

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055850	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/04/2025
NAME OF PROVIDER OR SUPPLIER Pine Ridge Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to immediately notify the responsible party (RP, a person who is designated in making decisions about health care and financial matters) for one out of two residents (Resident 1), when Resident 1's RP was not notified until 4/20/25 that Resident 1 fell on 4/18/25 and 4/19/25. This failure was a violation of residents' rights. Findings:A review of Resident 1's face sheet (front page of the chart that contains a summary of basic information about the residents) indicated Resident 1 was admitted to the facility in April of 2025 with a RP listed and a note that indicated, '[phone] number corrected to [xxx-xxx-1966] from [xxx-xxx-9518] on 4/20/25.A review of Resident 1's Nursing Progress note, dated 4/18/25 at 4:26 a.m., indicated, '[Resident 1] is found sitting on the floor next to his bed. [Resident 1] stated, 'I just fell on my butt.'Called RP.no answer.A review of Resident 1's Nursing Progress, dated 4/19/24 at 4:40 p.m., indicated, '[Resident 1] was sitting in his w/c [wheelchair] . resident was trying to turn his w/c around when he slid down from his w/c, landed [on] his bottom [buttocks].RP.left 3x [three times] voice mail, no return call noted.A review of Resident 1's Nursing Progress note, dated 4/20/25 at 11:15 a.m., indicated, '[Resident 1's RP] .during course of conversation, brought up to [RP] .writer called her at [phone number xxx-xxx-9518] and left a voicemail to call facility back; per [RP] she did not receive the voicemail. We then checked the face sheet. The contact number that is in the face sheet [xxx-xxx-9518], according to [RP] is not the number that she is using but it's [xxx-xxx-1966]. This may be the reason why she did not receive the call.During an interview on 8/4/25 at 3:44 p.m., Licensed Nurse (LN) B stated a fall was considered a change of condition (COC, a noticeable alteration in a patient's health status, either positive or negative) and should be reported to the resident's RP and the resident's physician. LN B stated fall incidents should be reported to RP immediately or at least before the end of shift. LN B stated the facility was responsible to ensure the correct contact information is listed on the resident's face sheet to be able to notify the RP for a fall. LN B stated not notifying the RP of a COC was a violation of residents' rights.During a concurrent interview and record review on 8/4/25 at 4:34 p.m. with LN A, Resident 1's face sheet was reviewed. LN A verified there was a note on Resident 1's face sheet indicating on 4/20/25, the day of Resident 1's discharge, the RP's contact number was changed to the correct contact number [xxx-xxx-1966]. LN A stated the facility was responsible for ensuring the RP's contact number on residents' files were accurate. LN A verified that due to the wrong contact number on the face sheet, the RP was not made aware of Resident 1's fall incidents on 4/18/25 or 4/19/25 timely. LN A stated it was important that RPs were aware of COC such as falls.During a telephone interview on 8/5/27 at 1:57 p.m., the Director of Nursing (DON) verified Resident 1's RP contact number listed on Resident 1's face sheet was incorrect and that was the reason why Resident 1's RP was not notified of the fall incidents on 4/18/25 and 4/19/25. The DON confirmed Resident 1's RP was only made aware of the falls on 4/20/25 when the RP was picking Resident 1 for discharge. The DON stated it was the facility's responsibility to ensure the contact information on the face sheet was correct.A review of the facility's policy and procedure (P&P) titled, Changes in Resident's Condition, undated, indicated, '[resident and/or resident representative [RP] (if resident has no capacity to make health care decisions or resident may have requested the Licensed Nurse to contact a family member during a change of condition), [RP] and physician are notified by [LN]/Company Designee when there is. an accident involving resident.and has the potential for requiring physician intervention.