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	01/08/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report an event of unknown source which resulted in a resident's death, when one resident (Sampled Resident 1) was found deceased by paramedics in the facility's driveway on [DATE], within the mandatory timelines. Findings:During an interview on [DATE] at 9:20 a.m., the Administrator stated someone had called 911 for a facility resident that was slumped over in his wheelchair in the lower parking lot on [DATE]. He stated the facility first became aware of the resident death after paramedics performed Cardiopulmonary Resuscitation, had pronounced the resident dead and then notified the nurses who were working in the facility. The Administrator stated he did not report this resident death to the Department because he did not consider it to be an unusual occurrence. During an interview on [DATE] at 9:57 a.m. the Administrator stated he did not have to report it to the Department. He stated he had not concluded his investigation and did not have interviews with staff who responded to the incident. During an interview with the Director of Staff Development on [DATE] at I0:12 a.m., he stated the death of Resident 1 was an unusual occurrence and should have been reported to the Department. During an interview Director of Nursing on [DATE] at 12:53 p.m., she stated she understood an unusual occurrence to be something like a fire flood or the sudden death of a resident. She stated the death of Resident 1 was definitely an unusual occurrence and it should have been reported.Review of a facility Policy & Procedure titled Unusual Occurrence Reporting, dated 2001, indicated As required by federal or state regulations, our facility reports unusual occurrences or other reportable events which affect the health, safety, or welfare of our residents, employees or visitors. Our facility will report the following events to appropriate agencies: .d. Death of a resident, employee or visitor because of unnatural causes (e.g., suicide, homicide, accidents, etc.). 3. A written report detailing the incident and actions taken by the facility after the event shall be sent or delivered to the state agency (and other appropriate agencies as required by law) within forty-eight (48) hours of reporting the event or as required by federal and state regulations.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure accuracy of assessments when one of three sampled resident's (Resident 1) assessments did not reflect his correct status mental capacity status, and his fall risk assessment was not completed. These failures had the potential for lack of coordination of care with the health team and not providing the care and services necessary to ensure residents were safe and achieving their highest level of day-to-day life.Findings: During an interview on [DATE] at 10:12 a.m., Director of Staff Development stated he had conducted the investigation for the death of Resident 1 incident with Administrator. He reviewed the BIMS score and the last quarterly summary score indicated 01. He stated could not understand how he had a score of 01 because as a Licensed Nurse he knew the resident and he was alert and oriented. During a concurrent interview and medical record review, for Resident 1, on [DATE] at 11:31 a.m., MDS stated when she had performed an assessment on him during the last quarter, she would have scored his Brief Interview of Mental Status (BIMS) (An assessment to evaluate how cognitively intact a resident was.) score at a 3. (A score of 13 to 15: Normal thinking and memory (no or very little impairment) 8 to 12: Moderate problems with thinking and memory. 0 to 7: Severe problems with thinking and memory.) She reviewed the medical record document titled BRIEF INTERVIEW FOR MENTAL STATUS, dated [DATE], for Resident 1, and it indicated a score of 1 on [DATE]. She stated the social services staff completed the evaluation and scored it wrong. She stated Resident 1 had capacity to make his own decision and was his own responsible party. During a medical record review, a document titled Physician Orders for Life-Sustaining Treatment (POLST)(A medical document that documents a patient's specific wishes for end-of life care like CPR, Ventilation and feeding tubes.) dated [DATE], indicated Patient Has Capacity. The document was signed by Resident 1.Record Review for a document titled NURSING -FALL RISK OBSERVATION / ASSESSMENT, for Resident 1, dated [DATE], indicated a score of 18 (High Risk 16-42), and had not been completed and was signed by MDS on [DATE].Record Review for Resident 1 titled NURSING - ELOPEMENT AND WANDERING RISK OBSERVATION ASSESSMENT, dated [DATE], MOBILITY STATUS, indicated Able to move or propel themselves in a wheelchair with some assistance from