| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 056359 | A. Building<br>B. Wing | 06/26/2025 |

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| San Pablo Healthcare & Wellness Center | 13328 San Pablo Avenue<br>San Pablo, CA 94806 |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>Based on observation, interview, and record review, the facility failed to treat one of two sampled residents (Resident 72) with dignity and respect when a staff member discussed Resident 72's diagnosis and condition while having lunch in front of another resident.<br><br>This failure had the potential to affect Residents 72's privacy and psychosocial well-being.<br><br>Findings:<br><br>During a record review of Resident 72's admission Record (AR), printed on 6/24/25, the AR indicated Resident 72 was admitted to the facility in May 2024 with diagnoses of Parkinsonism (a group of neurological conditions that share similar motor symptoms with Parkinson's disease, such as tremors, stiffness, and slow movement) and dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life.)<br><br>During a dining observation and interview on 6/23/25 at 12:20 p.m. with Activity Assistant (AA), without being asked, AA stated she was going to help Resident 72 during lunch because Resident 72 had Parkinson's disease (a progressive neurological disorder that primarily affects movement, causing symptoms like tremors, stiffness, and slow movement) and Resident 72's hands were shaking.<br><br>During a dining observation on 6/23/25 at 12:28 p.m., Resident 72 and another resident were seated right in front of AA during lunch. AA was feeding Resident 72 pureed meat and vegetables. Without being asked again, AA suddenly stated out loud, She has Parkinson's. Look, her hands are shaking. She's deaf. She cannot hear. while the other resident was in front of them and other residents were close by.<br><br>During a follow up interview on 6/23/25 at 12:48 p.m. with AA, AA stated she wanted to share Resident 72's conditions because she was assisting Resident 72. AA stated she got nervous and stated Resident 72's condition twice even if she was not asked for such information. AA stated she should not have said Resident 72's diagnosis and condition out loud because it was a Health Insurance Portability and Accountability Act (HIPAA, is a federal law that sets national standards for protecting sensitive patient health information. It aims to ensure patient privacy and security while also allowing for the flow of health information needed for patient care and public health.) violation.<br><br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 6/24/25 at 10:13 a.m. with the Director of Nursing (DON), the DON stated the staff who were assigned in the dining room during mealtimes were not supposed to disclose residents' diagnosis or personal information to others for privacy and dignity. The DON stated Resident 72's dignity and self esteem could have been affected when AA discussed Resident 72's information in front of the other resident.<br><br>During a record review of the facility's policy and procedure (P&P), titled, Resident 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 quality of life, dignity, respect, individuality and receives in a person-centered manner, as well as those that support the resident in attaining or maintaining his/her practicable well-being .Facility staff shall maintain an environment in which is confidential clinical information is protected .communication is conducted outside the hearing range of residents and public .Facility staff treats cognitively impaired residents with dignity and sensitivity |

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| F 0645<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | PASARR screening for Mental disorders or Intellectual Disabilities<br><br>Based on interview and record review the facility failed to ensure to refer the resident to the appropriate state-designated authority for level II PASARR evaluation for one of two sample selected resident (Resident 37) when Resident 37 was positive for level I PASARR (the preliminary screening process has identified a potential mental illness or intellectual/developmental disability), and did not refer for PASARR II evaluation.<br><br>This failure could result in placement in an inappropriate facility, lack of needed mental health services and increase of behavioral issues or hospitalizations.<br><br>Findings:<br><br>A review of Resident 37's admission Record indicated Resident 37 was admitted to the facility with diagnosis of Depression and Post Traumatic Stress Disorder (PTSD [a mental health condition that's caused by an extremely stressful or terrifying event, either being part of it or witnessing it. Symptoms may include flashbacks, nightmares, severe anxiety and uncontrollable thoughts about the event]).<br><br>During a review of Preadmission Screening and Resident Review (PASARR) Level one Screening dated 2024 indicated . Result of Level Screening: Level I- Positive .