STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555376	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Danville Post-Acute Rehab	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)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 51446 Based on observation, interview, and record review, the facility failed to maintain privacy and confidentiality for one of six sampled residents' (Resident 31) when diet and aspiration precautions (to prevent food or liquid going into the lungs instead of the stomach) information was left uncovered, posted on the wall by Resident 31's head of the bed while Resident 31 shared a room with two other residents. This failure resulted in Resident 31's care instructions being visible to staff not engaged in her care and visitors for other residents sharing the room with her. Findings: During a record review of Resident 31's Admission Record, printed on 10/9/24, the record indicated Resident 31 was admitted to the facility in June 2024. During a record review of Resident 31's quarterly Minimum Data Set (MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan), dated 9/20/24, the assessment indicated Resident 31's Brief Interview for Mental Status (BIMS, an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score was zero (0) out of 15, indicating Resident 31 had severe cognitive impairment. During an observation on 10/7/24 at 10:14 a.m., Resident 31 was lying in bed, while she shared room with Resident 5 and Resident 10. Resident 10's family was visiting Resident 10. There was an uncovered handwritten and typed up signage with Resident 31's name, dated 3/21/24, posted on a cork board above the Resident 31's headboard. The posted signage indicated: ASPIRATION PRECAUTIONS: 1:1 assist; Diet recommendations: Solids: Puree; Liquids: thin-[liquid]-small sips; Sit upright, for all solids/liquid intake; Remain upright, 20 min. after meals; Feed/eat only when alert; Stop eating if coughing, throat clearing, or increased shortness of breath observed; Meds: whole in applesauce. ADDITIONAL STRATEGIES: 1) Bite size-tsp, liquids-single sips from cup 2) Give [patient] extra time to swallow *hand over hand presentation with patient 3) Feed slowly . (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555376	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Danville Post-Acute Rehab	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)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 10/7/24 at 1:00 p.m., in Resident 31's room with Licensed Vocational Nurse (LVN) 3, LVN 3 stated, I'm not sure who posted the aspiration precaution sign. It could be the family. LVN 3 stated it was not the first time he saw the signage, but the sign could have been posted over the weekend and staff was not made aware of it. LVN 3 stated signage with Resident 31's health information should be covered under Health Information Portability and Accountability Act (HIPAA, a law that protects patients' health information from being revealed without their permission as some visitors could read it). LVN 3 stated keeping the signage covered was important as anybody visiting other residents (Resident 5 and 10) inside the room could see the signage including Resident 31's health information. During an interview on 10/10/24 at 10:17 a.m. with Certified Nursing Assistant (CNA) 2, CNA 2 stated the care instructions signage in Resident 31's room was posted several months ago. During an interview on 10/10/24 at 10:19 a.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated she had been seeing the care instructions uncovered signage over Resident 31's at least since August 2024. During a record review of the facility's Policy and Procedure (P&P) titled, Section: Administration, Subject: Confidentiality of Health Information, dated 10/2020, the P&P indicated, It is the policy of this facility to follow HIPAA (Health Information Portability and Accountability Act) regulations .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555376	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Danville Post-Acute Rehab	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)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51446 Based on observation, interview, and record review, the facility failed to accurately assess two of 14 sampled residents (Resident 18 and Resident 7) in the quarterly Minimum Data Set (MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan) assessments. 1. Resident 18's quarterly MDS assessment was inaccurately coded Yes for diagnosis of pneumonia (an infection of one or both lungs caused by bacteria, viruses or fungi causing difficulty in breathing, cough, fever, and chills) when Resident 18 did not have active pneumonia. 2. Resident 7's quarterly MDS was inaccurately coded 0 for verbal behavioral symptoms when Resident 7 had multiple episodes of verbal hostility during the look back period (a time period over which the resident's condition or status is captured in the MDS assessment and ends at 11:59 p.m. on the day of the Assessment Reference Date (ARD)). This failure resulted in an outdated and inaccurate reflection of Resident 18 and Resident 7's medical/clinical status. Findings: 1. During a review of Resident 18's Admission Record, printed on 10/9/24, the record indicated Resident 18 was admitted to the facility in November 2023. During a record review of Resident 18's MDS, dated [DATE], the assessment indicated Resident 18 had an active diagnosis of pneumonia. The assessment also showed Resident 18 was able to understand others and was able to make herself understood. During a concurrent observation and interview on 10/7/24 at 11:15 a.m. with Resident 18, Resident 18 lay in bed, wearing a nasal cannula for oxygen, with the head of the bed slightly elevated. Resident 18 stated she did not have current infections related to her lungs and had no difficulty in breathing. During an interview on 10/8/24 at 1:17 p.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated she was the regular assigned assistant for Resident 18, and she did not notice Resident 18 experiencing any active respiratory infections in the past few weeks. During an interview on 10/8/24 at 1:23 p.m. with Licensed Vocation Nurse (LVN) 3, LVN 3 stated he was the regular charge nurse for Resident 18 and was unaware of the diagnosis of pneumonia for Resident 18. LVN 3 stated Resident 18 did not have any signs and symptoms of pneumonia, such as fever, difficulty breathing, and presence of crackles (abnormal lung sounds that can be described as clicking and bubbling). LVN 3 also stated to his knowledge, there was no chest Xray (a painless test that takes a picture of the chest) taken to confirm the pneumonia. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555376	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Danville Post-Acute Rehab	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)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 10/8/24 at 12:56 p.m. with the MDS Coordinator (MDSC), Resident 18's Electronic Health Record for quarterly MDS assessment, dated 8/15/24, and progress notes from 8/9/24 thru 8/15/24 were reviewed. MDSC stated Resident 18's MDS assessment dated [DATE] Section I- Active Diagnosis indicated pneumonia was an active diagnosis during the look-back period. MDSC stated she had coded the pneumonia as an active diagnosis because Medical Doctor (MD) 1's progress notes, dated 8/14/24, indicated Resident 18 had bilateral (both sides) wheezing (a high-pitched sound made when breathing is restricted/obstructed in the lungs), diagnoses of acute on chronic respiratory failure (a long-term condition that occurs in the body's respiratory system can't exchange oxygen and carbon dioxide properly), and interstitial lung disease (a disease that causes inflammation and irritation in the lungs). MDSC stated, however she was unable to find any documentation indicating a diagnosis and/or signs and symptoms of active Pneumonia in the look back period. During an interview on 10/9/24 at 4:05 p.m. with MD 1, MD 1 stated Resident 18 had pneumonitis (an inflammation in the lung tissue) when she assessed Resident 18 on 8/14/24, however Resident 18 did not have pneumonia as an active diagnosis at that time. During an interview on 10/10/24 at 2:05 p.m. with Director of Nursing (DON), DON stated MDS assessment was used to assess and plan care for the residents. The DON stated inaccurate MDS assessment could lead to unsafe care to the residents. During a record review of the Centers of Medicare and Medicaid (CMS)'s RAI Version 3.0 Manual, dated 10/2023, the manual indicated, Active Diagnosis: Physician-documented diagnoses in the last 60 days that have a direct relationship to the resident's current functional status, cognitive [mental] status, mood or behavior, medical treatments, nursing monitoring, or risk of death during the 7 [seven]-day look-back period. During a record review of the facility's policy and procedure (P&P) titled Section: Resident Assessment, Subject: Accuracy of Assessment (MDS 3.0), issued on 10/2020, the P&P indicated, It is the policy of this facility to ensure that the assessment accurately reflect the resident's status. 