STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056077	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Tamalpais	501 via Casitas Greenbrae, CA 94904

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of 2 sampled discharge residents (Resident 26), had a discharge order and discharge summary maintained in their medical record. This failure had the potential to adversely affect Resident 26's continuity of care after discharge. Findings:During a review of Resident 26's Face Sheet, the Face Sheet indicated Resident 26 was admitted to the facility on [DATE] with diagnoses of atrial fibrillation (irregular heart rhythm), myocardial infarction (heart muscle damage), asthma (difficulty breathing), high blood pressure, and elevated liver enzymes.During a concurrent interview and record review on 9/10/2025 at 3:13 p.m. with Minimum Data Set Registered Nurse (MDSRN - nurse who specializes in collecting patient data in a long-term care facility), Resident 26's electronic medical record (EMR) was reviewed. The MDSRN indicated that the physician should write a discharge order and discharge summary to provide the resident guidance for continued medical treatment after discharge. MDSRN verified that no discharge order or discharge summary was in the EMR or provided to Resident 26.During an interview on 9/11/2025 at 10:00 a.m. with the Medical Director (MD) 1, the MD 1 indicated that it was the responsibility of the discharging physician to provide a discharge summary for the family and continuing care provider for continuity of care. MD 1 also stated the discharging physician was responsible for ensuring a signed discharge order was in the EMR.During a concurrent interview and record review on 9/11/2025 at 11:50 a.m. with the Director of Nursing (DON), Resident 26's EMR was reviewed. The DON verified that no doctor's discharge order, discharge note, or discharge summary was in Resident 26's EMR. During a concurrent interview and record review on 9/11/2025 at 3:00 p.m. with the Social Worker (SW), Resident 26's EMR was reviewed. The SW stated that the discharge physician should have provided a discharge order and discharge summary when it was determined the resident was ready for discharge. These documents should have been given to the resident upon discharge and forwarded to the primary care provider or specialist who will continue to care for the resident after discharge. The SW stated the importance of the summary was to make the primary care provider aware of the resident's current health status and any continued medical needs of the resident. The SW indicated that she did not forward a discharge summary to the primary care physician of Resident 26. The SW verified that Resident 26's EMR did not have a discharge order or discharge summary.During a review of the facility's policy and procedure (P&P) titled, Provision of physician services, alternate schedule for visits, and prompt notification of physicians, dated 4/2024, the P&P indicated, The resident shall be discharged only with a written order of the physician. A discharge summary shall be completed within 14 days of discharge.During a review of the facility's policy and procedure (P&P) titled, Discharge plan and post discharge plan of care, dated 3/2024, the P&P indicated, There shall be a physician order for discharge and the reason for discharge . At a minimum the discharge summary will contain a summary of the resident's status to include a description of the resident's medical condition, current medical status, . special treatments or procedures, . drug therapy and disposition of medications.

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
	056077	A. Building B. Wing	09/11/2025

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The Tamalpais	501 via Casitas Greenbrae, CA 94904