<br><br>During a concurrent interview and record review on 6/25/25 at 11:00 a.m., with the Minimum Data Set's coordinator (MDSC), MDSC stated that MDSC is responsible to review the residents PASARR and follow up with level II as needed, and when resident has PASARR level one positive it means resident can have serious mental illnesses and need level II evaluation to see if resident needs higher level of care. MDSC confirmed that they did not do PASARR II evaluation for Resident 37 and stated, they missed it.<br><br>A review of the facility's policy and procedure Pre-admission Screening Level II Resident Review NP-104B (PASARR Level II) revised July 2018, indicated . The facility staff will coordinate the recommendations from the level II PASARR determination and PASARR evaluation report with the resident's assessment, care planning and . |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>Based on observation, interview, and record review, the facility failed to ensure standards of professional practice were maintained during medication administration for four of four sampled residents (Residents 52, 253, 56 and 93) when licensed nurse pre-poured (generally refers to medications that have been prepared in advance and are ready for administration, rather than being prepared immediately before use) Residents 52, 253, 56 and 93's medication.<br><br>This failure had the potential for a significant medication error that can lead to serious harm or even death.<br><br>Findings:<br><br>During a record review of Resident 52's admission Record (AR), printed on 6/25/25, the AR indicated Resident 52 was admitted to the facility in March 2025 with diagnoses of chronic obstructive pulmonary disease (COPD, a group of lung diseases that cause airflow blockage and breathing problems) and anxiety disorder (a group of mental health conditions characterized by excessive, persistent fear and worry that can significantly interfere with daily life).<br><br>During a record review of Resident 253's AR, printed on 6/25/25, the AR indicated Resident 253 was admitted to the facility in June 2025 with diagnoses of multiple fractures (broken bone) of ribs and senile degeneration of the brain (neurological disorder that is tied to cognitive decline, memory impairment, and changes in behavior).<br><br>During a record review of Resident 56's AR, printed on 6/25/25, the AR indicated Resident 56 was admitted to the facility in May 2025 with diagnoses of end stage renal disease (the final stage of chronic kidney disease where the kidneys have severely reduced or completely stopped functioning) and congestive heart failure (a condition where the heart doesn't pump blood as efficiently as it should, leading to a buildup of fluid in the body).<br><br>During a record review of Resident 93's AR, printed on 6/25/25, the AR indicated Resident 93 was admitted to the facility in June 2025 with diagnoses of Fournier's gangrene (a severe and rapidly progressing necrotizing fasciitis, or flesh-eating disease, affecting the genitals, perineum, and surrounding areas) and type 2 diabetes mellitus (a chronic condition where the body doesn't use insulin properly, leading to high blood sugar levels).<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an observation and interview on 6/25/25, at 11:10 a.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 was inside Resident 56's room talking to Resident 56's roommate while she was holding a medication tray and the portable vital signs machine was right next to her. After talking to Resident 56's roommate, LVN 1 came out of the room while rolling the portable vital signs machine and carrying a medication tray that had multiple plastic cups of water and multiple medication cups with orals pills inside. LVN 1 proceeded to the nurse's station and sanitized the vital signs machine, while she was still holding the medication tray with her other hand. LVN 1 pushed the portable rolling vital signs machine back to the hallway and entered Resident 52 and Resident 93's room. LVN 1 placed the same medication tray she was carrying inside Resident 56's room on top of a tray table. LVN 1 assessed Resident 52's vital signs. LVN 1 asked Resident 52 if he was having anxiety because Resdient 52's heart rate was elevated. Resident 52 replied, yes to LVN 1. LVN 1 informed Resident 52 that the antianxiety medication was ready for administration. After taking Resident 52's vital signs, LVN 1 took one medication cup from the medication tray. The medication cup had a label that showed Resident 52's room number. LVN 1 admistered the oral medication to Resident 56. LVN 1 stated the medication cups in the medication tray were pre-poured for Residents 52, 253, 56 and 93.