

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  06/13/2025
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 0557</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 be treated with respect and dignity and to retain and use personal possessions.</p> <p>Based on observation, interview and record review the facility did not respect the right to maintain personal belongings securely for one of 18 sampled residents (Resident 53) when Resident 53's transfer sling, wheel chair and shoes had been missing.</p> <p>This created unnecessary distress for Resident 53's family.</p> <p>Findings:</p> <p>Record review of the document admission Record showed the facility admitted Resident 53 on 4/14/2017. Diagnoses included Intracranial Injury (brain injury).</p> <p>During an interview on 6/11/2025 at 2:25 p.m. Family Member 1 stated she had concerns regarding her son's missing items. She stated she had purchased a personal transfer sling for her son which was missing. In the past, he was missing a shoe which she also replaced for him. Family Member 1 stated she had not been reimbursed by the facility for these items. She stated the money wasn't important but she found it frustrating that staff could not keep her son's belongings in his room.</p> <p>During an interview on 6/12 at 9:20 a.m. Resident 53 was observed in bed nodding to questions, making audible sounds but not interviewable.</p> <p>Record review of the document Progress Notes *NEW* dated 4/21/2025, showed Family Member 1 had met with social services and had grievances which included (1) She personally bought a transfer sling for him - its labeled but has been missing for over 2 months. She has notified nursing. (2) The resident's wheelchair, that has his name labeled on it, had gone missing, nursing eventually found it in subacute. She is upset of the mishandling as it's usually and supposed to be outside of his room against the wall. (3) Resident has a pair of black shoes to prevent his feet from curling and one shoe went missing for about 3 months - she eventually bought a new pair for him. She states she brought the receipt and dropped it off at Social Services for potential reimbursement. Overall, the resident's mother is not concerned about the costs of the items, but more so that she feels there is a lack of care for the resident and his belongings. She got emotional and left before she could cry.</p> <p>Record review of the document Progress Notes *NEW* dated 5/5/2025, showed the ombudsman had visited social services to discuss the missing items. Review of the progress note showed Sling is still missing and black shoes have not been reimbursed.</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 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/10/2025 at 9:30 a.m., Social Services Assistant (SSA) stated she believed Resident 53's family had been reimbursed for the missing items but confirmed there was no documentation in the record which showed it had been done.</p> <p>During an interview on 6/10/2025 at 9:45 a.m., Certified Nursing Assistant 4 (CNA 4) stated Resident 53's transfer sling had been Missing. In a concurrent observation, the facility's transfer sling was hanging in the closet but not Resident 53's personal sling. Two black orthopedic support shoes were observed at the bedside.</p> <p>Record review of the facility document Personal Property, dated August 2022, showed Resident belongings are treated with respect by facility staff, regardless of perceived value.</p> <p>Based on interview and record review, for one of seven sampled residents (Resident 127) who needed help with activities of daily living, the facility failed to ensure Resident 127 was treated with respect and dignity when rolled towels were placed inside Resident 127's briefs.</p> <p>This failure had resulted in Resident 127's emotional distress.</p> <p>Findings:</p> <p>During a review of Resident 127's admission Record (AR), the AR indicated Resident 127 was admitted to the facility in December 2023, with diagnoses that included chronic kidney disease, heart failure and need for assistance with personal care.</p> <p>During a review of Resident 127's Minimum Data Set Assessment (MDS, an assessment tool used to direct resident care) dated 3/13/25, the MDS indicated a Brief Interview for Mental Status (BIMS, is a scoring system used to determine the resident's cognitive status in regard to attention, orientation, and ability to register and recall information) score of 15. A BIMS score of thirteen to fifteen is an indication of intact cognitive status. The MDS also indicated Resident 127 was incontinent of bowel and bladder and was dependent on staff for toileting and personal hygiene.</p> <p>During a joint interview on 6/9/25 at 11:40 a.m., Resident 127 and Resident Representative (RR) 1 both stated Certified Nursing Assistant (CNA) 2 left two rolled towels in Resident 127's briefs. Both stated Resident 127 was very upset about the incident.</p> <p>During an interview on 6/12/25 at 11:09 a.m. with CNA 3, CNA 3 stated, it was sometime last month, when CNA 3 walked into Resident 127's room at the start of the day shift. Resident 127 was very upset about the previous shift and wanted CNA 3 to check Resident 127's disposable brief. CNA 3 stated Resident 127 complained about feeling uncomfortable like something was stuck there. CNA 3 stated she opened Resident 127's brief to find two rolled towels that were wet with urine.</p> <p>During an interview on 6/13/25 at 10:36 a.m. with Unit Manager (UM), UM stated it was inappropriate to place rolled towels in Resident 127's brief. UM stated short cuts such as this was not allowed because it placed Resident 127 at risk for skin breakdown from moisture.</p> <p>(continued on next page)</p>		

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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 6/13/25 at 2:47 p.m. with CNA 2, CNA 2 stated Resident 127 was always wet. CNA 2 stated Resident 127 had always wanted to be dry at all times and CNA 2 placed wash towels, and sometimes paper towel to keep Resident 127 dry.</p> <p>During a review of Resident 127's bladder incontinence care plan (CP), undated, the CP indicated Resident 127 was at risk for incontinence-associated dermatitis. Staff was to provide perineal care (washing the genitals and the anal area) after each incontinent episode, and to offer toileting/change on rising, before and after meals and as needed.</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>Based on interview and record review, for one of four sampled residents (Resident 23) who were transferred to the hospital for acute care, the facility failed to notify Resident Representative (RR) 2 when Resident 23 vomited on 4/5/25. Resident 23's condition worsened and was transferred to the hospital the same day for fever and weakness.