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	06/25/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store and prepare food in accordance with professional standards for food service safety when:The dishwashing machine failed to reach the required sanitization temperature.Two dietary staff did not wear required beard restraints while in food preparation areas.This failure had the potential to result in food contamination and foodborne illnesses for a medically vulnerable population with a census of 114 residents.Findings:During a concurrent observation and interview on 6/22/26 at 1:53 p.m. in the Main Kitchen with Dietary Aide (DA) 1, DA 1 was operating the facility's dishwashing machine with a stationary rack and dual operating temperatures. The temperature gauges on the machine, labeled Rinse 180oF (Fahrenheit, unit of measurement for temperature) (MIN [minimum]), indicated a temperature of 170oF during the rinse cycle. DA 1 confirmed the temperatures were not rising to the minimum required temperature of 180oF for the rinse cycles.During an interview on 6/22/26 at 2:21 p.m. with the Dietary Supervisor (DS), the DS stated dietary staff were responsible for checking that the dishwasher machine reached the correct temperatures for every rinse cycle to ensure dishes were properly sanitized to prevent food˜borne illnesses. The DS further confirmed that all food served to residents was prepared in the Main Kitchen.During an interview on 6/24/26 at 2:18 p.m. with the Manufacturer Representative (REP), the REP stated the purpose of the final rinse temperature was to properly sanitize the dishes and must be at a minimum of 180 F.During a review of the facility provided Manufacturer's Guide titled, [Brand Name] Dishmachine, dated 2022, the guide indicated the facility's dishwasher was a high-temperature machine with a minimum operating temperature of 180 F for the rinse cycle.During a review of the facility's policy and procedure (P&P) titled, Dishwashing Machine Use, dated March 2010, the P&P indicated, Dishwashing machine hot water sanitation rinse temperatures may not be more than 194 F, or less than.180 F.During a review of the Food and Drug Administration's Food Code, dated 1/18/22, the Food Code indicated, .the temperature of the fresh hot water SANITIZING rinse as it enters the manifold may not be more than. (194 F), or less than. (180 F). 2.During a concurrent observation and interview on 6/22/26 at 1:29 p.m. with Dietary Aide (DA) 2 and DA 3 in the Main Kitchen, DA 2 and DA 3 were not wearing any nets or restraints over their full beards while near the food preparation area. DA 2 confirmed he was not wearing a beard covering and did not know where he could get one. DA 3 stated he should wear a beard covering but his reusable beard net was not in the kitchen.During an interview on 6/22/26 at 1:31 p.m. with the Dietary Supervisor (DS), the DS stated kitchen staff should wear a hair and beard net while in the kitchen. The DS further stated there were no available beard nets in the kitchen.During an interview on 6/24/26 at 9:10 a.m. with the Registered Dietician (RD), the RD stated dietary staff should cover their beards with a beard net at all times in the kitchen because hair can be dirty and residents would not want that on their food.During a review of the facility's policy and procedure (P&P) titled, Dress Code and Personal Hygiene, May 2019, the P&P indicated, Dietary staff must wear a hairnet and if applicable a beardnet.During a review of the Food and Drug Administration's Food Code, dated 1/18/22, the Food Code indicated, FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to (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
	555421	A. Building B. Wing	06/25/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	effectively keep their hair from contacting exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES.

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	06/25/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed ensure infection prevention and control practices was consistently implemented for three (Resident 88, 72 and 38) of 23 sampled residents when: Airborne Precautions (infection control measures used to prevent the spread of illnesses transmitted by tiny pathogens suspended in the air) for Resident 88 was not followed when the door to resident's room was open.Registered Nurse (RN) 1 did not wear a gown to administer antibiotics intravenously (IV, route directly into the bloodstream) to Resident 72 on Enhanced Barrier Precautions (EBP, infection control intervention used to reduce the transmission of multi-drug-resistant organisms (MDROs) by wearing gown and gloves during high contact resident care activities). The Oxygen (O2) concentrator (a medical device that draws in ambient air and delivers concentrated oxygen) for Resident 38 had a dusty filter.These failures had the potential to increase the risk of transmission of infectious organisms and adversely affect the health and safety of residents, staff and visitors. 1.During a review of Resident 88's admission Record (demographics), record indicated that Resident 88 was admitted to the facility on [DATE] with a diagnosis that included zoster without complications (localized Shingles outbreak where Varicella-Zoster virus reactivates – can be contagious to those who have not had chicken pox or the chicken pox vaccine). During a concurrent observation and interview on 6/22/26 at 3:58 p.m. with Licensed Vocational Nurse (LVN) 3 in front of Resident 88's room [ROOM NUMBER], the door to the room was wide open and an Airborne Precautions signage was posted that read, Door to room must remain closed. LVN 3 stated that door to Resident 88's room should have been closed because she was on airborne precautions for Shingles virus. During an interview on 6/24/26 at 2:30 p.m. with Infection Preventionist (IP), IP confirmed the door to Resident 88's room should have been closed. IP stated the importance of the door being closed was to prevent the possible spread of an airborne illness to other residents in the facility. During a review of the facility's policy and procedure (P&P) titled, Isolation – Categories of Transmission-Based Precautions, [undated], the P&P indicated, Transmission-based precautions are initiated when a resident develops signs and symptoms of a transmissible infection; arrives for admission with symptoms of an infection. and is at risk of transmitting the infection to other residents. 5. When a resident is placed on transmission-based precautions, appropriate notification is placed on the room entrance door. so that personnel and visitors are aware of the need for and type of precaution. 2. During a review of Resident 72's Admissions Record (demographics), dated 6/22/26, the record indicated Resident 72 was admitted on [DATE] with a diagnosis of extradural and subdural abscess (infection characterized by pockets of pus around the brain), bacteremia (bacterial infection in the blood), staphylococcus aureus infection (type of bacterial infection commonly treated with antibiotics). During an observation on 6/22/26 at 3:19 p.m. in Resident 72's room, there was signage posted by the door that indicated EBP applied to Resident 72 in Bed B. The sign instructed providers and staff to wear gloves and a gown for the following high-contact resident care activities such as device care or use including central line. Resident 72 was observed in bed with a peripherally inserted central catheter (PICC, type of central line inserted into a vein in the upper arm) in his right upper arm. (continued on next page)

