STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555104	A. Building B. Wing	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Concord Post Acute	1050 San Miguel Road Concord, CA 94518

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 - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to protect four of six sampled residents (Resident 2, Resident 3, Resident 4, and Resident 5) from physical abuse when following was noted:1. Resident 2 and Resident 3 got into a physical altercation with each other resulting in Resident 2 sustaining a one-inch scratch (shallow cut in the skin caused by trauma), to the left neck; and Resident 3 sustaining redness to the right forehead.2. Resident 4 and Resident 5 got into a physical altercation with each other resulting in Resident 4 sustaining a skin tear, (traumatic wound occurring when the top layer of skin separates from the underlying layer), to the front of the left arm, top of head, hand and forearm and a scratch to the right cheek and Resident 5 sustaining a scratch to the left upper lip. 1. During a review of admission Record for Resident 2 printed on 1/28/26, the record indicated Resident 2 was admitted to the facility in March 2025 with a diagnosis of dementia (a loss of brain function that occurs with certain diagnoses, affecting on or more brain functions such as memory, thinking, language, judgement or behavior), with behavioral disturbance, (a persistent pattern of disruptive or dysfunctional behavior). During a review of Resident 2's Minimum Data Set, (MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan) dated 12/23/25, the assessment indicated Resident 2 was able to make himself understood and able to understand others. During a review of admission Record for Resident 3, printed on 1/28/26, the record indicated Resident 3 was admitted to the facility in November 2023. During a review of Resident 3's MDS assessment dated [DATE], the assessment indicated Resident 3 had a Brief Interview for Mental Status score, (BIMS is a scoring system used to determine the resident's cognitive status regarding attention, orientation and ability to register and recall information), of three (3) out of 15 indicating severe cognitive impairment. During a concurrent observation and interview on 1/28/26 at 1:30 p.m. with Resident 2 in the facility patio area, Resident 2 stated he did not remember the incident of 4/23/25 and has never had a disagreement or altercation with any resident. Resident 3 was not available during the investigation. During a telephone interview on 1/29/26 at 3:34 p.m. with Licensed Vocational Nurse (LVN 2), LVN2 stated she was assigned to Station 4 on the evening shift on 4/23/25. LVN 2 stated at approximately 4:30 p.m. LVN2 was preparing medication for a resident when LVN 2 heard screaming coming from the direction of Station 3. LVN2 stated she rushed toward the noise and saw Resident 3 in his wheelchair in the hallway connecting Stations 3 and 4 yelling at Resident 2. LVN2 stated while she was redirecting Resident 3 back to the room, Resident 2 hit Resident 3 in the head with his fist and Resident 3 scratched Resident 2 on the left side of the neck with his fingernails. LVN2 stated she assessed Resident 3 and found a reddened area to the right side of the forehead. LVN2 stated Resident 3 denied pain when asked. During a telephone interview on 1/29/26 at 4:45 p.m. with LVN 3, LVN3 stated on 4/23/26 at approximately 4:45p.m. he heard someone yelling back up in the hallway between Stations 3 and 4. LVN 3 stated upon LVN (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3's arrival the residents, (Resident 2 and Resident 3), had been separated and were being taken back to their rooms. LVN 3 stated he assessed Resident 2 and noted an approximately one (1)-inch scratch on the left side of Resident 2's neck with minimal bleeding. LVN 3 assessed Resident 2 and noted Resident 2 had a scratch to the left neck and no complaint of pain. LVN3 stated the wound was cleaned with saline, (mixture of salt and water and patted dry. During a review of Resident 2's progress notes dated 4/23/25, LVN 3 documented, LVN3 was notified by a staff that Resident 2 and Resident 3 had gotten into an altercation. The record indicated [Resident 3] was yelling at [Resident 2] .[Resident 2] hit [Resident 3] in the face and [Resident 3] scratched Resident 2 on the left neck. The record indicated both residents were redirected to their rooms. 