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	05/29/2026

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 - 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure for one out of four sampled residents (Resident 1), was protected from sexual abuse (non-consensual sexual contact of any type with a resident) when Certified Nurse Assistant (CNA) 1 was witnessed with his face on Resident 1's exposed right breast.This failure resulted in Resident 1 experiencing sexual abuse.This failure had the potential to cause emotional distress, feelings of shame, embarrassment, and an unsafe living environment due to Resident 1 experiencing sexual abuse from CNA 1.Findings:During a record review of the facility's Report of Suspected Dependent Adult/Elder Abuse form SOC 341 sent to the State Agency, the form indicated that on 4/30/26 at 3:14 p.m., CNA 1 was reported to have sexually abused Resident 1.During a review of facility's admission Record (AR) printed on 5/14/26, the AR indicated Resident 1 was admitted on [DATE], with diagnoses that included Alzheimer's Disease With Late Onset and Other Specified Anxiety Disorder.During a review of Resident 1's Minimum Data Set (MDS - standardized resident assessment tool) dated 4/2/26, a Cognitive Patterns with Staff Assessment for Mental Status indicated Resident 1 had short-term and long-term memory problem. MDS Functional Abilities under Mobility indicated, Resident 1 was Independent with the following activities: The ability to roll left to right side of the bed, move from sitting on side of the bed to lying flat on the bed, the ability to move from lying on the back to sitting on the side of the bed with no back support, the ability to come to a standing position from sitting in a chair, wheelchair, or side of the bed, and the ability to transfer to and from a bed to a chair. Furthermore, Resident 1 could independently Walk 150 feet once standing and eat independently once the meal was placed before the resident.During a record review of Resident 1's Progress Notes (PN), dated 4/30/26, the PN indicated, Approx 1514 [Approximately 3:14 p.m.] CNA [2] approach this writer [Licensed Vocational Nurse (LVN) 1] and reported witnessing CNA [1] engaging in inappropriate contact with resident [1]. Resident [1]'s shirt was pulled up with right breast exposed. CNA [2] witnessed CNA [1] with his mouth on the resident [1]'s right breast. This writer [LVN 1] immediately proceeded to check the resident [1]. Resident [1] was observed lying in bed in room [Resident 1's room]. When asked about the incident, resident [1] was unable to provided a clear account of what occurred. A skin check was performed with resident consent, however the resident was noted to guard her chest area with her hand during the examination. Writer noted slightly redness to the right areola.During a concurrent observation and interview on 5/14/26 at 11:17 a.m., near the nursing station 4 with Resident 1, with the presence of CNA 4, CNA 4 asked Resident 1 to go to her room. Resident 1 walked to her room, and she sat on the side of the bed. Resident 1 could identify herself only. CNA 4 stated that Resident 1 could speak English and English. During an observation on 5/15/26 at 2:48 p.m., in Resident 1's room, Resident 1 walked around her room. Resident 1 had a roommate in bed B. Resident 1 sat on the edge of the right side of the bed, and then removed her slipped-on shoes, and Resident 1 laid down into her bed. While Resident 1 was lying in bed, she moved herself to the middle of the bed without assistance. Then Resident 1 got up to sit on the edge of the bed and put on her shoes. Further, Resident 1 walked around the room.During an interview on 5/15/26 at 3:32 p.m., with CNA 3, CNA 3 (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 - Actual harm Residents Affected - Few	stated that she regularly cared for Resident 1 during daytime. CNA 3 stated Resident 1 could get in and out of bed independently and that Resident 1 could put on and take off her shoes independently. Further, CNA 3 stated Resident 1 was mostly friendly and pleasant.During a concurrent interview and record review on 5/14/26 at 10:34 a.m., with Scheduling Coordinator (SC), SC reviewed facility's Nursing Staffing Assignment And Sign-In Sheet dated 04/30/2026 PM Shift for Station 4. SC stated that CNA 1 was assigned to Station 4 Run#2, which included from room numbers . [room numbers redacted]. CNA 1's room assignment did not include Resident 1's room. Resident 1's room was assigned to Station 4 Run#5, which included room numbers [room numbers redacted] . CNA 2 was assigned to care for Resident 1.During an interview on 5/15/26 at 12:29 p.m., with CNA 1, CNA 1 stated that on 4/30/26, he walked into Station 4 after a staff meeting. CNA 1 stated he saw Resident 1 holding hands and walking with another resident. CNA 1 stated the other resident was a high risk for fall, and that CNA 1 could not identify the other resident. CNA 1 stated he assisted Resident 1 to go to her room. CNA 1 stated the other resident was fine by herself, and was just