STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555421	A. Building B. Wing	12/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stonebrook Post Acute	4367 Concord Boulevard Concord, CA 94521

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure for one of two sampled residents, (Resident 2) the Physician's Orders for Life Sustaining Treatment (POLST) was completed and the Do not Resuscitate physician order was followed during a medical emergency. This failure resulted in medical interventions for CPR (Cardiopulmonary Resuscitation - an emergency technique combining chest compressions and rescue breaths to maintain blood flow and oxygen to the brain and vital organs when someone's heart has stopped (cardiac arrest) and defibrillation (uses an electrical shock inside or outside the body to stop an abnormal heart rhythm in the heart's ventricles to allow the heart to start a normal rhythm again) on Resident 2 which were not requested. During a review of Resident 2's admission record (AR), the AR indicated Resident 2 was originally admitted [DATE], initially admitted on [DATE], and readmitted on [DATE] and discharged to the hospital on [DATE]. AR indicated Resident 2 was self-responsible.During a review of Resident 2's Statement of Resident Capacity (SRC) dated [DATE], the SRC indicated Resident 2 had capacity and had been informed of their condition.During a concurrent interview and record review on [DATE] at 1:48 p.m. with Registered Nurse Supervisor (RNS) 2. Resident 2's progress notes (PNs) dated [DATE] and the physician orders were reviewed, the PN dated [DATE] at 5:38 indicated, Patient up on his wheelchair, unresponsive to verbal and tactile stimuli, pale in color, no neurological response, unable to obtain any vital signs including oxygen saturation, on a slouched position and drooling at the same time, assisted to lay down, CPR initiated. PN indicated, on [DATE] at 5:43 a.m. 911 emergency was called. The PNs indicated, at 5:53 a.m. two police officers came with a defibrillator and used it on Resident 2 and were able to get a pulse, then CPR was suspended. The PNs indicated Fire department and ambulance arrived at the facility at 5:55 a.m. and they were made aware that Resident 2 was DNR but no POLST on file, facility were asked to call the family to clarify the code status. Then Resident 2 was transported to the hospital at 6:05 a.m. The active physician orders for [DATE] indicated DNR (Do Not Resuscitate) with order date [DATE].During a concurrent interview and record review on [DATE] at 3:46 p.m. with Director of Nursing (DON), DON confirmed that Resident 2 had a DNR order but CPR was performed on him by Registered Nurse (RN) 3 when he was unresponsive. During a concurrent interview and record review on [DATE] at 5:23 p.m. with DON, DON stated there was no copy of Resident 2's POLST (medical form for individuals with chronic or self-limiting illnesses to specify their wishes for end-of-life care, and it is a set of medical orders that guides emergency responders and health care providers, often involving decisions on CPR, intubation, and artificial nutrition). DON stated that when the patient came from the hospital, he did not have a POLST that was sent with him and the facility did not have one completed.During an interview on [DATE] at 5:26 p.m. with DON, DON stated they were supposed to follow the DNR order (a specific physician's order to withhold CPR if the heart or breathing stops) since there was no POLST.During a concurrent interview and record review on [DATE] at 5:30 p.m. with Medical Record Assistant (MRA), the physician progress notes titled, POLST Verbal Discussion dated [DATE], indicated, if patient has no pulse and is not breathing. with a check mark in the box in front of Do not attempt resuscitation/DNR (Allow Natural Death) and with a check mark in the box in front of selective treatment-. It also indicated the physician's signature and verbal consent obtained from Resident 2 dated [DATE]. When asked for an updated one, MRA stated they did not have an updated one and there was no POLST on file for Resident 2.During a review of Resident 2's physician admission note (PAN) dated [DATE], PAN indicated Code status: with an X in front of POLST reviewed/signed. PAN also indicated Patient: with an X in the front of has capacity to understand and make medical decisions.During a review of the facility's policy and procedure (P&P) titled, Do Not Resuscitate Order revised [DATE], the P&P indicated, Our facility will not use cardiopulmonary and related emergency measures to maintain life functions on a resident when there is a DO Not Resuscitate Order in effect.In addition to the. and DNR order form, state-specific forms may be used to specify whether to administer CPR in case of a medical emergency. Stated- specific forms include: POLST.Do not resuscitate (DNR) orders will remain in effect until the resident (or legal surrogate) provides the facility with a signed and dated request to end the DNR order.During a review of the blank POLST form, under the Directions for Health Care Provider, indicated, if found pulseless and not breathing, no defibrillator (including automated external defibrillators) or chest compressions should be used on a patient who has chosen Do Not Attempt Resuscitation.