

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555710	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/20/2024
NAME OF PROVIDER OR SUPPLIER Tice Valley Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1975 Tice Valley Blvd. 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)		
<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p>46658</p> <p>Based on observation, interview, and record review, the facility failed to provide hygiene care in a reasonable time for one of nine sampled residents (Resident 43) when Resident 43 had to wait in stool and urine for 45 minutes before staff could change the resident.</p> <p>This failure caused Resident 43 to feel dejected because she had to wait 45 minutes for assistance and had the potential for Resident 43 to be at risk of skin breakdown due to exposure to urine and stool.</p> <p>Findings:</p> <p>A review of Resident 43's admission record, the record indicated Resident 43 was admitted for enterocolitis (inflammation of the digestive tract) due to clotridium difficile (a bacteria that causes diarrhea and inflammation of the colon which can be life-threatening), difficulty in walking, and muscle weakness.</p> <p>During a record review of Resident 43's minimum data set (MDS, an assessment tool to guide resident care), dated 5/26/24, the MDS indicated Resident 43 had a Brief Interview for Mental Status score of 14 (BIMS, was a scoring system used to determine the resident's cognitive status in regard to attention, orientation, and ability to register and recall information. A BIMS score of thirteen to fifteen is an indication of intact cognitive status). The MDS indicated Resident 43 required moderate assistance in toileting hygiene.</p> <p>During an interview on 6/17/24, at 12:09 p.m., Resident 43 was in her private room in bed. Resident 43 stated she needed one staff member to assist in cleaning her up after bowel movements. Resident 43 stated 25% of the time it took the staff an hour to answer the call light.</p> <p>During an observation on 6/19/24, at 11:15 a.m., Resident 43's room had the call light on and visible in the hallway. At the nurse's station, the call light monitoring panel indicated Resident 43's call light was on.</p> <p>During an observation on 6/19/24, at 11:27 a.m., Registered Nurse 1 (RN 1) observed the call light for Resident 43 was on and asked CNA 2 to answer the call light.</p> <p>(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 REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 555710
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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 6/19/24, at 11:29 a.m., Certified Nursing Assistant 2 (CNA 2) entered Resident 43's room to answer the call light. From outside the room, Resident 43 could be heard stating she was soiled and asked to be changed. CNA 2 responded to Resident 43 that Certified Nursing Assistant 3 (CNA 3) would change the resident after CNA 3 came back from break. CNA 2 exited the room and assisted another resident in a wheelchair out of the unit.</p> <p>During an observation on 6/19/24, at 11:32 a.m., CNA 3 came back to the unit from break.</p> <p>During an observation on 6/19/24, at 11:41 a.m., CNA 2 informed CNA 3 that Resident 43 needed to be changed. CNA 3 then went into another resident's room to assist them.</p> <p>During an observation on 6/19/24, at 11:54 a.m., CNA 3 exited the resident's room and began to don personal protective equipment (PPE, equipment, such as gowns and gloves, to protect against spread of infection) to enter Resident 43's room.</p> <p>During an observation on 6/19/24, at 12:13 p.m., CNA 3 was in the middle of cleaning up Resident 43. Linens, hygienic wipes and chucks (disposable barriers to protect linen) soiled with feces was visible.</p> <p>During a concurrent observation and interview on 6/19/24, at 2:50 p.m., with Resident 43, Resident 43 was in bed with the covers on. Resident 43 stated she waited 45 minutes before CNA 3 came in to help. Resident 43 stated she often had to wait this long to get changed and was disappointed and tired of being upset about the long waits.</p> <p>During an interview on 6/19/24, at 3:01 p.m., with RN 1, RN 1 stated certified nursing assistants (CNA) were expected to help each other answer call lights and to immediately help a resident according to their scope of practice. RN 1 stated if a CNA was unable to help the resident immediately, the CNA was expected to ask another CNA or licensed nurse to help. RN 1 stated licensed nurses could also help change a resident.</p> <p>During an interview on 6/19/24, at 3:17 p.m., with the Director of Staff Development (DSD), the DSD stated CNAs were expected to answer call bells and assist the resident with their request immediately and if they could not they should ask other CNAs or staff to help. The DSD stated any staff can answer a call bell and should assist within the scope of their practice. The DSD stated it was unacceptable for a soiled resident to wait 45 minutes before getting cleaned up.