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	12/23/2025

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to provide timely and appropriate nursing assessment, monitoring, and interventions to one sampled resident (Resident 1) under the care of a previously employed nursing staff member who was unlicensed and was using another individual's Registered Nurse (RN) license, when Resident 1 did not receive a physician ordered medication, nitroglycerin (medication used to treat chest pain by relaxing and widening blood vessels, which helps more blood and oxygen reach the heart) and emergency services were not initiated in a timely manner despite Resident 1 experiencing ongoing chest and abdominal pain lasting for approximately nine hours on [DATE].These failures resulted in actual harm to Resident 1, who experienced prolonged, untreated chest pain due to delayed nursing interventions, medication administration, and initiation of emergency medical services by an unlicensed nurse. Resident 1 was subsequently transferred from the facility to the hospital and expired approximately two hours after arrival at the emergency department (ED) due to a heart attack, following complaints of chest and abdominal pain. During a record review of Unlicensed Nurse (UN) 1's record, titled, Background Report (BR), dated [DATE], the professional license verification portion reflected inconsistencies between UN 1's identity and the name listed on the nursing license. The BR report showed the license belonged to a different RN with a similar name; however, the first name was spelled differently, and the individual had a different middle name. During a record review of UN 1's most recent publicly available nursing license verification record, dated [DATE], the record indicated UN 1's Licensed Vocational Nurse (LVN) license had been revoked (officially canceled) on [DATE], and UN 1's right to practice nursing was removed.During an interview on [DATE] at 12:42 p.m. with the Director of Nursing (DON), DON stated she was unaware that UN 1 was unlicensed during UN 1's employment at the facility until an investigation was initiated related to a drug diversion (when prescription medicine is taken or given to someone for a purpose other than what it was meant for) incident involving another resident. DON stated it was subsequently identified that the name listed on UN 1's submitted RN nursing license did not match the name on UN 1's driver's license or Social Security card, and that UN 1's LVN license had been revoked in 2020 due to drug diversion.During a record review of Resident 1's record titled, Physician History and Physical (H&P), dated on [DATE], documented by Medical Doctor (MD) 1, the H&P indicated Resident 1 was admitted to the facility on [DATE] with past medical history of hypertension, gastric outlet obstruction (the passage between the stomach and the small intestine becomes blocked), and history of stroke (when blood can't get to part of the brain). The H&P further indicated Resident 1 had a ventral hernial repair on 11/14 (fixing a hole or weak spot in the abdominal wall) .Afterward, Resident 1's recovery was complicated by a NSTEMI (Non-ST Elevated Myocardial Infarction, a type of heart attack when blood flow to part of the heart is blocked). Cardiology (branch of medicine that deals with the heart) was consulted and recommended medical management.had episode of chest pain 11/17. indicating Resident 1 had a history of heart attack. During a record review of Resident 1's record titled, Change in Condition Evaluation (CCE) record with effective date on [DATE] at 11:05 p.m., the CCE indicated, resident noted to have pain unrelieved by pain medication and complaining of abdominal and upper chest area pain, resident noted with increase respiration. The CCE record also showed Resident 1 had uncontrolled pain that started on [DATE], with no specific time documented other than afternoon. The CCE record further indicated that Resident 1 had occasional moaning and groaning, facial grimacing, rigid, fists clenched, and knees pulled up during the assessment.During a record review of Resident 1's Medication Administration Report (MAR), dated from [DATE] through [DATE], the MAR indicated the physician order for Nitroglycerin Sublingual (placed under the tongue) Tablet 0.4 milligrams (mg).Give 0.4 mg sublingually every 5 minutes as needed for chest pain.May repeat x2 (twice) every 5 minutes. Call 911 if the pain persists longer than 5 minutes after the first dose.Continue to