2. During a review of admission Record for Resident 4 printed on 1/28/26, the record indicated Resident 4 was admitted to the facility in December 2025 with diagnoses of Alzheimer's Disease, (a progressive brain disorder that destroys memory, thinking skills and the ability to perform simple tasks), with agitation, (state of extreme mental and physical arousal characterized by restlessness, irritability and purposeless motions like pacing). During review of Resident 4's MDS assessment dated [DATE], the assessment indicated Resident 4 usually understands others and usually able to make himself understood. During a review of admission Record for Resident 5 printed on 1/28/26, the record indicated Resident 5 was admitted to the facility in March 2025, with diagnosis of dementia with agitation, depression, (persistent low mood, loss if interest in activities, feeling of emptiness), anxiety, (feeling of dread fear and uneasiness). During a review of Resident 5's MDS assessment dated [DATE], the record indicated Resident 5 usually understands others and usually able to make himself understood. During a concurrent observation and interview on 1/28/26 at 1:00 p.m. with Resident 4 in the resident's room in the facility locked unit, Resident 4 was sitting on the bed with arms crossed and fidgeting, (small movements especially in the hands and feet caused by nervousness or impatience). Resident 4 stated he did not recall the incident of 12/10/25 and turned to face the wall. During a concurrent observation and interview on 1/28/16 at 1:10 p.m. at Resident 5's room with a Spanish speaking interpreter on the phone, Resident 5 stated through the interpreter he did not want to be interviewed. During a telephone interview on 2/1/26 at 7:30 a.m. with CNA 2, CNA 2 stated she was assigned to Resident 4 and Resident 5 on 12/10/25. CNA2 stated at approximately 5:30 a.m. CNA 2 was delivering care behind closed doors to residents across the hallway from Residents 4 and 5 when she heard yelling outside the room where CNA2 was working. CNA2 stated she went to investigate, and by the time she reached the Resident's room Resident 4 was at the nursing station with LVN1. CNA2 stated she observed Resident 5 pacing around the room as if angry. CNA 2 noted there was a wound on the left side of Resident 5's face. During an interview on 1/28/26 at 4:00 p.m. with LVN1, LVN1 stated on 12/10/25 at 5:30 a.m. LVN1 was preparing to do morning blood sugar testing on Station 1 when Resident 4 approached LVN1. LVN1 stated Resident 4 was visibly upset and told her his roommate (Resident 5) hit him while he was sleeping. LVN1 stated she observed a superficial cut on the top of Resident 4's head, a small scratch on the right cheek, and scratches to Resident 4's right hand and forearm. LVN1 stated she observed slight bleeding from all the wounds. LVN1 stated she seated Resident 4 in the hallway at Station 1 and went to the room shared by Resident 4 and Resident 5 to assess Resident 5. LVN1 stated she observed Resident 5 out of bed and pacing around the room. LVN1 stated she approached the doorway and used hand gestures to ask if Resident 5 was alright. LVN1 stated Resident 5 approached the doorway in an aggressive manner, (acting in a forceful way that threatens others), gestured for LVN1 to leave, and slammed the door closed not allowing an assessment. LVN1 stated she observed a scratch to Resident 5's left upper lip. LVN1 stated she cleansed Resident 4's wounds, applied dressings and medicated Resident 4 for pain per (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 4's request. During a review of Resident 4's progress notes dated 12/10/25, LVN 1 documented Resident 4 was visibly bleeding upon initial assessment . [Resident 4] had skin tears, on the crown of the head, the right cheek, (1x1 centimeter), back of the right hand, and the front of the left forearm .wounds were cleansed with normal saline and patted dry .[Resident 4] was medicated for pain and placed in a different room. During a review of Resident 5's Nurses Notes dated 12/10/25, LVN1 documented LVN1 entered Resident 5's room after being informed of a physical altercation with the roommate. Upon assessment LVN1 was able to observe a scratch on Resident 5's upper lip. During a concurrent interview and record review on 2/5/26 at 2:15p.m. with the Director of Nurses, (DON), the DON stated CNAs are updated on resident care plans during shift change huddles and facility is supposed to have individualized, person-centered care plans for all residents. The DON stated residents with dementia often experience agitation and aggression and to prevent abuse, the facility must have good training, communication, documentation and monitoring. During a review of Care Plan Reports for Residents 2, 3, 4, and 5 with varying dates, the DON stated Resident 2 did not have a care plan for dementia. The DON stated the altercation between Resident 2 and Resident 3 could have been avoided if Resident 2 had a care plan for dementia in effect. During a review of the facility's policy and procedure titled, Resident Rights, dated 2/2001, indicated.Residents have the right to be free from abuse, neglect, misappropriation of property and exploitation.