</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>Based on interviews and record reviews, the facility failed to ensure a summary of the baseline care plan (BCP, a document created within 48 hours of a resident's admission to a nursing home, outlining the initial care needed to ensure residents' safety and well-being, focusing on basic needs and resident-specific information) was provided for one resident out of two sampled residents (Resident 1), when there was no documentation indicating Resident 1's responsible party (RP, a person who is designated in making decisions about health care and financial matters) was provided the BCP summary. This failure has the potential to decrease the RP's ability to be informed about Resident 1's care and services. Findings: A review of Resident 1's face sheet (front page of the chart that contains a summary of basic information about the residents) indicated Resident 1 was admitted to the facility in April of 2025 with a RP listed. A review of Resident 1's BCP, dated 4/14/25, did not indicate a copy of the summary of the BCP was provided to Resident 1's RP. During a concurrent interview and record review on 8/4/25 at 4:34 p.m. with Licensed Nurse (LN) A, Resident 1's BCP, dated 4/14/25, was reviewed. LN A stated a BCP was important because it provided a map for the residents' safe care. LN A stated it was important to provide a resident's RP with a summary of the BCP so they can ensure the facility will provide quality care the resident requires. LN A stated there was no indication a summary of Resident 1's BCP was provided to Resident 1's RP. During a telephone interview on 8/5/25 at 1:57 p.m., the Director of Nursing (DON) verified she had looked into Resident 1's BCP dated 4/14/25 and acknowledged there was no indication a copy of the BCP summary, dated 4/14/25, was provided to the RP. The DON stated, if it was not documented, then it did not happen. A review of the facility's policy and procedure (P&P) titled Baseline Care Planning, undated, the P&P indicated, a baseline plan of care to meet the resident's immediate needs shall be developed for each resident within 48 hours of admission. the resident and their [RP] will be provided a summary of the [BCP]. Documentation In Electronic Health Record (EHR) .may use the paper form and will be uploaded in EHR.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on interviews and record reviews, the facility failed to ensure one out of two sampled residents (Resident 1) was provided an environment free of accident hazards and received adequate supervision to prevent accidents, when Resident 1 fell from a wheelchair (WC) provided by the facility. This failure could result in the increased risk of accidents. Findings: A review of Resident 1's face sheet (front page of the chart that contains a summary of basic information about the residents) indicated an admission date of 4/2025 with a diagnosis of Alzheimer's Disease (AD, a disease characterized by a progressive decline in mental abilities) and Anxiety (fear, worry). A review of the Fall care plan (CP, a detailed, written document that outlines a resident's individual needs, goals, and how their care will be managed), dated 4/14/25, did not indicate Resident 1 used a WC. A review of Resident 1's Nursing Progress Note, dated 4/14/25 at 11:00 a.m., indicated, "[Resident 1] ambulatory [walking] with cane, fall risk. Hx [history] of falls (1 fall per month) .prone to wandering behavior, 1:1 [a situation where a single healthcare professional provides care or observation to a single patient] redirection advised. A review of Physical Therapy (PT, a healthcare profession that focuses on improving and restoring physical function and mobility) evaluation and plan of treatment, dated 4/15/25, indicated Resident 1 did not use a wheelchair and there was no recommendation from the PT that Resident 1 was safe to use the WC. A review of Resident 1's Nursing Progress Note, dated 4/19/24 at 4:40 p.m., indicated, "[Resident 1] was sitting in his w/c [wheelchair] . resident was trying to turn his w/c around when he slid down from his w/c, landed [on] his bottom [buttocks]. A review of Resident 1's electronic health records produced no documentation that Resident 1 had a WC assessment (an evaluation to determine a person's specific needs for a wheelchair and related equipment). During a concurrent interview and record review, on 8/4/25 at 4:34 p.m., with Licensed Nurse (LN) A, Resident 1's electronic health records were reviewed. LN A verified the progress note dated 4/14/25 at 11:00 a.m. indicated Resident 1 walked with cane. LN A verified Resident 1's Nursing Progress Note, dated 4/19/25 at 4:40 p.m., indicated Resident 1 fell while he was on a WC. LN A stated Resident 1 should not be placed on a wheelchair since there was no evaluation done that Resident 1 needed or was safe to use a WC. During a telephone interview on 8/8/25 at 10:07 a.m., the Director of Nursing (DON) verified on 4/19/25 Resident 1 slid from a WC and landed on his buttocks. The DON verified there was no care plan to indicate Resident 1 should be using a WC. The DON verified Resident 1 was seen by PT with no note or assessment to indicate Resident 1 was safe to use the WC. A review of the facility's policy and procedure (P&P) titled Fall Management, undated, the P&P indicated, .based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to reduce the risk of the resident falling .</p>		