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	12/16/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to protect one resident (Resident 5) of six sampled residents from physical abuse when Resident 6 hit Resident 5 in the face.This failure had the potential to cause physical injury and emotional distress for Resident 5.A review of Resident 5's admission record indicated admission to the facility on 1/16/25 with diagnoses including atrial fibrillation (a type of irregular heart rhythm) and delirium (a sudden, severe change in mental status).A review of Resident 5's Minimum Data Set (MDS- an assessment tool) dated 10/9/25 indicated Resident 5 had severe cognitive impairment with a BIMS score of 3.A review of Resident 6's admission record indicated admission to the facility on 8/12/25. Resident 6 was admitted with a diagnosis of malignant neoplasm of colon (colon cancer).A review of Resident 6's MDS dated [DATE] indicated Resident 6 had no cognitive impairment with a BIMS score of 15.During an interview on 12/16/25 at 1:10 p.m., Resident 5 stated she did not recall anyone hitting her.During an interview on 12/16/25 at 1:12 p.m., Resident 6 stated he hit Resident 5 in self-defense. Resident 6 did not recall the date of the incident, but it was before Thanksgiving. Resident 6 stated when he wacked Resident 5, she woke up from a flashback.During an interview on 12/16/25 at 2 p.m., the Human Resource Director (HRD) stated he witnessed Resident 6 hit Resident 5. The HRD stated Resident 5 was in her wheelchair (WC) in the hallway by the nurse's station. The HRD stated Resident 6 came down the hall in his WC. The HRD stated Resident 5 cut off Resident 6 with her WC and Resident 6 then hit the left side of her face. The HRD also stated he immediately separated the two residents and then he notified the floor nurse, the Director of Nursing (DON), and the Administrator (ADM). The HRD stated he did not remember the date of the incident, but it was recorded on video.During a concurrent observation and interview on 12/16/25 at 3:47 p.m., the HRD pulled up a video of the altercation between Resident 5 and Resident 6. This surveyor watched the video with the HRD. The video was date stamped on 10/31/25 and time stamped at 10:37 a.m. The video clearly showed Resident 6 hit Resident 5 in the face and the HRD immediately separated the two residents.A review of the facility's policy and procedure titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program dated 2001, indicated, The resident abuse, neglect and exploitation prevention program consists of a facility-wide commitment and resource allocation to support the following objectives: Protect residents form abuse.by anyone including.other residents.

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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	055310	A. Building B. Wing	12/16/2025

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to report an allegation of abuse and failed to submit the results of their investigation to the California Department of Public Health (the Department) within the required timeframe.This failure impeded the ability of the Department to conduct a timely investigation and ensure the safety and well-being of the residents.A review of Resident 1's admission record indicated admission to the facility on 1/24/25 with diagnoses including Amyotrophic Lateral Sclerosis (ALS - a progressive disease affecting the nerve cells in the brain and spinal cord that control voluntary muscles), diabetes (a disorder characterized by difficulty in blood sugar control and poor wound healing), neuropathy (nerve pain), and chronic pain syndrome.A review of Resident 1's Minimum Data Set (MDS- an assessment tool) dated 10/2/25 indicated no cognitive impairment with a BIMS (Brief Interview for Mental Status-an assessment tool facilities used to screen and identify memory, orientation, and judgement status of the resident) score of 14.A review of Resident 5's admission record indicated admission to the facility on 1/16/25 with diagnoses including atrial fibrillation (a type of irregular heart rhythm) and delirium (a sudden, severe change in mental status).A review of Resident 5's MDS dated [DATE] indicated Resident 5 had severe cognitive impairment with a BIMS score of 3.A review of Resident 6's admission record indicated original admission to the facility on 8/12/24 and most recent admission on [DATE]. Resident 6 was admitted with a diagnosis of malignant neoplasm of colon (colon cancer).A review of Resident 6's MDS dated [DATE] indicated Resident 6 had no cognitive impairment with a BIMS score of 15.During an interview on 12/16/25 at 12:15 p.m., Resident 1 stated a CNA told her that Resident 6 hit Resident 5, a nurse had taken a video of the incident, and the nurse had shown it to the Administrator, the upstairs Director of Nursing (DON) and the downstairs DON.During an interview on 12/16/25 at 1:10 p.m., Resident 5 stated she did not recall anyone hitting her.During an interview on 12/16/25 at 1:12 p.m., Resident 6 stated he hit Resident 5 in self-defense. Resident 6 did not recall the date of the incident, but it was before Thanksgiving. Resident 6 stated when he wacked Resident 5, she woke up from a flashback.During an interview on 12/16/25 at 1:50 p.m., the Director of Staff Development (DSD) stated he had not heard about the incident where Resident 6 hit Resident 5. When asked about cameras in the hallways, the DSD stated the Human Resource Director (HRD), the Director of Nursing (DON), and the Administrator (ADM) had access to the camera recordings.During an interview on 12/16/25 at 2 p.m., the HRD stated he witnessed Resident 6 hit Resident 5. The HRD stated Resident 5 was in her wheelchair (WC) in the hallway by the nurse's station. The HRD stated Resident 6 came down the hall in his WC. The HRD stated Resident 5 cut off Resident 6 with her WC and Resident 6 then hit the left side of her face. The HRD also stated he immediately separated the two residents and then he notified the floor nurse, the DON, and the Administrator. The HRD stated he did not remember the date of the incident, but it was recorded on video.During an interview on 12/16/25 at 2:20 p.m., the DON stated she did not recall the incident where Resident 6 hit Resident 5. The DON also stated staff were expected to separate the residents, report the incident to her, the Social Services Director (SSD), and the ADM if a resident-to-resident altercation occurred. The DON stated the next step would be for the nurse to do an assessment, the SSD to do an interview, and the ADM to report the event or allegation to the Department. The DON also stated nursing staff were expected to have followed up with a change of condition report and monitor both residents every shift for 72 hours. When asked about a video recording of the incident, the DON confirmed they had a video, but she did not know how long it saved.During an interview on 12/16/25 at 2:30 p.m., the HRD stated he had pulled up the video on the facility computer, and it showed the incident had occurred on Halloween (10/31/25) at 10:37 a.m.During a concurrent record review and interview on 12/16/25 at 3:23 p.m., the DSD reviewed the progress notes for Resident 5 from 10/16/25 to 11/15/25 and verified there was not a note about the resident-to-resident altercation on 10/31/25. The DSD reviewed the care plans for Resident 5 and verified there had not been a care plan updated for the incident on 10/31/25. The DSD also reviewed the progress notes for Resident 6 from 10/16/25 to 11/15/25 and verified there was not a note about the resident-to-resident altercation on 10/31/25. Lastly, the DSD reviewed the care plans for Resident 6 and verified there had not been a care plan updated for the incident on 10/31/25.During a concurrent observation and interview on 12/16/25 at 3:47 p.m., the HRD pulled up a video of the resident-to-resident altercation. This surveyor watched the video with the HRD. The video was date stamped at 10/31/25 and time stamped at 10:37 a.m. The video clearly showed Resident 6 hit Resident 5 in the face

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. (continued on next page)

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to follow professional standards of practice when nursing staff left medications at the bedside for four residents (Resident 1, Resident 2, Resident 3, and Resident 4) of four sampled residents.This failure had the potential to increase the risk of medication errors, misuse and/or accidental ingestion of medication by the resident or others.A review of Resident 1's admission record indicated admission to the facility on 1/24/25 with diagnoses including Amyotrophic Lateral Sclerosis (ALS - a progressive disease affecting the nerve cells in the brain and spinal cord that control voluntary muscles), diabetes (a disorder characterized by difficulty in blood sugar control and poor wound healing), neuropathy (nerve pain), and chronic pain