others. COMMUNICATION - Does the resident have any communication, hearing or vision deficiencies? No. INTERVENTIONS Has the care plan been initiated / updated to reflect interventions aimed at reducing the risk of unsafe wandering or an elopement? Yes. Record Review for Resident 1 titled NURSING - ELOPEMENT AND WANDERING RISK OBSERVATION ASSESSMENT, dated[DATE], HISTORY OF ELOPEMENT ATTEMPTS Resident expressed that they plan to leave but has not attempted to leave facility. COMMUNICATION, indicated Resident 1 did not have any communication, hearing or vision deficiencies. INTERVENTIONS Has the care plan been initiated / updated to reflect interventions aimed at reducing the risk of unsafe wandering or an elopement? Yes.

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to provide adequate supervision for two of three sampled residents (Resident 1 and Resident 2), when:Resident 1 was able to leave the facility unnoticed by staff (elope), through the front doors in his wheelchair on [DATE], making it down a steep hill before being found deceased on the sidewalk in front of the building and next to a busy street, being discovered by a passerby who notified paramedics, who in turn notified facility staff, who was not aware Resident 1 had left the facility. Resident 2 was observed unsupervised and wandering around an area next to unlocked doors that led to a wet deck, a steep decline and a parking lot. These failures potentially contributed to Resident 1 being found outside the facility by a passerby, and pronounced dead by paramedics who notified facility staff, who were not aware Resident 1 was not in the facility, and had the potential to lead to injuries for Resident 2.Findings: On [DATE] at 9 a.m., the facility was observed to be three stories and was located on the side of a hill. The basement level of the facility was located on the lower level parking lot that faced the street. A very steep set of stairs was observed to get from the lower-level parking lot to the main entrance of the facility on the first floor. The entrance of the facility was accessible at the top of the stairs as well as a steep asphalt driveway with an uneven surface (see photograph). There were no secured gates to prevent a resident from leaving the sitting area outside the front doors of the facility and attempting to go down the steep driveway in wheelchairs.During an interview on [DATE] at 9:35 a.m., the Administrator stated he was informed on [DATE], by staff at the facility that Resident 1 had been in the main lobby of the facility and had been able to leave through the main double doors held open by a facility visitor. The Administrator stated, He was apparently found at the bottom of the driveway slumped over in his wheelchair. The Administrator stated somebody had called the paramedics, they arrived and attempted Cardiopulmonary Resuscitation (CPR) and declared him, Dead on Arrival. (DOA). The Administrator stated facility staff became aware Resident 1 was not in the facility when the paramedics came into the facility and requested information for Resident 1 around 5 p.m. The Administrator stated there was no receptionist in the front lobby by the main entrance on [DATE] at 4:53 p.m., when Resident 1 exited the facility. He stated there was usually a receptionist staffed by the main doors in the front lobby from 2 p.m. to 8 p.m., but she had recently quit.During an observation on [DATE] at 11:15 a.m., at the main entrance of the facility, the reception desk in the lobby was empty. Four people, without visible badges identifying them as employees if the facility or uniforms, entered the facility through the front lobby doors.Review of a facility document titled, admission Record, not dated, revealed Resident 1 was admitted to the facility [DATE], and expired [DATE]. He was admitted with diagnoses that included CEREBRAL INFARCTION (stroke), ATAXIA (poor muscle control), DYSPHAGIA (Difficult swallowing), MAJOR DEPRESSIVE DISORDER, RIGHT ABOVE-THE-KNEE AMPUTATION and MUSCLE WEAKNESS, DYSARTHRIA (motor speech disorder from poor muscle control) and ANARTHRIA (a more severe form of Dysarthia with complete inability to speak, though comprehension and writing are usually intact), among others. During an interview on [DATE] at 9:45 a.m., the Administrator stated he reviewed facility video surveillance of the incident of [DATE] at 4:49 p.m., when Resident 1 was observed self-propelling himself in his wheelchair from the elevator towards the lobby. The Administrator stated, at 4:53 p.m., visitors to the facility opened the front door to the facility, and Resident 1 went outside. The Administrator stated the front doors were not locked. He stated he did not save the video surveillance from [DATE]. The Administrator stated Resident 1 was his own Responsible Party and could leave