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	04/22/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, for one of two sampled residents (Resident 1), the facility failed to notify Resident 1's Attending Physician and Resident 1's Representative (RR) 1 following Resident 1's multiple falls.This failure violated Resident 1's right to have the physician and RR 1 promptly informed of an accident that may result in injury and had the potential to delay necessary medical assessment and involvement in care decisions.During a review of Resident 1's admission Record (AR) dated [DATE], the AR indicated Resident was initially admitted to the facility in February 2005 with diagnoses that included morbid obesity, open angle glaucoma (an eye disease that causes slow, symptomless vision loss), history of falling, and heart failure.During a review of Resident 1's Progress Notes (PN) from [DATE] to [DATE], the PN indicated an eInteract SBAR Summary for Providers (system-generated clinical summary that autoˆcompiled for practitioners when a resident has a change in condition) dated [DATE], when Resident 1 was exposed to the flu virus. A Nurse's Note dated [DATE] indicated, Resident 1 was found unresponsive on [DATE] at 4:45 a.m., with no pulse or spontaneous breathing; code blue was initiated and 911 was called. Paramedics arrived and Resident 1 was pronounced deceased at 5:29 a.m. The PN did not indicate documentation between [DATE] and [DATE].During a telephone interview on [DATE] at 3:06 p.m. with Family Member (FM) 1, FM 1 stated, after Resident 1 passed away, an anonymous caller informed FM 1 that Resident 1 had fallen twice, on [DATE] and [DATE], before being found unresponsive on the early morning of [DATE]. FM 1 stated Resident 1 was not taken to the hospital and no one from the facility told the family about the falls. FM 1 also stated Resident 1 had stayed in bed all day Sunday, [DATE], which seemed unusual since Resident 1 loved getting out of bed, suggesting something serious had happened. FM 1 stated the family was devastated by the treatment Resident 1 received after a 21-year stay at the facility.During a telephone interview on [DATE] at 3:25 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated, on the early morning of [DATE], a Certified Nursing Assistant (CNA) requested assistance after Resident 1 was found sitting on the floor next to the bed. LVN 1 stated, when she entered the room, two CNAs were already in Resident 1's room. LVN 1 stated Resident 1 could not go back to bed as the other side of the bed was tilted up. LVN 1 stated, due to Resident 1's weight, and the tilted bed, multiple staff helped move Resident 1 to a wheelchair instead of back to bed. LVN 1 stated she left for the day after the incident without documenting what had happened. LVN 1 also stated she was unaware documentation was required since similar incidents had occurred before.During an interview on [DATE] at 7 a.m. with Certified Nursing assistant (CNA) 4, CNA 4 stated Resident 1 had multiple falls that he knew of. The first occurred months ago, after breakfast between 8-10 a.m. CNA 4 stated Resident 1's CNA from a registry had to transfer Resident 1 using the standing lift (a mobility device designed to assist individuals with limited leg strength in transitioning from a seated to a standing position), during the transfer, Resident 1's knees buckled and Resident 1 slipped to the floor. CNA 4 stated about six staff members were needed to help Resident 1 with a Hoyer lift (a mechanical device used to safely transfer patients with limited mobility between beds, wheelchairs, and commodes). The second fall happened on the early morning of [DATE], when CNA 4 (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	found Resident 1 sitting on the floor. The third fall took place the next day, [DATE], after breakfast when CNA 4 transferred Resident 1 from the bed to the wheelchair using a standing lift. During the transfer, Resident 1's knees buckled again, so Resident 1 was lowered to the floor. CNA 4 stated LVN 3 instructed that Resident 1 remain in bed all day on [DATE] after the fall.During a concurrent interview and record review on [DATE] at 1:10 p.m. with ADON, a Nurse's Note dated [DATE] indicated Resident 1 was lowered down to the floor after a CNA transferred Resident 1 from the bed to the wheelchair using a standing lift but the lift was not properly used. Resident 