</p> <p>This failure had the potential to result in delayed interventions.</p> <p>Findings:</p> <p>During a review of Resident 23's admission Record (AR), the AR indicated Resident 23 was admitted to the facility in August 2022 with diagnoses that included senile degeneration of the brain (age-related cognitive decline, often used interchangeably with dementia) and major depressive disorder (persistent sadness, loss of interest, and difficulty functioning in daily life). The AR indicated Resident Representative (RR) 2 as Resident 23's emergency contact and guarantor.</p> <p>During a telephone interview on 6/9/25 at 9:55 a.m. with RR 2, RR 2 stated Resident 23 became very sick in the evening of 4/5/25. RR 2 stated receiving a call from facility staff when Resident 23 developed a high fever and was very weak that RR 2 strongly requested the facility to transfer Resident 23 to the hospital for further management. RR 2 stated she did not know Resident 23 had vomited early in the morning before getting very sick. RR 2 stated, had the facility called about Resident 23's vomiting, RR 2 would have taken Resident 23 to the hospital sooner.</p> <p>During an onsite interview on 6/10/25 at 2:52 p.m. with RR 2, RR 2 stated Resident 23 had severe infection and would have been gone if RR 2 had not made the decision to take Resident 23 to the hospital in time.</p> <p>During a concurrent interview and record review on 6/12/25 at 8:41 a.m. with Assistant Director of Nursing (ADON), ADON confirmed Resident 23's face sheet indicated RR 2 was Resident 23's Representative. ADON stated, because the change in condition happened early morning, there was chance the facility staff notified RR 2 later in the morning. ADON stated the clinical record did not indicate that RR 2 was notified of Resident 23's vomiting until Resident 23 developed fever of 100.2 degrees Fahrenheit (deg. F) later in the evening.</p> <p>During a review of Resident 23's clinical record, eInteract SBAR Summary for Providers (SBAR) dated 4/5/25 at 06:13 a.m. indicated Resident 23 had a Change in Condition for nausea/vomiting. The SBAR indicated the physician was notified but there was no documentation that RR 2 was notified. Change in Condition (CIC) notes that followed the SBAR dated 4/5/25 with timestamp 06:38 a.m., 16:46 p.m., and 19:07 p.m. did not indicate RR 2 was notified.</p> <p>During an interview on 6/13/25 at 10:13 a.m. with Unit Manager (UM), UM stated the SBAR indicated the AR indicated RR 2 was Resident 23's guarantor and the first emergency contact, so RR 2 should have been notified of the Change in Condition. UM stated it was important to let the representative know should there be a change in resident's condition for them to provide support to the resident.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>Based on observation, interview, and record review, the facility failed to ensure five of five sampled residents (Residents 148, 68, 109, 133, and 140) were provided a clean, sanitary and homelike environment when whitish grime, stains and dried matter were sticking on the surroundings of Residents 148, 68, 109, 133, and 140's mattresses.</p> <p>These failures had the potential to cause discomfort, emotional distress, and spread of disease-causing organisms to Residents 148, 68, 109, 133, and 140.</p> <p>Findings:</p> <p>During a review of Resident 148's admission Record (AR) printed on 6/12/25, the AR indicated, Resident 148 was admitted to the facility in June 2024 with diagnoses that included intracerebral hemorrhage (bleeding into the brain tissue), Alzheimer's Disease (progressive disease that destroys memory and other important mental functions), and unspecified stage pressure ulcer (o localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device) of sacral region.</p> <p>During an observation on 6/9/25 at 11:34 a.m., Resident 148 was awake in bed and had tracheostomy and TF. Resident 148's blue mattress had a whitish grime on the bottom left portion the mattress.</p> <p>During a review of Resident 68's AR, printed on 6/12/25, the AR indicated, Resident 68 was admitted to the facility in February 2025 with diagnoses that included diagnosis of hemiplegia (a condition caused by brain damage or spinal cord injury that leads to paralysis on one side of the body) and hemiparesis (a condition characterized by weakness on one side of the body, making it hard to perform everyday activities like eating or dressing) following cerebral infarction (occurs when blood flow to a part of the brain is blocked, depriving brain cells of oxygen and nutrients, leading to tissue damage or death) affecting left non-dominant side and persistent vegetative state (a condition where a person is alive but has no awareness of themselves or their environment).</p> <p>During an observation on 6/10/25 at 11:21 a.m. in Resident 68 was not in the room. Resident 68's dark blue mattress had whitish stains and dust like powder on the top, middle, and bottom portion of the mattress.</p> <p>During a review of Resident 133's AR printed on 6/13/25, the AR indicated, Resident 133 was admitted to the facility in June 2024 with diagnoses that included traumatic brain injury (brain dysfunction caused by an outside force, usually a violent blow to the head) and persistent vegetative state.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation and interview on 6/10/25 at 12:36 p.m. with Certified Nurse Assistant (CNA) 1, Resident 133's was sleeping in his bed. Resident 133 had tracheostomy (medical procedure that helps a person breathe better) that was hooked up in a ventilator (a type of breathing apparatus, a class of medical technology that provides mechanical ventilation by moving breathable air into and out of the lungs, to deliver breaths to a patient who is physically unable to breathe or breathing insufficiently). Resident 133 also had a tube feeding (TF, medical device used to provide nutrition to people who cannot obtain nutrition by mouth, are unable to swallow safely, or need nutritional supplementation) connected to a feeding pump (a medical device used to deliver nutrition to patients who cannot obtain nutrition by mouth, usually through a feeding tube). Resident 133's dark blue mattress had whitish stain on the right side and bottom portion of the mattress. CNA 1 stated the whitish stain on Resident 133's mattress looked like it was from an old ointment or lotion. CNA 1 stated when CNAs were supposed to wipe down and clean the mattress after performing care to the residents. CNA 1 also stated housekeeping (HK) department was also responsible in daily and deep cleaning residents' rooms per schedule. CNA 1 stated it was important to make sure the mattresses were cleaned and sanitized to prevent unwanted odor from body fluids like urine and bowel movement.