

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555104	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/08/2026
NAME OF PROVIDER OR SUPPLIER Concord Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview and record review, the facility failed to ensure it kept accurate records of controlled medications (medication with a potential for abuse) as evidenced by: 1. The facility failed to ensure, for Residents 1-17, the scheduled (controlled medication, narcotic) medication system was complete (all documents readily available) and accurate (information matched). The record system included Shipping Manifests (pharmacy delivery receipt), Controlled Substance Accountability Sheets (CDR, Controlled Drug Record), Medication Administration Records (MAR, record of medication administration) and destruction logs. The facility records were incomplete. The facility records were inaccurate. These failures had the potential to result in undetected loss and diversion of scheduled medications. In addition, these failures had the potential to result in preventable medication errors (medication not given as ordered). 2. The facility failed to ensure, between 9/23-3/24, the Consultant Pharmacist identified the scheduled (controlled medication, narcotic) medication system was incomplete (all documents available) and inaccurate (information matched). The record system included Shipping Manifests (pharmacy delivery receipt), Controlled Substance Accountability Sheets (CDR, Controlled Drug Record), Medication Administration Records (MAR, record of medication administration) and destruction logs. The facility records were incomplete. The facility records were inaccurate. These failures had the potential to result in undetected loss and diversion of scheduled medications. In addition, these failures had the potential to result in preventable medication errors (medication not given as ordered). Findings: 1. During an interview, on 3/11/26 at 10 a.m., Medical Record Director (MRD) was asked to describe the pharmacy documentation (Shipping Manifests, CDR) system. His description included that all pharmacy documents were retained by the facility. During an interview, on 3/11/26 at 10:45 10 a.m., Director of Nursing (DON) was asked to describe the scheduled medication record system. DON's description included that scheduled medications were delivered by the pharmacy with a corresponding Shipping Manifest and CDR. DON further stated that all scheduled medication records were in her office. DON was asked to provide the scheduled medication Shipping Manifests and CDRs from 9/1/23 through 3/31/24. During a concurrent tour and interview, on 3/11/26 at 11:28 a.m., at Station 2, Licensed Vocational Nurse (LVN 1) identified a medication cart. LVN 1 was requested to describe the scheduled medication documentation process. Her description included scheduled medications were delivered with a Shipping Manifest and a corresponding CDR. The Shipping Manifest was sent for retention. The medication was locked in the medication cart. The CDR was filed at the medication cart. The CDR was used to document removal of patient medications. Administration of the medication was documented on the MAR. Completed CDRs were sent for retention. If there were scheduled medications remaining upon discontinuation, the remaining medication and the CDR were sent to the DON. During a concurrent interview and medical record review, on 3/12/26 at 10:20 a.m., (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	DON identified the following CDRs that the facility did not have a corresponding Shipping Manifest. Resident 1 Rx 4818577.02 Oxycodone (narcotic pain reliever) 10 mg (milligram) tablet #60 Resident 2 Rx 4923263 Oxycodone 5 mg tablet #10 Resident 3 Rx 4872560 Hydrocodone (narcotic pain reliever)-Acetamin (acetaminophen, pain reliever) 5-325 tablet #28 Resident 3 Rx 4940244 Oxycodone 5 mg tablet #8 Resident 4 Rx 4925237 Hydrocodone-Acetamin 5-325 tablet #60 Resident 5 Rx 4872291 Hydrocodone-Acetamin 5-325 tablet #30 Resident 6 Rx 4925236 Oxycodone 5 mg tablet #60 Resident 6 Rx 4857714 Oxycodone 5 mg tablet #25 Resident 7 Rx 4857833 Hydrocodone-Acetamin 10-325 tablet #26 Resident 8 Rx 4855609 Morphine Sulf (narcotic pain reliever) 15 mg tablet #44 Resident 9 Rx 4925971 Hydrocodone-Acetamin 5-325 tablet #28 Resident 9 Rx 4935099 Hydrocodone-Acetamin 5-325 tablet #56 Resident 9 Rx 4864670 Hydrocodone-Acetamin 5-325 tablet #28 Resident 10 Rx 4859997 Oxycodone 5 mg tablet #28 Resident 11 Rx 4913753 Oxycodone-Acetaminophen 10-325 tablet #28 Resident 12 Rx 4933419 Hydrocodone-Acetamin 5-325 tablet #28 Resident 13 Rx 4844638 Hydrocodone-Acetamin 5-325 tablet #60 During a concurrent interview and record review, on 3/12/26 at 10:30 a.m., DON identified Resident 14's MAR. DON compared the 4807224 Oxycodone 10 mg tablet #60 date 11/27/23 CDR against the MAR. DON acknowledged the CDR removals did not have a corresponding MAR administration on the dates and times listed below. 12/4/23 1600, 2100 12/12/23 0000 12/20/24 1750 During a concurrent interview and record review, on 3/12/26 at 10:30 a.m., DON identified Resident 15's MAR. DON compared the 4823063 Hydrocodone-Acetamin 5-325 mg tablet #42 date 12/12/23 CDR against the MAR. DON acknowledged the CDR removals did not have a corresponding MAR administration on the dates and times listed below. 12/22/23 both doses 12/31/23 0010 During a concurrent interview and record review, on 3/12/26 at 10:30 a.m., DON identified Resident 16's MAR. DON compared the 4752178 Oxycodone 5 mg tablet #28 date 10/9/23 CDR against the MAR. DON acknowledged the CDR removal did not have a corresponding MAR administration on the date and time listed below. 10/21/23 500 During a concurrent interview and record review, on 3/12/26 at 10:30 a.m., DON identified Resident 17's MAR. She compared the 4686477 Hydrocodone-Acetamin 5-325 mg tablet #60 date 10/11/23 CDR against the MAR. DON acknowledged the CDR removals did not have a corresponding MAR administration on the dates and times listed below. 12/2/23 illegible 2/5/23 12002/7/23 12002/8/23 1600 During a concurrent interview and record review, on 3/12/26 at 10:30 a.m., DON identified Resident 11's MAR. She compared the 4840387 Hydrocodone-Acetamin 10-325 mg tablet #26 date 12/30/23 CDR against the MAR. DON acknowledged the CDR removal did not have a corresponding MAR administration on the date and time listed below. 1/15/24 856 During a concurrent interview and record review, on 3/12/26 at 12:30 p.m., DON identified the Policy for Controlled Substances (Revision Date November 2022). DON reviewed the policy and acknowledged it required the documentation (Shipping Manifests, CDRs and MARs) to be accurate (monitored and reconciled). An administrative record review, of the Policy for Controlled Substances (Revision Date November 2022) showed, Dispensing and Reconciling Controlled Substances, 1. Controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow-up. 2. The system of reconciling the receipt, dispensing and disposition of controlled substances includes the following: a. Records of personnel access and usage; b. Medication administration records; c. Declining inventory records. 2. During an interview, on 3/11/26 at 10 a.m., Medical Record Director (MRD) was asked to describe the pharmacy documentation (Shipping Manifests, CDR) system. MRD's description included that all pharmacy documents were retained by the facility. During an interview, on 3/11/26 at 10:45 a.m., Director of Nursing (DON) was asked to describe the scheduled medication record system. DON's description (continued on next page)		

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