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	02/19/2026

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 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. Based on interviews and record review, the facility failed to implement its policy and procedure for injuries of unknown origin to thoroughly investigate an unexplained injury of unknown source for one (Resident 1) of three sampled residents when facility did not know how Resident 1's right great toenail fell off exposing the nail bed. This failure had the potential to cause pain and placed Resident 1 at risk for emotional distress, mistreatment or abuse, and further injury.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 12/21/25, 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 difficulty communicating some words or finish thoughts but able if prompted or given time. MDS indicated Resident 1 had diagnoses that included seizure disorder or epilepsy. During a review of progress notes titled, Change in Condition Evaluation (COC), dated 2/13/26, COC indicated Certified Nursing Assistant (CNA) 1 reported a complete nail avulsion (the partial or complete tearing away of toenail from nail bed) on Resident 1's right foot, dry, red in appearance. Resident 1 was aphasic and could not describe what happened. During an observation on 2/19/26, at 11:33 a.m., Resident 1 laid in bed on her back asleep. Observed bed in lower position. Resident 1's right great toe was covered with a dressing. Resident 1's feet were close to footboard. Further review of COC, dated 2/13/26, indicated that Resident 1 often dangled her feet outside her bed at times hitting the hard parts of the bed and nearby table, causing damage on her skin and nails. During an interview on 2/19/26, at 11:45 a.m., with Certified Nursing Assistant (CNA1), CNA1 stated she found Resident 1's right great toe without nail and reported to Licensed Vocational Nurse (LVN 1). CNA1 stated she did not know how the nail fell off. During an interview on 2/19/26, at 11:55 a.m., with LVN 1, LVN 1 stated that CNA 1 informed LVN 1 that Resident 1's right great toenail fell off and CNA 1 did not know what happened. LVN 1 stated he asked other nurses, and no one knew how Resident 1's right great toenail fell off. During a concurrent interview and record review on 2/19/26, at 12:20 p.m., with LVN 1 and Director of Nursing (DON), Resident 1's COC and right great toenail avulsion care plan dated 2/13/26 were reviewed. LVN 1 stated staff did not know what happened with Resident 1's right great toenail avulsion. LVN 1 stated he assumed it may be because Resident 1 dangled feet outside of bed. During a concurrent interview and record review on 2/19/29, at 12:50 p.m., with DON, Resident 1's care plan was reviewed. DON stated facility did not investigate the source of the injury to Resident 1's right great toenail that fell off because there was an assumption that Resident 1 at times hit leg on the hard parts of bed. DON stated that the interdisciplinary team (IDT-a professional discipline that works together to provide the greatest benefit to the resident (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	which included the resident, the resident's family and/or representative, whenever possible, develops and implements approaches to care that are both clinically and appropriate and person - centered.) did not review Resident 1's injury to right great toenail. During a review of the facility's policy and procedure (P&P), titled, Injury of Unknown Origin-Investigation, revised November 18, 2015, P&P indicated, To protect the health and safety of residents by ensuring that all unexplained injuries are promptly and thoroughly investigated and addressed .An injury of unknown source is defined as an injury that meets both of the following conditions: The source of the injury was not observed by any person, or the source of the injury could not be explained by the resident; andThe injury is suspicious because of the extent of the injury; the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma; the number of injuries observed at one particular point in time; or the incidence of injury over time.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview, and record review, the facility failed to ensure one (Resident 1) of three sampled residents' behavior of dangling feet outside bed at times hitting the hard parts of the bed and nearby table were addressed on care plan with appropriate interventions. This failure had the potential to place Resident 1 at risk for pain and injuries.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 12/21/25, 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 difficulty communicating some words or finish thoughts but able if prompted or given time. MDS indicated Resident 1 had diagnoses that included seizure disorder or epilepsy. During a review of progress notes titled, Change in Condition Evaluation (COC), dated 2/13/26, COC indicated Certified Nursing Assistant (CNA) 1 reported a complete nail avulsion the partial or complete tearing away of toenail from nail bed) on Resident 1's right foot, dry, red in appearance. Resident 1 was aphasic and could not describe what happened. During an observation on 2/19/26, at 11:33 a.m., Resident 1 laid in bed on her back asleep. Observed bed in lower position. Resident 1 right great toe covered with a dressing. Resident 1's feet were close to the footboard, and there were no devices noted to prevent Resident 1's foot from kicking the foot board. Further review of COC, dated 2/13/26, indicated that Resident 1 often dangled her feet outside her bed, at times hitting the hard parts of the bed and nearby table, causing damage on her skin and nails. During an interview on 2/19/26, at 11:45 a.m., with Certified Nursing Assistant (CNA 1), CNA1 stated she found Resident 1's right great toe without nail and reported to Licensed Vocational Nurse (LVN 1). CNA1 stated she did not know how the nail fell off. During an interview on 2/19/26, at 11:55 a.m., with LVN 1, LVN 1 stated that CNA 1 informed LVN1 that Resident 1 right great toenail fell off, and CNA 1 did not know what happened. LVN 1 stated he asked other nurses, and no one knew how Resident 1's right great toenail fell off. During a concurrent interview and record review on 2/19/26, at 12:20 p.m., with LVN1 and Director of Nursing (DON), Resident 1's COC and right great toenail avulsion care plan, dated 2/13/26, were reviewed. LVN 1 stated staff did not know what happened with Resident 1's right great toenail avulsion. LVN 1 stated he assumed it may be because Resident 1 dangled feet outside the bed. During a concurrent interview and record review on 2/19/29, at 12:50 p.m., with DON, DON stated there was an assumption that Resident 1 at times hit leg on the hard parts of bed. DON stated facility's interdisciplinary team (IDT-a professional discipline that worked together to provide the greatest benefit to the resident which included the resident, the resident's family and/or representative, whenever possible, develops and implements approaches to care that are both clinically and appropriate and person - centered) had not addressed Resident 1's behavior of dangling feet outside the bed and at times hitting legs on hard parts of bed, with care plan interventions.