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	07/16/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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
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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report to the Department an injury of unknown source (an injury which was not observed, cannot be explained by the resident, and is suspicious because of the extent or location) for one of four sampled residents (Resident 1) when Resident 1 sustained a broken left arm. The facility was aware of Resident 1's injury on 7/6/25, but did not report it to the Department until 7/8/25.This failure resulted in a delay in the Department's investigation into Resident 1' s injury and its cause, putting Resident 1 at risk for additional harm. A review of Resident 1's Resident Face Sheet, printed 7/16/25, indicated Resident 1 was initially admitted to the facility on [DATE], with diagnoses including Alzheimer's disease (a progressive brain disorder that gradually impairs memory, thinking, and language skills, eventually affecting a person's ability to carry out daily tasks), epilepsy (defined by recurrent seizures, which are sudden, temporary disruptions of normal brain activity), and hemiparesis (a condition characterized by weakness on one side of the body) following cerebral infarction (a condition where brain tissue dies due to a lack of blood supply) affecting the left side of the body.During a review of Resident 1's Minimum Data Set (MDS-an assessment and care planning tool), Section B (describing hearing, speech and vision ability), dated 6/13/25, it indicated Resident 1 could not speak or communicate in any way that could be understood by others. During a review of Resident 1's MDS Section C (describing abilities relating to the mental process involved in knowing, learning, and understanding things), dated 6/13/25, it indicated Resident 1's ability to make decisions was severely impaired, and Resident 1 had short and long-term memory deficits.During a review of Resident 1's Resident Progress Notes, dated 7/5/25 at 9:54 p.m., it indicated resident was noted with facial grimace, moaning and almost crying upon repositioning left arm.resident with behavior of grabbing and pulling with right hand. N.O. (new order) from [MD]-Xray of LT (left) wrist 3 view; LT hand 3 view; LT forearm; noted and carried out.During a review of Resident 1's Radiology Report, dated 7/6/25, it indicated Resident 1 had the following , Forearm.Left, Results: Severely comminuted fracture (where the bone is broken into three or more pieces) of the distal radial (near the wrist joint) and ulnar metaphysis (the ulna is one of the two bones in your forearm, located on the pinky side. The metaphysis is the area between the diaphysis (shaft) and the epiphysis (end) of the bone). Radial fracture shows complete lack of apposition and alignment (apposition refers to the degree of contact between bone fragments at the fracture site, while alignment describes the overall position and orientation of the bone fragments). Ulnar fracture shows angulation (describes the degree to which the broken bone fragments are misaligned, forming an angle with each other).During a review of Resident 1's Resident Progress Notes, dated 7/6/25 at 1:30 p.m., it shows the time/date the facility became aware of Resident 1's left forearm fracture.A review of CDPH (California Department of Public Health) Incident/Intake Report for intake number CA00971772 (for incident date 7/6/25) indicated the facility reported this incident to CDPH on 7/8/25 at 5:40 p.m., via telephone voicemail message. During a concurrent interview and record review on 7/16/25 at 2:00 p.m. with Resident 1's primary care provider (PCP) and the Director of Nursing (DON), Resident 1's radiology results and recent skin assessments were reviewed. The DON agreed on multiple occasions Resident 1 was noted to have unexplained skin discoloration, redness, or other abnormal marks on her arms, face, trunk, thighs, and hands. The PCP stated it would be hard to determine exactly where or how Resident 1's broken arm occurred. The PCP further stated although Resident 1's medical conditions and medications may contribute to brittle bones and spontaneous fractures, he agreed a comminuted fracture is usually connected to falls, car accidents or other high-impact blows.During an interview with the facility's Administrator (ADM) on 7/16/25 at 3:30 p.m., the ADM stated he did not believe that this incident was required to be reported within two hours because abuse was not suspected. The ADM did not give any indication of how abuse could be ruled out for such a serious unexplained injury before a preliminary investigation was conducted. A review of facility policy and procedure titled Abuse Investigation and Reporting (undated), indicated: Reporting:1. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported to the Company Administrator, or his/her designee, to the following persons or agencies: a) The State licensing certification agency responsible for surveying/licensing the facility; b) The local/state Ombudsman (works independently as an intermediary to provide individuals with a confidential avenue to address complaints and resolve issues); c) The Resident's Representative (Sponsor) of Record; d) Adult Protective Services (where state law provides jurisdiction in