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop a care plan (an individualized plan that provides direction on the type of care a resident needs) for one of 17 sampled residents (Resident 2). This failure had the potential for Resident 2 to not receive the specific services necessary to meet her needs. Findings: During a review of Resident 2's Profile Face Sheet (demographic), the Profile Face Sheet indicated Resident 2 was admitted to the facility on [DATE] with a femur (bone of the thigh) fracture and Alzheimer's Disease (a progressive brain disorder that causes memory loss, confusion, and other cognitive decline). During an observation on 9/8/25 at 5:38 p.m., outside of Resident 2's room, an Enhanced Barrier Precautions (EBP, are infection control interventions designed to reduce the spread of multidrug-resistant organism, MDROs - a germ that is resistant to many antibiotics) sign was posted on the wall below Resident 2's name plate. The EBP indicated, Stop. Everyone must: clean their hands, including before entering and when leaving the room. Providers and staff must also: Wear gloves and a gown for the following high-contact resident care activities. Dressing, Bathing/Showering, Transferring, Changing Linens, Providing Hygiene, Changing briefs or assisting with toileting. Device care or use: central line, urinary catheter, feeding tube, tracheostomy. Wound care: any skin opening requiring a dressing. CNA (Certified Nursing Assistant) 1 entered Resident 2's room and informed Resident 2 that dinner was being served. CNA 2 entered Resident 2's room with a meal tray. CNA 1 and CNA 2 were observed moving and repositioning Resident 2 on her bed, preparing her to eat. CNA 1 and CNA 2 did not have on gloves or gown while moving and repositioning Resident 2 in bed. During an interview on 9/8/25 at 5:43 p.m., with CNA 1, CNA 1 stated Resident 2 was in EBP because Resident 2 had a dressing on her leg. CNA 1 stated staff did not need to wear a gown or gloves when the staff reposition a resident in bed.During a review of Resident 2's interdisciplinary notes dated 8/23/25 - 9/10/25, there was no documented evidence when EBP was initiated or the reason why Resident 2 was on EBP.During a review of Resident 2's Baseline and Comprehensive Care Plan, there was no care plan for EBP.During an interview on 9/10/25 at 3:21 p.m., with the Infection Preventionist (IP), the IP stated moving a resident in bed was considered high-contact care. IP stated the certified nursing assistants should have worn gown and gloves when moving a resident who was on EBP. IP stated the facility uses the Centers for Disease Control and Prevention (CDC) EBP as a guideline. IP further stated the facility did not have an EBP policy and procedures.During a concurrent interview and record review on 9/11/25 at 9:32 a.m. , with IP, Resident 2's medical record was reviewed. IP stated Resident 2 was on EBP because on 8/23/25 a skin tear was found on Resident 2's left leg. IP confirmed that between 8/23/25 - 9/10/25, Resident 2's interdisciplinary notes had no documented evidence when EBP was initiated or the reason why Resident 2 was on EBP. IP confirmed there was no documented evidence of EBP in Resident 2's care plan. During an interview on 9/11/25 at 11:44 a.m., with the IP, IP stated the CDC guidelines does not indicate that EBP was required to be care planned. The IP stated EBP was not part of the care planning process. During a review of the facility's policy and procedures (P&P) titled, Care Planning / Interdisciplinary Team Care Planning Conference, dated March 2024, the P&P indicated, All residents will have a comprehensive care plan to meet their individual needs that is prepared by an interdisciplinary Team within 7 days after the completion of the comprehensive assessment and periodically reviewed and revised after subsequent assessments. Procedure . 9. Care plans are revised per RAI (Resident Assessment Instrument) schedules and as changes in the resident's condition dictates .