take the 2nd and 3rd dose if pain persists. was not given at any time on [DATE], despite Resident 1's complaints of chest pain. The physician's order did not include any blood pressure (bp) parameters restricting administration of nitroglycerin.During a record review of Resident 1's record, titled, SNF/NF (Skilled Nursing Facility/Nursing Facility) to Hospital Transfer Form, dated [DATE], the SNF/NF to Hospital Transfer Form indicated Resident 1 was transferred to the hospital on [DATE] at 11:00 p.m.During a record review of Resident 1's emergency medical services (EMS) record, titled, Patient Care Report (PCR), dated [DATE], the PCR showed EMS assumed Resident 1's care at 10:53 p.m. The PCR indicated, Complaints: (Chief) chest pain as of 9 hours ago. The record also indicated, RP (Responsible

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the scheduled (controlled medication, narcotic) medication system was complete (all documents available) and accurate (correct information) for six (Residents 1, 2, 3, 4, 5, and 11) of 14 sampled residents when:1. Resident 1 and Resident 2's Controlled Drug Records (CDR, accountability records, an inventory sheet that keeps records of the usage of controlled medications) contained discrepancies and did not reconcile with the Medication Administration Records (MAR) while Resident 1 and Resident 2 under the care of previously employed nursing staff member who was unlicensed and was using another individual's Registered Nurse (RN) license.2. Residents 3, 4, 5, and 11's scheduled medication system that 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 were incomplete or inaccurate.These failures resulted in the potential for the undetected loss and diversion of scheduled medications. In addition, these failures resulted in the potential for avoidable medication errors (medication not given as ordered).1. During a record review of Unlicensed Nurse (UN) 1's record, titled, Background Report (BR), dated 2/6/24, the professional license verification portion reflected inconsistencies between UN 1's identity and the name listed on the nursing license. The BR report showed the license belonged to a different RN with a similar name; however, the first name was spelled differently, and the individual had a different middle name. During a record review of UN 1's most recent publicly available nursing license verification record, dated 11/20/25, the record indicated UN 1's Licensed Vocational Nurse (LVN) license had been revoked on 6/10/20, and UN 1's right to practice nursing was removed. During a record review of the facility's record, titled, Employee Counseling Form (ECF), dated 9/5/25, the ECF indicated, The employee was found to have committed serious violations of facility policy and state/federal regulations, including narcotic (strong pain medication) deviation, impersonating a licensed nurse, and working without a valid nursing license. Additionally, the employee falsely represented themselves as a Registered Nurse (RN), which constitutes both fraud and a direct threat to resident safety and quality of care.As a result, immediate termination of employment is warranted. During a record review Resident 1's admission Record (AR), printed on 11/3/25, the AR indicated Resident 1 was admitted to the facility in November 2024 with diagnoses of spinal stenosis (space inside your spine gets too tight, squeezing the nerves) of lumbar region (lower part of the spine) and ventral hernia (a hole or weak spot in the abdominal wall) with obstruction. During a record review of Resident 1's Medication Administration Record (MAR) dated 11/1/24 through 11/30/24, the MAR indicated Resident 1 had a physician order for Norco (also known as hydrocodone/APAP, a controlled substance used to relieve moderate to severe pain) Oral Tablet 5-325 mg (milligram).Give 1 tablet by mouth every 6 hours as needed for pain. The MAR indicated Resident 1 was administered one tablet of Norco 5-325 mg on 11/21/24 at 8:05 p.m. During a record review of Resident 1's record, titled, SNF/NF (Skilled Nursing Facility/Nursing Facility) to Hospital Transfer Form, dated 11/21/24, the SNF/NF to Hospital Transfer Form indicated Resident 1 was transferred to the hospital on [DATE] at 11:00 p.m. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a record review of the facility record, titled, Controlled Subs (substance). (CS) dated 11/20/24 through 11/22/24, the CS showed UN 1 removed one tablet of Norco 5-325 mg on 11/21/24 at 11:03 p.m. The CS indicated a discrepancy between the timing of the medication removal and the document administration of Norco 5-325mg to Resident 1. During a record review of Resident 2's AR, printed on 10/29/25, the AR indicated Resident 2 was admitted to the facility with diagnoses of fracture (broken bone) of right hand, left femur (thigh bone), left ilium (pelvis bone), and T9-T10 vertebra (two adjacent bones located in lower-middle portion of the thoracic spine or chest region). During a record review of Resident 2's CDR dated 8/29/25 through 9/1/25, the CDR indicated two tablets of oxycodone (a controlled substance used for moderate to severe pain) 5 mg were initialed and signed out by a nursing staff on 9/1/25 at 4:30 p.m. During a record review of Resident 2's MAR dated 9/1/25 through 9/30/25, the MAR indicated Resident 2 had a physician order of oxycodone HCl (hydrochloride) Oral Tablet 5 mg (milligram).Give 2 tablets by mouth every 4 hours as needed for severe (6-9) pain. The MAR showed Resident 2 did not receive the two tablets of oxycodone on 9/1/25 at 4:30 p.m. During an interview on 10/29/25 at 12:42 p.m. with the Director of Nursing (DON), DON stated LVN 1 informed her regarding the discrepancy on Resident 2's CDR when LVN 1 noticed her initials even though she did not administer the two tablets of oxycodone to Resident 2. DON stated an investigation was conducted and found out the discrepancy between Resident 2's MAR and CDR. DON stated subsequently, they identified that UN 1 did not have an active nursing license. DON stated the name listed on UN 1's submitted RN nursing license did not match the name on UN 1's driver's license or Social Security card, and that UN 1's LVN license had been revoked in 2020 due to drug diversion. During a phone interview on 10/29/25 at 3:43 p.m. with LVN 1, LVN 1 stated she reported the narcotic discrepancy to DON on 9/2/25. LVN 1 stated, after she came back from her two days off, she was about to give Resident 2 the oxycodone when LVN 1 noticed her initials written on Resident 2's CDR. LVN 1 stated the initials were not hers because she had never administered Resident 2 the oxycodone. During an interview on 11/3/25 at 11:58 a.m. with DON, DON stated they traced all the nursing staff who worked on the same cart LVN 1 had worked, including UN 1. DON stated they suspected UN 1 was involved with the narcotic discrepancies after reviewing the controlled substance records. DON stated upon reviewing UN 1's employee file, they discovered UN 1's LVN license was revoked due to similar issues related drug diversion. During a follow-up interview and record review on 11/13/25 at 2:18 p.m. with DON, DON stated she was unable to explain why the record reflected the issuance of Norco after Resident 1's transfer to ED, or why the timing of the issuance did not align with UN 1's documented administration of Norco to Resident 1 on 11/21/24. DON stated when pain medication was not administered, a resident's pain would remain unresolved, and the resident would continue to experience pain. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/23/25 at 11:57 a.m. with the Assistant Director of Nursing (ADON) 2, ADON 2 stated if there were discrepancies between the MAR and CDR, it made it difficult to determine whether the controlled substances were actually administered. ADON 2 stated when signing out narcotics, licensed nurses were expected to document the time of the administration on the MAR. ADON 2 further stated failure to accurately document narcotic administration created the potential for diversion, and result in residents experiencing unmanaged pain and increased risk of hospitalization. During a record review of the facility's policy and procedures (P&P), titled, Controlled Substances, revised in November 2022, the P&P indicated, The facility complies with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications.Handling of Controlled Substances.1. Only authorized licensed nursing and/or pharmacy personnel have access to Schedule II (refers to a category of drugs under the Controlled Substances Act in the United States including oxycodone and Norco) controlled substances maintained on premises.2. The director of nursing services identifies staff members who are authorized to handle controlled substances.Dispensing and Reconciling Controlled Substances.1. Controlled substance inventory is monitored and reconciled 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. MAR.12. Some controlled substances may be stored in the emergency medication