STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055850	A. Building B. Wing	05/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Ridge Care Center	45 Professional Center Pkwy 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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38088 Based upon observation, interview and record review, the facility failed to ensure the safety of one sampled resident (Resident 1), when he was allowed to leave out on pass (physician approval to leave for a few hours at a time) without a physician ' s order and against facility policy. This failure resulted in Resident 1 purchasing alcohol, consuming three fifths of vodka and attempting to leave the facility against medical advice (without the doctors orders or a discharge plan) while intoxicated. Findings: During an interview on 5/23/24, at 3:11 a.m., Complainant D stated she was a response team member for Specialized Assist for Everyone,(SAFE) (A mobile crisis team through the city that attempted to work with marginalized people to prevent homelessness.). She stated she had responded to a police call on 5/19/24 at 7:20 p.m. for a resident who was intoxicated, uncooperative, verbally aggressive and had attempted to leave the facility against medical advice. She stated she observed Resident 1 in the parking lot, holding onto his walker and facility staff had attempted to de-escalate the situation and persuade Resident 1 to return inside the facility. She stated she observed an almost empty bottle of clear liquid in a vodka bottle in his pocket. Complainant D stated a male nurse had stated that Resident 1 was observed to have already consumed two other bottles of vodka in his bedroom. The male nurse stated he had attempted to confiscate the remaining bottle of vodka and Resident 1 refused and stated he could do what he wanted and attempted to leave the facility. Complainant D stated the police had arrived and she attempted to de-escalate the situation with Resident 1. She stated Resident 1 had informed her that earlier in the day, he was accompanied to the corner convenience store by a facility staff who had purchased the three bottles of vodka with Resident 1 ' s personal money. She stated Resident 1 was blind, used a walker and was safety risk. She stated eventually Resident 1 agreed to return to the facility. A review of a document titled Resident Face Sheet, indicated Resident 1 was admitted [DATE], with diagnoses that included Alcoholic hepatitis(Inflammation of the liver caused by drinking excessive amounts of alcohol) without ascites (Abnormal build up of fluid in the abdomen). Visual Loss-Legally Blind: Slight vision, Glaucoma, Alcohol abuse, Alcohol dependence with withdrawal, Alcoholic cirrhosis of liver with ascites (Scar tissue in the liver caused by alcohol.), Falls with injuries, Difficulty in walking. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055850	A. Building B. Wing	05/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Ridge Care Center	45 Professional Center Pkwy 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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with facility Administrator, on 5/28/24 at 9:45 a.m., he stated he was aware of the incident that involved Resident 1 drinking alcohol. He stated he did not investigate it or had any documentation of the events that resulted in the incident. He stated residents requested to go the corner convenience store all the time. He stated staff accompanied residents for safety and did not know if the staff had reported that Resident 1 had purchased three bottles of vodka. He stated the nurse at the facility at the time of the incident, had assumed Resident 1 had a pass to go out. Administrator stated he had been informed by the nurse that Resident 1 had been observed drinking vodka in his room by unlicensed staff who told the nurse. Administrator stated the nurse observed Resident 1 was extremely intoxicated, had two of three bottles of vodka empty in Resident 1 ' s room, and observed the third bottle had an inch or so of vodka left. Administrator stated the nurse attempted to confiscate the bottles and Resident 1 became agitated and informed the nurse he wanted to leave against medical advice (AMA). Administrator stated the nurse accompanied Resident 1 outside, called the police and administrator and had resident 1 sign AMA documents. Administrator stated eventually the situation was de-escalated and Resident 1 returned inside the facility. He stated he did not investigate it. Administrator stated the nurse had assumed Resident 1 had a pass to go out but did not check for a physician ' s order. He stated Resident 1 did not have an order and it was wrong for him to go out. He stated the facility policy and procedure for a day pass was to have a physician order, sign the resident out and then sign them back into the facility. He stated it was important for resident to know the location of the resident while under the care of the facility. He stated it was resident safety issue. During an interview on 5/28/24, at 10:05 a.m., Unlicensed Staff B stated if a resident wanted to go out on pass, the nurse would document and sign the resident out of the facility. He stated a resident could buy anything he wanted and if he observed a resident to have purchased alcohol, he would have informed the nurse. During an interview on 5/28/24, at 10:15 a.m., Licensed Nurse C stated if a resident made a request to go out on pass, she would check for a physician ' s order, fill out documents and then sign them out. He stated resident had to have a physician ' s order to leave the facility on a day pass. She stated staff could accompany them if they had enough staff. She stated if a resident wanted to leave the facility, she would accompany the resident to keep the resident safe. She stated it was staff responsibility to always observe the resident to make sure they would not fall or get hurt. She stated if a resident wanted to leave AMA and they were assessed to have dementia or under the influence of alcohol they could not sign the AMA forms. She stated she would have called the physician, police and administrator. During an interview on 5/28/24, at 10:25 a.m., with Unlicensed Staff A, he stated residents needed a physician ' s order to go out on pass. He stated he would inform the nurse. He stated if he walked with the resident to the store, he would be sure the resident was safe, would not fall, and would not take his eyes off the resident. He stated alcohol is not allowed at the facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055850	A. Building B. Wing	05/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Ridge Care Center	45 Professional Center Pkwy 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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review and interview with Administrator on 5/28/24 at 10:35 a.m., a document titled Resident on Pass, not dated, indicated All residents leaving the facility must be signed out and have an appropriate ' out-on-pass physician order written. Residents must be signed in upon return to the facility. Record in the Progress Notes any information pertinent to the resident ' s absence from the facility. Administrator reviewed the facility Day Pass Binder for documentation on 5/19/24 and stated there was no documentation that Resident 1 went out of the facility, or was signed back into the facility. Administrator stated the staff did not follow the facility policy and procedure for Resident on Pass from the facility. He stated it was a safety issue. Administrator did not answer what the responsibilities were for staff who accompanied residents shopping outside the facility. Administrator stated the facility could not do anything about a Resident who wanted to purchase alcohol and bring it back to the facility. A review of a document titled Resident Progress Notes, dated 5/19/24, did not indicate any documentation that Resident 1 had left the facility, accompanied by staff, to walk to the convenience store. Administrator stated staff did not follow facility policy and procedure. A request was made to interview the nurse who did not check the order and the unlicensed staff who accompanied Resident 1 to the convenience store and was not provided an opportunity to interview them. A review of Resident 1 ' s Brief Inventory of Mental Status (BIMS)(An assessment of cognitive function), dated 4/26/24, indicated BIMS Summary Score 14 (No impairment of mental status). A review of a document titled Care Plan History, did not indicate a care plan had been initiated for alcohol intoxication, history of alcohol dependency, or the incident that occurred on 5/19/24 that included purchase of alcohol while out on pass, and intoxicated behaviors that included attempted AMA while intoxicated.