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide the necessary care and services to attain or maintain the highest practicable well-being for two of 17 sampled residents (Resident 8 and Resident 22) when:1. Resident 8 was observed without a wanderguard device (a wearable device designed to help prevent residents at risk of wandering from leaving a designated area in a care facility) per physician's order and there was no elopement assessment prior to placing a wander guard device on Resident 8. These failures had the potential to adversely affect Resident 8's physical and psychosocial well-being.2. Resident 22's floor mats were not placed as ordered by the physician. This failure had the potential to cause injury to Resident 22. Findings: 1.During a review of Resident 8’s “Profile Face Sheet (demographic),” the “Profile Face Sheet” indicated Resident 8 was admitted to the facility on [DATE] with a diagnosis of dementia (a general term for a decline in mental ability that is severe enough to interfere with a person’s daily life and functioning). During a review of Resident 8’s “Physician’s Orders,” dated 2/8/24, the “Physician’s Orders” indicated orders to change wanderguard as needed to the right wrist, to check the battery of the wander guard daily (on the right wrist), and to check the placement of the wander guard every shift. During a concurrent observation and interview on 9/9/25 at 11:56 a.m., with Resident 8’s Care Giver (CG) 1, Resident 8 was sitting on a wheelchair in the Sunroom. CG 1 stated she was familiar with Resident 8. CG 1 checked for a wanderguard device on Resident 8’s wrists and on Resident 8’s wheelchair. CG 1 stated there was no wanderguard device on Resident 8’s wrists nor on Resident 8’s wheelchair. During a concurrent observation, interview, and record review on 9/9/25 at 12:03 p.m., with Registered Nurse (RN) 1, RN 1 verified that Resident 8 had active physician’s orders for a wanderguard device. RN 1 stated the wander guard device was placed on her wheelchair because the wander guard bracelet would cut her skin. RN 1 checked the wheelchair Resident 8 was sitting on but was unable to locate the wanderguard device. During a concurrent interview and record review on 9/9/25 at 3:34 p.m., with RN 2, Resident 8’s medical record was reviewed. RN 2 confirmed Resident 8’s physician’s orders for wander guard device dated 2/8/24. RN 2 stated Resident 8 had a history of attempting to leave the unit by trying to go on the elevator on her own. RN 2 stated Resident 8 required supervision when she leaves the unit. RN 2 stated that on 2/8/25 at 10:25 p.m., the interdisciplinary note indicated Resident 8 was asking for the location of the elevator because she wanted to go back to her apartment and a wanderguard was put on Resident 8’s right wrist. RN 2 stated Resident 8 had only one “Elopement Risk Assessment” dated 4/15/24 which indicated Resident 8 was at risk for elopement. RN 2 stated a wanderguard device should have been on Resident 8’s right wrist and should always be on Resident 8. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/10/25 at 8:34 a.m., with the Director of Nursing (DON), the DON stated an elopement assessment is typically done upon admission, when there was a change of condition, and annually. The DON stated an elopement assessment for Resident 8 should have been completed prior to putting a wanderguard device on her. During a review of the facility’s policy and procedures (P&P) titled, “Elopement and Hazardous Wandering,” dated January 2016, the P&P indicated, “Prevention & Intervention I. Resident Assessments A. All new residents shall be assessed for risk of hazardous wandering. The assessment is completed during the admission process, annually, each time a resident moves to a different level of care, and more frequently in accordance with the resident’s condition.” 2. During a review of Resident 22’s “Profile Face Sheet (demographics),” the “Profile Face Sheet” indicated Resident 22 was admitted to the facility on [DATE] with diagnoses of cerebral infarction (also known as ischemic stroke, when blood flow to the brain is interrupted causing damage to the brain tissue) and muscle weakness. During a review of Resident 22’s “Physician’s Orders,” dated 5/15/24, the “Physician’s Orders” indicated floor pads (mats) to the side of the bed. During a review of Resident 22’s “Post Fall Risk Assessment,” dated 4/4/25, the “Post Fall Risk Assessment” indicated Resident 22 was at high risk for falls. During an observation on 9/9/25 at 9:18 a.m., in Resident 22’s room, Resident 22 was sitting up in bed. There was a floor mat on the right side of the bed and another floor mat rolled up in between a chair and a dresser. During a concurrent observation and interview on 9/9/25 at 9:22 a.m., in Resident 22’s room, with the Director of Nursing (DON), the DON confirmed that a floor mat was rolled up in between a chair and a dresser. The DON stated Resident 22 could not walk and Resident 22 did not have a history of falls. The DON stated the floor mats were a precautionary measure, and they should have been on the floor on each side of the bed. During an interview on 9/9/25 at 9:23 a.m., with Registered Nurse (RN) 1, RN 1 stated Resident 22 should have the floor mats on each side of her bed because Resident 22 had tendencies to slide out of her bed. During a review of Resident 22’s care plan for “Falls” dated 3/20/24, the “Falls” care plan indicated floor mats to be placed on side of the bed. During a review of the facility’s policy and procedures (P&P) titled, “Physician Order Recap System,” dated April 2024, the P&P indicated, “. B. Receiving Physician Orders . 8. Licensed nurse shall be responsible for noting and implementing the order.”

