

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 09/05/2024
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 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>32717</p> <p>Based on interviews and record review, the facility failed to ensure Resident's right to choose health care and providers of health care services was honored for one of three sampled residents (Resident 3), when Registered Nurse (RN) 1 proceeded to administer medications to Resident 3, after Resident 3 had already refused to receive care from RN 1.</p> <p>This failure resulted in emotional distress for Resident 3.</p> <p>Findings:</p> <p>During a review of Resident 3's Admission Record, the Admission Record indicated Resident 3 was initially admitted to facility during 11/23, and had multiple diagnoses that included, dependence on ventilator (breathing machine), chronic respiratory failure with hypoxia (a long-term condition that makes it difficult for the body to exchange oxygen and carbon dioxide), amyotrophic lateral sclerosis (nervous system disease that weakens muscles and impacts physical function, causes nerve cells in the brain and spinal cord to die, eventually causes the brain to lose ability to control voluntary movements and breathing), anxiety disorder (persistent and excessive worry that interferes with daily activities), and major depressive disorder (persistent feeling of sadness and loss of interest and can interfere with your daily life).</p> <p>During a review of Resident 3's Minimum Data Set (MDS, an assessment tool used to direct resident care) dated 8/16/24, the MDS indicated a Brief Interview for Mental Status (BIMS, a scoring system used to determine the resident's cognitive status regarding attention, orientation, and ability to register and recall information.) score of 15. A BIMS score of 13-15 indicated intact cognitive status.</p> <p>During an interview on 9/5/24 at 10:59 a.m., with Sub-Acute Manager (SAM), SAM stated, Resident 3 had a history of refusing new staff to provide care. SAM also stated Resident 3, having multiple medical issues that included ALS and anxiety, felt new staff were not familiar with Resident 3's daily routine.</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 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/5/24 at 11:12 a.m., with RN1, RN1 stated being assigned to Resident 3 on three separate occasions. RN1 stated, the first time, Resident 3 refused RN1, so RN1 switched assignment with another nurse. RN 1 stated, 8/21/24 was the third time RN1 was assigned to Resident 3. RN1 stated, RN1 entered the room and told Resident 3 she was the assigned nurse for the morning shift. RN 1 stated telling Resident 3 she will be preparing Resident 3's scheduled morning medications and will be right back. RN1 stated Resident 3 said, I don't like you; I want another nurse. RN1 stated she told Resident 3 that she will be back to administer Resident 3's medications.</p> <p>During an interview on 9/5/24 at 11:48 a.m., with Resident 3 through an ALS screen pad, Resident 3 stated RN1 was rude and unprofessional the last time RN1 was assigned to Resident 3's care. Resident 3 stated telling RN1 to call SAM to switch the assignment because Resident 3 did not like RN1. Resident 3 stated RN1 did not call SAM to the room and said, the assignment could not be switched because the other nurses were busy. Resident 3 stated, RN1 went ahead and administered Resident 3's medications despite Resident 3's refusal of RN1 and RN1's care. Resident 3 stated not being able to stay asleep at night because of the incident.</p> <p>During a follow-up interview on 9/5/24 at 12:18 p.m., with RN1, RN1 stated, Resident 3 had asked for a different nurse but told Resident 3 the other nurses were busy. RN1 stated she did not tell SAM because RN 1 did not want to be labeled by other nurses as picky with the assignment. RN1 also stated, the second time she was assigned to Resident 3 on 8/18/24, the Sunday before the 8/21/24 incident, RN1 told the scheduler about the first time Resident 3 had already refused her. RN 1 stated the scheduler said Resident 3 was always like that with new hires and that RN1 should be fine. RN1 stated, looking back, she should have called SAM to switch the assignment, but she did not.</p> <p>During a telephone interview on 9/5/24 at 1:16 p.m., with Certified Nursing Assistant (CNA)1, CNA1 stated being inside Resident 3's room while RN1 administered Resident 3's medication via g-tube (gastrostomy tube, a tube inserted through the abdominal wall, into the stomach. It is used to give drugs and liquid food to the patient).CNA 1 stated, after RN1 had finished giving medications, Resident 3 became teary-eyed. CNA 1 stated Resident 3 wanted to call 911 because RN1 had attacked Resident 3.</p> <p>During an interview on 9/5/24 at 12:35 p.m. with Administrator (ADM), ADM stated RN1 should have respected Resident 3's choice. ADM stated there were enough nurses in the unit for RN1 to switch assignment with. ADM also stated the facility did not have a specific policy and procedure about a resident's right to refuse a staff, it was because it is a basic, standard principle in health care that every resident has the right to refuse staff.</p>		