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	06/25/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 6/22/26 at 3:36 p.m. with RN 1, RN 1 was not wearing a gown while administering IV medication to Resident 72. RN 1 stated, I just administered IV nafcillin (medication classified as antibiotic to treat bacterial infection). RN 1 further stated staff were not required to wear a gown when administering IV medications through a PICC line. During an interview on 6/24/26 at 2:41 p.m. with the Infection Preventionist (IP), the IP confirmed Resident 72 was on EBP because of his PICC line. The IP further stated RN 1 should have worn a gown when giving IV medications through the PICC line to Resident 72 to decrease the risk of spreading MDRO infections. During a review of the facility's policy and procedure (P&P) titled, Enhanced Barrier Precautions – Infection Prevention, dated December 2024, the P&P indicated EBP applies when a resident has an indwelling medical device, including central lines, and that gown and glove use is required during high contact resident care activities including device care or use. 3. During observations on 6/23/26 at 9:10 a.m. and 6/24/26 at 2:41 p.m. in Resident 38's room, Resident 38 was on oxygen via nasal cannula and the oxygen concentrator had a filter clogged with dust. During a review of Resident 38's Order Summary (OS), dated 2/2/24, the OS indicated Resident 38 had an order for oxygen set to one to two liters of oxygen via nasal cannula. During an interview on 6/24/26 at 2:44 p.m. with LVN 2, LVN 2 stated the oxygen concentrators should be cleaned every so often, but didn't know timeframes. LVN 2 stated The filter should be cleaned to prevent potential respiratory infection to residents. During an interview on 6/24/26 at 3:14 p.m. with the Respiratory Therapist (RT), the RT stated the oxygen concentrators should have been cleaned at least monthly. The RT stated he did not know when the last time they were cleaned or serviced. The RT stated the cabinet filter should have been cleaned to prevent any respiratory infection to the residents and to work efficiently. During a review of the policy and procedure (P&P) titled Oxygen Administration, dated October 2010, the P&P indicated, .Oxygen equipment shall be maintained by the vendor in accordance with applicable standards; facility staff are responsible for notifying the vendor of any equipment concerns or malfunctions requiring attention. During a review of the manufacturer's guidelines titled Oxygen Concentrator User Manual, dated March 2025, indicated, . Cabinet filter should be inspected periodically and cleaned as needed by the user or caregiver.Recommended cleaning interval.Cabinet filter.7 days.

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	06/25/2026

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on interview and record review the facility failed to ensure the rights of one of 23 sampled residents (Resident 3), when Resident 3 did not give informed consent for an antidepressant (medications used to treat major depressive disorder-severe mental health condition causing persistent sadness, hopelessness, and a loss of interest in activities) medication.This failure resulted in Resident 3 not being informed of potential side effects or complications and the ability to refuse treatment.During a review of Resident 3's Order Summary (OS), dated 4/28/26, the OS indicated Resident 3 had Venlafaxine (antidepressant) ordered for major depressive disorder.During a review of Resident 3's Psychotherapeutic Drug Informed Consent Forms (IC), there was no IC before 6/22/26 for Venlafaxine.During an interview on 6/25/26 8:37 a.m. with Supervisor Registered Nurse (SRN) 1, SRN 1 stated the purpose of informed consent for antidepressants was to ensure the resident and resident's representative understood the indications for use, symptoms, and side effects before making a decision about receiving the medication. SRN 1 stated the IC for Venlafaxine should have been completed before the medication was ordered. SRN 1 stated there was no informed consent for Resident 3's antidepressant before 6/22/26.During a review of the facility's policy and procedure (P&P) titled, Resident Rights, dated October 2025, the P&P indicated, .be informed of, and participate in, their care planning and treatment.During a review of the facility P&P titled Medication Management, dated September 2010, the P&P indicated, .A resident and/or representative had the right to be informed about the resident's condition; treatment options, relative risks and benefits of treatment, required monitoring, expected outcomes of the treatment; and has the right to refuse care and treatment.

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	06/25/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview and record review, the facility failed to ensure safe smoking practices were implemented and monitored for one of 23 sampled residents (Resident 52) who used the designated smoking area. This failure placed Resident 52 and other residents who accessed the smoking area at risk for an uncontrolled fire and potential burns.Findings:During an observation on 6/24/26 at 7:45 a.m. the designated smoking area was observed to have no safety equipment, including the absence of a fire extinguisher or fire blanket. Multiple used cigarette butts were noted discarded in a flower planter rather than in proper receptacles. During an observation on 6/24/26 at 9 a.m. Resident 52 was noted to be smoking in the designated smoking area. During an interview on 6/24/26 at 2:35 p.m. with Administrator (ADM), ADM stated, there was no safety equipment placed in the smoking area. The ADM further stated he did not know who was responsible for monitoring the smoking area.During a review of the facility's policy and procedure (P&P) titled, Smoking Policy-Residents dated July 2017, the P&P indicated, . 5. The resident will be evaluated . d. ability to smoke safely . The facility was not able to provide documentation regarding safety equipment in smoking area.