| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056327 | A. Building<br>B. Wing | 05/20/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Walnut Creek Skilled Nursing & Rehabilitation Cent | 1224 Rossmoor Parkway<br>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) |
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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the comprehensive care plan was reviewed and revised for two out of four sampled residents (Residents 1 and 3). This failure had the potential to result in incorrect or delayed monitoring interventions, miscommunication among staff, and increased risk of harm for residents requiring enhanced behavioral safety supervision.During a review of facility's document titled, admission Record, for Resident 1, printed 5/19/26, the admission Record indicated Resident 1 was admitted to the facility on [DATE] with multiple diagnoses, including schizoaffective disorder (a mental health condition marked by a mix of symptoms including hallucinations, delusions, and mood disorders, such as depression or mania). During an interview on 5/19/26 at 4:30 p.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 stated there was an incident on 4/25/26 between Resident 1 and Resident 3 when Resident 3 became very agitated and suddenly escalated and tried to attack Resident 1. LVN 3 stated staff immediately separated the residents and both Resident 1 and Resident 3 were placed on 1 to 1 monitoring (residents may be placed on one-to-one observation when it is determined that they need additional monitoring for safety or other reasons). During a concurrent phone interview and record review with Behavioral Health Director (BHD) on 5/21/26 at 12:18 p.m., facility's document titled Health Status Note for Resident 1, dated 4/27/26 at 10:34 p.m., was reviewed. BHD stated the Health Status Note indicated Resident 1 was transitioned from 1 to 1 monitoring to every 15 (Q15) minute monitoring on 4/27/26 at 10:34 p.m. BHD stated the Health Status Note is potentially confusing, as it states Resident 1 .remained on continuous Q15-minute close observation. and does not clearly state that Resident 1 was transitioned from 1 to 1 monitoring to Q15 minute monitoring. BHD also stated there was an interdisciplinary team (IDT) meeting to discuss transitioning Resident 1 from 1 to 1 monitoring to Q15 and this meeting was not documented. BHD stated there should have been a clear note in Resident 1's medical record stating that there was an IDT meeting to discuss and that Resident 1 was switched from 1 to 1 monitoring to Q15 minute monitoring to avoid confusion.During a concurrent phone interview and record review on 5/21/26 at 12:18 p.m. with BHD, facility's document titled, Care Plan Report, printed 5/19/26, for Resident 1 was reviewed. BHD stated the Care Plan Report indicated Resident 1 was placed on 1 to 1 monitoring on 4/25/26. BHD stated Resident 1 was transitioned to Q15 minute monitoring on 4/27/26 and this was not reflected on Resident 1's care plan.During an interview on 5/20/26 at 8:35 a.m. with BHD, BHD stated when residents are changed from 1 to 1 monitoring to Q15 monitoring, it should be reflected in the care plan and that helps staff be aware of what's going on with the residents. BHD also stated the purpose of a care plan is to provide appropriate care and interventions to the residents.During a concurrent interview and record review on 5/20/26 at 8:25 a.m. with LVN 2 and BHD, facility's document titled Change in Condition Note x 72 hours, dated 5/18/26 at 4:07 p.m., was reviewed. LVN 2 stated this note indicated Resident 1 was transitioned to Q15 monitoring on 5/18/26 at 4:07 p.m. LVN 2 stated this was done because Resident 1 had been on 1 to 1 monitoring for over 24 hours. During a concurrent interview and policy review on 5/20/26 at 8:40 a.m. with BHD, facility's policy titled, Close Observation One-to-One Monitoring, revised March 2024<br>(continued on next page) |

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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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | was reviewed. BHD stated the policy indicated an interdisciplinary team would meet to discuss transitioning residents from 1 to 1 monitoring to Q15 monitoring. BHD stated he was on vacation on 5/18/26 and staff would have met with the Director of Nursing (DON) in his absence to discuss transitioning Resident 1 from 1 to 1 monitoring to Q15 minute monitoring.During an interview on 5/20/26 at 8:56 a.m. with the DON, DON stated there was not an IDT meeting on 5/18/26 to discuss transitioning Resident 1 from 1 to 1 monitoring to Q15, therefore the Close Observation One-to-One Monitoring policy was not followed.During a review of facility's document titled, admission Record, for Resident 3, printed 5/19/26, the admission Record indicated Resident 3 was admitted to the facility on [DATE] with multiple diagnoses, including schizoaffective disorder.During an interview on 5/20/26 at 9:13 a.m., with DON, DON stated Resident 3 was involved