if he wanted to.During an interview on [DATE] at 11:15 a.m., at the (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	main entrance of the facility, the Assistant Director of Nursing observed the front lobby and reception desk and stated, No one was monitoring the residents and the front doors of the facility. She stated there was supposed to be staff, and there was no active monitoring of residents. The Assistant Director of Nursing stated the risk to resident safety was that a resident could leave because no one was at the front desk monitoring, and the doors were not locked either.During an observation on [DATE] at 1:10 p.m., on the second floor of the facility outside the elevator, Resident 2 was in an unattended common area, with an unlocked sliding door on the right side that led out to a wet deck which overlooked a steep incline to the first level of the facility. To the left were unlocked double doors leading out to the parking lot across the hallway. Resident 2 appeared awake and did not communicate. She was walking around the room turning the lights on and off, opening cabinets and rearranging furniture without apparent reason. She walked continuously around the area and hallway from 1:10 p.m. to 1:50 p.m. No staff were checking on her or monitoring her behavior during this time.During an interview on [DATE] at 1:50 p.m., on the second floor of the facility, the Nurse Consultant stated the sliding doors in the common area where Resident 2 had been wandering were supposed to be locked. He stated the doors on the other side of the hallway, with a ramp leading to the parking lot, were supposed to be locked. He stated there was a risk Resident 2 could have gone out on the deck and slipped and fell on the wet leaves. He stated Resident 2 was being monitored remotely by the activity staff in the next room. He stated the activity staff were supposed to be supervising her. He stated the activity staff could not see her from where they were seated in the next room.Review of a facility document titled, admission Record, not dated, revealed Resident 2 was admitted [DATE], with diagnoses that included Dementia with behaviors (A loss of cognitive functioning), Muscle Weakness, Abnormality of gait and mobility (Changes in walking patterns), Glaucoma (eye condition leading to progressive vision loss and potential blindness), among others. During an interview with Unlicensed Staff C on [DATE] at 2 p.m., she stated residents in the facility could not leave on their own, and if residents wanted to leave, Unlicensed Staff C would tell a nurse. She stated residents who leave should have someone with them for their own safety. She stated Resident 1 left the second floor without being noticed and went outside the facility. She said she did not know how he made it down the driveway on his own, in a wheelchair, because it was so steep and uneven. She stated she could not have safely made it down the steep driveway if she were in a wheelchair.During an interview on [DATE] at 10:12 a.m., the Director of Staff Development (DSD) stated he was not working at the facility on the date Resident 1 expired in the lower parking lot. He stated he had received a phone call between 5 p.m. and 6 p.m., from the nursing supervisor who informed him Resident 1 had died unexpectedly in the lower parking lot of the facility. He stated the supervisor was informed by the paramedics they found Resident 1 unconscious in the lower parking lot, by the electric vehicle chargers, and had performed CPR. The DSD stated he reviewed the surveillance video with the Administrator, and stated the video indicated Resident 1 was observed getting into the elevator on the second floor and was then observed to head directly from the elevator down a long hallway directly to the front doors of the facility on the first floor. The DSD stated the video indicated Resident 1 sat and waited at the front doors of the main entrance until somebody came in the doors, and they held the doors open for him and let him go outside. He stated the last frame of the video indicated Resident 1 leaving the sitting area, onto the driveway and heading down the steep incline very slowly.During an interview on [DATE] at 12:52 p.m., the Director of Nursing (DON) stated the role of the person sitting at the front desk near the main entrance was to watch and monitor the residents who sat in the lobby. She stated they were supposed to monitor if a resident attempted to leave and either encourage them to come (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	back in or to call for help. If someone wanted to leave the facility, against medical advice, the nurse would try to convince them to stay, call the Physician, and then try to arrange for someone to come pick them up. The DON stated they could not just walk out. During