1 was assisted back to bed using a Hoyer lift. ADON stated, Resident 1's fall on [DATE] was documented in the record as CoC but there were no follow-through progress notes from nursing staff, which should have been completed. ADON stated licensed nurses must adhere strictly to the established fall protocol. ADON stated, whenever a resident experiences a fall, whether witnessed or assisted, an immediate assessment is required, followed by notification of both the attending physician and family members. In accidents involving unwitnessed falls, prompt neurological checks after the fall are necessary, along with completion of a fall risk assessment, eInteract charting, and documentation through 72-hour progress notes. An IDT conference should be conducted for risk management purposes on the subsequent workday. ADON also stated, for any change of condition, such as a fall, 72-hour monitoring is mandated and critical, as the resident's status may deteriorate rapidly. It is also essential to inform both the family and the attending physician. However, in these incidents, on 2/14 and [DATE], neither the physician nor the family was notified due to incomplete CoC documentation. During a review of the facility's policy and procedure (P&P) titled, Change in a Resident's Condition/Status last revised [DATE], the P&P indicated the licensed staff will notify the resident's Attending Physician or On-Call Physician following any accident or incident involving the resident, if the resident is involved in any accident or incident that results in an injury including injuries of an unknown origin, the resident's.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain a safe, comfortable and homelike environment for residents when:1. a. Resident 2's closet door was not repaired timely, despite staff awareness of the defect. The closet door subsequently detached and fell on Resident 2's ankle, causing pain, bruising and swelling. b. Staff repaired Resident 2's closet door using hinges that were not the correct size for the door. This resulted in a large gap on one side and the opposite side overlapping with another door. As a result, Resident 2's closet door must be left open so the other door can be accessed. Additionally, Resident 2's bottom drawer could not be accessed unless the top drawer was open.These failures resulted in Resident 2's avoidable injury to the left ankle, and negatively affected Resident 2's sense of safety and did not support a homelike environment.2. Room temperature in multiple resident rooms were uncomfortably cold, outside the required range of 71-81 degrees Fahrenheit (deg F). This failure had the potential to result in adverse health effects related to temperature extremes.1.During a review of Resident 2's admission Record (AR) dated 4/22/26, the AR indicated Resident 2 was admitted to the facility in February 2021 with diagnoses that included left hemiplegia and hemiparesis.During a review of Resident 2's Minimum Data Set (MDS, an assessment tool used to direct resident care) dated 3/21/26, the MDS indicated a Brief Interview for Mental Status (BIMS, a scoring system used to determine the resident's cognitive status in regard to attention, orientation, and ability to register and recall information) score of 13. A BIMS score of 13-15 is an indication of intact cognitive status.During a concurrent observation and interview on 4/22/26 at 10:57 a.m. with Resident 2, inside Resident 2's room, Resident 2 stated repeatedly requesting repairs for the closet door, which was not fixed properly. The closet door had a visible gap at the hinges, and overlapped with the adjacent closet door, misaligned, making it impossible to open drawers correctly. Resident 2 stated when she attempted to open the closet door, it fell onto Resident 2's head and left foot, resulting in a severely swollen and bruised left ankle that required ice packs.During a review of Resident 2's Progress Notes (PN), eInteract Summary for Providers (system-generated clinical summary that autoˆcompiled for practitioners when a resident has a change in condition) dated 10/16/25 indicated, Resident 2 reported that a closet door fell on her head, impacting the left side of her head, arm, and ankle. Resident 2 stated using her hands to deflect the door. Resident 2 had pain upon palpation and redness on the left hand and left ankle. During a concurrent observation and interview on 4/22/26 