</p> <p>During a review of Resident 109's AR printed on 6/12/25, the AR indicated, Resident 109 was admitted to the facility in October 2024 with diagnoses that included anoxic brain damage (An anoxic brain injury occurs when the brain receives no oxygen at all) and persistent vegetative state.</p> <p>During an observation on 6/10/25 at 12:39 p.m., Resident 109 was sleeping in the bed with tracheostomy connected to a ventilator and TF. Resident 109's dark blue mattress had a yellowish dried matter on the upper left side portion of the mattress.</p> <p>During an observation and interview on 6/10/25 at 12:54 p.m. with HK Supervisor in Resident 68 and Resident 109's room. HK Supervisor stated Resident 109's dark blue mattress looked like a dried stain from Resident 109's formula feeding (a liquid food, often called formula, which are given through a special tube to make sure you get the nutrition and water you need). HK Supervisor stated licensed nurses who were responsible for giving the formula to the residents on TF should have called the HK department for spills or if there was a need to clean an area. HK Supervisor further stated HK were also not comfortable wiping down areas like the ventilator and the feeding pump because they were scared, they might pull a plug or tube that could cause distress to the residents. HK Supervisor stated licensed nurses or CNAs should have tried to wipe down a spill or dirt on the mattress immediately to prevent from staining. HK Supervisor stated cleaning and sanitizing the mattresses were very important in preventing infection that could have affected the residents.</p> <p>During a review of Resident 140's AR printed on 6/12/25, the AR indicated, Resident 140 was admitted to the facility in December 2024 with diagnoses that included chronic respiratory failure with hypercapnia (a condition in which the lungs have a hard time loading blood with oxygen or removing carbon dioxide) and history of cardiac arrest (when the heart stops beating suddenly).</p> <p>During a record review of Resident 140's Brief Interview for Mental Status (BIMS, is a scoring system used to determine the resident's cognitive status regarding attention, orientation, and ability to register and recall information. A BIMS score 13 to 15 is an indication of an intact cognitive response.), dated 3/18/25, the record indicated Resident 140's BIMS score was 15.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation and interview on 6/11/25 at 1:20 p.m. with Resident 140, Resident 140 was connected to a ventilator and TF. Resident 140's dark blue mattress had whitish spot stains, brownish drip like stains and powder like grime on the top left top portion of the mattress. Resident 140 stated the mattress was dirty when Resident 140 looked over to her left side. Resident 140 stated no one from the facility had come to clean her mattress. Resident 140 stated she preferred her mattress clean.</p> <p>During an interview on 6/13/25 at 11:35 a.m. with Infection Preventionist (IP), IP stated it was important to make sure residents' mattresses were maintained clean and disinfected per schedule to eliminate microorganisms such as bacterial infection.</p> <p>During an interview on 6/13/25 at 1:40 p.m. with the Director of Nursing (DON), the DON state the staff should have cleaned and disinfected the mattress after they have provided personal care to a resident. The DON stated this will prevent increase in the infection rate. The DON stated the residents also have the rights to have a clean and homelike environment including clean mattresses.</p> <p>During a record review of the facility's document, titled, Daily Patient Room Cleaning, revised on 9/5/17, the document indicated, Every room to be cleaned is that resident's home - treat it as such .The gold of cleaning is Infection Control .</p> <p>During a record review of the facility's policy and procedure (P&amp;P), titled, Homelike Environment, dated February 2021, the P&amp;P indicated, Residents are provided with a safe, clean, comfortable and homelike environment .The facility staff and management maximizes, to extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include .a. clean, sanitary and orderly environment .</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>Based on observation, interview, and record review, the facility failed to ensure two of three sampled residents (Residents 60 and Resident 142) received necessary care to maintain good grooming and personal hygiene when Resident 60 and Resident 142 had long fingernails.</p> <p>This failure resulted in Residents 60 and Resident 142 at risk for skin irritation and infection.</p> <p>Findings:</p> <p>During a review of Resident 60's admission Record (AR), printed on 6/12/25, the AR indicated, Resident 60 was admitted to the facility in July 2024 with diagnosis that included hemiplegia (a condition caused by brain damage or spinal cord injury that leads to paralysis on one side of the body) and hemiparesis (a condition characterized by weakness on one side of the body, making it hard to perform everyday activities like eating or dressing) following cerebral infarction (occurs when blood flow to a part of the brain is blocked, depriving brain cells of oxygen and nutrients, leading to tissue damage or death) affecting right dominant side.</p> <p>During a record review of During a review of Resident 60's Activities of Daily Living (ADLs, are those needed for self-care and mobility and include activities such as bathing, dressing, grooming, oral care, ambulation, toileting, eating, transferring, and communicating) care plan initiated 8/16/24 and revised on 2/21/25, the care plan indicated Resident 60 had ADL self-care performance and dependent to staff. Resident 60's care plan had an intervention to check the nail length and trim on bath day as necessary.</p> <p>During an observation between 6/9/25 at 10:30 a.m., Resident 60 was sleeping in bed while hooked up to a ventilator (a device used medically to support or replace the breathing of a person) and feeding tube (a medical device used to provide nutrition to people who cannot obtain nutrition by mouth, are unable to swallow safely, or need nutritional supplementation). Resident 60 had long fingernails.</p> <p>During a follow-up observation and interview on 6/12/25 at 9:30 a.m. with Restorative Nurse Assistant (RNA) 1, who was also working on the floor as Certified Nurse Assistant (CNA), RNA 1 stated Resident 60's fingernails were long and needed to be trimmed. RNA 1 stated she noticed Resident 60's fingernails were long the other day. RNA 1 stated she was going to trim Resident 60's nails but could not find a clipper in the room.