</p> <p>During an interview on 6/20/24, at 12:50 p.m., with the Director of Nursing (DON), the DON stated the number one rule was nursing staff were expected to answer call lights when they see them and to assist residents immediately which included getting water or cleaning up a resident. The DON stated it was unacceptable for a soiled resident to wait 45 minutes before getting cleaned up.</p> <p>During a review of facility policy and procedure (P&P) titled, Call light answering, dated 7/2012, the P&P indicated staff answer the light/bell within a reasonable time .respond to the request .leave the resident comfortable .if you are unable to assist, explain to the resident and notify the charge nurse for further instruction.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49091</p> <p>Based on observation, interview, and record review, the facility failed to ensure supplies stored in the Lexington medication storage room were appropriate for use when:</p> <ol style="list-style-type: none"> Ten Female Luer Lock Caps (a device used to seal syringes [pumps used for drawing up and expelling liquids or suspensions into the body]) were expired. Two Statlock Catheter Stabilization Devices (designed to stabilize peripherally-inserted central catheters or PICCs [a long, thin tube inserted through an arm and passed through to the larger veins near the heart]) were expired. One IV Catheter was expired. One Kangaroo Feeding Bag Set (a spike, tubing, and bag for liquid nutrition delivery directly into the digestive tract) was expired. <p>These failures had the potential for residents to receive expired, ineffective, and contaminated medications and treatments.</p> <p>Findings:</p> <p>During a concurrent observation and interview on [DATE], at 10:50 a.m., with Licensed Vocational Nurse 1 (LVN 1), in the Lexington medication storage area:</p> <ol style="list-style-type: none"> Ten Female Luer Lock Caps had an expiration date of [DATE]. Two Statlock Catheter Stabilization Devices had an expiration date of [DATE]. One IV Catheter had an expiration date of [DATE]. One Kangaroo Feeding Bag Set had an expiration date of [DATE]. <p>LVN 1 stated expired items should be removed from resident use.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on [DATE], at 10:45 a.m., with the Director of Nursing (DON), the DON stated the facility used intravenous medical supplies and feeding bags regularly, and these expired supplies should have been discarded or returned to central supply.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Requisitioning Daily Supplies, dated 2001, the P&P indicated, Supervisors are responsible to remove all expired supplies and to ensure that supplies are replenished immediately.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>49091</p> <p>Based on observation, interview, and record review, the facility failed to ensure a stock medication bottle of Senna (a laxative for short-term treatment of constipation) had a legible expiration date and was removed from resident use.</p> <p>These failures had the potential for the residents to receive expired and ineffective medication treatment.</p> <p>Findings:</p> <p>During a concurrent observation and interview on 6/19/24, at 3:00 p.m., with Licensed Vocational Nurse 2 (LVN 2), at the Lexington Medication Cart #4, a stock medication bottle of Senna was observed with the expiration date completely faded and not readable. LVN 2 stated, I probably should not be using this, I cannot read the expiration date, and removed it from the cart for disposal. LVN 2 stated that many residents in the facility receive Senna.</p> <p>During an interview on 6/20/24, at 8:19 a.m., with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated medications with expired or illegible expiration dates should be removed from resident use and discarded immediately, as they may lose effectiveness.</p> <p>During a review of the facility's policy and procedure (P & P) titled, Administering Oral Medications, dated 2001, indicated, Steps in the Procedure .7. Check expiration date on the medication. Return any expired medications to the pharmacy.</p> <p>During a review of the facility's P & P titled, Storage of Medications, dated 2001, indicated, 4. Drug containers that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy for proper labeling before storing.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>44823</p> <p>Based on observation, interview and record review, the facility failed to follow kitchen practices that prevent cross-contamination and food borne illness when:</p> <ol style="list-style-type: none"> 1. Chopping boards were in poor condition and stained; 2. Freezer temperature log did not have temperatures recorded for 6/15/24 and 6/16/24. <p>These failures had the potential to cause food borne illness to a highly susceptible population of 117 residents who received food from the kitchen.</p> <p>Findings:</p> <p>1. During a concurrent observation and interview on 6/17/24, at 9:15 a.m., during the initial tour of the kitchen, there were four cutting boards (white, gray, green and red) that had black marks and smudges, faded colors, scratches, and deep cuts on the surfaces. Dietary Manager (DM) stated the boards needed to be changed due to food contamination.