/2025 at 3:35 p.m., in the hallway outside Resident 2 ' s room, Certified Nursing Assistant (CNA) 1 came out of Resident 2 ' s room with gloves on, holding soiled linen in his hand, and opened the doorknob to the soiled utility room. CNA 1 placed the soiled linen in the linen bin inside the soiled utility room, removed his gloves, closed the door to the utility room, and walked out to the hallway. During an interview on 1/16/2025 at 3:35 p.m., with CNA 1, CNA 1 stated staff were not supposed to wear gloves in the hallway. During an interview on 1/16/2025 at 3:42 p.m., with the Assistant Director of Nursing (ADON) 2, ADON 2 stated staff were required to take the hamper into the resident room and put the soiled linen in the hamper and transport the dirty linen inside the hamper to the soiled utility room. ADON 2 further stated no gloves in the hallway. During a review of facility ' s policy and procedure (P&P), titled Laundry and bedding, Soiled dated 2001, the P&P indicated, Soiled laundry/bedding shall be handled, transported and processed according to best practices for infection prevention and control . Handling - 1. All used laundry is handled as potentially contaminated using standard precautions (e.g., gloves and gowns when sorting). a. Contaminated laundry is bagged or contained at the point of collection (i.e., where it was used) . Transport . Separate carts are used for transporting clean and contaminated linen . Clean linen is protected from dust and soiling during transport and storage to ensure cleanliness . Storage . The use of separate rooms, closets, or other designated spaces with a closing door are used to reduce the risk of accidental contamination. Onsite Laundry Processing . Hand hygiene products, as well as appropriate PPE (i.e., gloves and gowns) are available and used while sorting and handling contaminated linens.