</p> <p>During a review of Resident 142's admission Record (AR), printed on 6/12/25, the AR indicated, Resident 142 was admitted to the facility in May 2025 with diagnoses that included malignant neoplasm (cancer) of tongue, systemic lupus erythematosus (chronic systemic rheumatic disease that can involve joints, kidneys, skin, mucous membranes, and blood vessel walls), and need for assistance with personal care.</p> <p>During a record review of Resident 142's Brief Interview for Mental Status (BIMS, is a scoring system used to determine the resident's cognitive status regarding attention, orientation, and ability to register and recall information. A BIMS score 8 to 12 is an indication of moderate cognitive impairment.), dated 5/22/25, the record indicated Resident 142's BIMS score was 12.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a record review of During a review of Resident 142's Activities of Daily Living care plan initiated 5/16/25 and revised on 5/20/25, the care plan indicated Resident 142 had ADL self-care performance and required one to two persons assist to start and complete most ADL task including hygiene and grooming.</p> <p>During an observation and interview on 6/10/25 at 12:24 p.m. with Resident 142, Resident 142 had long fingernails. Resident 142 who had a tracheostomy (a surgical procedure that creates an opening in the neck to access the trachea and insert a tube, called a tracheostomy tube to help with breathing) mouthed words and stated she preferred hair nails shorter and nobody from the staff had offered to trim her nails.</p> <p>During a concurrent observation and interview on 6/12/25 at 9: 28 a.m. with RNA 1, RNA 1 stated she was also assigned as a CNA to Resident 142. RNA 1 stated Resident 142's fingernails were long. RNA 1 stated she was going to speak with Resident 142 in Spanish to understand Resident 142 clearly. RNA 1 confirmed Resident 142 preferred her fingernails shorter.</p> <p>During a follow up interview on 6/12/25 at 9:32 a.m. with RNA 1, RNA 1 stated keeping Resident 60 and Resident 142's fingernails short was important and necessary to prevent them from becoming dirty and to avoid bacterial growth.</p> <p>During an interview on 6/13/25 at 11:43 a.m. with Director of Staff Development (DSD), DSD stated CNAs, and licensed nurses were responsible in maintaining residents' fingernails. DSD stated CNAs should have reported to licensed nurses if a diabetic resident needed a nail trim. DSD stated having clean and trimmed fingernails could give residents self-esteem and prevent skin issues.</p> <p>During an interview on 6/13/25 at 1:51 p.m. with the Director of Nursing (DON), the DON stated nail care should have been provided to Resident 60 and Resident 142 to maintain good hygiene, promote dignity and self-respect, and to prevent risk for infections.</p> <p>During a review of the facility's undated policy and procedure (P&amp;P), titled, Fingernails/Toenails, Care of, the P&amp;P indicated, The purpose of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections . 1. Nail care includes cleaning and trimming regularly .2. Proper nail care aid in the prevention of skin problems around the nail bed .</p> <p>During a review of the facility's P&amp;P titled, ADL Care Provided for Dependent Residents, revised in January 2025, the P&amp;P indicated, The facility provides assistance for residents unable to carry out ADLs .To ensure facility staff provide a necessary care and services that are based on the resident's comprehensive assessment, 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 .</p> <p>During a review of the facility's P&amp;P titled, ADL Care Provided for Dependent Residents, revised in February 2021, the P&amp;P indicated, Each resident shall be cared for manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem .When assisting with care, residents are supported in exercising their rights. For example, residents are .groomed as they wish to be groomed (hair styles, nails, facial hair, etc.) .</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>Based on observation, interview and record review, the facility failed to provide appropriate treatment and services to prevent further decrease in range of motion when Restorative Nursing Assistant (RNA) services ( RNA program, focuses on nursing interventions that help residents in long-term care maintain or regain their ability to perform activities of daily living (ADLs) and improve their overall well-being) to three of four sampled residents (Residents 60, 120 and 126) who were reviewed for range of motion/mobility needs, as indicated in the physician orders and comprehensive care plan.</p> <p>This failure had the potential to result in further decline in range of motion.</p> <p>Findings:</p> <p>1. During a review of Resident 60's admission Record (AR), printed on 6/12/25, the AR indicated, Resident 60 was admitted to the facility in July 2024 with diagnosis of hemiplegia (a condition caused by brain damage or spinal cord injury that leads to paralysis on one side of the body) and hemiparesis (a condition characterized by weakness on one side of the body, making it hard to perform everyday activities like eating or dressing) following cerebral infarction (occurs when blood flow to a part of the brain is blocked, depriving brain cells of oxygen and nutrients, leading to tissue damage or death) affecting right dominant side.</p> <p>During a review of Resident 60's Order Summary Report, dated 6/12/25, the Order Summary Report had an active physician order to provide RNA program three times a week for both upper and lower extremities.</p> <p>During a review of Resident 60's Minimum Data Set (MDS, an assessment tool used to direct resident care) dated 5/8/25, the MDS indicated Resident 60 had functional limitation in range of motion on both sides of the upper and lower extremity.</p> <p>During an observation 6/9/25 at 10:30 a.m., Resident 60 was sleeping in bed while hooked up to a ventilator (a device used medically to support or replace the breathing of a person) and feeding tube (a medical device used to provide nutrition to people who cannot obtain nutrition by mouth, are unable to swallow safely, or need nutritional supplementation).</p> <p>2. During a review of Resident 120's admission Record (AR), printed on 6/12/25, the AR indicated, Resident 120 was admitted to the facility in December 2024 with diagnoses that included cerebral infarction and persistent vegetative state (a condition where a person is alive but has no awareness of themselves or their environment).</p> <p>During a review of Resident 120's range of motion care plan initiated 2/8/25, the care plan indicated Resident 120 had limited range of motion related to contracture (a condition where muscles, tendons, or skin shorten and tighten, causing reduced range of motion and stiffness in a joint or body part) and Resident 120 was at risk for further decline of range of motion, stiffness, deformity, and joint pain. The care plan also indicated an intervention for Resident 120 to participate in RNA program three times weekly for bilateral upper and lower extremities passive range of motion (PROM, the movement of a joint through its range of motion by an external force, like a therapist or a machine, without any effort from the individual, who remains relaxed).</p> <p>(continued on next page)</p>

