STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056021	A. Building B. Wing	04/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lone Tree Post Acute	4001 Lone Tree Way Antioch, CA 94509

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview and record review, the facility failed to ensure it kept accurate records of controlled medications (medication with a potential for abuse) as evidenced by: 1. The facility failed to ensure, for residents (1-8), the scheduled (controlled medication, narcotic) medication system was complete (all documents available) and accurate (information matched). The record system included Shipping Manifests (pharmacy delivery receipt), Controlled Substance Accountability Sheets (CDR, Controlled Drug Record), Medication Administration Records (MAR, record of medication administration), and destruction logs. The facility records were incomplete. The facility records were inaccurate. These failures had the potential to result in undetected loss and diversion of scheduled medications. In addition, these failures had the potential to result in preventable medication errors (medication not given as ordered). 2. The facility failed to ensure, between 9/1/23 through 12/31/23, the Consultant Pharmacist identified the scheduled (controlled medication, narcotic) medication system was incomplete (all documents available) and inaccurate (information matched). The record system included Shipping Manifests (pharmacy delivery receipt), Controlled Substance Accountability Sheets (CDR, Controlled Drug Record), Medication Administration Records (MAR, record of medication administration), and destruction logs. The facility records were incomplete. The facility records were inaccurate. These failures had the potential to result in undetected loss and diversion of scheduled medications. In addition, these failures had the potential to result in preventable medication errors (medication not given as ordered).1. During an interview, on 4/9/26 at 9:15 a.m. with Medical Records Director (MRD), MRD was requested to describe the scheduled medication record system. Her description included that scheduled medications were delivered by the pharmacy with a corresponding Shipping Manifest. The Shipping Manifest was the documentation that the scheduled medication was delivered and received by the facility. She further described that the Shipping Manifests were retained by the facility. She stated that the CDR for each scheduled medication prescription was completed by the nurse and retained by the facility. She was requested to provide the Shipping Manifests and CDRs from 9/1/23 through 12/31/23.During a concurrent interview and record review, on 4/9/26 at 9:50 a.m. MRD identified the requested Shipping Manifests and CDRs. MRD stated that not all the requested Shipping Manifests were located.During a concurrent observation and interview, on 4/9/26 at 12:35 p.m. at medication cart (stores medication) A1, Licensed Vocational Nurse (LVN 1) was requested to describe the scheduled medication record system. Her description included scheduled medications were delivered with a Shipping Manifest and a corresponding CDR. The medication was locked in the medication cart. The CDR was filed at the medication cart. The CDR was used to document removal of patient medications. Administration of the medication was documented on the MAR. Completed CDRs were sent for retention. If there were scheduled medications remaining upon discontinuation, the remaining medications and the CDR were sent to the Director of Nursing.Durning a concurrent interview and record review, on 4/10/26 at 10:35 a.m. Assistant Director of Nursing (ADON) identified the Shipping Manifests for the Residents listed below.Resident 1, 4834441 Oxycodone (narcotic pain reliever) 5 mg (milligram) tablet #26 date 12/23/23Resident 2, 4838317 Hydrocodon (narcotic pain reliever) Acetamin (acetaminophen) 5-325 (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
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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	mg #88 date 12/28/23Resident 3, 4836437 Hydrocodone-Acetamin 5-325 mg #18 date 12/26/23ADON stated the facility could not located the corresponding CDRs for the above Shipping Manifests.Continuing the concurrent interview and record review, on 4/10/26 at 10:35 a.m. ADON identified CDRs and corresponding MARs. ADON inspected the CDRs and MARs. ADON stated the CDRs and MARs did not match at the dates and times listed below. Resident 4, 4704215.01 Hydrocodone-Acetamin 5-325 mg #56 date 9/11/239/14/23 08459/17/23 1015Resident 5, 4717560 Hydrocodone-Acetamin 5-325 mg #60 date 9/9/239/20/23 015710/6/23 44010/9/23 170010/11/23 0340Resident 6, 4790551 Hydrocodone-Acetamin 10-325 mg #30 date 11/11/2311/14/23 14011/15/23 085811/19/23 0200Resident 7, 4757090 Oxycodone (narcotic pain reliever) 5 mg tablet #30 date 10/12/2310/14/23 100010/16/23 83010/16/23 213010/22/23 211210/29/23 2000Resident 