

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 08/21/2025
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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to maintain three out of 13 resident bathrooms when they were found in disrepair. This failure had the potential to result in an unsanitary and uncomfortable homelike environment. t Findings:During a concurrent observation and interview on 8/20/2025 at 7:30 a.m. with the Director of Nursing (DON) in the shared bathroom for room [ROOM NUMBER] and room [ROOM NUMBER], the toilet seat had numerous scratches. The DON stated it was not normal, and it needed to be replaced.During a concurrent observation and interview on 8/20/2025 at 7:34 a.m. with the DON in the shared bathroom for room [ROOM NUMBER] and room [ROOM NUMBER], the door frame was corroded away at the baseboard exposing a large black hole with debris inside. The DON stated it needed to be repaired immediately.During a concurrent observation and interview on 8/20/2025 at 7:37 a.m. with the DON in the shared bathroom for room [ROOM NUMBER] and room [ROOM NUMBER], the baseboard was separated from the wall exposing rust to the toilet plumbing and discoloration on the wall. The DON stated the baseboard needed to be connected to the wall.During a review of the facility's policy and procedure (P&P) titled, Physical Plant Interior Maintenance, dated January 2018, the P&P indicated, Check all areas of vinyl flooring for repairs and cleanliness.During a review of the facility's policy and procedure (P&P) titled, Homelike Environment, dated January 2018, the P&P indicated, Residents are provided with a safe, clean, comfortable and homelike environment. The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: clean, sanitary and orderly environment.</p>

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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure services provided met professional standards of practice when Licensed Vocational Nurse (LVN 1) provided wound care to one of 15 sampled residents (Resident 1) without a physician's order. This failure had the potential to result in delayed wound healing for Resident 1. Findings: During a review of Resident 1's Face sheet (demographics), [undated], the face sheet indicated Resident 1 was admitted on [DATE] with a diagnoses of Chronic Obstructive Pulmonary Disease (COPD, a lung condition that causes long-term breathing problems) and sepsis (a serious condition in which the body responds improperly to an infection). During an observation on 8/20/2025 at 8:28 a.m. in Resident 1's room, Resident 1 had a white bandage, falling off on her left hand with a skin tear exposed. LVN 1 removed Resident 1's bandage, cleansed with wound cleanser and applied A&D ointment (skin protectant used to treat and prevent minor skin irritations). LVN 1 cut a 2-inch by 2-inch square of calcium alginate (a highly absorbent type of wound dressing) and applied overtop of the A&D ointment. LVN 1 then covered the calcium alginate with a 4-inch by 4-inch island dressing (bandage). During a concurrent interview and record review on 8/20/2025 at 12:49 p.m. with LVN 1, Resident 1's Treatment Administration Record (TAR-document that tracks all non-medication medical treatments given to a resident), dated 8/5/2025 was reviewed. Resident 1's TAR indicated there was no active wound care order. LVN 1 stated he should have called the doctor to request a new wound care order. During an interview on 8/20/2025 at 12:52 p.m. with the Director of Nursing (DON), the DON stated the expectation of staff was to contact the doctor to provide a wound update and obtain a new wound care order. During an interview on 8/21/2025 at 3:43 p.m. with the Pharmacist (Pharm), the Pharm stated calcium alginate was to be used for wounds with moderate drainage for absorption and improper utilization of calcium alginate could cause delay in wound healing. During a review of the facility's policy and procedure (P&P) titled, Wound Care, dated January 2018, the P&P indicated, Verify that there is a physician's order for this procedure.