STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055310	A. Building B. Wing	05/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marin Post Acute	234 N. San Pedro Rd San Rafael, CA 94903

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39621 Based on observation, interview and record review, the facility failed to ensure one resident (Resident 2) of three sampled residents received care which met professional standards when a Licensed Nurse B (LN B) left a cup of medications by the Resident 2 ' s bedside, unattended, without a physician ' s order. This failure decreased the facility ' s potential to safely administer medications to residents. Findings: A review of Resident 2 ' s admission record indicated she was admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis (muscle weakness or partial paralysis) following unspecified cerebrovascular disease (a term used for conditions that affect blood flow to the brain) affecting her left side. A review of Resident 2 ' s Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 2/9/25, indicated she had no memory impairment. During a concurrent observation and interview with Resident 2 on 5/1/25 at 10:40 a.m., a plastic cup containing nine pills were observed sitting on top of Resident 2 ' s bedside table, unattended. Resident 2 stated the nurse left them on her bedside table, after 10 a.m. that morning, to swallow, but one of her prescribed medications was missing. During an interview on 5/1/25 at 10:42 a.m., LN B confirmed she left Resident 2 ' s medications on top of Resident 2 ' s bedside table, unattended. During an interview with the Director of Staff Development (DSD) on 5/1/25 at 1:34 p.m., he stated Licensed Nurses were not allowed to leave unattended medications by a resident ' s bedside without a physician ' s order due to safety risks. The DSD also acknowledged there were no residents at the facility with a physician order for self-administration of medications, including Resident 2. A review of the facility ' s policy titled, Administering Medications, last reviewed in April of 2019, indicated, . Medications ordered for a particular resident may not be administered to another resident .Residents may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team, has determined that they have the decision-making capacity to do so safely. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility ' s document titled Job Description: LPN [Licensed Practical Nurse]/ [LVN [Licensed Vocational Nurse] prepared by Human Resources in February 2024 indicated, .Drug Administration Functions .Ensure that prescribed medication for one resident is not administered to another .Implement and maintain established nursing objectives and standards.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39621 Based on observation, interview and record review, the facility failed to ensure call lights for two residents (Resident 1 & Resident 2) of three sampled residents were answered promptly when the Surveyor observed Resident 2 ' s call light ringing for 25 minutes before intervening. This failure decreased the facility ' s potential to provide prompt assistance to residents and resulted in Resident 2 feeling neglected. Findings: A review of Resident 1 ' s admission record indicated she was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy (brain dysfunction caused by the body ' s metabolism). A review of Resident 1 ' s Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 2/26/25, indicated she had no memory impairment. During a phone interview on 5/1/25 at 3:02 p.m., Resident 1 stated the call light took from 30 minutes to an hour-and-a-half to be answered by staff. Resident 1 stated she pressed it on behalf of her roommate who required staff assistance, as she could not get out of bed. A review of Resident 2 ' s admission record indicated she was admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis (muscle weakness or partial paralysis) following unspecified cerebrovascular disease (a term used for conditions that affect blood flow to the brain) affecting her left side. A review of Resident 2 ' s MDS, dated [DATE], indicated she had no memory impairment. A review of Resident 2 ' s active care plan initiated on 2/10/21 regarding activities of daily living (ADLs - activities related to personal care such as bathing and dressing) indicated, Encourage the resident to use bell [or call light] to call for assistance. During an observation on 5/1/25 from 10:15 a.m. to 10:40 a.m., Resident 2 ' s call light was observed to be ringing for 25 minutes without a response from facility staff. After 25 minutes, the Surveyor entered Resident 2 ' s room for an interview with Resident 2 ' s permission. During a concurrent observation and interview with Resident 2 on 5/1/25 at 10:40 a.m., a plastic cup containing medications was observed on top of Resident 2 ' s bedside table, unattended. Resident 2 stated the nurse left them on the bedside table, after 10 a.m., for Resident 2 to swallow, but one of her prescribed medications was missing. Resident 2 stated she pressed her call light to notify the nurse of the missing medication and had been waiting for about twenty-five minutes for staff to respond to it. Resident 2 stated staff frequently took up to an hour to respond to call lights. Resident 2 stated she had been left wet and soiled for extended periods of time due to staff taking so long to answer call lights. Resident 2 stated she felt neglected when staff did not answer her call lights promptly. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/1/25 at 10:42 a.m., LN B was notified of Resident 2 ' s request for her missing medication. LN B was at the nurses ' station, which was not in the same hallway as Resident 2 ' s, therefore, the call light could not be visualized from there. LN B confirmed she left Resident 2 ' s medications on top of Resident 2 ' s bedside table, unattended after 10 a.m. LN B confirmed she missed a medication for Resident 2 during medication preparation, and stated she would get it immediately. The missing medication was metformin (a medication to regulate high blood sugar levels). During an interview with the Director of Nursing (DON) on 5/5/25 at 12:35 p.m., she stated staff were expected to answer call lights within 10 minutes. A review of the facility policy titled, Answering the Call Light, dated 2019, indicated, The facility will be adequately equipped to allow residents to call for staff assistance through a communication system which relay the all [sic] directly to a staff member or to a centralized staff work area .Answer the resident's call as soon as possible. A review of the facility ' s document titled Job Description: LPN [Licensed Practical Nurse]/ [LVN [Licensed Vocational Nurse] prepared by Human Resources in February 2024 indicated, .Ensure that personnel providing direct care to residents are providing such care in accordance with the resident ' s care plan and wishes .