8, 4763608 Hydrocodone-Acetamin 10-325 mg #30 date 10/18/2311/4/23 183011/5/23 1002Continuing the concurrent interview and record review, on 4/10/26 at 10:35 a.m. ADON acknowledged the facility did not have the Shipping Manifests that match the CDRs as documented above. She further acknowledged that information was inaccurate between CDRs and corresponding MARs as documented above. She stated that it was the facility's expectation that all documents were to be available and accurate. Durning a concurrent interview and record review, on 4/10/26 at 11:07 a.m. ADON identified the policy for Controlled Substances. She reviewed the policy and acknowledged it required the documentation (Shipping Manifests, CDRs and MARs) to be complete and accurate (monitored and reconciled). An administrative record review of the facility's Policy for Controlled Substances (November 2022) showed, Dispensing and Reconciling Controlled Substances, 2. The system of reconciling the receipt (Shipping Manifest) dispensing and disposition of controlled substances includes the following: a. Records of personnel access and usage (CDR, destruction log): b. Medication administration records (MAR): c. Declining inventory records (CDR): and d. Destruction, waste and return to pharmacy records.An administrative record review of the facility's Policy for Controlled Substances (November 2022) showed, Dispensing and Reconciling Controlled Substances, 1. Controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow-up. 2. During an interview, on 4/9/26 at 9:15 a.m. Medical Records Director (MRD) was requested to describe the scheduled medication record system. Her description included that scheduled medications were delivered by the pharmacy with a corresponding Shipping Manifest. The Shipping Manifest was the documentation that the scheduled medication was delivered and received by the facility. She further described that the Shipping Manifests were retained by the facility. She stated that the CDR for each scheduled medication prescription was completed by the nurse and retained by the facility. She was requested to provide the Shipping Manifests and CDRs from 9/1/23 through 12/31/23. During a concurrent interview and record review, on 4/9/26 at 9:50 a.m. MRD identified the requested Shipping Manifests and CDRs. MRD stated that not all the requested Shipping Manifests were located. During a concurrent observation and interview, on 4/9/26 at 12:35 p.m. at medication cart (stores medication) A1, Licensed Vocational Nurse (LVN 1) was requested to describe the scheduled medication record system. Her description included scheduled medications were delivered with a Shipping Manifest and a corresponding CDR. The medication was locked in the medication cart. The CDR was filed at the medication cart. The CDR was used to document removal of patient medications. Administration of the medication was documented on the MAR. Completed CDRs were sent for retention. If there were scheduled medications remaining upon discontinuation, the remaining medications and the CDR were sent to the Director of Nursing. Durning a concurrent interview and record review, on 4/10/26 at 10:35 a.m. Assistant Director of Nursing (ADON) identified the Shipping Manifests for the Residents listed below.Resident 1, 4834441 Oxycodone (narcotic pain reliever) 5 mg (milligram) tablet #26 date 12/23/23Resident 2, 4838317 Hydrocodone (narcotic pain reliever) Acetamin (acetaminophen) 5-325 mg #88 date 12/28/23Resident 3, 4836437 Hydrocodone-Acetamin 5-325 mg #18 date 12/26/23ADON stated the facility could not located the corresponding CDRs for the above Shipping Manifests. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Continuing the concurrent interview and record review, on 4/10/26 at 10:35 a.m. ADON identified CDRs and corresponding MARs. ADON inspected the CDRs and MARs. ADON stated the CDRs and MARs did not match at the dates and times listed below.Resident 4, 4704215.01 Hydrocodone-Acetamin 5-325 mg #56 date 9/11/239/14/23 08459/17/23 1015Resident 5, 4717560 Hydrocodone-Acetamin 5-325 mg #60 date 9/9/239/20/23 015710/6/23 44010/9/23 170010/11/23 0340Resident 6, 4790551 Hydrocodone-Acetamin 10-325 mg #30 date 11/11/2311/14/23 14011/15/23 085811/19/23 0200Resident 7, 4757090 Oxycodone (narcotic pain reliever) 5 mg tablet #30 date 10/12/2310/14/23 100010/16/23 83010/16/23 213010/22/23 211210/29/23 2000Resident 8, 4763608 Hydrocodone-Acetamin 10-325 mg #30 date 10/18/2311/4/23 183011/5/23 1002Continuing the concurrent interview and record review, on 4/10/26 at 10:35 a.m. ADON acknowledged the facility did not have the Shipping Manifests that match the CDRs as documented above. She further acknowledged that information was inaccurate between CDRs and corresponding MARs as documented above. She stated that it was the facility's expectation that all documents were to be available and accurate. Continuing the concurrent interview and record review, on 4/10/26 at 10:35 