STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555446	A. Building B. Wing	04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rossmoor Post Acute	1226 Rossmoor Parkway Walnut Creek, CA 94595

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 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. 36087 Based on interview and record review, for one of three sampled residents (Resident 1), the facility failed to ensure a suspicion of sexual abuse, including injuries of unknown origin, was reported to appropriate authorities within the required regulatory timeframe when the Ombudsman received a telephone call from the facility ' s Master of Social Work (MSW) on 2/20/24, at 3 pm., regarding a concern that had been brought up by Certified Nursing Assistant 1 (CNA 1) during Resident 1 ' s Care Conference. This failure resulted in the facility's ability to ensure a complete investigation was initiated timely and ensure interventions were initiated to protect Resident 1 as well as all other residents of the facility, from protection from abuse. Findings: A review of Resident 1's Admission Record, printed date 3/14/24, indicated Resident 1 was admitted to the facility in 2019 with diagnoses of Alzheimer ' s Disease (a decline in memory, thinking, learning, and organizing skills over time) and failure-to-thrive (state of decline in health and ability). A review of Resident 1's Minimum Data Set (MDS, an assessment tool used to guide care) dated 12/19/23, indicated Resident 1 was usually able to understand others and was usually understood with severely impaired cognition. The MDS also indicated Resident 1 was dependent (helper does all the effort. Resident does none of the effort to complete the activity. Or the assistance of two or more helpers is required for the resident to complete the activity) on toileting hygiene (the ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement). (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 3/13/24, at 12:05 p.m., with Ombudsman 1, Ombudsman 1 stated she learned from facility MSW that during Resident 1 ' s Care Conference on 2/20/24, CNA 1 shared to Hospice Registered Nurse (HRN) a suspicion of abuse incident by Resident 1 ' s spouse to Resident 1. Ombudsman 1 stated MSW seeked guidance thru a telephone call to Ombudsman 1 on what to do. On 2/20/24, the Ombudsman ' s office sent MSW an email attachment of the SOC 341 form (Report of Suspected Dependent Adult/Elder Abuse, statement acknowledging requirement to report Suspected Abuse of Dependent Adult and Elders) to be filled out as soon as possible. On 2/23/24, Ombudsman 1 sent another email to MSW to follow up on the SOC 341 form document and still did not get a response from MSW. A couple days later, Ombudsman 1 received an email from MSW, and stated facility had done their part and found it unnecessary to report and fill out the SOC 341. During a concurrent interview and record review on 3/14/24, at 10:20 a.m., with MSW, Resident 1 ' s clinical records were reviewed. A review of Resident 1 ' s Care Conference Meeting Notes by MSW, dated 2/20/24, at 2:49 p.m., indicated MSW placed a call and left a telephone message to Ombudsman 1. Review of an email from Ombudsman 2 to MSW, dated 2/20/24, at 3:18 p.m., indicated Ombudsman 2 sent an email to MSW, with an attachment of the SOC 341 form. Review of Ombudsman 1 ' s email to MSW, dated 2/23/24, at 4:05 p.m., indicated Ombudsman 1 followed up re the SOC 341 form Ombudsman 2 had sent which have not been emailed back to Ombudsman ' s office re a suspected abuse incident report. A review of MSW ' s email to Ombudsman 1, dated 2/26/24, at 8:42 p.m., indicated MSW replied to Ombudsman 1 and stated facility had done their part and found it unnecessary to report, hence, did not fill out and/or submit the SOC 341 form. MSW stated she spoke with the Administrator (ADM) and stated the facility did their part with the investigation in which facility was not able to prove there was a suspected or actual abuse that took place between Resident 1 and Resident 1 ' s spouse, so there was no need to report an abuse or suspicion of abuse to the appropriate authorities. During an interview on 3/14/24, at 11:48 a.m., with CNA 1, CNA 1 stated all staff are mandated reporters and should follow the facility protocol on Abuse Reporting. CNA 1 also stated the ADM was the main person responsible for Abuse Reporting in the facility. CNA 1 stated when she attended the care conference for Resident 1, on 2/20/24, at 3 p.m., CNA 1 shared Resident 1 was recently found to have bloody discharge on resident ' s brief. CNA 1 stated that day after the spouse had visited the resident, Resident 1 ' s blanket was partially pulled down, with resident ' s abdomen exposed, and brief suspiciously undone. CNA 1 stated she remembered seeing Resident 1 ' s hands were on her abdomen and appeared to have experienced some discomfort. CNA 1 stated she immediately reported this to Licensed Vocational Nurse 1 (LVN 1). CNA 1 stated she was unsure if LVN 1 had reported the incident to the ADM or Director of Nursing (DON). During a telephone interview on 3/28/24, at 3:31 p.m., with Hospice Registered Nurse (HRN), HRN, unable to recall the exact date, stated LVN 1 had mentioned to HRN about Resident 1 ' s spouse suspicious act of closing Resident 1 ' s room door and privacy curtain when spouse visited Resident 1. HRN stated HRN visited Resident 1 weekly on Thursdays. HRN stated LVN1 reported Resident 1 had a two-day incident of bloody discharge on resident ' s brief. HRN stated when she assessed Resident 1, Resident 1 denied pain and had no other signs of urinary tract infection. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 3/29/24, at 10 a.m., with LVN 1, LVN 1 strongly denied having witnessed or received a report from CNA 1 regarding a suspicion of abuse by Resident 1 ' s spouse towards Resident 1. LVN 1 also denied having received directions from either the ADM, DON, or the MSW to ensure Resident 1 ' s room door was left opened and privacy curtain not pulled when Resident 1 ' s spouse came to visit the resident in her room. LVN 1 stated abuse or any suspicion of abuse should be reported immediately to the ADM or DON. During an interview on 3/14/24, at 1:21 p.m., with the ADM, ADM stated the facility did not do an abuse investigation because the facility did not think there was a reportable incident that happened to Resident 1. ADM stated he knew the process for Abuse Reporting regarding suspected or actual abuse but believed there was no indication of actual or suspected abuse that took place. A review of the facility ' s P&P titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, revised September 2022, indicated, All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. 1. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. 2. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility; b. The local/state ombudsman; c. The resident ' s representative: d. Adult protective services (where state law provides jurisdiction in long-term care); e. Law enforcement officials; f. The resident ' s attending physician; and g. The facility medical director. 3. Immediately is defined as: a. within two hours of an allegation involving abuse or result in serious bodily injury; or b. within 24 hours of an allegation that does not involve abuse or result in serious bodily injury .