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	05/07/2026

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 0564 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform each resident of his or her visitation rights and ensure that all visitors enjoy equal visitation privileges. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that one of three sampled residents (Resident 1) was provided the right to immediate access by family members, as required when the facility restricted Resident 1 from receiving visits and telephone communication from one of her daughters (DTR 3) and her sonˆinˆlaw (SIL 1), based solely on another daughter's (DTR 1) designation as health care decision maker. The facility did not verify Resident 1's wishes, and there was no clinical, legal, or safety justification for restricting contact.This failure resulted in Resident 1 being denied communication and visitation with family members of her choosing, with the potential for psychosocial harm.A review of Resident 1's admission Record (facility demographic) indicated Resident 1 was originally admitted to the facility on [DATE] with an admitting diagnosis of pelvic fractures (breaks or disruptions in the bones that make up the pelvis, which is the ring-like structure located at the base of the spine).During a phone interview on 5/07/26 at 9:02 a.m., Resident 1's family member (DTR 3) reported the facility restricted her from communicating and visiting with Resident 1. DTR 3 stated she was upset because her family members (DTR 1 and DTR 2), who were listed as Resident 1's health care agents, instructed the facility to restrict her and her husband (SIL 1) from contacting Resident 1. DTR 3 stated she had called the facility multiple times, but nursing staff refused to allow her to speak with Resident 1.During a review of a one-page document titled, RESIDENT CAPACITY STATEMENT., dated 1/15/26, a Medical Doctor indicated Resident 1 had the capacity to make healthcare decisions.During an interview on 5/07/26 at 11 a.m., the Social Services Director (SSD) confirmed the facility had restricted communication and visitation from DTR 3 and SIL 1. After reviewing the medical record, the SSD stated there was no documented evidence that Resident 1 ever refused contact with them. The SSD confirmed the medical record contained no court order or clinical/safety justification supporting the restriction. The SSD stated she had never interviewed Resident 1 to determine her wishes regarding communication or visitation. The SSD acknowledged staff informed her that DTR 3 and SIL 1 had been upset on at least two occasions after being denied contact. The SSD reported that an Ombudsman visited the facility on 5/06/26 to inform staff that Resident 1's Advance Directive (a legal document that outlines an individual's preferences for medical treatment if he/she becomes too ill or injured to speak for him/herself) naming DTR 1 as primary agent and DTR 2 as alternate, did not authorize restricting Resident 1's communication or visitation with other family members. The SSD stated that after this clarification, the facility understood they could not restrict DTR 3 and SIL 1 if Resident 1 wished to see or speak with them. During the interview, the SSD displayed Resident 1's profile in the medical record, which still contained incorrect instructions to restrict DTR 3 and SIL 1. The SSD stated she did not know who entered or edited the information.During a review of a progress note in Resident 1's medical record dated 5/05/26, authored by Licensed Nurse 1 (LN 1), she indicated SIL 1 called requesting to visit the facility and bring food to Resident 1. LN 1 documented she denied the request based on the restriction listed in Resident 1's medical record, and instructed SIL 1 to contact DTR 1 and DTR 2 for clarification before transferring the call to the SSD.During an interview on 5/07/26 at 12:24 p.m., LN 1 (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0564 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated she was unfamiliar with Resident 1 but saw the restriction in her profile and denied SIL 1's visit request based solely on that information. LN 1 reported she had been told the SSD received an email from DTR 1 and DTR 2 stating that DTR 3 and SIL 1 were not permitted to visit or communicate with Resident 1.During an interview on 5/07/26 at 12:47 p.m., the facility's Admissions Director (FAD) stated he had spoken with DTR 3 previously after she submitted a message through the facility website requesting to contact Resident 1. The FAD stated DTR 3 was very upset that nursing staff told her she could not speak with Resident 1 when she attempted to call and speak with her. The FAD acknowledged he followed the instructions listed in Resident 1's profile directing staff to restrict DTR 3.During an interview on 5/07/26 at 1:20 p.m., with Resident 1, using an interpreter (INT 1), Resident 1 stated that she wanted to continue communicating and visiting with all three of family members (DTR 1, 2, and 3), in addition to SIL 1. Resident 1 expressed distress about not knowing why the facility had restricted contact from DTR 3 and SIL 1. Resident 1 stated she wished to remain in the facility longˆterm but wanted ongoing communication and visits with all her family members.During an interview on 5/07/26 at 1:48 p.m., the Director of Nursing (DON) acknowledged at least two incidents where Resident 1 was improperly restricted from contact with DTR 3 and SIL 1. The DON stated the issue had been cleared up, but acknowledged Resident 1's medical record still contained incorrect instructions directing staff to restrict contact. The DON confirmed Resident 1's Advance Directive did not authorize restricting access with DTR 3 and SIL 1, and that previous restrictions were made solely at the request of DTR 1 and DTR 2. The DON acknowledged the potential for psychosocial harm from restricting Resident 1's access to her family.A review of the facility policy titled, Resident Rights, revised February 2021, indicated, Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: . c. be free from abuse, neglect, misappropriation of property, and exploitation;. f. communication with and access to people and services, both inside and outside the facility; . h. be supported by the facility in exercising his or her rights;. i. exercise his or her rights without interference, coercion, discrimination or reprisal from the facility;. m. exercise rights not delegated to a legal representative;. p. be informed of, and participate in, his or her care planning and treatment;. aa. access to a telephone, mail and e-mail;. bb. communicate in person and by mail, e-mail and telephone with privacy .