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to implement a comprehensive care plan for one of five sampled residents (Resident 1). The facility did not provide supervision to Resident 1 when she was in facility's patio.This failure resulted in Resident 1 falling on the ground sustaining a cut and bump to the back of the head and transfer to the acute care hospital for further care and evaluation.During a review of Resident 1's admission Record printed on 1/28/26, the record indicated Resident 1 was admitted to the facility in January 2017. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan), dated 5/7/25, indicated Resident 1's 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 was zero (0) out of 15, indicating severe cognitive (mental status) impairment. The record indicated Resident 1 had a diagnosis of Alzheimer's Disease, (a progressive, irreversible brain disorder resulting in a loss of brain function affecting memory, thinking, language, judgment, or behavior). Resident 1 was unavailable for interview during the investigation. During a review of Resident 1's Fall Risk Assessment, (an evaluation used to identify a resident's likelihood of falling and suffering injury), dated 5/1/25, the assessment indicated Resident 1 was identified as high risk for fall and injury related to unsteady gait with use of a front wheel walker, greater than [AGE] years old, dependent and incontinent, easily distracted, periods of altered perception of surroundings, episodes of disorganized speech, periods of restlessness, lethargy, varying mental function, wandering, abusive and resists care. The record indicated Resident 1 has had 1-2 falls within the 90 days prior to the assessment. During a review of Resident 1's Fall Care Plan reviewed on 2/7/25, the care plan indicated Resident 1 was at high risk for falls related to confusion, gait/balance problems, incontinence and unaware of safety needs. The record indicated an intervention stating, Staff will monitor and assist resident while ambulating in the patio. During an interview with the (Director of Nursing) DON on 2/5/26 at 11:45 a.m. the DON stated Resident 1's fall could have been avoided if a member of the staff was on the patio with Resident 1 (as mentioned in Resident 1's care plan). During a review of the facility's policy and procedure titled, Care Plans, Comprehensive Person-Centered, dated 11/2019, indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide adequate supervision to one of three sampled residents (Resident 1), when Resident 1 with a history of wandering (traveling aimlessly form place to place), sustained an unwitnessed fall while ambulating on her own in the facility's patio area.This failure resulted in Resident 1 falling on the ground, sustaining a cut and bump to the back of the head, transfer to the acute care hospital for further care and evaluation. During a review of Resident 1's admission Record printed on 1/28/26, the record indicated Resident 1 was admitted to the facility in January 2017. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan), dated 5/7/25, indicated Resident 1's 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 was zero (0) out of 15, indicating severe cognitive (mental status) impairment. The record indicated Resident 1 had a diagnosis of Alzheimer's Disease, (a progressive, irreversible brain disorder resulting in a loss of brain function affecting memory, thinking, language, judgment, or behavior). During a review of Resident 1's Fall Risk Assessment, (an evaluation used to identify a resident's likelihood of falling and suffering injury), dated 5/1/25, the assessment indicated Resident 1 was identified as high risk for fall and injury related to unsteady gait with use of a front wheel walker, greater than [AGE] years old, dependent and incontinent, easily distracted, periods of altered perception of surroundings, episodes of disorganized speech, periods of restlessness, lethargy, varying mental function, wandering, abusive and resists care. The record indicated Resident 1 has had 1-2 falls within the 90 days prior to the assessment. During a review of Resident 1's Elopement and Wandering Risk Assessment, (a clinical, standardized checklist used to identify, monitor and prevent residents with cognitive decline from leaving supervised areas unattended), dated 5/1/25, the assessment indicated Resident 1 had a score of eighteen. The assessment specified a score