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure collaborative care with the contracted hospice agency was provided for one of 15 sampled residents (Resident 36). This failure had the potential to affect Resident 36's safety and comfort of care. Findings:During a review of Resident 36's admission Record, dated 8/23/2025, the admission record indicated Resident 36 was admitted to the facility on [DATE] with a diagnoses of dislocation of internal left hip prosthesis (a condition where surgically implanted left hip comes out of place) and Huntington's disease (a condition in which nerve cells in the brain break down over time). During a concurrent observation and interview on 8/20/2025 at 8:20 a.m. with the Hospice Registered Nurse Case Manager (HRN), in Resident 36's room, the HRN was observed standing next to Resident 36 wearing a gown and gloves and wound supplies on the table. The HRN stated she did not have the wound orders and had not updated the binder with wound care plans for Resident 36.During a concurrent interview and record review on 8/20/2025 at 8:42 a.m., with the Director of Nursing (DON), Resident 36's Hospice Aide Coordination of Care, report dated 8/4/2025 was reviewed. The Hospice Aide Coordination of Care report indicated, Resident 36 was enrolled in hospice care (a medical care that focuses on providing comfort and support to patients with terminal illnesses and their families) on 8/4/2025. The DON stated there were no wound orders or care plans for Resident 36 in the hospice binder, where it should have been. The DON further stated, this was overlooked and affected Resident 36's comfort of care. During an interview on 8/21/2025 at 10:00 a.m., with the DON, the DON stated the hospice binder should have been updated with the physician orders, wound change orders, comfort care plans and wound care plans for Resident 36 to ensure smooth communication and collaboration of care between the facility and the hospice agency. During a review of the facility's policy and procedures (P&P) titled, Hospice Program, dated January 2018, the P&P indicated Hospice providers who contract with this facility: are held responsible for meeting the same professional standards and timeliness of service as any contracted individual or agency associated with the facility. Coordinated care plans for residents receiving hospice services will include the most recent hospice plan of care as well as the care and services provided by the facility (including the responsible provider and discipline assigned to specific tasks) in order to maintain the resident's highest practicable physical, mental and psychosocial well-being.During a review of the facility's hospice contract titled, Skilled Nursing Facility And Hospice Contract Agreement, dated 8/30/2022, the hospice contract indicated, Hospice shall provide provider with the following: A written and specified treatment plan for each patient. Facility responsibility includes ensuring collaboration between the facility and the hospice agency and nursing care plan developed by the agency will be part of the resident's record in the facility.</p>		

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>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.</p> <p>Based on interview and record review, the facility failed to provide a Registered Nurse (RN) for eight hours a day for four days in July 2025. This failure had the potential to result in inadequate care for a medically fragile population of 48 residents. Findings: During a concurrent interview and record review on 8/21/2025 at 3:04 p.m. with the Director of Nursing (DON), the facility's, Job Code RN Time Sheet, report dated 1/1/2025 to 8/21/2025 was reviewed. The RN time sheet report indicated an RN worked less than 8 hours as follows: S 7/6/2025, 5.85 RN hours S 7/12/2025, no RN hours/no RN present S 7/13/2025, no RN hours/no RN present S 7/20/2025, 5 RN hours The DON confirmed, she did not work on 7/6/2025, 7/12/2025, 7/13/2025 and 7/20/2025 and there was no RN present for eight hours. The DON stated she and the MDS Registered Nurse (MDS RN) did not work weekends and did not know why they didn't see this, or catch this. The DON further stated it was not normal for an RN not to be present for a minimum of eight hours a day and there should have been an RN onsite. During an interview on 8/21/2025 at 3:29 p.m. with the Administrator (Admin), the Admin stated the expectation was to have enough staff in accordance with the Centers for Medicare & Medicaid Services (CMS) guidelines. During a review of the facility's policy and procedure (P&P) titled, Staffing, dated January 2018, the P&P indicated, Our facility maintains adequate staffing on each shift to ensure that our resident's needs and services are met. Licensed registered nursing are available to provide and monitor the delivery of resident care services.</p>		

