

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056327	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/26/2024
NAME OF PROVIDER OR SUPPLIER Walnut Creek Skilled Nursing & Rehabilitation Cent		STREET ADDRESS, CITY, STATE, ZIP CODE 1224 Rossmoor Parkway Walnut Creek, CA 94595	

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)
<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32717</p> <p>Based on interview and record review, for one of one sampled resident (Resident 8), the facility failed to develop and implement written polices and procedures that included re-training and re-education of staff who was accused of abuse before returning to work with residents.</p> <p>This failure had the potential to result in exposing vulnerable residents to abuse.</p> <p>Findings:</p> <p>During a review of Resident 8's Admission Record, the Admission Record indicated Resident 8 was admitted to the facility on ,d+[DATE] with diagnoses that included Alzheimer's disease (a form of dementia, loss of brain function that occurs with certain diseases, affecting one or more brain functions such as memory, thinking, language, judgment, or behavior), depressive disorder (persistent feeling of sadness and loss of interest and can interfere with your daily life), type 2 diabetes mellitus (abnormal blood sugar levels), hemiplegia (paralysis of one side of the body), and hemiparesis (weakness of one side of the body) following cerebral infarction (also called stroke, result of disrupted blood flow to the brain due to problems with the blood vessels that supply it) affecting right dominant side.</p> <p>During an interview on 1/24/24 at 4:14 p.m. with Director of Nursing (DON), DON stated Resident 8 had refused to use briefs, would go to the bathroom unassisted, but would sometimes miss the toilet. DON stated on 1/5/24 Certified Nursing Assistant (CNA) 7 entered Resident 8's room to see a trail of feces on the floor, from the side of the bed going to the bathroom. DON stated from interview with CNA 7, CNA 7 got surprised and might have said something to the effect Oh my God, why is feces all over? Resident 8 got upset and might have assumed CNA 7 was mad for having to do the clean-up.</p> <p>During an interview on 1/25/24 at 12:54 p.m. with Administrator (Admin), Admin stated at the end of the shift on 1/5/24, CNA 7 was given an in-service training and a suspension letter, but CNA 7 refused to sign. Admin stated CNA 7 appeared very distraught and expressed wanting to go home and not wanting to work for the facility anymore. Admin also stated CNA 7 refused to sign acknowledgement of abuse training upon returning to work on 1/13/24.</p> <p>(continued on next page)</p>

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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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 1/25/24 at 12:30 p.m. with CNA 7, CNA 7 stated being upset that the entire facility management had to talk to her at the same time on 1/5/24. CNA 7 stated feeling under so much stress that she felt like her blood pressure was very high. CNA 7 stated not wanting to do anything but go home that day. CNA 7 stated feeling very sad getting suspended despite doing everything to help Resident 8. When asked if she was given abuse training following the incident, and before returning to work, CNA 7 stated No!</p> <p>During a joint interview on 1/25/24 at 1:14 p.m. with Licensed Vocational Nurse (LVN) 8 and Director of Staff Development (DSD), DSD stated CNA 7 should have been given a one-on-one abuse training before returning to work but did not. LVN 8 stated receiving a message that CNA 7 would be in the DSD office before returning to work but did not show up, only to return to work on a Saturday, 1/13/24, when none of the managers were in the facility. DSD stated because CNA 7 was not given abuse training, CNA 7 should not have been permitted to be on the schedule.</p> <p>During a review of the facility's policy and procedure (P&P) titled In-Service Training, Resident Rights, last revised December 2006, the P&P indicated, all employees receive periodic in-service training relative to resident rights and abuse prevention program. They are also required to attend resident rights and abuse prevention program in-service training sessions prior to having any resident contact.</p> <p>During an interview on 1/25/24 at 2:48 p.m. with DON, DON stated staff should be re-trained before returning to work so they would be reminded and made to understand the facility's abuse policy and resident rights.</p> <p>During a follow-up interview on 1/26/24 at 10:50 a.m. with DON, DON stated the facility's policy on abuse did not indicate re-training of staff before returning to work after an alleged abuse incident.</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32717</p> <p>Based on interview and record review, for one of one sampled resident (Resident 8), the facility failed to ensure Resident 8 was protected from further potential abuse when Certified Nursing Assistant (CNA) 7, who was the alleged abuser, continued to work in resident care areas, with access to Resident 8 and other residents after an abuse allegation was reported.</p> <p>This failure had the potential to result in retaliation and further occurrences of abuse.</p> <p>Findings:</p> <p>During a review of Resident 8's Admission Record, the Admission Record indicated Resident 8 was admitted to the facility on ,d+[DATE] with diagnoses that included Alzheimer's disease (a form of dementia, loss of brain function that occurs with certain diseases, affecting one or more brain functions such as memory, thinking, language, judgment, or behavior), depressive disorder (persistent feeling of sadness and loss of interest and can interfere with your daily life), type 2 diabetes mellitus (abnormal blood sugar levels), and hemiplegia (paralysis of one side of the body) and hemiparesis (weakness of one side of the body) following cerebral infarction (also called stroke, result of disrupted blood flow to the brain due to problems with the blood vessels that supply it) affecting right dominant side.</p> <p>During an interview on 1/25/24 at 9:25 a.m. with Licensed Vocational Nurse (LVN) 4, LVN 4 stated Resident 8 was very upset that CNA was yelling and was not very nice. LVN 4 stated Resident 8 asked for another CNA to provide care for the rest of the shift.</p> <p>During an interview on 1/25/24 at 11:09 a.m. with CNA 7, CNA 7 stated she walked into Resident 8's room to find feces all over the bed, the chair where Resident 8 was sitting, and the floor going to the bathroom. CNA 7 stated she said, Why is feces all over the floor? and stated she told Resident 8 to press the call light sooner so CNA 7 could get to the room to help.</p> <p>During an interview and concurrent review on 1/25/24 at 11:40 a.m. with Employee Services Director, CNA 7's timecard dated 1/5/24 was reviewed. ESD stated CNA 7 clocked in at 7:06 a.m. and clocked out for the day at 3:52 p.m.</p> <p>During an interview and concurrent record review on 1/25/24 at 11:58 p.m. with LVN 3, Nursing Staffing Assignment And Sign-In Sheet, dated 1/5/24, for shift starting at 7:00 a.m. and ending at 3:30 p.m., was reviewed. LVN 3 stated as soon as learning about the incident and Resident 8's complaint, CNA 7 was removed from Resident 8's care but continued to work the same assignment.</p> <p>During a follow-up interview on 1/25/24 at 12:30 p.m. with CNA 7, CNA 7 stated she took care of nine other residents in her assignment, answered their call lights, helped them use the bathroom until the end of the morning shift. CNA 7 stated she left the facility at almost 4 p.m. CNA 7 stated she was not sent home before the shift ended because the facility managers wanted to talk to her.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's policy and procedure (P&P) titled Protection of Residents During Abuse Investigation, last revised December 2006, the P&P indicated during abuse investigations, the residents will be protected from harm by having the staff accused of participating in the alleged abuse be immediately reassigned to duties that do not involve resident contact.</p>