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	12/23/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 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 provide supervision for one resident (Resident 1) of five sampled residents when Resident 1 left the facility unaccompanied and wandered several busy streets until he was found by a friend and driven to his Responsible Party's (RP, a person who makes health care decisions on behalf of the resident when the resident does not have the mental capacity to do so) home. This failure decreased the facility's potential to provide supervision and to prevent severe injury to the residents. Findings: A review of Resident 1's admission record indicated he was admitted on [DATE] with a diagnosis of toxic encephalopathy (brain dysfunction from exposure to poisons, chemicals, drugs, or natural toxins, causing altered mental status, confusion, memory loss, personality changes, tremors, and coordination issues, with outcomes varying from reversible to permanent brain damage, depending on exposure).A review of Resident 1's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 11/3/25, indicated Resident 1 had severe memory impairment.A Review of Physician (MD) progress notes, dated 12/9/25, indicated Patient is a. with past medical history significant for anxiety and memory impairment was found wandering the street about 1 mile away from his assisted living facility. Check placement and function of wander guard left ankle.A review of Resident 1's Wander Risk Care Plan, initiated 10/30/25, indicated Resident 1 was at risk for elopement and/or wandering related to mental confusion and memory loss, and a wander management monitor was to be worn.A review of Resident 1's Treatment Administration Record (TAR), dated 12/25, indicated the wander management monitor was in place on left ankle and was confirmed functioning on the night shift of 12/9/25 and confirmed in place on left ankle day shift of 12/10/25. A review of Resident 1's MD orders, dated 10/28/25, indicated that Resident 1 may leave facility on a pass, with supervision. A review of Resident 1's Medication Administration Record (MAR), dated 12/25, indicated Resident 1 had received medications at 5:00 p.m. on 12/10/25.A review of Resident 1's nursing notes, dated 12/11/25 at 2:32 p.m. indicated at approximately 5:15 p.m. on 12/10/25, nursing staff noted Resident 1 was no longer in the facility. When they contacted the RP, they learned the resident had left the facility and walked to 4th street where a family friend picked him up and brought him to the RP's house. During an interview on 12/23/24 at 10:40 a.m. with the Director of Nursing (DON), the DON stated Resident 1 wore a wander guard because he always wanted to go out without supervision.During an interview on 12/29/25 at 12:31 p.m. with LN 1, LN 1 stated she first realized Resident 1 was missing when she went in to check on Resident 1 to see if he was ready for dinner. She looked around, requested assistance, called the family and called her supervisor. When the family called her back was when she learned Resident 1 had left the facility, walked down to 4th street, found a friend and the friend drove him to his RP's house. LN 1 stated she never heard the wander management monitor alarm. During an interview on 12/30/25 at 8:48 a.m. with CNA 1, CNA 1 stated Resident 1 was a part of his assignment that day; he had 8 residents. He had last worked with Resident 1 around 4:30 p.m. and left him in the Lobby on the sofa, a place Resident 1 likes to sit. A short time later LN1 came to him asking where Resident 1 was. They looked within the facility and outside and could not find him. That's when we called the family and found he was there. CNA 1 stated he did not hear the wander management monitor alarm. During an interview on 12/30/25 at 10:03 a.m. with Resident 1's RP, RP stated Resident 1 was wearing his wander management monitor when he arrived at her house on 12/10/25. She watched him take it off with scissors in the kitchen the next day. During a review of a facility policy titled, Wandering and Elopement, revision date 1/31/23, the policy stipulated, the facility will identify residents at risk for elopement upon admission. [in order] to enhance the safety of residents of the facility.During a review of a facility policy titled, Out on Pass, revision date 1/11/16, the policy stipulated, resident/responsible person will verbally notify a Licensed Nurse prior to going out on a pass and will sign out and back in on Form A - Resident Out On Pass Log.