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	04/29/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on interview, and record review, the facility failed to ensure one of six sampled residents (Resident 1) was free from physical abuse when Resident 1 and Resident 2 were left without staff supervision and Resident 2 hit Resident 1 on the back of the head two times. This failure had the potential to result in physical, mental and emotional harm for Resident 1.During a review of Resident 1's admission Record, printed 4/6/26, the Record indicated Resident 1 was admitted to the facility in 2025 with a diagnosis of, Cognitive Communication Deficit. During a review of Resident 2's admission Record, printed 4/28/26, the Record indicated Resident 2 was admitted to the facility in 2024 with a diagnosis of, Other Cerebral Infarct (brain tissue death due to lack of oxygen). During an interview on 4/28/26, at 1:03 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated on 4/6/26, LVN 1 assessed Resident 1 after Resident 1's alteration with Resident 2. LVN 1 stated Resident 1 had swelling and redness on their head. LVN 1 stated LVN 1 notified the physician, and the physician ordered Resident 1 to be sent to the hospital for further evaluation. LVN 1 stated the Activity Room should always have staff present and Residents had the right to be free from abuse. During an interview on 4/28/26, at 1:50 p.m., with Resident 2, Resident 2 stated a few weeks ago, while in the activity room, Resident 2 tapped Resident 1 on the back of the head two times because Resident 1 would not stop backing up into them. Resident 2 stated there were no staff in the Activity Room for about ten minutes when the incident happened and staff could have intervened if they were there. During an interview on 4/28/26, at 2:24 p.m., with Activity Assistant (AA) 1, AA 1 stated they were assigned to the Activity Room on 4/6/26. AA 1 stated the altercation between Resident 1 and Resident 2 occurred when AA 1 left the residents in the Activity Room for about ten minutes without any other staff present. AA 1 stated if they were present during the altercation, they could have separated the two residents before it escalated. During an interview on 4/28/26, at 3:28 p.m. with the Director of Nursing (DON), DON stated the video of the incident on 4/6/26 showed Resident 2 hitting Resident 1 in the Activity Room. DON stated there should have been staff in the Activity Room during the altercation. DON stated it was important for staff to be present in the Activity Room with residents for resident safety. During a review of the facility's Investigation Summary Report, dated 4/6/26, the Report indicated The administrator and director of nursing concluded that there was thorough evidence of the [Resident 2] perpetrator hitting the [Resident 1] victim. During a review of Resident 1's Nurses Note dated 4/6/26, the Note indicated, pt [patient] was involved in verbal altercation with another patient. During the incident pt sustained minor injury after bumping [sic] head. a visible swelling bump was noted on the head. MD [medical doctor] notified. During a review of the facility's policy and procedure (P&P) titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program Reviewed January 2026, the P&P indicated, Residents have the right to be free from abuse . This includes . physical abuse.

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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to assist one out of six residents (Resident 6) with impaired vision and prescription glasses in obtaining timely optometry care. This failure had the potential to cause Resident 6 frustration, decreased independence in managing daily activities, and increased fall risk.During a review of Resident 6's admission Record, printed 4/29/26, the Record indicated Resident 6 was admitted to the facility in 2020 with a diagnosis of, Dementia in other diseases (cognitive decline and memory loss occurring as a symptom of a primary, underlying condition). During an interview on 4/27/26, at 2:31 p.m., with Resident 6's Responsible Party (RP) 1, RP 1 stated Resident 6 has not had an eye exam and could not see with their glasses. During an interview on 4/29/26, at 1:54 p.m., with Assistant Director of Nursing (ADON), ADON stated there was no documentation or proof that Resident 6 had an eye exam during their entire stay at the facility. During a concurrent observation and interview on 4/29/26, at 3:21 p.m. with ADON, Resident 6's prescription glasses were inside their bedside drawer. During an interview on 4/29/26, at 3:31 p.m., with Director of Nursing (DON), DON stated Resident 6 should have had an optometry appointment during their stay at the facility and it was important for their safety. During a review of Resident 6's Minimum Data Set (MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan), dated 3/15/20, the MDS indicated, Vision. Ability to see in adequate light (with glasses or other visual appliances) . Impaired. The MDS indicated, Corrective Lessons. Yes. During a review of Resident 6's Order Summary Report, printed 4/29/26, indicated Resident 6 had a doctor's order for, Eye health and vision consult with follow up treatment as indicated. order date. 3/5/20. During a review of Resident 6's Care Plan dated 11/11/22, the Care Plan indicated, The resident has impaired visual function. The Care Plan indicated, Intervention. arrange consultation with eye care practitioner as required. The Care Plan indicated Goal.The resident will maintain optimal quality of life within limitations imposed by visual function. During a review of the facility's policy and procedure (P&P) titled, Referrals, Social Services, Revised [DATE], the P&P indicated, Referrals for medical services must be based on physician evaluation or resident need and a related physician order. The P&P indicated Social services will collaborate with the nursing staff or other pertinent disciplines to arrange for services that have been ordered by the physician.