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<p>F 0730</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observe each nurse aide's job performance and give regular training.</p> <p>Based on interview and record review, the facility failed to complete annual performance evaluations for two of two employees (Certified Nursing Assistant [CNA] 3 and CNA 4). This failure had the potential to result in an inability to correct poor performance and compromise patient safety. Findings: During a concurrent interview and record review on 8/21/2025 at 11:17 a.m. with the Director of Staff Development (DSD), CNA 3's employee record was reviewed. There was no annual performance evaluation for 2024/2025. The DSD stated CNA 3 should have had an annual performance evaluation. During a concurrent interview and record review on 8/21/2025 at 11:38 a.m. with the DSD, CNA 4's employee record was reviewed. There was no annual performance evaluation for 2024/2025. The DSD stated CNA 4 should have had an annual performance evaluation. During an interview on 8/21/2025 at 11:50 a.m. with the Director of Nursing (DON), the DON stated she was unaware of multiple staff not having performance evaluations and the evaluations needed to be completed annually. During a review of the facility's policy and procedure (P&P) titled, Performance Evaluations, dated January 2018, the P&P indicated, A performance evaluation will be completed on each employee at the conclusion of his/her 90-day probationary period, and at least annually thereafter. The completed performance evaluation will be sent by the director or supervisor to the director of human resources to be placed in the employee's personnel record.</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>Based on observation, interview, and record review, the facility failed to properly dispose of used fentanyl patches (potent opioid medication used to pain management). This failure had the potential to result in drug diversion, inaccurate medication accountability and unsafe medication management. Findings: During a concurrent observation and interview on 8/20/2025 at 11:36 a.m. with Licensed Vocational Nurse (LVN 2), in the east wing hallway, the medication cart had nine opened and used fentanyl patches stored in a plastic cup. LVN 2 stated the fentanyl patches needed to be disposed of by the Director of Nursing (DON). During an interview on 8/20/2025 at 12:39 p.m. with the DON, the DON stated used fentanyl patches should not have been stored in the medication cart and should have been brought to the DON for proper disposal. During an interview on 8/21/2025 at 3:43 p.m. with the Pharmacist (Pharm), the Pharm stated used fentanyl patches should be cut up and placed into a disposal bin that was filled with liquid to ensure it was unable to be reused. The Pharm further stated fentanyl patches have a residual amount of medication that could be dangerous if touched. During a review of the facility's policy and procedure (P&P) titled, Discarding and Destroying Medications, dated January 2018, the P&P indicated Destruction of a controlled substance must render it non-retrievable, meaning that the process permanently alters the physical or chemical properties of the substance so that it is no longer available or usable and cannot be illegally diverted.</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>(continued on next page)</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the medication error rate did not exceed five percent when seven identified medication errors out of 26 opportunities were observed:1. The wrong form of aspirin was administered to Resident 29 and Resident 34.2. Senna (medication used to stimulate bowel movement) and docusate sodium (medication used to soften bowel movements) were not held in accordance with the physician order for Resident 25.3. Resident 25 was not instructed to chew a chewable aspirin.4. The wrong form of Vitamin C was administered to Resident 25.5. Resident 25 did not receive dapagliflozin (medication used to treat diabetes mellitus- a condition when the body doesn't create enough insulin) when ordered.These failures resulted in an overall facility medication error rate of 26% and had the potential to result in negative health outcomes for Resident 25, Resident 29, and Resident 34. Findings:1a. During a review of Resident 29's admission Record, dated 8/21/2025, the admission record, indicated Resident 29 was admitted on [DATE] with diagnosis of sudden cardiac arrest (condition when the heart stops beating).During an observation on 8/20/2025 at 8 a.m. in Resident 29's room, Licensed Vocational Nurse (LVN 1) administered one tablet of aspirin 81 milligrams (mg).During a concurrent interview and record review on 8/20/2025 at 11:18 a.m. with LVN 1, Resident 29's Physician Orders, dated 8/20/2025 was reviewed. The physician orders indicated, aspirin EC [enteric coated] tablet delayed release 81 mg. Give 1 tablet by mouth one time a day for PROPHALAXIS [preventative treatment]. LVN 1 confirmed he did not administer Resident 29 the delayed release aspirin and overlooked the order for delayed release aspirin. During an interview on 8/20/2025 at 11:24 a.m. with the Director of Nursing (DON), the DON stated the expectation for licensed nurses administering medication was to follow the doctor order and administer the correct medication.During an interview on 8/21/2025 at 3:43 p.m. with the Pharmacist (Pharm), the Pharm stated delayed release medication is used to prevent gastrointestinal (stomach) discomfort. The Pharm further stated licensed nurses were to follow the doctor's order.During a review of the facility's policy and procedure (P&P) titled, Administering Medications, dated January 2018, the P&P indicated, The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route of administration) before giving the medication. Medications are administered in accordance with prescribers orders.1b. During a review of Resident 34's admission Record, dated 8/21/2025, the admission record, indicated Resident 34 was admitted on [DATE] with diagnosis of cerebral infarction (ischemic stroke- when the blood flow to the brain is interrupted, leading to tissue damage).During an observation on 8/20/2025 at 8:15 a.m. in Resident 34's room, Licensed Vocational Nurse (LVN 1) administered one tablet of aspirin 81 milligrams (mg).During a concurrent interview and record review on 8/20/2025 at 11:21 a.m. with LVN 1, Resident 34's Physician Orders, dated 8/20/2025 was reviewed. The physician orders indicated, aspirin EC [enteric coated] tablet delayed release 81 mg. Give 1 tablet by mouth one time a day related to CEREBRAL INFARCTION. LVN 1 confirmed he did not administer Resident 34 the delayed release aspirin and stated he should have given delayed release aspirin.During an interview on 8/20/2025 at 11:24 a.m. with the Director of Nursing (DON), the DON stated the expectation for licensed nurses administering medication was to follow the doctor order and administer the correct medication.During an interview on 8/21/2025 at 3:43 p.m. with the Pharmacist (Pharm), the Pharm stated delayed release medication is used to prevent gastrointestinal (stomach) discomfort. The Pharm further stated licensed nurses were to follow the doctor's order.During a review of the facility's policy and procedure (P&P) titled, Administering Medications, dated January 2018, the P&P indicated, The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route of administration) before giving the medication. Medications are administered in accordance with prescribers orders.2. During a review of Resident 25's admission Record, dated 8/21/2025, the admission record, indicated Resident 25 was admitted on [DATE] with diagnosis of cerebral infarction (ischemic stroke- when the blood flow to the brain is interrupted, leading to tissue damage).During an observation on 8/20/2025 at 9:01 a.m. in Resident 25's room, Licensed Vocational Nurse (LVN 1) prepared Resident 25's medications and placed one tablet of senna 8.6 milligrams (mg) and one capsule of docusate sodium 250 mg in a medicine cup. Resident 25 informed LVN 1 that he had been up majority of the night having multiple bowel movements and needed to be changed because he had a large cushy diaper. A strong foul odor was noted. LVN 1 then administered one tablet of senna 8.6 mg and one</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to safely store and label drugs in accordance with acceptable standards of practice when:1. One medication cart was left unlocked and unattended. This failure had the potential to result in residents and staff obtaining unauthorized access to medications and supplies that could lead to adverse effects.2. An open bottle of Senna syrup (laxative medication used to stimulate a bowel movement), stored in the medication cart did not have an expiration date. This failure had the potential to result in Senna syrup having a reduced effectiveness, potential bacterial contamination and unpredictable side effects.Findings:1. During an observation on 8/20/2025 at 8:27 a.m. in the hallway of the west wing between room [ROOM NUMBER] and room [ROOM NUMBER], Licensed Vocational Nurse (LVN 1) was standing next to the medication cart and walked away into room [ROOM NUMBER]. The medication cart was left unlocked and unattended.During a concurrent observation and interview on 8/20/2025 at 8:41 a.m. with LVN 1 in front of room [ROOM NUMBER], LVN 1 walked over to the medication cart and started to prepare medications. LVN 1 confirmed the medication cart was unlocked and unattended. LVN 1 stated he made a mistake, and the medication cart should always be locked.During an interview on 8/20/2025 at 12:14 p.m. with the Director of Nursing (DON), the DON stated the medication carts should always be locked when not in use to prevent residents from accessing medications.During a review of the facility's policy and procedure (P&P) titled, Storage of Medications, dated January 2018, the P&P indicated Drugs and biologicals used in the facility are stored in locked compartments. unlocked medication carts are not left unattended.2. During a concurrent observation and interview on 8/20/2025 at 11:36 a.m. with Licensed Vocational Nurse (LVN 2), in the hallway of the east wing between room [ROOM NUMBER] and room [ROOM NUMBER], the medication cart had an opened bottle of Senna syrup that did not have an expiration date. LVN 2 stated the liquid senna needed to be discarded because it did not have an expiration date and was not in the original packaging. During an interview on 8/20/2025 at 12:42 p.m. with the Director of Nursing (DON), the DON stated Senna syrup should have been kept in the original packaging with the expiration date, otherwise it should have been discarded.During an interview on 8/21/2025 at 3:43 p.m. with Pharmacist (Pharm), Pharm stated Senna syrup expiration date was located on the original packaging and should be stored in the box to show the expiration date.During a review of the facility's policy and procedure (P&P) titled, Storage of Medications, dated January 2018, the P&P indicated Drugs and biologicals are stored in the packaging in which they are received.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>This REQUIREMENT is NOT MET as evidenced by:Based on observation, interview, and record review, the facility failed to ensure food was stored, labeled, and prepared under sanitary conditions when: 1) Staff food items were stored in Refrigerator #2 with the resident food items.2) An unlabeled and undated container of peaches was stored in Refrigerator #2 and was not properly disposed of.3) A dietary staff member with facial hair was observed in the kitchen preparing lunch for the residents without a beard restraint.4) Chopped salad was observed outside the cold holding temperature of 41 degrees Fahrenheit (measurement of temperature) or below.These failures had the potential to place residents at risk for developing food-borne illnesses (sickness by consuming contaminated food or drinks) by exposing residents to contaminated food and unsanitary practices. Findings:1. During a concurrent observation and interview on 8/18/2025 at 3:10 p.m. with the Certified Dietary Manager (CDM), in the facility's kitchen, an unlabeled food item wrapped in a paper towel was observed inside Refrigerator #2 alongside food ingredients for resident meals. CDM confirmed the food item belonged to a staff member who placed it in the refrigerator for cold storage.During an interview on 8/20/2025 at 3:25 p.m. with the Registered Dietitian (RD), the RD stated the improper storage of staff food items in the kitchen refrigerator may result in cross-contamination (unwanted transfer of germs or harmful substances from one food or surface to another food or surface) and resident foodborne illness (sickness caused by contaminated food).During a review of the facility's policy and procedure (P&P) titled, Employee Meals, dated 2023, the P&P indicated, Food brought by employees from outside the facility shall not be kept in the facility's refrigerator in the kitchen nor prepared or reheated in the facility's kitchen.2. During a concurrent observation and interview conducted on 8/18/2025 at 3:10 p.m. with the Certified Dietary Manager (CDM), in the facility's kitchen, an unlabeled and undated container of diced peaches was observed inside Refrigerator #2. CDM confirmed the unlabeled and undated container of peaches should have been thrown away to minimize the risk of foodborne illness to residents.During an interview on 8/20/2025 at 3:25 p.m. with the Registered Dietician (RD), the RD stated the improper storage of expired or unlabeled food items in the kitchen refrigerators was unacceptable due to the risk of food-borne illness (sickness caused by contaminated food).During a review of the Food and Drug Administration (FDA) Food Code (a guide for food safety to prevent foodborne illness), sections S3-302.12 and S3-501.17, dated 2022, the FDA food code indicated, It requires that working containers of food removed from their original packaging must be identified with the common name of the food. Foods that are prepared and held in a refrigerator must be clearly marked with the date they must be consumed, sold, or discarded.3. During an observation on 8/20/2025 at 11:55 a.m. in the facility kitchen, Dietary Staff (DS 1) was observed with an exposed beard and mustache while preparing and cooking food during lunch preparation without a beard restraint to cover his facial hair. During an interview on 8/20/2025 at 3:25 p.m. with the Registered Dietician (RD), the RD stated that it was unacceptable for dietary staff with facial hair to work in the kitchen without a beard restraint because hair can fall into the food and it is not a sanitary practice.During a review of the Food and Drug Administration (FDA) Food Code (a guide for food safety to prevent foodborne illness), section S2-402.11, dated 2022, the FDA food code indicated, Food employees must wear hair restraints and clothing that covers body hair in order to keep hair from contacting food, equipment, and utensils.4. During a concurrent observation and interview on 8/20/2025 at 11:59 a.m. with Dietary Staff (DS 2), in the facility kitchen during lunch preparation, DS 2 was observed using a food thermometer to check and re-check the temperature of chopped salad that had been distributed into 16 bowls. DS 2 confirmed the temperature of the chopped salad measured 63 degrees Fahrenheit (measurement of temperature) and that the salad temperature should measure 40 degrees Fahrenheit or less.During a concurrent observation and interview on 8/21/25 at 9:25 a.m. with DS 1 and the Assistance Maintenance Director (AMD), in the facility's kitchen, AMD was observed measuring the temperature of the kitchen using an infrared thermometer gun. AMD confirmed it read 84.4 degrees Fahrenheit. DS 1 stated two of two air conditioning units in the kitchen were on and blowing cool air during this temperature reading and during lunch preparation the previous day when the temperature was measured at 86 degrees Fahrenheit.During a review of the Food and Drug Administration (FDA) Food Code (a guide for food safety to prevent foodborne illness), section S3-501.16, dated 2022, the FDA food code indicated, Bacterial growth and/or toxin production can occur if time/temperature control for safety food remains in the temperature 'Danger Zone' of 41 to 135 degrees Fahrenheit too long.Maintaining Time/Temperature Control for Safety (TCS) foods that germs can grow on quickly if they are not kept at the</p>		

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 08/21/2025
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)
<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Dispose of garbage and refuse properly.</p> <p>This REQUIREMENT is NOT MET as evidenced by the following:Based on observation, interview, and record review, the facility failed to ensure garbage was properly disposed of when trash was observed on the ground and in an unsecured garbage dumpster, creating an unsanitary environment with the potential to attract pests.Findings:During an observation on 8/20/2025 at 7:41 a.m. in the facility's garbage storage area, one trash dumpster was observed with both lids unsecured and open due to overflowing garbage. Multiple bags and boxes of trash were also observed on the ground in the garbage storage area.During an interview on 8/20/2025 at 11:20 a.m. with Certified Dietary Manager (CDM), CDM stated leaving trash unsecured and on the ground was unacceptable because it attracts pests and rodents to the facility.During a review of the facility's policy and procedure (P&P) titled, Garbage and Trash, dated 2023, the P&P indicated, Adequate, clean, vermin-proof areas must be provided for storage of garbage and rubbish.all food waste must be placed in sealed leak-proof, non-absorbent, tightly closed containers (i.e., plastic bags) and shall be disposed of as necessary to prevent a nuisance or unsightliness.no debris is on the ground or surrounding area, and that the lids are closed.</p>

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.</p> <p>(continued on next page)</p>

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<p>F 0849</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 observation, interview, and record review, the facility failed to ensure hospice services met professional standards for one of 15 sampled residents (Resident 36) when:1. The Hospice Registered Nurse (HRN) left Resident 36 exposed to the public for approximately 22 minutes, with no clothes from the waist to the feet.2. The Hospice Registered Nurse's (HRN) conduct was unprofessional towards Resident 36. These failures had the potential to cause physical and psychosocial harm to Resident 36. Findings:1. During a review of Resident 36's admission Record, dated 8/23/2025, the admission record indicated Resident 36 was admitted to the facility on [DATE] with a diagnoses of dislocation of internal left hip prosthesis (a condition where surgically implanted left hip comes out of place) and Huntington's disease (a condition in which nerve cells in the brain break down over time). During a review of Resident 36's Patient Billing/Care Level Change, document dated 8/4/2025, the document indicated, Resident 36 was enrolled in hospice care (medical care that focuses on providing comfort and support to residents with terminal illnesses and their families) on 8/4/2025. During a concurrent observation and interview on 8/20/2025 at 8:20 a.m. with the HRN, in Resident 36's room, the HRN was observed standing next to Resident 36 wearing a gown and gloves and wound supplies observed on the table. Resident 36 was observed with no clothes from the waist to feet, and visible to the public from the door. During a concurrent observation and interview on 8/20/2025 at 8:42 a.m. with the Director of Nursing (DON), in Resident 36's room, Resident 36 still had no clothes from the waist to the feet and wound change had not started. The DON confirmed it had been approximately 22 minutes for Resident 36 to be without clothes from the waist to feet, while waiting for the HRN. The DON stated this could lead to physical and psychological harm. The DON further stated the HRN's conduct was unprofessional. During a review of the facility's policy and procedure (P&P) titled, Accommodation of Needs, [undated], the P&P indicated, In order to accommodate individual needs and preferences, staff attitudes and behaviors are directed towards assisting the residents in maintaining independence, dignity and well-being to the extent possible and in accordance with the residents' wishes. interacting with the residents in ways that accommodate the physical or sensory limitations of the residents, promote communication, and maintain dignity. During a review of the facility's policy and procedure (P&P) titled, Hospice Program, dated January 2018, the P&P indicated, Hospice providers who contract with the facility are held responsible for meeting the same professional standards and timeliness of service as any contracted individual or agency associated with the facility.2. During a review of Resident 36's admission Record, dated 8/23/2025, the admission record indicated Resident 36 was admitted to the facility on [DATE] with a diagnoses of dislocation of internal left hip prosthesis (a condition where surgically implanted left hip comes out of place) and Huntington's disease (a condition in which nerve cells in the brain break down over time). During an observation on 8/20/2025 at 8:42 a.m., in Resident 36's room, the HRN was observed crying and yelling, unprovoked and next to Resident 36. Resident 36 was observed having a confused and scared facial expression. The Director of Nursing (DON) was observed asking the HRN to leave the room. During an interview on 8/21/2025 at 9:30 a.m., with the DON, the DON stated HRN's behavior was unprofessional and was not acceptable. The DON further stated, this caused Resident 36 to feel scared. During an interview on 8/21/2025 at 2:00 p.m., with Resident 36, Resident 36 stated he was scared when the HRN cried and yelled, thinking it was because of his wounds. During a review of the facility's policy and procedure (P&P) titled, Accommodation of Needs, [undated], the P&P indicated, In order to accommodate individual needs and preferences, staff attitudes and behaviors are directed towards assisting the residents in maintaining independence, dignity and well-being to the extent possible and in accordance with the residents' wishes. interacting with the residents in ways that accommodate the physical or sensory limitations of the residents, promote communication, and maintain dignity. During a review of the facility's hospice contract titled, Skilled Nursing Facility And Hospice Contract Agreement, dated 8/30/2022, the hospice contract indicated, The responsibility of the hospice is to assure that the services covered by the agreement shall be performed and rendered in competent, efficient and satisfactory manner.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to identify the need to place one of 15 sampled residents (Resident 37) on Enhance Barrier Precautions (EBP-infection control strategy used to prevent spread of bacteria), while having multiple open wounds. This failure had the potential to result in the spread of dangerous multidrug-resistant organisms (MDROs) among the residents and staff. Findings: During a review of Resident 37's admission Record, dated 8/21/2025, the admission record indicated Resident 37 was admitted to the facility on [DATE] with diagnosis of complete traumatic amputation (surgical removal) of the left midfoot. During a concurrent observation and interview on 8/18/2025 at 4:08 p.m. with Resident 37, in Resident 37's room, Personal Protective Equipment (PPE, specialized clothing and equipment to protect infectious agents) and EBP signage were not posted outside of Resident 37's room. Resident 37 had a white kerlix (woven gauze used for absorbing fluids), bandage on her left foot. Resident 37 stated she was receiving wound care for her left foot and buttocks. During a concurrent interview and record review on 8/19/2025 at 9:45 a.m. with the Infection Preventionist (IP), Resident 37's Wound Care note, dated 7/24/2025 was reviewed. Resident 37's wound care note