syndrome. A review of Resident 1's Minimum Data Set (MDS- an assessment tool) dated 10/2/25 indicated no cognitive impairment with a BIMS (Brief Interview for Mental Status-an assessment tool facilities used to screen and identify memory, orientation, and judgement status of the resident) score of 14.A review of Resident 2's admission record indicated admission to the facility on 4/23/24 with diagnoses including cerebral ischemia (a condition where there is insufficient blood flow to the brain), chronic hepatitis (long lasting inflammation of the liver), heart failure (a condition where the heart cannot pump blood effectively), and chronic kidney disease (a condition where the kidneys gradually lose their ability to filter waste and toxins from the blood). A review of Resident 2's MDS dated [DATE] indicated severe cognitive impairment with a BIMS score of 4.A review of Resident 3's admission record indicated admission to the facility on 8/15/25 with diagnoses including acute respiratory failure (a sudden inability of the lungs to provide enough oxygen to the blood) and acute kidney failure (a sudden loss of kidney function). A review of Resident 3's MDS dated [DATE] indicated severe cognitive impairment with a BIMS score of 5.A review of Resident 4's admission record indicated admission to the facility on [DATE] with diagnoses including dementia (a chronic, progressive decline in cognitive function), diabetes (a disorder characterized by difficulty in blood sugar control and poor wound healing), and hyperlipidemia (a condition where a person has a high level of fats in their blood). A review of Resident 4's MDS dated [DATE] indicated moderate cognitive impairment with a BIMS score of 10.During a concurrent observation and interview on 12/16/25 at 12:15 p.m., Resident 1 had two small plastic cups on top of a closed water container on her tray table. Resident 1 stated one cup contained a 10 mg (milligram - a unit of measure) tablet of oxycodone (a strong opioid (a broad group of pain-relieving medications that work with your brain cells) medication used to treat severe pain) and the second cup contained a 100 mg capsule of gabapentin (a prescription medication used to treat neuropathy (nerve pain)) and a 400 mg capsule of gabapentin for a total of 500 mg of gabapentin. Resident 1 stated Licensed Nurse 1 (LN 1) delivered her medications and left them in the two small cups around 11 a.m. Resident 1 also stated pills had been left for her all the time.During an interview on 12/16/25 at 12:37 p.m., Resident 2 stated sometimes the nurse left his pills on the table and told him they were there.During an interview on 12/16/25 at 12:42 p.m., Resident 3 stated sometimes the nurse left the medication cup on his tray. Resident 3 stated sometimes the nurse returned to see if he had taken the medication and sometimes the nurse had not returned.During an interview on 12/16/25 at 12:50 p.m., Resident 4 stated occasionally the nurse left his pills in a cup and had not come back to see if he took the pills.During an interview on 12/16/25 at 12:52 p.m., Resident 2 stated after the nurse left the pills they had not come back to see if he had taken them.During a concurrent observation and interview on 12/16/25 at 12:55 p.m., LN 1 stated he had stayed with the residents and watched them take their medications. LN 1 entered Resident 1's room and observed with surveyor that Resident 1 had two pill cups on her tray table with medications in the cups. LN 1 stated he had dropped off the pill cups at 11:49 a.m. LN 1 stated one cup contained oxycodone which had been scheduled to be administered at noon. LN 1 stated the second cup contained gabapentin which had been scheduled to be administered at 2 p.m. LN 1 stated Resident 1 did not have an order for self-administration of medications.During an interview on 12/16/25 at 1:50 p.m., the Director of Staff Development (DSD) stated it was Absolutely not OK to leave medications at the bedside. During an interview on 12/16/25 at 2:33 p.m., the Director of Nursing (DON) stated it was, Absolutely not OK for nurses to leave medications at the bedside. The DON stated the facility had many in-services about medication administration. The DON stated the training included instructions to stay with the residents until all medications were taken. The DON stated anyone could have accidentally taken medications left at the bedside or the resident might not have taken the medications at all.A review of a facility policy and procedure