STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056359	A. Building B. Wing	04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Pablo Healthcare & Wellness Center	13328 San Pablo Avenue San Pablo, CA 94806

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32717 Based on interview and record review, for one of three sampled residents (Resident 1), the facility failed to provide pain management to Resident 1 consistent with comprehensive person-centered plan of care and resident's goals when Resident 1 was not administered pain medication (hydromorphone, an opioid analgesic to treat moderate to severe pain) as ordered. This failure resulted in Resident 1's pain not being control resulting in increased agitation and verbal aggression. Findings: During a review of Resident 1's Admission Record, dated 4/24/24, the Admission Record indicated Resident 1 was admitted to the facility in January 2024 with diagnoses that included peripheral vascular disease (circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), chronic kidney disease (a condition in which the kidneys are damaged and cannot filter blood as well as they should), polyneuropathy (condition in which a person's peripheral nerves are damaged, affecting the nerves in the skin, muscles, and organs), cellulitis (common bacterial skin infection that causes redness, swelling, and pain in the infected area of the skin) of the left and right lower limb, depression (persistent feeling of sadness and loss of interest interfering daily life), acquired absence of the right toe and angina pectoris (chest pain or discomfort caused by inadequate blood supply to the heart). During a review of Resident 1's Minimum Data Set (a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan), dated 2/1/24, 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). During a review of Resident 1's Acute/Chronic Pain care plan, initiated on 3/25/24, the care plan indicated the goal of care was for Resident 1 to report satisfactory pain control. The interventions included applying hot or cold packs for comfort, encourage rest and relaxation, and to medicate with prn (as needed) medications if non-medication interventions are ineffective. (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 a review of another pain care plan initiated on 1/26/24, the care plan indicated Resident 1 was at [NAME] for pain related to complex medical conditions that included peripheral vascular disease, polyneuropathy, depression, and chronic kidney disease. The care plan indicated the goals of care included for Resident 1 to verbalize adequate pain relief and for Resident 1 to have decrease in behaviors showing inadequate pain control that included irritability, agitation, restlessness, and crying. Planned interventions included for licensed staff to administer pain medication as ordered, anticipate Resident 1's need for pain relief, respond immediately to any complaint of pain, and for staff to monitor, record and report to licensed staff Resident 1's complaint of pain or requests for pain treatment. During an interview on 4/24/24 at 10:55 a.m. with Resident 1, Resident 1 stated asking the afternoon shift nurse for pain medication for severe pain on the lower extremities at around 9-9:30 p.m. on 4/18/24. Resident 1 stated feeling like climbing the wall in pain and the licensed staff refused to give pain medication. Resident 1 stated he waited until 12:30 a.m. to ask the night shift nurse for the pain medication, but it was not given the medication until Resident 1 had called the cops about five times. Resident 1 stated he received the pain medication at 3:45 a.m. During a review of Resident 1's Order Summary Report, dated 4/10/24, The Order Summary Report indicated an order to administer hydromorphone oral tablet 2 milligrams (mg) three tablets by mouth every four hours as needed for severe pain. During an interview on 4/24/24 at 3:23 p.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated, on the evening of 4/18/24, around 9:30 p.m., Resident 1 had asked for pain medication. CNA 1 stated telling Licensed Vocational Nurse (LVN) 1 that Resident 1 was in pain and was asking for pain medication. CNA 1 stated she went back to Resident 1's room around 10:30 p.m. to 11 p.m. before leaving for the day. CNA 1 stated Resident 1 verbalized he had not received the pain medication yet. CNA 1 stated she told Resident 1 that LVN 1 already knew of the request for pain medication. During an interview on 4/24/24 at 3:38 p.m. with LVN 1, LVN 1 stated CNA 1 had told her of Resident 1's request for pain medication around 9:30 p.m. LVN 1 stated, because of previous complaints from Resident 1 about her, she was not allowed to enter Resident 1's room to provide any care and had to ask LVN 2 to administer medications to Resident 1 as needed. LVN 1 stated, after being told by CNA 1 of Resident 1's pain, LVN 1 went near Resident 1's room to assess if Resident 1 had any sign of pain. Without entering Resident 1's room and without talking to Resident 1, LVN stated, Resident 1 was alright and did not have any pain. During an interview on 4/24/24 at 3:03 p.m. with LVN 2, LVN 2 stated LVN 1 did not report that Resident 1 was asking for pain medication. LVN 2 stated had he known Resident 1 had asked for pain medication, LVN 2 stated he would have given it right away. During a review of Resident 1's Medication Administration Record (MAR) for April 2024, the MAR indicated Resident 1 did not receive hydromorphone from 9:30 p.m. to 12 midnight on 4/18/24. The MAR also indicated the last hydromorphone dose Resident 1 received on 4/18/24 was at 5:49 p.m. (continued on next page)

