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	12/12/2024

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 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident's assessment is updated at least once every 3 months. 51680 Based on record review, interview, and document review, the facility failed to complete the quarterly Minimum Data Set (MDS) for 2 (Resident #5 and Resident #22) of 18 sampled residents. The facility further failed to timely complete a quarterly MDS for 2 (Resident #1 and Resident #48) of 18 sampled residents. Findings included: The Centers for Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3. 0 User's Manual dated 10/2024, indicated, The Quarterly assessment is an OBRA [Omnibus Budget Reconciliation Act] non-comprehensive assessment for a resident that must be completed at least every 92 days following the previous OBRA assessment of any type. It is used to track a resident's status between comprehensive assessments to ensure critical indicators of gradual change in a resident's status are monitored. Per the User's Manual, The MDS completion date must be no later than 14 days after the ARD. 1. A Resident Face Sheet indicated the facility readmitted Resident #5 on 08/22/2024. Resident #5's medical record revealed evidence to indicate a quarterly MDS, with an Assessment Reference Date (ARD) of 09/06/2024. There was no further evidence to indicate another MDS had been completed. 2. A Resident Face Sheet indicated the facility admitted Resident #22 on 08/19/2024. Resident #22's medical record reviewed evidence to indicate an admission MDS, with an Assessment Reference Date (ARD) of 08/23/2024. There was no further evidence to indicate another MDS had been completed. During an interview on 12/11/2024 at 2:47 PM, the MDS Coordinator stated he was not aware of Resident #5's need for an MDS in 12/2024. Per the MDS Coordinator, he was aware of Resident #22's MDS for 11/2024 had not been completed. During an interview on 12/11/2024 at 3:00 PM, the Director of Nursing (DON) stated the MDS Coordinator was responsible for MDS completion. The DON stated she was notified on 12/10/2024 of the late MDS assessments. Per the DON, she expected the MDS to be completed timely. (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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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/11/2024 at 3:36 PM, the Administrator stated he was aware of late MDS assessments, and his expectation was for MDS assessments to be timely submitted. 45554 3. A Resident Face Sheet revealed the facility admitted Resident #1 on 12/06/1997. Resident #1's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/08/2024, revealed the MDS was signed as being completed on 12/02/2024. During an interview on 12/11/2024 at 1:31 PM, the MDS Coordinator stated he had 14 days from the ARD to sign the MDS as being completed. The MDS Coordinator acknowledged he was late with completing some MDS assessments. During an interview on 12/11/2024 at 3:07 PM, the Director of Nursing stated she did not know the MDS Coordinator was behind with the completion of MDS assessment and expected the MDS assessments to be completed timely. During an interview on 12/12/2024 at 1:02 PM, the Administrator stated there had not been any issues with MDS assessments in the past and did not know there was an issue with the MDS assessments being late. The Administrator stated the MDS Coordinator was new and had not let anyone know there was a problem with the MDS assessments. Per the Administrator, he expected the MDS assessments to be completed in a timely manner. 35314 4. A Resident Face Sheet revealed the facility admitted Resident #48 on 04/15/2021. Resident #48's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/16/2024, revealed the MDS was signed as being completed on 12/02/2024. During an interview on 12/11/2024 at 1:29 PM, the MDS Coordinator stated he had been the MDS Coordinator since 07/2024 and struggled to complete MDS assessment timely. The MDS Coordinator acknowledged the MDS assessment for Resident $38 was late During an interview on 12/11/2024 at 3:07 PM, the Director of Nursing stated she did not know the MDS Coordinator was behind with the completion of MDS assessment and expected the MDS assessments to be completed timely. During an interview on 12/12/2024 at 1:02 PM, the Administrator stated there had not been any issues with MDS assessments in the past and did not know there was an issue with the MDS assessments being late. The Administrator stated the MDS Coordinator was new and had not let anyone know there was a problem with the MDS assessments. Per the Administrator, he expected the MDS assessments to be completed in a timely manner.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. 35314 Based on observation, interview, record review, document review, and facility policy review, the facility failed to ensure staff provided a communication board and a pointer to 1 (Resident #189) of 2 sampled residents reviewed for communication. Findings included: An undated facility policy titled Alternative Communication Device revealed, The purpose of developing and training use of an alternative communication device is to provide the non-verbal resident with a means of functionally communicating his or her wants and needs. Background An alternative communication device is any system of communication used in place of or as a supplement to normal speech and language to facilitate functional communication. The system may be manual or electronic and may include the use of gestures, pictures, words, symbols, voice output, or writing A Resident Face sheet revealed the facility admitted Resident #189 on 02/22/2021. According to the Resident Face Sheet, the resident had a medical history that included diagnoses of cerebral infarction due to embolism of the right middle cerebral artery and need for assistance with personal care. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/29/2024, revealed Resident #189 had a Staff Assessment for Mental Status (SAMS) that indicated the resident had modified independence in cognitive skills for daily decision making. Per the MDS, the resident had no speech - absence of spoken words. Resident #189's Care Plan included a problem statement initiated 06/10/2021, that indicated the resident was unable to verbally communicate in a dominant language. Interventions directed staff to provide the resident a commination board and communication cards for basic needs. During an observation on 12/09/2024 at 11:13 AM, the surveyor noted a sign posted in Resident #189's room that indicated the resident was unable to speak, used a letter board for basic communication, and to provide the resident with a pointer, that was kept in the drawer. The surveyor noted the resident was not able to use their communication board as the communication board was not within the resident's reach and there was no pointer present. During an interview on 12/10/2024 at 9:26 AM, Resident #189 informed the surveyor that staff did not always ensure they had access to their pointer. During an interview on 12/10/2024 at 11:49 AM, Resident informed the surveyor they did not have a pointer to use. During an observation on 12/10/2024 at 1:15 PM, the surveyor noted there was no pointer in Resident #189's drawer. During an observation on 12/11/2024 at 8:49 AM, the surveyor noted Resident #189 in bed and there was no pointer within the resident's reach or in the drawer. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/11/2024 at 9:39 AM, Certified Nurse Aide (CNA) #11 stated Resident #189 did not speak, used signed to communicate, and pointed to things they needed. CNA #11 acknowledged the resident did not have a pointer and he had never seen a pointer in the resident's room During a concurrent observation and interview on 12/11/2024 at 9:54 AM, Registered Nurse (RN) #8 entered Resident #189's room and could not locate the pointer. RN #8 stated she did not know how long the resident's pointer had been missing During an interview on 12/11/2024 at 9:58 AM, the Director of Nursing (DON) stated she did not notice Resident 189's pointer was missing. The DON asked Resident #189 if they wanted a pointer and the resident gave a thumbs up, which indicated yes. The DON stated the pointer will be replaced. During an interview on 12/12/2024 at 1:24 PM, the Administrator stated all resident should be able to make their needs known.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49044 Based on interview, record review, and facility policy review, the facility failed to ensure the environment of a resident did not provide a means to exit the facility without staff knowledge for 1 (Resident #13) of 3 sampled residents reviewed for accidents. Findings included: An undated facility policy titled, Resident Elopement, indicated, Purpose The facility will provide a safe environment and preventive measures for elopement with the aim to monitor and document patients at risk for elopement. A Resident Face Sheet revealed the facility admitted Resident #13 on 11/14/2023. According to the Resident Face Sheet, the resident had a medical history that included diagnoses of chronic pain, acute systolic heart failure, and epilepsy. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/11/2024, revealed Resident #13 had a Brief Interview for Mental Status (BIMS) score of 6, which indicated the resident had severe cognitive impairment. The MDS indicated the resident did not display wandering behavior. Resident #13's Elopement Risk assessment dated [DATE], revealed the resident was not at risk for elopement. Resident #13's Resident Progress Notes dated 09/05/2024 at 11:48 AM revealed the resident was noted to head out of the facility and two licensed nurses immediately followed the resident and intervened. Per the Resident Progress Notes, the resident stated they needed to go to the bank and get some money. The Resident Progress notes indicated the resident was informed that was not safe for them to go out of the facility unsupervised. Resident #13's Resident Progress Notes dated 09/10/2024 at 6:30 PM, revealed the facility received a telephone call from the local police department which indicated the resident was found strolling on the sidewalk of a street by themselves. Resident #13's Care Plan included a problem statement initiated 09/05/2024, that indicated the resident was noted to have exit-seeking behavior and left the facility without assistance on 09/11/2024. Interventions directed staff to transfer the resident to a room with no sliding door and no fence (initiated 09/11/2024 During an interview on 12/10/2024 at 3:22 PM, Licensed Vocational Nurse #3 stated at the time Resident #13 eloped from the facility on 09/10/2024, the resident resided in a room that had a sliding door, which exited to outside the facility. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/11/2024 at 3:32 PM, Registered Nurse (RN) #7 stated she received a telephone call from the police department that indicated Resident #13 had been found near the facility. RN #7 stated when Resident #13 arrived back in the facility, the resident stated they jumped over the fence. RN #7 stated the resident had not had any issue with exit seeking, except the few days prior that they were found outside by staff. According to RN #7, since the elopement incident on 09/10/2024, the resident had not had any other incidents of elopement. During an interview on 12/12/2024 at 8:19 AM, the interim Social Services Director stated Resident #13 was moved to a different room after the resident left of the facility without staff knowledge by way of the sliding door that was in their room During an interview on 12/12/2024 at 10:54 AM, the Director of Nursing (DON) stated 09/05/2024 was the first time the resident eloped from the facility. The DON stated prior to 09/05/2024, the facility had no knowledge the resident had exit-seeking behavior or attempted to leave out of the sliding door in their room. According to the DON, after the resident eloped again on 09/10/2024, the resident was moved to a room without a sliding door. During an interview on 12/12/2024 at 11:57 AM, the Administrator stated Resident #13 had been in the same room for a long time and had never tried to go out the sliding door and there were no indicators that the room could pose an issue to the resident. The Administrator acknowledged the facility did not consider moving the resident to a different room once the resident started to display exit-seeking behaviors. The Administrator stated he expected residents to remain in the facility so that staff could monitor them.

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F 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35314 Based on observation and interview, the facility failed to ensure residents' rooms measured at least 80 square (sq) feet (ft) per resident in 7 (Rooms 26 through 29, room [ROOM NUMBER], room [ROOM NUMBER], and room [ROOM NUMBER]) of 45 resident rooms in the facility. Findings included: On 12/11/2024 at 3:13 PM, the Environmental Services staff person measured the following rooms and confirmed the following dimensions: - In room [ROOM NUMBER], there was 74.96 sq ft for each resident. - In room [ROOM NUMBER], there was 74.96 sq ft for each resident. - In room [ROOM NUMBER], there was 73.92 sq ft for each resident. - In room [ROOM NUMBER], there was 74.29 sq ft for each resident. - In room [ROOM NUMBER], there was 71.31 sq ft for each resident. - In room [ROOM NUMBER], there was 73.92 sq ft for each resident. - In room [ROOM NUMBER], there was 70.19 sq ft for each resident. During an interview on 12/11/2024 at 3:43 PM, the Administrator stated was aware of the rooms that did not meet the regulatory guidance for the required square footage During an interview on 12/12/2024 at 8:35 AM, the Director of Nursing stated she was not aware of the square footage requirement for resident rooms. the residents.