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	04/18/2025

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on interview, record review, and facility policy review, the facility failed to resubmit a Preadmission Screening and Resident Review (PASRR) Level I evaluation for 2 (Resident #120 and Resident #124) of 5 residents reviewed for PASRR. Findings included: An undated facility policy titled, PASRR (Pre-admission Screening & Resident Review), indicated, 2. The PASRR Level I form will be maintained in the patient's medical record. The policy also indicated, 4. A positive PASRR Level I screen necessitates an in-depth evaluation of the individual, by the state-designated authority, known as Level II PASRR, which must be conducted prior to admission to the facility. 1. An admission Record revealed the facility admitted Resident #120 on 10/02/2023. According to the admission Record, the resident had a medical history that included diagnoses of bipolar disorder and major depressive disorder. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/29/2025, revealed Resident #120 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated the resident's active diagnoses for psychiatric/mood disorder included depression and bipolar disorder. Resident #120's Care Plan Report, included a focus area revised on 12/16/2024, that indicated the resident was at risk for psychosocial refusal of care. The focus area revealed the resident refused care and services within their rights as manifested by non-compliance/refusal of medical care, medications, and nursing care with associated behaviors. Interventions (initiated 01/19/2024) directed staff to obtain behavioral and psychological services as indicated, encourage active participation in care, inform the resident of procedures and the purpose prior to start, inform the resident of risks and ramifications of continued noncompliance, and re-approach the resident when they are refusing care to the extent possible. A letter from the Department of Health Care Services dated 10/02/2023 indicated Resident #120's PASRR Level I Screening result was negative. The letter revealed the resident was determined an Exempted Hospital Discharge and a Level II mental health evaluation referral was not required. The letter revealed that if the resident remained in the nursing facility longer than 30 days, the facility should resubmit a new Level I Screening as a resident review on the 31st day. (continued on next page)

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

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	04/18/2025

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/17/2025 at 9:53 AM, the Admissions Assistant stated a new PASRR Level 1 was not resubmitted for Resident #120 on the 31st day, and the facility did not have a current Level I Screening. During an interview on 04/17/2025 at 10:14 AM, the MDS Coordinator reviewed Resident #120's PASRR letter and confirmed the resident did not receive a new PASRR Level I on the 31st day. During an interview on 04/17/2025 at 10:39 AM, the Director of Nursing (DON) stated the facility had not identified an individual responsible for resubmitting Resident #120's PASRR on the 31st day, and anyone with access could have submitted it. During a follow-up interview with the DON on 04/17/2025 at 10:49 AM, she stated her expectation for timeliness for completion of PASRRs was to act promptly on the letters the facility received. During an interview on 04/18/2025 at 10:29 AM, the Administrator stated his expectation was if a PASRR was needed after thirty days, then one of the staff with access to submit a PASRR would complete it. 2. An admission Record revealed the facility admitted Resident #124 on 01/17/2023. According to the admission Record, the resident had a medical history that included diagnosis of schizophrenia. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/02/2025, revealed Resident #124 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated the resident's active diagnoses for psychiatric/mood disorder included schizophrenia. Resident #124's Care Plan Report, included a focus area initiated on 01/24/2023, that indicated the resident had a psychosocial wellbeing problem related to schizophrenia. Interventions (revised 06/25/2023) directed staff to assist the resident in developing coping skills to manage feelings, use prior skill and strengths, relaxation or talking; offer to accompany the resident to situation outside of room; facilitate interaction with others, and ways in which meaningful contact could be initiated. A letter from the Department of Health Care Services, dated 01/17/2023, indicated Resident #124's Level I Screening result was positive for suspected mental illness. The letter revealed the resident was determined a Level II mental health evaluation referral was required. A letter from the Department of Health Care Services dated 02/01/2023 indicated that after reviewing the positive Level I Screening and speaking to staff, a Level II mental health evaluation was not scheduled because the resident was isolated as a health or safety precaution. The letter revealed that the case was closed and to reopen it, the facility needed to submit a new Level I Screening. During an interview on 04/17/2025 at 10:09 AM, the Admissions Assistant reviewed Resident #124's letters and stated a PASRR Level II should have been done at the facility. The Admissions Assistant stated that as of that day, the resident had not received a Level II Screening. The Admissions Assistant stated that the MDS Coordinator would need to request the Level II Screening. (continued on next page)

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	04/18/2025

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/17/2025 at 10:24 AM, the MDS Coordinator reviewed Resident #124's PASRR letters and confirmed that a new Level I Screening was not submitted to complete the Level II Screening as instructed. The MDS Coordinator could not explain who was responsible for submitting the PASRR evaluations. During an interview on 04/17/2025 at 10:39 AM, the Director of Nursing (DON) stated that the Assistant Administrator was the only one with access for submitting the PASRR and would have had to do it for Resident #124. The DON stated the Assistant Administrator no longer worked at the facility. During a follow-up interview with the DON on 04/17/2025 at 10:49 AM, she stated her expectation for timeliness for completion of PASRRs was to act promptly on the letters the facility received. During an interview on 04/18/2025 at 10:29 AM, the Administrator stated his expectation was if a PASRR was needed for a resident that was on isolation when the evaluation was scheduled, then one of the staff with access to submit a PASRR would complete it.

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	04/18/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on interview, record review, and facility policy review, the facility failed to ensure staff documented medication administration on the electronic Medication Administration Record (eMAR) in a timely manner for 1 (Resident #72) of 4 residents observed during medication administration. Findings included: An undated facility policy titled, Administering Medications, revealed the section titled, Policy Interpretation and Implementation, included, 19. The individual administering the medication must initial the resident's MAR on the appropriate line after giving each medication and before administering the next ones. An admission Record indicated the facility admitted Resident #72 on 05/01/2024. According to the admission Record, the resident had a medical history that included diagnoses of essential primary hypertension, type 2 diabetes mellitus, bilateral primary osteoarthritis of the knee, and adult failure to thrive. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/28/2025, revealed Resident #72 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderate cognitive impairment. Resident #72's Care Plan Report, included a focus area initiated 05/02/2024, that indicated the resident was at risk for side effects with the use of antihypertensive medication. Interventions directed staff to administer medications as ordered. The Care Plan Report included a focus area initiated 05/02/2024, that indicated the resident had a nutritional problem or potential nutritional problem. Interventions directed staff to provide and serve supplements as ordered. The Care Plan Report included a focus area initiated 05/01/2024, that indicated the resident had pain. Interventions directed staff to monitor/document for side effects of pain medication. Resident #72's Order Summary Report with active orders as of 04/17/2025, included the following orders: - An order dated 05/01/2024, for amlodipine 5 milligrams (mg), with instructions to give one tablet by mouth one time a day for hypertension. - An order dated 05/01/2024, for ferrous sulfate 324 mg, with instructions to give one tablet by mouth one time a day for supplement. - An order dated 05/01/2024, for gabapentin 100 mg, with instructions to give one capsule by mouth three times a day for neuropathy. - An order dated 05/01/2024, for metoprolol tartrate 25 mg give one tablet by mouth one time a day for hypertension. Resident #72's April 2025 Medication Administration Record [MAR] revealed the amlodipine, ferrous sulfate, gabapentin, and metoprolol tartrate were all scheduled to be administered at 9:00 AM. (continued on next page)

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	04/18/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation of medication administration on 04/16/2025 at 8:59 AM, Licensed Vocational Nurse (LVN) #9 administered amlodipine 5 mg one tablet, ferrous sulfate 325 mg one tablet, metoprolol tartrate 25 mg one tablet, and gabapentin 100 mg one capsule to Resident #72, but did not sign the medications as administered on the eMAR when they were given. During an interview on 04/16/2025 at 10:55 AM, LVN #9 confirmed that she had not documented that the medications were administered yet. She stated she was in a hurry to get to the next resident. She stated she should have documented the administration of the medications on the MAR right after they were given. A Medication Admin [Administration] Audit Report, for Resident #72's medications on 04/16/2025, revealed LVN #9 documented on the eMAR that ferrous sulfate 324 mg was administered at 11:47 AM, amlodipine 5 mg was administered at 9:47 AM, gabapentin 100 mg was administered at 11:47 AM, and metoprolol tartrate 25 mg was administered at 9:49 AM. The Medication Admin Audit Report revealed this documentation was put into the eMAR on 04/16/2025 at 11:48 AM and 11:49 AM, almost three hours after the medications were administered. During an interview on 04/17/2025 at 3:20 PM, LVN #11 stated the nurse administering the medication needed to document that they administered the medication on the MAR as soon as they were given. He stated if the nurse was pulled to an emergency, then there was a record of the medication being given. During an interview on 04/18/2025 at 8:53 AM, Assistant Director of Nursing (ADON) #14 stated the nurse should document that they administered the medication right after it was given. He stated it was not good practice to wait until later to document a medication was given, especially an as-needed medication. He stated if the medication was not documented at the right time, the next nurse might not be able to give the next dose timely. During an interview on 04/18/2025 at 9:23 AM, the Director of Nursing (DON) stated that after a resident was administered medication, then the medication should be documented as administered on the MAR. She stated it was not good practice to wait to document. She stated they needed to have an accurate time of administration. During an interview on 04/18/2025 at 10:13 AM, the Administrator stated the nurse should document the administration of medication at the time it was given.

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	04/18/2025

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 - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on interview, record review, facility document review, and facility policy review, the facility failed to ensure medication orders were accurately transcribed for 1 (Resident #42) of 5 sampled residents reviewed for unnecessary medications. Findings included: An undated facility policy titled, Administering Medications, indicated, Medications shall be administered in a safe and timely manner, and as prescribed. The policy revealed, 3. Medications must be administered in accordance with the orders, including any required time frame. An admission Record indicated the facility admitted Resident #42 on 07/01/2022. According to the admission Record, the resident had a medical history that included diagnoses of dementia, major depressive disorder, and unspecified mood affective disorder. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/19/2024, revealed Resident #42 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident had diagnoses of depression and psychotic disorder. The MDS revealed the resident received antipsychotic medications during the assessment's lookback period. Resident #42's Care Plan Report, included a focus area initiated 03/31/2025, that indicated the resident received an antipsychotic medication and had the potential for side effects, complications, or adverse reactions related to ordered use of the drug Seroquel. Interventions directed staff to administer medications as ordered. A physician's order dated 03/29/2025 revealed Medical Doctor (MD) #8 changed Resident #42's Seroquel to 50 milligrams (mg) with instructions to take one tablet twice a day and two tablets at bedtime. Resident #42's Order Summary Report, with orders for the timeframe from 01/01/2025 through 04/17/2025, revealed order dated 03/29/2025, for quetiapine fumarate (Seroquel) oral tablet 25 mg, with instructions to give one tablet by mouth two times a day for agitation related to dementia. The Order Summary Report revealed an order dated 03/29/2025, for quetiapine fumarate oral tablet 25 mg, with instructions to give two tablets by mouth at bedtime for agitation related to dementia. Resident #42's March 2025 Medication Administration Record [MAR], revealed a transcription of an order dated 03/29/2025, for quetiapine fumarate oral tablet 25 mg, with instructions to give one tablet by mouth two times a day at 9:00 AM and 5:00 PM. Further review revealed staff documented that the medication was administered to the resident from 03/29/2025 to 03/31/2025. The MAR revealed a transcription of an order dated 03/29/2025, for quetiapine fumarate oral tablet 25 mg, with instructions to give two tablets by mouth at bedtime at 8:00 PM, for agitation related to dementia. Further review revealed staff documented that the medication was administered to the resident from 03/29/2025 to 03/31/2025. (continued on next page)

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	04/18/2025

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 - Minimal harm or potential for actual harm Residents Affected - Few	Resident #42's Medication Administration Record for the timeframe from 04/01/2025 through 04/15/2025, revealed a transcription of an order dated 03/29/2025, for quetiapine fumarate oral tablet 25 mg, with instructions to give one tablet by mouth two times a day at 9:00 AM and 5:00 PM. Further review revealed staff documented that the medication was administered to the resident from 04/01/2025 to 04/15/2025. The MAR revealed a transcription of an order dated 03/29/2025, for quetiapine fumarate oral tablet 25 mg, with instructions to give two tablets by mouth at bedtime at 8:00 PM, for agitation related to dementia. Further review revealed staff documented that the medication was administered to the resident from 04/01/2025 to 04/15/2025. During an interview on 04/16/2025 at 5:33 PM, Assistant Director of Nursing (ADON) #14 stated he was unaware of the medication error but that he would get it updated. ADON #14 stated he expected the nurses to review the orders closely to try to not have any medication errors. ADON #14 stated he needed to do more audits or have another nurse review orders more often to try to catch those medication errors. ADON #14 stated that Resident #42 had no negative outcomes from this medication error. Multiple attempts were made on 04/17/2025 at 2:20 AM and 04/18/2025 at 7:18 AM and 9:19 AM to reach MD #8 but were not successful. During an interview on 04/17/2025 at 2:40 PM, Licensed Vocational Nurse (LVN) #6 stated he was notified by ADON #14 of the medication error with Resident #42. He confirmed that he entered Resident #42's order for Seroquel wrong and he should have changed the order to 50 mg but instead he left it as 25 mg. He stated that he should have paid attention when transcribing the orders for the resident. During an interview on 04/18/2025 at 9:05 AM, the Director of Nursing (DON) stated she expected her staff to enter medication orders accurately. During an interview on 04/18/2025 at 9:35 AM, the Administrator stated he expected the staff to double-check the orders and to get the orders correct and put them into the system accurately.

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	04/18/2025

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 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. Based on observation, interview, record review, facility document review, and facility policy review, the facility failed to ensure medications were properly stored and not left at the bedside for 2 (Resident #94 and Resident #34) of 2 residents reviewed for accident hazards. Findings included: An undated policy titled, Administering Medications, indicated, Medications shall be administered in a safe and timely manner, and as prescribed. The policy revealed, 24. Residents may self-administer their own medications only if the Attending Physician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have the decision-making capacity to do so safely. An undated policy titled, Self-Administration of Medications, revealed, Residents have the right to self-administer medications if the interdisciplinary team has determined that is it clinically appropriate and safe for the resident to do so. The policy revealed, 8. Self-administered medications are stored in a safe and secure place, which is not accessible by other residents. 1. An admission Record indicated the facility admitted Resident #94 on 10/29/2020. According to the admission Record, the resident had a medical history that included diagnoses of essential primary hypertension, chronic obstructive pulmonary disease, cerebral aneurysm, and anemia. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/19/2025, revealed Resident #94 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. Resident #94's Care Plan Report, included a focus area revised 01/25/2022, that indicated the resident had impaired cognitive function and impaired thought processes related to their disease process. Interventions directed staff to administer medications as ordered (initiated 10/14/2021). The plan of care did not include self-administering medications or leaving medications at the bedside. During an observation on 04/14/2025 at 10:41 AM, Resident #94 was in bed holding a souffle cup (a disposable paper cup) that contained multiple pills. The resident stated staff gave them the pills to take that morning, but they were waiting for their stomach to not be upset before they took the pills. During an observation on 04/16/2025 at 10:31 AM, Resident #94 was in bed and the souffle cup with pills was on the over-the-bed table next to their bed. During an observation and interview on 04/16/2025 at 10:41 AM, Assistant Director of Nursing (ADON) #14 stated medications should not be left at the bedside. He removed the cup of pills from the over-the-bed table and told Resident #94 he would confirm the medications and then bring them back. ADON #14 went to the medication cart where Resident #94's medications were stored and compared each pill with the medication cards and the medication administration record (MAR) to confirm the pills were the resident's morning medications. ADON #14 returned to the room and gave the pills to Resident #94. ADON #14 stated the medications should not have been left at the bedside; the nurse should have watched the resident to make sure they were all taken safely. (continued on next page)

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	04/18/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/16/2025 at 11:17 AM, ADON #14 confirmed that Resident #94 had not been assessed to self-administer medication. Resident #94's Order Summary Report, with active order as of 04/17/2025, revealed it did not include physician orders for the resident to self-administer medications or for their medications to be left at the bedside. Resident #94's April 2025 Medication Administration Record [MAR] revealed that Licensed Vocational Nurse (LVN) #9 documented that she administered the residents 9:00 AM medications on 04/14/2025 and 04/16/2025. An Employee Counseling Form, dated 04/16/2025, indicated LVN #9 received a final written warning for a policy violation for the infraction of leaving medication at the bedside. During an interview on 04/16/2025 at 10:55 AM, LVN #9 confirmed that she left Resident #94's medications at the bedside. She stated Resident #94 was not ready to take the pills and asked her to leave the pills so they could take them when they were ready. During an interview on 04/18/2025 at 9:23 AM, the Director of Nursing (DON) stated medications should not be left at the bedside. She stated if the resident was not ready to take the medications, the nurse should ask the resident to notify them when they were ready. She stated the nurse should go back three times, and if the resident still was not ready, the nurse should educate the resident, discard the medication, call and inform the physician, and then care plan the refusal. The DON stated the nurse was responsible for ensuring the medications were taken. She stated not knowing what time the resident took the medication was a risk, and other residents could take the medication if they had poor cognition. The DON stated it was not safe to leave Resident #94's medications at the bedside as they may fall asleep. During an interview on 04/18/2025 at 10:13 AM, the Administrator stated medications should not be left at the bedside. He stated if the resident did not want them at the time they were offered, then the nurse should take the medications back to the medication cart and offer them later. He stated the risks of leaving medications at the bedside were that another resident could pick them up, the resident may not take them, or they may get dropped on the floor and then there would be an infection control issue. 2. An admission Record indicated the facility admitted Resident #34 on 04/22/2023. According to the admission Record, the resident had a medical history that included diagnoses of type 2 diabetes mellitus with diabetic chronic kidney disease and age-related cognitive decline. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/01/2025, revealed Resident #34 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated the resident had moderate cognitive impairment. Resident #34's Care Plan Report, included a focus area initiated 04/11/2025, that indicated the resident exhibited cognitive loss related to altered cognitive performance with a BIMS score of 11. Interventions instructed staff to administer medications as ordered (initiated 04/11/2025). (continued on next page)

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	04/18/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 04/14/2025 at 10:57 AM, Resident #34 was in bed with their eyes closed. A souffle cup (a disposable paper cup) that contained five pills was noted on the over-the-bed table in front of the resident. Resident #34's Order Summary Report, with active orders as of 04/17/2025, revealed it did not include physician orders for the resident to self-administer medications or for their medications to be left at the bedside. Resident #34's April 2025 Medication Administration Record [MAR] revealed that Licensed Vocational Nurse (LVN) #9 documented that she administered the residents 9:00 AM medications on 04/14/2025. During an interview on 04/18/2025 at 9:23 AM, the Director of Nursing (DON) stated medications should not be left at the bedside. She stated if the resident was not ready to take the medications, then the nurse should take the medication back and ask the resident to notify them when they were ready. She stated the nurse should go back three times, and if the resident still was not ready, the nurse should educate the resident, discard the medication, call and inform the physician, and then care plan the refusal. She stated the nurse was responsible for ensuring the medications were taken. She stated not knowing what time the resident took the medication was a risk, and other residents could take the medication if they had poor cognition. The DON stated it was not safe to leave Resident #34's medications at the bedside. During an interview on 04/18/2025 at 10:13 AM, the Administrator stated medications should not be left at the bedside. He stated if the resident did not want them at the time they were offered, then the nurse should take the medications back to the medication cart and offer them later. He stated the risks of leaving medications at the bedside were that another resident could pick them up, the resident may not take them, or they may get dropped on the floor and then there would be an infection control issue.

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	04/18/2025

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, record review, interview, and facility policy review, the facility failed to have a medication error rate of less than 5%, with an error rate of 17.86%, affecting 2 (Resident #113 and Resident #72) of 4 residents observed during medication administration. The facility had five errors out of 28 opportunities. Findings include: An undated facility policy titled, Administering Medications, indicated, Medications shall be administered in a safe and timely manner, and as prescribed. The policy indicated, 3. Medications must be administered in accordance with the orders, including any required time frames. Further review revealed, 7. The individual administering the medication must check the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. 1. An admission Record, revealed the facility admitted Resident #113 on 05/19/2022. According to the admission Record, the resident had a medical history that included a diagnosis of essential hypertensin. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/11/2025, revealed Resident #113 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident had intact cognition. Resident #113's Order Summary Report, with active orders as of 04/17/2025, included an order dated 09/11/2022, for chewable aspirin 81 milligrams (mg), with instructions to give one tablet by mouth in the morning for deep vein thrombosis (DVT) prophylaxis. During a medication administration observation on 04/16/2025 at 8:42 AM, Licensed Vocational Nurse (LVN) #9 administered enteric coated aspirin to Resident #113. During an interview on 04/16/2025 at 10:55 AM, LVN #9 stated she should have ensured the right resident, medication, dose, route, and time and checked it two to three times for each medication to ensure she was giving the right medication. During an interview on 04/18/2025 at 8:53 AM, Assistant Director of Nursing (ADON) #14 stated that when passing medications, the nurse should do a triple check. He stated that to make sure the medication was not missed, the nurse should pull the medication out of the medication cart and check the six rights (right resident, medication, dose, route, time, and indication). He stated they should compare the medication label with the electronic Medication Administration Record (eMAR), remove the medication from its container, and read the medication label again. He stated that when giving the medication the nurse should explain to the resident the medication they were giving and what it was for, and the nurse should not leave until the medication was taken. During an interview on 04/18/2025 at 9:23 AM, the Director of Nursing (DON) stated that when the nurse was administering medication, they should check the medication package with the MAR. (continued on next page)

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	04/18/2025

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/18/2025 at 10:13 AM, the Administrator stated he expected the medication error rate to be 0%. He stated the nurses needed to be more thorough to ensure the residents were getting what they were supposed to when they were supposed to. 2. An admission Record indicated the facility admitted Resident #72 on 05/01/2024. According to the admission Record, the resident had a medical history that included diagnoses of essential primary hypertension, asthma, and adult failure to thrive. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/28/2025, revealed Resident #72 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderate cognitive impairment. Resident #72's Order Summary Report, with active orders as of 04/17/2025, included the following orders: - An order dated 01/22/2025, for famotidine 20 milligrams (mg), with instructions to give one tablet by mouth one time a day to prevent acid indigestion. - An order dated 09/05/2024, for fluticasone propionate nasal suspension 50 micrograms (mcg) per actuation, with instructions to give one spray in both nostrils two times a day for allergy symptoms. - An order dated 05/02/2024, for lactobacillus (probiotic), with instructions to give one capsule by mouth two times a day. - An order dated 09/05/2024, for loratadine 10 mg, with instructions to give one tablet by mouth one time a day for allergy symptoms. During a medication administration observation on 04/16/2025 at 8:59 AM, Licensed Vocational Nurse (LVN) #9 did not administer Resident #72's famotidine, fluticasone, lactobacillus, or loratadine. During an interview on 04/16/2025 at 10:55 AM, LVN #9 stated she should have ensured the right resident, medication, dose, route, and time and checked it two to three times for each medication to ensure she was giving the right medication. During an interview on 04/18/2025 at 8:53 AM, Assistant Director of Nursing (ADON) #14 stated that when passing medications, the nurse should do a triple check. He stated that to make sure the medication was not missed, the nurse should pull the medication out of the medication cart and check the six rights (right resident, medication, dose, route, time, and indication). He stated they should compare the medication label with the electronic Medication Administration Record (eMAR), remove the medication from its container, and read the medication label again. He stated that when giving the medication the nurse should explain to the resident the medication they were giving and what it was for, and the nurse should not leave until the medication was taken. During an interview on 04/18/2025 at 9:23 AM, the Director of Nursing (DON) stated that when the nurse was administering medication, they should check the medication package with the MAR. She stated the nurse should count how many pills were on the MAR and count how many were in the medication cup to ensure they were giving all the medications and go line by line on the MAR. (continued on next page)

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	04/18/2025

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/18/2025 at 10:13 AM, the Administrator stated he expected the medication error rate to be 0%. He stated the nurses needed to be more thorough to ensure the residents were getting what they were supposed to when they were supposed to.

