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	01/02/2025

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 50474 Based on observation, interview and record review, the facility failed to provide choice based on resident preferences for one of two sampled residents (Resident 1) when Resident 1 was not changed to his hospital gown upon request and was left in street clothes overnight. This failure had the potential to cause physical discomfort and emotional distress to Resident 1. Findings: During a record review of Resident 1 ' s Admission Record, printed 12/31/24, the Admission Record indicated Resident 1 was admitted to the facility in May 2024 with multiple diagnoses that included congestive heart failure (a chronic condition where the heart can't pump blood efficiently) and type 2 diabetes (a long-term disease in which the body cannot regulate the amount of sugar in the blood). During a record review of Resident 1 ' s Care Plan, dated 1/26/24, the Care Plan indicated Resident 1 had decreased ability to perform self-care related to impaired activity tolerance, impaired balance/safety, pain limiting function, weakness . During an observation and interview on 12/27/24, at 8:55 a.m., with Resident 1, Resident 1 wore a jacket, t-shirt and pants that were halfway down his thighs. Resident 1 stated he requested a Certified Nurse Assistant (CNA), from the night shift, change him to his gown before going to bed the other night because he wore the same clothes the whole day. Resident 1 stated the CNA did not assist him and told him he would be more comfortable wearing his street clothes because it was cold. Resident 1 stated it was not the first time a CNA refused to assist him with changing clothes at night. Resident 1 stated he reported it to the Long-Term Care Ombudsman in the past. Resident 1 stated he felt he was treated differently when the CNA did not assist him, and it affected his self-esteem and dignity. During an interview on 12/27/24, at 10:15 a.m., with CNA 1, CNA 1 stated when she arrived, Resident 1 was wearing street clothes. CNA 1 stated Resident 1 should have been assisted by the night shift CNA if Resident 1 had requested to have his clothes changed to hospital gown. CNA 1 stated Resident 1 could have been more comfortable when sleeping. CNA 1 further stated Resident 1 ' s skin could also have been checked for any skin issues. (continued on next page)

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/27/24, at 10:36 a.m., with Registered Nurse (RN) 1, RN 1 stated Resident 1 should have been assisted before going to bed so he could be comfortable at night. RN 1 stated if Resident 1 refused to be changed, CNAs should document the refusal. RN 1 stated Resident 1 did not have behaviors of refusing Activities of Daily Living (ADLs: Activities of daily living are those needed for self-care and mobility and include activities such as bathing, dressing, grooming, oral care, ambulation, toileting, eating, transferring, and communicating). During an interview on 12/27/24, at 12:40 p.m., with the Director of Nursing (DON), the DON stated changing residents to hospitals gowns at bedtime was a preference. The DON stated if a resident refused to be provided ADLs at night, there should be documentation and care plan about the refusals. The DON stated if Resident 1 preferred to wear his hospital gown, Resident 1 should have been assisted. The DON stated Resident 1 ' s dignity could have been affected and must have been disappointed. During a follow up interview on 1/2/25, at 10:08 a.m., with the DON, the DON stated there was no documentation from the nursing staff that Resident 1 refused ADLs which included changing clothes before going to bed. During a record review of the facility ' s policy and procedure (P&P) titled, Residents Rights - Quality of Life, revised in March 2017, the P&P indicated, Each resident shall be cared for in a manner that promotes and enhances the quality of life, dignity, respect, individuality and receives services in a person-centered manner, as well as those that support the resident in attaining or maintaining his/her highest practicable well-being . Residents are groomed as they wish, including bathing, dressing and oral care. Based on observation, interview and record review, the facility failed to provide choice based on resident preferences for one of two sampled residents (Resident 1) when Resident 1 was not changed to his hospital gown upon request and was left in street clothes overnight. This failure had the potential to cause physical discomfort and emotional distress to Resident 1. Findings: During a record review of Resident 1's Admission