

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055150	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/03/2025
NAME OF PROVIDER OR SUPPLIER Diablo Valley Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>(continued on next page)</p>

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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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview and record review, the facility failed to ensure safe administration of medication for one out of six sampled residents (Resident 2) when the licensed nurse who prepared the medication handed it to another licensed nurse for administration. This resulted in the accidental ingestion of Dakin's solution (diluted solution of made of bleach and other ingredients usually used to cleanse wood to prevent infection) by Resident 2. This failure had the potential to cause harm to Resident 2's health due to the ingestion of a chemical not intended for oral consumption. During a review of the facility's admission Record, the admission record indicated Resident 2 was admitted to the facility in April 2025 with multiple diagnoses that included osteomyelitis (Inflammation of bone caused by infection, generally in the legs, arm, or spine). During an interview on 09/24/25 at 01:57 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated she could recall Dakin's solution incident that happened during 04/06/24 involving Resident 1. LVN 1 stated Registered Nurse (RN) 2 was the medication administration nurse and RN 3 was the wound treatment nurse involved in the incident. LVN 1 stated RN 2 only works on weekends, and RN 3 was no longer working for the facility. During an interview on 09/26/25 at 12:20 p.m. with LVN 1, LVN 1 stated she reviewed Resident 2's progress notes. LVN 1 stated on 04/06/24, she wrote the following in Resident 2's progress notes. After donning PPE [personal protective equipment] writer brought the pain medication that is prepared by the nurse [RN 2] and cup of clear liquid about less than halfway in the cup that was on top of the treatment cart to the resident. Resident took a sip of what was in the cup and stated it was bleach. LVN 1 stated the RN 2 who was the medication nurse had prepared Resident 2's medication. During a review of Resident 2's progress notes written by RN 3 dated 04/06/24 indicated At around 8am. This nurse came to the resident to do his admission assessment. Resident was yelling to CNA [Certified Nursing Assistant] that he was in pain. Writer notified the charge nurse [RN2] that the resident is [having] pain, and requesting Morphine. Writer poured half cup of quarter strength Dakin's solution for his abscess tx [treatment] when the resident started yelling and cursing. So, this nurse came to calm the resident. Another nurse [LVN 1] took the Dakin's solution into the resident room, mistaking it for water. After the resident took a sip of the solution, he complained it tasted like bleach. During a review of Resident 2's progress notes written by RN 2 dated 04/06/24 indicated pt [Patient] accidentally ingested 10 ml [milliliter] of Dakin's solution at around 0817. During a review of Resident 2's physician Order Summary Report for the month of April 2024 indicated Morphine Sulfate ER tablet Extended Release 15 mg given 1 tablet by mouth every 12 hours for pain management. Resident 2's Medication Admin Audit Report for 4/6/24 indicated an administration time of 04/06/2024 08:17 and documented by RN 2. During a review of the facility's policy and procedure titled Administering Medication indicated Medications shall be administered in safe and timely manner, as prescribed. 22. The individual administering the medication initial the resident's MAR on the appropriate line after giving each medication and before administering the next ones. 20. As required or indicated for medication, the individual administering the medication will record in the resident's medical record: a. The date and time the medication was administered. g. The signature and title of the person administering the drug.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observation, interview, and record review, the facility failed to ensure for one out six residents (Resident 1), Resident 1's was in a room with enhanced barrier precautions (EBP - an infection control intervention designed to reduce transmission of resistant organisms that employ targeted gown and glove use during high contact resident care activities), EBP was not followed during nursing care and treatment. This failure had potential to spread infection when prevention of was not consistently practiced.</p> <p>Findings:During a review of facility's admission Record indicated Resident 1 was admitted to the facility in March 2025, with diagnoses that included pressure ulcer (localized skin and soft tissue injuries that develop due to prolonged pressure exerted over specific areas of the body), chronic diastolic heart (heart's main pumping chamber becomes stiff and unable to fill properly), and atrial fibrillation (irregular and often rapid heartbeat), and hypertension.During a concurrent observation and interview on 09/25/27 at 08:27 a.m., with Registered Nurse (RN) 1, RN 1 stated she would prepare Resident 1's medications. Resident 1's room had a poster sign indicating the room was designated as EBP room. RN 1 did not put on personal protective equipment (PPE) when RN 1 entered the room. RN 1 stood on the right side next to bed, and checked Resident 1's blood pressure, then checked Resident 1's pulse with ungloved hands for one minute. RN 1 exited the room, and prepared Resident 1's medications. Resident 1's medications included Amiodarone HCL 200 milligram (mg) tablet (medication used to prevents and treats a fast or irregular heartbeat), Bisoprolol Fumarate 10 mg tablet (medication used to treat high blood pressure), Isosorbide Extended Release (ER) 30 mg tablet (medication used to prevent chest pain), and Lidocaine External patch 4% (medication used to manage pain). RN 1 entered Resident 1's room to administer the medications. RN 1 asked Resident 1, if he would like the medications to help prevent constipation, RN 1 exited the room to prepare the bowel management regimen for Resident 1. Resident 1's bowel management medications included Docusate Sodium 250 mg capsule and Senna oral tablet 8.6 mg. RN 1 entered the room to administer the Docusate Sodium and Senna tablets. RN 1 went to Resident 1's left side, RN 1 removed the blanket covering Resident 1's left leg. RN 1 removed Lidocaine external patch that was previously applied on Resident 1 left knee, and then RN 1 applied a new Lidocaine external patch 4%.During an interview on 09/25/2025 at 1:44 p.m., with RN 1, RN 1 stated Resident 1's room was assigned at EBP due to Resident 1's pressure ulcer. RN 1 stated she did not put on PPE to check Resident 1's blood pressure and pulse and removed and applied the Lidocaine external patch during medication administration.During a review of facility's policy and procedures titled Enhanced Barrier Precautions indicated Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents. Enhanced barrier precautions (EBPs) refer to infection prevention and control interventions designed to reduce the transmission of multi-drug resistant (MDROs) during high contact resident care activities. h. prolonged high-contact with items in the resident's room, with resident's equipment, or with resident's clothing or skin.</p>		