STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055049	A. Building B. Wing	08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant Hill Post Acute	1625 Oak Park Boulevard Pleasant Hill, CA 94523

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 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. (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 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, for one of one sampled resident (Resident 63), the facility failed to ensure Resident 63 was allowed to obtain a copy of his requested medical records within the required time frame. This failure resulted in Resident 63's undue concern and anxiety pertaining to obtaining the requested medical records and contact number of his former physician.A review of Resident 63's admission Record, printed on 8/14/24, indicated that resident was admitted to the facility on [DATE] and discharged to home upon completion of care on 4/16/23. A review of Resident 63's admission Minimum Data Set (MDS, a resident assessment tool used to provide care) dated 3/15/23, indicated resident was understood, able to understand others, and had a Brief Interview of Mental Status (BIMS, an assessment tool for a resident's orientation to time, and capacity to remember. The BIMS score ranges from 0-15, with 15 as an indication of intact skills) score of 15. A review of Resident 63's letter of request for medical records, dated 7/10/25, indicated the resident was requesting his medical records and would like to speak to his former facility physician, Physician 1. A review of Resident 63's facility document titled, Cost Letter for Resident Records, dated 7/10/25, indicated resident was assisted by the Operations Manager (OP) in completing Resident 63's request form on 7/10/25. The request form showed resident requested a delivery method of paper copy delivered via secured email, charge for records was pre-billed request, and request for all his medical records from 3/9/23-4/16/23. During a phone interview on 8/11/25, at 11:05 a.m., with Resident 63, resident stated he first called the facility on 7/10/25, personally went to the facility twice, made several phone calls to follow up on his request, and anxiously waited until the facility finally sent the hard copy of his requested medical records via mail, three weeks later. Resident 63 stated the facility also denied the resident information regarding his inquiry of his former facility physician, Physician 1's contact number. Resident 63 was unable to speak to Physician 1 up to this present time. During an interview on 8/14/25, at 1:05 p.m., with the Director of Nursing (DON), DON stated she spoke to Resident 63 regarding the resident's inquiry on former facility physician but could not provide Physician 1's contact number because the physician had retired from work and was no longer connected with their facility. During a concurrent interview and record review on 8/14/2025, at 12:13 p.m., with the Medical Records Director (MRD), MRD stated resident or resident representative was required to complete and sign an authorization form called Cost Letter for Resident Records, to release copies of resident's requested medical records. MRD stated the resident or resident representative may obtain a copy of his or her personal or medical records within two business days. MRD stated the facility's most recent request for medical records was from a former resident three to four weeks ago. MRD stated on 7/10/25, Resident 63 came to the facility and requested medical records pertaining to his stay in March 2023. Resident 63, assisted by the Operations Manager (OM) as MRD was unavailable at that time, completed and signed the facility form, Cost Letter for Resident Records, dated 7/10/25. MRD stated she was informed Resident 63 has a pending active legal case against the facility's sister company so that on 7/14/25, MRD emailed Defense Council Team Member 3 (DCTM 3) on how to proceed with the resident's record request. On 7/15/25, DCTM 2 replied to MRD's email to DCTM 3 and stated DCTM 2 will reach out to Resident 63 via email regarding the release of his requested records. MRD was advised to provide the resident DCTM 2's contact number in case the resident called the facility another time. MRD stated on 7/30/25, Resident called the facility and asked for more specific records. MRD, with the assistance of the Administrator (ADM), emailed DCTM 1, who responded on the same day to resident's call, confirmed and clarified specific records requested. A review of facility's email from DCTM 1, dated 8/14/25, indicated on 7/31/25, DCTM 1 sent Resident 63 a hard copy of all his requested medical records. A review of the facility policy and procedure (P&P) titled, Access to Personal and Medical Records, revised date May 2023, indicated, Each resident has the right to access and/or obtain copies of his or her personal and medical records upon request. A resident may submit his/her request either orally or in writing for access to personal or medical information pertaining to him/her. The information will be provided in the form and format requested by the resident as long as the records are available in that format. If the format requested by the resident is not available, then the records will be provided in a form and format agreed to by the resident. The resident may obtain a copy of his or her personal or medical record within two business days of an oral or written request .

