

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056430	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/11/2026
NAME OF PROVIDER OR SUPPLIER Northgate Postacute Care		STREET ADDRESS, CITY, STATE, ZIP CODE 40 Professional Center Parkway 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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on interview and record review, the facility failed to ensure medications were administered according to professional standards for one of three sampled residents reviewed for medication administration (Resident 1) when he was not given his blood pressure medication per the physician's (MD) order and missed doses on two consecutive days. This failure had the potential to result in elevated blood pressure and increased leg swelling for Resident 1. Findings: A review of Resident 1's admission record indicated he was admitted in 12/24 with diagnoses of essential hypertension (HTN- high blood pressure with no single identifiable cause) and venous insufficiency, chronic and peripheral (condition in which the vein valves in the legs are weakened or damaged causing blood to pool in the legs). A review of Resident 1's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 4/6/26, indicated he had no memory impairment. A review of Resident 1's Medication Administration Record (MAR), dated 5/26, indicated a MD order for hydrochlorothiazide (a diuretic used to treat HTN and fluid retention) oral tablet, 1 tablet daily at 9 a.m., hold for SBP (systolic blood pressure- the pressure in the arteries when the heart beats and pumps blood out to the body) < 110. The MAR indicated the daily dose had not been given on 5/29 and 5/30/26. A review of Resident 1's nursing notes, dated 5/29- 5/30/26, indicated there were no notes regarding Resident 1's MD being called and informed of the missed doses of hydrochlorothiazide. During an interview on 6/10/26 at 3:32 p.m. with Resident 1, Resident 1 stated about two weeks ago he was told by Licensed Nurse 1 (LN 1) the facility was out of his blood pressure medication. Resident 1 stated he was not sure how many doses he had missed. During a concurrent interview and record review on 6/11/26 at 10:48 a.m. with LN 1, LN 1 stated she had been Resident 1's nurse on 5/30/26 and the facility had run out of his hydrochlorothiazide. LN 1 stated she called the pharmacy and the pharmacy could not tell her when it would be delivered, so she was unable to administer the medication. LN 1 stated she should have called the MD and notified him of the missed dose but acknowledged there was no documentation in Resident 1's medical record she had done so. LN 1 reviewed Resident 1's MAR, dated 5/26, and confirmed Resident 1 had missed the medication on 5/29/26 as well. During an interview on 6/11/26 at 11:58 a.m. with the Director of Nursing (DON), the DON stated it was her expectation that the LNs followed up and called the pharmacy when a resident's medication was running low. The DON stated if the pharmacy could not tell them when a medication was going to be delivered, the LNs could reach out to her and she could request a STAT (immediate, without delay) delivery. The DON further stated she expected the LNs to call the MD and notify him of the missed medication and document his instructions in a nursing note. The DON confirmed Resident 1 missed two doses of his hydrochlorothiazide and there were no nursing notes regarding either missed dose. The DON agreed these were medication errors and this did not meet her expectations for medication administration. The DON stated the missed doses could have resulted in elevated blood pressure or increased swelling for Resident 1. During a review of the facility's policy and procedure (P&P) titled, Medication Administration- General Guidelines, dated 10/17, the P&P stipulated, Medications are administered as prescribed in accordance with good nursing principles and practices. During a review of the facility's P&P titled, Unavailable Medications, dated 1/26, the P&P stipulated, The facility must make every effort to ensure that medications are available to meet the needs of each resident. Nursing staff shall: Notify the attending physician of the situation and explain the circumstances.		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 056430
		If continuation sheet Page 1 of 1