in an altercation with Resident 1 on 4/25/26. DON stated at that time, Resident 3 was a danger to self and to other residents and was put on 1 to 1 monitoring. During a concurrent phone interview and record review on 5/21/26 at 12:41 p.m. with BHD, facility's document titled, Care Plan for Resident 3, print date 5/19/26, was reviewed. BHD stated the document indicated on 4/25/26, Resident 3 would be placed on 1 to 1 monitoring for 72 hours. During a concurrent phone interview and record review on 5/21/26 at 12:41 p.m. with BHD, facility's documents titled, NSG: Skilled Charting, dated 4/25/26 and 4/27/26 and Health Status Note, dated 4/29/26 for Resident 3 were reviewed. BHD stated NSG: Skilled Charting, dated 4/25/26 indicated Resident 3 was started on 1 to 1 monitoring at 5:17 p.m. on 4/25/26. BHD stated NSG: Skilled Charting, dated 4/27/26, indicated Resident 3 was transitioned from 1 to 1 monitoring to Q15 monitoring on 4/27/26 at 9:52 p.m. BHD also stated NSG: Skilled Charting, dated 4/27/26, was a potentially confusing note, as it stated Resident 3 .remains on close 15-minute observation. and it does not clearly state that Resident 3 was transitioned from 1 to 1 monitoring to Q15 monitoring. BHD also stated that there was an IDT meeting to discuss and this was not documented in Resident 3's medical record. BHD stated there was approximately 52 hours between Resident 3 starting 1 to 1 monitoring on 5:17 p.m. on 4/25/26 and transitioning to Q15 monitoring at 9:52 p.m. on 4/27/26 and this was less than the 72 hours stated on the care plan.During a phone interview on 5/20/26 at 11:59 a.m. with Facility Psychiatrist (MD 1), MD 1 stated there should be an IDT meeting to discuss if patients should be transitioned from 1 to 1 monitoring to Q15 minute monitoring and it should be a team decision.During a review of facility's policy and procedure titled, Special Treatment Program (STP) - Care Planning, dated 7/1/25, the policy indicated, .The care plan must be:. Modified as needed based on progress toward goals or change in diagnosis or level of care.During a review of facility's policy and procedure titled, Close Observation One-to-One Monitoring, revised March 2024, the policy indicated, . Once the resident no longer displays the targeted concern, the interdisciplinary team will convene to assess the necessity of continuing the close observation one-to-one monitoring and move to the close observation every 15-minute monitoring. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to obtain daily weights as ordered by the physician for one of four sampled residents (Resident 4). This failure had the potential to lead to fluid overload (a condition where there is too much fluid in the body) in a patient with heart failure (a condition where the heart cannot pump enough blood to meet the body's needs) which could result in Resident 4 needing to be readmitted to the hospital.During a record review of facility's document titled, admission Record, printed 5/22/26, for Resident 4, Resident 4 was admitted to the facility on [DATE] with multiple diagnoses including heart failure, fluid overload (a condition where there is too much fluid in the body) and localized edema (swelling caused by excess fluid trapped in the body's tissues).During a concurrent interview and record review on 5/19/26 at 3:35 p.m. with the Director of Nursing (DON), facility's documents titled Order Summary Report, printed 5/20/26, for Resident 4, was reviewed. DON stated the Order Summary Report indicated there was an order dated 9/3/25 stating Weight Daily in the morning for Heart Failure Monitoring for Resident 4. During a concurrent interview and record review on 5/19/26 at 3:35 p.m. with the DON, facility's document titled Order Summary Report, printed 5/20/26, for Resident 4, was reviewed. DON stated the Order Summary Report indicated there was an order dated 9/3/25 for Furosemide Oral Tablet 20 MG (a medication that helps the body get rid of excess water) stating Give 1 tablet by mouth as needed for weight gain if weight gain of 2 or more pounds in 1 day or 4 or more pounds in 4 days, take 2 tabs every morning for 3 days. DON stated this order is written so the nurses can adjust the medication based on the resident's weight. DON also stated it would be impossible to follow this order without checking Resident 4's weight every day.During a concurrent interview and record review on 5/19/26 at 4:03 p.m. with DON and Registered Dietician (RD), facility's document titled, Treatment Administration Record, dated September 2025, for Resident 4, was reviewed. DON stated the Treatment Authorization Record indicated Resident 4 did not have daily weights entered on 9/4/25, 9/5/25, and 9/6/25. During a concurrent interview and record review on 5/19/26 at 4:03 p.m. with DON and Registered Dietician (RD), facility's documents titled, Medication Administration Record, dated September 2025, for Resident 4, was reviewed. RD stated the Medication Administration Record indicated that Resident 4 had an order for weekly weights and this was completed on 