</p> <p>During an interview on 6/18/24, at 10:20 a.m., with Registered Dietician (RD), RD stated deep scratches on the chopping boards carried the risk of contamination.</p> <p>During an interview on 6/18/24, at 10:40 a.m., DM stated kitchen inspection walk was done with RD early this month and chopping board inspection was missed.</p> <p>During an interview on 6/20/24, at 7:32 a.m., with [NAME] (CK), CK stated cuts on chopping boards were dangerous, moldy, poisonous, patients get sick.</p> <p>According to the 2017 Federal Food Code, food contact surfaces are to be smooth, free from inclusions, pits, and similar imperfections and are to be smooth and clean to sight and touch. Also, according to the Food Code Annex, cutting surfaces such as cutting boards and blocks that become scratched and scored may be difficult to clean and sanitize. As a result, pathogenic microorganisms transmissible through food may build up or accumulate. These microorganisms may be transferred to foods that are prepared on such surfaces.</p> <p>2. During a concurrent observation and interview on 6/17/24, at 9:15 a.m., during the initial tour of the kitchen, the freezer temperature log did not have temperatures recorded for PM shift on 6/15/24 and 6/16/24. DM stated the freezer log did not get completed by PM shift cook.</p> <p>During a record review, the Freezer Temperature log for June 2024 did not have entries for the PM columns on 6/15/24 and 6/16/24 for Inside Thermometer Temperature, Outside Thermometer Temperature and (Staff) Initials.</p> <p>During an interview on 6/18/24, at 10:20 a.m., with RD, RD stated the freezer temperature log ensured food item temperatures were checked and were not in a temperature danger zone.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/18/24, at 2:55 p.m., with Dietary Aide (DA), DA stated he forgot and did not document PM freezer temperatures on the log. DA could not identify the potential harmful consequences of not having the required freezer temperatures.</p> <p>During an interview on 6/20/24, at 7:32 a.m., with CK, CK stated the cook is responsible to fill out the freezer temperature log.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Refrigerators and Freezers, dated November 2022, the P&P indicated, Food service supervisors or designated employees check and record refrigerator and freezer temperatures daily with first opening and at closing in the evening.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46658</p> <p>Based on observation, interview and record review, the facility failed to ensure staff followed infection control procedures for four of nine sampled residents (Residents 43, 326, 331, and 328) when facility did not ensure staff:</p> <ol style="list-style-type: none"> 1. washed hands with soap and water after caring for resident rooms who had clostridioides difficile (c. diff, bacteria that causes diarrhea and inflammation of the colon which can be life-threatening), 2. used appropriate germicidal wipes to disinfect equipment after use on a resident with c. diff and, 3. were trained on infection control and hand hygiene techniques. <p>This failure had the potential for the spread of c. diff through the facility.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. A record review of Resident 43's admission record indicated Resident 43 was admitted for enterocolitis (inflammation of the digestive tract) due to c. diff., difficulty in walking, and muscle weakness. <p>During a record review of Resident 43's minimum data set (MDS, an assessment tool to guide resident care), dated 5/26/24, the MDS indicated Resident 43 had a Brief Interview for Mental Status score of 14 (BIMS, was a scoring system used to determine the resident's cognitive status in regard to attention, orientation, and ability to register and recall information. A BIMS score of thirteen to fifteen is an indication of intact cognitive status).</p> <p>During a record review of Resident 43's physician order set titled, Order Summary Report, dated 6/20/24, indicated Resident 43 was on contact precautions (infection control measure which includes wearing gloves and gown when entering the room and washing hands with soap and water after exiting the room) for c. diff and received vancomycin (antibiotic to treat c. diff infection) oral suspension daily for c. diff until 7/3/24.</p> <p>A review of Resident 326's admission record indicated Resident 326 was admitted for sepsis, a personal history of other diseases of the digestive system, muscle weakness and difficulty walking.</p> <p>A review of Resident 326's MDS, dated [DATE], indicated Resident 326 had a BIMS of 15, was frequently urine and bowel incontinent, and was on physical therapy.</p> <p>A record review of Resident 326's physician order set titled, Order Summary Report, dated 6/20/24, indicated Resident 326 had physician orders to be on contact precautions and vancomycin oral solution twice a day for hx of clostridium difficile infection for 14 days.