

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055093	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/23/2026
NAME OF PROVIDER OR SUPPLIER South Marin Health & Wellness Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1220 South Eliseo Drive Greenbrae, CA 94904	
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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p>Based on interviews and record reviews, the facility failed to send a notice of discharge to the Office of the State Long-Term Care Ombudsman (an independent, impartial official that mediates complaints in the long-term care setting) at the same time the notice was given to one resident (Resident 1) of three sampled residents. This failure decreased the facility's potential to ensure Resident 1 was not unsafely discharged. Findings: A review of Resident 1's Notice of Transfer or Discharge dated 10/21/25, indicated Resident 1's spouse received a notice of Resident 1's discharge from the facility on the same day Resident 1 was expected to leave on 10/21/25. Further review of this document indicated, The facility must send a copy of this notice to a representative of the Office of the Long-Term Care Ombudsman. A review of a facility fax transmission report indicated a copy of Resident 1's notice of discharge was sent to the Office of the State Long-term Care Ombudsman on 11/11/25 at 10:01 a.m., which was 22 days after Resident 1 was discharged from the facility. During an interview on 1/26/26 at 1:46 p.m., the SSD (Social Services Director) acknowledged she was responsible for sending notices of transfers or discharges to the Ombudsman in October 2025. The SSD director stated Resident 1's discharge was a facility-initiated discharge. The SSD stated she understood that the Ombudsman advocated for residents and the notice should have been sent before Resident 1's discharge from the facility. During an interview on 2/3/26, at 2:25 p.m., Resident 1's family member stated Resident 1's family did not request Resident 1's discharge home. Resident 1's family member stated the family wanted Resident 1 to stay at the facility. A review of the facility's policy and procedure (P&P) titled, Transfer or Discharge Notice, dated December 2016 indicated, Our facility shall provide a resident and/or a resident's representative (sponsor) with a thirty (30)- day written notice of an impending transfer or discharge. Under the following circumstances, the notice will be given as soon as practicable but before the transfer or discharge. A copy of the notice will be sent to the Office of the State Long-Term Care Ombudsman.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 055093	If continuation sheet Page 1 of 2

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>Based on interviews and record reviews, the facility failed to ensure licensed nurses administered significant medication (a medication that increased the risk of harm when not taken) to one resident (Resident 1) of three sampled residents on 10/15/25 because they did not reorder the medication prior to it running out. This failure decreased the facility's potential to ensure Resident 1 received medication as ordered and decreased Resident 1's risk of developing a blood clot. Findings: A review of Resident 1's admission record indicated admission to the facility on 9/27/25 with diagnoses which included wedge compression fracture (occurs when the front part of one of the bones in the spine collapses and forms a wedge shape and causes back pain), chronic pulmonary embolism (a blockage in a lung artery), atrial fibrillation (an irregular and often rapid heart rhythm that can lead to blood clot formation and an increase in the risk of stroke and heart disease), and muscle weakness. A review of Resident 1's Order Summary Report, dated October 2025 indicated, Rivaroxaban [a medication that thins blood] Oral Tablet 15 mg [milligram, a unit of measure], give 1 tablet by mouth one time a day for thromboembolism [a condition in which a blood clot breaks off from its original site and travels through the bloodstream to obstruct a blood vessel, causing tissue and organ damage] for chronic atrial fibrillation. During a concurrent interview and record review with Licensed Nurse 1 (LN 1) and LN 2 on 1/23/26, at 1:55 p.m., both nurses reviewed Resident 1's Medication Administration Record (MAR) dated October 2025. Both LN 1 and LN 2 stated the number 8 was documented on Resident 1's MAR which meant the rivaroxaban was not available on 10/15/25 to be administered. During an interview on 1/26/26 at 4:03 p.m., LN 3 stated that on 10/15/25, she did not administer Resident 1's rivaroxaban because the supply ran out. LN 3 stated if the rivaroxaban was not available in the emergency medication supply kit (E-Kit), Resident 1 had to wait until the following day when the supply of the medication would be delivered by the pharmacy. LN 3 stated the medication bubble pack's (a specialized, organized packing system used in a long-term care facility) background turned blue to signal to the nurse that the medication supply was getting low. During an interview on 2/2/26 at 9:33 a.m., the Director of Nursing (DON) stated that if medication was not available the nurse should check the E-Kit, follow-up with the pharmacy, and notify the doctor through a secure message system or via phone call. The DON stated the medication bubble pack had a blue background at medication number 4 which indicated the supply was low and needed to be reordered by the nurse. The DON stated the nurses were responsible for reordering the medication when the supply became low. A review of the facility's pharmacy policy and procedure (P&P) titled, Medication Ordering and Receiving from Pharmacy, dated January 2022, indicated, .If not automatically refilled by the pharmacy. Reorder medication five days in advance of need to assure an adequate supply is on hand. The refill order is called in, faxed, or otherwise transmitted to the pharmacy. A review of the facility's P&P titled, Medication Administration (General), dated 8/18/22, indicated, To be able to safely administer in a timely manner, and as prescribed, in accordance to nursing scope and practices.</p>		