STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055331	A. BUILDING _____ B. WING _____	C 06/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAN RAFAEL HEALTHCARE & WELLNESS CENTER, LP	1601 5TH AVENUE SAN RAFAEL, CA 94901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an abbreviated survey for the investigation of one (1) complaint #CA00964792 and two (2) facility reported incidents #CA00964378 and #CA00964832. The inspection was limited to the specific complaint and facility reported incidents investigated and does not represent the findings of a full inspection of the facility. There was no deficiency issued for Facility Reported Incident Numbers: CA00964378 and CA00964832 There were three deficiencies issued for Complaint Number: CA00964792 (Refer to F557, F658, and F880)	F 000		Atom Vaughn POC and EOC approved 7/9/25 BIC 7/1/25
F 557 SS=D	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record reviews, the facility failed to ensure two out of five sampled residents (Resident 1 and Resident 2) were treated with respect and dignity when:	F 557		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Robert Bauman | TITLE: Administrator | (X6) DATE: 6/25/25

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.

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F 557	Continued From page 1 1. A call light (a signal that residents in healthcare facilities use to alert staff when they need assistance) was not answered timely by facility staff, and 2. A foley catheter (FC, a hollow tube inserted into the bladder to drain or collect urine) drainage bag (bag that collects the drained urine) did not have a privacy cover. These failures had the potential to negatively affect residents' sense of dignity and privacy. [AV3] Findings: A review of Resident 1's face sheet (front page of the chart that contains a summary of basic information about the resident) indicated Resident 1 was admitted to the facility in May of 2025 with diagnoses including Chronic Pain Syndrome (CPS, pain that lasts longer than three months) and Functional Quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury). A review of Resident 1's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 5/11/25, indicated Resident 1 was dependent on staff (staff does all the efforts and resident does none of the effort to complete the activity) for care with toileting and personal hygiene. A review of Resident 2's face sheet indicated Resident 2 was admitted to the facility in March of 2022 with diagnoses including Dysphagia	F 557		

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F 557	Continued From page 2 (difficulty swallowing) and a need for assistance with personal care. A review of Resident 2's Brief Interview for Mental Status (BIMS, an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident), dated 3/7/25, indicated a score of 15, cognition in tact and no assessed memory problems. 1.During a concurrent observation and interview on 6/3/25 at 11:21 a.m., the call light for room 1 was on, indicating a need for assistance, and multiple staff were observed passing by without responding to the call light. Unlicensed Staff A, when stopped, stated she was a new employee and looked at the call light but did not respond to the residents in room 1 that were signaling for assistance. During an interview on 6/3/25 at 11:23 a.m., Resident 1 in room 1 acknowledge the call light was on for assistance and stated staff does not respond to the call light promptly. Resident 1 stated previously she had to wait for hours before staff answered her call light. Resident 1 stated sometimes she would yell and still no one would come. Resident 1 stated when staff do not respond to the call light promptly, she felt like staff did not care about her. During a concurrent observation and interview on 6/3/25 at 11:39 a.m., Licensed Nurse (LN) B verified the call light for room 1 was still on. LN B stated everyone was responsible for answering call lights, and added, since everyone oversees answering call lights, call lights must be	F 557		

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F 557	Continued From page 3	F 557		

answered promptly, at least within 3 to 5 minutes. LN B stated there was no reason why a call light should not be answered promptly since anyone could answer it. LN B stated it was not acceptable for residents to wait over 15 minutes for call light to be answered. LN B stated not answering call light timely could make residents feel like staff did not recognize their needs or that the residents' needs did not matter.

During an interview on 6/3/25 at 11:44 a.m., Unlicensed Staff C stated it was every staff's responsibility to respond to and answer call lights. Unlicensed Staff C added, call lights should be answered promptly, within two to three minutes, and it was not acceptable for residents to wait over 10 minutes for a call like to be answered.

During an interview on 6/3/25 at 11:53 a.m., Resident 2 stated she had experienced waiting for about 30 minutes to an hour before staff have answered her call light. Resident 2 stated some staff just don't answer call lights timely. Resident 2 explained, it was very frustrating when her call light was on but no one was coming and she felt disrespected.

During an interview on 6/3/25 at 1:30 p.m., the Director of Staff Development (DSD) stated answering a call light was everyone's responsibility per the facility's policy. The DSD stated call lights should be answered immediately within 2 to 3 minutes and it was not acceptable for residents to wait over 10 minutes for the call light to be answered. The DSD stated call lights should be answered in a timely manner to ensure the residents were safe and to prevent

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F 557	Continued From page 4 accidents and injuries. A review of the facility's policy and Procedure (P&P) titled "Communication-Call System," revised 1/1/12, the P&P indicated, "Purpose ...To provide a mechanism for resident to promptly communicate with nursing staff ... nursing staff will answer call bells promptly ... " 2. During a concurrent observation and interview on 6/3/25 at 11:23 a.m., Resident 1 had a FC hanging on the right side of the bed with no cover on the drainage bag. Resident 1 stated staff never placed a cover on her FC drainage bag and did not think the facility had any FC drainage bag covers. During a concurrent observation and interview on 6/3/25 at 11:32 a.m., LN B verified Resident 1s FC drainage bag had no cover. LN B stated the facility policy was to ensure FC drainage bag were covered even when in bed to protect residents' privacy and dignity. LN B stated not placing a cover on the drainage bag could make the resident feel upset, ashamed, humiliated and could lead to increase discomfort around visitors. During an interview on 6/3/25 at 11:44 a.m., Unlicensed Staff C stated it was the facility's policy to ensure FC drainage bag was covered even when resident was in bed. Unlicensed Staff C stated it was a dignity issues cause not putting a cover on a FC drainage bag could result in resident feeling humiliated or undignified. During an interview on 6/3/25 at 1:30 p.m., the DSD stated it was the facility's policy to ensure FC drainage bags were covered. The DSD stated	F 557		

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F 557	Continued From page 5 if the FC drainage bag was not covered it meant the facility policy was not followed and would be a privacy and dignity issue for the resident. A review of the facility policy and procedure (P&P) titled "Catheter- Care of," revised 6/10/21, the P&P indicated, "... the resident's privacy and dignity will be protected by placing cover over drainage bag ... " A review of the facility's P&P titled "Resident's Rights" revised 1/1/12, the P&P indicated, " ...Purpose ...To promote and protect the rights of all residents...state and federal laws guarantee basic rights to all residents of the facility, these right includes.... privacy and confidentiality ... "	F 557		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to provide service aligned with professional standards for one out of five sampled residents (Resident 1) when medication was left unattended on Resident ' s overbed table. This failure had the potential for the medication to be taken by unintended persons with potentially serious consequences. Findings:	F 658		

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F 658	Continued From page 6 A review of Resident 1's face sheet (front page of the chart that contains a summary of basic information about the resident) indicated Resident 1 was admitted to the facility in May of 2025 with diagnoses including Dysphagia (difficulty swallowing). A review of Resident 1's care plan (CP, a detailed, written document that outlines a resident's individual needs, goals, and how their care will be managed), date initiated 10/25/24, indicated, "The resident requires tube feeding [TF, a medical device used to provide nutrition and medication to people who are unable to swallow safely] r/t [related to] dysphagia ... " During a concurrent observation and interview on 6/3/25 at 11:23 a.m., in Resident 1's room, there was a whitish watery substance in plastic cup and a syringe in a cup on Resident 1's overbed table. Resident 1 verified the whitish watery substance in plastic cup was her medication that the nurse left there. Resident 1 indicated she did not know why the medication was left and added, staff would sometimes leave her medications at her bedside or overbed table. During a concurrent observation and interview on 6/3/25 at 11:39 a.m., Licensed Nurse (LN) B verified the whitish watery substance in the medicine cup on Resident 1's overbed table, appeared to be Resident 1's medication. LN B stated it was the facility's policy not to leave medications at residents' bedside as it was a "big " safety concern. LN B added, the facility had a lot of confused residents who wandered around that could go to another residents' rooms and	F 658		

