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	04/08/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to inform a Resident's responsible party regarding change of condition and transfer from facility to acute care hospital for one of three sampled Residents (Resident 1). This failure resulted in Resident 1 being transferred to an acute care hospital alone, without notice to their responsible party. During a record review of admission record, printed on 4/7/26, Resident 1 was admitted on [DATE]. Under ?Contacts', the Resident's daughter was listed as emergency contact #1, responsible party.During a record review of Resident 1's Minimum Data Set (MDS, an assessment used to guide care) dated 12/23/25, indicated Resident 1's Brief Interview for Mental Status (BIMS, an assessment tool used to assess mental status) score was 2 out of 15, and indicated Resident 1's cognition was severely impaired. During a review of Resident 1's Baseline Care Plan-Centered Care Planning, dated 12/18/2025, the baseline care plan indicated Resident 1 was confused. During a review of Resident 1's Cognitive Impairment Care Plan Report, initiated 12/18/2025, the care plan report indicated, Resident exhibits cognitive loss . The ?Goals' within the cognitive care plan indicated, Discuss concerns regarding overall status/health with resident/family as needed.During a review of Progress Note, dated 12/22/25, at 4:37 a.m., created by Registered Nurse (RN) 1, the progress note indicated, Patient was noticed to be bleeding from injury sites -both from the Lt elbow and lateral side of Rt thumb, Patient's gown and some parts of beddings were soaked with patient's blood. On assessment, patient was alert, could not able to state what happened, blood noticed to be seeping from injury sites, patient might needs sutures to stop bleeding. Wound was cleaned with saline, gauze applied with minimal pressure, patient was also cleaned and gown changed. Emergency responders was called to take patient to the hospital for further evaluation of injury/wound/bleeding site. Patient left the facility around 2am on a gurney with EMT.During a phone interview on 4/7/26, at 1:56 p.m., with RN 1, RN 1 stated they did not recall the documented progress note on 12/22/25 or incident with Resident 1. RN 1 stated they usually always notify family regarding any incident via phone and left a voicemail if family or responsible party was unable to be reached. RN 1 stated she did not recall sending Resident 1 to acute care hospital via emergency responders at time of interview. RN 1 stated the importance of contacting family or responsible party when a Resident had a change of condition or was transferred out of facility was to ensure loved ones were aware of Resident's change of condition or new location.During a concurrent interview and record review on 4/8/26, at 11:13 a.m., Director of Nursing (DON) stated there was no documentation of Resident 1's responsible party being notified of transfer to acute care hospital on [DATE]. DON stated there was no change of condition documented regarding Resident 1's bleeding as noted by RN 1 in progress note on 12/22/25. DON stated the importance of documenting change of condition was to document and notify the physician when there has been a change of resident's health status. DON stated the importance of informing resident's family or responsible party of change of condition and transfer out of facility was to ensure family or responsible party was aware of resident's health changes and make appropriate decisions as needed. During a review of the facility's policy and procedure (P&P) titled, Change in a Resident's Condition or Status, the P&P indicated, Our 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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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.).Unless otherwise instructed by the resident, a nurse will notify the resident's representative when the resident is involved in any accident or incident that results in an injury including injuries of an unknown source, there is a significant change in the resident's physical, mental, or psychosocial status, there is a need to change the resident's room assignment, a decision has been made to discharge the resident from the facility; and/or it is necessary to transfer the resident to a hospital/treatment center.