

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

Printed: 07/30/2026  
Form Approved OMB  
No. 0938-0391

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                               |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>555710                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                          | (X3) DATE SURVEY<br>COMPLETED<br><br>05/07/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Tice Valley Post Acute                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1975 Tice Valley Blvd.<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                               |                                                 |
| F 0677<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | <p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to provide services to maintain grooming and personal hygiene for one of three sampled residents (Resident 1) when Certified Nursing Assistant (CNAs) did not provide Resident 1 showers as scheduled by the facility. This failure placed Resident 1 at risk for poor hygiene, body odor, infection, and transmission of diseases. During a review of Resident 1's admission Record (AR), printed 3/25/26, the AR indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included end stage renal disease and dependence on renal dialysis (Kidney failure impossible to service without dialysis). During 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 2/18/26, the MDS indicated Resident 1's Basic Interview of Mental status (BIMS, a scoring system used to determine the resident's cognitive status regarding attention, orientation, and ability to register and recall information. A BIMS score of thirteen to fifteen is an indication of intact cognitive status.) score was 11 and indicated impaired mental status. MDS indicated Resident 1 had clear speech, makes self-understood and understands others. MDS indicated Resident 1 was dependent on staff for shower. Resident 1 needed the assistance of two or more helpers required to complete the activity. During an interview on 3/19/26, at 1:33 p.m., with Resident 1, Resident 1 stated CNAs did not give her shower for two weeks. During a review of Resident 1's Nurse's Note (NN), dated 2/26/26, the NN indicated Resident 1 stated I didn't get a shower. During a review of Resident 1's Shower Schedule (SS), the SS indicated the facility scheduled Resident 1 to receive showers twice weekly on Wednesday and Saturday. During an interview on 3/25/26, at 1:02 p.m., with CNA 1, CNA 1 stated Resident 1 refused shower due to back pain. CNA 1 stated Resident 1 complained of back pain and difficulty sitting. CNA 1 stated bed bath was provided for Resident 1. CNA 1 stated there was no documentation of Resident 1's refusal to shower. CNA 1 stated he did not notify charge nurse that Resident 1 refused to shower. During a review of Resident 1's ADL documentation report dated February and March 2026, the report indicated no documentation that CNAs provided Resident 1 a shower as scheduled. During a concurrent interview and record review on 5/7/25, at 3:10 p.m., with Director of Nursing (DON), Resident 1's shower schedule, progress notes and ADL documentation reports for February and March 2026, were reviewed. DON stated the facility's expectation was that Resident 1 receive a shower as scheduled. DON could not provide documentation that CNAs offered or provided Resident 1 shower as scheduled. DON could not provide documentation that charge nurse was notified of Resident 1's refusal to shower. During a review of the facility's policy and procedure (P&amp;P) titled, Shower/Tub Bath, revised October 2025, the P&amp;P indicated, The following information should be recorded on the resident's ADL record and /or in the resident's medical record:The date and time the shower/tub bath was performed.The name and title of the individual(s) who assisted the resident with the shower/tub bath.All assessment data (e.g., any reddened areas, sores, etc., on the resident's skin) obtained during the shower/tub bath.How the resident tolerated the shower/tub bath.If the resident refused the shower/tub bath, the reason(s) why and the intervention taken.The signature and title of the person recording data.Notify the supervisor if the resident refuses the shower/tub bath.Notify the physician of any skin areas that may need to be (continued on next page)</p> |                                                                                               |                                                 |

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<br>REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|--------------------------------------------------------------------------|-------|-----------|

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

Printed: 07/30/2026  
Form Approved OMB  
No. 0938-0391

|                                                                                                                                    |                                                                                                                           |                                                                                               |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>555710                                                       | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                      | (X3) DATE SURVEY<br>COMPLETED<br><br>05/07/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Tice Valley Post Acute                                                                         |                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1975 Tice Valley Blvd.<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |                                                                                               |                                                 |
| F 0677<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | treated.Report other information in accordance with facility policy and professional standards of<br>practice.            |                                                                                               |                                                 |