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a record review of Resident 326's care plan titled, Isolation Precautions: Resident requires contact single room isolation precautions due to C. Diff., undated, the care plan indicated staff maintain isolation using contact single room precautions due to c. diff .perform hand washing after completing care and leaving the room .use PPE as recommended for type of infection.</p> <p>A review of Resident 328's admission record indicated Resident 328 was admitted for acute respiratory failure, difficulty walking and muscle weakness.</p> <p>A review of Resident 331's admission record indicated Resident 331 was admitted for Parkinson's disease (a disease which causes gradual loss of muscle control) and muscle weakness.</p> <p>During an observation on 6/19/24, at 12:13 p.m., Certified Nursing Assistant 3 (CNA 3) was in the middle of cleaning up Resident 43. Linens and chucks (disposable barriers to protect linen) soiled with stool were visible. After cleaning up Resident 43, CNA 3 removed her PPE and performed hand hygiene using hand sanitizer. After exiting the room, CNA 3 entered and exited the soiled utility room and used hand sanitizer to perform hand hygiene. CNA 3 went to a linen cart outside of Resident 43's room and removed a pillowcase. CNA 3 donned PPE and entered Resident 43's room to finish making Resident 43's bed. CNA 3 removed her PPE, used hand sanitizer for hand hygiene, and exited the room to document her care on a computer in the hallway.</p> <p>During a continuous observation on 6/19/24, at 12:51 p.m., CNA 3 donned PPE and entered Resident 326's room with Resident 326's meal tray. CNA 3 assisted Resident 326 by setting up the meal tray on the bedside table. CNA 3 repositioned various objects on the bedside table and repositioned the bedside table in front of Resident 326. CNA 3 doffed her PPE and exited the room without performing any hand hygiene. CNA 3 walked to the meal cart, opened the door to the meal tray and took out Resident 43's meal tray. CNA 3 donned PPE, entered Resident 43's room, gave Resident 43's meal tray, doffed PPE and exited the room using only hand sanitizer. CNA 3 entered Resident 331's room and began to set up Resident 331's table with ungloved hands. CNA 3 used the silverware from the meal tray to cut up Resident 331's food. CNA 3 exited the room using hand sanitizer for hand hygiene. CNA 3 then entered Resident 328's room, put on gloves and began to feed Resident 328.</p> <p>During a record review of Resident 328's progress notes, dated 6/20/24, a progress note entered on 6/19/24, at 3:56 p.m., indicated Resident 328 was resting in bed and had her breakfast and lunch 25%. Due to cognitive impairment staff assisted accordingly.</p> <p>During a concurrent observation and interview on 6/19/24, at 2:50 p.m., with Resident 43, Resident 43 was in bed with the covers on. Resident 43 recalled CNA 3 came in at around 12:00 p.m. to clean her up.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview and record review on 6/19/24, at 3:17 p.m., with Infection Preventionist (IP), CNA 3's unit orientation documents were reviewed. IP recalled CNA 3 was very specifically informed Resident 43 and Resident 326 were on contact precautions for c. diff and that washing hands with soap and water was required after removing PPE. IP stated both residents were on contact precautions for c. diff. IP stated for c. diff infected residents, only washing with soap and water would be effective in preventing the spread of c. diff. IP stated hand sanitizer was not effective in preventing spread of c. diff. IP stated the expectation was for all staff to wash their hands with soap and water at the resident's bathroom or at the sink at the nurse's station after caring for residents with c. diff infection. IP stated staff were expected to not touch anything after exiting the room if they decided to wash their hands at the nurse's station.</p> <p>During a review of facility policy and procedure (P&P) titled, Handwashing/Hand Hygiene, dated 10/2023, the P&P indicated staff wash hands with soap and water .after contact with a resident with infectious diarrhea including . C. difficile .the use of gloves does not replace handwashing/ hand hygiene.</p> <p>During a review of CDC fact sheet titled Clostridioides Difficile (formerly known as Clostridium difficile), undated, the fact sheet indicated healthcare professional can prevent c. diff spread by washing hands with soap and water, wearing gloves and gown when treating patients with c. diff. The fact sheet indicated hand sanitizer doesn't kill c. diff.</p> <p>2. During an observation on 6/20/24, at 10:21 a.m., physical therapy aide (PTA), wearing PPE, was in Resident 326's room for a physical therapy session. PTA placed a heart rate device (device to measure heart rate) on Resident 326's finger to measure Resident 326's heart rate during physical therapy exercises. After using the device, PTA slipped their hands under their gown and placed the heart rate device into their pocket. PTA used a gait belt and assisted Resident 326 to a standing position. After PTA had finished Resident 326's physical therapy session, PTA doffed their PPE and then exited the room. PTA used a germicidal wipe, on the PPE cart outside of Resident 326's room, to clean the heart rate device and gait belt.