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F 658	Continued From page 7 ingest the medication that was left unattended at the bedside. During an interview on 6/3/25 at 1:22 p.m., the Director of Staff Development (DSD) verified Resident 1's medications were given via feeding tube and Resident 1's medication was left unattended at Resident 1's overbed table. The DSD stated the nurse in charge of Resident 1 had called her because she was having trouble administering the medication. The DSD stated the nurse left the medication at Resident 1's bedside unattended. The DSD acknowledged it was a safety issue to leave a medication at bedside unattended and could lead to serious consequences which could harm residents. A review of the facility's policy and procedure (P&P) titled "Specific Medication Administration Procedure" effective 4/2008, the P&P indicated, " ...To administer medications in a safe and effective manner ...[medication] once removed from the package or container, unused doses should be disposed of in accordance with the medication destruction policy ... " A review of the facility's policy and procedure (P&P) titled, " ...Self-Administration of Medications, " dated 4/2008, indicated, " ...Bedside medication storage is permitted only when it does not present a risk to confused residents who wander into the rooms ... "	F 658		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program	F 880		

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F 880	Continued From page 8 designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism	F 880		

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F 880	Continued From page 9 involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record reviews, the facility failed to a safe and sanitary environment for three out of five sampled residents when: 1. Toothbrushes found in a shared bathroom were not labeled with the resident names, and 2. Resident's foley catheter (FC, a hollow tube inserted into the bladder to drain or collect urine) tubing (a thin, flexible tube connected to a catheter that drains urine from the bladder into a	F 880		

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F 880	Continued From page 10 collection bag) was on a contaminated surface. These failures put the residents at risk for the transmission of infections. Findings: 1.During a concurrent observation and interview on 6/3/25 at 12:19 p.m., Licensed Nurse (LN) B in Resident 3's and Resident 6's room, verified Resident 3 did not have a toothbrush on or in the bedside table/bedside drawer. During a concurrent observation and interview on 6/3/25 at 12:49 p.m., in the shared bathroom for Resident 3 and Resident 6, Unlicensed Staff D verified there were 2 toothbrushes in the bathroom that were not labeled with names. Unlicensed Staff D stated if the toothbrushes were not labeled with the residents' name it meant the facility policy was not followed. Unlicensed Staff D stated, "I'm not sure" which toothbrush belonged to which resident since they were unlabeled. Unlicensed Staff D stated staff should put the resident names on their toothbrush and toothpaste to prevent confusion and accidental use of a toothbrush that does not belong to the resident. During an interview on 6/3/25 at 1:45 p.m., the Director of Staff Development (DSD) verified residents' toothbrushes, especially when kept in the bathroom that was shared with a roommate, should be labeled with their names. The DSD added, toothbrushes labeled with each resident's name was important for infection control and to ensure each resident used their own toothbrush.	F 880		

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F 880	Continued From page 11 A review of the facility's policy and procedure (P&P) titled "Oral Care," revised 1/1/12, the P&P indicated, " ...each toothbrush of a resident must be labeled with resident's name, unless kept in the resident's bedside drawer .... " 2. During an observation on 6/3/25 at 11:23 a.m., Resident 1 had a FC hanging on the right side of her bed while the FC tubing was touching a fall mattress (mat placed on the floor that decreases the impact of a fall and reduces the risk of fall-related injuries). During a concurrent observation and interview on 6/3/25 at 11:32 a.m., LN B verified Resident 1's FC tubing was touching the fall mattress and added, the FC tubing should not touch the floor or the fall mattress because those were dirty/contaminated surfaces. LN B stated allowing the FC tubing to touch the fall mattress was unsanitary and could result in resident getting sick with an infection. During an interview on 6/3/25 at 11:44 a.m., Unlicensed Staff C stated it was the facility's policy to ensure FC tubing did not touch the floor or the fall mattress because these surfaces are dirty and contaminated. Unlicensed Staff C stated allowing the FC tubing to touch the floor or fall mattress could result in the resident getting an infection. During an interview on 6/3/25 at 1:30 p.m., the DSD stated the FC tubing should not touch the floor or the fall mattress because these were considered dirty surfaces. The DSD stated if the FC tubing lays on the floor or fall mattress, it could cause an infection.	F 880		

