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	05/21/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and a review of facility records, the facility failed to ensure a safe environment and adequate supervision for one of five sampled residents (Resident 1) when Resident 1 first eloped from the facility and later, while back in the facility, Resident 1 fell and sustained a fracture.This deficient practice resulted in serious and preventable harm to Resident 1, including injury and fracture.A review of Resident 1's admission RECORD indicated Resident 1 was admitted to the facility with multiple diagnosis including bipolar disorder (a chronic mental health condition characterized by extreme mood swings, alternating between high-energy mania (or milder hypomania) and low-energy depression) and Alcohol abuse.A review of Resident 1's progress noted, IDT (Interdisciplinary Team) dated 3/17/26 indicated .On 03/15/2026 at approximately 2030, the resident was heard calling for help from her room. When the nurse entered, the resident was found sitting on the floor next to her bed. She complained of pain in her right shoulder and head. The physician was notified, and orders were received to transfer to ER (Emergency Room) for a CT scan (Computed tomography) of the brain and Xˆray (radiology picture) of the right shoulder. Resident refused to be transferred despite teaching on importance of further evaluation. Although the resident initially refused transfer to the ER despite education on risks, she later agreed to transfer due to uncontrolled pain.She admitted to consuming an entire bottle of vodka and stated, to be honest I drank a bottle of vodka (alcohol), and I don't know how I ended up on the floor. She reported that she left the facility earlier in the day with another resident, taking County Link transportation to CVS (pharmacy and store) where they both purchased vodka. She confirmed she did not inform nursing staff of her intent to leave and did not have physician approval for an outside pass.The resident returned from the hospital on [DATE] with x-ray result indicating a mildly displaced comminuted fracture of the distal right clavicle (part of shoulder bone).A review of Resident 1's Order Summary Report dated 3/1/26 indicated Resident 1 had no approval order from the physician to leave the facility.A review of the hospital ED (Emergency Department) AFTER VISIT SUMMARY dated 3/16/26, for Resident 1, indicated .Diagnosis: Closed displaced fracture of right clavicle (part of shoulder bone), unspecified part of clavicle, initial encounter.A review of Resident 1's X-ray chest AP (Anteroposterior) portable dated 3/16/26 indicated .Impression 1. Mildly displaced comminuted fracture of distal right clavicle.A review of Resident 1's Care Plan indicated Resident 1 had a history of fall . Falls (name of Resident1) is at risk for fall or injury due to generalized weakness, diabetes, anemia (is a common blood condition characterized by a low number of healthy red blood cells or insufficient hemoglobin, resulting in decreased oxygen delivery to body tissues), hypothyroidism (a condition where the thyroid gland does not produce enough thyroid hormones), pain, HX (History) of convulsions (seizure), HX of lumbar FX (fracture) s/p(Status Post), kyphoplasty (a minimally invasive surgical procedure used to treat painful vertebral compression fractures, often caused by osteoporosis [bones lose density], tumors, or trauma) in 2023, medication side effects, Date Initiated: 10/02/2025 Goal: Will be free from fall or injury.A review of Resident 1's FALL RISK OBSERVATION/ASSESSMENT dated 12/11/2025, indicated Resident 1's fall score was . Score: 20, .C. HIGH RISK 16-42. During an interview on 4/23/26, at 3:35 p.m. with the Director of (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing (DON), DON stated that Resident 1 told her that she left the facility with another resident with paratransit (transportation) in daytime (not sure what time) to the store and did not inform anyone at the facility. DON stated staff have responsibility to supervise the residents, however they did not know Resident 1 was not in the facility at that time.During an interview on 4/23/26 at 3:25 p.m. with the Administrator (ADM), ADM stated residents are supposed to sign out when they leave the facility if they have a physician permission and staff need to ask the resident where they are going and questioning their representative or transportation agency about the plan and make sure resident stay safe and free of any incidents.During an interview on 4/23/26 at 2:50 p.m. with Resident 1, Resident 1 stated on the date of incident (3/15/26), she called the paratransit and left the facility with her friend and both went to the CVS (Pharmacy) and bought bottle of Vodka and couple of hours later went back to the facility, drank the [NAME] of Vodka at night time and went to bed and slept, then in a middle of night she woke up on the floor with pain on her shoulder and did not remember anything how it that happened. Resident 1 stated she did not inform anybody nor sign any paper.During an interview on 4/23/26 at 3:15 p.m., with the Registered Nurse (RN)1, RN 1 stated nobody told her about Resident 1 in day shift left the facility and RN 1 did not know anything about Patient 1 being out of the facility.A review of the facility's policy and procedures Safety and Supervision of Residents Revised July 2017, indicated .Our facility-oriented approach to safety addresses risks for groups of residents.Our individualized, resident-centered approach to safety addresses safety and accident hazards for individual residents.A review of the facility's policy and procedures Resident Freedom of Movement revised July 2025 indicated .C. Leaving the Facility - NOT ON PASS (Unplanned / AMA) If Resident is Alert & Oriented: Staff will: Assess decision-making capacity Educate resident on risks (falls, meds, treatment interruption) Attempt to notify responsible party. Resident must not be physically prevented from leaving. All exits (planned or unplanned) must be documented. Patterns of frequent unplanned exits should trigger: Care plan review, Social services involvement, Facility will monitor for: Elopement risk Unsafe behaviors.A review of the facility's policy and procedure Wandering and Elopements revised March 2019, indicated The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents.