STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055534	A. Building B. Wing	01/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Reutlinger Community	4000 Camino Tassajara Danville, CA 94506

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 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 observation, interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for Resident 1 to assess and maintain psychosocial well-being.This failure had the potential to negatively impact Resident's safety, psychosocial well-being and quality of life. During a record review of admission record, printed on 1/13/26, Resident 1 was admitted on [DATE].During a record review of Resident 1's Minimum Data Set (MDS, an assessment used to guide care), dated 9/23/25, the MDS indicated Resident 1's Brief Interview for Mental Status (BIMS, an assessment used to assess mental status) score was 3 out of 15, which indicated Resident 1's cognition was severely impaired.During an interview on 1/13/26, at 1:02 p.m., Director of Nursing (DON) stated there was no care plan initiated after verbal abuse was observed by Resident 1's Family Representative (FR) 1 on 10/04/2025. DON stated because abuse was not committed by staff or another Resident, a care plan was not initiated. DON stated facility initiated 72-hour monitoring after incident occurred and concluded abuse was unsubstantiated based on Resident 1 having no emotional distress and FR 1 being educated on verbal communication and observations feeding Resident 1 appropriately. DON stated staff educated and instructed FR 1 to feed Resident 1 in dining hall where staff are readily available to assist FR 1 or Resident 1 during feedings, which was communicated and initiated on 10/8/25 during an Interdisciplinary meeting (IDT meeting; a collaborative discussion where various healthcare professionals (doctors, nurses, therapists, social workers, etc.) meet to coordinate and plan a patient's comprehensive care). DON stated the importance of care planning was to serve as the blueprint to resident care and outline plan for treatment and goals. DON stated care plans were typically initiated on admission, and after a change of condition. DON stated there should have been a care plan initiated after incident to serve as a blueprint for resident's care.During a record review on 1/13/26, at 11:47 a.m., of Resident 1's Physician Order, dated 11/7/ 25, indicated Diet: Pureed texture, regular diet, mildly thick liquids consistency, 1:1 feeding.During a record review on 1/13/26, at 11:47 a.m., of Resident 1's Nutritional Observation, dated 10/02/2025 at 2:43 p.m., indicated Resident 1 Requires total assist with food/fluid intake mostly; encouraged resident to self-feed with L hand.During a record review on 1/13/26, at 11:47 a.m., of Resident 1's Acute Change in Mental Status Event, dated 10/04/25 at 10:35 p.m., indicated Resident 1 exhibited emotional distress and verbal abuse observed. Within the Notifications subsection indicated care plan reviewed: no. The progress note within the document indicated, Pt seen tearing up around 6PM today, I overheard [FR 1] repeatedly yelling at pt. He was frustrated that [Resident 1] was unable to feed herself. [FR 1] kept telling [Resident 1] to use her arms to feed herself and that he was tired of having to help her. [FR 1] stormed out of the room, visibly angered.During a record review on 1/13/26, at 11:47 a.m., of Resident 1's Progress notes, dated 10/08/25 at 4:46 p.m., indicated Administrator met with [Resident 1's FR 1] yesterday at 4:00pm to discuss incident of 10/4. [FR1] stated that he was frustrated (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

Printed: 04/02/2026
Form Approved OMB
No. 0938-0391

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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	with her not feeding herself well and stated that she gets stubborn sometimes. [FR 1] stated that he told her that he felt that she should be able to feed herself and acknowledged that he should have been more patient with her, but that when he became frustrated he did leave and stated that he won't be in for her dinners. Administrator reviewed with [FR 1] facility's policies and regulations surrounding elder abuse and reporting, and he acknowledged this and stated it won't happen again. Administrator followed up with [FR 1] via telephone today regarding the 10/4/25 incident to suggest options for ensuring continued safety and well-being of resident. [FR 1] stated that he hasn't been involved with her meals since 10/4/25 and that he still will not come in for those.During a record review on 1/13/26, at 11:47 a.m., of Resident 1's Progress notes, dated 10/09/25 at 7:37 p.m., indicated Nurse went to check resident room intermittently while [FR 1] present, resident was sitting in wheelchair with [FR 1] at a comfortable distance, the meal tray was in front of the resident, [FR 1] assisted resident with meal in a gentle and prompting to encourage feeding.Staff will continue to monitor resident safety and overall wellbeing.During a record review on 1/13/26, at 11:47 a.m., of Resident 1's Care Plan, with a start date of 12/19/2025, indicated Psychosocial well-being, resident has potential to have psychosocial issues due to living in facility.During a record review on 1/13/26, at 11:47 a.m., of the facility's policy and procedure (P&P) titled, Interdisciplinary Team/ Care Plan Process, the P&P indicated, An interdisciplinary assessment team, in coordination with the resident and his/her family or representative, develops and maintains a comprehensive care plan for each resident.The comprehensive care plan has been designed to incorporate identified problem areas.incorporate risk factors associated with identified problems.prevent declines in the resident's functional status and/or functional levels.care plans are reviewed and revised as needed upon identification of a medical change in condition.