wandering. CNA 1 stated he walked with Resident 1 to her room. CNA 1 stated he assisted Resident 1 to sit on the edge of the bed, and then he sat next to Resident 1 on the left side of the bed. Further, CNA 1 stated that he knelt to help Resident 1 remove her shoes. CNA 1 then lifted Resident 1's legs and assisted her to lay down in bed. CNA 1 stated he helped Resident 1's alignment in the middle of the bed when CNA 2 walked in the room at the time.During a concurrent observation and interview on 5/15/26 at 2:58 p.m., with CNA 2, in Resident 1'and Resident 2's shared room, the room had two beds. Resident 1's bed was by the door (bed A), and Resident 2's bed was by the window (bed B). There were curtains being used in the room for privacy. There was a curtain that hung that would cover the foot of the bed, and the other curtain that would cover the area in between the residents. CNA 2 stated on 4/30/26, her regular room assignment included Resident 1 and Resident 2's room. CNA 2 stated on 04/30/2026 at around 3:14 p.m., she walked into Residents 1 and Resident 2's shared room, because she saw Resident 2 was in bed, and her bed elevated. CNA 2 stated she wanted to lower Resident 2's bed. CNA 2 stated as she walked into the room, Resident 1's curtain by the foot of the bed was pulled closed, and the other curtain in between Resident 1 and Resident 2 was halfway closed. CNA 2 stated she as she was passing by Resident 1's foot of the bed on the right side corner, CNA 2 peeked into Resident 1's bed, and she saw Resident 1 was lying flat in bed, with CNA 1 was sitting on the left side of the bed. Furthermore, CNA 2 stated that CNA 1's face was on Resident 1's exposed right breast. CNA 1 stated she was shocked, but she confronted CNA 1. CNA 2 stated she asked CNA 1 What are you doing? CNA 2 stated CNA 1 immediately stood up and pulled down Resident 1's shirts to cover Resident 1's breast. Then, CNA 1 pulled up his face mask to cover his mouth. CNA 2 stated that CNA 1 replied to her that he was assisting Resident 1 to get into her bed. CNA 2 stated that CNA 1 stepped outside of the curtain and he stood in front of her. CNA 2 stated that she looked at CNA 1, and she told him that it was not what she saw. CNA 2 stated that CNA 1 stepped towards her and raised his arms. Then, CNA 2 stated that CNA 1 walked out of the room. CNA 1 stated she called LVN 1 and to report the event. CNA 2 stated she was regularly assigned to Resident 1, and Resident 1 does not like to have her room curtains closed. CNA 2 stated that if Resident 1's curtains were closed, and the resident was in bed, the resident would get up to open the curtains.During an interview on 5/15/26 at 3:53 p.m., with LVN 1, LVN 1 stated that on 4/30/26, she finished getting the report from the morning shift nurse. LVN 1 stated that CNA 2 approached her and reported that she had witnessed CNA 1 sitting on the left side of Resident 1's bed and that CNA 1's face was on Resident 1's exposed right breast. LVN 1 stated that she immediately went to Resident 1's bedside with CNA 2. LVN 1 stated that Resident 1 could not recall the incident, but Resident 1 allowed her to check her chest area. LVN 1 stated that Resident 1 was guarding herself with her arms across her chest. LVN 1 stated that she assessed Resident 1's breast area, and she noted some circular shaped redness above the areola about 1 1/2 inches in size. LVN 1 stated that she reported the event to her supervisor. Furthermore, LVN 1 stated that Resident 1 did not allow other nurses to assess her during her shift.During an interview on (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	5/26/26 at 12:21 p.m., with Resident 1's Responsible Party (RP), RP stated that if Resident 1 did not have Alzheimer's Disease, she would not tolerate sexual abuse to happen. RP stated that Resident 1 was a strong and religious woman, and Resident 1 would stand her ground. RP stated that he visited Resident 1 after the incident, and RP noted Resident 1 had some hesitation during their hug, and that Resident 1 was somber and more reserved during the visit. Furthermore, RP added that as a close family member, he noticed something was different with Resident 1.During a review of the facility's policy and procedure (P&P) titled, Abuse, Neglect, Exploitation or Misappropriation Prevention Program, with revision date of 4/2021, the P&P indicated, Policy Statement Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but not limited to freedom from corporal punishment [physical punishment, used as a means to correct or control behavior], involuntary seclusion, verbal, mental, sexual or physical abuse, physical or chemical restraint not required to treat the resident's symptoms. Policy Interpretation and Implementation. The resident abuse, neglect and exploitation prevention program consists of a facility-wide commitment and resource allocation to support the following objectives: 1. Protect the residents for abuse, neglect, exploitation or misappropriation of property by anyone including, but not necessarily limited to: a. facility staff.