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 6/9/25 at 10:51 a.m., Resident 120 was awake in bed. Resident 120 was also connected to a ventilator and feeding tube. Resident 120 had stiffness on bilateral upper extremities.</p> <p>During a concurrent record review and interview on 6/12/25 at 9:16 a.m., with RNA 1, the facility's document titled, Restorative Nursing Program Master List/Schedule dated from 5/26/25 to 6/8/25 was reviewed. RNA 1 stated Resident 120 and Resident 60 only received two sessions of PROM on the week of 5/26/25 to 6/1/25 and one session on the week of 6/2/25 to 6/8/25 instead of three times a week. RNA 1 stated she was unable to consistently provide RNA program to Resident 60 and Resident 120 because there were times that she had been re-assigned as a Certified Nurse Assistant (CNA) to work on the floor when the facility was short of staff. RNA 1 stated it was very important for Resident 60 and Resident 120 to receive PROM for muscle strengthening. RNA 1 stated not providing PROM had the risk for Resident 60 and Resident 120 in becoming weaker.</p> <p>During a record review of the facility's policy and procedure (P&amp;P), titled, Range of Motion Exercises, dated October 2010, the P&amp;P indicated, The purpose of this procedure is to exercise the resident's joints and muscles .Verify that there is a physician's order .Review the resident's care plan .</p>

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident must receive and the facility must provide necessary behavioral health care and services.</p> <p>Based on observation, interview, and record reviews, the facility did not provide immediate necessary care and investigate potential self-harm for two of 18 sampled residents (Residents 101 and 210). Staff did not implement safety measures when Residents 101 and 210 expressed feeling suicidal. Staff did not investigate the cause of Resident 210's wrist wound.</p> <p>These failures have the potential to not ensure the residents' safety and/or promote and maintain the residents' highest practicable physical, mental, and psychosocial well-being.</p> <p>Findings:</p> <p>Record review of the document admission Record showed the facility admitted Resident 101 on 11/29/2024. Resident 101's diagnoses included depression.</p> <p>Record review of the document MDS 3.0 Nursing Home Quarterly (NQ) Version 1.19.1 (resident assessment) dated 5/29/2025, showed Resident 101 was alert and oriented to the day, month, and year.</p> <p>Record review of the document Progress Notes dated 6/13/2025, showed Resident 101 required some assist with ADLs (activities of daily living), was able to move all extremities and could feed herself.</p> <p>Record review of the document Progress Notes *NEW* dated 5/27/2025 showed Resident 101 had a weight loss of 28 pounds over the past 6 months.</p> <p>Record review of the document Progress Notes dated 6/11/2025 showed Resident 101 reported to Licensed Vocational Nurse 1 (LVN 1) she was feeling suicidal.</p> <p>On 6/12/2025 at 1:10 p.m. Resident 101 was observed asleep in bed with a gait belt hanging on the wall across from her bed. (gait belt: long narrow belt used by physical therapy which is placed around the resident's waist and used to support the resident during transfer/ambulation).</p> <p>During an interview on 6/12/2025 at 1:15 p.m., Resident 101's nurse, Licensed Vocational Nurse 2 (LVN 2) stated she had no concerns regarding Resident 101's behaviors or mental state. LVN 2 stated at times Resident 101 required encouragement to take her medication. She stated Resident 101 was depressed and needed to be Encouraged but had no concerns regarding her mental health status.</p> <p>During an interview on 6/12/2025 at 3:05 p.m. LVN 1 stated the physical therapist had reported to her Resident 101 was depressed. On 6/11/2025 LVN 1 then met with Resident 101 who reported she wanted To kill herself. LVN 1 reported this information to the Unit Manager and took no further action. LVN 1 confirmed there was no 1:1 monitoring form in the clinical record which would have shown staff remained with her in the room.</p> <p>During an interview on 6/12/2025 at 4:20 p.m., the Unit Manager (UM) stated the speech therapist had reported to him Resident 101 was depressed and Refusing to work with rehab or get out of bed. The UM stated he then sent an email/request for a psychological referral.</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the document Clinical Documentation MH/BH dated 6/9/2025, showed Resident 101 had been seen by mental health and Acknowledged feelings of depression . There was no documentation regarding suicidal thoughts. The mental health assessment on 6/9/2025 took place two days prior to Resident 101 stating she was feeling suicidal.</p> <p>During an interview on 6/12/2025 at 4:18 p.m. Resident 101 stated she thinks about suicide Daily.</p> <p>Record review of the document Care Plan Report dated 2/25/2025 showed the plan of care for Resident 101 was to be free from discomfort related to antidepressant therapy. There was no plan for suicidal ideation.</p> <p>During an interview on 6/13/2025 at 11:15 am, the UM stated, when a resident reports to staff they are suicidal staff should Immediately provide one-on-one monitoring, remove all sharp objects from the room, call the doctor and family. The UM stated a Social Service evaluation would need to be completed and the resident should be sent out to the hospital. The UM stated these steps were necessary to prevent the resident from Harming themselves.</p> <p>Record review of the document admission Record showed the facility admitted Resident 210 on10/4/2023. Resident 210's diagnoses included depression.</p> <p>Record review of the document Progress Notes *NEW* (Physician/NP/PA note) dated 9/18/2024 showed Patient does have the capacity to make medical decisions.</p> <p>Record review of the document Progress Notes *NEW* (doctor's progress note) dated 5/18/2025 showed Resident 210 had Normal Range of Motion and was alert and oriented to person, place and time.