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review, the facility failed to provide a Registered Nurse (RN) for eight consecutive hours a day, seven days a week from January 2025 to August 2025 for all the residents residing in the facility.This failure had the potential to result in insufficient nursing care and services for the vulnerable residential population residing in the facility.During a review of the facility's Payroll Based Journal (PBJ) Staffing Data Report, dated Quarter 2 2025 (January 1 - March 31), the PBJ Staffing Data Report indicated, the facility had no RN hours for the following Sundays: 1/5/2025, 2/2/2025, 2/16/2025, 3/2/2025, and 3/30/2025.During a review of the facility's Skilled Daily Staffing, assignment report dated Sunday, 8/17/2025, the Skilled Daily Staffing report indicated there was no RN coverage for skilled nursing.During a review of the facility's Skilled Daily Staffing, assignment report dated Sunday, 8/31/2025, the Skilled Daily Staffing report indicated there was no RN coverage for skilled nursing.During an interview on 9/10/2025 at 7:47 a.m. with Administrator (Admin), the Admin stated there was no RN coverage for the skilled nursing facility on the dates indicated on the PBJ Staffing Data Report (1/5/2025, 2/2/2025, 2/16/2025, 3/2/2025, and 3/30/2025.)During an interview on 9/11/2025 at 10:12 a.m. with the Admin, the Admin confirmed there were additional dates not indicated on PBJ Staffing Data Report where there was no RN coverage for the skilled nursing facility. Admin stated the facility was unaware RN coverage was needed specifically for the skilled nursing facility, and confirmed there was no RN coverage scheduled for every other Sunday.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to remove one multidose vial of PPD diagnostic antigen (chemical used to indicate tuberculosis) from the medication refrigerator 30 days after opening per facility policy. This failure had the potential to expose all the residents to use of an outdated antigen which could lead to an incorrect medical diagnosis for Tuberculosis (bacterial respiratory infection.)During an observation and interview on 9/9/2025 at 3:02 p.m. in the medication refrigerator located in the nursing station, with the Director of Nursing (DON), the DON verified a vial of PPD diagnostic antigen label indicated an opening date of 7/25/2025. The DON stated that the vial should have been discarded 30 days after opening.During an interview on 9/10/2025 at 4:48 p.m. with DON, the DON indicated that the facility policy was to label a multidose vial with the date when opened and to discard the vial 30 days after opening. The DON stated that medications lose effectiveness or potency after opening. During a review of the facility's policy and procedures (P&P) titled, Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles, dated 8/1/24, the P&P indicated, The facility should ensure that medications and biologicals . have an expiration date on the label . once . opened, facility should follow manufacturer/supplier guidelines.During a review of the www.fda.gov for APLISOL, dated 11/2013, the site stated, Vials in use more than 30 days should be discarded due to possible oxidation which may affect potency.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure the kitchen preparation area was maintained in a safe and sanitary manner when one of the staff with facial hair was observed cooking food not wearing a beard net. This failure had the potential to place all residents who received food prepared in the kitchen at risk for food contamination.During an observation on 9/8/2025 at 2:20 p.m. of the kitchen, [NAME] 1 was observed without a beard net covering his facial hair while standing next to the stove cooking. During a concurrent observation and interview on 9/10/2025 at 10:04 a.m. with Director of Dining Services (DDS), in the kitchen, the DDS verified that [NAME] 1 did not wear a beard net.During a record review of the facilities policy and procedure (P&P) titled, Uniform Dress Code, dated 1/2020, the P&P indicated, Restrain all facial hair with a beard net/restraint.During a review of the FDA Food Code 2022, 2-402 - Hair Restraints, the code states, Food employees shall wear hair restraints such . beard restraints . that covers hair, that are designed and worn to effectively keep their hair from contacting . FOOD.

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	056077	A. Building B. Wing	09/11/2025

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. Based on interview and record review, the facility failed to have a dedicated full-time infection preventionist (IP) according to the California Assembly [NAME] (AB) 2644 (Chapter 287, Statutes of 2020). This failure had the potential to negatively affect the facility's infection prevention and control program and the residents' quality of care.Findings:During an interview on 9/10/25 at 3:21 p.m., with the IP, the IP stated her responsibilities included assist with infection surveillance, track and trend infections, train staff in infection control, keep up to date with infection control and prevention guidelines, and participate in the infection control committee and the quality assurance and performance improvement (QAPI). The IP stated she was employed as a full-time IP for the Continuing Care Retirement Community's (CCRC, a residential community for seniors that offers various levels of care on a single campus) 3 levels of care - independent living, assisted living, and the skilled nursing facility (SNF). IP stated she tries to devote most of her time to the SNF because the residents require a higher level of care, but her time oscillates to the three levels of care. The IP stated that when there was an outbreak in an area outside of the SNF, she would spend more time in that area. The IP stated she did not document how much time she spends as an IP in the SNF.During a concurrent interview and record review on 9/11/25 at 2:02 p.m., with the Administrator (Admin), the California All Facility Letter (AFL) 20-85 dated 11/9/2020 which had AB 2644 (Chapter 287, Statutes of 2020) and the IP's employment status were reviewed. AB 2644 indicated that effective 1/1/2021, a skilled nursing facility requires to have a full-time IP. The Admin stated the AFL 20-85 only indicated the need to employee a full-time IP, but it did not specify that the IP should only work in the SNF. The Admin stated the IP's primary job was a full-time infection preventionist in the healthcare level of care also known as their SNF. The Admin confirmed that the IP was not solely an IP for the SNF, but rather she was an IP for the CCRC. The Admin further stated the IP goes to the 2 other levels of care, independent living and assisted living, and works as an IP for those two levels of care as well.During a review of AFL 20-85 titled, Assembly [NAME] (AB) 2644 - Skilled Nursing Facilities: Infection Preventionists and Communicable Disease Reporting, dated 11/9/2020, the AFL 20-85 indicated, Effective January 1, 2021, AB 2644 requires a SNF to have a full-time IP, a role that may be shared by two staff members if the total time dedicated to the IP role is equivalent to one full-time staff member.During a review of the facility's policy and procedures (P&P) titled, Infection Preventionist, dated August 2023, the P&P indicated, Hours of Work 1. The infection preventionist is employed in accordance with state and federal regulations.During a review of the facility's position description titled, Infection Preventionist, dated 6/11/2020, the position description indicated, Essential functions: Plans, organizes, develops, coordinates, and directs the Infection Prevention Program and its activities in accordance with Federal and State laws and regulations. Acts as Community Infection Preventionist.

