STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056327	A. Building B. Wing	06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Walnut Creek Skilled Nursing & Rehabilitation Cent	1224 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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. Based on observation, interview and record review the facility did not respect the right to maintain personal belongings securely for one of 18 sampled residents (Resident 53) when Resident 53's transfer sling, wheel chair and shoes had been missing. This created unnecessary distress for Resident 53's family. Findings: Record review of the document admission Record showed the facility admitted Resident 53 on 4/14/2017. Diagnoses included Intracranial Injury (brain injury). During an interview on 6/11/2025 at 2:25 p.m. Family Member 1 stated she had concerns regarding her son's missing items. She stated she had purchased a personal transfer sling for her son which was missing. In the past, he was missing a shoe which she also replaced for him. Family Member 1 stated she had not been reimbursed by the facility for these items. She stated the money wasn't important but she found it frustrating that staff could not keep her son's belongings in his room. During an interview on 6/12 at 9:20 a.m. Resident 53 was observed in bed nodding to questions, making audible sounds but not interviewable. Record review of the document Progress Notes *NEW* dated 4/21/2025, showed Family Member 1 had met with social services and had grievances which included (1) She personally bought a transfer sling for him - its labeled but has been missing for over 2 months. She has notified nursing. (2) The resident's wheelchair, that has his name labeled on it, had gone missing, nursing eventually found it in subacute. She is upset of the mishandling as it's usually and supposed to be outside of his room against the wall. (3) Resident has a pair of black shoes to prevent his feet from curling and one shoe went missing for about 3 months - she eventually bought a new pair for him. She states she brought the receipt and dropped it off at Social Services for potential reimbursement. Overall, the resident's mother is not concerned about the costs of the items, but more so that she feels there is a lack of care for the resident and his belongings. She got emotional and left before she could cry. Record review of the document Progress Notes *NEW* dated 5/5/2025, showed the ombudsman had visited social services to discuss the missing items. Review of the progress note showed Sling is still missing and black shoes have not been reimbursed. (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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/10/2025 at 9:30 a.m., Social Services Assistant (SSA) stated she believed Resident 53's family had been reimbursed for the missing items but confirmed there was no documentation in the record which showed it had been done. During an interview on 6/10/2025 at 9:45 a.m., Certified Nursing Assistant 4 (CNA 4) stated Resident 53's transfer sling had been Missing. In a concurrent observation, the facility's transfer sling was hanging in the closet but not Resident 53's personal sling. Two black orthopedic support shoes were observed at the bedside. Record review of the facility document Personal Property, dated August 2022, showed Resident belongings are treated with respect by facility staff, regardless of perceived value. Based on interview and record review, for one of seven sampled residents (Resident 127) who needed help with activities of daily living, the facility failed to ensure Resident 127 was treated with respect and dignity when rolled towels were placed inside Resident 127's briefs. This failure had resulted in Resident 127's emotional distress. Findings: During a review of Resident 127's admission Record (AR), the AR indicated Resident 127 was admitted to the facility in December 2023, with diagnoses that included chronic kidney disease, heart failure and need for assistance with personal care. During a review of Resident 127's Minimum Data Set Assessment (MDS, an assessment tool used to direct resident care) dated 3/13/25, the MDS indicated a Brief Interview for Mental Status (BIMS, is a scoring system used to determine the resident's cognitive status in regard to attention, orientation, and ability to register and recall information) score of 15. A BIMS score of thirteen to fifteen is an indication of intact cognitive status. The MDS also indicated Resident 127 was incontinent of bowel and bladder and was dependent on staff for toileting and personal hygiene. During a joint interview on 6/9/25 