

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 03/30/2026
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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record reviews, the facility failed to prevent the elopement (a resident leaving the facility unsupervised or without permission) of one of two sampled residents (Resident 1), when staff did not relock the front main door at 6:30 a.m. after letting kitchen staff enter the facility. This failure resulted in Resident 1 leaving the facility unsupervised and without permission and placed the resident at risk for exposure to unfavorable weather conditions and possible injuries. During a review of Resident 1's admission record, printed 1/29/2026, the admission record indicated the resident was admitted to the facility in November 2025 11/26/25 with a diagnosis of encephalopathy (any disease, damage or malfunction that affects the brain's structure or function, resulting in an altered mental status), traumatic brain injury (a disruption in brain function caused by a blow, jolt or penetrating head injury) without loss of consciousness, unsteadiness of feet and type 2 diabetes mellitus (a disorder characterized by high blood sugar) with kidney disease. During a review of Resident's 1 Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 11/3/25, the MDS indicated a Brief Interview for Mental Status (BIMS-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) summary score of 11 out of 15. A score of eleven (11) indicated moderate cognitive decline: may include forgetting daily routines or making minor errors. Section E of the MDS evaluated Resident 1's behaviors and indicated the resident had not exhibited any wandering behaviors. Section GG of the MDS for functional abilities indicated the resident required supervision, verbal cues and touching assistance as the resident completed activities and range of motion for upper or lower extremity without limitations. Resident 1's Minimum Data Set, dated [DATE] indicated Resident1 had memory problems and was moderately impaired when making decisions regarding tasks of daily life. Section GG of the MDS indicated no changes in functional abilities. During a concurrent interview and record review on 1/29/26, at 12:00 p.m., with the Director of Nursing (DON), the facility investigative summary dated 11/27/25 was reviewed. The Investigative summary indicated that the resident had removed his wander guard and exited the facility through the unlocked front door without supervision or authorization. The DON stated the front door was unmanned and facility staff were busy with other resident care activities. The DON stated, during his interview of the kitchen staff, that the kitchen staff stated they unlocked the front door to allow another kitchen staff in and forgot to relock the door as it was almost 7:00 a.m. The resident returned to the facility on [DATE]. During a review of Resident's 1 Situation, Background, Assessment, Recommendation communication form (SBAR), dated 10/31/25, the SBAR form indicated around 9:05 p.m. on 10/31/25, Resident 1, unattended, exited the facility through an emergency door. The SBAR indicated Resident 1 was observed walking away from the facility, where three staff followed and attempted to redirect Resident 1 back to the facility. During a review of Resident 1's elopement evaluation, dated 10/31/25, the elopement evaluation indicated Resident 1 had a history of elopement or attempted leaving the facility without informing staff, the resident wandered, the resident had expressed the desire to go home, wandering behavior was goal directed and the wandering was likely to affect safety of self and others. During a (continued on next page)</p>

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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>review of the care plan for risk of wandering/elopement, initiated on 10/31/25 and reviewed on 12/02/25, the care plan did not include the wander guard as an intervention. During a review of the Interdisciplinary (IDT) note, dated 11/25/25, the IDT note indicated at approximately 6:30 a.m. the staff noted Resident 1 was not present on the unit during routine rounding. There was no witness to the departure. The resident elopement was confirmed by reviewing the close circuit television footage. During a review of Resident 1's elopement evaluation, dated 11/27/25, the elopement evaluation indicated the resident had a history of elopement or attempted leaving the facility without informing staff, the resident wandered, the resident had expressed the desire to go home, wandering behavior was goal directed and the wandering was likely to affect safety of self and others. During a review of Resident 1's progress note, dated 11/28/25, the progress note indicated the resident continued to demonstrate noncompliance with wearing the assigned wander guard. Resident was assessed as a high elopement risk, with a pattern of attempts to leave the unit and exit seeking behaviors. During an interview on 2/6/26, at 12:24 p.m., with the DON, the DON stated staff unlocked the front main door on 11/25/25 to allow the kitchen staff to enter and forgot to relock the door as it was almost 7:00 a.m. DON stated he did interview the staff who unlocked the door, but the investigation summary lacked the written interviews. Other attempts to interview the staff who unlocked the main front door was unsuccessful. During a review of the facility's policy and procedure (P&P) titled, Wandering and Elopement, dated 1/31/23, the P&P indicated elopement is a behavior that leads to a resident leaving the facility unsupervised or without permission. If the resident exits the facility despite efforts to stop them, a staff member may accompany or follow the resident. During a review of the facility's P&P titled, Unusual Occurrence reporting, dated 5/30/24, the P&P indicated, the investigation and documentation should include but is not limited to interviews with residents, staff and any other witnesses.</p>		