Record, printed 12/31/24, the Admission Record indicated Resident 1 was admitted to the facility in May 2024 with multiple diagnoses that included congestive heart failure (a chronic condition where the heart can't pump blood efficiently) and type 2 diabetes (a long-term disease in which the body cannot regulate the amount of sugar in the blood). During a record review of Resident 1's Care Plan, dated 1/26/24, the Care Plan indicated Resident 1 had decreased ability to perform self-care related to impaired activity tolerance, impaired balance/safety, pain limiting function, weakness . (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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 12/27/24, at 8:55 a.m., with Resident 1, Resident 1 wore a jacket, t-shirt and pants that were halfway down his thighs. Resident 1 stated he requested a Certified Nurse Assistant (CNA), from the night shift, change him to his gown before going to bed the other night because he wore the same clothes the whole day. Resident 1 stated the CNA did not assist him and told him he would be more comfortable wearing his street clothes because it was cold. Resident 1 stated it was not the first time a CNA refused to assist him with changing clothes at night. Resident 1 stated he reported it to the Long-Term Care Ombudsman in the past. Resident 1 stated he felt he was treated differently when the CNA did not assist him, and it affected his self-esteem and dignity. During an interview on 12/27/24, at 10:15 a.m., with CNA 1, CNA 1 stated when she arrived, Resident 1 was wearing street clothes. CNA 1 stated Resident 1 should have been assisted by the night shift CNA if Resident 1 had requested to have his clothes changed to hospital gown. CNA 1 stated Resident 1 could have been more comfortable when sleeping. CNA 1 further stated Resident 1's skin could also have been checked for any skin issues. During an interview on 12/27/24, at 10:36 a.m., with Registered Nurse (RN) 1, RN 1 stated Resident 1 should have been assisted before going to bed so he could be comfortable at night. RN 1 stated if Resident 1 refused to be changed, CNAs should document the refusal. RN 1 stated Resident 1 did not have behaviors of refusing Activities of Daily Living (ADLs: Activities of daily living are those needed for self-care and mobility and include activities such as bathing, dressing, grooming, oral care, ambulation, toileting, eating, transferring, and communicating). During an interview on 12/27/24, at 12:40 p.m., with the Director of Nursing (DON), the DON stated changing residents to hospitals gowns at bedtime was a preference. The DON stated if a resident refused to be provided ADLs at night, there should be documentation and care plan about the refusals. The DON stated if Resident 1 preferred to wear his hospital gown, Resident 1 should have been assisted. The DON stated Resident 1's dignity could have been affected and must have been disappointed. During a follow up interview on 1/2/25, at 10:08 a.m., with the DON, the DON stated there was no documentation from the nursing staff that Resident 1 refused ADLs which included changing clothes before going to bed. During a record review of the facility's policy and procedure (P&P) titled, Residents Rights - Quality of Life , revised in March 2017, the P&P indicated, Each resident shall be cared for in a manner that promotes and enhances the quality of life, dignity, respect, individuality and receives services in a person-centered manner, as well as those that support the resident in attaining or maintaining his/her highest practicable well-being . Residents are groomed as they wish, including bathing, dressing and oral care. Based on observation, interview and record review, the facility failed to provide choice based on resident preferences for one of two sampled residents (Resident 1) when Resident 1 was not changed to his hospital gown upon request and was left in street clothes overnight. This failure had the potential to cause physical discomfort and emotional distress to Resident 1. Findings: (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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of Resident 1's Admission Record, printed 12/31/24, the Admission Record indicated Resident 1 was admitted to the facility in May 2024 with multiple diagnoses that included congestive heart failure (a chronic condition where the heart can't pump blood efficiently) and type 2 diabetes (a long-term disease in which the body cannot regulate the amount of sugar in the blood). During a record review of Resident 1's Care Plan, dated 1/26/24, the Care Plan indicated Resident 1 had decreased ability