STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055241	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willow Pass Healthcare Center	3318 Willow Pass Road Concord, CA 94519

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to prevent exploitation (taking advantage of a resident for personal gain, through the use of manipulation, intimidation, threats, or coercion) of one of three sampled residents (Resident 3), when Certified Nursing Assistant (CNA) 1, received a new pair of shoes bought by Resident 3 for CNA 1's personal use.This failure had the potential to cause Resident 3 to be taken advantage of resources, manipulation and abuse.During a review of Resident 3's admission Record (AR), printed 3/11/26, the AR indicated, Resident 3 was admitted to the facility on [DATE] with diagnoses that included pain in the right knee.During a review of Resident 3's Minimum Data Set (MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan), dated 1/23/26, the MDS indicated Resident 3's Basic Interview of Mental status (BIMS, a scoring system used to determine the resident's cognitive status regarding attention, orientation, and ability to register and recall information. A BIMS score of thirteen to fifteen is an indication of intact cognitive status.) score was 15 and indicated intact mental status. The BIMS score indicated Resident 3 was able to recall the correct year, month, and day of the week. During an interview on 3/13/26, at 7:15 a.m., with CNA 1, CNA 1 stated Resident 3 bought a pair of new shoes and gave the shoes to CNA 1. CNA 1 stated Resident 3 saw that CNA 1's feet were swollen, and asked what was wrong with CNA 1's feet. CNA1 stated she told Resident 3 that she had arthritis (a chronic condition causing joint inflammation, pain and stiffness). CNA 1 stated Resident 3 bought the new pair of shoes and gave it to CNA 1. CNA1 stated she did not see anything wrong accepting the new pair of shoes from Resident 3. CNA 1 stated after receiving the shoes CNA 1 gave Resident 3 twenty dollars for the shoes. During an interview on 3/13/26, at 8:28 a.m., with Administrator (Admin) and Director of Nursing (DON), Admin stated he was not aware that CNA 1 received a new pair of shoes bought by Resident 3. Admin stated facility did not expect CNA 1 to receive shoes from Resident 3 for personal use.During a review of the facility's policy and procedure (P&P) titled, Abuse, Prevention of, dated 9/1/2008, the P&P indicated, Abuse, neglect, abandonment, isolation, financial abuse will not be tolerated in this facility at any time.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055241	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willow Pass Healthcare Center	3318 Willow Pass Road Concord, CA 94519

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement its Care Planning-IDT Care Planning Conference, policy and procedure when: Interdisciplinary Team (IDT-a professional discipline that works together to provide the greatest benefit to the resident which included the resident, the resident's family and/or representative, whenever possible, develops and implements approaches to care that are both clinically and appropriate and person-centered) did not develop a care plan that addressed Resident 1's refusal to shower for over a month with appropriate interventions. IDT did not develop a care plan that addressed Resident 1's discharge plan upon admission to the facility. This failure placed Resident 1 at risk for poor hygiene, body odor, transmission of diseases and misunderstanding with discharge process. During a review of Resident 1's admission Record (AR), printed 3/11/26, the AR indicated, Resident 1 was admitted to the facility on [DATE] with diagnoses that included malignant neoplasm of skin (skin cancer). During a review of Resident 1's Minimum Data Set (MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan), dated 2/16/26, the MDS indicated Resident 1's Basic Interview of Mental status (BIMS, a scoring system used to determine the resident's cognitive status regarding attention, orientation, and ability to register and recall information. A BIMS score of thirteen to fifteen is an indication of intact cognitive status.) score was 15 and indicated intact mental status. MDS indicated Resident 1 had no discharge plan. MDS indicated Resident 1 had clear speech, made self-understood and understood others. During a concurrent observation and interview on 3/11/26, at 12:10 p.m., with Resident 1 in Resident 1's room, Resident 1 lay in bed on his back awake and verbally responsive. Resident 1 stated that he had not showered for some time. Resident 1 stated that he refused to shower at times. During a concurrent interview and record review on 3/11/26, at 1:20 p.m., with Director of Nursing (DON), Resident 1's Shower schedule, Shower record dated 2/10/26 to 3/11/26 and ADL (activities of daily living) care plan were reviewed. Resident 1's shower record indicated Resident 1 had not showered for more than a month. Resident 1's ADL care plan did not address Resident 1's refusal to shower. DON stated Resident 1 was scheduled to shower twice a week. DON stated Resident 1 refused showers. DON stated facility's expectation was to update Resident 1's care plan with refusal to shower with appropriate interventions. During a concurrent interview and record review on 3/11/26, at 1:45 p.m., with Director of Nursing (DON), Resident 1's MDS, Social Services progress notes dated 9/22/25 and care plan conferences dated 8/26/25, 9/22/25, 10/20/25 and 2/19/26 were reviewed. The care plan conference indicated Resident 1 had discharge potential. Care plan conferences indicated Resident 1's family member was not invited to participate in care plan conferences. DON could not provide Resident 1's discharge care plan. DON stated facility addressed discharge plan during care conferences. DON stated Resident 1's family member was not consistently invited to care plan conferences. DON stated Resident 1's discharge plan was not addressed with a care plan upon admission. During a review of the facility's policy and procedure (P&P) titled, Shower for Residents, dated 3/29/12, the P&P indicated, Facility will schedule a shower at least two times a week. Shower will be documented in the ADL flow sheet. If resident refuses a shower, the charge nurse will be involved to encourage regular shower or may offer a bath. If resident continually refuses to shower/bathe, the social services will become involved, and the resident care plan will reflect intervention to remedy the situation. During a review of the facility's policy and procedure (P&P) titled, Care Planning, dated 9/1/2008, the P&P indicated, To assure that all residents' care needs are identified through continuous assessments and that those needs are care planned with corresponding measurable objectives and adequate interventions.

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NAME OF PROVIDER OR SUPPLIER Willow Pass Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3318 Willow Pass Road Concord, CA 94519	

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 2), was provided services to maintain grooming and personal hygiene when: Certified Nursing Assistants (CNAs) did not shave Resident 2's facial hair with showers as scheduled. This failure placed residents at risk for poor hygiene, body odor, infection, and transmission of diseases.During a review of Resident 2's admission Record (AR), printed 3/11/26, the AR indicated, Resident 2, was admitted to the facility on [DATE] with diagnoses that included hip fracture. During a review of Resident 2's Minimum Data Set (MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan), dated 12/12/26, MDS indicated Resident 2's Brief Interview for Mental Status (BIMS-a scoring system used to determine the resident's cognitive status regarding attention, orientation, and ability to register and recall information. A BIMS score of thirteen to fifteen is an indication of intact cognitive status.) score was 03 and indicated impaired mental status. The BIMS score indicated Resident 2 was unable to recall the correct year, month, and day of the week. MDS indicated Resident 2 was dependent, needed assistance of two or more helpers with toileting and hygiene and needed maximal assistance, helper does more than half the effort for resident 1's ability to shower/bathe self. During a concurrent observation and interview on 3/11/25, at 11:42 a.m., with Certified Nursing Assistant (CNA) 1 and Registered Nurse (RN) 1, Resident 2 sat up in a wheelchair next to her bed in her room and had facial hairs around her chin. Resident 2 stated she had asked staff before for a shave and would want to be shaved. CNA 1 stated facial hairs were shaved during residents showers. CNA 1 stated she did not know why Resident 2 was not shaved. During a review of Resident 2's Shower Day Skin Inspection (SSI), dated 2/20/26, 2/26/26, and 3/3/26, the SSI indicated, Resident 2 had facial hair. During an interview on 3/11/25, at 11:44 a.m., with Director of Nursing (DON), DON stated facility's expectation was for CNAs offer to shave residents with shower schedule after obtaining consent. DON stated CNAs were expected to notify charge nurses and document residents' refusals to shower or shave. During a review of the facility's policy and procedure (P&P) titled, Shower for Residents, dated 3/29/12, the P&P indicated, Facility will schedule a shower at least two times a week. Shower will be documented in the ADL flow sheet. If resident refuses a shower, the charge nurse will be involved to encourage regular shower or may offer a bath. If resident continually refuses to shower/bathe, the social services will become involved, and the resident care plan will reflect intervention to remedy the situation.