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	03/13/2025

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

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36593 Based on observation, interview and record review, the facility failed to ensure three of three sampled residents (Resident 14, Resident 96 and Resident 5) Minimum Data Set (MDS-Resident Assessment and Care Screening tool used to guide care), were accurate when: 1. Resident 14 MDS section A was not coded accurately to reflect Preadmission Screening and Resident Review (PASRR, a federal requirement to ensure that residents are not inappropriately placed in nursing homes for long term care) PASRR Level II evaluation. Resident 14 MDS section GG was not coded accurately to reflect lower extremities range of motion status. 2. Resident 96, ARD for discharge assessment was coded inaccurately. 3. Resident 5 MDS Section N, was coded inaccurately for antidepressant, antibiotic, anticoagulant and anticonvulsant. These failure had the potential for residents to not receive appropriate care. Findings: 1. During a review of Resident 14's Admission Record (AR), dated 3/12/25, the AR indicated the facility admitted Resident 14 on 1/29/23 with diagnoses that included bipolar disorder, schizophrenia (a chronic and severe mental disorder that affect how a person thinks, feels, behaves) and contracture right foot. During a review of Resident 14's PASRR dated 6/13/22, the PASRR indicated Resident 14's Level I screening was positive for mental illness followed by Level II evaluation on 6/1/22. The result of Level II evaluation are provided. During a review of Resident 14's Annual MDS dated [DATE], the MDS indicated section A PASRR was coded zero meaning Resident 14 was not considered by the state level II PASRR process to have serious mental illness. (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 3/11/25 at 2:56 p.m. with the MDS coordinator (MDSC 1), Resident 14's annual MDS section A and PASRR Level I and II were reviewed. MDSC1 stated MDS Section A for PASRR was not coded accurately. MDSC1 said Resident 14's Level I was positive for mental illness and Level II evaluation was conducted and copy was on record. MDSC1 stated the staff responsible for the coding no longer worked at the facility. During a review of Resident 14's MDS dated [DATE], the MDS indicated section GG functional limitation in range of motion was coded 2 indicated impairment on both side of lower extremities (hip, knee, ankle and foot). During a concurrent observation and interview on 3/11/25 at 11:28 a.m. with Certified Nursing Assistant (CNA1), Resident 14 had contracture on right foot . Resident 14 had no limitation on left lower extremities and was able to turn from side to side with minimal help. During an interview on 3/12/25 at 10:03 a.m. with MDSC 1, MDSC1 stated Resident 14 MDS's section G lower extremities was not coded accurately. MDSC1 stated Resident 14 had contracture on right foot. MDSC1 said Resident 14 had no limitation left side lower extremities. 49498 2. During a review of Resident 96's undated Admission Record, the Admission Record printed on 3/12/25 indicated, Resident 96 was admitted in the facility on 1/3/25 with a diagnosis of myeloid leukemia (a type of blood cancer that affects the bone marrow, where blood cells are produced). The Admission Record also indicated; Resident 96 was discharged on [DATE] at 4:19 p.m. During a review of Resident 96's Against Medical Advice (AMA indicates that a patient has chosen to leave a healthcare facility or discontinue treatment despite the recommendation of their healthcare provider) note dated 1/4/25, the note indicated, Resident 96 left the facility AMA. During a concurrent interview and record review on 3/12/25 at 9:20 a.m. with MDS Coordinator (MDSC) 1, Resident 96's discharge MDS dated [DATE] was reviewed. The discharge MDS indicated, Resident 96's discharge date was 1/10/25. MDSC1 stated, the assessment reference date should have been 1/4/25 because Resident 96 was in the facility for only one day. MDSC1 stated, she made an error and should have checked the discharge date . During a review of The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (published by the Centers for Medicare & Medicaid Services (CMS) to disseminate information broadly to facilitate accurate and effective resident assessment practices in long-term care facilities) dated 10/1/23, indicated, The RAI process has multiple regulatory requirements. Federal regulations at 42 CFR 483.20 (b)(1)(xviii), (g), and (h) require that (1) the assessment accurately reflects the resident's status . (https://www.cms.gov/files/document/finalmds-30-rai-manual-v11811october2023.pdf) 52135 3. During a review of Resident 5's Annual History and Physical (H&P), dated 05/15/24, the H&P indicated Resident 5 was admitted to facility on 07/13/23 with diagnoses of stroke causing right -side hemiplegia (paralysis), atrial fibrillation (A-fib, an irregular and often rapid heart rhythm) and major depressive disorder. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a record review of Resident 5's Order Summary Report (provides an overview of doctors' orders for a specific period) printed on 03/12/25, showed Resident 5 had the following prescriptions: Eliquis (a blood thinner) 5 mg, one tablet by mouth twice daily for A Fib, started on 08/02/24; Fluoxetine (an antidepressant medication) 20 mg, one tablet by mouth once daily for depression, started on 08/23/24; and Levetiracetam (an anticonvulsant medication to treat seizure) solution, 10ml by mouth twice daily for seizure, started on 08/03/24. During a concurrent interview and record review on 3/11/25 at 3:48 p.m. with MDS Coordinator (MDCS) 2 and MDSC 1, Resident 5's Medication Administration Record (MAR) for 02/2025 and MDS assessment dated [DATE] was reviewed. The MAR indicated Resident 5 received Eliquis, Levetiracetam and Fluoxetine medication from 02/04/25 through 02/10/25, the observation period for MDS assessment dated [DATE]. The MAR also indicated Resident 5 did not receive antibiotics in the observation period. MDSC 2 stated Resident 5's MDS assessment inaccurately indicated that Resident 5 did not receive anticoagulant, anticonvulsants, antidepressants and that they received antibiotics during the observation period. The MDSC 2 stated she was new to the role when she completed Resident 5's MDS assessment. MDSC 1 stated she should have audited/corrected MDS assessments that MDSC 2 was completing when she was new to the role. MDSC 1 stated she did not audit Resident 5's MDS assessment. During an interview on 3/12/25 at 11:28 a.m., with Director of Nursing (DON), the DON stated inaccurate MDS assessments did not reflect resident's true clinical condition and could trigger wrong care plan thus affecting resident's care. During a review of facility's Policy and Procedure (P&P) titled Resident Assessments dated 10/2023, the P&P indicated, Information in the MDS assessment will consistently reflect information in the progress notes, plan of care and resident observations/interviews.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 36593 Based on observation, interview and record review, for one (Resident 3) of two sampled residents, the facility failed to implement its Care Planning - Interdisciplinary Team policy and procedure when there was no care plan developed to address Resident 3's gum pain and discomfort with appropriate interventions. This failure had the potential to result in Resident 3 not receiving appropriate care and treatment. Findings: During a review of Resident 3's Minimum Data Set (MDS), Resident Assessment and care guide tool, dated 12/15/24, MDS indicated Resident 3 had a clear speech, able to make self understood had ability to understand others. Resident 3's diagnoses included Non-Alzheimer's Dementia (a group of diseases characterized by progressive deficits in behavior, executive function or language). During a concurrent observation and interview on 3/10/25 at 10:57 a.m. with Resident 3 in her room. Resident 3 pointed to her gum area and stated her gum was painful and she had not seen a dentist. Resident 3 stated she felt discomfort with eating for sometime. During an interview on 3/11/25 at 12:16 p.m. with Licensed Vocational Nurse (LVN 1), LVN 1 stated she was aware that Resident 3 had painful gum .LVN 1 stated Resident 3 was seen by the dentist and had an order to apply oral gel as needed. LVN 1 stated Resident 3 did not have a care plans for painful gum. During a concurrent interview and record review on 3/11/25 at 12:20 p.m. with Director of Nursing (DON), Resident 3's care plans were reviewed. DON stated she could not find a care plan that address Resident 3's painful gum. DON stated Resident 3 was evaluated in 2024 by the dentist .