</p> <p>Record review of the document Care Plan Report dated 9/16/2024 showed Resident 210 had Body weakness and a goal was to Provide supportive care, assistance with mobility (transfer/ambulation/bed mobility). Further review of the care plan dated 8/28/2024 showed Resident 210 was At risk for self-harm due to resident being observed with placement of scissors on wrist and stated to licensed nurse I want to die.</p> <p>Record review of the document Progress Notes *NEW* dated 8/28/2024 showed licensed staff had gone into Resident 210's room to administer medication. Resident 210 was Crying holding scissors on his left wrist. Staff removed the scissors, notified the doctor and sent Resident 210 to the hospital.</p> <p>Record review of the document SBAR Communication Form dated 5/8/2025 showed Licensed Vocational Nurse 3 (LVN 3) documented he had observed a skin tear on Resident 210's right wrist area. The doctor had been notified, and treatment orders were provided. There was no documentation which showed staff investigated how the tear happened.</p> <p>During an interview on 6/10/2025 at 9:52 a.m. Resident 210 was observed moving from lying to sitting position at the bedside independently. Resident 210 stated he could Use more mental health support as he had Screaming episodes which the staff knew about because they happened A lot.</p> <p>During an interview on 6/10/2025 at 11:30 a.m., LVN 1 stated Resident 210 had Behaviors, anxiety, depression and he will Yell out and cry. LVN 1 stated the behaviors would occur Every other day and her typical response was to go into his room and provide reassurance.</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the document Social Service Note dated 6/10/2025 showed the SSA had met with Resident 210, and he was Very depressed and said that he thought he was running out of energy and can't do this anymore. He stated a few months ago he was Using a butter knife to mark his arm. When asked if he intended to harm himself, Resident 210 stated If I were to ever say something like that, this is the closest I've ever been.</p> <p>During an interview on 6/10/2025 at 2:15 p.m., the Social Services Assistant (SSA) stated she had spoken with Resident 210 earlier in the day and was concerned because he mentioned Something about hurting himself. The SSA stated she emailed the staff, so everyone was aware of the situation. The SSA stated she was not aware of Resident 210's yelling and crying behaviors. In a concurrent interview the Social Services Director (SSD) stated clinical nursing staff initiate psych consults (referrals for mental health services) and not social work. However, the SSD stated it would have been good for nursing to have notified social services regarding the behaviors as they could have been able to provide More frequent visits with him.</p> <p>During an interview on 6/10/2025 at 2:30 p.m. Resident 210 stated he was Emotionally unstable and needed to Talk to someone. Resident 210 stated he was having trouble Dealing with life and was trying to Get control of himself as sometimes Bad thoughts sneak in.</p> <p>During an interview on 6/10/2025 at 2:45 p.m. the Director of Nursing (DON) stated if a resident expresses a desire to hurt themselves, staff are expected to look for things in the room that could be used for harming oneself, review the medications, increase monitoring of the resident and make a referral for psychological support. The DON stated he had not been made aware of Resident 210's behaviors.</p> <p>On 6/10/2025 at 3:15 p.m. Resident 210 was observed in his room without staff present with a floor fan chord on the floor, TV chords on the walls and a plastic bag draped over the entrance door's handle.</p> <p>During an interview on 6/10/2025 at 4 p.m., LVN 3 stated he was not sure how the cut happened, and he didn't know If he was trying to kill himself or not.</p> <p>During an interview on 6/12/2025 at 1:55 p.m., the Assistant Director of Nursing (ADON) stated, if a resident reports they are suicidal, even if they say they can't go through with it, staff must Act. The ADON stated the resident would require One to one monitoring and staff notify the doctor, administrator, social services, family or responsible party.</p> <p>Record review of the document Suicide Threats dated 12/2007 showed Resident suicide threats shall be taken seriously and addressed appropriately. A staff member shall remain with the resident until the nurse supervisor/charge nurse arrives to evaluate the resident. After assessing the resident in more detail, the nurse supervisor/charge nurse shall notify the resident's attending physician and responsible party and shall seek further direction from the physician. All nursing personnel and other staff involved in caring for the resident shall be informed of the suicide threat and instructed to report changes in the resident's behavior immediately.</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to ensure for two out of 31 (Residents 138 and 49), were routinely given pain medications without clarification of physician's order and adequate indications.</p> <p>For Resident 138, he was regularly given Norco oral tablet (medication used to treat moderate to severe pain) 5-325 milligram (mg) tablet to be administered one tablet three times a day, and Tylenol Extra Strength oral tablet (medication used to treat minor pain and fever reducer) 500 mg tablet to be administered one tablet two times a day.</p> <p>For Resident 49, was regularly given Acetaminophen 325 mg tablet to be administered two tablets via gastric tube (g-tube - surgically tube placed through the abdominal wall used to administer fluid, nutrition, and medication) two times a day.</p> <p>These failures had a potential to affect Resident 138 and 49's health and safety due to regular use of pain and fever reducing medications without pain manifestations or could masks symptoms of illnesses.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. During a review of Resident 138's admission Record (AR), indicated Resident 1 was admitted on [DATE] with diagnoses that included end stage renal disease (chronic and advance stage of kidney disease). Resident 138's Minimum Data Set (MDS - resident assessment tool) dated 05/19/25, 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 13, (BIMS score of 13 - 15, cognitively intact).</li> </ol> <p>During a review of Resident 138's physician's Order Summary Report for the month of 06/2025 indicated the following medications:</p> <ol style="list-style-type: none"> <li>1. Norco Oral Tablet 5-325 MG (Hydrocodone-Acetaminophen) Give 1 tablet by mouth three times a day for pain, with an order date of 02/13/25.</li> <li>2. Norco Oral Tablet 5-325 MG (Hydrocodone-Acetaminophen) Give 1 tablet by mouth every 6 hours as needed for Moderate to severe pain. Hold for sedation or RR [respiratory rate] less than 12. NTE [not to exceed] 3 gm per day, with an order date of 02/13/25</li> <li>3. Tylenol Extra Strength Oral Tablet 500 MG (Acetaminophen) Give 1 tablet by mouth two times a day for pain NTE 3 grams in 24 hours, with an order date of 09/9/24.