STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056327	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Walnut Creek Skilled Nursing & Rehabilitation Cent	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)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that Resident 1 was treated with dignity and respect when staff placed a timer on the resident's table to indicate the duration of feeding and repositioning. This failure created pressure on Resident 1, making the resident feel rushed during meals, which had the potential to compromise Resident1's dignity and safety.Findings:A review of Resident 1's admission Record (AR), printed on 2/12/26, indicated, Resident 1 was admitted to the facility in April 2023, with a diagnosis of Quadriplegia (paralysis of all four limbs).A review of Resident 1's Minimum Data Set, (MDS, a standardized assessment tool used to evaluate a resident's physical, mental, and psychosocial health), dated 12/3/25, indicated, Resident 1's Brief Interview of Mental Status (BIMS, a score that measures cognition) score was 12. A BIMS score of 12 indicates that the resident has moderate cognitive impairment.A review of Resident 1's MDS dated [DATE], indicated, Resident 1 was completely dependent on staff during meals and required staff assistance with feeding. During an interview on 2/11/26 at 10:00 a.m., Certified Nursing Assistance (CNA) 1 stated that they regularly provide care to Resident 1. CNA 1 stated they were aware of the timer that was placed inside the resident's room.During an observation on 2/11/25 at 10:05 a.m., Resident 1 was seen lying in bed with the head of the bed elevated. A small, white-colored, rectangular timer that was palm-sized, with visible red markings on the front display, was seen on the resident's overbed table. Resident 1 stated that the Director of Nursing (DON) put the timer on the table two months ago. Resident 1 stated he felt rushed and worried that eating too fast could cause choking. Resident 1 stated that no one at the facility asked for his permission and/or consent before placing a timer in front of him. Resident 1 stated the last time staff used the timer was about a month ago.During an interview on 2/11/26 at 12:46 p.m., with the DON, DON stated that Resident 1 required two CNAs for one to two hours, and sometimes longer, to provide care. DON stated that Resident 1 had complained that CNAs did not spend enough time on his care. DON stated that after discussion with the Interdisciplinary Team (IDT), the team decided to place a timer in Resident 1's room to make Resident 1 aware of the amount of time CNAs were spending with him. During an interview on 2/12/26 at 11:01 a.m., with the Unit Manager (UM), UM stated that he placed the timer in Resident 1's room in December 2025 after speaking with Resident 1 and obtaining verbal permission from Resident 1. UM was unable to locate any documentation regarding the resident's agreement and/or consent for use of the timer. A review of facility's Policy and Procedure (P&P) titled, Resident Rights, dated February 2021, indicated, Employees shall treat all residents with kindness, respect, and dignity. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to a. dignified existence. be treated with respect, kindness, and dignity. self-determination.

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

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide the necessary activities of daily living (ADL) care for one dependent resident (Resident 2) when Resident 2's face appeared oily, crust-like matter was stuck between the eyelids, and pale, white-color dry matter was noted on the mouth and teeth.Failure to provide grooming and personal hygiene has the potential to affect the resident's physical and psychosocial comfort and wellbeing and could also place the resident at risk for aspiration and infection. Findings:During a review of Resident 2's admission Record (AR) printed on 2/12/25, the AR indicated Resident 2 was admitted to the facility on [DATE].A record review of Resident 2's Minimum Data Set (MDS, an assessment tool to evaluate a resident's physical, mental, and functional status, and help determine the resident's care needs.) dated 12/12/25, indicated, Resident 2's Brief Interview of Mental Status (BIMS, a score that measures cognition) score was 8. A BIMS score of 8 indicates that the resident has moderate cognitive impairment. A record review of Resident 2's MDS dated [DATE], indicated, Resident 2 had diagnoses that included, Traumatic Brain Injury and Dysphagia (difficulty swallowing). The MDS also indicated that Resident 2 was dependent on staff for ADLs including oral hygiene and personal hygiene. During a concurrent observation and interview on 2/11/26 at 10:46 a.m., with Licensed Vocational Nurse (LVN) 1, Resident 2 was observed lying in bed with head of the bed elevated. Gastrostomy tube (GT) feeding (providing nutrition directly into the stomach through a tube for individuals unable to eat by mouth) was ongoing. Resident 2's face appeared oily, pale, white-color dry matter was noted between the upper roof of the mouth and the tongue, as well as between the upper and lower teeth. LVN 1 stated Resident 2 required oral care. LVN 1 explained that Resident 2's oral care involves suctioning, which is the responsibility of a licensed nurse. LVN 1 stated they would provide oral care for Resident 2 immediately.During a concurrent observation and interview on 2/11/26 at 12:07 p.m., with Certified Nursing Assistant (CNA) 2, CNA 2 stated Resident 2's face needed to be washed and shaved.During a concurrent observation and interview on 2/11/26 at 3:28 p.m., with the Infection Preventionist (IP) present, Resident 2 was noted to have crust-like matter stuck between the left upper and lower eye lids. IP stated Resident 2's eyes needed to be cleaned. IP stated that good oral care was important for residents who are dependent on GT feeding to reduce the risk of bacterial growth in the mouth, prevent the development of aspiration pneumonia, and maintain personal hygiene, which supports the resident's dignity and comfort.During an interview on 2/12/26 at 11:20 a.m., with the Unit Manager (UM), UM stated that oral hygiene and personal hygiene should be provided at least twice a day and as needed. The UM emphasized that it was the responsibility of licensed staff and CNAs to ensure residents receive proper ADL care.A review facility's Policy and Procedure (P&P) titled, ADL Care Provided for Dependent Residents, revised in January 2025, indicated, the facility provides assistance to ensure that a resident who is unable to carry out activities of daily living receive necessary services to maintain good nutrition, grooming, personal and oral hygiene.