50474 2. During a record review of Resident 7's Admission Record, printed 10/9/24, the Admission Record indicated Resident 7 was admitted to the facility in August 2012 and had diagnoses of Chronic Obstructive Pulmonary Disease (COPD, refers to a group of diseases that cause airflow blockage and breathing-related problems. It includes emphysema and chronic bronchitis), bipolar disorder (A mental condition in which a person has wide or extreme swings in their mood. Periods of feeling sad and depressed may alternate with periods of intense excitement and activity or being cross or irritable), and unspecified dementia (a loss of brain function that occurs with certain diseases, affecting one or more brain functions such as memory, thinking, language, judgment, or behavior). During a record review of Resident 7's Medication Administration Record (MAR), dated from 8/7/24 thru 8/15/24, the MAR indicated Resident 7 had orders to Monitor and record number of psychiatric behaviors manifested by accusatory behaviors with verbal hostility and Monitor and record mood fluctuations as evidenced by verbal outburst of calling the staff inappropriate names and accusing staff of stealing her belongings. The MAR: further indicated Resident 7 had verbal behavior symptoms every day from 8/7/24 thru 8/15/24 as documented by the licensed nurses. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555376	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Danville Post-Acute Rehab	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)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 10/9/24 at 2:07 p.m. with Case Manager (CM) 1, Resident 7's MDS assessment, dated 8/15/24, and MAR, dated from 8/7/24 thru 8/15/24, were reviewed. CM 1 stated when she documented Resident 7's MDS Section E - Behavior assessment, Resident 7 did not have any verbal behavioral symptoms during the seven-day look-back period. CM 1 was observed reviewing the MAR in the electronic health record. CM 1 confirmed the MAR indicated the licensed nurses had documented that Resident 7 had multiple episodes of verbal behavior symptoms during the look-back period. CM 1 stated she did not review the licensed nurses' notes when she did the behavior assessment for Resident 7 on 8/15/24. CM 1 stated she should have reviewed and coded Resident 7's behavior assessment accurately. During an interview on 10/10/24 at 7:59 a.m. with DON, DON stated Resident 7's MDS assessment for behavior on 8/15/24 should have been accurately coded. DON stated documenting incorrect assessment could have had an effect on Resident 7's overall care. During a record review of the Centers of Medicare and Medicaid (CMS)'s Resident Assessment (RAI) Instrument Version 3.0 Manual, dated 10/2023, the manual indicated, Identification of the frequency and the impact of behavioral symptoms on the resident and on others is critical to distinguish behaviors that constitute problems from those that are not problematic. Once the frequency and impact of behavioral symptoms are accurately determined, follow-up evaluation and care plan interventions can be developed to improve the symptoms or reduce their impact. During a record review of the facility's policy and procedure (P&P) titled Section: Resident Assessment, Subject: Accuracy of Assessment (MDS 3.0), issued in October 2010, the P&P indicated, It is the policy of this facility to ensure that the assessment accurately reflect the resident's status.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555376	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Danville Post-Acute Rehab	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)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. 51636 Based on observation, interview, and record review, the facility failed to provide nail care and hygiene to one of two sampled residents (Resident 11). Resident 11 had long toenails on both feet. This failure placed Resident 11 at risk for poor hygiene, pain/discomfort from long nails, scratching themselves and infections. Findings: During a review of Resident 11's Admission Record, the record indicated Resident 11 was admitted to the facility in December 2022. During a review of Resident 11's Minimum Data Set (MDS is a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan), dated 6/28/24, the assessment indicated Resident 11 was able to understand others and was able to make herself understood. Resident 11 required setup or clean-up assistance to maintain personal hygiene. During a concurrent observation and interview on 10/07/24 at 09:47 a.m. with Resident 11, Resident 11 was lying in bed and her toenails were approximately an inch long on both feet. Resident 11 stated she wanted her toenails to be trimmed. During an interview on 10/08/24 at 11:44 a.m. with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated CNAs and/or licensed nurses were responsible for trimming Resident 11's toenails. During a concurrent interview and record review on 10/8/24 at 12:05 p.m. with the Assistant Director of Nursing (ADON), Resident 11's Progress Notes, dated 1/15/24 through 10/8/24 were reviewed. ADON stated direct care staff including CNAs and licensed nurses were responsible for assessing if a resident needed their toenails to be trimmed during ADL (Activities of daily living are those needed for self-care and mobility and include activities such as bathing, dressing, grooming, oral care, ambulation, toileting, eating, transferring, and communicating care. ADON stated trimming toenails was important to prevent fungal infection, hygiene issues, and pain. ADON stated Resident 11 was confused and moody at times. ADON stated if Resident 11 refused trimming the toenails, licensed nurses were to document the attempts and interventions regarding if staff attempted to trim her toenails and any attempted interventions for Resident 11's refusals in the progress notes from 8/1/24 till 10/8/24. During a review of the facility's policy and procedure (P&P) titled ADL, Services to carry out, dated 10/2016, the P&P indicated Residents who are unable to carry out activities of daily living (ADL) will receive necessary services, on a daily and on as needed basis, to maintain: personal hygiene .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555376	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Danville Post-Acute Rehab	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 51446 Based on observation, interview, and record review, the facility failed to assess, evaluate, treat, and care for edema (swelling) in both feet of one of six sampled residents (Resident 5) for at least 24 hours. This failure resulted in Resident 5 experiencing discomfort, pain, and limited range of motion in both feet, and placed her at risk of untreated edema, causing further pain, skin breakdown and fluid overload. Findings: During a record review of Resident 5's Admission Record, printed on 10/9/24, the record indicated Resident 5 was admitted to the facility in January 2023. During a record review of Resident 5's Minimum Data Set (MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan), dated on 7/25/24, the record indicated Resident 5's cognition (mental status) was moderately impaired. The MDS record also indicated Resident 5 had an active diagnosis of hypertension (high blood pressure), and paroxysmal atrial fibrillation (heart rate is irregular and fast then goes back to normal). During a concurrent observation and interview on 10/7/24 at 10:13 a.m. with Resident 5, Resident 5 was sitting upright in her bed with a pillow under both legs. Resident 5's feet were swollen, and skin was stretched. Resident 5 stated both feet were swollen for days, and facility staff did not check on it. Resident 5 stated both feet were painful, and she had difficulty moving around the bed. During a concurrent observation and interview on 10/8/24 at 3:46 p.m. with Licensed Vocational Nurse (LVN) 3, Resident 5's feet were observed, while she was sitting upright in her bed. LVN 3 stated he was the regular assigned charge nurse for Resident 5 and was unaware of swelling and pain in Resident 5's feet. LVN 3 checked Resident 5's feet and stated she had pitting edema (swelling due to excessive accumulation of fluid under the skin defined by a persistent indentation, or a pit when pressure is applied to the swollen area). LVN 3 stated Resident 5's left foot was +2 (a scoring system for edema; +2 means the edema formed a pit of at least 4 millimeters-mm deep) and the right foot was +1 (a score indicating slight pitting of at least 2 mm deep). LVN 3 then asked LVN 5's assistance to validate the pitting edema. LVN 5 stated and confirmed it was pitting edema in the feet. LVN 5 stated Resident 5's feet had +1 pitting edema. LVN 3 also stated if Resident 5's edema was not assessed and treated in a timely manner, it placed her at risk for other health issues such as difficulty in breathing as she has a history of heart related conditions. During a concurrent interview and record review with LVN 3, on 10/8/24 at 3:55 p.m., Resident 5's Electronic Health Record (EHR) for assessments, progress notes, care plans from 9/15/24 thru 10/8/24 was reviewed. LVN 3 stated he didn't find any written documentation in the EHR for any changes of condition, indicating Resident 5 was experiencing edema in her feet. LVN 3 stated Resident 5 had a history of developing edema. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555376	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Danville Post-Acute Rehab	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/8/24 at 4:14 p.m. with the Director of Nursing (DON), DON stated she expected the direct care staff, including both certified nursing assistants and licensed nurses, to notice and act upon any changes in a resident's health condition daily. DON stated noticing edema was part of routine checkup of residents. DON stated licensed nurses were expected to document and notify the medical doctor of any changes in residents' health condition. DON stated untreated edema could lead to skin breakdown and heart-related issues. During a record review of the facility's Policy and Procedure (P&P) titled Section: Care and Treatment-Quality of Care, Subject: Change of Condition Reporting, revised on 11/2022, the P&P indicated, It is the policy of this facility that all changes in resident condition will be communicated to the physician. During a record review of the facility's Policy and Procedure (P&P) titled, Section: Quality of Care, Subject: ADL, Services to carry out, issued on 10/2016, the P&P indicated, It is the policy of this facility that residents are given the appropriate treatment and services to maintain or improve his/her abilities. According to the Mayo Clinic, Edema is swelling caused by too much fluid trapped in the body's tissues. Edema can affect any part of the body. But it's more likely to show up in the legs and feet . If left untreated, edema can cause: swelling that gets more and more painful; problems walking; stiffness; stretched skin, which can itch; increased risk of infection in the swollen area; scarring between layers of tissue; less blood flow; less ability of the of arteries, veins, joints, and muscles to stretch; increased risk of skin ulcers . [Edema-Symptoms and causes | Mayo Clinic (www.mayoclinic.org)]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555376	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Danville Post-Acute Rehab	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)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 50474 Based on observation, interview, and record review the facility failed to provide the appropriate indwelling catheter (a flexible tube used to empty the bladder and collect urine) care and services for two of two sampled residents (Resident 242 and Resident 4) when Resident 242 and Resident 4's indwelling urinary catheter bags and tubes were touching the floor. This failure had the potential for Resident 242 and Resident 4 to develop urinary tract infection (UTI, an infection in any part of the kidneys, bladder, or urethra [the tube which empties urine from the bladder]) Findings: During a record review of Resident 242's Admission Record (AR), printed on 10/10/24, the AR indicated Resident 242 was admitted to the facility in October 2024 with a diagnosis of sepsis (serious condition in which the body responds improperly to an infection). During a record review of Resident 242's Care Plan, dated on 10/7/24, the Care Plan indicated Resident 242 had a foley catheter (type of indwelling catheter) related to urinary retention (Difficulty urinating and completely emptying the bladder). During an observation on 10/07/24 at 10:44 a.m. with Resident 242, Resident 242 was observed lying in his bed. Resident 242's indwelling catheter bag and tube were touching the floor. During a concurrent observation and interview on 10/8/24 at 8:05 a.m. with LVN 3, Resident 242's indwelling catheter bag was touching the floor. LVN 3 was observed picking up the indwelling catheter bag off the floor. LVN 3 stated the indwelling catheter bag should never have touched the floor because it could have caused Resident 242 an infection. During a record review of Resident 4's AR, printed on 10/10/24, the AR indicated Resident 4 was admitted to the facility in April 2012 with diagnoses of chronic kidney disease (gradual loss of kidney function) and flaccid neurogenic bladder (the muscles of the bladder lose ability to contract normally due to disease or injury of the central nervous system or peripheral nerves involved in the control of urination). During a record review of Resident 4's Care Plan, dated 3/5/23, the Care Plan indicated Resident 4 had chronic indwelling catheter related to neurogenic bladder (loss of bladder control due to nerve damage). During an observation and interview on 10/09/24 at 8:00 a.m. with Certified Nurse Assistant (CNA) 3, Resident 4 was sleeping in his bed. Resident 4's indwelling catheter bag and the tube were observed touching the floor. CAN 3 stated the CNAs were responsible for draining the catheter bag and making sure the catheter bag and tube were not touching the floor. CAN 3 stated the indwelling catheter bag and the tube should not be on floor because it could spread infection. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555376	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Danville Post-Acute Rehab	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)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/9/24 at 9:16 a.m. with Infection Preventionist (IP), IP stated she expected the CNAs or the licensed nurses to keep the indwelling catheter bag and the tube off the floor for risk of contamination that could lead to infection like UTI. The IP stated the CNAs or the licensed nurses should have placed a black bag to protect the indwelling catheter and the tube from touching the floor. During an interview on 10/10/24 at 7:51 a.m. with Director of Nursing (DON), DON stated indwelling catheter bags and the tubes of Resident 242 and Resident 4 should have not touched the floor. The DON stated these practices had the risk to spread the infection to Residents 240 and Resident 4. During a record review of the facility's undated policy and procedure, titled, Catheter Care, Urinary, the P&P indicated, The purpose of this procedure is to prevent catheter-associated urinary tract infections . Infection Control .1. Use standard precautions when handling or manipulating the drainage system. 2. Maintain clean technique when handling or manipulating the catheter, tubing, or drainage bag .b. Place a black bag under the foley catheter bag if resident is in low bed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555376	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Danville Post-Acute Rehab	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)
