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 02/12/2026
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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to protect the resident's right to be free from verbal abuse by another resident, when Resident 6 yelled and cursed at one of four residents sampled for abuse (Resident 7) after they became roommates on 12/10/25.This failure caused Resident 7 to be upset and angry and had the potential to negatively impact her psychosocial well-being.Findings:A review of Resident 7's admission record indicated she was last admitted to the facility on [DATE] with diagnoses of Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), unspecified dementia (progressive state of decline in mental abilities) and generalized anxiety (a mental health disorder characterized by feelings of worry, anxiety or fear that are strong enough to interfere with one's daily activities).A review of Resident 7's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 1/28/2026, indicated Resident 7 had severe cognitive impairment (a decline in mental abilities such as memory, reasoning, language, and judgment).A review of Resident 6's admission record indicated she was last admitted to the facility on [DATE] and had a diagnosis of anxiety disorder (a mental health disorder characterized by feelings of worry or fear that are strong enough to interfere with one's daily activities) and depression (mood disorder that causes a persistent feeling of sadness and loss of interest).A review of Resident 6's MDS, dated [DATE], indicated Resident 6 had severe cognitive impairment.A review of Resident 6's medical record revealed: A social service progress note (documentation of a resident's clinical status, response to treatment, and care updates), dated 12/10/2025 at 12:41 p.m., indicated, Resident [6] moved. to room [ROOM NUMBER]B for compatibility as she will have a Spanish speaking roommate.A nursing progress note, dated 12/11/25 at 1:49 p.m., indicated, . Resident is not adjusting to room change well. Roommate [Resident 7] was in dining room for most of AM [day shift from approximately 7 a.m. to 3 p.m.] shift to separate residents.A nursing progress note, dated 12/11/25 at 10:51 p.m., indicated, . Resident is not adjusting to room change well. Resident is yelling at staff and roommate.A nursing progress note, dated 12/12/25 at 1:42 a.m., indicated, .resident noted shouting, 'WHO LET THIS WOMAN IN MY HOUSE'.Not adjusting to roommate well.A nursing progress note, dated 12/12/25 at 2:30 p.m., indicated, Monitoring for s/sx [signs and symptoms] of emotional distress d/t [due to] room adjustment. currently agitated.resident noted [sic] continuously shouted at roommate and staff. resident is not adjusting to room change or roommate well.A Change of Condition (a significant, often sudden, deviation from a patient's or resident's established baseline in physical, mental, or functional health) note, subtitled Narrative Notes, dated 1/9/26 at 11:21 p.m., indicated, Monitoring for increase of yelling and verbal aggression.resident continue [sic] to yell towards staff and roommate.During an observation on 2/10/26 at 11:22 a.m., Resident 7 was out of her room and Resident 6 was in her bed. A certified nursing assistant (CNA D) went into the room and Resident 6 yelled (in English), This is my house. Resident 6's yelling was very loud and she continued to yell, (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: 055850	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Ridge Care Center	45 Professional Center Pkwy San Rafael, CA 94903

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Call the police.During an interview a on 2/10/26 at 11:30 a.m., CNA D stated Resident 6 did not want a roommate and she thought her room at the facility was her house. CNA D stated Resident 6 and Resident 7 fought all the time. CNA D stated the staff closed their room's door to the hall because they upset and disturbed other residents.During an observation on 2/10/26 at 11:36 a.m., Resident 6 was still yelling in her room.During a concurrent observation and interview on 2/10/26 at 11:45 p.m., Confidential Family Member X (CFM X) and Confidential Family Member Y (CFM Y) were sitting with Resident 7 in the hall near nurse station #2 while she ate lunch. Resident 7 was not conversive and continued to eat her lunch.During an interview on 2/10/26 at 12:40 p.m., CFM X and CFM Y stated Resident 7 had been roommates with Resident 6 but Resident 6 did not want anyone in the room with her and said offensive words directed at Resident 7. CFM X and CFM Y stated Resident 7 was angry and upset when her roommate swore at her.During an interview on 2/10/26 at 2:10 p.m., Licensed Nurse C (LN C) stated Resident 6 and Resident 7 had been roommates but she did not like to put Resident 7 in her room because the roommates would [NAME]. LN C stated Resident 6 was angry and swore at Resident 7 in Spanish and used very ugly and hateful words. She stated she directed these words at Resident 7 calling her, Son of a b- - - -. LN C stated Resident 6 had said, Get this b- - - - out of my house. During an interview on 2/10/26 at 4:15 p.m., CNA F stated Resident 6 was, really confused and agitated. He stated when Resident 7 returned to her room, Resident 6 would get agitated.During an interview on 2/11/26 at 10:45 a.m., CNA E