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	07/18/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 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 observation, interview, and record review, the facility failed to protect one resident (Resident 1) of four sampled residents from abuse when Resident 1 wandered into Resident 2's room and became verbally and physically aggressive. This failure resulted in Resident 2 punching Resident 1 in the face when Resident 1 would not leave Resident 2's room after repeated requests.On 7/3/25 at 4:33 p.m., the Department received a report from the facility that indicated, On 7/3/25 at 1:40 p.m. [Resident 1] was observed in [Resident 2's] room by the housekeeper and had to be separated immediately. Upon interviewing [Resident 2], he stated that [Resident 1] came into his room and would not leave. [Resident 1] was standing at the bedside with his hands up in a fist while [Resident 2] was laying down telling him to leave. According to [Resident 2] he struck [Resident 1] in the face and chest.During an observation on 7/16/25 at 1:17 p.m., Resident 1 was walking in the hallway of Station 1. Staff were trying to encourage him to come to his room to eat some lunch, which he did.During an interview on 7/16/25 at 1:43 p.m., Resident 2 stated that on 7/3/25, he was asleep in bed when Resident 1 came in his room yelling and screaming. Resident 2 stated he asked Resident 1 to leave three times, but Resident 1 did not leave. Resident 2 stated Resident 1 came over to him yelling, You die! You die! and grabbed his (Resident 2's) shirt. Resident 2 stated that at that point he punched Resident 1 several times in the face, and staff came in and separated them. Resident 2 stated Resident 1 had come in his room before at night and taken his belongings, but had never been physically aggressive. Resident 2 stated he felt unsafe because Resident 1 had made threats against his life. Resident 2 stated there was nowhere for him to run (since he was in bed), so he hit Resident 1 because his only other alternative was to get beat up. During an interview on 7/16/25 at 1:56 p.m., the Activities Director (AD) stated that during the Resident Council meeting last month (June), Resident 1 had wandered in and out a couple of times. The AD stated he went around the facility to ask residents what topics they would like discussed at the upcoming ad hoc Resident Council meeting, and one of the issues that residents complained of the most was wandering residents. The AD stated the facility was currently experiencing a COVID outbreak, and residents were concerned that the wandering resident was spreading the infection around the building by wandering in and out of rooms. The AD stated the residents also felt the wandering resident was invading their privacy.During an interview on 7/16/25 at 2:09 p.m., Resident 3 stated Resident 1 wandered in her room occasionally. Resident 3 stated Resident 1 came in, nods at her, and then goes away.During an interview on 7/16/25 at 2:12 p.m., Resident 4 stated she lived in a room just a few doors down from where Resident 1 lived. Resident 4 stated Resident 1 went in and out of people's rooms including hers. Resident 4 stated the reason she kept her door closed was to keep Resident 1 out of her room. Resident 4 stated she preferred to keep her door open and keeping it closed made her feel isolated. Resident 4 stated she felt violated when Resident 1 wandered into her room. Resident 4 stated that when her door was open, Resident 1 would wander in several times a day.During an interview on 7/16/25 2:19 p.m., Resident 5 stated Resident 1 had come into his room on a nightly basis until two weeks ago. Resident 5 stated that when Resident 1 came into his room he would stand and babble a lot, and sometimes Resident 1 would be argumentative, combative, and irritable. Resident 5 stated that when Resident 1 wandered into his room it made him feel annoyed. During an interview on 7/16/25 at 3:22 p.m., the Social Services Director verified Resident 1 had a wandering behavior.During a phone interview on 7/17/25 at 3:15 p.m., Environmental Services Staff (ESS) stated he recalled that on 7/3/25, he was taking his bucket to the room where Resident 2 resided. ESS stated he heard Resident 1 yelling, I killing you! I killing you! and then he saw Resident 2 punched Resident 1 in the face. ESS stated he yelled for help and then told Resident 1, This is not your room. ESS stated three staff came and helped separate the residents, but ESS could not recall who came. ESS stated that when he entered Resident 2's room, Resident 1 had his hands in fists and was touching Resident 2 with his fists, but did not hit him.During an interview on 7/18/25 at 10:30 a.m., the Administrator verified that when Resident 2 punched Resident 1 in the face on 7/3/25, it was considered abuse per facility policy for abuse prevention. The Administrator stated that the abuse could have been prevented by redirecting Resident 1 away from Resident 2's room. The Administrator stated Resident 1 should not have been in Resident 2's room.Review of Resident 1's medical record revealed Resident 1's face sheet indicated an admission date of 10/18/23, and medical diagnoses including dementia (loss of the ability to think, remember, and reason to the extent that it interferes with daily life and activities) with behavioral disturbance, cognitive (related to thinking