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	03/26/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to protect one (Resident 1) of the six sampled residents from verbal abuse. Certified Nursing Assistant 1 (CNA 1) used profanity (irrelevant language and behavior that shows disrespect, used to express anger and frustration), raised his voice, yelled/shouted at Resident 1, when Resident 1 asked CNA 1's help for Resident 2 when Resident 2 was crying out for help in the TV dining area (a common area used for dining and to watch television). This failure resulted in Resident 1 crying and becoming visibly upset after the incident.During a record review of Resident 1's admission record, dated 2/10/26, the record indicated Resident 1 was admitted to the facility on [DATE]. During a record review of Resident 1's Minimum Data Set (MDS, a standardized assessment tool used to evaluate a resident's functional capabilities, health needs, and clinical status), dated 3/6/26, the assessment indicated Resident 1 was able to express ideas and wants clearly and was able to understand others clearly. The assessment also indicated Resident 1's Brief Interview for Mental Status (BIMS, an assessment for mental status) score was 15 out of 15, indicating the Resident 1's mental status is intact. During an observation and interview on 3/26/26 at 9:44 a.m. with Resident 1, Resident 1 was lying in his bed. Resident 1 stated he was in facility's TV dining room on a Super Bowl Sunday, when a female resident (Resident 2) began crying out for help. Resident 1 stated he saw a CNA (CNA 1) sitting in the room and he called out to him for help. Resident 1 stated CNA 1 in a rude tone of voice said, We got a problem? Resident 1 stated other staff members had to remove CNA 1 from the TV dining room. Resident 1 stated the whole incident made him feel like people should not talk to residents that way, and that CNA 1 should have been fired. Resident 1 stated CNA 1's tone during the incident was, pissed and loud. During an interview on 3/26/26 at 10:26 a.m., with CNA 1, CNA 1 stated that he's been working at the facility for 10 years and previously had been talked to about being professional on the job. CNA 1 stated on 2/8/26, he was sitting in the tv dining room. CNA 1 stated Resident 1 was upset that Resident 2 was upset and crying, while he was watching television. CNA 1 stated Resident 1 wanted me to move Resident 2 out of the TV room, but he told Resident 1 to calm down instead. CNA 1 stated it made Resident 1 more upset. CNA 1 stated he had to raise his voice at Resident 1 because Resident 1 did not back down. CNA 1 stated he should have swallowed his pride instead of raising his voice at Resident 1. During an interview on 3/26/26 at 11:10 am with Director of Staff Development (DSD), the DSD stated CNA 1 had a loud voice and some of the facility residents did not like loud voices. DSD stated having direct care staff talking in a loud voice could make the residents feel hurt or scared. The DSD stated CNA 1 had been talked to about his loud voice previously as well. During an observation and interview on 3/26/26 at 11:56 in tv dining area, Resident 3 was walking out of the dining area. Resident 3 stated CNA 1 could be obnoxious (highly offensive, unpleasant or annoying) at times. Resident 3 stated CNA 1 tries to take on others' job but that's what he had observed about CNA 1. During an interview on 3/26/26 at 12:33 pm with Social Services Director 1 (SSD 1), SSD 1 stated on 2/8/26 around noon time, she heard commotion outside her office door, located near tv dining room. SSD 1 stated when she walked into the TV room, she saw CNA 1 and Resident 1 yelling and (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	shouting at each other. SSD1 stated CNA 1 and Resident 1 were exchanging profanities. SSD 1 stated she did not remember exact words that CNA 1 was using, but it was profanity and he was clearly hot headed at that time. SSD 1 stated she and her coworker had to separate them both. SSD 1 stated she stayed with Resident 1 after this incident and Resident 1 was trembling from anger. During a record review of Resident 1's progress notes dated 2/8/26, SSD 1 documented, Resident [Resident 1] had a verbal altercation with one of the CNAs [CNA 1]. During a record review of witness statement (a written statement by someone who has witnessed the incident) dated 2/8/26, CNA 2 documented, I was at the nursing station and heard yelling.seen [CNA 1] and [Resident 1] arguing.Resident 1 was sitting drinking his coffee while crying. During an interview on 3/30/26 at 3:06 p.m., CNA 2 stated on 2/8/26, she was at the nursing station down the hall from the tv dining room when she heard loud voices, like screaming. CNA 2 stated one of the staff members was walking down the hallway and stated to her, Hey [CNA 1] is in here fighting with a resident. CNA 2 stated she went into the room and saw CNA 1 and Resident 1 arguing. CNA 2 stated CNA 1 was upset; Resident 1 was visibly upset, frustrated and crying after the incident. CNA 2 stated they have had complaints about CNA 1 in the past involving, CNA 1 was a little aggressive with the residents. During a record review of Resident 1's progress notes dated 2/08/26, Licensed Vocational Nurse 1 (LVN 1) documented, Resident [Resident 1] noted in a verbal exchange with a CNA [CNA 1]. [Resident 1] stated that he perceived the [CNA 1]'s tone as rude and loud and verbalized, He [CNA 1] was rude to me. When I asked him to move the other resident who was yelling, he [CNA 1] talked to me in a loud voice. That's not the way they can talk to me. During a record review of the facility policy and procedure (P&P) titled, Abuse, Prevention, dated, 01/01/24, the P&P indicated, Each resident has the right to be free from verbal, sexual, physical, and mental abuse.Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to remove Certified Nursing Assistant (CNA 1) from resident care areas for over three hours, after he had an altercation with Resident 1. CNA 1 used profanity (irrelevant language and behavior that shows disrespect, used to express anger and frustration), raised his voice, yelled/shouted at Resident 1 in front of other residents when Resident 1 asked CNA 1's help for Resident 2 when Resident 2 was crying out for help in the TV dining area (a common area used for dining and to watch television). CNA 1 continued to provide direct care to his nine (9) other assigned residents until end of his shift. This failure placed Resident 1 at risk for further abuse and nine other assigned residents at risk for abuse/mistreatment from CNA 1.(Cross Reference F600)During a record review of Resident 1's admission record, dated 2/10/26, the record indicated Resident 1 was admitted to the facility on [DATE]. During a record review of Resident 1's Minimum Data Set (MDS, a standardized assessment tool used to evaluate a resident's functional capabilities, health needs, and clinical status), dated 3/6/26, the assessment indicated Resident 1 was able to express ideas and wants; and was able to understand others clearly. The assessment also indicated Resident 1's Brief Interview for Mental Status (BIMS, an assessment for mental status) score was 15 out of 15, indicating the Resident's mental status is intact. During an observation and interview on 3/26/26 at 9:44 a.m. with Resident 1, Resident 1 was lying in his bed. Resident 1 stated he was in facility's TV dining room on a Super Bowl Sunday, when a female resident (Resident 2) began crying out for help. Resident 1 stated he saw a CNA (CNA 1) sitting in the room and he called out to him for help. Resident 1 stated CNA 1 in a rude tone of voice said, We got a problem? Resident 1 stated other staff members had to remove CNA 1 from the TV dining room. Resident 1 stated the whole incident made him feel like people should not talk to residents that way, and that CNA 1 should have been fired. Resident 1 stated CNA 1's tone during the incident was, pissed and loud. During an interview on 3/26/26 at 10:26 a.m., with CNA 1, CNA 1 stated that he had been working at the facility for 10 years and previously had been talked to about being professional on the job. CNA 1 stated on 2/8/26, he was sitting in the tv dining room when Resident 1, while watching television. became upset that Resident 2 was upset and crying. CNA 1 stated Resident 1 wanted him to move Resident 2 out of the TV room, but he told Resident 1 to calm down instead. CNA 1 stated it made Resident 1 more upset. CNA 1 stated he had to raise his voice at Resident 1 because Resident 1 did not back down. CNA 1 stated he should have swallowed his pride instead of raising his voice at Resident 1. CNA 1 stated the Director on Nursing (DON), and the Administrator (ADM) spoke to him regarding the incident same day and that an investigation was needed. During an interview on 3/26/26 at 12:33 pm with Social Services Director 1 (SSD 1), SSD 1 stated on 2/8/26 around noon time, she heard commotion outside her office door, located near tv dining room. SSD 1 stated when she walked into the TV room, she saw CNA 1 and Resident 1 yelling and shouting at each other. SSD1 stated CNA 1 and Resident 1 were exchanging profanities. SSD 1 stated she did not remember exact words that CNA 1 was using, but it was profanity and he was clearly hot headed at that time. SSD 1 stated she and her coworker had to separate them both. SSD 1 stated she stayed with Resident 1 after this incident and Resident 1 was trembling from anger. During a record review of Resident 1's progress notes dated 2/8/26, SSD 1 documented, Resident [Resident 1] had a verbal altercation with one of the CNAs [CNA 1]. During an interview on 3/26/26 at 10:48 a.m. with DON, the DON stated he interviewed CNA 1 after the incident. The DON stated CNA 1 had a loud voice in general and had been told to lower his voice and treat the residents with respect in the past. During a review of facility's Nursing Staffing Assignment and Sign-in Sheet dated 2/8/26 indicated, CNA 1 worked between the hours of 7:00 am thru 3:30 pm. The record indicated CNA 1 served as a direct care staff for nine residents throughout the shift on that day. During a record review of CNA 1's timecard, the timecard indicated that CNA 1 clocked into work on 2/08/26 at 7:03 am and did not leave the facility until 3:32 (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pm, which was over three (3) hours after the incident had occurred between CNA 1 and Resident 1. During an interview and record review on 3/26/26 at 12:59 p.m. with the ADM, facility's investigation report dated 2/10/26 and Abuse prevention policy and procedure (P&P) dated 1/1/24 were reviewed. The ADM stated he was facility's assigned Abuse Coordinator. The ADM first stated, CNA 1 was separated from Resident 1 immediately after the incident and that he did not think CNA 1 was doing anything intentional to Resident 1. ADM stated it's just sometimes people got scared of CNA 1 because he was a big guy. ADM stated facility investigation report indicated the incident occurred on 2/8/26 at around 12 noon. ADM then stated if the incident happened around noon, CNA 1 should have been sent home immediately after the incident and suspended until the investigation was completed for the safety of all residents. The ADM also stated facility's P&P indicated .if the suspected perpetrator is an employee: i. remove employee immediately from the care or vicinity of the resident.