Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 05/28/2025
Form Approved OMB
No. 0938-0391

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	02/13/2025

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 51682 Based on record review, interview, and facility policy review, the facility failed to ensure a preadmission screening and resident review (PASARR) was accurately completed for 1 (Resident #105) of 3 sampled residents reviewed for PASARR requirements. Findings included: A facility policy titled, Admission Criteria, revised March 2023, indicated, 9. All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) per the Medicaid Pre-Admission and Resident Review (PASARR) process. a. The acute hospital performs a Level I PASARR screen for all potential admissions, regardless of payor source, to determine if the individual meets the criteria for a MD, ID or RD. b. If the level I screen indicates that the individual may meet the criteria for a MD, ID, or RD, he or she is referred to the state PASARR representative for the Level II (evaluation and determination) screening process. (1) The admitting nurse notifies the social services department when a resident is identified as having a possible (or evident) MD, ID or RD. (2) The social worker is responsible for making referrals to the appropriate state-designated authority. An Admission Record indicated the facility admitted Resident #105 on 12/11/2024. According to the Admission Record, the resident had a medical history that included diagnoses of bipolar disorder and generalized anxiety disorder. Resident #105's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/18/2024 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS revealed the resident had active diagnoses of anxiety disorder and bipolar disorder. Resident #105's Care Plan, revealed a focus area, initiated 12/12/2024, that indicated the resident was at risk for changes in behavior due to diagnoses of depression, anxiety, and bipolar disorder. Additionally, Resident #105's Care Plan revealed a focus area, initiated 12/12/2024, that indicated Resident #105 had the potential for side effects, complications, or adverse reactions related to ordered use of Seroquel (an antipsychotic medication) related to bipolar disorder. (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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #105's Level I PASARR, dated 12/12/2024, revealed Section III - Serious Mental Illness reflected that the resident did not have a serious diagnosed mental disorder such as depressive disorder, anxiety disorder, panic disorder, schizophrenia/schizoaffective disorder, or symptoms of psychosis, delusions, and/or mood disturbance, was not suspected to have a mental illness, and had not been prescribed psychotropic medications for a serious mental illness. Resident #105's Level I PASARR screening results letter from the state agency, dated 12/12/2024, revealed the resident's Level I screening was negative for a serious mental illness, and a Level II screening was not required. During an interview on 02/12/2025 at 2:47 PM, the Director of Nursing (DON) stated Resident #105's Level I PASARR did not reflect the resident's mental illness diagnoses or psychotropic medication use. The DON stated that because the resident's Level I PASARR was inaccurate, the results were negative, and a Level II determination was not required. The DON stated she expected all PASARRs to be reviewed for accuracy upon admission.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 51682 Based on observation, interview, and record review, the facility failed to ensure infection control was maintained to prevent the development and/or transmission of communicable diseases and infections for 1 (Resident #313) of 8 residents reviewed for infection control. Specifically, the facility failed to dispose of an intravenous (IV) catheter used to administer IV fluids to Resident #313. Findings included: During an interview on 02/13/2025 at 8:21 AM, the Director of Nursing (DON) stated IV catheter should be discarded immediately in a sharps container (a puncture resistant container with leak-resistant sides and bottom and a tight-fitting lid with an opening not large enough for a hand to enter). An Admission Record indicated the facility admitted Resident #313 on 02/04/2025. According to the Admission Record, the resident had a medical history that included diagnoses of encephalopathy and altered mental status. Resident #313's Care Plan revealed a focus area initiated on 02/09/2025 that indicated the resident was at risk for dehydration. Interventions directed to staff to administer IV fluids per physician orders (initiated 02/09/2025). Resident #313's Progress Note, dated 02/07/2025 at 2:31 PM, revealed a registered nurse (RN) on duty started IV hydration for the resident at 2:30 PM via a peripherally inserted central catheter (PICC) line in the right upper arm. Resident #313's Progress Note, dated 02/09/2025 at 10:10 PM, revealed Licensed Vocational Nurse (LVN) #5 documented that at 6:00 PM, she found the resident's peripheral IV line out. An observation on 02/10/2025 at 12:38 PM of Resident #313 revealed an exposed IV catheter and bandage was attached to a bag of IV solution that was hanging from an IV pole. During an interview on 02/10/2025 at 12:44 PM, LVN #4 revealed Resident #313 was supposed to be receiving IV fluids for severe dehydration but pulled out their IV line the night before. LVN #4 stated she was waiting for an RN to place a new IV line. She stated she did not know why the IV line was still hanging on the IV pole or why the IV catheter was still attached. During an interview on 02/13/2025 at 7:56 AM, LVN #5 revealed she was the nurse on duty on 02/09/2025 when Resident #313's IV catheter came out. She stated she could not recall whether she placed the IV catheter on the IV pole while waiting on an RN to assess the resident. During an interview on 02/13/2025 at 8:01 AM, RN #6 revealed he was working on another unit during the night shift of 02/09/2025, when he was notified that Resident #313's IV catheter came out while repositioning the resident. RN #6 stated he assessed Resident #313's IV site and looked to see if he could insert another IV catheter. He stated he did not notice the IV setup on the pole and thought the LVN had already discarded the items. He stated all used IV supplies should be discarded immediately in a white bin with a blue top in the medical room behind the nurse's station. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/13/2025 at 8:09 PM, RN #7 revealed he was on duty during the night shift on 02/09/2025 into the morning of 02/10/2025; however, he only recalled checking Resident #313's blood sugar. RN #7 stated all used IV catheters and supplies should be discarded immediately if an IV catheter became dislodged. During an interview on 02/10/2025 at 12:53 PM, the Assistant Director of Nursing (ADON) revealed she was made aware Resident #313 had pulled out their IV catheter the night before and was awaiting a new IV catheter placement. The ADON stated the used IV catheter should not have been left in the room because it posed a concern for bloodborne infections to others who may come into contact with the used IV catheter. During an interview on 02/12/2025 at 10:45 AM, the Director of Staff Development/Licensed Vocational Nurse, who was also the Infection Preventionist, stated the IV catheter and dressing should have immediately been discarded in a sharps container. She stated leaving the IV catheter attached to IV tubing posed a risk for bloodborne infection transmission to residents or staff who may come in contact with the items. During an interview on 02/13/2025 at 8:21 AM, the Director of Nursing (DON) revealed she was notified on 02/10/2025 that Resident #313's IV catheter had come out and was not discarded. The DON stated she expected the IV catheter to be discarded immediately in a sharps container. During an interview on 02/13/2025 at 8:32 AM, the Administrator stated she was made aware Resident #313's IV catheter was left in the resident's room when it was dislodged. The Administrator stated she expected IV tubing and catheters to be placed in a sharps container immediately because it posed a risk for infection and safety issues for residents and staff because of bloodborne pathogens.