at 11:40 a.m., Resident 127 and Resident Representative (RR) 1 both stated Certified Nursing Assistant (CNA) 2 left two rolled towels in Resident 127's briefs. Both stated Resident 127 was very upset about the incident. During an interview on 6/12/25 at 11:09 a.m. with CNA 3, CNA 3 stated, it was sometime last month, when CNA 3 walked into Resident 127's room at the start of the day shift. Resident 127 was very upset about the previous shift and wanted CNA 3 to check Resident 127's disposable brief. CNA 3 stated Resident 127 complained about feeling uncomfortable like something was stuck there. CNA 3 stated she opened Resident 127's brief to find two rolled towels that were wet with urine. During an interview on 6/13/25 at 10:36 a.m. with Unit Manager (UM), UM stated it was inappropriate to place rolled towels in Resident 127's brief. UM stated short cuts such as this was not allowed because it placed Resident 127 at risk for skin breakdown from moisture. (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 6/13/25 at 2:47 p.m. with CNA 2, CNA 2 stated Resident 127 was always wet. CNA 2 stated Resident 127 had always wanted to be dry at all times and CNA 2 placed wash towels, and sometimes paper towel to keep Resident 127 dry. During a review of Resident 127's bladder incontinence care plan (CP), undated, the CP indicated Resident 127 was at risk for incontinence-associated dermatitis. Staff was to provide perineal care (washing the genitals and the anal area) after each incontinent episode, and to offer toileting/change on rising, before and after meals and as needed.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview and record review, for one of four sampled residents (Resident 23) who were transferred to the hospital for acute care, the facility failed to notify Resident Representative (RR) 2 when Resident 23 vomited on 4/5/25. Resident 23's condition worsened and was transferred to the hospital the same day for fever and weakness. This failure had the potential to result in delayed interventions. Findings: During a review of Resident 23's admission Record (AR), the AR indicated Resident 23 was admitted to the facility in August 2022 with diagnoses that included senile degeneration of the brain (age-related cognitive decline, often used interchangeably with dementia) and major depressive disorder (persistent sadness, loss of interest, and difficulty functioning in daily life). The AR indicated Resident Representative (RR) 2 as Resident 23's emergency contact and guarantor. During a telephone interview on 6/9/25 at 9:55 a.m. with RR 2, RR 2 stated Resident 23 became very sick in the evening of 4/5/25. RR 2 stated receiving a call from facility staff when Resident 23 developed a high fever and was very weak that RR 2 strongly requested the facility to transfer Resident 23 to the hospital for further management. RR 2 stated she did not know Resident 23 had vomited early in the morning before getting very sick. RR 2 stated, had the facility called about Resident 23's vomiting, RR 2 would have taken Resident 23 to the hospital sooner. During an onsite interview on 6/10/25 at 2:52 p.m. with RR 2, RR 2 stated Resident 23 had severe infection and would have been gone if RR 2 had not made the decision to take Resident 23 to the hospital in time. During a concurrent interview and record review on 6/12/25 at 8:41 a.m. with Assistant Director of Nursing (ADON), ADON confirmed Resident 23's face sheet indicated RR 2 was Resident 23's Representative. ADON stated, because the change in condition happened early morning, there was chance the facility staff notified RR 2 later in the morning. ADON stated the clinical record did not indicate that RR 2 was notified of Resident 23's vomiting until Resident 23 developed fever of 100.2 degrees Fahrenheit (deg. F) later in the evening. During a review of Resident 23's clinical record, eInteract SBAR Summary for Providers (SBAR) dated 4/5/25 at 06:13 a.m. indicated Resident 23 had a Change in Condition for nausea/vomiting. The SBAR indicated the physician was notified but there was no documentation that RR 2 was notified. Change in Condition (CIC) notes that followed the SBAR dated 4/5/25 with timestamp 06:38 a.m., 16:46 p.m., and 19:07 p.m. did not indicate RR 2 was notified. During an interview on 6/13/25 at 10:13 a.m. with Unit Manager (UM), UM stated the SBAR indicated the AR indicated RR 2 was Resident 23's guarantor and the first emergency contact, so RR 2 should have been notified of the Change in Condition. UM stated it was important to let the representative know should there be a change in resident's condition for them to provide support to the resident.