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 39939 Based on observation, interview and record review, the facility failed to provide services to meet professional standards of quality for one of one sampled resident (Resident 302) when Resident 302's lidocaine patch (medicine that prevents pain by blocking the signals at the nerve endings in the skin) 5% was not removed according to physician's order. This failure resulted in Resident 302 to receive excessive dose of lidocaine in a 24-hour period. Findings: During a review of Resident 302's undated Admission Record, the Admission Record printed on 3/12/25 indicated, Resident 302 was admitted in the facility on 2/28/25 with a diagnosis of cellulitis (bacterial infection of the skin and underlying tissues) of the left lower limb. During a concurrent medication administration observation and interview, on 3/11/25 at 8:52 a.m. with Registered Nurse (RN) 1, in Resident 302's room, RN 1 removed one lidocaine patch with handwritten letters JS and numbers 3/10 from Resident 302's back. RN 1 stated the lidocaine patch she removed was the patch she had applied yesterday morning. RN 1 stated the letters JS was her initials. RN 1 stated the numbers 3/10 meant the patch was applied on 3/10/25. During a concurrent interview and record review, on 3/11/25 at 8:54 a.m., with RN 1, Resident 302's Electronic Medication Administration Record (E-MAR) dated 3/10/25 was reviewed. The E-MAR indicated, Resident 302's Lidocaine patch was to be applied daily at 9:00 a.m. and removed daily at 9:00pm. RN 1 stated Resident 302's Lidocaine patch should have been removed on 3/10/25 at 9:00 p.m. During a review of Resident 302's Order Summary Report dated 2/28/25, The Order Summary Report indicated, Resident 302's Lidocaine patch was for pain and to be removed per schedule. During a review of Resident 302's Medication Administration Record (MAR) dated 3/10/25, the MAR indicated, Lidocaine patch 5% was applied to Resident 302's upper back at 9:15 a.m. During a review of facility's policy and procedure (P&P) titled Administering Medications, dated 2001, the P&P indicated, 3. Medications must be administered in accordance with the orders, including any required time frame. During a review of Lidocaine Patch 5% manufacturer's specification dated 11/18, the manufacturer's specification indicated, Apply the prescribed number of patches only once for up to 12 hours within a 24-hour period .Excessive dosing by applying . for longer than the recommended wearing time could result in increased absorption of lidocaine and high blood concentrations, leading to serious adverse effects. (https://www.accessdata.fda.gov/drugsatfda_docs/label/2018/020612s014lbl.pdf)