to perform self-care related to impaired activity tolerance, impaired balance/safety, pain limiting function, weakness . During an observation and interview on 12/27/24, at 8:55 a.m., with Resident 1, Resident 1 wore a jacket, t-shirt and pants that were halfway down his thighs. Resident 1 stated he requested a Certified Nurse Assistant (CNA), from the night shift, change him to his gown before going to bed the other night because he wore the same clothes the whole day. Resident 1 stated the CNA did not assist him and told him he would be more comfortable wearing his street clothes because it was cold. Resident 1 stated it was not the first time a CNA refused to assist him with changing clothes at night. Resident 1 stated he reported it to the Long-Term Care Ombudsman in the past. Resident 1 stated he felt he was treated differently when the CNA did not assist him, and it affected his self-esteem and dignity. During an interview on 12/27/24, at 10:15 a.m., with CNA 1, CNA 1 stated when she arrived, Resident 1 was wearing street clothes. CNA 1 stated Resident 1 should have been assisted by the night shift CNA if Resident 1 had requested to have his clothes changed to hospital gown. CNA 1 stated Resident 1 could have been more comfortable when sleeping. CNA 1 further stated Resident 1's skin could also have been checked for any skin issues. During an interview on 12/27/24, at 10:36 a.m., with Registered Nurse (RN) 1, RN 1 stated Resident 1 should have been assisted before going to bed so he could be comfortable at night. RN 1 stated if Resident 1 refused to be changed, CNAs should document the refusal. RN 1 stated Resident 1 did not have behaviors of refusing Activities of Daily Living (ADLs: Activities of daily living are those needed for self-care and mobility and include activities such as bathing, dressing, grooming, oral care, ambulation, toileting, eating, transferring, and communicating). During an interview on 12/27/24, at 12:40 p.m., with the Director of Nursing (DON), the DON stated changing residents to hospitals gowns at bedtime was a preference. The DON stated if a resident refused to be provided ADLs at night, there should be documentation and care plan about the refusals. The DON stated if Resident 1 preferred to wear his hospital gown, Resident 1 should have been assisted. The DON stated Resident 1's dignity could have been affected and must have been disappointed. During a follow up interview on 1/2/25, at 10:08 a.m., with the DON, the DON stated there was no documentation from the nursing staff that Resident 1 refused ADLs which included changing clothes before going to bed. During a record review of the facility's policy and procedure (P&P) titled, Residents Rights - Quality of Life , revised in March 2017, the P&P indicated, Each resident shall be cared for in a manner that promotes and enhances the quality of life, dignity, respect, individuality and receives services in a person-centered manner, as well as those that support the resident in attaining or maintaining his/her highest practicable well-being . Residents are groomed as they wish, including bathing, dressing and oral care.

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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	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 provide treatment and care in accordance with professional standards of practice for one of two sampled residents (Resident 1) when Resident 1 ' s call light was not answered in a timely manner. This failure had the potential to cause physical discomfort and emotional distress to Resident 1. Findings: During a record review of Resident 1 ' s Admission Record, printed 12/31/24, the Admission Record indicated Resident 1 was admitted to the facility in May 2024 with multiple diagnoses that included congestive heart failure (a chronic condition where the heart can't pump blood efficiently) and type 2 diabetes (a long-term disease in which the body cannot regulate the amount of sugar in the blood). During a record review of Resident 1 ' s Care Plan, dated 1/26/24, the Care Plan indicated Resident 1 had decreased ability to perform self-care related to impaired activity tolerance, impaired balance/safety, pain limiting function, weakness . During an observation and interview on 12/27/24, at 9:00 a.m., with Resident 1, Resident 1 ' s room was located across the nurse ' s station. Resident 1 ' s call light was within Resident 1 ' s reach and located on the right side of his bed. Resident 1 stated the facility was always slow to answer the call lights. Resident 1 stated there were multiple occasions that he had to call the front desk because no one responded to his call light. Resident 1 stated the front desk paged the nursing staff assigned to him, but the nursing staff still took a long time until they arrived. Resident 1 stated there were times that he had to wait for hours for a CNA or a licensed nurse to assist him especially during the PM shift (3:00 p.m.-11:00 p.m.). Resident 1 stated the staff were just passing by even if his call light was on. Resident 1 stated he required staff ' s assistance in his ADL care because he was a fall risk. Resident 1 stated he felt he was being neglected and treated differently when the facility did not answer his call light promptly. During an observation on 12/27/24, at 9:52 a.m., in Resident 1 ' s room, Resident 1 pressed his call light button. Resident 1 ' s call light on indicator was lit inside Resident 1 ' s room and at the nurse ' s station. A beeping sound was also heard while Resident 1 ' s call light was continuously on. During an observation on 12/27/24, at 10:06 a.m., no staff entered the room to check on Resident 1. Multiple staff were observed passing by Resident 1 ' s room while the call light was on. A licensed nurse was also observed stationed in the hallway, near Resident 1 ' s room, working on the medication cart. The licensed nurse did not respond to Resident 1 ' s call light. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 12/27/24, at 10:12 a.m., with CNA 1, CNA 1 entered Resident 1 ' s room after 20 minutes had passed. CNA 1 stated she was assisting another resident. CNA 1 stated nobody had informed her the call light was on in Resident 1 ' s room. CNA 1 stated any staff from the facility could answer the call light. CNA 1 stated it was important for the call lights to be answered promptly to assess the residents' needs. During a follow up interview on 12/27/24, at 10:36 a.m., with RN 1, RN 1 stated the call light for Resident 1 should be answered promptly to check on Resident 1's needs. RN 1 stated waiting for 20 minutes for a staff to answer the call light was too long and could have been an emergency for Resident 1. During an interview on 12/27/24, at 12:38 p.m., with the DON, the DON stated the facility call light policy was to promptly check a resident when they pressed their call light button and not have a resident wait for more than 15 minutes. The DON stated anybody from the facility ' s staff could respond to the call light. The DON stated Resident 1 should not have to wait 20 minutes for nursing staff to arrive. The DON stated the licensed nurse who was in the hallway while Resident 1 ' s call light indicator was on should have checked Resident 1. The DON stated the call light must be answered to avoid situations such as an emergency or worsening of conditions. During a record review of the facility ' s policy and procedure (P&P) titled, Residents Rights - Quality of Life, revised in March 2017, the P&P indicated, Each resident shall be cared for in a manner that promotes and enhances the quality of life, dignity, respect, individuality and receives services in a person-centered manner, as well as those that support the resident in attaining or maintaining his/her highest practicable well-being . Residents are groomed as they wish, including bathing, dressing and oral care. During a record review of the facility ' s P&P, titled, Communication Call System, dated 1/1/12, the P&P indicated, The Facility will provide a call system to enable residents to alert the nursing staff from their rooms and toileting/bathing facilities . III. Nursing Staff will answer call bells promptly, in a courteous manner . V. In answering to request, Nursing Staff will return to resident with the item or reply promptly .A. Assistance will be offered before leaving. Based on observation, interview and record review, the facility failed to provide treatment and care in accordance with professional standards of practice for one of two sampled residents (Resident 1) when Resident 1's call light was not answered in a timely manner. This failure had the potential to cause physical discomfort and emotional distress to Resident 1. Findings: During a record review of Resident 1's Admission Record, printed 12/31/24, the Admission Record indicated Resident 1 was admitted to the facility in May 2024 with multiple diagnoses that included congestive heart failure (a chronic condition where the heart can't pump blood efficiently) and type 2 diabetes (a long-term disease in which the body cannot regulate the amount of sugar in the blood). During a record review of Resident 1's Care Plan, dated 1/26/24, the Care Plan indicated Resident 1 had decreased ability to perform self-care related to impaired