

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056359	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/30/2025
NAME OF PROVIDER OR SUPPLIER San Pablo Healthcare & Wellness Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview and record review, the facility failed to implement its policy and procedure to report an allegation of financial abuse and misappropriation of resident property as required by law and regulations to the appropriate agencies for one (Resident 1) of three sampled residents when Administrator did not notify law enforcement and report to the department when it was suspected that Certified Nursing Assistant/Customer Relations (CNA 1) used Resident 1's bank card with online purchases. Misappropriation of resident property and Financial Abuse- defined as the deliberate displacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent. This failure had the potential to place Resident 1 at risk for emotional distress, mistreatment, or abuse. During a 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 9/10/25, the MDS indicated Resident 1's Basic Interview of Mental status (BIMS, a scoring system used to determine the resident's cognitive status regarding attention, orientation, and ability to register and recall information. A BIMS score of thirteen to fifteen is an indication of intact cognitive status.) score was 11 and indicated mild cognitive impairment. The MDS indicated Resident 1 was not able to recall the day of the week. MDS indicated Resident 1 had clear speech, difficulty communicating some words or finish thoughts but able if prompted or given time. MDS indicated Resident 1 had adequate vision see fine detail, such as regular print in newspapers/books and does not use corrective lenses. MDS indicated Resident 1 had diagnoses that included anxiety disorder (a mental condition characterized by excessive and persistent feelings of anxiety and fear that interfere with daily life). During a review of Resident 1's progress notes titled, Social Services, dated 10/29/25, the social services notes indicated Resident 1 stated he believed that someone was using his bank card and online store account. The social services notes indicated facility assisted Resident 1 to replace debit card and change password for online store account and online bank account. The social services notes indicated facility informed Resident 1 that if he needed assistance with purchasing items from an online store to inform social services for assistance. During an interview on 12/4/25, at 10:28 a.m., with Resident 1, Resident 1 stated he believed that a staff that had assisted him with purchases online used his debit card on his online store account. Resident 1 stated facility was aware of his concern and the staff that had assisted Resident 1 with purchases. Resident 1 stated he did not want to talk about the staff anymore. Resident 1 stated facility had assisted him to change his password to his bank and online store account. During an interview on 12/4/25, at 11:15 a.m., with Social Services Director (SSD), SSD stated Resident 1 suspected that CNA 1 used his bank card to make purchases online. SSD stated Resident 1 asked CNA 1 to assist with purchases online. SSD stated facility asked the bank to replace Resident 1's bank card. SSD stated initially facility did not take it seriously when implementing intervention to replace Resident 1's bank card. During an interview on 12/4/25, at 11:30 a.m., with Administrator (Admin) and SSD, Admin stated Resident 1 complained to the department head that there were missing items regarding use of Resident 1's bank card. Admin stated the incident was assigned to social services with expectation to do a search and check inventory. Admin stated he did not report incident to appropriate agencies, i.e., Police and Licensing and Certification department. During an interview on 12/4/25, at 12:18 p.m., with CNA 1, CNA 1 stated Resident 1 asked for help with purchases online. CNA 1 stated, in Resident 1's presence, that he helped Resident 1 enter Resident 1's bank card number online while Resident 1 picked items to be purchased. CNA 1 stated Resident 1 had vision problems so CNA 1 helped Resident 1 in case Resident 1 could not see well. CNA 1 stated he helped Resident 1 return some of the items purchased. CNA 1 stated he received the purchases at the facility for Resident 1 and updated Resident 1's inventory list. CNA 1 stated SSD asked CNA 1 to stop assisting Resident 1 with online purchases because Resident 1 may allege theft of properties or money. During a review of Resident 1's Resident Inventory List dated 7/20/25, 8/30/25, 8/31/25, 9/16/25, 10/11/25, 9/12/23, and 9/18/25, Resident 1's inventory list indicated duplicate personal items on records i.e. shoes, shirts, sunglasses, watch, magnetic bracelet, short sleeves, long sleeve shirts etc. During an interview on 12/4/25, at 1:08 p.m., with Admin and DON, Admin stated facility did not report to appropriate agencies as required by law because there was no missing money from Resident 1's bank account. During a review of the facility's policy and procedure, titled, Abuse Prevention and Management, dated 2022 indicated, The facility will report all allegations of abuse and criminal activity as required by law and regulations to the appropriate agencies.</p>		