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F 880	Continued From page 12 A review of the facility P&P titled "Catheter- Care of," revised 6/10/21, the P&P indicated, "... the catheter tubing, bag or spigot will be anchored to not touch the floor ... " A review of the facility's P&P titled "Infection Control- Policies and Procedures" dated 1/1/12, the P&P indicated, " ... to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of disease and infections... "	F 880		

Complaint Number: CA00964792
F-557

SAN RAFAEL
HEALTHCARE & WELLNESS CENTER

SAN RAFAEL HEALTHCARE & WELLNESS CENTER, LP makes every effort to operate in substantial compliance with Federal and State laws and regulations. Nothing in this Plan of Correction is an admission otherwise. SAN RAFAEL HEALTHCARE & WELLNESS CENTER, LP is submitting this Plan of Correction in compliance with its regulatory obligations and does not waive any objections it may have as to the merit or form of any allegations contained herein. Please note that the facility may contest the merits or form of any of the alleged deficient findings and may take reasonable steps to appeal them. This Plan of Correction constitutes SAN RAFAEL HEALTHCARE & WELLNESS CENTER, LP's written credible allegation of compliance for the deficiencies noted.

It is the facility's policy to ensure residents are treated with respect and dignity, including the right to retain and use personal possessions, and to ensure call lights are answered promptly and catheter drainage bags are properly covered to maintain resident privacy and dignity.

Corrective Action for Affected Residents: On 6/3/25, Resident 1's foley catheter drainage bag was immediately provided with a privacy cover. On 6/3/25, the Director of Nursing (DON) and DSD conducted one-on-one counseling with staff members who failed to respond to Resident 1's call light. The DON met with both Resident 1 and Resident 2 to address their concerns regarding call light response times and implemented immediate monitoring of call light response times for their rooms.

Identifying other Residents having the Potential to be Affected: On 6/4/25, the DON and DSD conducted a facility-wide audit of all residents with foley catheters to ensure proper privacy covers were in place. A facility-wide assessment of call light response times was conducted for all residents from 6/4/25 to 6/6/25 to identify any additional concerns with call light response times.

Measures put into place or Systemic Changes: The DON or designee will conduct in-service education for staff by 7/1/2025 on:

- Call light response protocols and expectations for maximum response (promptly)
- Proper use and importance of foley catheter privacy covers
- Resident dignity and respect requirements
- Staff accountability for responding to call lights regardless of assignment

New processes implemented include:

- Call light monitoring audit to track response times

- Implementation of call light audit by DSD and/or DON
- Nursing staff members to monitor catheter care compliance during each shift
- Orientation process for new staff regarding call light responsibilities policy review

Plan to Monitor Performance: The DSD will conduct audits of call light response times and catheter privacy cover compliance weekly for 8 weeks, and monthly thereafter. Audits will include:

- Random observations of call light response times
- Review of call light monitoring audit data
- Inspection of all catheter drainage bags for proper privacy covers & positioning
- Interviews with residents regarding satisfaction with call light response times via audit tool

The DON will analyze audit results and report findings to the Quality Assurance and Performance Improvement (QAPI) committee quarterly. The QAPI committee will review the effectiveness of interventions and make additional recommendations as needed until substantial compliance is achieved and maintained.

July 1, 2025