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F 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor each resident's preferences, choices, values and beliefs. 36593 Based on observation, interview, and record review, the facility failed to provide necessary care and services to maintain physical and psychosocial well-being for one of twenty four sampled residents (Resident 44) when Resident 44 was not positioned properly in the dining room prior to eating lunch. This failure had the potential to cause Resident 44 aspiration and emotional distress. Findings: During a review of Resident 44's Minimum Data Set (MDS - a federally mandated resident assessment and care guide tool), dated 1/8/25, the MDS indicated Resident 44's Basic Interview of Mental status (BIMS, a scoring system used to determine the resident's cognitive status regarding attention, orientation, and ability to register and recall information. A BIMS score of thirteen to fifteen is an indication of intact cognitive status.) Resident 44's score was 10 (meaning mild cognitive impairment). MDS indicated Resident 44 had clear speech, able to express ideas and wants, make self-understood and understood others. MDS indicated Resident 44 need helper assistance prior to or following eating activities. Resident 44 need helper assistance to lifts, holds, or supports trunk or limbs. Resident 44's diagnoses included need for assistance with personal care, muscle wasting and atrophy. During an observation on 3/10/25 at 11:54 a.m. in the dining room, Resident 44 laid on a high rise wheelchair with head of wheelchair at about 45 degree. During a concurrent observation and interview on 3/10/25 at 12:14 p.m. with Resident 44 and Activity Aide (AA) in the dining room, Resident 44 requested to be seated up before meal tray was served. AA served lunch meal tray to Resident 44 without sitting Resident 44 up properly. Resident 44 ate his lunch with food items dropping on his chest area. During an interview on 3/10/25 at 12:46 p.m. with AA, AA stated she served Resident 44 his lunch tray without making sure Resident 44 was positioning properly because she was not a nurse and could not reposition. AA stated she did not want to return the lunch tray so she left the tray in front of the Resident 44. AA stated the nurses eventually repositioned Resident 44 and he had his lunch. During an interview on 3/13/25 at 10:04 a.m. with Director of Nursing (DON), DON stated facility's expectation was for activity staff and nursing staff assist resident with positioning before serving meal trays because everyone want to eat as soon as meal trays served.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52135 Based on observation, interview, and record review, the facility failed to provide quality of care to two of 24 sampled residents (Resident 5 and Resident 10) when the following were noted: 1. Resident 5, with a right hand contracture (muscles, tendons, or tissues get really tight and can't stretch out properly), wore a loosely fitted hand roll which kept coming off and it was difficult for Resident 5 to keep it in the right place. 2. Swelling, black/bluish discoloration and pain in Resident 10's both feet was not addressed for at least two days. These failures resulted in Resident 5 feeling frustrated, getting teary and placed her at risk of discomfort, pain, skin breakdown, and worsening of right hand contracture. Resident 10's untreated swelling, discoloration and pain placed him at risk for further discomfort and potential for compromised blood circulation. Findings: During a record review of Resident 5's Admission Record (AR, record with resident 's basic personal information) printed on 3/11/25, the AR indicated Resident 5 was admitted to the facility on [DATE]. A review of Resident 5's Minimum Data Set (MDS, an assessment used to guide care) dated 02/10/25, indicated Resident 5 was usually able to make herself understood and was usually able to understand others. The MDS assessment indicated Resident 5's Brief Interview for Mental Status (BIMS, an assessment used to assess mental status) score was 15 out of 15, indicating Resident 5 was cognitively intact. During a record review of Resident 5's Annual History and Physical (H &P) dated 05/15/24, indicated Resident 5 had a diagnosis of stroke with right side hemiplegia (paralysis). During an observation on 03/10/25 at 10:23 a.m., Resident 5 was in bed with the head of the bed raised. Resident 5 was awake and had a pillow between her right arm and chest. Resident 5 was holding a dark gray hand roll with a white elastic band in her right hand. Resident 5 stated the hand roll was too big, and the elastic band was too loose. She also said the hand roll kept falling out of place when she tried to open the fingers on her right hand using her left hand. Resident 5 started to get teary and stated she was frustrated because of improperly fitted hand roll. During an interview on 03/10/25 at 10:41 a.m. in Resident 5's room, Restorative Nursing Assistant (RNA) 1 stated that Resident 5 had been in the RNA program for two to three months for her right-hand contracture with a hand roll. RNA 1 stated We don't have a small hand roll. RNA 1 stated rehabilitation department were aware that the hand roll was too big, and the band was too loose. RNA 1 stated Resident 1 needed a smaller hand roll. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview with Resident 5 on 03/11/25 at 9:30 a.m., Resident 5 had a new hand roll (dark gray). Resident 5 stated she received the new hand roll on the evening of 03/10/25 but was still too big and loose for her. During an interview and record review on 03/12/25 at 9:01 a.m., with Rehabilitation Director (RD), RD stated an improper fitted hand roll could not provide proper support to Resident 5. RD stated she already asked central supply to order more hand rolls. During an interview on 03/12/25 at 9:14 a.m., with Assistant Director of Nursing (ADON), who is new to her role and oversees the RNA program, ADON stated that she was not aware of Resident 5's hand roll was too big and loose. ADON stated an improper hand roll could cause discomfort, worsen the contracture and increase risk for skin breakdown. During a review of facility's Policy and Procedure (P&P) titled Resident Mobility and Range of Motion dated 2001, the P&P indicated residents with limited mobility will receive appropriate services, equipment and assistance to maintain or improve mobility unless reduction in mobility is unavoidable. 52233 2. During a review of Resident 10's MDS assessment dated [DATE], Section C indicated, Resident 10's BIMS score was 15 out of 15, indicating his mental status was intact. Section I Active Diagnoses indicated, Resident 10 had active diagnosis of Peripheral Vascular Disease (PVD, a slow and progressive narrowing or blockage in blood vessels), Peripheral Arterial Disease (PAD, a condition in which narrowed arteries reduce blood flow to the arms and legs), Renal Insufficiency (a state in which the kidneys are not functioning at their full capacity), Renal Failure or End Stage Renal Disease (ESRD, a medical condition in which the kidneys can no longer adequately filter waste products from the blood, functioning at less than 15% of normal levels) and Other Inflammatory Polyneuropathies (a neurological disorder characterized by nerve swelling and irritation/ inflammation that leads to loss of strength or sensation especially of the arms and legs. During an observation and interview on 3/10/25 at 09:23 a.m. Resident 10 was lying in bed, both feet and ankles exposed. Resident 10 stated his feet were swollen, and had bluish/ blackish discoloration of toes and feet. Resident 10 stated he did not know why his feet were swollen. During a concurrent observation and interview on 3/11/25 at 11:07 a.m., in Resident 10's room with License Vocational Nurse (LVN) 2, Resident 10 was sitting in a wheelchair. LVN 2 stated he was assigned to Resident 10 for last two days and it was the first time he was assessing the Resident 10's feet. LVN 2 stated Resident 10's feet were discolored and he did not know if discoloration was getting worse. Resident 10 stated his right and left leg were cold, and it has been painful for him to wear socks and shoes for a long time. Resident 10 stated he had seven out of 10 pain in his feet (moderate pain). During a concurrent observation and interview on 3/12/25 at 11:28 am License Vocational Nurse (LVN 3) and LVN 4, in Resident 10's room, Resident 10 was sitting up in wheelchair. LVN 3 stated Resident 10's feet had bluish discoloration on all toes and plantar area of foot. LVN 3 stated she did not see any edema but Resident 10's feet were cold, and when pressed, Resident 10 felt pain of 3-4 out of 10 (mild to moderate pain). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 3/12/25 at 11:45 a.m., with LVN 3, Resident 10's Electronic Health Record (EHR) for progress notes, evaluations from 12/1/24 till 3/12/25 was reviewed. LVN 3 stated she was not able to find any documentation on skin issues in Resident 10's EHR. During an interview on 3/13/25 at 10:36 a.m. Director of Nursing (DON) stated if Resident 10's discoloration on his bilateral feet was left untreated for greater than 72 hours, it could be a sign of poor blood circulation in his feet and in extreme cases, it may lead to needing an amputation (surgical removal of the organ). DON stated staff was expected to act immediately on resident's change in health condition.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 49498 Based on observation, interview and record review, the facility failed to provide routine medication, as ordered by the prescriber, and provide pharmaceutical services which includes procedures that assure the accurate acquiring, receiving, dispensing, and administering of medications to meet each resident's needs when: 1. Lisinopril (medication to treat high blood pressure) was not available for administration for one of five sampled residents (Resident 304). 2. One of two intravenous (IV, into the vein) drug emergency kits (E-kit) was opened and the IV Drug Emergency Kit Use Form had no accurate record of medication used and was not re-ordered timely. These failures resulted in Resident 304 not receiving the medication as prescribed and had the potential for facility residents with a census of 97 to not receive emergency IV medications when needed. Findings: 1. During a review of Resident 304's undated Admission Record, the Admission Record printed on 3/12/25 indicated, Resident 304 was admitted in the facility on 3/3/25 with a diagnosis of essential hypertension (a condition characterized by persistently high blood pressure without an identifiable underlying cause). During a concurrent medication administration observation and interview, on 3/11/25 at 8:40 a.m. with Registered Nurse (RN) 1, RN 1 prepared and administered Resident 304's morning medications which included one tablet of amiodarone (medication to treat heart rhythm problems), one tablet of amlodipine (medication to treat high blood pressure), one tablet of toprol xl (medication to treat high blood pressure) extended release (ER), and one tablet of furosemide (medication to treat fluid build-up and swelling and high blood pressure). RN 1 stated she can't find Resident 304's lisinopril medication. RN 1 stated she will call the pharmacy to re-order the medication. During a follow up interview on 3/11/25 at 3:18 p.m. with RN 1, RN 1 stated Resident 304's lisinopril has not been delivered by the pharmacy. RN 1 stated Resident 304 did not receive the lisinopril yet. During a concurrent observation and interview on 3/12/25 at 12:21 p.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 checked Resident 304's lisinopril supply in the medication cart. LVN 2 stated Resident 304's lisinopril was not in the medication cart. LVN 2 stated Resident 304 did not receive the lisinopril yet. During an interview on 3/12/25 at 12:52 p.m. with LVN 5, LVN 5 stated Resident 304's lisinopril supply was missing. LVN 5 stated she called the pharmacy to re-order the lisinopril. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 304's Order Summary Report dated 3/3/25, The Order Summary Report indicated, Resident 304 had an order to receive one tablet of lisinopril once a day for hypertension. During a review of Resident 304's Medication Administration record (MAR) dated March 2025, indicated, Resident 304 was scheduled to receive lisinopril once a day at 9:00 a.m. During a review of Resident 304's Administration History of lisinopril, dated 3/11/25 and 3/12/25, the administration documentation was strike out due to correction. During a review of facility's policy and procedure (P&P) titled Administering Medications, dated 2001, the P&P indicated, Medications shall be administered in a safe and timely manner, and as prescribed . 3. Medications must be administered in accordance with the orders, including any required time frame . 4. Medication must be administered within one hour of their prescribed time, unless otherwise specified. 2. During concurrent observation and interview on 3/10/25 at 3:31 p.m. with Registered Nurse (RN) 2, in the station one medication room, one orange container with IV drug emergency kit label had a blue plastic security seal zip tie. RN 2 stated the blue zip tie meant the container was opened. RN 2 stated the container contained IV emergency medications. RN 2 stated nurses re-ordered opened IV drug E-kit by calling the pharmacy. During a concurrent interview and record review on 3/10/25 at 3:33 p.m. with RN 2, in the station one medication room, the E-kit Utilization Log was reviewed, the log indicated, meropenem (an IV medication used to treat infections caused by bacteria) was removed from the e-kit on 1/18/25. RN 2 stated she was not sure if the log had the accurate information. During a concurrent observation and interview on 3/11/25 at 2:55 p.m. with the Assistant Director of Nursing (ADON), in the station one medication room, one orange container with IV drug emergency kit label had a blue plastic security seal zip tie. The ADON stated she recalled the IV drug (E-kit) was last opened on 3/5/25. The ADON stated she had updated the E-kit utilization log to 3/5/25 as the last time it was opened. During a concurrent interview and record review on 3/11/25 at 4:14 p.m. with the ADON, the unfilled IV Drug Emergency Kit Use Form taken from the IV drug E-kit container was reviewed, the form did not indicate what medication was removed from the E-kit or the date it was opened. The ADON stated the form should be filled out of what medication was removed from the E-kit and the date the medication was used. The ADON stated the filled-up form should be faxed to the pharmacy to re-order the E-kit. During a review of Pharmacy Delivery Manifest Report Details, dated 3/6/25, the report indicated, the IV drug E-kit was delivered and received in station two on 3/6/25. During a review of facility's P&P titled Emergency Medications, dated 2001, indicated, The facility shall maintain a supply of medications typically used in emergencies . 8. Any medications that is removed from the emergency kit must be documented on the emergency medication administration log . 9. Medications and supplies used from the emergency medication kit must be replaced upon the next routine drug order.