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview and concurrent review of Resident 1's clinical records on 4/25/24 at 10:20 a.m. with LVN 3, LVN 3 she stated working the night shift on 4/18/24 from 11 p.m. to 7 a.m. LVN 3 stated, at the start of the night shift on 4/18/24, Resident 1 had already asked for pain medication. LVN 3 stated Resident 1 had usually asked for hydromorphone every four hours during the evening and night shift. LVN 3 stated the evening shift had always administered at least two doses of hydromorphone, but that night, Resident 1 had only one dose at 5:49 p.m. LVN 3 stated, although 11-11:30 p.m. was too early for Resident 1 to request for hydromorphone, LVN 3 had asked Registered Nurse (RN) 2 to give the hydromorphone dose anyway because Resident 1 had gotten very agitated and verbally aggressive toward staff. Progress Notes, dated 4/19/24, indicated Resident 1 became verbally aggressive toward staff, banging on the wall bothering other residents who were sleeping, after alleging hydromorphone was not administered. Resident 1 called 911 sending the paramedics to the facility.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 32717 Based on interview and record review, for one of three sampled residents (Resident 1), the facility failed to provide pharmaceutical services and procedures that assure accurate dispensing and administration of controlled drugs when administration of hydromorphone (a controlled opioid medication to treat pain) was not accurately recorded in the Medication Administration Record (MAR). This failure had the potential to result in confusion in dosing administration and drug diversion. Findings: During a review of Resident 1's Admission Record, dated 4/24/24, the Admission Record indicated Resident 1 was admitted to the facility in January 2024 with diagnoses that included peripheral vascular disease (circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), chronic kidney disease (a condition in which the kidneys are damaged and cannot filter blood as well as they should), polyneuropathy (condition in which a person's peripheral nerves are damaged, affecting the nerves in the skin, muscles, and organs), cellulitis (common bacterial skin infection that causes redness, swelling, and pain in the infected area of the skin) of the left and right lower limb, depression (persistent feeling of sadness and loss of interest interfering daily life), acquired absence of the right toe and angina pectoris (chest pain or discomfort caused by inadequate blood supply to the heart). During a review of Resident 1's Minimum Data Set (a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan), dated 2/1/24, the MDS indicated a Brief Interview for Mental Status (BIMS, 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). During an interview on 4/24/24 at 10:55 a.m. with Resident 1, Resident 1 stated he asked the afternoon shift nurse for pain medication for severe pain in the lower extremities at around 9-9:30 p.m. on 4/18/24. Resident 1 stated waiting until 12:30 a.m. to ask the night shift nurse for pain medication that was not given until Resident 1 had called the cops about five times. Resident 1 stated he received the pain medication at 3:45 a.m. and denied ever getting pain medication at 12:30 a.m. During an interview and concurrent record review on 4/24/24 at 12:15 p.m. with Registered Nurse (RN) 1, Resident 1's MAR, dated April 2024, and Individual Narcotic Record, dated 4/10/24, were reviewed. The Individual Narcotic Record indicated hydromorphone 4 milligram (mg) tablet, 1.5 tablets were popped from the bubble pack (blister pack, tamper-evident packaging where an individual pushes individually sealed tablets through the foil in order to take the medication) on the following dates and times: 4/17/24 at 7:30 a.m., 4/18/24 at 7:30 a.m., 4/18/24 at 11:30 p.m., 4/19/24 at 3:30 a.m., and 4/20/24 at 8:30 a.m. The MAR did not indicate these doses were signed off as administered to Resident 1 on the dates and times as indicated in the Individual Narcotic Record. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview and concurrent review of Resident 1's clinical records on 4/25/24 at 10:20 a.m. with LVN 3, LVN 3 stated she worked the night shift on 4/18/24 from 11 p.m. to 7 a.m., 4/19/24. LVN 3 stated at the start of the night shift on 4/18/24, Resident 1 had already asked for pain medication. LVN 3 stated she was not allowed to enter and assist with Resident 1's care and asked RN 2 to assist and administer Resident 1's medication. LVN 3 stated she removed the medication from the bubble pack and signing it off in the MAR, but RN 2 administered the medication to Resident 1. During a review of the facility's policy and procedure (P&P) titled Medication-Administration last revised 1/1/12, the P&P indicated the time and dosage of the drug administered to the resident will be recorded in the resident's individual medication record by the person who administers the drug. The record will include the date, time, and dosage of the drug administered.