supply. Reconciliation of controlled substances in the emergency supply is conducted at intervals established by the director of nursing services. During a record review of the facility's P&P, titled, Administering Medications, revised in April 2024, the P&P indicated Medications are administered in accordance with prescriber orders, including any required timeframe.1. Only persons licensed or permitted by this state to prepare, administer and document administration of medications may do so.2. The director of nursing services supervises and directs all personnel who administered medications and/or have related functions.22. The individual administering the medication initials the resident's MAR I the appropriate line after giving each medication.23. As required or indicated for a medication, the individual administering the medication records in the resident's medical records.a. the date and time the medication was administered.b. the dosage.any complaints or symptoms for which the drug was administered.g. the signature and title of the person administering the drug. 2. During an interview, on 11/12/25 at 9:45 am, Director of Medical Records (DMR) was asked to describe the scheduled medication record system. His description included that scheduled medications were delivered by the pharmacy with a corresponding Shipping Manifest. The Shipping Manifest was the documentation the scheduled medication was delivered to the Facility. He further described that the Shipping Manifests were retained by the Facility. The DMR was requested to provide all the scheduled medication Shipping Manifests for the months of 3/24, 5/24, 7/24, 10/24, 2/25, 4/25, and 8/25. During an interview, on 11/12/25 at 10:20 am, Director of Nursing (DON) and DMR, were asked to describe the scheduled medication record system. Their description included that a CDR was created for each patient's scheduled medication. The CDR documented the date and time medication was received. The CDR documented the date and time medication was removed from the patient's supply. The CDR documented staff responsible for the above actions. They further described that all CDRs were retained by the Facility. (continued on next page)

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and document review, on 11/12/25 at 12:15 pm, the DMR was asked to provide the corresponding CDRs for the Shipping Manifest deliveries listed below. Resident 3, 7961425 Oxycodone (narcotic pain reliever) 15 mg tablet #60 manifest date 2/7/25 Resident 4, 800636 Oxycodone 10 mg tablet #56 manifest date 8/18/25 Resident 5, 851984 Oxycodone 10 mg tablet #56 manifest date 8/30/25 Resident 6, 7937537 Oxycodone 5 mg tablet #30 manifest date 2/3/25 Resident 7, 7550403 Oxycodone 5 mg tablet #60 manifest date 10/30/24 Resident 8, 6878310 Oxycodone 5 mg tablet #60 manifest date 5/6/24 Resident 9, 7459449 Oxycodone 10 mg tablet #56 manifest date 10/5/24 Resident 10, 6867046 Oxycodone 5 mg tablet #90 manifest date 5/2/24 Resident 11, 277593 Oxycodone 10 mg tablet #30 manifest date 4/20/25 Resident 12, 6709389 Oxycodone 5 mg tablet #56 manifest date 3/25/24 Resident 13, 805331.01 Oxycodone 5 mg/5 ml soln 280ml manifest date 8/29/25 Resident 14, 277582 Oxycodone 5 mg tablet #54 manifest date 4/20/25 Resident 15, 317614 Oxycodone 5 mg tablet #26 manifest date 4/29/25 Resident 16, 6692640 Oxycodone 10 mg tablet #28 manifest date 3/20/24 During a concurrent observation and interview, on 11/13/25 at 2 pm, at Station 2, Licensed Vocational Nurse (LVN 2) identified medication cart 2B. LVN 2 was requested to describe the scheduled medication documentation process. His description included scheduled medications that were delivered with a Shipping Manifest and a corresponding CDR. 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 medications and the CDR were sent to the DON. During a concurrent interview and electronic (computer) medical record (EMR) review, on 11/14/25 at 11:55 am, The DON and DMR identified Resident 11's EMR. The DON and DMR acknowledged the EMR showed Resident 11 was discharged on 5/12/25. Continuing the interview and record review, Resident 11's Shipping Manifest dated 4/20/25 for prescription 277593 Oxycodone 10 mg tablet #30 was identified. The DON and DMR acknowledged the corresponding Controlled Drug Record could not be located. The DON and DMR reviewed Resident 11's MAR and acknowledged four doses of oxycodone 10 mg were documented administered between 4/20/25-5/12/25. 