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	056077	A. Building B. Wing	09/11/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow and implement infection control practices for two of 17 sampled residents (Resident 2 and Resident 7) when:1.Two staff members did not wear personal protective equipment (PPE) while providing care to Resident 2 who was in Enhanced Barrier Precautions (EBP, are infection control interventions designed to reduce the spread of multidrug-resistant organism, MDROs - a germ that is resistant to many antibiotics) 2. One staff member did not clean and disinfect reusable blood pressure cuff in between resident use. These failures had the potential to cause the spread of infections to residents.Findings: 1.During a review of Resident 2’s “Profile Face Sheet (demographic),” the “Profile Face Sheet” indicated Resident 2 was admitted to the facility on [DATE] with a femur (bone of the thigh) fracture and Alzheimer’s Disease (a progressive brain disorder that causes memory loss, confusion, and other cognitive decline). During an observation on 9/8/25 at 5:38 p.m., outside of Resident 2’s room, an Enhanced Barrier Precautions sign was posted on the wall below Resident 2’s name plate. The EBP indicated, “Stop. Everyone must: clean their hands, including before entering and when leaving the room. Providers and staff must also: Wear gloves and a gown for the following high-contact resident care activities. Dressing, Bathing/Showering, Transferring, Changing Linens, Providing Hygiene, Changing briefs or assisting with toileting. Device care or use: central line, urinary catheter, feeding tube, tracheostomy. Wound care: any skin opening requiring a dressing.” CNA (Certified Nursing Assistant) 1 entered Resident 2’s room and informed Resident 2 that dinner was being served. CNA 2 entered Resident 2’s room with a meal tray. CNA 1 and CNA 2 were observed moving and repositioning Resident 2 on her bed, preparing her to eat. CNA 1 and CNA 2 did not have on gloves or gown while moving and repositioning Resident 2 in bed. During an interview on 9/8/25 at 5:43 p.m., with CNA 1, CNA stated Resident 2 was in EBP because Resident 2 had a dressing on her leg. CNA 1 stated staff did not need to wear a gown or gloves when staff reposition a resident in bed. During an interview on 9/10/25 at 3:21 p.m., with the Infection Preventionist (IP), the IP stated moving a resident in bed was considered high-contact care. IP stated the certified nursing assistants should have worn gown and gloves when moving a resident who was on EBP. IP stated the facility uses the Centers for Disease Control and Prevention (CDC) EBP as a guideline. During a review of CDC’s guideline titled, “Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs),” dated 4/2/24, the guideline indicated for “Enhanced Barrier Precautions to expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing.” 2. During a review of Resident 7’s Face Sheet (Resident Demographics), the Face Sheet indicated Resident 7 was admitted to the facility on [DATE] with diagnoses which included chronic diastolic heart failure (condition where the heart muscle becomes stiff and less able to relax between heartbeats) and dysphagia (difficulty swallowing). (continued on next page)

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	056077	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 9/10/2025 at 9:03 a.m. with Registered Nurse (RN) 1, RN 1 was observed leaving Resident 20’s room after taking her blood pressure measurement and walking into Resident 7’s room. RN 1 was observed using the same blood pressure machine and reusable blood pressure cuff without cleaning or disinfecting them on Resident 7. During an interview on 9/10/2025 at 10:31 a.m. with RN 1, RN 1 stated blood pressure machine and reusable cuff needed to be cleaned and disinfected after each resident use. RN 1 confirmed blood pressure machine and reusable cuff were not cleaned and disinfected after Resident 20 use and before Resident 7’s blood pressure measurement was performed. During an interview on 9/10/2025 at 2:39 p.m. with the Infection Preventionist (IP), IP stated blood pressure machine and reusable blood pressure cuff were to be cleaned and disinfected in between resident use. IP also stated if blood pressure machine and reusable cuff were not cleaned and disinfected, and used on a resident, it could lead to microbe (microscopic organism that includes bacteria and viruses) transmission between residents. During a review of the facility’s policy and procedure (P&P) titled, “Cleaning and Disinfecting Non-Critical Resident-Care Items,” dated September 2025, the P&P indicated, “Reusable items are to be cleaned and disinfected or sterilized between residents (e.g., stethoscopes, durable medical equipment).”