a.m. ADON was requested to provide the Pharmacist inspection reports for 9/1/23 through 12/31/23. ADON identified the Pharmacy QAPI (Quality Assurance and Performance Improvement, process to improve resident safety and compliance) Report, Q4 2023, October, November, December and Pharmacy QAPI Report, Q1 2024, January, February, March. She inspected the reports and stated they did not document issues with incomplete or inaccurate scheduled medication records. Durning a concurrent interview and record review, on 4/10/26 at 11:04 a.m. ADON identified the Consultant Pharmacist Policy for Pharmacy Services-Role of the Consultant Pharmacist. She stated that it was the facility's expectation that issues with scheduled medications should have been identified. Durning a concurrent interview and record review, on 4/10/26 at 11:07 a.m. ADON identified the policy for Controlled Substances. She reviewed the policy and acknowledged it required the documentation (Shipping Manifests, CDRs and MARs) to be complete and accurate (monitored and reconciled). An administrative record review of the Facility's Policy for Controlled Substances (November 2022) showed, Dispensing and Reconciling Controlled Substances, 2. The system of reconciling the receipt (Shipping Manifest) dispensing and disposition of controlled substances includes the following: a. Records of personnel access and usage (CDR, destruction log): b. Medication administration records (MAR): c. Declining inventory records (CDR): and d. Destruction, waste and return to pharmacy records. An administrative record review of the facility's Policy for Controlled Substances (November 2022) showed, Dispensing and Reconciling Controlled Substances, 1. Controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow-up. An administrative record review, of the Policy for Pharmacy Services-Role of the Consultant Pharmacist (Revision Date April 2019) showed, Policy Interpretation and Implementation, 3. The consultant pharmacist shall provide consultation on all aspects of pharmacy services in the facility, and collaborate with the facility and medical director to:, a. develop, implement, evaluate, and revise (as necessary) the procedures for the provision of all aspects of pharmacy services.

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. Based on observation, interview and record review, the facility failed to follow state Title 22 regulations and ensure the social services department was staff and supervised by a qualified social worker which affected all 98 residents.This failure resulted in all residents receiving social services care from unqualified staff.During an interview on 4/9/26, at 1:24 p.m., with the Social Services Director (SSD), SSD stated they were the primary staff responsible for the social services department. SSD stated they had bachelor's degree in engineering.During a concurrent interview and record review on 4/10/26, at 9:40 a.m., with Human Resources (HR), SSD's two job descriptions both titled, Job Description: Social Services Director, dated 3/2017 and 2/2024 was reviewed. HR stated after review of the job descriptions, both job descriptions indicate a minimum education requirement of Bachelor's Degree in Social Work or Human Services. HR stated they did not have record of SSD's past education but stated SSD had a bachelor's degree in engineering.During an interview on 4/10/26, at 3:50 p.m., with the administrator (ADM), the ADM stated they were aware SSD did not meet the qualifications based the facility job description and the facility did not have a qualified social worker to supervise or direct the department. The ADM stated SSD possessed a bachelor's degree but the subject of study did not meet the job requirement.During a review of facility assessment titled, [Facility] Facility Assessment, dated 2/26, the facility assessment indicated the facility staffing plan included a full-time social worker.During a review of facility policy and procedure (P&P) titled, Social Services, dated 2001, the P&P indicated the facility provides medically related social services.the director of social services is a qualified social worker.During a review of California state regulation titled, Title 22 S72433, the state regulation indicated 'Social Work Service' means those services which assist.a patient and a patient's family to understand and cope with.personal, emotional and related health and environmental problems.During a review of California state regulation titled, Title 22 S72105, the state regulation indicated a Clinical Social Worker was person who is a licensed clinical social worker by the Board of Behavioral Sciences.During a review of California state regulation titled, Title 22 S72437, the state regulation indicated Social Work Service Unit-Staff.the social work service unit shall be organized, directed and supervised by a social worker, who is responsible for supervision of other social work staff, including social work assistants.