</p> <p>During a concurrent observation and interview on 6/20/24, at 1:08 p.m., with the Director of Nursing (DON), the germicidal wipe on the PPE cart outside of Resident 326's room was inspected. The DON inspected the informational sticker on the germicidal wipe container and stated there was no indication the germicidal wipes were an effective disinfectant for c. diff contaminated equipment. The DON stated bleach products were effective disinfectants for c. diff and the germicidal wipe did not contain bleach. The same germicidal wipe was also found on the PPE cart outside of Resident 43's room.</p> <p>During a record review of the germicidal wipe brochure titled, (Germicidal wipe name) Clinical Wipes, undated, the brochure indicated clinical evidence of c. diff reductions but did not indicate it was approved in preventing the spread of c. diff infections.</p> <p>During a review of CDC fact sheet titled Clostridioides Difficile (formerly known as Clostridium difficile), undated, the fact sheet indicated healthcare professional can prevent c. diff spread by cleaning surfaces . with EPA-approved spore killing disinfectant.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A record review of Environmental Protection Agency (EPA) document titled, EPA's registered Antimicrobial Products Effective Against Clostridioides difficile spores, dated 6/26/24, was reviewed. The EPA document did not list the (germicidal wipe brand) as effective against spread of c. diff contaminated surfaces.</p> <p>3. During a concurrent observation and interview on 6/17/24, at 12:20 p.m., with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated staff did not need to wash their hands with soap and water after exiting a contact precaution room for a resident with c. diff. CNA 1 stated she had learned from working at other facilities that alcohol based hand sanitizer was effective in eliminating c. diff. CNA 1 stated she was not oriented to the unit by facility staff. CNA 1 stated she was assigned to Resident 43 and stated the contact precaution sign was affixed to Resident 43 because of a c. diff infection.</p> <p>During a record review on 6/17/24, at 12:55 p.m., the Facility Daily Staffing sheet, dated 6/17/24, was reviewed. The Facility Daily Staffing sheet indicated CNA 1 was assigned to Resident 43.</p> <p>During a concurrent observation and interview on 6/17/24, at 12:24 p.m., with case manager (CM), CM stated Resident 326 had a c. diff infection and based on the contact precaution sign at the Resident 326's door, staff only need to use hand sanitizer for hand hygiene after exiting the room. CM stated he was unsure what type of hand hygiene was required for residents on contact precautions with c. diff.</p> <p>During a concurrent interview and record review on 6/17/24, at 12:57 p.m., with Director of Staff Development (DSD), CNA 1 and CM's orientation to facility hand hygiene standards were reviewed. The DSD stated CNA 1 was contracted from an outside staffing agency and could not verify CNA 1 had completed hand hygiene training from the staffing agency. The DSD stated CNA 1 was expected to have an onsite orientation by facility staff before working in the facility. The DSD stated she did not orient CNA 1 and could not find records of CNA 1's orientation to the facility. The DSD stated CM was hired on 3/2024 and was expected to have completed infection control and hand hygiene orientation. After checking the last three months of infection control and hand hygiene in-service records, DSD stated the records did not indicate CNA 1 or CM had attended any of those in-services. The DSD stated all staff were trained and expected to follow facility P&P which was based on Centers for Disease Control (CDC) guidance for c. diff prevention.</p> <p>During an interview on 6/17/24, at 2:03 p.m., with the DON, the DON stated the facility did not have records of CM having hand hygiene in-services or orientation.</p> <p>During a review of CDC fact sheet titled Clostridioides Difficile (formerly known as Clostridium difficile), undated, the fact sheet indicated healthcare professional can prevent c. diff spread by washing hands with soap and water. The fact sheet indicated hand sanitizer doesn't kill c. diff.</p> <p>During a review of facility P&P titled, P&P Infection Prevention and Control, dated 12/2023, the P&P indicated infection prevention and control P&P apply to all personnel, consultants, contractors .all personnel are trained on infection prevention control policies and procedures upon hire and periodically after.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555710	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/20/2024
NAME OF PROVIDER OR SUPPLIER Tice Valley Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1975 Tice Valley Blvd. 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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of facility policy and procedure (P&P) titled, Handwashing/Hand Hygiene, dated 10/2023, the P&P indicated staff wash hands with soap and water .after contact with a resident with infectious diarrhea including . C. difficile .the use of gloves does not replace handwashing/ hand hygiene.</p>		