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39621 Based on observation, interview and record review, the facility failed to ensure one resident (Resident 2) of three sampled residents was kept free of significant medication errors, when Licensed Nurse B (LN B) administered her morning medications more than one hour late, left her medications by the resident ' s bedside unattended, and missed an important morning medication that was required to be administered with breakfast. These findings increased the potential to result in elevated blood pressure, elevated glucose levels, and harm to Resident 2. Findings: A review of Resident 2 ' s admission record indicated she was admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis (muscle weakness or partial paralysis) following unspecified cerebrovascular disease (a term used for conditions that affect blood flow to the brain) affecting her left side. A review of Resident 2 ' s Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 2/9/25, indicated she had no memory impairment. During a concurrent observation and interview with Resident 2 on 5/1/25 at 10:40 a.m., a plastic cup containing nine medications was observed on top of Resident 2 ' s bedside table, unattended. Resident 2 stated the nurse left them on her bedside table, after 10a.m., to swallow, but one of her medications was missing. During an interview on 5/1/25 at 10:42 a.m., LN B confirmed she left Resident 2 ' s morning medications on top of Resident 2 ' s bedside table, unattended after 10a.m. LN B confirmed she missed a medication for Resident 2 during medication preparation, and stated she would get it immediately. The missing medication was metformin (a medication to regulate high blood sugar levels). During an observation on 5/1/25 at 10:50 a.m., Resident 2 was observed swallowing the nine medications in the cup, whole, with water, along with the new tablet of metformin LN B had just brought for her. A review of Resident 2 ' s Medication Administration Record (MAR) dated May 2025, indicated she had the following medications scheduled the morning of 5/1/25: 1. Gabapentin (medication used to treat chronic pain) 600 milligram (mg) tablet scheduled at 8 a.m. 2. Meclizine Hydrochloride (medication used to treat nausea) 12.5 mg tablet scheduled at 8 a.m. 3. Saccharomyces Boulardi (a supplement for gastrointestinal health) 250 mg capsule scheduled at 8 a.m. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Metformin 1000 mg tablet scheduled at 8 a.m. which also indicated, GIVE WITH BREAKFAST AND DINNER. 5. Metoprolol Tartrate (medication used to treat high blood pressure) 25 mg tablet scheduled at 8 a.m. which also indicated, GIVE WITH FOOD. 6. Famotidine (medication for heartburn or acid indigestion) oral tablet 40 mg scheduled at 9 a.m. 7. Duloxetine Hydrochloride (medication used to treat depression) 800 mg tablet scheduled at 8 a.m. 8. Clopidogrel Bisulfate (medication used to prevention of strokes) 75 mg tablet, scheduled at 8 a.m. 9. Amlodipine Besylate (medication used to treat high blood pressure) 5 mg tablet scheduled at 9 a.m. 10. Aspirin (medication used to prevent a blockage of blood flow to the brain) 81 mg tablet, scheduled at 8 a.m. Resident 2 ' s MAR did not indicate any medication scheduled to be administered at 10 a.m. or 11 a.m. During an interview on 5/1/25 at 1:03 p.m., LN B confirmed the 8 a.m. and 9 a.m. medications in Resident 2 ' s MAR were the medications left on Resident 2 ' s bedside table on 5/1/25 at 10:40 a.m., LN B stated breakfast was served between 8 a.m. and 8:30 a.m.; therefore, metformin had been administered after the prescribed time. During an interview on 5/1/25 at 1:34 p.m. the Director of Staff Development (DSD) stated medications were required to be administered within two hours of the scheduled time, from one hour before to one hour after. The DSD stated medications given outside of these parameters were considered medication errors. The DSD stated medications that were required to be given with food were expected to be administered when there was food in the stomach. The DSD stated administering which required it to be administered with breakfast but was administered at 10:30 a.m. was considered a medication error. A review of the facility policy titled, Administering Medications, last revised in April of 2019 indicated, Medications are administered in a safe and timely manner, and as prescribed . The individual administering the medication checks the label to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication .

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39621 Based on interview and record review, the facility failed to ensure rehabilitative services were provided for one resident (Resident 2) of three sampled residents when restorative nursing services (nursing interventions that focus on helping residents maintain and improve their ability to function independently in activities of daily living and mobility) were not performed according to physician ' s orders. This failure decreased the facility ' s potential to ensure residents attained their highest practicable level of physical and functional well-being. Findings: A review of Resident 2 ' s admission record indicated she was admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis (muscle weakness or partial paralysis) following unspecified cerebrovascular disease (a term used for conditions that affect blood flow to the brain) affecting her left side. A review of Resident 2 ' s clinical record included the following documents: -A Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 2/9/25, indicated she had no memory impairment. -An Order Summary Report, dated 5/1/25, indicated an active physician ' s (MD) order, started on 2/25/25, for restorative nursing services three times per week as tolerated. There was no end date indicated for this order. -Restorative Nurse Assistant (RNA- a staff member who assists residents in regaining or maintaining their skills and abilities through therapy and rehabilitation programs) Progress Reports dated 4/5/25 through 5/5/25 indicated Resident 2 received RNA services two times during the weeks of: 4/6/25 - 4/12/25, 4/20/25-4/26/25, and 4/27/25- 5/3/25. During an interview on 5/1/25 at 10:40 a.m., Resident 2 stated she had not received her regular therapy services which were supposed to be provided three times per week. Resident 2 stated she needed these services to prevent her left hand from becoming stiff, since she could not move it due to a stroke (an interruption of blood flow to the brain which can result in physical changes to the body). During an interview on 5/1/25 at 1:52 p.m., RNA A stated the facility was frequently short-staffed for Certified Nursing Assistants (CNA- a staff member who provides basic nursing care and assistance with activities of daily living to residents) and as a result, RNA A was often assigned to work as CNA. Due to this, RNA A was unable to provide rehabilitation nursing services to the residents that required them, including Resident 2. RNA A stated he was not replaced by another RNA when assigned to work as a CNA. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 5/5/25 at 12:19 p.m., the Director of Rehabilitation (DOR) stated Resident 2 should have been receiving restorative nursing services three times per week, but the RNA providing these services was sometimes assigned to work as a CNA and could not provide them. The DOR confirmed the RNA Progress Reports dated 4/6/25 - 4/12/25, 4/20/25- 4/26/25, and 4/27/25- 5/3/25 indicated Resident 2 received restorative nursing services two times per week instead of three. The DOR stated he had no control over staffing. The DOR stated restorative nursing services were aimed at maintaining the residents ' abilities so they would not decline. During an interview on 5/5/25 at 12:02 p.m., the Staffing Coordinator (SC) confirmed RNAs, including RNA A, were assigned to work as CNAs when other CNAs called off. The SC was asked to provide the following information to the Surveyor: 1. The dates in April 2025, RNA A was assigned to work as CNA instead of RNA. 2. The names of staff members who replaced RNA A as a restorative nursing assistant when RNA A was assigned the CNA position. A review of an electronic mail sent to the Surveyor from the facility Administrator (ADM) on 5/5/25 at 1 p.m. indicated, In reference to our RNA, [RNA A] The assignment sheets and times we emailed will show which days he worked. [RNA A] worked as a CNA for a portion of his days on 4/18/25 and 4/29/25 only. A review of the assignment sheets provided by the ADM on 5/5/25 at 1 p.m. indicated RNA A worked from 4/14/25-4/17/25, 4/19/25-4/23/25, and 4/25/25-4/28/25. The assignment sheets did not indicate which days or portion of the days RNA A was assigned to work as a CNA or an RNA. During an interview on 5/5/25 at 1:10 p.m., RNA A stated he was assigned to work as CNA more than half of his shifts (approximately more than 10 shifts) in April 2025. RNA A confirmed on the days he was assigned to work as CNA, no other RNAs replaced him. RNA A further stated that since there were no RNAs on the evening shift, the entire facility did not receive restorative nursing services for the day. RNA A also stated when CNAs did not come to work, he was automatically assigned to take the position of the absent CNA. RNA A stated he provided services to 20 to 22 residents per day; therefore, on the days when he worked as CNA, those 20 to 22 residents did not receive restorative nursing services. A review of the facility ' s policy titled, Therapy Services, last revised in July of 2013, indicated, Therapy services shall be scheduled in accordance with the resident ' s treatment plan .The therapist shall interview the resident and consult with the attending physician as to the type of treatment to be administered. A review of the facility ' s policy titled, Restorative Nursing Services, last revised in July of 2017, indicated, Residents will receive restorative nursing care as needed to help promote optimal safety and independence.