

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555376	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/30/2024
NAME OF PROVIDER OR SUPPLIER  Danville Post-Acute Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  336 Diablo Road Danville, CA 94526	

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 0573</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Let each resident or the resident's legal representative access or purchase copies of all the resident's records.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40968</p> <p>Based on interview and record review, the facility failed to ensure copies of all medical records were provided to one of three sampled resident's (Resident 1) designated legal representative.</p> <p>As a result, Resident 1's rights were not honored.</p> <p>Findings:</p> <p>During a review of Resident 1's face sheet, dated 8/28/24, the face sheet indicated, Resident 1 was admitted to the facility on [DATE] and discharged to an acute care hospital on 8/26/24.</p> <p>During a telephone interview on 12/17/24, at 12:15 p.m., with Resident 1's Designated Legal Representative (DLR) 2, DLR 2 stated, Resident 1's DLR 1 submitted a written request to the facility for all of Resident 1's medical records. DLR 2 further stated, the medical records given by the facility did not include Resident 1's nursing progress and social services notes, assessments, Medication Administration Record (MAR) and all other relevant clinical information.</p> <p>During a concurrent interview and record review on 12/17/24 at 1:18 p.m. with Medical Records Supervisor (MRS), the Release of Information Authorization (ROI), dated 8/28/24, indicated, Resident 1's DLR 1 submitted a written request for copies of all medical records. MRS confirmed, he did not provide all medical records as requested by the DLR 1.</p> <p>During a follow up interview and record review on 12/30/24 at 12:39 p.m., the ROI revealed, All Medical Records box was marked under description of Patient Health Information (PHI). MRS stated, full set of medical records that included nursing notes, Interdisciplinary Team (IDT) notes, social services notes, medication/treatment (MAR/TAR) records, SBAR (Situation, Background, Assessment, Recommendation) reports, were not provided to DLR 1 as requested. MRS further added, these are important clinical documents that are all part of Resident 1's medical records.</p> <p>During a review of facility's Policy and Procedures (P&amp;P) titled, Designated Record Set, dated 7/27/21, the P&amp;P indicated, Under HIPAA, a Covered Entity is defined as a healthcare provider who must comply with the Rules' requirements to protect the privacy and security of health information and must provide individuals with certain rights with respect to their health information, including the right to inspect and/or obtain copies of their medical information held within a Designated Record Set.</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
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