9/4/25. RD and DON confirmed that Resident 4 did not have his weight checked in the morning on 9/5/25 or 9/6/25. During a telephone interview on 5/22/26 at 1:52 p.m., with DON, DON stated it is potentially confusing to have weekly weights on the Medication Administration Record and daily weights on the Treatment Administration Record. DON also stated if there is an order to give Furosemide for weight gain and weights are not checked, then there is a risk that a resident would not get Furosemide and that could lead to more fluid overload and potentially to rehospitalizationDuring a record review of facility's document titled, admission Record, printed 5/22/26, for Resident 4, Resident 4 was sent to an acute care hospital on 9/6/25 at 6:53 p.m.During a review of facility's policy titled, Weight Assessment and Intervention, dated 2001, the policy indicated .Residents are weighed upon admission and at intervals established by the interdisciplinary team. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, facility failed to maintain complete and accurate medical records for three out of four (Residents 1, 2, and 3) reviewed residents. This failure had the potential to lead to incorrect monitoring for residents in the behavioral health unit, potentially leading to harm. During a review of facility's document titled, admission Record, for Resident 1, printed 5/19/26, the admission Record indicated Resident 1 was admitted to the facility on [DATE] with multiple diagnoses, including schizoaffective disorder (a mental health condition that is marked by a mix of symptoms, including hallucinations and delusions and mood disorder symptoms). During a record review of facility's document titled, Close Observation Log, for Resident 1, dated 5/19/26, the Close Observation Log indicated Resident 1 was on monitoring for auditory hallucination (hearing things or voices that are not real) and self-harm. During an observation on 5/19/26 at 2:07 p.m., Licensed Vocational Nurse (LVN) 2 got up from the nursing station, went to the room for Resident 1 and observed Resident 1. LVN 2 then charted that Resident 1 was observed on 5/19/26 at 1:45 pm and 2:00 p.m.During an interview and concurrent record review on 5/19/26 at 2:09 p.m. with LVN 2, facility's document titled, Close Observation Log, dated 5/19/26, for Resident 1, was reviewed. LVN 2 stated she had just entered that Resident 1 had been observed at 1:45 p.m. and 2:00 p.m. and she had made the 1:45 p.m. entry late.In a record review of facility's document titled Close Observation Log, dated 5/19/26, for Resident 1, the entry at 1:45 p.m. on 5/19/26 did not state it was a late entry.During a review of facility's document titled, admission Record, for Resident 2, printed 5/20/26, the admission Record indicated Resident 2 was admitted to the facility on [DATE] with multiple diagnoses, including schizoaffective disorder.In a record review of facility's document titled Close Observation Log, dated 5/19/26, for Resident 2, the Close Observation Log indicated Resident 2 was being monitored because she was a new admission to the behavioral health unit.During a record review on 5/19/26 at 2:12 p.m., facilities document titled, Close Observation Log, for Resident 2, dated 5/19/26 was reviewed. The Close Observation Log on 5/19/26 at 2:12 p.m. indicated that Resident 2 was last observed on at 5/19/26 at 1:30 p.m.During an observation on 5/19/26 at 2:13 p.m., Certified Nursing Assistant (CNA) 2, at the nursing station of the behavioral health unit, charted on the Close Observation Log, dated 5/19/26, that Resident 2 was observed on 5/19/26 at 1:45 p.m. and 2:00 p.m.During an interview on 5/19/26 at 2:14 p.m. with CNA 2, CNA 2 stated she had entered the times for both 1:45 p.m. and 2:00 p.m. at 2:13 p.m.During a record review of facility's document titled Close Observation Log, dated 5/19/26, for Resident 2, the entry on 5/19/26 at 1:45 p.m. did not indicate that it was a late entry.During a concurrent interview and record review on 5/20/26 at 5:18 a.m. with Certified Nursing Assistant (CNA) 1, facility's documents titled, Close Observation Log for Resident 1 and Resident 2, dated 5/19/26, were reviewed. CNA 1 stated the Close Observation Log for Resident 1 and Resident 2, dated 5/19/26, indicated Resident 1 and Resident 2 were observed on 5/20/26 at 5:30 a.m. and 5:45 a.m. and those times are in the future, and the log should not be filled out in advance.During a concurrent interview and record review on 5/20/26 at 8:45 a.m., with Behavioral Health Director (BHD), photographs of facility's documents titled Close Observation Log, dated 5/19/26 at 5:19 a.m., for Residents 1 and 2 were reviewed. BHD stated the photograph of the Close Observation Log, dated 5/19/26, indicated that at 5:19 a.m. it was charted that Residents 1 and 2 were checked on at 5:30 a.m. and 5:45 a.m. BHD stated it is never OK to chart early; it is impossible to know what will happen in the future and it is incorrect documentation. BHD stated that if CNA 1 made a mistake and charted too early, they should have put a