greater than ten indicates a resident would be considered at risk for wandering or elopement. During a review of Resident 1's Fall Care Plan reviewed on 2/7/25, the care plan indicated Resident 1 was at high risk for falls related to confusion, gate/balance problems, incontinence and unaware of safety needs. The record indicated an intervention stating, Staff will monitor and assist resident while ambulating in the patio. During an observation on 2/5/26 at 11:15 a.m. in the facility patio, where Resident 1 was found on 5/22/25, at the entrance to the patio area alongside the building and to the left of the door has a patio made of concrete slabs placed next to each other extending the length of the back of the building. The area is approximately three (3) feet wide. Alongside the patio is a grassy area extending to the fence and along the fence are garden containers. During a telephone interview on 2/3/26 at 10:30 a.m. with Certified Nursing Assistant (CNA 3), CNA 3 stated he was the assigned direct care staff for Resident 1 on 5/22/25. CNA 3 stated he provided incontinent care (changing of briefs) to Resident 1 around 6:25 p.m. in her room on that day and did not see her after that until he learnt about Resident 1's fall around 7:00 pm. CNA 3 stated Resident 1 was awake, alert and ambulatory. During a telephone interview on 2/3/26 at 2:00 p.m. with CNA 4, CNA 4 stated she was the hallway monitor (staff assigned to monitor the facility hallways for resident's safety) for Station 3 from 6:30 p.m. until 7:00 p.m. on 5/22/25. CNA 4 stated she observed Resident 1 when CNA 4 came out to the hallway from another resident's room. CNA 4 stated Resident 1 was walking towards Station 4, she called out to Resident 1, Resident 1 turned to look at CNA 4, then Resident 1 turned back and continued to walk. CNA 4 stated she did not pursue (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 1 because Resident 1used to become agitated when her walking was interrupted. During an interview on 1/29/26 at 5:30 p.m. with CNA 1, CNA 1 stated on 5/22/25 at approximately 7:00 p.m. she observed Resident 1 lying on the pavement alone in the Station 4 patio area holding the back of her head, crawling on the ground. CNA 1 stated she called for help and waited with Resident 1 for the nurse to come. During an interview on 1/29/26 at 3:34 p.m. with Licensed Vocational Nurse (LVN 2), LVN 2 stated on 5/22/25 at approximately 7:00 p.m. she responded to a distress call from CNA1 stating there was a resident on the ground in the patio. LVN 2 stated when she arrived Resident 1 was awake, alert and lying on the grass. Resident 1 was slightly bleeding at the back of her head. LVN 2 stated she noticed that Resident 1's front wheel walker was tipped over on the grass near Resident 1. During an interview on 1/29/25 at 4:45p.m with LVN 3, LVN 3 stated she was the assigned nurse for Resident 1 on 5/22/25. LVN 3 stated she used saline to cleanse Resident 1's back of the head where it was bleeding and applied a dressing to the area. LVN 3 stated the door to patio area was supposed to be an alarmed door, however the alarm did not work for a very long time. LVN 3 also stated the alarm to patio door was not fixed until after Resident 1's fall. During a review of Resident 1's Change in Condition progress notes dated 5/22/25, LVN 3 documented [Resident 1] was observed to be on the ground in the patio resident kept trying to get up unassisted during the nursing assessment was assisted to a wheelchair .noted bump on the back of the head with slight bleeding . resident was taken to the acute hospital by ambulance on 5/22/25 at 8:40 p.m. During an interview on 1/29/26 at 3:00 p.m., the Director of Nurses, (DON), stated LVN3 informed him about Resident 1's fall. The DON stated the primary safeguards in place for resident safety and accidents prevention were staff monitoring the hallways, and coded/alarmed doors between each unit. The DON then stated however facility kept the door to the patio area open during the day to allow residents access to the patio. The DON stated the door lock for the door from Station 4 to the patio was not activated until 8:00 p.m. every day, allowing Resident 1 to go into the patio unsupervised on her own resulting in an unwitnessed fall. During an interview with the DON on 2/5/26 at 11:45 a.m. the DON stated Resident 1's fall could have been avoided if a member of the staff was on the patio with Resident 1 (as mentioned in Resident 1's care plan). During review of the facility's policy and procedure titled, Falls and Fall Risk, Managing dated 3/2018, indicated Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and try to minimize compilations from falling.