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	10/04/2024

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 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. 50474 Based on observation, interview and record review, the facility failed to ensure two of four sampled residents (Resident 1 and Resident 2), were free from physical abuse when Resident 1 hit Resident 2 on his left lower leg while Resident 2 was sleeping and Resident 2 punched Resident 1 on the chest during a second altercation few hours later. This failure placed Resident 1 and Resident 2 at significant risk for physical and emotional harm. Findings: During a record review of Resident 1's Admission Record (AR), dated 10/4/24, the AR indicated, Resident 1 was initially admitted to the facility in August 2024. During a record review of Resident 1 ' s Minimum Data Set (MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan.), dated 9/18/24, Resident 1 had diagnoses of Chronic Obstructive Pulmonary Disease (COPD, refers to a group of diseases that cause airflow blockage and breathing-related problems. It includes emphysema and chronic bronchitis), major depressive disorder (a mental health condition that causes a persistently low or depressed mood and a loss of interest in activities that once brought joy) and cerebrovascular disease (death of an area of brain tissue when a blocked blood vessel prevents delivery of an adequate blood and oxygen supply to the brain) affecting right dominant side. During a record review of Resident 2 ' s AR, dated 10/4/24, the AR indicated, Resident 2 was initially admitted to the facility in September 2024. During a record review of Resident 2 ' s MDS record, dated 9/12/24, Resident 2 had diagnoses of encephalopathy (brain disease that alters brain function or structure, manifested by declining ability to reason, and concentrate, memory loss, personality change, seizures, and twitching are common symptoms) and cognitive communication deficit. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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	During an observation and interview on 10/4/24 at 9:35 a.m. with Resident 2, Resident 2 was sitting on his bed in his room. Resident 2 stated Resident 1 was his former roommate. Resident 2 stated on 9/18/24, Resident 1 attacked him while he was sleeping and hit him on his left lower leg. Resident 2 further stated Resident 1 was cursing and calling him names. Resident 2 stated the CNAs took Resident 1 outside of the room to separate them. Resident 2 stated the CNAs brought Resident 1 back again inside his room even after their first physical altercation. During a record review of Resident 1's Progress Notes (PN), dated 9/18/24, the PN indicated, Resident 1 hit his roommate Resident 2, on his legs while sleeping. The PN also indicated, that Certified Nurse Assistants (CNAs) brought Resident 1 back to his room and Resident 2 hit Resident 1 on the chest. The PN further indicated Resident 1 appeared agitated and restless. During a record review of Resident 2 ' s PN, dated 9/18/24, the PN indicated, the staff were unable to do a room change because there were no available male beds on the day of the incident. The PN also indicated Resident 1 was brought back to the room around 5:20 a.m., when Resident 2 punched Resident 1 on the chest. During a phone interview on 10/4/24 at 10:29 a.m. with CNA1, CNA 1 stated on 9/18/24 around midnight, CNA 1 saw Resident 1 was in his wheelchair facing Resident 2 ' s bed. CNA 1 stated Resident 1 was cursing and yelling at Resident 2. CNA1 stated Resident 1 was agitated and restless. CNA 1 stated she separated Resident 1 from Resident 2 and moved Resident1 to the nurse ' s station for monitoring. CNA 1 stated there were no available rooms to transfer Resident 1 at the time of the incident. CNA 1 stated around 5:00 a.m., CNA 1 brought Resident 1 back to Resident 1 ' s room [same room where the altercation occurred] because she needed to provide personal care to Resident1. CNA1 stated after providing care, Resident 1 was transferred back to the wheelchair and Resident 1 was left in the hallway, just outside Resident 1 ' s room, while she attended another resident. CNA 1 stated the LN called her and told her that Resident 1 and Resident 2 were having verbal altercation again. CNA 1 stated she saw Resident 1 was already halfway through the door of Room where Resident 2 was. CNA 1 stated she saw Resident 2 got up from the bed and walked towards Resident 1 and hit him on the chest. During an interview on 10/4/24 at 11:48 a.m., with the Director of Nursing (DON), the DON stated the CNAs, and the LN should have completely separated Resident 1 and Resident 2 because of the risk of another physical or verbal altercation. The DON also stated it was not acceptable that staff brought Resident 1 back to the same room where Resident 2 was. The DON further stated the staff should have looked for other places where they could have provided personal care to Resident 1. During a record review of the facility ' s policy and procedure (P&P) titled, Resident-To-Resident Altercations, dated 11/1/15, the P&P indicated, I. Prevention . A. Facility staff observes resident for aggressive or inappropriate behavior toward other residents . II. Response to Altercation . A. Separate the residents, and institute measures to calm the situation. During a record review of the undated facility ' s record, titled, If an alleged abuse occurs right now: the record indicated, If Resident-to-Resident, separate immediately and supervise residents for safety. During a record review of the facility ' s P&P, titled,Room or Roommate Change,dated March 2018, the P&P indicated, The facility may make an emergency change in room or roommate assignment if the change is necessary for the health, safety, or well-being of the resident.