line through their initials and then documented that they checked at the correct time.During an interview on 5/20/26 at 9:00 a.m. with the Director of Nursing (DON), the DON stated it is never acceptable to chart too early and if a staff member realized that they charted too early, they should put a line through what they charted and (continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | then document at the correct time.During a concurrent interview and record review on 5/20/26 at 8:15 a.m., with Licensed Vocational Nurse (LVN) 1, facility's document titled, SBAR Summary for Providers, for Resident 1, dated 5/17/26 at 3:16 p.m. was reviewed. LVN 1 stated she wrote the SBAR Summary for Providers, for Resident 1, dated 5/17/26, which states .Primary Care Provider Feedback: Primary Care Provider responded with the following feedback: A. Recommendations: 1:1 Close Observations for 72 hours. LVN 1 stated this was incorrect documentation and that this was not the Primary Care Provider's recommendation. LVN 1 stated putting Resident 1 on one to one monitoring (residents may be placed on one-to-one observation when it is determined that they need additional monitoring for safety or other reasons) was a nursing decision and she should have written the recommendation for one to one monitoring in a different box on the form. During a concurrent interview and record review on 5/20/26 at 8:20 a.m. with BHD, facility's documents titled, Health Status Note, dated 5/20/26, 5/19/26, and Change of Condition Note x 72 hours, dated 5/19/26 were reviewed. BHD stated the documents indicate Resident 1 was on one to one monitoring on 5/19/26 and 5/20/26. BHD stated the documents are incorrect and Resident 1 was on every 15 minute monitoring on those dates.During a concurrent interview and record review on 5/20/26 at 8:25 a.m. with LVN 2 and BHD, facility's document titled Change in Condition Note x 72 hours, dated 5/18/26 at 4:07 p.m., LVN 2 stated she wrote this note and it states, .Q15 minute monitoring continues BHD stated the note is confusing and it should have stated that Resident 1 was no longer on one to one monitoring and Resident 1 was now on every 15 (Q15) minute monitoring. BHD stated this note is unclear medical chart documentation.During a concurrent interview and record review on 5/20/26 at 8:47 a.m., with BHD, facility's document titled, Close Observation Log, dated 5/18/26 and 5/19/26 for Resident 1 was reviewed. BHD stated the Close Observation Log indicated Resident 1 was on one to one monitoring. BHD stated on 5/18/26 after 4:07 p.m. and on 5/19/26, Resident 1 was on Q15 monitoring and the Close Observation Log, dated 5/18/26 and 5/19/26 is incorrect documentation.During a concurrent interview and record review on 5/20/26 at 11:45 a.m. with BHD, facility's document titled Close Observation Log, dated 5/18/26 for Resident 2, was reviewed. BHD stated the document does not indicate if Resident 2 is on one to one observation or Q 15 monitoring and it is incomplete and potentially confusing and is incomplete medical chart documentation. During a review of facility's document titled, admission Record, for Resident 3, printed 5/19/26, the admission Record indicated Resident 3 was admitted to the facility on [DATE] with multiple diagnoses, including schizoaffective disorder.During a concurrent phone interview and record review on 5/21/26 at 12:41 p.m. with BHD, facility's documents titled, NSG: Skilled Charting, dated 4/25/26 and 4/27/26 and Health Status Note, dated 4/29/26 for Resident 3 were reviewed. BHD stated NSG: Skilled Charting, dated 4/25/26 indicated Resident 3 was started on 1 to 1 monitoring at 5:17 p.m. on 4/25/26. BHD stated NSG: Skilled Charting, dated 4/27/26, indicated Resident 3 was transitioned from 1 to 1 monitoring to Q15 monitoring on 4/27/26 at 9:52 p.m. BHD also stated NSG: Skilled Charting, dated 4/27/26, was a confusing note, as it stated Resident 3 .remains on close 15-minute observation. and it does not clearly state that Resident 3 was transitioned from 1 to 1 monitoring to Q15 monitoring and is unclear medical chart documentation.During a concurrent phone interview and record review on 5/21/26 at 12:41 p.m. with BHD, facility's document titled, Change in Condition Note x 72 hours for Resident 3, dated 4/28/26 at 14:27 p.m. was reviewed. BHD stated this note indicated Resident 3 was continuing on 1:1 monitoring on 4/28/26. BHD stated he believed this note was incorrect medical chart documentation.During a review of facility's policy and procedure, titled, Guidelines for Charting and Documentation, dated 2012, the policy indicated, .If an error is made while recording data in the medical record, line through the error with a single line and then record the correct data. If a chart entry must be made late, enter the current date and time and indicate that it is a late entry.During a review of facility's policy and procedure, titled, Guidelines for Charting and Documentation, dated 2012, the policy indicated, Documentation should also include .whenever the level of care changes . |