

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055310	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/04/2025
NAME OF PROVIDER OR SUPPLIER Marin Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an effective infection prevention and control program when:1. 3 of 3 pill crushers contained a white and black colored powder-like substances.2. The licensed staff did not wear a gown while checking vital signs (measurement of body functions) for Resident 36, who was in an isolation room that had signage posted on his room door to indicate Enhanced Barrier Precautions (EBP- gown and glove use, required during high contact resident care activities, designed to reduce transmission of organisms). 3. Resident 17's nebulizer tubing (used to inhale medication) was not changed weekly. These failures had the potential to result in the spread of infectious diseases for the facility's residents and staff. Findings:1. During a concurrent observation and interview on 12/02/25 at 4:12 p.m. with Registered Nurse (RN) 1, the pill crusher on the blue medication cart was coated with white and black colored powder-like substances. RN 1 used the pill crusher to administer medication for Resident 21. RN 1 stated the pill crusher appeared dirty with a mixture of dust and medication residue. RN 1 stated sometimes the medication bag would rip which caused the residue to build up. During a concurrent observation and interview on 12/2/25 at 4:28 p.m. with Licensed Vocational Nurse (LVN) 1, the pill crusher on the purple medication cart was coated with white and black colored powder-like substance. LVN 1 stated the pill crusher was dirty with medication residue. LVN 1 stated the pill crusher should be clean to prevent cross-contamination. During a concurrent observation and interview on 12/2/25 at 4:30 p.m. with LVN 2, the pill crusher on the green medication cart was coated with white and black colored powder-like substance. LVN 2 stated the pill crusher was dirty with medication residue. LVN 2 stated the pill crusher should be clean to prevent cross-contamination. During an interview on 12/4/25 at 10 a.m. with the Infection Preventionist (IP), IP stated the pill crushers should have been cleaned once per shift and as needed. IP stated the purpose of cleaning the pill crusher was to prevent infection and contamination. During a review of the Instruction for Using (IFU) [Brand Name] pill crusher titled Cleaning and Maintenance Instructions, undated was reviewed. The IFU indicated, .May be cleaned regularly with a damp cloth .Using a damp cloth, wipe clean the [Brand Name] Pill Crusher using a normal detergent and water. Wipe down with dry cloth .2. During an observation on 12/1/25 at 3:11 p.m., Resident 36's room door had EBP signage posted. Resident 36 was observed lying in bed while LVN 2, who was ungowned, checked his vital signs. During an interview on 12/1/25 at 3:22 p.m., with LVN 2, LVN 2 stated Resident 36 was on EBP because he had a urinary catheter (a catheter tube inserted into the bladder through the urethra to allow urine to drain into a collection bag). LVN 2 stated that he should have worn a gown while checking Resident 36's vital signs to prevent cross-contamination. During a review of Resident 36's admission Record, undated, the admission Record indicated Resident 36 was admitted to the facility on [DATE], with diagnoses that included obstructive uropathy (blockage in the urinary tract). During an interview on 12/4/25 at 9:56 a.m. with the Infection Preventionist (IP), the IP stated that any high touch activities require a gown in the EBP isolation room. The IP stated for EBP nursing staff should wear gloves and gowns when checking vital signs. During a review of the policy and procedure titled, Enhanced Barrier Precautions, dated 12/2024, indicated, .Gloves and gown are applied prior to (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 055310	Facility ID: 055310 If continuation sheet Page 1 of 6

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	performing the high contact resident care activities .3. During a concurrent observation and interview on 12/2/25 at 9:50 a.m. with Resident 17, Resident 17's nebulizer tubing was dated 11/23/25 (nine days ago). Resident 17 stated she used the nebulizer daily and that the tubing had not been changed. Resident 17 stated she did not want to get sick and wanted the tubing to be changed.During an interview on 12/2/25 at 9:59 a.m. with LVN 4, LVN 4 confirmed Resident 17's nebulizer tubing was dated 11/23/25 and stated the tubing should have been changed.During an interview on 12/4/25 at 9:58 a.m. with the Infection Preventionist (IP), the IP stated that nebulizer tubing should be changed weekly or as needed to prevent the spread of infection.During a review of the policy and procedure titled, Departmental (Respiratory Therapy) Prevention of Infection dated 11/2011, indicated, .Change the oxygen .tubing every (7) days, or as needed .		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, and record review, the facility failed to provide a safe environment when one sharps container (a specially made box used to safely discard sharp items) was overfilled in Unit 2, Shower Room A. This failure had the potential to cause harm to residents and staff. Findings: During a concurrent observation and interview on 12/1/25 at 4:42 p.m. in Unit 2, Shower Room A with Licensed Vocational Nurse (LVN) 1, there was an overfilled sharps container that had razors sticking out of the opening. LVN 1 stated that housekeeping and nursing staff were responsible for emptying the sharps container. During a review of the facility's policy and procedure (P&P) titled, Sharps Disposal, dated January 2012, the P&P indicated, Designated individuals will be responsible for sealing and replacing containers when they are 75% to 80% full to protect employees from punctures and/or needlesticks when attempting to push sharps into the container.