<br><br>During a follow up interview on 6/25/25, at 11:23 a.m., with LVN 1, LVN 1 stated she prepared the medications ahead of time because it always made her medication pass and administration a lot faster. LVN 1 stated she left the medication cart by the nurse's station because she did not like pushing it because it was hard for her to move it around the hallway. LVN 1 stated she did not know what the facility's policies were for medication administration and that she was trained by her preceptor to perform pre-pour technique when passing the medications. LVN 1 stated she did not think there were any risks for medication errors with pre-poured medications. LVN 1 stated she memorized all the medications that she prepared for her residents. LVN 1 further stated if she accidentally knocked the medication cups and the tablets or capsules were mixed, LVN 1 stated she would just have to waste (medications that are discarded or thrown away) the medications and start over again in preparing them.<br><br>During an interview on 6/25/25, at 11:28 p.m., with the Director of Nursing (DON), the DON stated the licensed nurses were supposed to give medications to one resident at a time. The DON stated the licensed nurses were expected to bring their medication carts and prepare medications right before they administer them to a resident. The DON stated the licensed nurses were also expected to verify the resident through the electronic health record before entering a resident's room. The DON stated LVN 1 should never have prepared the medications for Residents 52, 253, 56 and 93 ahead of time because it had a great risk of medication errors and break in infection control. The DON further stated there was no way LVN 1 could have memorized all the medications she prepared. The DON stated some residents were not able to identify their medications and they could have taken the medications that were not meant for them.<br><br>During a record review of the facility's policy and procedure (P&P), titled, Medication Administration-General Guidelines, effective October 2017, the P&P indicated, Medications are administered as prescribed in accordance with good nursing principles and practices .Procedures .B. Administration .4. Medications are administered at the time they are prepared. Medications are not pre-poured .7. Residents are identified before medication is administered. Methods of identification include .b. Checking photograph attached to medical record .C. Documentation .1. The individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given . |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.<br><br>Based on observation, interview, and record review, the facility failed to provide appropriate care and services related to enteral feeding (also referred to as tube feeding, is the delivery of nutrients through a feeding tube directly into the stomach, duodenum, or jejunum) nutrition for one sampled resident (Resident 252) on a feeding tube when Resident 252 did not receive the calculated amount of tube feeding formula (designed to provide nutrition to individuals who cannot consume adequate food orally) per physician's order.<br><br>This failure had the potential to cause dehydration, weight loss, and gastrointestinal (GI, relating to stomach and intestines) problems such as abdominal pain and diarrhea.<br><br>Findings:<br><br>During a record review of Resident 252's admission Record (AR), printed on 6/25/25, the AR indicated Resident 252 was admitted to the facility in April 2025 with diagnoses of traumatic subarachnoid hemorrhage (bleeding into the space surrounding the brain caused by head trauma) and gastrostomy status (refers to the presence of a gastrostomy tube, a surgically placed tube into the stomach for feeding or medication administration).<br><br>During record review of Resident 252's Order Summary Report, dated 6/25/25, the record indicated Resident 252 had an active physician order with a start date on 5/23/25 to provide Resident 252 the formula of Jevity 1. 5 (calorically dense, fiber-fortified therapeutic nutrition that provides complete, balanced nutrition for long- or short-term tube feeding) at 75 millimeters (ml, a unit of volume)/hour for 20 hours to provide a total of 1550 ml formula. The order also showed Resident 252's enteral feeding should have been off from 8:00 a.m. to 12:00 p.m. everyday.<br><br>During an observation and interview on 6/25/25, at 8:20 a.m., with Licensed Vocational Nurse (LVN) 1, Resident 252 was sleeping in the bed while the tube feeding was being administered. Resident 252's feeding formula bottle that was half full and the feeding pump machine showed Resident 252 was receiving a volume rate of 60 ml/hour. When asked about the physician's orders including the total volume of formula per day and the time the tube feeding pump had to be stopped, LVN 1 stated Resident 252's enteral feeding was continuous for 24 hours every day.