activity tolerance, impaired balance/safety, pain limiting function, weakness . (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 12/27/24, at 9:00 a.m., with Resident 1, Resident 1's room was located across the nurse's station. Resident 1's call light was within Resident 1's reach and located on the right side of his bed. Resident 1 stated the facility was always slow to answer the call lights. Resident 1 stated there were multiple occasions that he had to call the front desk because no one responded to his call light. Resident 1 stated the front desk paged the nursing staff assigned to him, but the nursing staff still took a long time until they arrived. Resident 1 stated there were times that he had to wait for hours for a CNA or a licensed nurse to assist him especially during the PM shift (3:00 p.m.-11:00 p.m.). Resident 1 stated the staff were just passing by even if his call light was on. Resident 1 stated he required staff's assistance in his ADL care because he was a fall risk. Resident 1 stated he felt he was being neglected and treated differently when the facility did not answer his call light promptly. During an observation on 12/27/24, at 9:52 a.m., in Resident 1's room, Resident 1 pressed his call light button. Resident 1's call light on indicator was lit inside Resident 1's room and at the nurse's station. A beeping sound was also heard while Resident 1's call light was continuously on. During an observation on 12/27/24, at 10:06 a.m., no staff entered the room to check on Resident 1. Multiple staff were observed passing by Resident 1's room while the call light was on. A licensed nurse was also observed stationed in the hallway, near Resident 1's room, working on the medication cart. The licensed nurse did not respond to Resident 1's call light. During an observation and interview on 12/27/24, at 10:12 a.m., with CNA 1, CNA 1 entered Resident 1's room after 20 minutes had passed. CNA 1 stated she was assisting another resident. CNA 1 stated nobody had informed her the call light was on in Resident 1's room. CNA 1 stated any staff from the facility could answer the call light. CNA 1 stated it was important for the call lights to be answered promptly to assess the residents' needs. During a follow up interview on 12/27/24, at 10:36 a.m., with RN 1, RN 1 stated the call light for Resident 1 should be answered promptly to check on Resident 1's needs. RN 1 stated waiting for 20 minutes for a staff to answer the call light was too long and could have been an emergency for Resident 1. During an interview on 12/27/24, at 12:38 p.m., with the DON, the DON stated the facility call light policy was to promptly check a resident when they pressed their call light button and not have a resident wait for more than 15 minutes. The DON stated anybody from the facility's staff could respond to the call light. The DON stated Resident 1 should not have to wait 20 minutes for nursing staff to arrive. The DON stated the licensed nurse who was in the hallway while Resident 1's call light indicator was on should have checked Resident 1. The DON stated the call light must be answered to avoid situations such as an emergency or worsening of conditions. During a record review of the facility's policy and procedure (P&P) titled, Residents Rights - Quality of Life , revised in March 2017, the P&P indicated, Each resident shall be cared for in a manner that promotes and enhances the quality of life, dignity, respect, individuality and receives services in a person-centered manner, as well as those that support the resident in attaining or maintaining his/her highest practicable well-being . Residents are groomed as they wish, including bathing, dressing and oral care. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of the facility's P&P, titled, Communication Call System, dated 1/1/12, the P&P indicated, The Facility will provide a call system to enable residents to alert the nursing staff from their rooms and toileting/bathing facilities . III. Nursing Staff will answer call bells promptly, in a courteous manner . V. In answering to request, Nursing Staff will return to resident with the item or reply promptly .A. Assistance will be offered before leaving. Based on observation, interview and record review, the facility failed to provide treatment and care in accordance with professional standards of practice for one of two sampled residents (Resident 1) when Resident 1's call light was not answered in a timely manner. This failure had the potential to cause physical discomfort and emotional distress to Resident 1. Findings: During a record review of Resident 1's Admission Record, printed 12/31/24, the