at 11:28 a.m. with Maintenance Director (MD), inside Resident 2's room, MD stated the hinges to the closet door were the wrong size, resulting in a large gap on the right and overlap on the left. MD stated he will order proper hinges and fix the door properly.2. During an interview on 4/21/26 at 6:45 a.m. with Licensed Vocational Nurse (LVN) 5, LVN 5 stated when the weather outside was cold, residents reported feeling chilly. LVN 5 stated providing extra blankets and heat packs.During a concurrent interview on 4/22/26 at 10:22 a.m. with Activities Director (AD), resident council meeting minutes were reviewed. There were issues raised regarding room temperatures, the Management's response was for staff to do daily temperature checks for both buildings starting 4/1/26.During a concurrent observation and interview on 4/22/26 at 11:11 a.m. with MD, MD stated a temperature gun was used to check room temperatures during maintenance, with thermostats set between 74-76 deg F for comfort but must read between 71-81 deg F per regulation. MD stated if the temperatures are outside this range, the facility contacts the contractor, who provides 24-hour service. The facility's HVAC units were checked weekly and as needed. MD stated the daytime range was 72-75 deg F, nighttime is 73-76 deg F. Temperatures for several rooms were checked:a. room [ROOM NUMBER]= 68 deg Fb. room [ROOM NUMBER]= 67 deg Fc. room [ROOM NUMBER]= 60 deg Fd. room [ROOM NUMBER]= 67 deg Fe. room [ROOM NUMBER]= 68 deg Ff. room [ROOM NUMBER]= 67 deg F.During interviews on 4/22/26 at 2:38 p.m. with Certified Nursing (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assistant (CNA) 5, CNA 5 stated some residents would sometimes complain of their rooms being cold. Resident 3 and Resident 4 both stated their room was cold, and that the facility did not seem to have working heaters.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, for one of two sampled residents (Resident 1), the facility failed to identify and assess a change in condition for Resident 1 who experienced multiple falls when facility did not complete a timely evaluation of Resident 1's post-fall status, including neurological checks (neuro checks, relating to the brain, spinal cord and the nerves, checks for alertness, language, level of consciousness, muscle strength and coordination, sensation), pain assessment, and monitoring for injury according to professional standards of care.This failure resulted in a delay in identifying Resident 1's change of condition and in implementing necessary interventions.During a review of Resident 1's admission Record (AR) dated [DATE], the AR indicated Resident was initially admitted to the facility in February 2005 with diagnoses that included morbid obesity, open angle glaucoma (an eye disease that causes slow, symptomless vision loss), history of falling, and heart failure.During a review of Resident 1's Minimum Data Set assessment (MDS, an assessment tool used to direct resident care) dated [DATE], the MDS indicated Resident 1 needed two or more helpers during transfers from bed to chair (helper does all of the effort), and maximum assistance (the helper lifts or holds the trunk or limbs and provides more than half the effort) with bed mobility (rolling from lying to left and right side, sitting on the side of the bed to lying flat, move from lying on the back to sitting on the side of the bed and to come to a standing position from sitting in a chair, wheelchair or on the side of the bed).During a review of Resident 1's Fall Risk Observation/Assessment dated [DATE], the Fall Risk Assessment indicated a Fall Risk Score of 16 (a score of 16-42 indicates high risk of falling).During a review of Resident 1's Progress Notes (PN) from [DATE] to [DATE], the PN indicated an eInteract SBAR Summary for Providers (system-generated clinical summary that autoˆcompiled for practitioners when a resident has a change in condition) dated [DATE], when Resident 1 was exposed to the flu virus. A Nurse's Note dated [DATE] indicated, Resident 1 was found unresponsive on [DATE] at 4:45 a.m., with no pulse or spontaneous breathing; code blue was initiated and 911 was called. Paramedics arrived and Resident 1 was pronounced deceased at 5:29 a.m. The PN did not indicate documentation between [DATE] and [DATE].During a telephone interview on [DATE] at 3:06 p.m. with Family Member (FM) 1, FM 1 stated, after Resident 