</li> <li>4. Tylenol Acetaminophen Oral Tablet 500 MG (Acetaminophen) Give 1 tablet by mouth every 4 hours as needed for mild pain. NTE [not to exceed] 3 grams per day, with an order date of 08/22/24.</li> <li>5. Pain - Monitor For Presence of Pain - Verbal/Non-verbal Every Shift Using Pain Scale 0 - 10. 0 = No Pain. 1 - 2 = Least Pain. 3 - 4 = Mild Pain. 5 - 6 Moderate Pain .</li> </ol> <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent observation and interview on 06/11/25 06:46 a.m., with Licensed Vocational Nurse (LVN) 6, LVN 6 stated she would prepare Resident 138's medications. Resident 138's medications included Norco oral tablet 5/325 mg tablet. LVN 6 asked Resident 138, if he have any pain, and Resident 138 did not respond. LVN 6 administered Resident 138's medications including Norco oral tablet 5/325 mg tablet.</p> <p>During a review of Resident 138's medication administration record (MAR) for the months of 02/2025 through 06/2025, the MAR indicated: Norco oral tablet 5-325 mg tablet, give 1 tablet by mouth three times a day for pain, was scheduled for administration at 6:00 a.m., 2:00 p.m., and 11:00 p.m. Resident 138 was given Norco oral tablet 5-325 mg tablet three times a day as scheduled, and the pain level was written as 0 most of the time. Resident 138's Tylenol Extra Strength oral tablet 500 mg, give 1 tablet by mouth two times a day for pain, was scheduled at 9:00 a.m. and 5:00 p.m. Resident 138 was given Tylenol Extra Strength oral tablet given two times a day as scheduled, and the pain level was written at 0 most of the time. The ordered Pain - Monitor For Presence of Pain - Verbal/Non-Verbal Ever Shift Using Pain Scale indicated 0 or no pain most of the time.</p> <p>During a concurrent interview and record review on 06/11/25 at 03:12 p.m., with LVN 4, LVN 4 stated Resident 138 could report to the staff if he was having pain. LVN 4 reviewed Resident 138's physician's order summary report for the month of 06/25, LVN 4 stated Resident 138's Norco oral tablet 5-325 mg tablet and Tylenol Extra Strength oral tablet 500 mg tablet were ordered to be administered routinely so it would be administered as ordered. LVN 4 stated that Norco oral tablet 5-325 mg tablet and Tylenol Extra Strength 500 mg tablet would be administered routinely even if Resident 138 did not report having any pain. LVN 4 stated the Norco and Tylenol were given to Resident 138 to control pain, LVN 4 reviewed Resident 138's diagnoses, and LVN 4 stated Resident 138 did not have a chronic pain diagnosis.</p> <p>During a concurrent interview and record review on 06/13/25 at 12:19 p.m., with Director of Nursing (DON), DON reviewed Resident 138's physician's order summary report and MAR, DON stated the nurse needs to assess Resident 138 if he was having pain. DON stated just because Norco oral tablet 5-325 mg tablet and Tylenol Extra Strength 500 mg tablet were ordered routinely, the nurses should not administer the pain medications if Resident 138 was not having pain. DON stated the nurses should have clarified the pain medication orders with the physician for Resident 138.</p> <p>2. During a review of Resident 49's AR, the AR indicated Resident 49 was admitted on [DATE] with diagnoses that included persistent vegetative state (chronic state of brain dysfunction in which a person shows no signs of awareness).</p> <p>During a review of Resident 49's Order Summary Report for the month of 6/2025 indicated:</p> <ol style="list-style-type: none"> <li>1. Acetaminophen Tablet 325 MG give 2 tablets via G-Tube two times a day for pain management. APAP [Acetaminophen] NTE [not to exceed] 3 grams/day from all sources with an order date of 5/10/24.</li> <li>2. Acetaminophen Tablet 325 MG Give 2 tablets via G-Tube every 4 hours as needed for Moderate breakthrough pain, scale 4 - 6 APAP [Acetaminophen] NTE [not to exceed] 3 grams/day from all sources with an order date of 5/10/24.</li> <li>3. Pain - Monitor For Presence of Pain - Verbal/Non-verbal Every Shift Using Pain Scale 0 - 10. 0 = No Pain. 1 - 2 = Least Pain. 3 - 4 = Mild Pain. 5 - 6 Moderate Pain .</li> </ol> <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent observation and interview on 06/11/25 at 08:26 a.m., with LVN 7, LVN 7 stated she would prepare Resident 49's medications that included Acetaminophen 325 mg tablet, give two tablets administered via g-tube. LVN 7 administered Resident 49's medications including two tablets of Acetaminophen 325 mg tablet.</p> <p>During a review of Resident 49's MAR for the months of 3/2025 and 6/2025, the MAR indicated Acetaminophen Tablet 325 MG Give 2 tablet[s] via G-Tube two times a day for pain management was scheduled at 9:00 a.m. and 9:00 p.m. Resident 49 was given two tablets of Acetaminophen Tablet 325 mg tablet as scheduled, and with pain level written 0 most of the time.</p> <p>During a concurrent interview on 06/13/25 at 12:19 p.m., with Director of Nursing (DON), DON stated the nurses should have clarified the pain medication orders with the physician for Resident 49.</p> <p>During an interview on 06/12/25 at 12:44 p.m., with LVN 5, LVN 5 stated Resident 38 was non-verbal, LVN 5 stated Acetaminophen 325 mg tablet was given routinely for pain. LVN 5 stated the pain level monitoring was recorded in Resident 38's MAR.</p>

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  06/13/2025
NAME OF PROVIDER OR SUPPLIER  Walnut Creek Skilled Nursing & Rehabilitation Cent		STREET ADDRESS, CITY, STATE, ZIP CODE  1224 Rossmoor Parkway Walnut Creek, CA 94595	

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, interview and record review, the facility failed to prepare food in accordance with professional standards of food service safety when Facility [NAME] (FC) touched ready-to-eat food on multiple plates with the same gloved hand that was used to hold oven handles.</p> <p>This failure had the potential to result in cross-contamination and food-borne illness.</p> <p>Findings:</p> <p>During trayline observation and concurrent interview on 6/12/25 from 11:32 a.m. through 1:10 p.m. with Facility [NAME] (FC) and Kitchen Manager (KM), FC began to scoop food from the trays on the steam table, placed the food items on individual plates by pushing them off the ladle while wearing disposable gloves, at times gently pushing the food item towards the center of the plate. FC opened and closed handles of steamer and oven multiple times in-between plating food from the steam table with the same gloved hand. KM stated I can see what you are trying to say and told FC to stop touching the food on the plates. FC acknowledged, apologized for the mistake, continued with food service, and occasionally touched the food with the same gloved hand before placing the plates on individual trays.