Admission Record indicated Resident 1 was admitted to the facility in May 2024 with multiple diagnoses that included congestive heart failure (a chronic condition where the heart can't pump blood efficiently) and type 2 diabetes (a long-term disease in which the body cannot regulate the amount of sugar in the blood). During a record review of Resident 1's Care Plan, dated 1/26/24, the Care Plan indicated Resident 1 had decreased ability to perform self-care related to impaired activity tolerance, impaired balance/safety, pain limiting function, weakness . During an observation and interview on 12/27/24, at 9:00 a.m., with Resident 1, Resident 1's room was located across the nurse's station. Resident 1's call light was within Resident 1's reach and located on the right side of his bed. Resident 1 stated the facility was always slow to answer the call lights. Resident 1 stated there were multiple occasions that he had to call the front desk because no one responded to his call light. Resident 1 stated the front desk paged the nursing staff assigned to him, but the nursing staff still took a long time until they arrived. Resident 1 stated there were times that he had to wait for hours for a CNA or a licensed nurse to assist him especially during the PM shift (3:00 p.m.-11:00 p.m.). Resident 1 stated the staff were just passing by even if his call light was on. Resident 1 stated he required staff's assistance in his ADL care because he was a fall risk. Resident 1 stated he felt he was being neglected and treated differently when the facility did not answer his call light promptly. During an observation on 12/27/24, at 9:52 a.m., in Resident 1's room, Resident 1 pressed his call light button. Resident 1's call light on indicator was lit inside Resident 1's room and at the nurse's station. A beeping sound was also heard while Resident 1's call light was continuously on. During an observation on 12/27/24, at 10:06 a.m., no staff entered the room to check on Resident 1. Multiple staff were observed passing by Resident 1's room while the call light was on. A licensed nurse was also observed stationed in the hallway, near Resident 1's room, working on the medication cart. The licensed nurse did not respond to Resident 1's call light. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 12/27/24, at 10:12 a.m., with CNA 1, CNA 1 entered Resident 1's room after 20 minutes had passed. CNA 1 stated she was assisting another resident. CNA 1 stated nobody had informed her the call light was on in Resident 1's room. CNA 1 stated any staff from the facility could answer the call light. CNA 1 stated it was important for the call lights to be answered promptly to assess the residents' needs. During a follow up interview on 12/27/24, at 10:36 a.m., with RN 1, RN 1 stated the call light for Resident 1 should be answered promptly to check on Resident 1's needs. RN 1 stated waiting for 20 minutes for a staff to answer the call light was too long and could have been an emergency for Resident 1. During an interview on 12/27/24, at 12:38 p.m., with the DON, the DON stated the facility call light policy was to promptly check a resident when they pressed their call light button and not have a resident wait for more than 15 minutes. The DON stated anybody from the facility's staff could respond to the call light. The DON stated Resident 1 should not have to wait 20 minutes for nursing staff to arrive. The DON stated the licensed nurse who was in the hallway while Resident 1's call light indicator was on should have checked Resident 1. The DON stated the call light must be answered to avoid situations such as an emergency or worsening of conditions. During a record review of the facility's policy and procedure (P&P) titled, Residents Rights - Quality of Life , revised in March 2017, the P&P indicated, Each resident shall be cared for in a manner that promotes and enhances the quality of life, dignity, respect, individuality and receives services in a person-centered manner, as well as those that support the resident in attaining or maintaining his/her highest practicable well-being . Residents are groomed as they wish, including bathing, dressing and oral care. During a record review of the facility's P&P, titled, Communication Call System, dated 1/1/12, the P&P indicated, The Facility will provide a call system to enable residents to alert the nursing staff from their rooms and toileting/bathing facilities . III. Nursing Staff will answer call bells promptly, in a courteous manner . V. In answering to request, Nursing Staff will return to resident with the item or reply promptly .A. Assistance will be offered before leaving.