1 passed away, an anonymous caller informed FM 1 that Resident 1 had fallen twice, on [DATE] and [DATE], before being found unresponsive on the early morning of [DATE]. FM 1 stated Resident 1 was not taken to the hospital and no one from the facility told the family about the falls. FM 1 also stated Resident 1 had stayed in bed all day Sunday, [DATE], which seemed unusual since Resident 1 loved getting out of bed, suggesting something serious had happened. FM 1 stated the family was devastated by the treatment Resident 1 received after a 21-year stay at the facility.During a telephone interview on [DATE] at 3:25 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated, on the early morning of [DATE], a Certified Nursing Assistant (CNA) requested assistance after Resident 1 was found sitting on the floor next to the bed. LVN 1 stated, when she entered the room, two CNAs were already in Resident 1's room. LVN 1 stated Resident 1 could not go back to bed as the other side of the bed was tilted up. LVN 1 stated, due to Resident 1's weight, and the tilted bed, multiple staff helped move Resident 1 to a wheelchair instead of back to bed. LVN 1 stated she left for the day after the incident without documenting what had happened. LVN 1 also stated she was unaware documentation was required since similar incidents had occurred before.During a concurrent interview and review of the medical records on [DATE] at 3:38 p.m. with Director of Nursing (DON), Resident 1's fall care plans, progress notes and evaluations were reviewed. DON stated, after learning about Resident 1's passing on [DATE], DON first spoke with LVN 1 to ask if Resident 1 fell. DON stated, on [DATE], Resident 1 slid down the bed rather than fell, with half his body still on the bed and only needing assistance from staff due to his weight. DON stated no fall was documented for that day, no progress notes or investigation notes by the Interdisciplinary Team (IDT, a group composed of (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	individuals representing different departments of the facility) were entered. DON stated the medical record had already been closed, and the DON could not reopen it to add documentation. DON stated the incident was not considered a fall since Resident 1 had part of his body on the bed and tried to prevent himself from falling, though Resident needed help from staff to be safely lowered to the floor due to his weight. However, DON stated LVN 1 should have documented the event with a progress note. DON also stated Resident 1 likely did not sustain an injury, as the bed was set to its lowest height. When asked whether any diagnostic test or imaging was performed after the incident to confirm there were no injuries, DON stated that none were conducted, and nothing was noted in the medical record. DON also stated there was no documentation of any assessment or intervention following the incident.During a follow-up telephone interview on [DATE] at 3:55 p.m. with LVN 1, LVN 1 stated, when she entered Resident 1's room on [DATE], Resident 1 was already sitting on the floor, his back leaned against the bed, and two CNAs were already at the bedside. LVN 1 stated she did not see how Resident 1 ended up on the floor (unwitnessed).During interviews on [DATE] to [DATE], multiple staff stated the following:a. [DATE] at 11:28 a.m. with CNA 1, CNA 1 stated, sometime in February 2026, in the early morning after she clocked in for the morning shift, there was a commotion from Resident 1's room. CNA 1 stated she was told Resident 1 needed help; CNA 1 entered the room and found Resident 1 sitting on the floor with his back against the bed. CNA 1 stated there were four CNAs in the room that included CNA 2, CNA 3, CNA 4 and LVN 2.b. On [DATE] at 11:50 a.m. with CNA 2, CNA 2 stated on [DATE], upon arriving for the day shift, entered Resident 1's room and found Resident 1 lying flat on the floor. CNA 2 stated several staff were already in the room that included Infection Preventionist (IP), CNA 3, and CNA 4. CNA 2 stated she assisted by holding the wheelchair so Resident 1 could be seated. A sling was placed under Resident 1, and he was lifted into the wheelchair. CNA 2 stated this was not Resident 1's first fall incident as Resident 1 had fallen before.c. On [DATE] at 11:58 a.m. with LVN 2, LVN 2 stated he was in the hallway about to start medication pass when one of the CNAs came to ask for