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	04/18/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview, record review, and facility policy review, the facility failed to maintain an accurate medical record related to the use of pain medications for 1 (Resident #46) of 3 residents reviewed for pain management. Findings included: An undated facility policy titled, Pain - Clinical Protocol, revealed the section titled Monitoring, included, 2. The staff will evaluate and report the resident/patient's use of standing and PRN [pro re nata, as needed] analgesics. a. Depending on the characteristics of pain, the physician may start with PRN doses or supplement standing doses with PRN doses for breakthrough pain. b. If there are more than occasional analgesic requests, the physician will consider changing to regular administration of at least one analgesic with another medication for PRN use, increasing the standing dose of an existing analgesic, switching to another analgesic, and/or adding nonpharmacological measures. An admission Record indicated the facility admitted Resident #46 on 08/26/2022. According to the admission Record, the resident had a medical history that included diagnoses of a left lower leg fracture, bilateral primary osteoarthritis of the knees, and polyneuropathy. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/28/2025, revealed Resident #46 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated the resident received PRN pain medication during the assessment's lookback period. Resident #46's Care Plan Report, included a focus area initiated 09/26/2024, that indicated the resident experienced pain or discomfort due to fractures. Interventions (initiated 09/26/2024) directed staff to administer medication as ordered, monitor for side effects, and notify the physician if observed; allow time to participate in activities of daily living (ADLs) to minimize discomfort; assess for non-verbal indicators of pain; assess pain every shift and as indicated; encourage to verbalize feelings; maintain a calm and quiet environment; notify the physician if the resident experienced unmanageable or intolerable pain; offer activities of choice; and arrange pain consults as ordered. Resident #46's Order Summary Report, with active orders as of 04/17/2025, revealed an order dated 04/15/2025, for Percocet 10-325 milligrams (mg) (an opioid pain medication), with instructions to give one tablet by mouth every four hours as needed for moderate to severe pain. Resident #46's April 2025 Medication Administration Record [MAR] revealed that staff documented Percocet 10-325 mg was administered 37 times during the timeframe from 04/01/2025 through 04/16/2025. Resident #46's Individual Patient's Narcotic Record for Percocet 10-325 mg for the timeframe from 04/01/2025 through 04/16/2025 revealed staff documented that they signed out a total of 73 pills during this timeframe. (continued on next page)

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	04/18/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/17/2025 at 3:13 PM, Licensed Vocational Nurse (LVN) #10 stated she documented medication administration on the MAR and signed out medications on the narcotic record when she removed the medication from the medication cart. She stated Resident #46 took their Percocet at 9:00 AM and 1:00 PM and the resident was set on these times as they wanted it before therapy. She confirmed her signature on the narcotic record for 04/04/2025 at 9:00 AM and 1:00 PM. LVN #10 stated that she always documented medication administration on the MAR and was surprised when she saw that she had not. She stated that she must have overlooked it. She stated it was important to document so that the records matched, and it was documented that the resident received it. During an interview on 04/17/2025 at 3:20 PM, LVN #11 stated that when giving a narcotic, he would check the MAR and the narcotic record to see when it was last given. He stated he would then remove the medication from the medication cart, give it to the resident, and sign the MAR and the narcotic record when he returned to the medication cart. He reviewed the narcotic record (for Percocet) for Resident #46 and verified his initials were documented on the narcotic record (as signing out the medication) for 04/04/2025, 04/05/2025, 04/09/2025, and 04/11/2025 at 9:00 PM. He stated he did not know why he did not document on the MAR that the Percocet was given. He stated if it was not documented on the MAR then it looked like the medication was not given. During an interview on 04/18/2025 at 8:53 AM, Assistant Director of Nursing (ADON) #14 stated the narcotic record should be signed as soon as the medication was removed from the medication cart, and then it should be documented as administered on the MAR right after the resident took the medication. He stated that for Resident #46 it was important for the nurses to sign the MAR, because it was one way for the physician to see what medication the resident was getting. He stated that by not signing the MAR, it was not an accurate record of what the resident was taking and what was going on. During an interview on 04/18/2025 at 9:23 AM, the Director of Nursing (DON) stated it was important for staff to sign the MAR to ensure it was an accurate record, as the physician looked at the document to determine what medication the resident received and if adjustments were necessary. During an interview on 04/18/2025 at 10:13 AM, the Administrator stated the staff should be signing out the medications at the time they were given. He stated it was important for the physician to be aware of what the resident was taking in order to get the big picture. He stated he expected proper documentation to be completed.