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	056359	A. Building B. Wing	01/02/2025

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

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 50474 Based on observation, interview, and record review, the facility failed to maintain a clean and sanitary environment for one of two sampled residents (Resident 1) when Resident 1 ' s room had: 1. Uncovered trash bin which contained an overflow of soiled diapers and dirty gloves. 2. Resident 1 ' s clothing stored in a mesh bag which was on the floor right next to the overflowing trash. This deficient practice had the potential to cause an unsanitary environment and spread of infection. Findings: During a record review of Resident 1 ' s Admission Record, printed on 12/31/24, the Admission Record indicated Resident 1 was admitted to the facility in May 2024 with multiple diagnoses that included congestive heart failure (a chronic condition where the heart can't pump blood efficiently) and type 2 diabetes (a long-term disease in which the body cannot regulate the amount of sugar in the blood). During an observation and interview on 12/27/24, at 8:55 a.m., with Resident 1, Resident 1 was sitting on his bed. Under Resident 1 ' s edge of the bed, there was a small trash bin with no covering which was overflowing with soiled diapers and dirty gloves. Right next to the uncovered trash bin, a pair of dirty gloves and a mesh bag with clothes inside were found on the floor. Resident 1 stated the mesh bag contained his dirty laundry. Resident 1 stated he did not know his laundry was still there because he had asked his Certified Nurse Assistant (CNA) from the previous shift to take it to the laundry. Resident 1 stated he did not know the uncovered trash bin was placed under the edge of his bed. Resident 1 stated it made him sick to his stomach to know that the trash bin with overflowing soiled diapers was close to his bed. Resident 1 stated he felt upset because the facility was not following the procedure in maintaining proper sanitary and clean rooms. During an interview on 12/27/24, at 9:40 a.m., with CNA 1, CNA 1 stated the uncovered overflowing trash with soiled diapers and the clothes in a mesh bag were already present when she arrived. CNA 1 stated the CNAs from the previous shift must have left them in Resident 1 ' s room. CNA 1 stated the trash bin should not have been left exposed and overflowing. CNA 1 stated the trash with soiled diapers should have been disposed of immediately after providing care to Resident 1. CNA 1 further stated Resident 1 ' s clothes in a mesh bag should have been placed in a plastic bag and brought to the laundry room. CNA 1 stated exposed and overflowing trash with soiled diapers and laundry with no plastic covering on the floor could cause the spread of infection. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/27/24, at 12:34 p.m., with the Director of Nursing (DON), the DON stated the CNAs were responsible for making sure the rooms were clean and sanitary. The DON stated the CNA who was assigned to Resident 1 should have thrown away the bag of trash with soiled diapers before leaving Resident 1 ' s room. The DON stated the CNAs should have placed Resident 1 ' s laundry in a plastic bag instead of leaving it on the floor. The DON stated these practices had risk of infection. During a record review of the facility ' s policy and procedure (P&P), titled, Resident Rooms and Environment, dated 1/1/12, the P&P indicated, The facility provides resident with a safe, clean, comfortable, and homelike environment .Facility staff aim to create a personalized, homelike atmosphere, paying close attention to .A. Cleanliness and order Based on observation, interview, and record review, the facility failed to maintain a clean and sanitary environment for one of two sampled residents (Resident 1) when Resident 1's room had: 1. Uncovered trash bin which contained an overflow of soiled diapers and dirty gloves. 2. Resident 1's clothing stored in a mesh bag which was on the floor right next to the overflowing trash. This deficient practice had the potential to cause an unsanitary environment and spread of infection. Findings: During a record review of Resident 1's Admission Record, printed on 12/31/24, the Admission Record indicated Resident 1 was admitted to the facility in May 2024 with multiple diagnoses that included congestive heart failure (a chronic condition where the heart can't pump blood efficiently) and type 2 diabetes (a long-term disease in which the body cannot regulate the amount of sugar in the blood). During an observation and interview on 12/27/24, at 8:55 a.m., with Resident 1, Resident 1 was sitting on his bed. Under Resident 1's edge of the bed, there was a small trash bin with no covering which was overflowing with soiled diapers and dirty gloves. Right next to the uncovered trash bin, a pair of dirty gloves and a mesh bag with clothes inside were found on the floor. Resident 1 stated the mesh bag contained his dirty laundry. Resident 1 stated he did not know his laundry was still there because he had asked his Certified Nurse Assistant (CNA) from the previous shift to take it to the laundry. Resident 1 stated he did not know the uncovered trash bin was placed under the edge of his bed. Resident 1 stated it made him sick to his stomach to know that the trash bin with overflowing soiled diapers was close to his bed. Resident 1 stated he felt upset because the facility was not following the procedure in maintaining proper sanitary and clean rooms. (continued on next page)

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