F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. 50474 Based on observation, interview, and record review, the facility failed to ensure that one of one sampled resident (Resident 240), with a peripherally inserted central catheter (PICC, a long, thin, flexible tube that is placed into a small vein in the upper arm and moved forward until it is in a larger vein near the heart) received appropriate care and services when: 1. Resident 240 did not receive his intravenous (IV, a way to give fluids, medicine, nutrition, or blood directly into the blood stream through a vein) antibiotic (medication used to treat infection) on time per physician's order. 2. The facility did not obtain Resident 240's arm circumference measurement during PICC line dressing change on 10/2/24. These failures had the potential for Resident 240 to not receive the antibiotic effectively and develop complications such as catheter migration and dislodgement (PICC line displacement). Findings: 1. During a record review of Resident 240's Admission Record (AR), printed on 10/9/24, Resident 240 was admitted to the facility in September 2024 with diagnoses of right ankle and foot osteomyelitis (infection in the bone) and methicillin-resistant staphylococcus aureus (MRSA, a bacterial infection resistant to some antibiotics). During a record review of Resident 240's Medication Administration Record (MAR), dated from 9/24/24 thru 10/9/24, the MAR indicated Resident 240 had an IV antibiotic order for Cefazolin Sodium intravenous solution reconstituted 2 grams intravenously every 8 hours scheduled at 6:00 a.m., 2:00 p.m., and 10:00 p.m. until 11/14/24. The MAR further indicated Resident 240 received some of the IV antibiotics on 9/25/24 at 4:29 p.m. and 12:50 a.m., 9/29/24 at 3:45 p.m., 10/1/24 at 11:52 p.m., 10/2/24 at 12:00 a.m., 10/6/24 at 3:57 p.m., and 10/7/24 at 1:22 a.m. During a concurrent observation and interview on 10/7/24 at 12:30 p.m. with Resident 240, Resident 240 was sitting on the edge of the bed. Resident 240 was observed to have PICC line on his right upper arm. Resident 240 stated he was receiving IV antibiotic for his right foot infection. Resident 240 stated there were multiple times that he received his IV antibiotics two to three hours late. Resident 240 stated he was concerned the IV antibiotic will not be effective and his stay in the facility could have been prolonged. Resident 240 stated the Registered Nurses (RNs) were inconsistent with the time they administered his IV antibiotic. During a follow up interview on 10/8/24 at 9:00 a.m. with Resident 240, Resident 240 stated around 1:00 a.m. on 10/8/24, he had to remind Registered Nurse (RN) 1 that he was still waiting for his IV antibiotic that was due at 10:00 p.m. Resident 240 stated if he did not remind RN 1 about his IV antibiotic, he probably would not have received it. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555376	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Danville Post-Acute Rehab	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)
F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview on 10/09/24 11:56 a.m. with RN 1, RN 1 stated she was scheduled to work 11:00 p.m.-7:00 a.m. on 10/7/24. RN1 stated the IV antibiotic order was scheduled at 10:00 p.m. and was not endorsed to her that she needed to administer the medication to Resident 240. RN 1 stated the IV antibiotic was in the refrigerator when she found out that she needed to administer it. RN 1 stated the IV administration was delayed because she had to wait for the IV solution to be at room temperature. RN 1 stated she did not notify the physician that Resident 240's IV antibiotic administration was more than three hours delayed. RN 1 stated the delay in IV antibiotics administration could have caused side effects to Resident 240. During an interview on 10/9/24 at 1:11 p.m. with Director of Nursing (DON), DON stated the licensed nurses should have communicated with each other that Resident 240's IV medication needed to be taken out from the refrigerator prior to the scheduled administration time. The DON stated RN1 should have notified the physician when Resident 240's IV antibiotic was delayed for more than three hours. The DON further stated delay in IV administration was not safe and could have affected the effectiveness of the antibiotic. During a record review of the facility's policy and procedure (P&P) titled Medication Administration-General Guidelines, dated May 2022, the P&P indicated Medications are administered as prescribed in accordance with good nursing principles and practices .4. Five Rights - Right resident, right drug, right dose, right route, and right time are applied for each medication being administered .12. Medications are administered within 60 minutes of scheduled time. 2. During a record review of Resident 240's Progress Note, dated 10/2/24, the progress note indicated Resident 240 had a PICC line dressing change at 1:31 p.m. by DON. The Progress Note indicated Resident 240's PICC line on right upper arm had blood clots and bluish discoloration around the area. The Progress Note did not show an assessment of the arm's circumference measurement. During a concurrent interview and record review on 10/09/24 at 1:15 p.m. with DON, Resident 240's Electronic Health Record (EHR) was reviewed. DON stated she changed Resident 240's PICC line dressing on 10/2/24. The DON confirmed she did not document Resident 240's arm circumference measurement in the Progress Notes when she changed the PICC dressing on 10/2/24. During a follow up interview on 10/10/24 at 4:25 p.m. with DON, DON stated she did not find other documentation that Resident 240's arm circumference was measured on 10/2/24. The DON further stated she should have included the arm circumference on her progress note when she changed Resident 240's PICC line dressing. The DON further stated measuring arm circumference during PICC line dressing change was important practice to identify swelling of the arm or infection around the PICC line site. During a record review of the facility's policy and procedure (P&P) titled Central Venous Catheter Care and Dressing Change, revised March 2022, the P&P indicated The purpose of this procedure is to prevent complications associated with IV therapy, including catheter infections that are associated with contaminated, loosened, soiled, or wet dressings . For PICCs, measure arm circumference and compare to a baseline when clinically indicated to assess for edema and possible deep-vein thrombosis.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555376	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Danville Post-Acute Rehab	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)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 49613 Based on observation, interview, and record review, the facility failed to ensure the appropriate use of lidocaine patches (to treat pain) and the accountability of controlled medications (those with high potential for abuse and addiction) when: 1. The nursing staff failed to remove lidocaine patches after 12 hours as ordered by the prescriber and per manufacturer recommendations for two out of eight residents (Residents 27 and 194). This failure had the potential for residents to receive an excessive dose of lidocaine which could result in side effects, including swelling and skin irritation; and 2. The Controlled Drug Records (CDR, accountability records, an inventory sheet that keeps records of the usage of controlled medications) for four out of four sampled residents (Residents 2, 10, 240, and 241) did not reconcile with the Medication Administration Records (MAR). This failure resulted in inaccurate accountability and the potential for abuse and diversion of controlled medications. Findings: 1a. During a medication pass observation and concurrent interview on 10/07/24 at 9:27 a.m., licensed vocational nurse (LVN) 4 was observed preparing six medications for Resident 194, including a lidocaine patch. LVN 4 was observed removing a lidocaine patch from Resident 194's back. LVN 4 stated she will not yet give the new lidocaine patch to give the skin a break. A review of Resident 194's electronic medical record indicated a physician order, dated 09/29/24, for Lidoderm (brand name for lidocaine) 5% patch, apply to left upper back in the morning for pain at 9:00 a.m. 1b. During a medication pass observation and concurrent interview on 10/07/24 at 9:38 a.m., LVN 4 was observed preparing eight medications for Resident 27, including a lidocaine patch. LVN 4 was observed removing a lidocaine patch from Resident 27's shoulder. LVN 4 stated she will not yet give the new lidocaine patch to give the skin a break. A review of Resident 27's electronic medical record indicated a physician order, dated 09/30/24, for lidocaine 4% patch, apply to right shoulder in the morning for pain management, remove after 12 hours per schedule, apply at 9:00 a.m. During an interview on 10/07/24 at 9:59 a.m., LVN 4 stated the lidocaine patches for Residents 27 and 194 were supposed to be removed last night. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555376	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Danville Post-Acute Rehab	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)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/09/24 at 9:09 a.m. with Consultant 1 and Director of Nursing (DON), Consultant 1 stated lidocaine patches are placed on and removed at specific times. Consultant 1 verified that Resident 27's and Resident 194's lidocaine patches were left on overnight and removed by the morning nurse. Consultant 1 stated the lidocaine patches should have been removed at night on 10/06/24 as scheduled. DON stated physician orders need to be followed. DON stated even when there is no physician order, the manufacturer labeling to remove lidocaine patch after 12 hours needs to be followed. During a phone interview on 10/09/24 at 4:10 p.m., Consultant Pharmacist 1 (CP 1) stated lidocaine patches should be removed after 12 hours. A review of the Prescribing Information (PI, detailed description of a drug's uses, dosage range, side effects, drug-drug interactions, and contraindications that is available to clinicians) for Lidoderm 5% patch, dated 2/1/10, retrieved from DailyMed (internet database operated by the U.S. National Library of Medicine providing labeling for prescription and nonprescription drugs) indicated: .Apply LIDODERM to intact skin to cover the most painful area. Apply up to three patches, only once for up to 12 hours within a 24-hour period . and .Excessive dosing by applying LIDODERM to larger areas or for longer than the recommended wearing time could result in increased absorption of lidocaine and high blood concentrations, leading to serious adverse effects . and .the skin at the site of application may develop blisters, bruising, burning sensation .discoloration, edema (swelling) .irritation . 2a. A review of Resident 2's medical record indicated a physician order, dated 08/25/22, for oxycodone with acetaminophen (a controlled medication for pain, generic for Percocet) 5-325 milligrams (mg), give one tablet by mouth every four hours as needed for moderate to severe pain (pain score 4-10 out of 10). Resident 2 had an additional physician order, dated 12/02/23, for Percocet 5-325 mg, give one tablet by mouth at bedtime for pain relief. Resident 2's September 2024 and October 2024 electronic MAR, printed on 10/8/24, were compared to Percocet 5-325mg CDR. The CDR indicated the nursing staff signed out one tablet on the following dates and times but did not document the administration on the September 2024 MAR (total of four doses): - 09/11/24 at 4h (time unclear) - 09/12/24 at 10:35 (no documentation of a.m. or p.m.) - 09/18/24 at 9:20 p.m. - 09/23/24 at 9:00 a.m. The CDR indicated the nursing staff signed out one tablet on the following dates and times but did not document the administration on the October 2024 MAR (total of one dose): - 10/4/24 at 2:30 p.m. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555376	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Danville Post-Acute Rehab	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)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The September 2024 MAR indicated the nursing staff administered one tablet on the following dates and times but did not document on the CDR (total of six doses): - 09/14/24 at 9:00 p.m. - 09/19/24 at 9:00 p.m. - 09/23/24 at 9:00 p.m. - 09/24/24 at 9:00 p.m. - 09/27/24 at 9:00 p.m. - 09/28/24 at 9:00 p.m. The October 2024 MAR indicated the nursing staff administered one tablet on the following dates and times but did not document on the CDR (total of one dose): - 10/5/24 at 9:00 p.m. 2b. A review of Resident 10's medical record indicated a physician order, dated 02/28/24, for hydrocodone with acetaminophen (a controlled medication for pain, generic for Norco) 5-325 mg, give one tablet by mouth every six hours as needed for moderate to severe pain (pain score 4-10 out of 10). Resident 10's September 2024 and October 2024 MARs, printed on 10/8/24, were compared to Norco 5-325mg CDR. The CDR indicated the nursing staff signed out one tablet on the following dates and times but did not document the administration on the September 2024 MAR (total of four doses): - 09/23/24 at 9:00 a.m. - 09/27/24 at 1:00 p.m. - 09/28/24 at 9:00 a.m. - 09/29/24 at 9:00 a.m. The CDR indicated the nursing staff signed out one tablet on the following dates and times but did not document the administration on the October 2024 MAR (total of three doses): - 10/01/24 at 1:30 p.m. - 10/02/24 at 1:30 p.m. - 10/03/24 at 1:00 p.m. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555376	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Danville Post-Acute Rehab	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)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2c. A review of Resident 240's medical record indicated a physician order, dated 09/24/24, for Percocet 10-325 mg, give one tablet by mouth every four hours as needed for moderate to severe pain (pain score 4-10 out of 10). Resident 240 had an additional physician order, dated 09/26/24, for Percocet 10-325 mg, give one tablet by mouth one time a day for pain management. Resident 240's September 2024 and October 2024 MARs, printed on 10/8/24, were compared to Percocet 10-325mg Controlled Drug Record (CDR). The CDR indicated the nursing staff signed out one tablet on the following dates and times but did not document the administration on the September 2024 MAR (total of three doses): - 09/26/24 at 1:00 p.m. - 09/27/24 at 1:00 p.m. - 09/28/24 at 8:20 a.m. The September 2024 MAR indicated the nursing staff administered one tablet on the following dates and times but did not document on the CDR (total of one dose): - 09/30/24 at 9:00 a.m. The October 2024 MAR indicated the nursing staff administered one tablet on the following dates and times but did not document on the CDR (total of two doses): - 10/03/24 at 9:00 a.m. - 10/04/24 at 8:35 a.m. 2d. A review of Resident 241's medical record indicated a physician order, dated 09/14/24, for Percocet 5-325 mg, give one tablet by mouth every six hours as needed for moderate to severe pain. Resident 2's September 2024 MARs, printed on 10/8/24, were compared to Percocet 5-325mg CDR. The CDR indicated the nursing staff signed out one tablet on the following dates and times but did not document the administration on the September 2024 MAR (total of one dose): - 09/16/24 at 6:50 a.m. During an interview on 10/09/24 at 8:28 a.m., the DON stated her expectation is for each resident's MAR and CDR to match. During an interview on 10/09/24 at 2:18 p.m., the DON verified the controlled drug discrepancies for Residents 2, 10, 240, and 241. Regarding the controlled pain medications documented as administered on the MAR but not documented as removed from the CDR, the DON stated the concern is that residents could suffer because their pain isn't managed. During a phone interview on 10/09/24 at 3:58 p.m., CP 1 stated it's important for the MAR, the CDR, and the physical tablet count to match to prevent drug diversion. CP 1 stated the residents' medical records need to be accurate. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555376	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Danville Post-Acute Rehab	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)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P) titled, Preparation and General Guidelines IIA7: Controlled Substances, dated May 2022, the policy indicated: .Accurate accountability of the inventory of all controlled drugs is maintained at all times. When a controlled substance is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record and the medication administration record (MAR) .Date and time of administration (MAR, Accountability Record [CDR]) .Amount administered (Accountability Record) . Remaining quantity (Accountability Record) .Initials of the nurse administering the dose, completed after the medication is actually administered (MAR, Accountability Record) .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555376	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Danville Post-Acute Rehab	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)