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that one of five sampled residents (Resident 68) was not given unnecessary anticoagulant (a prescription medication and powerful blood thinner) medication without a doctor's order. This failure resulted in Resident 68 to receive anticoagulant medication unnecessarily and posed a significant health risk, potentially leading to serious and life-threatening outcome. During a review of Resident 68's admission record, printed on 8/15/25, indicated Resident 68 was originally admitted to the facility on [DATE] and was readmitted on [DATE]. During a review of Resident 68's Minimum Data Set (a federally mandated assessment tool) dated 5/11/25, indicated Resident 68 had multiple diagnoses that included Cerebrovascular Accident (CVA or stroke, where blood vessels in the brain suddenly ruptures and bleeds into the brain).The MDS revealed Resident 68 was taking anticoagulant.During a concurrent interview and record review on 8/15/25 at 1:30 p.m. with the Director Of Nursing (DON), Resident 68's progress notes/ admission summary, dated [DATE] indicated under assessment and plan revealed, . Consider stopping Eliquis given recurrent falls (ok to resume 5/16/25) Hold all blood thinners for at least 2 weeks. DON showed Resident 68's History and Physical Encounter note, dated 5/1/25, under Plan: Active Hospital Problems; ICH (intracerebral hemorrhage- bleeding within brain tissue), consider stopping Eliquis (anticoagulant), hold all blood thinners, hold Eliquis. Under Hospital Course: .Anticoagulation currently recommended to be held for 2 weeks however given recurrent falls should consider coming off of Eliquis. DON stated, Resident 68 was given Eliquis for two weeks by mistake from 5/5/25 - 5/16/25. DON added, Resident 68 was at risk for internal bleeding from receiving Eliquis.During a telephone interview on 8/15/25 at 2:10 p.m. with Nursing Supervisor (NS), NS stated she made a mistake by activating order for Eliquis on 5/5/25 upon admission. NS added, Resident 68 was not supposed to be on Eliquis until 5/17/25 as indicated on the new orders for the facility. NS also added, she did not closely check new orders for the facility and match it to the existing order in Resident 68's electronic health record. NS further added, this error could have resulted in Resident 68's bleeding or possibly death.During a concurrent interview and record review on 8/15/25 at 3:20 p.m. with the DON, Resident 68's New Orders for Facility, dated 5/5/25, indicated under Medication List: PAUSE taking these medications, apixaban (Eliquis) 5 milligrams (mg - unit of measurement) Tablet Wait to take this until: May 17, 2025.During a review of Resident 68's May 2025 Medication Administration Record (MAR), printed on 8/15/25, revealed Resident 68 was administered Apixaban (Eliquis) Oral table 5 MG once on 5/5/25 and twice a day from 5/6/5 until 5/17/25.During a review of the facility's policy and procedure (P&P) titled, Administering Medications, dated 4/2019, the P&P indicated, Medications are administered in a safe and timely manner, and as prescribed. The P&P also indicated under policy interpretation and implementation: .4. Medications are administered in accordance with prescriber orders.During a review of the facility's P&P titled, Unnecessary Medications, dated 7/2022, the P&P indicated, the purpose is to ensure residents are free from unnecessary medications by promoting safe, effective, and appropriate medication use. The P&P also indicated, the facility shall: Prevent, identify, and address the use of unnecessary medications. Ensure each resident's drug regimen is free from unnecessary drugs.During a review of facility's P&P titled, Anticoagulation - Clinical Protocol, dated 11/2018, the P&P indicated under monitoring and follow-up .5. The staff and physician will monitor for possible complications in individuals who are being anticoagulated, and will manage related problems.b. The physician will order measures to address any complications, including holding or discontinuing the anticoagulant as indicated.During a review of facility's P&P titled, Reconciliation of Medications on Admission, dated 7/2017, the P&P indicated, The purpose of this procedure is to ensure medication safety by accurately accounting for the resident's medications, routs and dosages upon admission or readmission to the facility. Under general guidelines 1. Medication reconciliation is the process of comparing pre-discharge medications to post-discharge medications by creating an accurate list. Under Steps in Procedure .5. Review the list carefully to determine if there are discrepancies/conflicts.According to the National Library of Medicine, undated, Medication reconciliation is the process of comparing a patient's medication orders to all of the medications that the patient has been taking. This reconciliation is done to avoid medication errors such as omissions, duplications, dosing errors, or drug interactions. It should be done at every transition of care in which new medications are ordered or existing orders are rewritten. Furthermore, this process comprises five steps: (1) develop a list of current medications; (2) develop a list of