stated Resident 6 thinks her room is her house and she does not want anyone in her house. He stated staff move Resident 7 out of the room during the day because the roommates fight.During an interview on 2/11/26 at 12 p.m., LN G stated Resident 6 sometimes used curse words when she got triggered, and her screaming was loud. LN G stated examples of verbal abuse could include someone cursing you, calling you names and yelling at you; she stated if that caused emotional distress, it would be verbal abuse.During a follow-up interview on 2/11/26 at 3:15 p.m., LN C was asked if the interactions between Resident 6 and Resident 7 were abusive. LN C stated they might be abusive if emotional distress was an outcome.During a concurrent interview and record review on 2/11/26 at 4 p.m., the Director of Nursing (DON) reviewed Resident 6's electronic medical record and multiple nursing progress notes. The DON confirmed Resident 6 and Resident 7 had become roommates on 12/10/2025. The DON reviewed the monitoring that occurred during the initial 72-hours period following the room change on 12/10/25, when Residents 6 and 7 became roommates. The DON stated the terms b- - - - and stupid, or other ugly words, would be considered abusive if they upset the recipient.During an interview, on 2/11/26 at 5 p.m., the Administrator stated staff had reported that Resident 6 was yelling but did not report the exact words utilized. The administrator stated he would want to know if residents were name-calling each other and saying, Get the b - - - - out of [the] room or Get stupid out of the room. He stated he would have investigated the issue because if the terms were directed toward Resident 7, it was potential verbal abuse.During a review of the facility's policy titled, Abuse, Neglect and Exploitation Prohibition, subtitled, Definitions, (undated), indicated, . Verbal abuse is defined as the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents. within their hearing distance regardless of their age, ability to comprehend, or disability. Under subtitle, Prevention the policy indicated, . 2. Company supervisors will immediately correct and intervene in reported or identified situations in which abuse. is at risk for occurring.

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of seven sampled resident's (Resident 6) Minimum Data Set (MDS, a federally mandated resident assessment tool) accurately reflected the resident's condition when Resident 6 was assessed as having no verbal behaviors impacting other people.This failure placed Resident 6 at risk for inadequate care planning.Findings:A review of Resident 6's admission record indicated she was last admitted to the facility on [DATE] and had diagnoses of anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety or fear that are strong enough to interfere with one's daily activities) and depression (mood disorder that causes a persistent feeling of sadness and loss of interest).A review of Resident 6's MDS, dated [DATE], indicated Resident 6 had severe cognitive impairment (a decline in mental abilities such as memory, reasoning, language, and judgment). Section E of the MDS indicated Resident 6 had no verbal behavior symptoms (like screaming and cursing at others) directed toward other people.A review of Resident 6's Change of Condition (a significant, often sudden, deviation from a patient's or resident's established baseline in physical, mental, or functional health) note, subtitled Narrative Notes, dated 1/9/26 at 11:21 p.m., indicated, Monitoring for increase of yelling and verbal aggression toward staff, resident continue [sic] to yell towards staff and roommate.Review of Resident 6's Medication Administration Record (MAR, a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 1/1/26 through 1/31/26 indicated, Antianxiety Lorazepam (medication used to decrease anxiety): Manifested by constant yelling causing exhaustion to self. Monitor behavior. q [every] shift.During an interview on 2/10/26 at 2:10 p.m., Licensed Nurse C (LN C) stated she spoke Spanish; she stated Resident 6 cursed at Resident 7 in Spanish and used very ugly, hateful words directed at Resident 7.During a concurrent interview and record review on 2/12/26 at 1 p.m., LN H stated he was the MDS nurse and he used various sources of data for his resident assessments including observations and review of the electronic MAR and nursing progress notes (documentation of a resident's clinical status, response to treatment, and care updates). LN H reviewed Section E of Resident 6's MDS, dated [DATE], and confirmed it indicated she had no verbal behaviors symptoms (including screaming) directed toward other people. LN H reviewed Resident 6's January 2026 MAR and confirmed she was being monitored for yelling that caused her to become exhausted; he confirmed the MAR indicated she had multiple episodes of yelling incidents. LN H stated yelling to exhaustion could meet the criteria of behaviors affecting others. LN H stated he did not know why he didn't catch that and added, he probably just missed it.Review of facility policy titled, Resident Assessment Instrument (RAI) Process (undated) indicated, The facility shall complete the RAI. using standardized tools (MDS 3.0.) . All assessments shall be: Completed accurately. Used to guide individualized, resident-centered care planning and quality outcomes.