help. LVN 2 stated going to Resident 1's room and found Resident 1 already sitting on the floor, back against the bed. d. On [DATE] at 12:54 p.m. with CNA 3, CNA 3 stated helping other staff to get Resident 1 up in the wheelchair using a sling.e. On [DATE] at 1:06 p.m. with LVN 3, LVN 3 stated being told by LVN 1 about Resident 1's fall on [DATE], no 24-hour report was completed, only verbal communication. LVN 3 stated all incidents should be documented in progress notes, after a fall, residents must be assessed, vital signs and neuro checks done as indicated, and any abnormal findings reported to the physician. LVN 3 stated falls are considered a Change of Condition (CoC, any significant alteration in a resident's physical, mental, or functional baseline, demanding prompt assessment and intervention). Progress notes should be completed every shift for 72 hours following a fall.f. On [DATE] at 1:46 p.m. with IP, IP stated, on the morning of [DATE], a CNA requested assistance after finding Resident 1 on the floor. IP stated she entered the room and found staff helping Resident 1 into the wheelchair as the bed was not functioning properly. IP stated she communicated with IP to follow appropriate fall procedures, including completing the CoC documentation, notifying the physician and informing Resident 1's family. IP stated, the next day, LVN 4 reported the incident to Director of Staff Development (DSD) stating IP sustained an injury during the transfer. IP stated she provided a detailed account of the incident to the facility leadership and subsequently took leave due to the injury.g. On [DATE] at 7 a.m., CNA 4 stated Resident 1 had multiple falls that he knew of. The first occurred months ago, after breakfast between 8-10 a.m. CNA 4 stated Resident 1's CNA from a registry had to transfer Resident 1 using the standing lift (a mobility device designed to assist individuals with limited leg strength in transitioning from a seated to a standing position), during the transfer, Resident 1's knees buckled and Resident 1 slipped to the floor. CNA 4 stated about six staff members were needed to help Resident 1 with a Hoyer lift (a mechanical device used to safely transfer patients with limited mobility between beds, wheelchairs, and commodes). The second fall happened on the early morning of [DATE], when CNA 4 found Resident 1 sitting on the floor. The third fall took place the next day, (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[DATE], after breakfast when CNA 4 transferred Resident 1 from the bed to the wheelchair using a standing lift. During the transfer, Resident 1's knees buckled again, so Resident 1 was lowered to the floor. CNA 4 stated LVN 3 instructed that Resident 1 remain in bed all day on [DATE] after the fall.h. On [DATE] at 7:53 a.m. with CNA 6, CNA 6 stated on [DATE], after breakfast, another CNA requested assistance, upon entering the room, Resident 1 was sitting on the floor waiting to be helped up. CNA 6 stated he was one of the last CNAs to arrive at Resident 1's room and Resident 1 was helped back to bed.i. On [DATE] at 7:49 a.m. with CNA 5, CNA 5 stated, on [DATE], CNA 4 had asked for assistance with Resident 1. CNA 5 stated when he entered the room, several people were present and Resident 1 was already sitting at the edge of the bed after being helped up. CNA 5 stated he assisted in moving Resident 1 back onto the bed.During an interview on [DATE] at 7:29 a.m. with LVN 3, LVN 3 stated she was not aware of Resident 1's fall on [DATE]. LVN 3 also stated she would have notified Assistant Director of Nursing (ADON) about it. LVN 3 further stated the Hoyer lift was more appropriate due to Resident 1's weight and advised against the standing lift. When asked about Resident 1's fall care plan, LVN 3 stated she could not access Resident 1's medical record.During a concurrent interview and record review on [DATE] at 1:10 p.m. with ADON, a Nurse's Note dated [DATE] indicated Resident 1 was lowered down to the floor after a CNA transferred Resident 1 from the bed to the wheelchair using a standing lift but the lift was not properly used. Resident 1 was assisted back to bed using a Hoyer lift. ADON stated, Resident 1's fall on [DATE] was documented in the record as CoC but there were no follow-through progress notes from nursing staff, which should have been completed. ADON stated licensed nurses must adhere strictly to the established