STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055331	A. Building B. Wing	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Rafael Healthcare & Wellness Center, LP	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)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on observation, interview, and record review, the facility failed to ensure pain management was provided to 1 of 3 sampled residents (Resident 1), when Resident 1 ' s pain intensity level was not re-assessed for effectiveness one hour after administration of pain medication administration. This failure resulted in Resident 1 ' s report of experiencing pain, feeling like she had a ball inside her, while grimacing and holding her hands around her abdomen. Findings: A review of Resident 1 ' s face sheet (front page of the chart that contains a summary of basic information about the resident) indicated Resident 1 was admitted to the facility in July 2024, with diagnoses including chronic pain syndrome (a condition in which a person experiences pain longer than 3 months), stage IV pressure ulcer (wound with full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) to sacrum area (lower back area) and recently placed on hospice care (compassionate care for people who are near the end of life provided at the person ' s home or within a health care facility). During a review of Resident 1 ' s Acute Pain [sudden pain] / Chronic Pain [long term pain] . care plan, initiated on 12/30/24, indicated, . Goal Resident will report satisfactory pain control Interventions [actions taken to prevent, diagnose or treat health condition] . Administer pain medications per order, if non-medication interventions are ineffective . Medicate with PRN [as needed] medications if non-medication interventions are ineffective . Monitor for factors/activities that precipitate [bring about abruptly] or aggravate pain . A review of Resident 1 ' s MAR and active medication orders, for April 2025, indicated, Resident 1 had been prescribed oxycodone-acetaminophen (oxycodone, a pain medication) 3/325 mg (milligram, unit of measure) every four hours as needed (PRN) for pain and morphine sulphate (morphine, a pain medication) solution, 0. 25 ml (milliliters, a unit of measure) every one hour PRN. During an interview on 4/23/25 at 12:05 p.m., with Licensed Nurse 1 (LN 1), LN 1 stated when assessing a resident ' s pain, she used the pain scale tool (a tool used to help residents communicate the intensity of their pain to medical professionals on a scale zero to 10, with zero is no pain and 10 is the worst pain imaginable). LN 1 added, after giving pain medication to a resident, she would re-assess the resident in one hour to monitor the effectiveness of the pain medication. (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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/24/25 at 10:50 a.m. with LN 1, LN 1 stated she administered morphine to Resident 1 around 8:03 a.m. to treat her pain. As of 10:50 a.m., LN 1 stated she had not yet performed the follow-up pain level re-assessment for determination of medication effectiveness, and/or whether Resident would need additional medication to treat any possible remaining pain. An observation on 4/24/25 at 10:52 a.m. LN 1 entered Resident 1 ' s room and asked Resident 1 if she was in any pain. Resident 1 replied yes, and added she felt like she had, a ball inside her, while motioning with her hands around her abdominal area. LN 1 asked Resident 1 what her pain level was. Resident 1 stated, while she grimaced and held her abdomen, she was still in pain at a pain level of five. During a record review of Resident 1 ' s MAR, dated April 2025, LN 1 had documented a follow up pain assessment to her 8:03 a.m. administration of morphine sulphate at 10:53 a.m. as Effective with a pain level of 5. During a concurrent interview and record review on 4/24/25, at 2:42 p.m., with the Director of Nursing (DON), the facility ' s policy and procedure (P&P) titled, Administration of Pain Medication, undated, was reviewed. The DON stated the facility ' s policy for reassessing pain level after a pain medication administration was to occur 1 hour after the pain medication is given and read the verbiage directly off the facility P&P. The DON explained, her expectation is that the licensed nurses follow the facility policy for pain medication administration, including re-assessment of intensity of the resident ' s pain one hour after pain medication has been administered, and acknowledged the risk of not doing so is the resident may experience pain which could have been prevented if the pain had been assessed timely, after a pain medication administration, per the facility ' s policy.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation, interview, and record review, the facility failed to ensure four of five sampled residents (Resident 1, Resident 3, Resident 4 and Resident 5) could call for staff assistance through a communication system when the call lights (a device that allows residents to signal staff for assistance) were not found within the residents' reach. These failures had the potential to result in residents ' inability to notify staff when needing help and could lead to safety issues. Findings: During a concurrent observation and interview on 4/23/25 at 12:47p.m, Resident 1 was in her room in bed and her call light was hanging on a dresser in a box. Resident 1 stated she did not know where her call light was. In a concurrent observation and interview on 4/23/25 at 12:50 p.m. with Licensed Nurse (LN) 1, LN 1 entered Resident 1 room, LN 1 confirmed that the call light was not within reach of Resident 1 and that it should have been. During an observation and interview on 4/23/25 at 1:07 p.m., Resident 3 was in her room lying in bed. She gestured, trying to reach the call light but was unable to reach it as it was clipped to the curtain out of her reach. During a concurrent interview and observation on 4/23/25 at 1:08 p.m. with LN 2, LN 2 entered Resident 3 ' s room and confirmed the call light was not within Resident 3's reach. LN 2 stated the call light should be within the resident ' s reach and being out of reach would be a problem if the resident needed to call for help. During a concurrent interview and observation on 4/23/25 at 1:11p.m. with Resident 4, Resident 4 was alone in her room, sitting up in bed with a tray table with food in front of her. Resident 4 stated she did not know where her call light was. During a concurrent interview and observation on 4/23/25 at 1:12 p.m. with the Social Services Director (SSD), the SSD confirmed that Resident 4 ' s call light was attached to the curtain, where it should not be because the resident could not reach it. During a concurrent interview and observation on 4/23/25 at 1:15p.m with the Registered Dietician (RD) in Resident 5 ' s room, Resident 5 was alone in her room in a reclined chair next to her bed. The RD confirmed the call light was behind Resident 5, on the dresser in a drawer, and not in reach of the resident. During an interview on 4/24/25 at 2:42 p.m. with the Director of Nursing (DON), the DON stated it was her expectation that call lights would be in easy reach of the residents. The DON added, call lights out of reach of residents could be a potential safety issue for example, if a resident fell. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility ' s policy and procedure titled, Communication-Call System, revised 1/1/12, the policy stipulated, .Call cords will be placed within the resident ' s reach in the resident ' s room .