| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055310 | A. Building<br>B. Wing | 04/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Marin Post Acute | 234 N. San Pedro Rd<br>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 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews and record review, the nursing staff failed to initiate and implement a person-centered care plan within seven days of admission and notify the physician and Registered Dietician (RD) for one resident (Resident 1) of three sampled residents, when Resident 1 was not weighed as ordered by the physician and lost 7 pounds in 13 days.This failure resulted in a significant loss of weight for Resident 1 and decreased the facility's potential to ensure accurate communication among its care team.Findings:A review of Resident 1's face sheet indicated admission to the facility on 3/25/26 with a diagnosis that included Dysphagia (a language disorder characterized by partial loss of the ability to produce or understand speech, caused by brain injury or disease) following a Cerebrovascular Disease (conditions affecting blood vessels supplying the brain, often causing reduced blood flow, oxygen deprivation, or hemorrhaging), Muscle Wasting and Atrophy, and Wernicke's Encephalopathy (a life-threatening acute neurological emergency caused by severe thiamine (Vitamin B1) deficiency, most commonly related to alcohol misuse, malnutrition, or prolonged vomiting).A review of Resident 1's Braden Scale [an assessment tool used by healthcare professionals to predict a resident's risk of developing pressure ulcers (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence)] Observation/Assessment dated 3/25/26 at 7:08 p.m. indicated Resident 1's usual food intake pattern was adequate (he ate over half of most meals).A review of Resident 1's admission assessment dated [DATE] at 10:40 p.m. indicated Resident 1 needed assistance with eating.A review of Resident 1's Minimum Data Set (an assessment tool) dated 3/26/26 indicated Resident 1 had a Brief Interview for Mental Status (BIMS, a screening tool used to measure cognition [the ability to think and problem-solve]) score of 8 which indicated moderate cognitive impairment. A review of Resident 1's Nutritional Risk Assessment dated 4/1/26 at 7:18 p.m. indicated the Registered Dietician (RD) assessed that Resident 1 had a chewing/swallowing problem, his ideal body weight was 148 pounds (lbs.), and his goal weight as 125 to 130 lbs. The RD's recommendations included that staff weigh Resident 1 per the facility's protocol. The RD also indicated Resident 1's nutrition goal was No significant weight changes, [for staff to] monitor [Resident 1's] weight trend.[and for Resident 1 to eat more than] 65% of all meals. A review of Resident 1's Weight and Vitals Summary report dated 3/25/26 to 4/6/26, indicated Resident 1 weighed 128.1 lbs. upon admission on [DATE] and lost approximately 12.1 lbs. 12 days later when staff documented his weight as 116 lbs. on 4/6/26. This document further indicated the following warning to nursing staff, -5.0% change [Comparison Weight 3/25/26, 128.1 lbs., -9.4%, -12.1 lbs.].A review of Resident 1's Medication Administration Record (MAR) dated March 2026 indicated Resident 1 had the following order starting on 3/30/26 at 7 a.m., admission weekly weights x [for] 4 weeks, then Monthly Weights. Every day shift every Mon [Monday] for 4 weeks. This MAR further indicated nursing staff did not obtain a weight for Resident 1 on 3/30/26 as instructed in the physician's order.A review of Resident 1's MAR dated April 2026 indicated nursing staff weighed Resident 1 on 4/6/26 and he weighed 128.1 lbs.A review of Resident 1's progress notes dated 3/25/26 to 4/6/26 showed no documented evidence that nursing staff notified the physician or the RD of Resident 1's weight loss.A review of Resident 1's progress note (continued on next page) |

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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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | dated 4/7/26 at 9:30 p.m. indicated, BLS [Basic Life Support ambulance] came to pick up [Resident 1].Writer called [hospital] ED [Emergency Department] and.[gave] report.A review of Resident 1's care plan regarding his high risk for nutritional concern was initiated on 4/10/26 indicated staff was expected to weigh Resident 1 weekly for four weeks upon admission and then monthly if his weight was stable. This care plan did not include Resident 1's need for assistance when eating, monitoring the percentage of food Resident 1 ate during meals, or any indication that Resident 1 refused meals.A review of Resident 1's hospital documentation regarding his stay from 4/7/26 to 4/14/26 indicated Resident 1 weighed 121 lbs. when he arrived at the ED (a 5.54% weight loss in 13 days) and Resident 1 was discharged from the hospital to a different skilled nursing facility.In an interview with Certified Nursing Assistant 1 on 4/16/26 at 1:20 p.m., CNA 1 stated she took care of Resident 1. CNA 1 stated Resident 1 would refuse to eat at times and that CNA 1 had to push Resident 1 to eat his breakfast and lunch.In an interview with Licensed Nurse 3 (LN 3) on 4/16/26 at 2:11 p.m., LN 3 stated she took care of Resident 1. LN 3 stated Resident 1 would refuse to eat at times.During a telephone interview on 4/22/26 at 3p.m., LN 1 stated if there was a change in a resident's weight she would report to the nurse manager, notify the physician and the dietician, and start a change of condition (COC) report.During a telephone interview on 4/22/26 at 4:35 p.m., LN 2 stated she had taken care of Resident 1 a few times and took care of him on 4/7/26 when he was transferred to the hospital. LN 2 stated she spoke with the RD on 4/7/26 and stated the documented weight must have been an error and she planned to retake Resident 1's weight when he returned. LN 2 stated for any significant weight change she would have retaken the weight, notified the physician and RD and started a COC report. LN 2 confirmed that Resident 1's weight change was not documented in the progress notes or reported to the physician.During a record review and concurrent interview on 4/23/26 at 11:30 a.m., the Director of Nursing (DON), acknowledged Resident 1's weight loss variance and stated she expected t staff to report any weight changes to the physician, RD, and to start a COC document. The DON confirmed there was no documented evidence that nursing staff notified the physician or the Inter-disciplinary team (IDT) of the weight change, nor was there documented evidence of a revision of the care plan. A review of the facility's policy titled Weight Assessment and Intervention revised, March 2022, indicated, Weight Assessment.Any weight change of 5% or more since the last weight assessment is retaken the next day for confirmation .If the weight is verified, nursing will immediately notify the dietician in writing. Evaluation.The physician and the multidisciplinary team identify conditions and medications that may be causing. weight loss Care Planning.Individualized care plans shall address to the extent possible.the identified causes of weight loss. goals and benchmarks for improvement. and.time frames and parameters for monitoring.A review of the facility's policy titled Care Plans, Comprehensive Person-Centered dated March 2022 indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical.and functional needs is developed and implemented for each resident.The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment.The comprehensive, person-centered care plan.describes the services that are to be furnished to attain or maintain the resident's highest practicable physical.well-being, including.services that would otherwise be provided for the above.reflects currently recognized standards of practice for problem areas and conditions.Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.A review of the American Medical Directors Association (AMDA) Clinical Practice Guidelines for Long Term Care (LTC) Facilities article titled Altered Nutritional Status in the Long-Term Care Setting dated 2011 indicated, At any time during the patient's stay in a LTC facility, observation of any one of the following conditions should trigger a prompt initiation of an assessment of the patient's nutritional and fluid status.weight change of 5% in one month.Decline in food or fluid intake over several days.Consumption of less than 75% of the patient's meals is the most common symptom associated with weight loss. |