fall protocol. ADON stated, whenever a resident experiences a fall, whether witnessed or assisted, an immediate assessment is required, followed by notification of both the attending physician and family members. In accidents involving unwitnessed falls, prompt neurological checks after the fall are necessary, along with completion of a fall risk assessment, eInteract charting, and documentation through 72-hour progress notes. An IDT conference should be conducted for risk management purposes on the subsequent workday. ADON also stated, for any change of condition, such as a fall, 72-hour monitoring is mandated and critical, as the resident's status may deteriorate rapidly. It is also essential to inform both the family and the attending physician. However, in these incidents, on 2/14 and [DATE], neither the physician nor the family was notified due to incomplete CoC documentation. During a review of Resident 1's fall care plan, undated, the care plan indicated interventions that included following facility fall protocol and notifying the physician and family in the event of a fall. Another fall care plan last revised [DATE], the care plan indicated interventions that included educating staff on how to operate a standing lift.During a concurrent interview and record review on [DATE] at 2:10 p.m. with ADON, the In-Service Training Attendance Sign-in Sheet for the course title Using Hoyer lift and Standing Lift dated [DATE] was reviewed. CNA 4 and CNA 7's names were missing from the in-service attendance sheet; both CNAs were assigned to Resident 1.During an interview on [DATE] at 3:39 p.m. with Physical Therapist (PT) 1, PT 1 stated the last evaluation of Resident 1 by the Rehabilitation Department (Rehab) was some time ago when Resident 1 was stronger. PT 1 stated Rehab did not receive a nursing referral to assess if a standing lift was still appropriate. PT 1 stated that nurses were trained to do Hoyer and standing lift transfer whichever was more appropriate for a resident.During a review of the facility's policy and procedure (P&P) titled Falls-Clinical Protocol last revised [DATE], the P&P indicated staff will evaluate and document falls that occur while the resident is in the facility, when and where they happen and any observations of the events, etc. Falls are categorized by whether they occur while trying to rise from a sitting or lying to an upright position and slide out of a chair or rolling from a low bed to the floor. Within 24 hours after the fall, staff must identify possible causes, with ongoing evaluation by staff and physician until a cause is found or deemed uncorrectable. Complications like fractures, bruising, or intracranial (inside the brain) bleeding can appear hours to weeks after a fall.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview and record review, the facility failed to follow infection control practices to prevent cross-contamination during resident care when Certified Nursing Assistant (CNA) 8 was placed dirty linens directly on the floor without bagging them and touched multiple items at the bedside, including personal care supplies and environmental surfaces, without removing and changing gloves between tasks.These failures created a risk for the spread of infectious organisms.During a concurrent observation and interview on 4/21/26 at 6:19 a.m. with CNA 8, inside Resident 5's room, CNA 8 placed a soiled linen on the floor near the trash can without bagging it. CNA 8, wearing gloves, repositioned Resident 8, adjusted the curtain and bed remote without changing gloves. CNA 8 then picked up the linen and trash, bagged them and exited the room. CNA 8 acknowledged placing the linen on the floor without bagging and apologized for her actions.During an interview on 4/22/26 at 1:46 p.m. with Infection Preventionist (IP), IP stated used linen must be bagged and not placed on the floor. Unrolled bags are kept at the foot of the bed so staff can easily bag linen or garments removed from residents. Used linen is not placed on the floor because it may contain microorganisms, which could be spread by staff stepping on them, as shoes can transfer bacteria throughout the facility.During a review of the facility's policy and procedure (P&P) titled, Laundry and Bedding, Soiled last reviewed January 2026, the P&P indicated all used laundry is treated as contaminated and bagged at the collection point with standard precautions.