26 doses of oxycodone could not be accounted for with the Facility's scheduled medication system (CDR, MAR, destruction record). (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and EMR review, on 11/14/25 at 12:15 pm, DON and DMR identified Resident 3's MAR. They compared the 7961425 Oxycodone 15 mg tablet #60 manifest date 2/7/25 CDR against the MAR. DON and DMR acknowledged the CDR removals did not have a corresponding MAR administration on the 22 dates and times listed below. 2/9/25 1730, 2130 2/11/25 1330, 1730, 2130 2/12/25 1730, 2130 2/13/25 2130 2/15/25 0130 2/16/25 0130, 1730, 2130 2/17/25 0930, 1300, 1730, 2130 2/18/25 0130, 0930, 1300, 1730, 2130 2/19/25 0130 During a concurrent interview and medical record review, on 11/14/25 at 12:30 pm, The DON and DMR identified Resident 5's EMR. They compared the 851984 Oxycodone 10 mg tablet #56 Controlled Drug Record CDR medication removal against the MAR. DON and DMR acknowledged the CDR removals did not have a corresponding MAR administration on the 7 dates and times listed below. 8/30/25 1630, 2020 8/31/25 0330 9/2/25 0900, 1300, 2030 9/3/25 6:13 pm During a concurrent interview and medical record review, on 11/14/25 at 12:45 pm, The DON and DMR identified Resident 4's EMR. They compared the 800636 Oxycodone 10 mg tablet #56 Controlled Drug Record CDR medication removal against the MAR. DON and DMR acknowledged the CDR removals did not have a corresponding MAR administration on the 22 dates and times listed below. 8/20/25 illegible times x 2 entries 8/21/25 0120, 0810, 1230, 1730, 2100 8/22/25 0100, 1300, 1830 8/23/25 0010 (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8/22/25 1000, 0400 8/23/25 0020, 0400 8/23/25 401 pm, 815 pm 8/24/25 0000, illegible times x 2 entries 8/25/25 0010, 0400 During an administrative record review, Resident 3's 7961425 Oxycodone 15 mg tablet #60 manifest date 2/7/25 CDR was compared to the EMR MAR. The comparison showed the CDR documented medication removal that did not correspond to the MAR as listed below. 2/9/25 1730, 2130 2/11/25 1330, 1730, 2130 2/12/25 1730, 2130 2/13/25 2130 2/15/25 0130 2/16/25 0130, 1730, 2130 2/17/25 0930, 1300, 1730, 2130 2/18/25 0130, 0930, 1300, 1730, 2130 2/19/25 0130 During an administrative record review, Resident 4's 800636 Oxycodone 10 mg tablet #56 CDR was compared to the EMR. The comparison showed the CDR documented medication removal but did not document medication administration as listed below. 8/20/25 illegible times x 2 entries 8/21/25 0120, 0810, 1230, 1730, 2100 8/22/25 0100, 1300, 1830 8/23/25 0010 8/22/25 1000, 0400 8/23/25 0020, 0400 (continued on next page)

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8/23/25 401 pm, 815 pm 8/24/25 0000, illegible times x 2 entries 8/25/25 0010, 0400 During an administrative record review, Resident 5's 851984 Oxycodone 10 mg tablet #56 CDR was compared to the EMR. The comparison showed the CDR documented medication removal but did not document medication administration as listed below. 8/30/25 1630, 2020 8/31/25 0330 9/2/25 0900, 1300, 2030 9/3/25 6:13 pm During an administrative record review of the Facility's Policy for Controlled Substances (November 2022) showed, Policy Interpretation and Implementation, Handling Controlled Substances, 3. Controlled substances are counted upon delivery. The nurse receiving the medication, along with the person delivering the medication, must count the controlled substances together. Both individuals sign the designated controlled substance record (CDR). During an administrative record review of the Facility's Policy for Controlled Substances (November 2022) showed, Dispensing and Reconciling Controlled Substances, 1. Controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow-up. During an administrative record review of the Facility's Policy for Controlled Substances (November 2022) showed, Dispensing and Reconciling Controlled Substances, 2. The system of reconciling the receipt, dispensing and disposition of controlled substances includes the following: a. Records of personnel access and usage (CDR, destruction log): b. Medication administration records (MAR): c. Declining inventor records (CDR): and d. Destruction, waste and return to pharmacy records. During an administrative record review of the Facility's Policy for Controlled Substances (November 2022) showed, Dispensing and Reconciling Controlled Substances, 14. Accountability records for discontinued controlled substances are kept with the unused supply until it is destroyed or disposed of as required by applicable law or regulation.