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	03/13/2025

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

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 49498 Based on observations, interviews, and record review, the facility failed to ensure a medication error rate below five percent for two of five sampled residents (Resident 75 and 304) when: 1. Resident 75 was administered multi-vitamin with minerals instead of multi-vitamins as prescribed by physician's order. 2. Resident 304's toprol xl (medication to treat high blood pressure) extended release (ER) was crushed and administered. 3. Resident 304's lisinopril (medication to treat high blood pressure) was not administered as ordered. These failures resulted in three medication errors out of 28 opportunities during observation of medication administration which resulted in the facility having a medication error rate of 10.71%. These failures also resulted in residents not receiving the correct medication or receiving the medication as prescribed or according to the manufacturer's specification. Finding: 1. During a review of Resident 75's undated Admission Record, the Admission Record printed on 3/12/25 indicated, Resident 75 was admitted in the facility on 10/26/24 with a diagnosis of chronic obstructive pulmonary disease (COPD, a group of lung diseases that block airflow and make it difficult to breathe). During medication administration observation on 3/11/25 at 8:22 a.m., Licensed Vocational Nurse (LVN) 2 was observed preparing and administering seven medications to Resident 75. These medications included one puff of Spiriva (medication that relaxes muscles in the airways and increases air flow to the lungs) inhaler, two tablets of acetaminophen (medication to treat minor aches and pains, and reduces fever), one capsule of stool softener, two puffs of combivent (medication that relax muscles in the airways and increase air flow to the lungs) inhaler, one tablet of multivitamins with minerals, two tablets of paroxetine (medication that treats depression and other mental illnesses by increasing the amount of serotonin, a natural substance in the brain that helps maintain mental balance) and two puffs of wixela (inhaled medication to help manage breathing problems, such as asthma or chronic obstructive pulmonary disease (COPD). It reduces inflammation and relaxes the muscles around the airways to make it easier to breathe) inhaler. During a review of Resident 75's Order Summary Report, dated 2/9/24, and March 2025 MAR (Medication Administration Record) indicated that multiple vitamin was scheduled to be given one time a day for Resident 75. During a review of facility's policy and procedure (P&P) titled Administering Medications, dated 2001, the P&P indicated, 3. Medications must be administered in accordance with the orders, including any required time frame. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a review of Resident 304's undated Admission Record, the Admission Record printed on 3/12/25 indicated, Resident 304 was admitted in the facility on 3/3/25 with a diagnosis of essential hypertension (a condition characterized by persistently high blood pressure without an identifiable underlying cause). During medication administration observation on 3/11/25 at 8:40 a.m., Registered Nurse (RN) 1 crushed four tablets of Resident 304's medications, mixed with apple sauce and administered. These medications included one tablet of amiodarone (medication to treat heart rhythm problems), one tablet of amlodipine (medication to treat high blood pressure), one tablet of toprol xl ER, and one tablet of furosemide (medication to treat fluid build-up and swelling and high blood pressure). During a review of Resident 304's Order Summary Report, dated 3/3/25, and the March 2025 MAR indicated that toprol xl ER was scheduled to be given one time a day for Resident 304. During an interview on 3/11/25 at 11:40 a.m. with RN 1, RN 1 stated extended-release medication cannot be crushed. RN 1 stated crushing the toprol xl ER could drop Resident 304's blood pressure to a very low level. During a review of Resident 304's toprol xl ER medication label with RN 1, the label indicated not to crush the medication. During a review of toprol xl ER manufacturer's specification dated 3/23, the manufacturer's specification indicated, toprol xl tablets are scored and can be divided; however, do not crush or chew the whole or half tablet. (https://www.accessdata.fda.gov/drugsatfda_docs/label/2023/019962s050s052lbl.pdf) 3. During a concurrent medication administration observation and interview, on 3/11/25 at 8:40 a.m. with RN 1, RN 1 prepared and administered Resident 304's morning medications which included one tablet of amiodarone, one tablet of amlodipine, one tablet of toprol xl ER, and one tablet of furosemide. RN 1 stated she can't find Resident 304's lisinopril medication. RN 1 stated she will call the pharmacy to re-order the medication. During a follow up interview on 3/11/25 at 3:18 p.m. with RN 1, RN 1 stated Resident 304's lisinopril has not been delivered by the pharmacy. RN 1 stated Resident 304 did not receive the lisinopril yet. During a concurrent observation and interview on 3/12/25 at 12:21 p.m., with LVN 2, LVN 2 checked Resident 304's lisinopril supply in the medication cart. LVN 2 stated Resident 304's lisinopril was not in the medication cart. LVN 2 stated Resident 304 did not receive the lisinopril yet. During an interview on 3/12/25 at 12:52 p.m. with LVN 5, LVN 5 stated Resident 304's lisinopril supply was missing. LVN 5 stated the medication will be delivered by the pharmacy as soon as possible. During a review of Resident 304's Order Summary Report dated 3/3/25, The Order Summary Report indicated, Resident 304 had an order to receive one tablet of lisinopril once a day for hypertension. (continued on next page)

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	056381	A. Building B. Wing	03/13/2025

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 304's Medication Administration record (MAR) dated March 2025, indicated, Resident 304 was scheduled to receive lisinopril once a day at 9:00 a.m. During a review of Resident 304's Administration History of lisinopril, dated 3/11/25 and 3/12/25, the administration documentation was strike out due to correction. During a review of facility's policy and procedure (P&P) titled Administering Medications, dated 2001, the P&P indicated, Medications shall be administered in a safe and timely manner, and as prescribed . 3. Medications must be administered in accordance with the orders, including any required time frame . 4. Medication must be administered within one hour of their prescribed time, unless otherwise specified.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. 36593 Based on observation, interview and record review, the facility failed to ensure food waste trash and garbage was disposed of in a sanitary manner when the lid of outside trash container was not closed. This failure had the potential of harborage and feeding of pest. Findings: During a concurrent observation and interview on 3/10/25 at 9:48 a.m. with Dietary Manager (DM) at the dumpster area located behind the kitchen building, the trash container overflowed with bags of trash and the lid of the container was not closed. DM stated the trash in the container was food waste. During an interview on 3/11/25 at 9:06 a.m. with [NAME] (CK), CK stated food wastes are disposed of into trash can after each shift. CK stated trash container lid was expected to be closed at all times. During a review of the facility's policy and procedure (P&P) titled, Sanitation and Infection Control, dated 2023, the P&P indicated, Outside trash compactors require a protective cover to prevent pests, animals, or debris from falling in. Keep lids of outside trash dumpster's closed.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 49498 Based on observation, interview and record review, the facility failed to maintain medical records that was accurately documented when: 1. One of five sampled residents (Resident 302) lidocaine patch (medicine that prevents pain by blocking the signals at the nerve endings in the skin) 5% was documented as administered in the Electronic Medication Administration Record (E-MAR) prior to administration. 2. Facility staff back dated Resident 47's discharge care planning notes. These failures resulted in Resident 47 and 302's medical record to reflect inaccurate clinical information. Findings: 1. During a review of Resident 302's undated Admission Record, the Admission Record printed on 3/12/25 indicated, Resident 302 was admitted in the facility on 2/28/25 with a diagnosis of cellulitis (bacterial infection of the skin and underlying tissues) of the left lower limb. During medication administration observation on 3/11/25 at 8:52 a.m., RN 1 was observed preparing and administering one lidocaine patch 5% to Resident 302's back. During a concurrent interview and record review, on 3/11/25 at 8:56 a.m., with RN 1, Resident 302's E-MAR dated 3/11/25 was reviewed. The E-MAR indicated, Resident 302's lidocaine patch 5% administration was documented at 8:26 a.m. RN 1 stated Resident 302 wanted the patch applied later when offered at 8:26 a.m. RN 1 stated the reason she documented ahead was she didn't want the documentation to turn red in the E-MAR. RN 1 stated when the E-MAR turned red it meant the administration of the medication was late. RN 1 stated she should document the administration after giving the medication. During a record review of Resident 302's Order Summary Report dated 2/28/25, The Order Summary Report indicated, Resident 302's had an order of lidocaine patch 5% for pain. During a review of facility's policy and procedure (P&P) titled Documentation of Medication Administration, dated 2001, the P&P indicated, 2. Administration of medication is documented immediately after it is given. 52233 2. During a concurrent interview and record review on 3/12/25 at 10:41 a.m. with Social Services Assistant (SSA) Resident's 47's social services progress notes from 12/9/24 till 3/12/25 were reviewed. The SSA stated the progress notes were indicative of her efforts made to contact different facilities and discharge planning for Resident 47. The SSA stated she created the progress notes on 3/12/25 and backdated it for 12/9/24, 1/17/25, 2/21/25, 3/7/25 and 3/11/25. SSA stated she had been practicing backdating progress notes and nobody had ever questioned that. (continued on next page)

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	056381	A. Building B. Wing	03/13/2025

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/13/25 at 9:25 a.m. with Director of Nursing (DON), the DON stated for the accuracy of the medical records, staff should document within a day or two atleast as the documentation should reflect exactly what happened in real time. The DON stated she over sees social services department but was not aware of social services personnel backdating their progress notes as far back as up to 3-4 months. During a review of the facility's undated policy and procedure (P&P) titled, Charting - Late Entries and Errors (the P&P indicated, Accurate medical records shall be maintained by the facility. Late entries in the medical record shall be dated at the time of entry and noted as a late entry.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 36593 Based on observation, interview, and record review, the facility failed to provide a safe, sanitary environment to prevent transmission of infections for three (Resident 21, 24 and 247) of eleven sampled residents when; 1. Resident 21's urinary drainage bag laid on the floor; 2. Resident 247's urinary bag was touching the floor without privacy cover. 3. Resident 24's tube feeding pole had dried light mater sticking on it; tube feeding pole is a portable, vertical pole used to support and hold the bag of formula or medication during tube feeding. This failure placed the residents at increased risk for healthcare associated infections. Findings: 1. During a review of Resident 21's Annual-Minimum Data Set (MDS - a federally mandated resident assessment and care guide tool), dated 9/19/24, the MDS indicated Resident 21's Basic Interview of Mental status (BIMS, a scoring system used to determine the resident's cognitive status regarding attention, orientation, and ability to register and recall information. A BIMS score of thirteen to fifteen is an indication of intact cognitive status.) score was 15 and indicated intact mental status. MDS indicated Resident 21 was able to recall the correct year, month and day of the week. Resident 21 had clear speech, able to express ideas and wants, and understood others. MDS indicated Resident 21 had indwelling supra pubic catheter (a thin flexible tube inserted into the bladder through the urethra to collect and drain urine). MDS indicated Resident 21 diagnoses included obstructive and reflux uropathy (a condition where the flow of urine is blocked, preventing it from draining normally through the urinary tract). During an observation at 3/10/25 at 09:11 a.m. Resident 21 laid in bed asleep. Resident 21's urine bag laid on the floor in room. During a concurrent observation and interview on 3/10/25 at 9:59 a.m. with Licensed Vocational Nurse (LVN)1 and Certified Nursing Assistant (CNA) 2 in Resident 21's room, Resident 21's urine bag laid on the floor. CNA2 stated Resident 21 liked his urine bag on the floor. During an interview on 3/12/25 at 9:21 a.m. with Resident 21, Resident 21 stated he placed his urine bag on the floor because it was easier for him to get up, out of bed and go. Resident 21 stated when his urine bag was hooked up to his bed he found it difficult to get up out of bed. Resident 21 stated it takes a while for staff to respond to his call light for assistance so he placed urine bag on the floor. During a review of Resident 21's care plan, titled At risk for occurrence of bladder infection related to use of Foley catheter and history of urinary retention. Intervention included to keep catheter below the level of the bladder. (continued on next page)

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	056381	A. Building B. Wing	03/13/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/13/25 at 10:48 a.m. with Director of Staff Development/Infection Preventionist (DSD/IP), DSD/IP stated she was not aware that it took time for staff to help him remove the urine bag from the hook to the bed. During a review of the facility's policy and procedure (P&P) titled, Catheter Care, Urinary,dated 2001, the P&P indicated, Infection Control - Be sure the catheter tubing and drainage bag are kept off the floor. 43771 2. During record review of Resident 247's Face Sheet (FS), the FS indicated Resident 247 was newly admitted to the facility in 2025, less than 30 days. The FS also indicated Resident 247 had diagnoses that included Person Injured In unspecified Motor-Vehicle-Accident, Metabolic Encephalopathy (a brain dysfunction caused by systemic illness leading to changes in mental status such as confusion), Multiple Fracture of Ribs, left side, Laceration of Spleen (a wound characterized by a tear or split in the skin reaching the spleen, Laceration of Liver, Pneumonia, Unspecified Organism (an infection that affects one or both lungs, causes the air sac of the lung to fill up with flid or pus), Significant Acute kidney failure (a condition in which the kidney suddenly cant filter waste from the blood), Retention of urine (difficulty of urinating and completely emptying the bladder), Benign Prostatic Hyperplasia symptoms [enlargement of the prostate that is not cancer] with lower urinary tract. During an observation on 03/10/25 at 11:04 a.m., Resident 247 was laying in bed resting. Resident 247's bed was lowered close to the floor, with his urinary catheter/opening of drainage part directly touching the floor and not covered with a privacy bag. Resident 247 was cohorted in a three-bed bedroom, in the B or middle bed. During an interview on 03/10/25 at 12:10 p.m., with License Vocational Nurse (LVN) 6, LVN 6 stated he had been in Resident 247's room earlier today, had given his medications and took his vital signs, but had not noticed the urinary catheter on the floor. LVN 6 stated the urinary bag is to be kept off the floor, because the floor is dirty and for infection control. During an interview on 03/10/25 at 12:08 p.m., with Director of Staff Development/Infection Preventionist (DSD/IP), the DSD/IP stated the urinary catheter should be positioned lower than the bladder with a privacy bag, that the privacy bag is for dignity. DSD/IP stated the bag should not be touching the floor as it could cause infection for the Resident. During a record review on 03/10/25 of facility's policy and procedure (P&P) titled Catheter Care, Urinary dated 2001, the P&P indicated, Purpose - the purpose of this procedure is to prevent urinary catheter-association complications, including urinary tract infection .Infection control - 2. Be sure the catheter tubing and drainage bag are kept off the floor. 52135 3. During a record review of Resident 24's Admission Record (record with resident's basic personal information) printed on 03/11/25, the record indicated Resident 24 was admitted the facility on 11/29/23. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 24's Minimum Data Set (MDS, an assessment used to guide care) dated 12/12/24, indicated Resident 24 had no speech, was severely impaired of vision and cognitive skills for daily decision making. During a review of Resident 24's Order Summary Report (provides an overview of orders for a specific period) printed on 03/11/25, indicated Resident 24 was to receive formula feeding Jevity 1.2 via Gastrostomy tube (G-tube, a tube inserted through a surgically created hole through the abdomen to deliver food/medications/fluids directly into the stomach) for daily nutritional needs. During an observation on 03/10/25 at 9:55 a.m., Resident 24 was lying in bed. A G-tube feeding bottle containing 500 ml of Jevity 1.2 was hanging on the pole. The feeding pole had light brown matter sticking on it. During a concurrent observation and interview on 03/11/25 at 8:44 a.m., with Licensed Vocational Nurse (LVN 2), at Resident 24's bedside, LVN 2 stated he was the primary nurse for Resident 24 over the past two days. The tube feeding pole still had dried splashes of brown matter sticking at the bottom. LVN 2 stated the brown matter was feeding formula and stated the feeding pole should be cleaned as needed because an unsanitary pole placed Resident 24 at risk for bacteria transmission-based infection. During an interview on 03/11/25 at 12:33 p.m., with Director of Staff Development (DSD)/ Infection Preventionist (IP), stated a dirty pole may increase risk for infection, especially Resident 24 had a surgical opening on the abdomen, it can affect Resident 24's health and safety. DSD further stated feeding pole should cleaned every day and as needed. During a review of facility's undated Policy and Procedure (P&P) titled Cleaning and Disinfection of Resident-Care Items and Equipment, the P&P indicated, [Durable Medical Equipment] DME is cleaned and disinfected once a day and as needed.

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	056381	A. Building B. Wing	03/13/2025

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43771 Based on observation, interviews and record review, the facility failed to provide at least 80 square feet per resident for residents who occupied the following multiple resident bedrooms: Rooms 1, 3, 5, 6, 9, 10, 11, 12, 14, 15, 16, 17, 18, 19, 20, 23, 24, 25, 26, 27, 29, 31, 32, 33, 34, 35, 37, and 39. This failure had the potential to result in a lack of sufficient space for the provision of care by facility staff and a lack of sufficient space for residents to have personal belongings at the bedside. Findings: During random interviews and observations of care and services from 03/10/25 to 03/13/25, there was sufficient space for the provision of care for the residents in all rooms. There was no heavy equipment kept in the rooms that might interfere with residents' care, and each resident had adequate personal space and privacy. There were no complaints from residents regarding insufficient space for their belongings. There were no negative consequences attributed to the decreased space and/or safety concerns in the identified rooms. During a record review of the Client Accommodations Analysis, dated 3/6/25, the following multiple resident rooms were identified having below the required 80 square feet requirement per resident: room [ROOM NUMBER] had 3 beds and 75.75 sq. ft/bed room [ROOM NUMBER] had 3 beds and 75.56 sq. ft/bed room [ROOM NUMBER] had 3 beds and 76.23 sq. ft/bed room [ROOM NUMBER] had 3 beds and 75.93 sq. ft/bed room [ROOM NUMBER] had 3 beds and 75.33 sq. ft/bed room [ROOM NUMBER] had 3 beds and 75.33 sq. ft/bed room [ROOM NUMBER] had 3 beds and 78.00 sq. ft/bed room [ROOM NUMBER] had 3 beds and 75.86 sq. ft/bed room [ROOM NUMBER] had 2 beds and 78.56 sq. ft/bed room [ROOM NUMBER] had 2 beds and 79.73 sq. ft/bed room [ROOM NUMBER] had 3 beds and 76.77 sq. ft/bed (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	room [ROOM NUMBER] had 3 beds and 78.35 sq. ft/bed room [ROOM NUMBER] had 3 beds and 76.76 sq. ft/bed room [ROOM NUMBER] had 2 beds and 79.76 sq. ft/bed room [ROOM NUMBER] had 2 beds and 79.76 sq. ft/bed room [ROOM NUMBER] had 3 beds and 73.84 sq. ft/bed room [ROOM NUMBER] had 3 beds and 73.70 sq. ft/bed room [ROOM NUMBER] had 3 beds and 72.36 sq. ft/bed room [ROOM NUMBER] had 3 beds and 70.26 sq. ft/bed room [ROOM NUMBER] had 3 beds and 70.26 sq. ft/bed room [ROOM NUMBER] had 3 beds and 72.83 sq. ft/bed room [ROOM NUMBER] had 3 beds and 73.39 sq. ft/bed room [ROOM NUMBER] had 3 beds and 73.39 sq. ft/bed room [ROOM NUMBER] had 3 beds and 73.39 sq. ft/bed room [ROOM NUMBER] had 3 beds and 73.39 sq. ft/bed room [ROOM NUMBER] had 3 beds and 73.08 sq. ft/bed room [ROOM NUMBER] had 3 beds and 73.39 sq. ft/bed room [ROOM NUMBER] had 3 beds and 73.39 sq. ft/bed. During an interview on 3/13/25 at 3:31p.m., with Resident 79, Resident 79 stated she has enough space to move around, and she can do what she wants to do in the room. During an interview on 3/13/25 at 3:30 p.m., with Certified Nursing Assistant (CNA) 4, CNA 4 stated the room is a bit small, but she is able to manage, she can move things around to do what she wants to do. CNA 4 stated she has been with facility since 2014. During an interview on 3/13/25 at 3:35 p.m., with Licensed Vocational Nurse (LVN) 7, LVN 7 stated she can move around, she might have to move something here and there to make way. LVN 7 stated she is not bothered by the room space. During an observation on 3/13/25 at 3:41 p.m., in room [ROOM NUMBER], Maintenance staff and Maintenance Assistant used a tape measure and measure the square footage of one bed in the room, room [ROOM NUMBER] had 3 beds and one bed measured at 72.60 sq. ft/bed. (continued on next page)

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	03/13/2025

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 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	During an observation on 3/13/25 at 3:51 p.m., in room [ROOM NUMBER], Maintenance staff and Maintenance Assistant used a tape measure and measure the square footage of one bed in the room, room [ROOM NUMBER] had 3 beds, one bed measured at 72.21 sq. ft/bed.