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the results of the investigations of an abuse allegation were reported timely to the State Agency (SA, which is the California Department of Public Health, CDPH), for one sampled resident (Resident 1) when Resident 1 alleged that staff was rough with him.This failure had the potential to compromise the safety of all residents in the facility from unreported investigations and results of the investigations. Review of Resident 1's admission record, undated, indicated that he was admitted on [DATE] with diagnoses that included diabetes, urine retention, and hyperlipidemia.Review of Resident 1's Minimum Data Set (MDS- an assessment and care screening tool used to guide care) dated 8/23/25 indicated Resident 1's Brief Interview for Mental Status (BIMS- a short scanner to help detect cognitive impairment) score was 14, indicating no cognitive impairment.During a review of the social services note (SSN) note dated 8/7/25, the SSN note indicated, Resident 1 stated that a CNA (certified Nursing Assistant) has been rough with him and hurt him when she was putting his brief on by pulling it up aggressively 2 times, Resident claims his testicles were sore and he could not urinate for 2 days. CDPH, Ombudsman, Concord PD & MD notified by phone. Social Services notified. SOC341 faxed to CDPH & Ombudsman.During an interview on 12/18/25 at 9:10 a.m. with Director of Nursing (DON), When asked for the investigation summary for this allegation, DON stated they don't have it as the facility transitioned to a new company. DON stated they have all the documentation in the Point Click Care (PCC- Electronic Health Record). DON stated the CNA was suspended for three days and when she came back, was assigned to a different station.During an interview on 12/18/25 at 11:10 a.m. Administrator (ADM) stated they are still unable to find the investigation documents done by former Administrator (ADM) and staff have been trying to reach her to ask about it.During a telephone interview on 12/18/25 at 1:39 pm, with the former ADM, former ADM stated she did the investigation for that incident. She stated she could not remember all the specific details. She stated former AADM would be able to remember the details. Former ADM stated she had left all her investigation documents/notes in the ADM's office.During a telephone interview on 12/18/25 at 2:30 p.m. with former Assistant Administrator (AADM), AADM stated she left a day before transition to the new company on 10/31/25, reported it to the new company and they left all the investigation documents. Former AADM stated she was the one that reported the abuse allegation to the appropriate agencies.During an interview on 12/18/25 at 4 p.m. with DON, DON stated the incident was reported to them on 8/7/25 and it happened on the night of 8/6/25 going to 8/7/25. DON stated he and the former AADM went in to interview Resident 1.During an interview on 12/22/25 at 5:55 p.m. with ADM, ADM stated he had searched for the former ADM's investigation notes and summary and cannot locate them.During a telephone interview on 12/26/25 at 10:18 a.m. with DON, DON stated it was very important to keep the investigation reports, to know what happened as everything is in that report; they can see what happened, what the allegation was, and what they could do about it and then they would let everybody know this and make sure this does not happen again. DON stated they do not have the policy and procedure for reporting of investigation notes/summary in the P&P provided but did not know why. DON stated that was the P&P they were following at the time of the incident. DON stated the new company for the facility took over on 11/1/25. During an interview on 12/29/25 at around 12:05 p.m. with ADM, ADM stated his expectation, after sending the SOC 341, is to conduct the investigation within 5 days, reach a conclusion and send it to the State agency. When asked, ADM stated he did not know if the 5 day investigation report about Resident 1's allegation was sent to the state agency. He also confirmed there was no fax confirmation that it was sent.During an interview on 12/29/25 at 12:14 p.m. with ADM, ADM stated the new company would hold onto the investigation records for seven years. ADM stated he expected the old company to follow the regulations to keep them. He stated further, .if they don't have documentation it didn't happen. ADM stated it was important for them to keep the investigation records to protect the patient, staff, and the building.During a review of the facility's P&P, titled, Abuse Prevention, undated, the P&P indicated, When an incident or suspected incident of resident abuse is reported, .shall utilize abuse/.investigation process as required by federal and stated law.