F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 51636 Based on observation, interview, and record review, the facility failed to accurately monitor, document, and intervene for potential side effects of haloperidol (an antipsychotic medication, used to treat symptoms of psychosis, such as perception of something that is not real and suspiciousness, etc.) for one of five sampled residents (Resident 11) when Resident 11 exhibited abnormal, consistent, involuntary lateral movements of the jaw while talking. This failure resulted in inaccurate reflection of Resident 11's clinical status and placed her at risk for experiencing further increased side effects of haloperidol. Findings: During a review of Resident 11's Admission Record, printed on 10/8/24, the record indicated Resident 11 was admitted to the facility in December 2022 with unspecified dementia with psychotic disturbances (memory loss accompanied by loss of touch with reality such as perception of something that is not real, suspiciousness, etc.) During a review of Resident 11's Physician Order, dated 6/16/23, the order indicated to give one tablet of haloperidol oral tablet 5 (five) milligrams (mg) by mouth once a day for unspecified dementia with psychotic behavior manifested by delusional beliefs as evidenced by verbalization that Satan gave her the disease and the cult behind all of this. During a review of Resident 11's Medication Administration Record (MAR) from 9/25/24 through 10/10/24, the MAR indicated Resident 11received haloperidol 5 mg one tablet every day as scheduled. The MAR also indicated licensed nurses were to monitor side effects of antipsychotic medication (haloperidol) including tardive dyskinesia (abnormal, recurrent, involuntary movements that may be irreversible and typically present as lateral movements of the tongue of jaw, tongue thrusting, chewing, frequent blinking, brow arching, grimacing, and lip smacking . The MAR indicated Resident 11 did not experience any side effects from use of haloperidol from 9/25/24 through 10/10/24. During an observation with Resident 11 on 10/7/24 at 9:47 a.m., Resident 11 jutted her jaw out, moved to both sides and then moved the jaw in throughout the conversation. During another observation on 10/8/24 at 4:32 p.m., Resident 11 consistently jutted her jaw out, moved to both sides and then moved the jaw in throughout the conversation. During an interview with Certified Nursing Assistant 1 (CNA 1-Resident11's routine nursing assistant) on 10/10/24 at 2:23 p.m., CNA 1 stated she had always noticed Resident 11's recurring jaw movements during talking. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555376	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Danville Post-Acute Rehab	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)
F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 10/10/24 at 9:52 a.m. with Assistant Director of Nursing (ADON), Resident 11's Abnormal Involuntary Movement Scale (AIMS, a 12-item clinician-rated scale to assess severity of dyskinesia, specifically, orofacial movements and extremity and truncal movements in patients taking neuroleptic medications) assessment, dated 9/25/24, was reviewed. The assessment indicated Resident 11 exhibited minimal/normal movements around her facial muscles, however it did not specify the exact area for facial muscles movements. During an interview on 10/10/24 at 2:32 p.m. with ADON, the ADON stated Resident 11 exhibited involuntary mouth/jaw movement, and it was something that comes and goes. During an interview on 10/10/24 at 2:43 p.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated she had been working with Resident 11 for about two months. LVN 2 stated she had always noticed Resident 11 having recurrent involuntary jaw movement, but she thought it was mannerism (habitual gesture or way of speaking or behaving). LVN 2 was unable to state what to watch for symptoms of tardive dyskinesia (one of the potential side effects of haloperidol) to be monitored every shift daily by the licensed nurses. During a concurrent interview and record review on 10/10/24 at 2:51 p.m. with the ADON, Resident 11's AIMS assessment, dated 9/25/24, was reviewed. The ADON stated she did not report Resident 11 having movements around her facial muscles that she noticed on 9/25/24 to her medical doctor or the pharmacy. The ADON stated it was important to involve the care team to have this information in a timely manner, so that they could investigate her medications more closely. The ADON stated uncontrollable jaw movements were one of the symptoms of tardive dyskinesia (a side effect of haloperidol). During a review of Resident 11's Care Plan for use of haloperidol, revised on 7/17/23, the Care Plan indicated the goal for Resident 11 was to remain free of drug related complications, including movement disorder. The Care Plan indicated licensed nursing staff were to monitor/document for side effects; Consult with pharmacy and physician to consider dosage reduction when clinically appropriate; Monitor/record/report to physician for side effects and adverse reactions of psychoactive medications: unsteady gait, tardive dyskinesia . During a review of facility's Policy and Procedure (P&P) titled Behavior Management and the use of Psychoactive Medications, dated 5/2019, the P&P indicated, 3. The Interdisciplinary Team will review findings of both Nursing and Social Services and [make] a decision regarding further interventions. 4. The physician will be contacted, an order will be requested, and he/she will determine the appropriate psychiatric or psychological treatment needed .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555376	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Danville Post-Acute Rehab	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)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 49613 Based on observation, interview, and record review, the facility had a medication error rate of 6.67% when two medication errors occurred out of 30 opportunities during medication administration for two out of eight residents (Residents 27 and 33). This failure resulted in medications not given according to the physician's orders and had the potential for residents to not receive the full therapeutic effects of medications. Findings: 1. During a medication pass observation on 10/07/24 at 9:38 a.m., licensed vocational nurse (LVN) 4 was observed preparing and administering seven medications to Resident 27. LVN 4 was observed pulling a bubble pack of Eliquis (brand name for apixaban, a blood thinner) 2.5 mg labeled for Resident 194 and preparing for Resident 27. LVN 4 put the Eliquis 2.5 mg tablet with the rest of Resident 27's medications. LVN 4 brought the medications to Resident 27 for administration. The surveyor intervened before administration of Resident 194's Eliquis 2.5 mg tablet. During a concurrent interview and record review on 10/07/24 at 9:50 a.m. with LVN 4, Resident 27's electronic medication administration record was reviewed. LVN 4 stated that Resident 27 was supposed to get one tablet of Eliquis 5 mg. LVN 4 verified that she had accidently taken an Eliquis 2.5 mg tablet from Resident 194's medication bubble pack to prepare for Resident 27. LVN 4 verified she would have given Resident 194's Eliquis 2.5 mg tablet to Resident 27 if surveyor had not intervened. A review of Resident 27's electronic medical record indicated a physician order, dated 09/30/24, for Eliquis 5mg, give one tablet by mouth two times a day for prevention of blood clots. A review of Resident 194's electronic medical record indicated a physician order, dated 09/19/24, for Eliquis 2.5 mg, give one tablet by mouth every 12 hours for atrial fibrillation. During an interview on 10/09/24 at 9:09 a.m., the Director of Nursing (DON) acknowledged that LVN 4 almost gave Resident 27 the wrong dose of Eliquis from Resident 194's medications before the surveyor intervened. 2. During a medication pass observation on 10/07/24 at 4:34 p.m., LVN 2 was observed preparing and administering four medications to Resident 33. LVN 2 was observed preparing and administering one capsule of potassium chloride (a supplement) extended release 10 milliequivalents (mEq, a unit of measurement) to Resident 33. During an interview on 10/07/24 at 4:48 p.m., LVN 2 verified she gave Resident 33 one capsule of potassium chloride, not a tablet. A review of Resident 33's electronic medical record indicated a physician order, dated 08/20/24, for potassium chloride extended release 10 mEq oral tablet, give one tablet by mouth two times a day for supplement. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555376	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Danville Post-Acute Rehab	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)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/09/24 at 9:09 a.m., the DON stated the facility needed to get a new order from the physician before switching from the potassium chloride tablet to the capsule. During a phone interview on 10/09/24 at 4:07 p.m., Consultant Pharmacist 1 (CP 1) stated the facility should have called the pharmacy or the physician before switching from the potassium chloride tablet to the capsule. A review of the Orange Book (a publicly available list of drugs evaluating equivalence published by the U.S. Food and Drug Administration), last updated 09/11/24, indicated that potassium chloride extended release tablets are not considered therapeutically equivalent (can be substituted) to potassium chloride extended release capsules. During a review of the facility's policy and procedure (P&P) titled, Preparation and General Guidelines IIA2: Medication Administration - General Guidelines, dated May 2022, the policy indicated: .Right resident, right drug, right dose, right route, and right time, are applied for each medication being administered . and . Medications are administered in accordance with written orders of the attending physician . and .Medications supplied for one resident are never administered to another resident .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555376	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Danville Post-Acute Rehab	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)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 49613 Based on observation, interview, and record review, the facility failed to ensure proper labeling and storage of medications according to the facility policy and procedures (P&P) and/or manufacturer's specifications when an opened eye drop bottle was not properly labeled in one of one sampled medication carts. This failure had the potential for medication error due to medication not being labeled and being used for multiple residents. Findings: During a concurrent observation and interview on 10/8/24 at 9:21 a.m. at Medication Cart #2 with licensed vocational nurse (LVN) 3, an unlabeled box of Artificial Tears (to treat dry eyes) eye drops was identified. The box contained an unlabeled eye dropper bottle of Refresh Tears (a different medication to treat dry eyes). LVN 3 verified the observations and stated the eye dropper bottle was almost empty. During an interview on 10/08/24 at 9:37 a.m., LVN 3 stated he did not know who the eye drops belonged to or why the Refresh Tears were in the wrong box. LVN 3 stated the eye drops should be labeled with a resident's name. During an interview on 10/09/24 at 9:06 a.m. with Director of Nursing (DON), DON stated opened eye drops should be labeled with the resident's name and the date opened.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555376	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Danville Post-Acute Rehab	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)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48616 Based on observation, interview, and record review, the facility failed to store food in accordance with professional standards of practice for food service safety when: 1. Perishable food items in the kitchen were stored after the labeled used-by date; and, 2. The floor below Refrigerator 2 in the kitchen storage room was not clean. These failures had the potential to result in food borne illnesses (sickness caused by consuming contaminated food or beverages) for 38 residents who ate food from the kitchen. Findings: 1. During a concurrent observation and interview on [DATE] at 9:05 a.m. with Dietary Manager (DM) in the kitchen, Refrigerator 1 was observed. On the top shelf, there were five (5) different colors of liquid, each about a quarter to half full, placed in a transparent plastic container. These containers were labeled with handwritten names of fruit juices, two different numerical dates, and a use-by date. DM stated that the liquid in the containers were fruit juices. DM also stated that the first date on the label would be the preparation date, and the second would be the use-by date. DM identified names of fruit juices on each container: concentrated kiwi juice, tea, apple, kiwi-strawberry and cranberry juice, with used-by dates of [DATE], [DATE], [DATE], [DATE], and [DATE] respectively. During an interview on [DATE] at 9:22 a.m. with DM, DM stated that fruit juices with dates past the use-by-date should have been disposed of, as they were expired. During a continued concurrent observation and interview on [DATE] at 9:39 a.m. with DM in the kitchen's storage room, there were 12 red and eight (8) green apples stored in a plastic bin on the lower shelf of the dry goods storage rack. The bin had a preprinted label of apple and two handwritten numerical dates of [DATE] and [DATE]. DM stated that apples were beyond use-by date. During a review of the facility's policy and procedure (P&P) titled, Labeling and Dating of Foods, dated 2023, the P&P indicated, All food items in the storeroom, refrigerator, and freezer need to label and dated based on established procedures for either food safety .The use by date will be the absolute date in which the food must be consumed or discarded by the facility. 2. During an observation on [DATE] at 9:42 a.m. in the kitchen's dry storage room, the floor underneath Refrigerator 2 had a dark brown to black colored area with a shiny splattered stain. The floor was also observed to contained granular particles. During a follow up observation on [DATE] at 11:14 a.m. in the kitchen's dry storage room, the floor underneath Refrigerator 2 remained the same. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555376	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Danville Post-Acute Rehab	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)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on [DATE] at 9:00 a.m. with DM in the kitchen's dry storage room, the floor underneath Refrigerator 2 was observed. DM stated she did not know what was on the floor. During an interview on [DATE] at 11:04 a.m. with Environmental Services (ES), ES stated he went to the kitchen's dry storage room and inspected the floor underneath Refrigerator 2. ES stated he touched the stain on the floor, and it was grease. According to U.S. Food and Drug Administration Federal Food Code 2022, Food Storage, food shall be protected from contamination by storing food in a clean, dry location, where it is not exposed to splash, dust, or other contamination. According to U.S. Food and Drug Administration Federal Food Code 2022, Maintenance and Operation. Physical facilities shall be cleaned as often as necessary to keep them clean.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555376	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Danville Post-Acute Rehab	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)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 49613 Based on interview and record review, the facility failed to maintain accurate medication administration records (MARs) for controlled substances (those with high potential for abuse and addiction) in accordance with facility policy and professional standards of practice when the electronic MAR for three out of four residents (Residents 10, 240, and 241) reviewed was altered during the survey. This failure had the potential to result in inaccurate documentation of the resident's medical history and response to care and had the potential for abuse and diversion of controlled medications. Findings: During a concurrent interview and record review on 10/09/24 at 8:39 a.m. with the Director of Nursing (DON) and Consultant 1, Resident 241's September 2024 MAR, printed on 10/09/24, was reviewed for controlled substance accountability. The MAR indicated Resident 241 received oxycodone with acetaminophen (a controlled medication for pain, generic for Percocet) 5-325 milligrams (mg), on two dates: 09/16/24 and 09/19/24. Resident 241's September 2024 MAR for Percocet 5-325 mg printed by surveyor on 10/08/24 indicated one dose administered on 09/19/24. DON and Consultant 1 both acknowledged that Resident 241's September 2024 MAR printed on 10/09/24 was different from the MAR printed on 10/08/24. Consultant 1 stated the electronic medical record does not allow staff to back-fill administration in the MAR. Consultant 1 stated the medication administration needs to be documented at the time of administration. During an interview on 10/09/24 at 8:55 a.m., the Assistant Director of Nursing (ADON) stated the MAR entries can be edited after the date had passed. ADON stated she believed the MAR entries could be edited up to one month back but was unsure of the exact cutoff. During an interview on 10/09/24 at 1:37 p.m., Consultant 1 stated she was told the MAR entries can be edited after the fact. When asked if this was an acceptable practice, she did not answer. During an interview on 10/09/24 at 1:40 p.m., DON stated the nurse needs to document the medication administration in the MAR right away. DON stated medication administration is documented in real time as proof the nurse gave medications to the resident. DON verified all changes to the MAR were made by licensed vocational nurse (LVN) 3. DON stated LVN 3 was not directed to edit the MAR by facility leadership and was in-serviced to document administration of medications right away. Referring to the practice of back-filling the MAR, DON stated she was concerned about the practice because of danger to the resident. When asked to clarify what kind of danger, DON did not specify. During an interview on 10/09/24 at 1:54 p.m., DON verified the MARs printed on 10/09/24 had been changed from the original MARs printed on 10/08/24. During a comparison of Resident 10's September 2024 MAR printed on 10/8/24 at 10:52 a.m. and 10/10/24 at 12:42 p.m., the following additions were noted to the administration of hydrocodone with acetaminophen (a controlled medication for pain, generic for Norco) 5-325 mg: - 09/23/24 at 9:00 a.m. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555376	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Danville Post-Acute Rehab	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)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 09/27/24 at 1:00 p.m. - 09/28/24 at 9:00 a.m. - 09/29/24 at 9:00 a.m. These four additions were not present on Resident 10's September 2024 MAR printed on 10/08/24. During a comparison of Resident 10's October 2024 MAR printed on 10/8/24 at 10:51 a.m. and 10/10/24 at 12:43 p.m., the following additions were noted to the administration of Norco 5-325 mg: - 10/01/24 at 1:30 p.m. - 10/02/24 at 1:30 p.m. - 10/03/24 at 1:00 p.m. These three additions were not present on Resident 10's October 2024 MAR printed on 10/08/24. During a comparison of Resident 240's September 2024 MAR printed on 10/08/24 at 10:55 a.m. and 10/10/24 at 12:45 p.m., the following additions were noted to the administration of Percocet 10-325 mg: - 09/26/24 at 1:10 p.m. - 09/27/24 at 8:00 a.m. - 09/27/24 at 1:00 p.m. - 09/29/24 at 9:00 a.m. These four additions were not present on Resident 240's September 2024 MAR printed on 10/08/24. During a comparison of Resident 241's September 2024 MAR printed on 10/08/24 at 11:01 a.m. and 10/10/24 at 12:46 p.m., the following additions were noted to the administration of Percocet 5-325 mg: - 09/16/24 at 9:00 a.m. This one addition was not present on Resident 241's September 2024 MAR printed on 10/08/24. During a phone interview on 10/09/24 at 3:58 p.m., Consultant Pharmacist 1 (CP1) stated ideally the MAR should be initialed immediately after giving the dose. CP1 stated the residents' medical records need to be accurate. When asked his response if he discovered a MAR was altered after controlled substance reconciliation, CP1 stated he would be concerned about sloppy record keeping and potential for diversion. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555376	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Danville Post-Acute Rehab	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)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a phone interview on 10/10/24 at 12:49 p.m., LVN 3 stated he did not check with anyone at the facility before altering the records. LVN 3 stated the MAR is supposed to be filled out in real time. LVN 3 stated the MAR entries need to be completed timely so that the nurses in later shifts will know when the residents got their medications. During an interview on 10/10/24 at 1:05 p.m., Medical Records supervisor (MR) stated the medication administration needs to be documented during the nurse's shift. MR stated the administration is supposed to be documented as soon as it happens for accuracy. During an interview on 10/10/24 at 2:39 p.m., Consultant 1 stated the facility could not find the electronic audit logs for the residents' (Residents 10, 240, and 241) September and October 2024 MARs initially requested on 10/09/24 at 2:19 p.m. During a review of the annual performance evaluation for LVN 3, dated 02/21/24, the evaluation indicated, Documentation need to improve and Met all expectations but need to improve in documentation. A review of the facility's policy and procedure (P&P) titled, Policy / Procedure Administration - Medical Record, dated September 2018, indicated: .All physicians, nursing staff, and other health care professionals involved in the resident's care will be responsible for making prompt, appropriate entries in the record . A review of the facility's P&P titled, Preparation and General Guidelines IIA2: Medication Administration - General Guidelines, dated May 2022, indicated: .The individual who administers the medication dose records the administration on the resident's MAR/eMAR [electronic MAR] directly after the medication is given .In no case should the individual who administered the medications report off-duty without first recording the administration of any medications . A review of the facility's P&P titled, Preparation and General Guidelines IIA7: Controlled Substances, dated May 2022, indicated: .Accurate accountability of the inventory of all controlled drugs is maintained at all times. When a controlled substance is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record and the medication administration record (MAR) .Date and time of administration (MAR, Accountability Record [CDR]) .Initials of the nurse administering the dose, completed after the medication is actually administered (MAR, Accountability Record) .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555376	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Danville Post-Acute Rehab	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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 49613 Based on observation and interview, the facility failed to implement infection control practices when: 1. One out of three licensed nurses did not wear gloves when directly handling a capsule during medication pass. 2. One licensed nurse did not remove contaminated gloves and wash hands before adjusting Resident 242's nasal cannula These failures had the potential of exposing residents to infections. Findings: 1. During a medication pass observation on 10/07/24 at 4:34 p.m., Licensed Vocational Nurse (LVN) 2 was observed preparing and administering four medications to Resident 33. LVN 2 was observed preparing and administering one capsule of potassium chloride (a supplement) to Resident 33. LVN 2 used her bare hands to open the capsule and add the contents to apple sauce before giving to Resident 33. During an interview on 10/07/24 at 4:48 p.m., LVN 2 verified she did not wear gloves when handling the potassium chloride capsule for Resident 33. LVN 2 stated she did not need to wear gloves when handling medications unless the medication was hazardous. During an interview on 10/09/24 at 9:12 a.m., Director of Nursing (DON) stated the nurse needs to wear gloves when opening a medication capsule for infection control. 50474 2. During a record review of Resident 242's Admission Record (AR), printed on 10/10/24, the AR indicated Resident 242 was admitted to the facility in October 2024 with a diagnosis of sepsis (serious condition in which the body responds improperly to an infection). During a record review of Resident 242's Care Plan, dated on 10/7/24, the care plan indicated Resident 242 had a foley catheter related to urinary retention (difficulty urinating and completely emptying the bladder). During a concurrent observation and interview on 10/8/24 at 8:05 a.m. with LVN 3, Resident 242's foley catheter bag was touching the floor. LVN 3 stated the foley catheter bag should have not touched the floor at all. With gloved hands, LVN 3 was observed touching and picking up Resident 242's foley catheter bag off the floor. LVN 3 did not remove his gloves or wash his hands. LVN 3 was then observed touching Resident 242's nasal cannula (a device that delivers extra oxygen through a tube and into the nose) and Resident 242's shoulder using the same contaminated gloves he used to touch the foley catheter bag. LVN 3 stated he should have removed his gloves and washed his hands before touching Resident 242 and the nasal cannula. LVN 3 stated when he touched Resident 242 and the nasal cannula, it had the potential to spread infection. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555376	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Danville Post-Acute Rehab	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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/10/24 at 7:51 a.m. with DON, DON stated the standards of practice for the staff was to remove gloves and wash hands after touching a contaminated area. The DON further stated LVN 3 should have changed his gloves prior to touching Resident 240's nasal cannula and Resident 240's shoulder. The DON stated these practices had the risk to spread infection. During a record review of the facility's undated policy and procedure (P&P), titled, Catheter Care, Urinary, the P&P indicated, The purpose of this procedure is to prevent catheter-associated urinary tract infections . Infection Control .1. Use standard precautions when handling or manipulating the drainage system. 2. Maintain clean technique when handling or manipulating the catheter, tubing, or drainage bag . During a record review of the facility's P&P, titled, Infection Control, revised in February 2023, the P&P indicated, Prevention of spread of infections is accomplished by use of universal precautions and other barriers .Policies, procedures and aseptic techniques are followed by personnel in performing procedures and in disinfection of equipment.