STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555710	A. Building B. Wing	06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tice Valley Post Acute	1975 Tice Valley Blvd. Walnut Creek, CA 94595

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview and record review, the facility failed to ensure it kept accurate records of controlled medications (medication with a potential for abuse) as evidenced by: 1. The facility failed to ensure, for residents 1-8, the scheduled (controlled medication, narcotic) medication system was complete (all documents available) and accurate (information matched). The record system included Shipping Manifests (pharmacy delivery receipt), Controlled Substance Accountability Sheets (CDR, Controlled Drug Record), Medication Administration Records (MAR, record of medication administration) and destruction logs. The facility records were incomplete. The facility records were inaccurate. These failures had the potential to result in undetected loss and diversion of scheduled medications. In addition, these failures had the potential to result in preventable medication errors (medication not given as ordered).2. The facility failed to ensure, between 2/1/24-6/30/24, the Consultant Pharmacist identified the scheduled (controlled medication, narcotic) medication system was incomplete (all documents available) and inaccurate (information matched). The record system included Shipping Manifests (pharmacy delivery receipt), Controlled Substance Accountability Sheets (CDR, Controlled Drug Record), Medication Administration Records (MAR, record of medication administration) and destruction logs. The facility records were incomplete. The facility records were inaccurate. These failures had the potential to result in undetected loss and diversion of scheduled medications. In addition, these failures had the potential to result in preventable medication errors (medication not given as ordered).Findings:1. During a concurrent observation and interview on 9/22/25 at 9:50 a.m., Registered Nurse (RN 1) was requested to describe the scheduled medication process. RN 1's description included that the pharmacy delivered medication with a corresponding Shipping Manifest and CDR. She further described that the medication and CDR were placed in the medication cart. Her description included that the CDR was used to maintain a record of medication use. The CDR included medication count, date/time and nurse signature. Continuing the concurrent observation and interview on 9/22/25 at 9:50 a.m., RN 1 identified the Lexington medication room. Inspection of the medication room showed an automated dispensing cabinet (ADU, device to dispense medication). RN 1 was requested to describe the role of the ADU in the scheduled medication process. RN 1's description included the ADU was used to obtain medication for the residents. The nurse would obtain pharmacy authorization, and the ADU would dispense the scheduled medication. RN 1 stated that the ADU did not provide a corresponding receipt of the dispensed scheduled medication. In addition, RN 1 stated that the scheduled medication administration would be documented in the MAR.During an interview on 9/22/25 at 10:45 a.m., Medical Record Director (MRD) was asked to describe the scheduled medication record keeping process. MRD's description included the pharmacy delivery receipts and corresponding CDRs were filed in Medical Records. MRD was requested to provide the pharmacy delivery receipts for scheduled medications from 3/1/24 to 5/31/24.During an interview on 9/22/25 at 3:45 p.m., MRD was requested to provide the ADU scheduled medication delivery receipts and corresponding CDRs from 3/1/24 to 5/31/24.During an interview on 9/23/25 at 9:35 a.m., MRD was asked to describe the process for scheduled medications obtained from the ADU. MRD's description included that the facility did not have ADU delivery receipts or the equivalent. MRD (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated the facility did not have ADU CDRs or the equivalent. During a concurrent interview and record review 9/25/25 at 10 a.m., Director of Nursing (DON) identified the ADU Transaction by Item/Procedure report (scheduled medications removed from the ADU). DON acknowledged the ADU removal did not have a corresponding MAR entry on the following dates and times:Resident 1 Oxycodone (narcotic pain reliever)-Acetamin (non-narcotic pain reliever) 5-325 tablet #15/19/24 10:15 pmResident 2 Hydrocodon (narcotic pain reliever)-Acetaminophn 10-325 #15/15/24 0228 am5/14/24 10:37 pmDuring a concurrent interview and record review on 9/25/25 at 10:25 a.m., DON identified Resident 8's MAR. DON compared the R71273170 Oxycodone 15mg (milligram) tablet CDR against the MAR. DON acknowledged the CDR removals did not have a corresponding MAR administration on the dates and times listed below.2/27/24 16402/28/24 16302/29/24 1230, 16303/2/24 0430, 0830, 1230, 2030During a concurrent interview and record review on 9/25/25 at 10:28 a.m., DON identified Resident 7's MAR. She compared the R73660709 Oxycontin 10mg tablet CDR against the MAR. DON acknowledged the CDR removal did not have a corresponding MAR administration on the date and time listed below.3/29/25 2100During a concurrent interview and record review on 9/25/25 at 10:32 a.m., DON identified Resident 6's MAR. She compared the R73595744 Hydrodone-Acet 5mg-325mg tablet CDR against the MAR. DON acknowledged the CDR removal did not have a corresponding MAR administration on the date and times listed below.3/18/25 0800, 2044During a concurrent interview and record review on 9/25/25 at 10:37 a.m., DON identified Resident 3's MAR. She compared the R73804476 Hydrocodone-Acet 5mg-325mg tablet CDR against the MAR. DON acknowledged the CDR removal did not have a corresponding MAR administration on the date and time listed below.4/11/25 2200During a concurrent interview and record review on 9/25/25 at 10:40 a.m., DON identified Resident 5's MAR. She compared the R73697484 Hydrodone-Acet 5mg-325mg tablet CDR against the MAR. DON acknowledged the CDR removal did not have a corresponding MAR administration on the date and time listed below.3/24/25 1215During a concurrent interview and record review on 9/25/25 at 10:55 a.m., DON identified Resident 4's MAR. She compared the R71805741 Hydrodone-Acet 5mg-325mg tablet CDR against the MAR. DON acknowledged the CDR removals did not have a corresponding MAR administration on the dates and times listed below.5/24/24 20115/27/24 09405/31/24 21356/1/24 21306/3/24 21306/4/24 0900During a concurrent interview and record review on 9/25/25 at 3:15 p.m., DON acknowledged the Shipping Manifests, CDRs and MARs did not account for all scheduled medications. She acknowledged the Controlled Substance policy required inventory to be monitored and reconciled. An administrative record review, of the Policy for Controlled Substances (Dated: 2001 Med-Pass) showed, Dispensing and Reconciling Controlled Substances, 1. Controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow-up. Continued review showed, 2. The system of reconciling the receipt, dispensing and disposition of controlled substances includes the following: a. Records of personnel access and usage; b. Medication administration records; c. Declining inventory records. 