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview, and record review, the facility failed to ensure 1 of 30 sampled residents (Resident 8) care plan interventions were implemented when Resident 8's indwelling urinary catheter (a flexible tube that drains urine from the bladder) collection bag was not positioned below the bladder. This failure placed Resident 8 at risk for urinary tract infections. Findings: During a concurrent observation and interview on 12/1/25 at 3:34 p.m. with Licensed Vocational Nurse (LVN) 2, in Resident 8's room, Resident 8's catheter collection bag was positioned above the bladder. LVN 2 stated the catheter collection bag was not positioned correctly to allow urine to drain into the collection bag. LVN 2 stated the catheter collection bag should have been positioned below Resident 8's bladder. During a review of Resident 8's care plan, dated 1/30/25, the care plan indicated, .position catheter bag and tubing below the level of the bladder .During an interview on 12/3/25 at 3:48 p.m. with the Director of Nursing (DON), the DON stated the urinary catheter collection bag should be placed below the level of bladder to prevent back flow which can lead to infection. During a review of the policy and procedure titled, Catheter Care, Urinary, dated 8/2022, indicated, .Position the drainage bag lower than the bladder at all times to prevent urine from flowing back into the urinary bladder .		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure the residents' environment remained free of accident and hazards for 3 of 30 sampled residents (Residents 4, 17, and 53) when:1. A portable space heater was on the floor in the middle of Resident 4,17, and 53's shared room. This failure had the potential to result in a fire and tripping hazard for the residents.2. Resident 53's, who was at risk for falls, floor pad was not on the floor as ordered. This failure had the potential to result in significant injuries for the resident. Findings:1. During a concurrent observation and interview on 12/1/25 at 2:32 p.m. with Resident 17, in Resident 17's room (shared by Resident 4 and 53), a portable space heater was on the floor in the middle of the room. Resident 17 stated a Certified Nursing Assistant (CNA) brought it to her room about a week ago because she was cold. During an interview on 12/2/25 at 9:59 a.m. with Licensed Vocational Nurse (LVN) 4, LVN 4 stated she was aware the portable space heater was on the floor in the middle of the room.During an interview on 12/3/25 at 3:16 p.m. with the Administrator (ADM), the ADM stated it was facility's policy for residents not to have space heaters because of fire hazard. The ADM stated it was his expectation for staff to inform him if they see a space heater, so they can offer other interventions.During a review on the facility policy titled Electrical Appliances dated 1/2019, the policy indicated .Portable space heaters are not allowed in resident areas .2. During a concurrent observation and interview on 12/2/25 at 2:49 p.m. with Certified Nursing Assistant (CNA) 1, in Resident 53's room, Resident 53 was observed lying in bed. There was a floor pad stored in an upright position next to Resident 53's nightstand. CNA 1 stated the floor pad should have been placed on the floor next to the bed to protect Resident 53 in the event of a fall. During a concurrent observation and interview on 12/3/25 at 9:51 a.m. with CNA 2, in Resident 53's room, Resident 53 was observed lying in bed. There was a floor pad stored in an upright position next to Resident 53's nightstand. CNA 2 stated Resident 53 was a fall risk and the floor pad should have been placed on the floor next to her bed. During a concurrent interview and record review on 12/3/25 at 3:50 p.m. with the Director of Nursing (DON), Resident 53's physician orders, dated 7/27/24, were reviewed. The physician order indicated, .Floor Pad at bedside: Ensure proper placement every shift for fall risk . The DON stated it was nursing staff's responsibility to ensure the floor pad was placed on the floor to prevent injury if a fall were to occur. During a review of the facility policy titled Fall and Fall risk, Managing, dated 3/2018, the policy indicated .The staff .will implement a resident-centered fall prevention plan .		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to safely store drugs and supplies in accordance with acceptable standards of practice when: 1. One medication cart (Medication Cart A) was left unlocked and unattended. 2. One treatment cart (Treatment Cart A) was left unlocked and unattended. These failures had the potential for residents and staff to have unauthorized access to medications and treatments. Findings: 1. During a concurrent observation and interview on 12/1/25 at 3:31 p.m., with LVN 2, Medication Cart A was left unlocked and unattended next to the Beauty Shop against the wall. LVN 2 walked out of room [ROOM NUMBER] towards Medication Cart A and confirmed Medication Cart A was unlocked. LVN 2 stated that Medication Cart A should have been locked when unattended to prevent unauthorized access. 2. During a concurrent observation and interview on 12/2/25 at 4:27 p.m. with Registered Nurse (RN) 1, Treatment Cart A was unlocked and unattended. RN 1 stated Treatment Cart A should have been locked when unattended to prevent unauthorized access. During a concurrent interview and record review on 12/3/25 at 3:46 p.m. with the Director of Nurses (DON), the facility's policy and procedure titled, Medication Labeling and Storage, dated 2023 was reviewed. The policy indicated, .The facility stores all medications and biologicals in locked compartments .Compartments .containing medications and biologicals are locked when not in use .carts .are not left unattended . The DON stated medication carts and treatment carts should be locked when unattended to prevent unauthorized access.		