

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 02/05/2026
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 0571</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Limit the charges against residents' personal funds for items or services for which payment is made under Medicare or Medicaid.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, for one of three sampled residents (Resident 1), the facility failed to ensure Resident 1 was not charged for services covered by Medicare when the facility repeatedly billed Resident 1 and/or Resident Representative (RR) for an extended stay at the facility. This failure resulted in unnecessary billing, inconvenience and potential for emotional distress to RR. During a review of Resident 1's admission Record (AR) printed 2/5/26, the AR indicated Resident 1 was admitted on [DATE] with diagnoses that included chronic kidney disease stage 3 (kidneys have mild to moderate damage and are less able to filter waste and fluid out of your blood), abnormalities of gait (manner of walking) and mobility, depression (a common, serious mood disorder characterized by persistent sadness, loss of interest in activities, fatigue, and physical pain) and transient ischemic attack (short period of symptoms similar to those of a stroke, caused by a brief blockage of blood flow to the brain). The AR indicated Resident Representative (RR) was Resident 1's Guarantor. During a concurrent interview and record review on 2/5/26 at 10:15 a.m. with Case Manager (CM) 1, Resident 1's Referral Information dated 2/17/23 and NOMNC (Notice of Medicare Non-Coverage, a mandatory Centers for Medicare and Medicaid Services-approved form delivered to patients in skilled nursing facilities when their Medicare-covered services are ending, notifying beneficiaries of the last day of coverage, expected financial liability, and their right to an expedited, fast-track appeal) dated 3/17/23 were reviewed. CM 1 stated Resident 1 was a Kaiser member who had full Medicare coverage for 100 days of services upon admission. CM 1 stated the NOMNC indicated Medicare-covered services would end on 3/20/23, with the discharge scheduled for 3/21/23. CM 1 also stated the NOMNC was unsigned and lacked attestation. During a review of Resident 1's Progress Notes, the Progress Notes indicated the following:- On 3/20/23, a Health Status Note indicated Resident 1 had an oxygen saturation of 85 percent (%) in the morning, which remained low after repositioning. Oxygen was administered at two liters via nasal cannula, and the physician was informed.-A late entry Physician/NP (Nurse Practitioner)/PA (Physician Assistant) Note dated 3/20/23, indicated Resident 1 was transferred to the hospital for further evaluation after a desaturation episode (low level of oxygen in the blood).- The Plan of Care Note dated 3/20/23 at 4:16 p.m., indicated Resident 1's Kaiser Case Manager (KCM) sent a NOMNC via email to the Facility Case Manager (FCM), stating that Resident 1 was to be discharged on 3/21/23 to a board and care. KCM was informed the FCM would follow up the next day.- Another Plan of Care Note dated 3/20/23 at 4:32 p.m., indicated KCM had reached out to FCM about Resident 1's board and care and the need for a physician to sign the 602 (mandatory document for seniors entering residential care in California, outlining medical needs). - A Social Services Note dated 3/20/23 at 4:42 p.m., indicated Social Service Assistant (SSA) 1 called the board and care to schedule discharge assessment for Resident 1 but did not receive an answer.- The Health Status Note dated 3/21/23 at 12:49 a.m., indicated Resident 1 returned to the facility from the Emergency Department.- Social</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 056327	Facility ID: 056327 If continuation sheet Page 1 of 5