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled General Food Preparation and Handling last copyrighted 2023, the P&amp;P indicated Bare hands should never touch ready to eat food directly. Disposable gloves</p> <p>are a single use item and should be discarded after each use . Food should be prepared and served with clean tongs, scoops, spatulas or other suitable implements to avoid manual contact of prepared foods.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observation, interview and record review, the facility failed to implement their infection prevention and control program for two of three sampled residents (Residents 125 and Resident 46) when two staff members did not wear appropriate Personal Protective Equipment (PPE, protective items or garments worn to protect the body or clothing from hazards that can cause injury and to prevent the transmission of infectious agents from one person to another, also known as cross-contamination) while providing care to Resident 125 and Resident 46, who were placed on enhanced barrier precaution (EBP, an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities).</p> <p>This failure had the potential to result in spread of infection.</p> <p>Findings:</p> <p>During a record review of Resident 125's admission Record (AR), printed on 6/13/25, the AR indicated Resident 125 was admitted to the facility in November 2024 with diagnoses of quadriplegia (a loss of motor function can present as either weakness or paralysis leading to partial or total loss of function in the arms, legs, trunk, and pelvis) and dependence to ventilator (a type of breathing apparatus, a class of medical technology that provides mechanical ventilation by moving breathable air into and out of the lungs, to deliver breaths to a patient who is physically unable to breathe, or breathing insufficiently) status.</p> <p>During a review of the facility's undated signage titled, Enhanced Barrier Precaution (EBP), the EBP indicated, Anyone participating in any of these six moments must also: [NAME] gown and gloves .Device care or use .</p> <p>During an observation and interview on 6/9/25 at 11:42 a.m., inside Resident 125's room located in the subacute unit, where an Enhanced Barrier Precaution sign was posted on the door, Respiratory Therapist (RT) 1 was not wearing a gown while performing oral suctioning to Resident 125 who had a tracheostomy (an opening surgically created through the neck into the trachea to allow air to fill the lungs) connected to a ventilator. Inside, Resident RT 1 asked Resident 125 if she needed another round of suctioning to which Resident 125 refused. RT 1 stated he did not really need to wear PPE when providing care for Resident 125. When RT 1 was asked about the EBP sign on the door, RT 1 then stated he should have performed proper PPE as protection to prevent contamination and transmission of secretions and bodily fluid.</p> <p>During a concurrent observation and interview on 6/10/25 at 10:33 a.m., inside Resident 46's room where an Enhanced Barrier Precaution sign was posted on the door, Certified Nursing Assistant (CNA) 5 and Resident 46's family member were at the bedside providing care. CNA 5 did not wear PPE while the family member did. CNA 5 stated, it was an Enhanced-Barrier Precaution room and one should wear PPE when providing care to the resident.</p> <p>During an interview on 6/13/25 at 11:20 a.m. with the Infection Preventionist (IP), IP stated the EBP signs were posted on the door for staff's compliance. IP stated all residents in the subacute unit were placed under EBP. IP stated not wearing PPE inside EBP rooms had the risk of spreading the infection. IP stated PPE was used as a protection from transmitting diseases to the residents and the community.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/13/25 at 1:47 p.m. with the Director of Nursing (DON), the DON stated the staff who were assigned to subacute unit should have known better that wearing PPE was a must when providing care to protect the residents and the staff. The DON stated not wearing PPE was a break in their infection control protocol.</p> <p>During a record review of the facility's policies and procedures, titled, Enhance Barrier Precautions, revised in December 2024, the P&amp;P indicated, EBPs refer to infection prevention and control interventions designed to reduce the transmission of multi-drug-resistant organisms (MDROs) during high contact resident care activities .7. EBPs employ targeted gown and glove use in addition to standard precaution ( ) during a high contact resident care activities when contact precautions do not otherwise apply .a. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room) . 8. Example of high-contact resident care activities requiring the use of gown and gloves for EBPs include .e. transferring .f. providing bed mobility .i. device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc.)</p> <p>Based on observation, interview and record review, the facility failed to implement their infection prevention and control program to two of three sampled residents (Residents 125 and Resident 46) when two staff members did not wear appropriate Personal Protective Equipment (PPE, protective items or garments worn to protect the body or clothing from hazards that can cause injury and to prevent the transmission of infectious agents from one person to another, also known as cross-contamination) while providing care to Resident 125 and Resident 46 who were placed on enhanced barrier precaution (EBP, an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities).</p> <p>This failure had the potential to result in spread of infection.</p> <p>Findings:</p> <p>During a record review of Resident 125's admission Record (AR), printed on 6/13/25, the AR indicated Resident 125 was admitted to the facility in November 2024 with diagnoses of quadriplegia (a loss of motor function can present as either weakness or paralysis leading to partial or total loss of function in the arms, legs, trunk, and pelvis) and dependence to ventilator (a type of breathing apparatus, a class of medical technology that provides mechanical ventilation by moving breathable air into and out of the lungs, to deliver breaths to a patient who is physically unable to breathe, or breathing insufficiently) status.</p> <p>During a review of the facility's undated signage titled, Enhanced Barrier Precaution (EBP), the EBP indicated, Anyone participating in any of these six moments must also: [NAME] gown and gloves .Device care or use .</p> <p>(continued on next page)</p>		

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