

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055331	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/24/2025
NAME OF PROVIDER OR SUPPLIER San Rafael Healthcare & Wellness Center, LP		STREET ADDRESS, CITY, STATE, ZIP CODE 1601 5th Avenue San Rafael, CA 94901	

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 0559</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made.</p> <p>41283</p> <p>Based on interviews and record review, the facility failed to provide a written notice to a resident's Responsible Party (RP) for one resident (Resident 2) of three sampled residents when Resident 2 was moved to a different room without prior notification of the reason why, when the change would occur, and the opportunity to participate in the decision. This failure decreased the facility's potential to respect the resident or the RP's right to participate in the decision to move to a different room which had the potential to affect the resident's psychosocial well-being.</p> <p>Findings:</p> <p>A review of Resident 2's admission record indicated admission to the facility in October 2024 with diagnoses which included autistic disorder (a developmental disability caused by differences in the brain characterized by problems with social communication and interaction), anxiety disorder (a group of mental health conditions characterized by excessive and persistent worry, fear, and nervousness that can significantly interfere with daily life), schizoaffective disorder bipolar type (a rare type of mental health condition that combines symptoms of hallucinations or delusions and intense emotional shifts in mood and energy levels which affect a person's ability to function). This admission record also indicated Resident 2's RP was his family member.</p> <p>A review of Resident 2's order summary report printed on 2/26/25 indicated, [Resident 2] is incapable of making healthcare decisions [due to a diagnosis of] Autism. Healthcare decision maker assigned to [RP] . Order date .11/13/24 .</p> <p>A review of Resident 2's room change notification dated 1/21/25 at 4:11 a.m. indicated, Room Change Information .Date and Time of Occurrence 1/20/25 16:00 [4 p.m.] .Resident responsible party notified .Yes . Date Notified 1/20/25 .Care Plan updated .No .Reason for room change .[Resident 2] moved on previous shift. I do not have all this information. Will not lock this so it can be put in .Is room change voluntary .[no option check marked].</p> <p>A review of Resident 2's social service progress note dated 1/22/25 at 3:30 p.m. indicated, Resident's responsible party notified of room change.</p> <p>In an interview on 2/21/25 at 4:42 p.m., Resident 2's RP stated the facility transferred Resident 2 without her consent.</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
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<p>F 0559</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/26/25 at 3:10 p.m., the Social Services Director (SSD) stated Resident 2 was transferred to another room because it was necessary for his safety and his roommate's safety because Resident 2 was going over his roommate's belongings and was always standing by his roommate's bed. The SSD confirmed she notified Resident 2's RP after the room change was done.</p> <p>A review of the facility's policy and procedure titled Room or Roommate Change dated March 2018 indicated, .Prior to changing a room or roommate assignment, the resident, the resident's representative ., and the resident's new roommate will be provided timely advance notice of such a change .The notice of a change in room or roommate assignment must be given in writing, and will include the reason(s) for such change .The resident/resident representative is notified in a timely manner of room changes in an emergency situation .</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41283</p> <p>Based on interviews and record review, the facility failed to develop and implement a person-centered care plan for one resident (Resident 1) when the facility did not initiate a care plan for Resident 1's wandering and high risk of elopement behavior. This failure contributed to a breakdown in the facility's system to provide the person-centered supervision required for Resident 1 when she eloped from the facility unsupervised in her wheelchair.</p> <p>Findings:</p> <p>A review of Resident 1's admission record indicated she was admitted on [DATE], with a primary diagnosis was Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities).</p> <p>A review of Resident 1's Minimum Data Set (MDS- an assessment tool) dated 1/23/25 indicated a Brief Interview for Mental Status (BIMS- a screening tool used to assess a person's orientation and short-term memory) score was 3 which meant a severe impairment in cognition (the mental process of acquiring knowledge and understanding through thought, experience, and senses). The MDS also indicated Resident 1 used a manual wheelchair for mobility.</p> <p>A review of Resident 1's Medication Administration Record (MAR) dated February 2025 indicated, Apny [Wander Management Monitor (WMM- a device or system that detects, tracks, and alerts staff when a resident tries to leave a safe area)] to resident right wrist. Check for function and placement q [every] shift- Start Date- 10/17/2024 .