

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555287	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2026
NAME OF PROVIDER OR SUPPLIER Diamond Ridge Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2351 Loveridge Road Pittsburg, CA 94565	
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)		
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to treat Resident 1 with respect and dignity when Certified Nursing Assistant (CNA) 1 did not wash Resident 1's buttocks when CNA 1 gave Resident 1 a shower. This failure resulted in Resident 1 feeling upset and angry. During an interview on 1/13/26 at 11:07 a.m., with Resident 1, the resident stated CNA 1 did not wash her buttocks when CNA 1 gave her a shower on 12/27/25 at 10 a.m. Resident 1 stated she asked CNA 1 to wash her buttocks because the resident could not reach it. Resident 1 stated CNA told her that CNA 1 did not want to hurt her back if CNA 1 bent too much to wash Resident 1's buttocks. Resident 1 stated she felt upset and angry. During a review of Resident 1's Facesheet (information containing contact details, brief medical history at-a-glance) dated 1/16/26, indicated, Resident 1 was admitted to the facility on [DATE] with diagnoses that included need for assistance with personal care. Review of Resident 1's Minimum Data Set (MDS, an assessment tool used to direct resident care) dated 11/7/25 under Section C, indicated Brief Interview for Mental Status (BIMS, a screening tool to identify resident's cognitive status) score of 15, indicating Resident 1 was cognitively intact. The MDS Section GG titled, Functional Abilities and Goals indicated, Resident 1 needed substantial/maximal assistance in showering meaning the helper lifts or holds trunk and limbs of the resident and provides more than half the effort when giving a shower to the resident. During an interview on 1/13/26 at 12:09 p.m., with CNA 1, CNA 1 confirmed she did not wash Resident 1's buttocks when she gave the shower on 12/27/25 because she was worried that she was going to hurt her back if she bent and washed the resident's buttocks. Further stated that it did not cross her mind to call for assistance from another CNA. Stated, she gave the shower to the resident in the morning of 12/27/25 at around 10:00 a.m. and was only able to clean Resident 1's buttocks in the afternoon around 1:30 p.m. because the resident was upset about the incident after the resident's shower. During an interview on 1/16/26 at 215 p.m., with the Director of Staff Development (DSD), the DSD stated CNA 1 should not have refused to wash the resident's buttocks and should have asked for help from another CNA to fulfill the task. During an interview on 1/16/26 at 3:00 p.m., with the Director of Nursing (DON), the DON stated that CNA 1 should have cleaned Resident 1's buttocks to preserve the resident's dignity and to prevent the risk of skin breakdown. A review of the facility's policy and procedure (P&P) titled, Resident Rights, Revised on 12/19/22, the P&P indicated, .11. The facility will ensure that all direct care and indirect care staff members. are educated on the rights of residents and the responsibility of the facility to properly care for its residents.</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 555287	Facility ID: 555287 If continuation sheet Page 1 of 2

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure Resident 2's family member (FM) 1 was provided proper training in the use of broda wheelchair (a broda wheelchair is a specialized, highly adjustable positioning wheelchair). This failure resulted in Resident 2 falling from the broda wheelchair and hitting her face on the floor while being wheeled by FM 1. During an interview on 1/13/26 at 10:14 a.m., with Resident 2, the resident stated that on 12/16/25, while being wheeled by FM 1, she fell from her wheelchair and hit her face in the floor. Further stated her fall could have been prevented if the facility trained FM 1 on how to safely and properly wheel Resident 2 with the broda wheelchair. During a review of Resident 2's Facesheet (information containing contact details, brief medical history at-a-glance) dated 1/16/26, indicated Resident 2 was admitted to the facility on [DATE] with diagnoses that included unsteadiness on feet and compression fracture of vertebra (meaning the resident's backbones had cracks). During a review of Resident 2's Minimum Data Set (MDS, an assessment tool used to direct resident care) dated 10/10/25 under Section C, indicated Brief Interview for Mental Status (BIMS, a screening tool to identify resident's cognitive status) score of 13, indicating Resident 2 was cognitively intact or has normal thinking and memory. During a review of Resident 2's Situation, Background, Assessment, and Recommendation notes (SBAR, is a structured communication framework that can help teams share information about the condition of a resident) dated 12/16/25, indicated, Resident 2 had a witnessed fall on 12/16/25 at 3:30 p.m. at the facility while the resident was being wheeled by FM 1. The SBAR indicated that Resident 2 stated she fell real hard with head first and hurt all over. During an interview 1/16/26 at 2:21 p.m., with FM 1, FM 1 stated the facility did not teach her on how to properly use and wheel the broda wheelchair. During a review of Resident 2's post fall Interdisciplinary Team Care Conference (IDT, a group of individuals representing different departments of the facility) meeting notes dated 12/21/25 indicated a recommendation to educate FM 1 on wheelchair safety. No departmental notes were found on educating FM 1 on wheelchair safety before the resident fell on [DATE]. During an interview and concurrent review on 1/16/26 at 12:03p.m., Resident 2's care plan and progress notes were reviewed with Physical Therapist (PT) 1. PT 1 confirmed that Resident 2 had been using a broda wheelchair in the facility and also stated that she could not find any documentation that FM 1 was trained on the use of the broda wheelchair. PT 1 acknowledged it could have helped FM 1's safety awareness if FM 1 was trained on the proper use of the wheelchair. PT 1 further stated she could not find a care plan addressing the resident's safety while using the broda wheelchair. During an interview and concurrent review on 1/16 at 2:13 p.m., Resident 2's care plans were reviewed with the Minimum Data Set Coordinator (MDSC), MDSC confirmed there was no care plan on the safe use of the broda wheelchair. During an interview on 1/16/26 at 3:30 p.m., with the Director of Nursing (DON), the DON stated that facility did not have a policy and procedure on use of broda wheelchair.</p>		