STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056381	A. Building B. Wing	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Delta View Post Acute	1210 A Street Antioch, CA 94509

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement and maintain an effective infection prevention and control program, including an infection surveillance system (an ongoing, systematic, and active monitoring of infections, as well as the practices used to prevent them) to prevent transmission of communicable disease (an infectious illness that can spread from one person to another), during an Respiratory Syncytial Virus (RSV, a respiratory infection that infects the lungs and breathing passages) infection for two of six sampled residents (Resident 1 and Resident 2) when:1. Resident 1 who had RSV infection was cohorted (grouping of residents) with other residents during the RSV isolation period without implementation of appropriate transmission-based precautions (also called Isolation Precautions, are actions implemented in addition to standard precautions that are based upon the means of transmission for the infectious agent in order to prevent or control infections)2. Resident 1 and Resident 2's RSV infection were not assessed and monitored during the isolation period. 3. The facility did not maintain records showing the RSV outbreak (6 residents) was reported to local and state health authorities as required.These failures had the potential to result in increased transmission of RSV among residents and staff, delayed nursing evaluation of Residents 1 and 2's progression of RSV symptoms such as worsening of respiratory illness, and serious complications such as pneumonia (an infection that causes inflammation in the air sacs of one or both lungs), hospitalization, or death. During a record review of Resident 1's admission Record (AR) printed on 2/5/26, the AR indicated Resident 1 was admitted to the facility in November 2025 with diagnoses of pneumonia and chronic obstructive pulmonary disease (COPD, refers to a group of diseases that cause airflow blockage and breathing-related problems).During a record review of Resident 1's record, titled, Inter-Facility Transfer Report (IFTR), dated 1/22/26, the IFTR indicated Resident 1 was admitted to hospital due to acute hypoxic (a critical, sudden drop in blood oxygen levels) and hypercapnic failure (a condition where the respiratory system fails to properly remove carbon dioxide from the blood) due to COPD exacerbation (a sudden worsening) triggered by RSV infection. The IFTR indicated Resident 1 tested positive of RSV on 1/19/26.During a record review of undated facility-provided record, titled, RSV, the record indicated five residents tested positive of RSV within the previous 30 days (1/5/26 through 2/5/26). However, Resident 1, who was identified as RSV positive on 1/19/26, was not included on the facility's RSV line list.During a record review of Resident 2's AR printed on 2/5/26, the AR indicated Resident 2 was admitted to the facility in December 2025 with diagnoses of cerebral infarction (death of an area of brain tissue when a blocked blood vessel prevents delivery of an adequate blood and oxygen supply to the brain) and Alzheimer's disease (a progressive, irreversible neurodegenerative brain disorder that destroys memory, thinking skills, and eventually the ability to perform daily tasks).During a record review of Resident 2's record of laboratory results, dated 1/29/26, the result showed Resident 2 tested positive of RSV infection. During a record review of Resident 2's Electronic Health Record (EHR), (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	RSV disease .5. Residents diagnosed with RSV are placed on contact precautions (prevent the spread of infectious diseases transmitted through direct or indirect contact) for the duration of their illness .6. The IP is responsible for surveillance and reporting of infectious diseases .During a record review of the facility's P&P, titled, Outbreak of Communicable Diseases, revised in April 2025, the P&P indicated, Outbreaks of communicable diseases within the facility are promptly identified and managed .1. An outbreak is defined as one of the following .a. One case of an infection that is highly communicable or has serious health implications .c. Occurrence of three or more cases of the same infection over a specified period of time and in defined area .6. The IP and DON services are responsible for .b. communicating with local and state health authorities .d. monitoring ill residents and staff .initiating transmission-based precautions, as appropriate .f. communicating with the medical director and the attending physicians .During a record review of the facility's P&P, titled, Infection Prevention and Control Program, revised in August 2019, the P&P indicated, 6. Outbreak Management .a. Outbreak management is a process that consists of .2. managing the affected resident .3. preventing spread to other residents .documenting information about the outbreak .5. reporting the information to appropriate public health authorities .