<br><br>During a follow up interview on 6/25/25, at 11:22 a.m., with LVN 1, LVN 1 confirmed that she did not know Resident 252 had an order to receive 75 ml/hour of enteral feeding for 20 hours a day. LVN 1 stated she thought Resident 252's feeding amount per hour had always been 60 ml/hour. LVN 1 also stated she did not know that Resident 252's enteral feeding had to be off at 8:00 a.m. and start the daily feeding at 12:00 p.m. everyday. LVN 1 stated she only replaced Resident 252's formula bottle whenever it was almost empty. LVN 1 stated the correct enteral feeding nutrition order should have been followed because Resident 252 could have had malnutrition and dehydration.<br><br>During an interview on 6/25/25, at 11: 29 a.m., with the Registered Dietician (RD), the RD stated when her recommendations were approved by the physician, she would have expected the licensed nurse to carry out the order. RD stated Resident 252 was at risk for weight loss because Resident 252 received less amount of the enteral nutrition than what she had recommended.<br><br>(continued on next page) |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 6/25/25, at 11:35 a.m., with the Director of Nursing (DON), the DON stated the licensed nurses were responsible in making sure enteral feeding orders were verified every shift. The DON stated LVN 1 should have assessed Resident 252 and verified the enteral feeding orders every time she was assigned to Resident 252. The DON stated he expected the licensed nurses to follow the correct orders when providing enteral nutrition to the residents. The DON stated residents who did not receive enough nutrition were also at risk for infections and delayed healing because they were not getting enough nutrients.<br><br>During a record review of the facility's policy and procedure (P&P), titled, Enteral Feeding - Closed, dated 1/1/12, the P&P indicated, Enteral feeding will be administered via pump as ordered by the attending physician .Review order for feeding .Calculate the amount of formula to be given per shift per attending physician's order of volume per hour . |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.<br><br>Based on observation, interview, and record review, the facility failed to serve food for four of 12 sampled residents (Residents 22, 56, 38 and 254) that was palatable when food was bland (lacked flavor).<br><br>This failure had the potential to result in a negative dining experience that could lead to poor dietary intake, compromising the health and nutritional status of Residents 22, 56, 38 and 254 who received food from the kitchen.<br><br>Findings:<br><br>During an observation and interview on 6/23/25, at 10:41 a.m. with Resident 22, Resident 22 stated the facility's food always tasted bland and lacked flavor. Resident 22 stated, Look at those salt and pepper I have on my table. That's how terrible their food is. Resident 22's tray table had plastic cups that contained multiple packets of salt and pepper. Resident 22 also had a personal small saltshaker. Resident 22 stated the facility's food had no flavor at all.<br><br>During an interview on 6/23/25, at 11:45 a.m., with Resident 56, Resident 56 stated the facility's food could have been better because the food they served did not have a taste at all.<br><br>During an interview on 6/23/25, at 11:51 a.m., with Resident 38, Resident 38 stated the facility's food was awful and did not taste good. Resident 38 stated most entrees served by the kitchen were always bland and lacked taste.<br><br>During a dining observation and interview on 6/23/25, at 12:36 p.m., in the dining room with Resident 254, Resident 254 was having lunch and observed complaining about his food to a staff. Resident 254 stated the meal that was served during lunch did not have a taste at all and it needed more flavor and seasoning. Resident 254 stated, I thought this place was meant to provide healthy and tasty food. They always mess up with my food.<br><br>During a record review of the daily menu, dated 6/25/25, the lunch menu indicated the residents received fish, tartar sauce, scalloped potatoes, and Italian herb vegetables.<br><br>During a concurrent observation an interview on 6/25/25, at 1:00 p.m., with Registered Dietician (RD) and Dietary Services Supervisor (DSS), a test tray was conducted. The test tray contained the same regular texture and pureed food served to residents for lunch. The food was tasted by three surveyors, RD, and DSS. All three surveyors agreed that the regular fish and the scalloped potatoes were bland and lacked flavors. DSS stated she could only taste the oregano seasoning in the fish.<br><br>During a follow up interview on 6/26/25, at 10:34 a.m., with DSS, DSS stated it was important for the residents to receive flavorful meals for residents to enjoy their food preference and promote dignity.<br><br>During a record review of the facility's P&P, titled, Standard Recipes, dated 7/1/14, the P&P indicated, Recipe accuracy concerns will be reported to the Dietician for evaluation and modification as necessary. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, interview, and record review, the facility failed to ensure the ice supply was stored and prepared under sanitary conditions when there was reddish-brown matter inside the residents' ice machine and around the ice chute dispenser.<br><br>These failures had potential to put residents at risk for food borne illness (an illness that comes from eating contaminated food and infection) and cross-contamination (transfer of bacteria or other microorganisms from one substance to another) that could have resulted in infection or spread of infection.<br><br>Findings:<br><br>During an observation and interview on 6/24/25 at 2:10 p.m. with the Maintenance Director (MD) and Registered Dietician (RD). MD opened the ice machine, and it showed a reddish-brown matter inside the back part of the ice container and around the ice chute dispenser. Using a paper towel, RD wiped the visible reddish-brown matter. RD showed the reddish-brown matter was transferred to the paper towel she used. RD stated she did not know what it was or where it came from. MD stated the reddish-brown matter looked like a residue that could have been left from the last time the machine was cleaned. MD stated the ice machine should have been maintained and cleaned and not have any residues at all. MD stated the dirty ice machine had the potential to contaminate the ice that was supplied to the residents.<br><br>During an interview on 6/24/25 at 2:16 p.m. with the Director of Nursing (DON), the DON stated the ice machine should have been always cleaned and free from any dirt to prevent any food borne illnesses. The DON stated the residue that was found in the ice machine could have caused food poisoning to the residents.<br><br>During a record review of the facility's policy and procedure (P&P), titled, Ice Machine - Operation and Cleaning, revised on October 1, 2014, the P&P indicated, The dietary staff will operate the ice machine according to the manufacturer's guidelines. The ice machine will be cleaned routinely .II. Sanitation of Equipment .F. On no less than a monthly basis, remove ice to wash inside of the machine .H. Sanitize the inside of the machine using a sanitizing solution and a clean cloth .<br><br>During a record review of the Food and Drug Administration (FDA) Federal Food Code 2022, the food code indicated, 4-601.11 .Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils . Equipment food-contact surfaces and Utensils shall be clean to sight and touch. |

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|---|---|
| F 0912<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Many | Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility had 12 residents (Rt)'s rooms (room [ROOM NUMBER],10, 11, 15, 16, 17, 22, 25, 26, 29, 30, and 40) with multiple beds that provided less than 80 square feet (sq. ft) per resident who occupied these rooms.<br><br>This deficient practice had potential to result in inadequate space for delivery of care to each of the residents in each room, or for storage of the resident's belongings.<br><br>Findings:<br><br>During an observation on 6/23/25, at 11;00 a.m., the following rooms and corresponding square footage per bed were identified:<br><br>Room Activity Room size Floor area<br><br>3 Rt room [ROOM NUMBER] in x 227 in 78 sq. ft per bed<br><br>10 Rt room [ROOM NUMBER].5 in x 155.5 in 71.54 sq. ft per bed<br><br>11 Rt room [ROOM NUMBER].5 in x 227 in 79.6 sq. ft per bed<br><br>15 Rt room [ROOM NUMBER] in x 156 in 72.58 sq. ft per bed<br><br>16 Rt room [ROOM NUMBER] in x 156 in 79.08 sq. ft per bed<br><br>17 Rt room [ROOM NUMBER] in x156 in 79.08 sq. ft per bed<br><br>22 Rt room [ROOM NUMBER] in x 156 in 77.66 sq. ft per bed<br><br>25 Rt room [ROOM NUMBER] in x 224.5 in 79 sq. ft per bed<br><br>26 Rt room [ROOM NUMBER] in x 224.5 in 79.51 sq. ft per bed<br><br>29 Rt room [ROOM NUMBER].5 in x 226.5 in 79.43 sq. ft per bed<br><br>30 Rt room [ROOM NUMBER] in x 156 in 75.02 sq. ft per bed<br><br>40 Rt room [ROOM NUMBER] in x 227 in 79.34 sq. ft per bed<br><br>During random observations of care and services from 6/23/25 to 6/26/25, there was sufficient space for the provision of care for the residents in all rooms. There was no heavy equipment kept in the rooms that might interfere with residents' care and each resident had adequate personal space and privacy. There were no complaints from the residents regarding insufficient space for their belongings. There were no negative consequences, attributed to the decreased space and/or safety concerns in the five rooms.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056359 | A. Building<br>B. Wing | 06/26/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| San Pablo Healthcare & Wellness Center | 13328 San Pablo Avenue<br>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 0912<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Many | Granting of room size waiver recommended. |