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<p>F 0571</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Service Note dated 3/21/23 at 11:36 a.m., indicated SSA 1 called the board and care again with no answer.- Social Service Note dated 3/21/23 at 11:38 a.m., indicated SSA 1 told RR that Resident 1's discharge is on hold for two days for observation due to a recent emergency room visit.- Physician/NP/PA Note dated 3/21/23 at 3:50 p.m., indicated Resident 1 was seen by Attending Physician (AP) after hospitalization. AP ordered CBC with diff (a complete blood count measures the number and type of cells in your blood. It may be done as part of a routine exam or to monitor or diagnose health conditions), CMP (Comprehensive Metabolic Panel, a blood test measuring 14 different substances to assess kidney and liver function, blood sugar, and protein levels) and chest x-ray done STAT (critical diagnostics required immediately, within minutes to a few hours). - A Physician/NP/PA Note dated 3/23/23 at 2:40 p.m., indicated AP saw Resident 1 again for lab follow-up and planned to continue current management and monitoring.- Physician/NP/PA Note late entry dated 3/23/23 at 2:50 p.m., indicated Resident 1 should be discharged with home health services and Primary Care Physician (PCP) follow-up.- A Social Service Note dated 3/24/23 at 3:36 p.m., indicated Resident 1 was discharged to board and care on the same day.During a concurrent interview and record review on 2/5/26 at 11:25 a.m. with Business Office Manager (BOM), Resident 1's Census List (insurance coverage information) was reviewed. BOM stated, Resident 1's Payer Change was changed effective 3/21/23, requiring private payment for services from 3/21/23 to discharge on [DATE] due to lack of a secondary insurance. BOM stated the change in payor was based on an unsigned NOMNC dated 3/17/23. BOM acknowledged that the NOMNC should have been signed by Resident 1 and a notice of private pay costs provided, but neither occurred.During an interview on 2/5/26 at 11:36 a.m. with Travelling Business Office Manager (TBOM), TBOM stated the facility should review Resident 1's Emergency Department visit and request authorization for Resident 1's stay upon return. TBOM stated the Admissions Department should review the case and request authorization from Kaiser. TBOM stated the Business Office acts based on insurance information provided by the Admissions Department.During a concurrent interview and record review on 2/5/26 at 11:40 a.m. with Admissions Coordinator (AC), Resident 1's Census List was reviewed. AC stated that if a resident returns from the hospital with remaining Medicare days, coverage should continue automatically. AC also stated the Admissions Department checks coverage for new referrals but not after admission when a resident is sent to the hospital. AC also stated she was unsure about what happened with Resident 1's coverage since he still had remaining Medicare days when the NOMNC was issued.During a concurrent interview and record review on 2/5/26 at 1:50 p.m. with TBOM, the Statement dated 5/1/23 was reviewed. TBOM stated the first bill for Resident 1's three-day Room and Board Charges of \$1,425 was sent to Resident 1's RR on 5/1/23. TBOM stated Kaiser was not billed due to lack of authorization to change the NOMNC to the new discharge date .During an interview on 2/5/26 at 2:15 p.m. with SSA 2, SSA 2 stated the facility should have requested an extension of the NOMNC with a new discharge date after Resident 1's return from the hospital. SSA 2 stated the extension request was sent to Kaiser long after Resident 1 had been discharged , following several attempts by the facility to collect payments from RR.During a review of the Notes Info, undated, the Notes Info indicated Kaiser sent a referral message to the facility on 3/21/23 at 5:54 p.m. that showed Resident 1's discharge date was 3/21/23, with 3/20/23 as the last covered day. The note was the final documented communication between the facility and Kaiser regarding Resident 1's NOMNC. No authorization request was documented by the facility.During a review of the Business Office Activity Report dated 2/5/26, the Activity Report indicated that on 4/14/23, facility Business Office was to generate collection letter # 1 to Resident 1. On 7/19/23, RR called and inquired about Kaiser covering the three-day stay; RR was informed the facility would contact Kaiser due to the absence of an updated NOMNC on file. The Activity</p> <p>(continued on next page)</p>		

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<p>F 0571</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Report further indicated, after multiple communications with Kaiser about RR 1's grievance, collection letters # 2 and #3 were generated and sent to RR, exhausting all collection efforts. Resident 1 passed away on 5/31/25. Numerous communications between RR, Kaiser and facility occurred before the payment was settled by Kaiser to the facility on [DATE]. During a review of the facility's contract with Kaiser titled Healthcare Services Agreement. effective 7/18/22, the contract indicated if the facility provides non-covered or unauthorized services, the resident may be billed only if the resident is notified beforehand and signs a Financial Responsibility Form. If these conditions are not met, the facility cannot charge more than the resident's cost of share as if the services were authorized. Further review of the facility's contract with Kaiser, titled, First Amendment to the Health Care Services Agreement . effective 1/1/23, the contract also required regular communication between Kaiser and the facility regarding each resident, with both parties documenting these communications in their records. During a review of the facility's Policy and Procedure (P&P), titled, Notice of Covered and Non-Covered Services, dated March 2021, the P&P indicated, Residents are notified of the covered and non-covered items and services provided by the facility.</p>		

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<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, for one of three sampled residents (Resident 1), the facility failed to notify Resident 1 and/or Resident Representative (RR) of potential financial liability for an extended stay when the payer source changed to private pay. This failure had the potential to result in uninformed decisions about care, and emotional distress due to unnecessary financial liability. During a review of Resident 1's admission Record (AR) printed 2/5/26, the AR indicated Resident 1 was admitted on [DATE] with diagnoses that included chronic kidney disease stage 3 (kidneys have mild to moderate damage and are less able to filter waste and fluid out of your blood), abnormalities of gait (manner of walking) and mobility, depression (a common, serious mood disorder characterized by persistent sadness, loss of interest in activities, fatigue, and physical pain) and transient ischemic attack (short period of symptoms similar to those of a stroke, caused by a brief blockage of blood flow to the brain). The AR indicated Resident Representative (RR) was Resident 1's Guarantor. During a concurrent interview and record review on 2/5/26 at 10:15 a.m. with Case Manager (CM) 1, Resident 1's Referral Information dated 2/17/23 and NOMNC (Notice of Medicare Non-Coverage, a mandatory Centers for Medicare and Medicaid Services-approved form delivered to patients in skilled nursing facilities when their Medicare-covered services are ending, notifying beneficiaries of the last day of coverage, expected financial liability, and their right to an expedited, fast-track appeal) dated 3/17/23 were reviewed. CM 1 stated Resident 1 had full Medicare coverage for 100 days of services upon admission. CM 1 stated the NOMNC indicated Medicare-covered services would end on 3/20/23, with the discharge scheduled for 3/21/23. CM 1 also stated the NOMNC was unsigned and lacked attestation. During a review of the Plan of Care Note dated 3/20/23 at 16:16, the note indicated Resident 1's Kaiser Case Manager (KCM) sent a NOMNC via email to Facility Case Manager (FCM), stating that Resident 1 was to be discharged on 3/21/23 to a board and care. KCM was informed the FCM would follow up the next day. During a concurrent interview and record review on 2/5/26 at 11:25 with Business Office Manager (BOM), Resident 1's Census List (insurance coverage information) was reviewed. BOM stated, Resident 1's Payer Change was effective 3/21/23, requiring private payment for services from 3/21/23 to discharge on [DATE] due to a lack of secondary insurance. BOM stated the change in payor was based on an unsigned NOMNC dated 3/17/23. BOM acknowledged that the NOMNC should have been signed by Resident 1 and a notice of private pay costs should have been provided, but neither occurred. During a telephone interview on 2/9/26 at 2:07 p.m. with Medical Records Assistant (MRA), MRA stated she could not find a signed NOMNC in Resident 1's chart, also there was no documentation that a notice about the private pay cost was issued to Resident 1. During a review of the facility's contract with Kaiser titled Healthcare Services Agreement, effective 7/18/22, the contract indicated, if the facility provides non-covered or unauthorized services, the resident may be billed only if the resident is notified beforehand and signs a Financial Responsibility Form. If these conditions are not met, the facility cannot charge more than the resident's cost of share as if the services were authorized. Further review of the facility's contract with Kaiser, titled, First Amendment to the Health Care Services Agreement, effective 1/1/23, the contract also required regular communication between Kaiser and the facility regarding each resident, with both parties documenting these communications in their records. During a review of the facility's policy and procedure (P&P) titled Notice of Covered and Non-Covered Services last revised 3/2021, the P&P indicated, residents must receive a notice detailing covered (items and services that are included as part of a covered Medicare/Medical stay and for which a resident may not be charged) and non-covered (those that are not included as part of the Medicare/Medicaid covered stay</p> <p>(continued on next page)</p>		

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<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>or the facility per diem rate, but that the facility offers and for which the resident may be charged) services upon admission and periodically throughout their stay. The notice includes available services and charges for those services.</p>		