</p> <p>A review of Resident 1's Situation, Background, Appearance, Review (SBAR) form dated 2/10/25 indicated, [Resident 1 had a] Brief elopement .</p> <p>A review of a facility document titled Unusual Occurrence dated 2/11/25 indicated, On 2/10/25, [Resident 1] was brought back to the facility by a good Samaritan/neighbor. It was during this time that it came to the attention of the staff that [Resident 1] may have potentially eloped for a period of 15 minutes .</p> <p>During an interview on 2/24/25 at 11:30 a.m., the Director of Nursing (DON) stated Resident 1 had attempted to leave the facility in the past. The DON confirmed Resident 1 was able to elope outside the facility on 2/10/25.</p> <p>During an interview on 2/24/25 at 11:35 a.m. the Administrator (ADM) verified the front door of the facility was the only door Resident 1 had access to and was able to leave the facility.</p> <p>During a concurrent record review and interview on 2/24/25 at 1:29 p.m., the ADM was unable to provide documented evidence of Resident 1's care plan for a risk of elopement initiated prior to her elopement on 2/10/25. The ADM stated he could not find a care plan initiated on or around 10/17/24 when the physician ordered a wander management monitor to be placed on Resident 1's right wrist.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/24/25 at 3 p.m., the Certified Nursing Assistant (CNA 1) stated he had been assigned to be the front desk clerk when an unknown male person brought Resident 1 back to the facility. The CNA 1 stated he had not noticed Resident 1 leave the facility from the front lobby. The CNA 1 stated he did not hear the door alarm go off.</p> <p>A review of the facility's policy and procedure titled Comprehensive Person-Centered Care Planning revised November 2018 indicated, It is the policy of this Facility to provide person-centered, comprehensive and interdisciplinary care that reflects best practice standards for meeting .safety .behavioral .and environmental needs of residents in order to obtain or maintain the highest physical, mental, and psychosocial well-being . Additional changes or updates to the resident's comprehensive care plan will be made based on the assessed needs of the resident .In addition, the comprehensive care plan will also be reviewed and revised at the following times .Onset of new problems .Change of condition .To address changes in behavior and care .</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>41283</p> <p>Based on interviews and record review, the facility failed to provide adequate supervision to one resident (Resident 1) of three sampled residents when Resident 1 eloped from the facility. This failure resulted in Resident 1 leaving the facility without staff knowledge and decreased the facility's potential to prevent accident and injury to Resident 1.</p> <p>Findings:</p> <p>A review of Resident 1's admission record indicated admission to the facility in January 2024 with a primary diagnosis of Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities).</p> <p>A review of Resident 1's Minimum Data Set (MDS- an assessment tool) dated 1/23/25 indicated a Brief Interview for Mental Status (BIMS- a screening tool used to assess a person's orientation and short-term memory) score was 3 which meant a severe impairment in cognition (the mental process of acquiring knowledge and understanding through thought, experience, and senses). The MDS also indicated Resident 1 used a manual wheelchair for mobility.</p> <p>A review of Resident 1's Medication Administration Record (MAR) dated February 2025 indicated, Apny [Wander Management Monitor (WMM- a device or system that detects, tracks, and alerts staff when a resident tries to leave a safe area)] to resident right wrist. Check for function and placement q [every] shift- Start Date- 10/17/2024 .</p> <p>A review of Resident 1's Situation, Background, Appearance, Review (SBAR) form dated 2/10/25 indicated, [Resident 1 had a] Brief elopement .</p> <p>A review of a facility document titled Unusual Occurrence dated 2/11/25 indicated, On 2/10/25, [Resident 1] was brought back to the facility by a good Samaritan/neighbor. It was during this time that it came to the attention of the staff that [Resident 1] may have potentially eloped for a period of 15 minutes .</p> <p>During an interview on 2/24/25 at 11:30 a.m., the Director of Nursing (DON) stated Resident 1 had attempted to leave the facility in the past. The DON confirmed Resident 1 was able to elope outside the facility on 2/10/25.</p> <p>During an interview on 2/24/25 at 11:35 a.m. the Administrator (ADM) verified the front door of the facility was the only door Resident 1 had access to and was able to leave the facility.</p> <p>During a concurrent record review and interview on 2/24/25 at 1:29 p.m., the ADM was unable to provide documented evidence of Resident 1's care plan for a risk of elopement initiated prior to her elopement on 2/10/25. The ADM stated he could not find a care plan initiated on or around 10/17/24 when the physician ordered a wander management monitor to be placed on Resident 1's right wrist.</p> <p>(continued on next page)</p>		

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