an interview with Administrator at 12:53 p.m., the Administrator stated elopement was somebody without capacity leaving the building without permission. Administrator stated Resident 1 had capacity.During an interview on [DATE] at 1:45 pm., Resident 3 stated he was really sad to hear about the death of his friend and roommate Resident 1. He stated Resident 1, Hated it here. Resident 3 stated he did not understand how Resident 1 made it down the driveway in his wheelchair because it was steep and dangerous. He said, even if Resident 1 had made it down the driveway, he would have never been able to make it up the hill to come back. Resident 3 stated he had observed Resident 1 in the hallway prior to his elopement and stated he wore a red flannel shirt, something grey on his leg and a shoe. Resident 1 was a right above the knee amputee.A review of a document from a web site titled WORLD of WEATHER, indicated for [DATE] the weather in the evening, was 48 degrees Fahrenheit, and raining, with northwest winds at 7.4 miles per hour.Review of a facility document titled, admission Record, not dated, revealed Resident 3 was admitted to the facility [DATE]. Review of Resident 3's medical record indicated a BIMS score of 12. During an interview on 1//8/26 at 2:28 p.m., Physician B stated she was Resident 1's primary care doctor. She stated she was really sad about what happened to Resident 1, and it never should have happened. She stated Resident 1 hated it at the facility and was really unhappy there. She stated Resident had expressive aphasia and was able to make his needs known if staff would have taken the time for him to use his communication board or write something down. She stated it was hard to think of him all alone in the parking lot when it was cold and raining outside and dying there all alone. She stated, He should have only left with a responsible party for safety reasons, no one should be able to just leave. He never should have been able to leave the building alone. She stated there was an order that he could only leave with a facility pass and a responsible party.Review of a document titled Order Summary Report dated [DATE], printed [DATE] (after Resident 1 passed away) revealed a physician order, dated [DATE] (date of admission) Resident may go out on pass with responsible party for dr appointments only. The order status indicated Discontinued, however, no end date was documented. During a phone interview on [DATE] at 1:29 p.m., Family Member A stated she was the emergency contact for Resident 1 and had not been informed by the facility that Resident 1 had died. She stated she heard about Resident 1's death from Resident 1's friend. Family Member A stated this was very upsetting.Record review of a document titled, Progress Notes*NEW*, dated [DATE] at 9 p.m. indicated, LATE ENTRY Note Text: per activity staff, resident stated he wants to die and tried going out the ramp door but was redirected and brought back to his room by activity staff. Then resident went out to the balcony (on the second floor) and told activity staff he wants to leave this place and will jump off the balcony. They brought the resident back to his room. LN went to this resident and asked what happened that made him upset. Resident said, he was trying to asked for help for his bedridden roommate but nobody is helping. Record review of a document titled, Progress Notes*NEW*, dated [DATE], indicated, Nursing observations, evaluation, and recommendations are: resident had suicidal thought, and verbalized wanting to die and jump off the balcony, redirected and brought back to his room. When asked by LN (Licensed Nurse) what happened, resident said he did not mean what he said and he was just upset because his roommate is not getting any help from the staff. Review of a document titled: Care plan report, not dated, for Resident 1, revealed a Focus area indicating Behavior Monitor d/t (due to) suicidal ideation/thought, and staff were to Continuously monitor for suicidal thoughts as well as Check resident every hour per facility protocol. Review of facility Policy & Procedure (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	titled, Wander and Elopement, revised 3/2019, indicated, 1. If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety.A review of the facility Policy & Procedure titled, Safety and Supervision of Residents, revised 7/2017, indicated, Individualized, Resident-Centered Approach to Safety 1. Our individualized, resident-centered approach to safety addresses safety and accident hazards for individual residents. 2. The interdisciplinary care team shall analyze information obtained from assessments and observations to identify any specific accident hazards or risks for individual residents. 3. The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices.