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	11/12/2024

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36087 Based on interview and record review, the facility failed to accurately assess one of two sampled residents (Resident 1) on the Minimum Data Set (MDS, an assessment tool used to direct care). This failure resulted in an inaccurate reflection of Resident 1's current health condition which had the potential for Resident 1 to not receive the person-centered care that Resident 1 deserved. Findings: A review of Resident 1's Admission Record, printed 11/12/24, indicated Resident 1 was admitted to the facility on [DATE], with multiple diagnoses that included acute respiratory failure with hypoxia (when the lungs are unable to provide oxygen in the body's tissues) and obesity (excessive weight). A review of Resident 1's Care Plan, revised date 4/15/22, indicated Resident 1 was at risk for respiratory impairment related to sleep apnea. A review of Resident 1's Order Summary Report, active orders as of 11/12/24, indicated: 1. 8/6/2023 - BIPAP Ventilator Respironics V60 (a breathing machine that helps people breathe when they are having trouble): BIPAP Mode: spontaneous/timed, every evening and night shift for acute respiratory failure. 2. 8/17/24 - Oxygen (O2) at 2 liters per minute (LPM) connected to BIPAP mask at night and as needed (PRN) at bedtime. A review of Resident 1's Quarterly Minimum Data Set (MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan) Assessment, dated 10/23/24, showed no indication that resident had a diagnosis of sleep apnea nor used a non-invasive mechanical ventilator (a breathing machine that helps people breathe when they are having trouble), either from a bilevel positive airway pressure (BIPAP) or a continuous positive airway pressure (CPAP) machine, during sleep. During a concurrent interview and record review on 11/20/24, at 10:07 a.m. with MDS Coordinator (MDSC), MDSC stated Resident 1's MDS Assessment for use of non-invasive mechanical ventilator was blocked out. MDSC further stated she was unsure whether Resident 1 used a BIPAP or CPAP machine but knew that resident had used the machine for sleep apnea since admission to the facility. (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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(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 - Few	During a concurrent interview and record review on 11/20/24 at 1:40 p.m. with Director of Nursing (DON), DON stated Resident 1's Quarterly MDS Assessment did not indicate that Resident 1 used a non-invasive mechanical ventilator for resident's sleep apnea. DON stated MDSC had coded the special treatment on MDS in error and did not reflect Resident 1's current health status. A review of the facility records titled, Center of Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual, dated October 2024, indicated, Code any type of CPAP or BIPAP respiratory support devices that prevent airways from closing by delivering slightly pressurized air through a mask or other device continuously or via electronic cycling throughout the breathing cycle. The BIPAP/CPAP mask/device enables the individual to support their own spontaneous respiration by providing enough pressure when the individual inhales to keep their airways open .This item may be coded if the resident places or removes their own BIPAP/CPAP mask/device .

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36087 Based on observation, interview, and record review, the facility failed to ensure resident received the necessary respiratory care in accordance with professional standards of practice when facility failed to provide in a timely manner, the missing connector for the appropriate-sized BIPAP (bilevel positive airway pressure, a machine used to treat sleep apnea [a sleep-related breathing disorder]) mask used by one of two sampled residents (Resident 1). This failure resulted in Resident 1's inconvenience, discomfort, several nights of interrupted sleep, skin breakdown to nose bridge (related to use of unfit, temporary BIPAP mask), anxiety, and mood swings. This failure also had the potential to result in serious harm and potential death to the resident. Findings: A review of Resident 1's Admission Record, printed 11/12/24, indicated Resident 1 was admitted to the facility on [DATE], with multiple diagnoses that included acute respiratory failure with hypoxia (when the lungs are unable to provide oxygen in the body's tissues) and obesity (excessive weight). A review of Resident 1's Minimum Data Set (MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan), dated 10/23/24, indicated Resident 1 had clear speech, was understood, and was able to understand others. The MDS also indicated Resident 1 required substantial/maximal assistance (Helper does more than half the effort) to supervision or touching assistance (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) during her activities of daily living (ADLs, the basic self-care tasks an individual does on a day-to-day basis). A review of Resident 1's Care Plan, revised date 4/15/22, indicated Resident 1 was at risk for respiratory impairment related to sleep apnea. A review of Resident 1's Order Summary Report, active orders as of 11/12/24, indicated: 1. 8/6/2023 - BIPAP Ventilator Respironics V60 (a breathing machine that helps people breathe when they are having trouble): BIPAP Mode: spontaneous/timed, every evening and night shift for acute respiratory failure. 2. 8/17/24 - Oxygen (O2) at 2 liters per minute (LPM) connected to BIPAP mask at night and as needed (PRN, pro re nata, as the need arises)) at bedtime. A review of Resident 1's Medication Administration Record (MAR), dated 11/1/24 - 11/30/24, indicated to apply thin hydrocolloid to nose bridge as barrier/cushion from the BIPAP, dated 10/31/24. A review of Resident 1's Progress Notes, dated 10/30/24, by Registered Nurse 2 (RN 2), indicated, Patient is complaining of (c/o) redness that extends to the side of her both cheeks that she claims caused by the BIPAP mask. Medical Doctor (MD) notified. Applied hydrocolloid to nose bridge as a barrier/cushion from the BIPAP mask. New BIPAP mask is ordered . (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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility records titled, Order Information, dated 10/26/24, at 6:57 p.m., indicated Central Supply Manager's (CSM's) online purchase order of item Airfit F20 and Airfit F30 Replacement QuietAir Elbow, was placed to Vendor 1. The Order Detail indicated Vendor 1 received the request on Sunday, 10/27/24 and the estimated delivery date was Thursday, October 31, 2024. On Monday, 11/1/24 at 7:45 a.m. , Vendor 1 sent a related email to CSM which indicated, Shipment Delay. Review of the email showed, We're encountering a delay in shipping your order .New estimated delivery date: Sunday, November 3, 2024 .View or cancel order . On Monday 11/4/24, at 7:55 a.m., Vendor 1 sent a second related email to CSM which indicated, Shipment Delay. Review of the email showed, There is a delay in shipping your order because of a supply chain issue .New estimated delivery date: Saturday, November 9, 2024 - Tuesday November 12, 2024, and the CSM replied with, I still want this item . On Saturday 11/9/24, at 7:59 a.m., Vendor 1 sent a third related email to CMS which indicated, We wanted to let you know that we have shipped your items . Expected delivery: Sunday, November 10 . A review of the facility records titled, Order Information, dated 11/5/24, at 11:34 a.m., indicated, Director of Staff Development's (DSD's) placed an online purchase order of item, Airfit F20 and Airfit F30 Replacement QuietAir Elbow, to Vendor 2. The Order Detail indicated Vendor 2 received the request on Tuesday, 11/5/24, and the estimated delivery date was Wednesday, November 6, 2024. On Wednesday, 11/6/24, at 12:57 p.m. , Vendor 2 sent a related email to DSD which indicated, Your parcel has been delivered to reception. During a concurrent observation, interview, and record review on 11/12/24, at 11:45 a.m., with Resident 1, in the resident's room, Resident 1 stated, It took 10 days and a mental breakdown to get the missing piece replaced by the facility. Resident 1 stated, on 10/25/24, when the BIPAP machine/tubing was replaced by the facility, a connecting piece of the BIPAP mask went missing resorting to use of an older mask. Resident 1 stated she was unable to sleep well at night that made her mentally and physically exhausted due to use of a mask that did not fit well, which constantly rubbed on her cheeks and nose area, and caused skin breakdown, during the 10 nights of waiting period. Resident 1 further stated during subsequent follow-ups, resident could not even get an update from CSM. Resident 1 stated waiting for the replacement piece had caused her so much anxiety and inconvenience to the point of ordering the missing piece herself, via online on 11/4/24. Resident 1 also mentioned the facility did not address the skin breakdown to her nose bridge until 10/31/24. During a concurrent interview and record review on 11/12/24, at 1:04 p.m., with CSM, CSM stated LVN 1 made him aware of Resident 1's BIPAP missing piece on 10/26/24 so CSM ordered the piece online that evening from Vendor 1, with an estimated delivery date of 10/31-11/1/24. CSM stated on 11/31/24, CSM received an email from Vendor 1 which indicated, Shipment Delay., and a new estimated delivery date of 11/3/24 was given. CSM continued that on Monday, 11/4/24, at 7:55 a.m., Vendor 1 sent a second related email which indicated another shipment delay with a new estimated delivery date of Saturday, November 9, 2024 - Tuesday November 12, 2024, of which CSM replied to the email with, I still want this item. CSM confirmed he did try to order from another vendor after Vendor 1's second notice of delayed delivery, nor tell Resident 1 in person, about the delivery delays because he preferred the nurses to inform the resident directly. During an interview on 11/12/24, at 12:40 p.m., with the Director of Staff Development (DSD), DSD stated Resident 1 raised the concern to DSD regarding resident's BIPAP mask missing piece which was initially ordered by CSM but kept receiving a pushed back delivery date. DSD stated when she worked with CSM on 11/5/24, to reorder the missing piece online, Vendor 2 delivered the item overnight, on 11/6/24, as indicated. (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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 11/19/24, at 11:33 a.m., with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated on 10/26/24, Resident 1 had mentioned that on 10/25/24, a staff (unable to recall who staff was) had misplaced one of the BIPAP mask pieces while replacing the tubing for the resident. LVN 1 stated Resident 1 complained that she slept very uncomfortably that night as the spare mask used felt a little too tight. LVN 1 stated she informed Central Supply Manager (CSM) about the missing piece and confirmed it will be ordered immediately for the Resident 1. LVN 1 denied seeing Resident 1's facial redness or skin breakdown to the nose bridge. During an interview on 11/20/24, at 11:30 a.m., with LVN 2, LVN 2 stated Resident 1 used a temporary blue BIPAP mask which created adverse reactions to the resident's cheeks and nose bridge, so LVN 2 followed up a treatment order from the doctor, which was received and started on 10/31/24. A review of the facility's policy and procedure (P&P) titled, CPAP (Continuous Positive Airway Pressure)/BIPAP Support, dated 2001, indicated, Purpose - To provide the spontaneously breathing resident with continuous positive airway pressure with or without supplemental oxygen .BIPAP delivers CPAP but allows separate pressure settings for expiration (EPAP, nasal expiratory positive airway pressure) and inspiration (IPAP, inspiratory positive airway pressure) .The mask should fit firmly but does not need to be airtight . A review of the facility's P&P titled, Oxygen Administration, dated 2001, indicated, .The oxygen mask is a devise that fts over the resident's nose and mouth. It is held in place by an elastic band placed around the resident's head .Check the mask .to be sure they are in good working order and are securely fastened . Based on observation, interview, and record review, the facility failed to ensure resident received the necessary respiratory care in accordance with professional standards of practice when facility failed to provide in a timely manner, the missing connector for the appropriate-sized BIPAP (bilevel positive airway pressure, a machine used to treat sleep apnea [a sleep-related breathing disorder]) mask used by one of two sampled residents (Resident 1). This failure resulted in Resident 1's inconvenience, discomfort, several nights of interrupted sleep, skin breakdown to nose bridge (related to use of unfit, temporary BIPAP mask), anxiety, and mood swings. This failure also had the potential to result in serious harm and potential death to the resident. Findings: A review of Resident 1's Admission Record, printed 11/12/24, indicated Resident 1 was admitted to the facility on [DATE], with multiple diagnoses that included acute respiratory failure with hypoxia (when the lungs are unable to provide oxygen in the body's tissues) and obesity (excessive weight). A review of Resident 1's Minimum Data Set (MDS, a resident assessment tool used to provide care), dated 10/23/24, indicated Resident 1 had clear speech, was understood, and was able to understand others. The MDS also indicated Resident 1 required substantial/maximal assistance (Helper does more than half the effort) to supervision or touching assistance (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) during her activities of daily living (ADLs, the basic self-care tasks an individual does on a day-to-day basis). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1's Care Plan, revised date 4/15/22, indicated Resident 1 was at risk for respiratory impairment related to sleep apnea. A review of Resident 1's Order Summary Report, active orders as of 11/12/24, indicated: - 8/6/2023 - BIPAP Ventilator Respironics V60 (a breathing machine that helps people breathe when they are having trouble): BIPAP Mode: spontaneous/timed, every evening and night shift for acute respiratory failure. - 8/17/24 - Oxygen (O2) at 2 liters per minute (LPM) connected to BIPAP mask at night and as needed (PRN, pro re nata, as the need arises)) at bedtime. A review of Resident 1's Medication Administration Record (MAR), dated 11/1/24 - 11/30/24, indicated: - 10/31/24 - Apply thin hydrocolloid to nose bridge as barrier/cushion from the BIPAP. A review of Resident 1's Progress Notes, dated 10/30/24, by Registered Nurse 2 (RN 2), indicated, Patient is complaining of (c/o) redness that extends to the side of her both cheeks that she claims caused by the BIPAP mask. Medical Doctor (MD) notified. Applied hydrocolloid to nose bridge as a barrier/cushion from the BIPAP mask. New BIPAP mask is ordered . A review of the facility records titled, Order Information, dated 10/26/24, at 6:57 p.m., indicated Central Supply Manager's (CSM's) online purchase order of item Airfit F20 and Airfit F30 Replacement QuietAir Elbow, was placed to Vendor 1. The Order Detail indicated Vendor 1 received the request on Sunday, 10/27/24 and the estimated delivery date was Thursday, October 31, 2024. On Monday, 11/1/24, at 7:45 a.m. , Vendor 1 sent a related email to CSM which indicated, Shipment Delay. Review of the email showed, We're encountering a delay in shipping your order .New estimated delivery date: Sunday, November 3, 2024 .View or cancel order . On Monday 11/4/24, at 7:55 a.m., Vendor 1 sent a second related email to CSM which indicated, Shipment Delay. Review of the email showed, There is a delay in shipping your order because of a supply chain issue .New estimated delivery date: Saturday, November 9, 2024 - Tuesday November 12, 2024, and the CSM replied with, I still want this item . On Saturday 11/9/24, at 7:59 a.m., Vendor 1 sent a third related email to CMS which indicated, We wanted to let you know that we have shipped your items . Expected delivery: Sunday, November 10 . A review of the facility records titled, Order Information, dated 11/5/24, at 11:34 a.m., indicated, Director of Staff Development's (DSD's) placed an online purchase order of item, Airfit F20 and Airfit F30 Replacement QuietAir Elbow, to Vendor 2. The Order Detail indicated Vendor 2 received the request on Tuesday, 11/5/24, and the estimated delivery date was Wednesday, November 6, 2024. On Wednesday, 11/6/24, at 12:57 p.m. , Vendor 2 sent a related email to DSD which indicated, Your parcel has been delivered to reception. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation, interview, and record review on 11/12/24, at 11:45 a.m., with Resident 1, in the resident's room, Resident 1 stated, It took 10 days and a mental breakdown to get the missing piece replaced by the facility. Resident 1 stated, on 10/25/24, when the BIPAP machine/tubing was replaced by the facility, a connecting piece of the BIPAP mask went missing resorting to use of an older mask. Resident 1 stated she was unable to sleep well at night that made her mentally and physically exhausted due to use of a mask that did not fit well, which constantly rubbed on her cheeks and nose area, and caused skin breakdown, during the 10 nights of waiting period. Resident 1 further stated during subsequent follow-ups, resident could not even get an update from CSM. Resident 1 stated waiting for the replacement piece had caused her so much anxiety and inconvenience to the point of ordering the missing piece herself, via online on 11/4/24. Resident 1 also mentioned the facility did not address the skin breakdown to her nose bridge until 10/31/24. During a concurrent interview and record review on 11/12/24, at 1:04 p.m., with CSM, CSM stated LVN 1 made him aware of Resident 1's BIPAP missing piece on 10/26/24 so CSM ordered the piece online that evening from Vendor 1, with an estimated delivery date of 10/31-11/1/24. CSM stated on 11/31/24, CSM received an email from Vendor 1 which indicated, Shipment Delay., and a new estimated delivery date of 11/3/24 was given. CSM continued that on Monday, 11/4/24, at 7:55 a.m., Vendor 1 sent a second related email which indicated another shipment delay with a new estimated delivery date of Saturday, November 9, 2024 - Tuesday November 12, 2024, of which CSM replied to the email with, I still want this item. CSM confirmed he did try to order from another vendor after Vendor 1's second notice of delayed delivery, nor tell Resident 1 in person, about the delivery delays because he preferred the nurses to inform the resident directly. During an interview on 11/12/24, at 12:40 p.m., with the Director of Staff Development (DSD), DSD stated Resident 1 raised the concern to DSD regarding resident's BIPAP mask missing piece which was initially ordered by CSM but kept receiving a pushed back delivery date. DSD stated when she worked with CSM on 11/5/24, to reorder the missing piece online, Vendor 2 delivered the item overnight, on 11/6/24, as indicated. During a telephone interview on 11/19/24, at 11:33 a.m., with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated on 10/26/24, Resident 1 had mentioned that on 10/25/24, a staff (unable to recall who staff was) had misplaced one of the BIPAP mask pieces while replacing the tubing for the resident. LVN 1 stated Resident 1 complained that she slept very uncomfortably that night as the spare mask used felt a little too tight. LVN 1 stated she informed Central Supply Manager (CSM) about the missing piece and confirmed it will be ordered immediately for the Resident 1. LVN 1 denied seeing Resident 1's facial redness or skin breakdown to the nose bridge. During an interview on 11/20/24, at 11:30 a.m., with LVN 2, LVN 2 stated Resident 1 used a temporary blue BIPAP mask which created adverse reactions to the resident's cheeks and nose bridge so LVN 2 followed up a treatment order from the doctor, which was received and started on 10/31/24. A review of the facility's policy and procedure (P&P) titled, CPAP (Continuous Positive Airway Pressure)/BIPAP Support, dated 2001, indicated, Purpose - To provide the spontaneously breathing resident with continuous positive airway pressure with or without supplemental oxygen .BIPAP delivers CPAP but allows separate pressure settings for expiration (EPAP, nasal expiratory positive airway pressure) and inspiration (IPAP, inspiratory positive airway pressure) .The mask should fit firmly but does not need to be airtight . (continued on next page)

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