2. During a concurrent observation and interview on 9/22/25 at 9:50 a.m., Registered Nurse (RN 1) was requested to describe the scheduled medication process. RN 1's description included that the pharmacy delivered medication with a corresponding Shipping Manifest and CDR. She further described that the medication and CDR were placed in the medication cart. Her description included that the CDR was used to maintain a record of medication use. The CDR included medication count, date/time and nurse signature. Continuing the concurrent observation and interview on 9/22/25 at 9:50 a.m., RN 1 identified the Lexington medication room. Inspection of the medication room showed an automated dispensing cabinet (ADU, device to dispense medication). RN 1 was requested to describe the role of the ADU in the scheduled medication process. RN 1's description included the ADU was used to obtain medication for the residents. The nurse would obtain pharmacy authorization, and the ADU would dispense the scheduled medication. RN 1 stated that the ADU did not provide a corresponding receipt of the dispensed scheduled medication. In addition, RN 1 stated that the scheduled medication administration would be documented in the MAR.During an (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Continued review showed, 2. The system of reconciling the receipt, dispensing and disposition of controlled substances includes the following: a. Records of personnel access and usage; b. Medication administration records; c. Declining inventory records.An administrative record review, of the Policy for Pharmacy Services-Role of the Consultant Pharmacist (April 2024), Policy Interpretation and Implementation, 3. The consultant pharmacist shall provide consultation on all aspects of pharmacy services in the facility, and collaborate with the facility and medical director to: a. develop, implement, evaluate, and revise (as necessary) the procedures for the provision of all aspects of pharmacy services.

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. Based on interview and record review, the facility failed to follow state Title 22 regulations and ensure the social services department was staffed and supervised by qualified and competent staff which affect all 123 residents.This failure resulted in all 123 residents receiving social services care from unqualified staff. During an interview on 9/23/25, at 10:35 a.m., with Social Services Director (SSD), SSD stated they were the director of the social services department and were responsible for admission assessments, discharge planning. SSD stated the social services department assisted residents with dental, optometry, podiatry and psychiatric appointments to ensure residents' physical, mental and psychosocial needs were met. SSD stated they had been working since 5/2025.During a concurrent interview and record review on 9/24/25, at 4:23 p.m., with Director of Staff Development (DSD), SSD's two job descriptions, dated 5/15/25 and 8/18/25, were reviewed. DSD stated after review of the job descriptions, SSD did not meet the qualifications of the 5/25/25 description and did not meet the preferred qualifications of the 8/18/25 copy because SSD did not meet the education requirement of Bachelor's Degree in Social Work or in Human Services.During a concurrent interview and record review on 9/24/25, at 4:30 p.m., with DSD, SSD's resume titled [SSD] Professional Summary, undated, and education registration form titled SSD Online Certification Course, undated, was reviewed. DSD stated the SSD's resume did not indicate list any education and the education registration form indicated SSD had completed a high school education.During a concurrent interview and record review on 9/25/25, at 10:14 a.m., with Human Resources (HR), SSD's two job descriptions, dated 5/15/25 and 8/18/25, were reviewed. HR stated they were responsible to ensure staff had current credentials and qualifications before hire. After review SSD's job descriptions the 5/15/25 job description, HR stated SSD was not qualified for the position because SSD did not have a bachelor's degree in social work. HR stated SSD was hired without the required qualifications because everyone was confused by the qualifications section on the job description. HR stated the SSD didn't need to have a bachelor's degree and the facility created another job description which SSD signed on 8/18/25.During a concurrent interview and review of facility policy and procedure (P&P) on 9/25/25, at 4:15 p.m., with Administrator (ADM), the facility's P&P titled, Social Services, dated September 2024, was reviewed. The ADM stated the P&P indicated the director of social services was a qualified social worker. ADM stated the social services department did not have social workers, and there was no plan to hire a qualified social worker. ADM stated SSD was the only supervisor of the social services department. ADM stated they were unaware of any regulations which required the social services department to be supervised by a qualified social worker.During a review of facility's facility assessment titled, [Facility] Facility Assessment, dated 8/27/25, the facility assessment indicated a staffing plan which included Total Number Needed or Average or Range.Social Worker.FULL-TIME on AM and PM shift.During a review of California state regulation titled, Title 22 S72433, the state regulation indicated 'Social Work Service' means those services which assist.a patient and a patient's family to understand and cope with.personal, emotional and related health and environmental problems.During a review of California state regulation titled, Title 22 S72437, the state regulation indicated Social Work Service Unit-Staff.the social work service unit shall be organized, directed and supervised by a social worker, who is responsible for supervision of other social work staff, including social work assistants.