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	04/02/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to report an injury of unknown origin for one of three sampled Residents (Resident 1) in a timely manner when Resident 1's left middle fingernail came off on 3/6/26, and no staff knew what had caused it. This failure placed Resident 1 at risk of continued injury, as the lack of timely reporting could delay the investigation and the implementation of necessary protective measures. A review of Resident 1's Face Sheet (FS, a summary document in a resident's medical record that contains key identifying and administrative information), printed on 4/2/26, indicated Resident 1 was admitted to the facility on [DATE]. A review of Resident 1's Progress Notes (PN), subtitled admission History and Physical (H&P), dated 3/26/26, indicated Resident 1 to have diagnoses of Stroke (blood flow to part of the brain stops and causes problems with movement, speaking, or thinking) with left side hemiplegia (paralysis of the arm, leg, and trunk on one side of the body), trouble swallowing, dementia (a condition that affects the brain and makes it hard for a person to remember things, think clearly, or make decisions), and anxiety (a person feels very worried, nervous, or scared, even when there may not be a clear reason). During a phone interview on 4/1/26, at 12:51 p.m., Licensed Vocational Nurse (LVN) 1 stated that on 3/6/26 at approximately 6:50 a.m., Certified Nursing Assistant (CNA)1 told her Resident 1 was bleeding. LVN 1 stated when she went into Resident 1's room and saw Resident 1 lying with their left hand on their chest, there was dried blood on the middle finger, but no active bleeding. She saw that the whole fingernail had come off and was lying on the resident's chest, and there was blood on the nightgown where Resident 1's left hand had been. During an interview on 4/1/26, at 2:57 p.m., CNA1 stated that on 3/6/26 at about 6:30 a.m., she walked into Resident 1's room and saw Resident 1's left hand resting on their chest. There was dark, dried blood covering the middle finger and blood on Resident 1's nightgown. Without touching the resident, she immediately left the room and reported it to the charge nurse. CNA 1 stated she did not know what happened to Resident 1's finger. During an interview on 4/1/26, at 3:56 p.m., Unit Supervisor (US) stated Resident 1's middle fingernail came off on 3/6/26 due to an unknown reason and that it should have been reported. A review of the picture of Resident 1's left hand, taken on 3/6/26, showed that the nail bed of the middle finger was covered with a dark, dried blood clot, and the surrounding skin was red. The picture also showed that Resident 1's left index fingernail was healthy and firmly attached to the nail bed on that date. A review of the picture of Resident 1's left hand, taken on an unknown date, showed that Resident 1's left index fingernail and left small fingernail were missing, and the skin around both nails were torn. During an interview on 4/1/26, at 4:03 p.m., the Administrator (ADM) stated that it was not unusual for a resident's fingernail to come off, so the facility did not report the incident that occurred on 3/6/26 in which resident 1's left middle fingernail was removed. During a phone interview on 4/1/26, at 4:53 p.m., CNA 2 stated that on 3/6/26, at 6:50 a.m., while she was providing care to another resident, she was called into Resident 1's room. CNA 2 stated she was shocked and scared when she entered the room and saw a baseball-sized amount of blood on Resident 1's nightgown, and she did not know what had happened. During a phone interview on 4/1/26, at 12:17 p.m., LVN 2 stated that on 3/9/26, (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	after dinner, he went into Resident 1's room to check on resident and saw that the left index finger was bleeding. He noticed blood in Resident 1's mouth and a small amount of blood on the right hand. LVN 2 stated he began applying pressure to stop the bleeding and did not notice the missing fingernail. A review of Resident 1's PN dated 3/10/26 [0000], indicated that during LVN 1's midnight medication round, she saw Resident 1's left small finger was bleeding and noted that the fingernail had come off. During an interview on 4/1/26 at 4:05 p.m., the ADM stated that since there were multiple incidents involving Resident 1's fingernails coming off, the facility felt that they needed to report it. A review of the facility's Policy and Procedure (P&P) titled, Elder and Dependent Adult Suspected Abuse & Reporting, last revision date on 11/28/21, No. 5 Reporting Requirements indicated, the facility must (1) Ensure that all alleged violations involving.including injuries of unknown source.are reported immediately ., but not later than 2 hours after the allegation is made, .