indicated, Wound 1: left foot. open wound. moderate serosanguineous [mixture of blood and fluid] drainage. Wound 2: Sacral [triangular bone at the bottom of the spine]. light serosanguineous drainage. IP confirmed Resident 37 was not on EBP and should have been on EBP due to her wounds. During an interview on 8/20/2025 at 5:04 p.m. with the Director of Nursing (DON), the DON stated she was unaware Resident 37 was not on EBP and she should be on EBP due to her wounds. During a review of the facility's policy and procedure (P&P) titled, Enhanced Barrier Precaution (EBP), dated June 2022, the P&P indicated, EBP are an infection control intervention designed to reduce transmission of resistant organisms. EBP applies to: All residents with any of the following: Wounds. make PPE, including gowns and gloves, available immediately outside of the resident room. Post clear signage at the door.</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep all essential equipment working safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain equipment in a safe and operating condition when: One of the laundry machine was covered in rust and was broken. The bed locks for Resident 36 were not working. These failures had the potential to affect the resident's health and safety. Findings: 1. During a concurrent observation and interview on 8/19/2025 at 2:05 p.m. with the Housekeeping Staff (HSK) and the Maintenance Director (MDR), in the laundry room, two laundry machines were observed. One of the laundry machine was broken and covered with rust. The MDR confirmed one of the laundry machines was broken. The HSK stated the broken laundry machine had been broken for quite some time, and it delayed the laundry process for the residents. During an interview on 8/21/2025 at 2:53 p.m. and at 4:59 p.m., with the MDR, the MDR stated the broken laundry machine should be repaired as soon as it is found to be broken, to better serve the residents and for the safety of the staff. MDR stated the facility did not do any maintenance for the machines unless there was something wrong with it. The MDR stated this was the wrong practice and regular maintenance was needed to ensure the laundry machines work properly. MDR stated he could not find the laundry machine manual and it was important to keep the manual to refer to troubleshooting. During a review of the facility's policy and procedures (P&P) titled Maintenance Service, dated January 2018, the P&P indicated, 1. The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. 2. Functions of maintenance personnel include but are not limited to: providing routinely scheduled maintenance service to all areas. 3. The maintenance director is responsible for developing and maintaining a schedule of maintenance service to assure that the buildings, grounds, and equipment are maintained in a safe and operable manner. 4. A copy of the maintenance schedule shall be provided to each department director so that appropriate scheduling can be made without interruption of services to residents. 2. During a review of Resident 36's admission Record, dated 8/23/2025, the admission record indicated Resident 36 was admitted to the facility on [DATE] with a diagnoses of dislocation of internal left hip prosthesis (a condition where surgically implanted left hip comes out of place), Huntington's disease (a condition in which nerve cells in the brain break down over time), and fall from chair. During a concurrent observation and interview on 8/20/2025 at 12:11 p.m. with Certified Nursing Assistant (CNA 1) and CNA 2 in Resident 36's room, CNA 1 and CNA 2 were observed trying to lock Resident 36's bed. CNA 1 and CNA 2 stated the bed locks were not working. CNA 1 stated the bed needed to be locked to prevent Resident 36 from falling. During a concurrent observation and interview on 8/20/2025 at 12:30 p.m. with the Maintenance Director (MDR), outside of Resident 36's room, MDR stated Resident 36's bed locks' were not working. The MDR further stated it was important for all the beds to have functioning locks for safety. During an interview with the Director of Nursing (DON) on 8/20/2025 at 2:00 p.m., the DON stated it was important to lock all the beds to prevent injury and fall. The DON confirmed Resident 36's bed locks were broken. During a review of the facility's policy and procedures (P&P) titled, Maintenance Service, dated January 2018, the P&P indicated, The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times.</p>		

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<p>F 0924</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Put firmly secured handrails on each side of hallways.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one handrail was secured to the wall. This failure had the potential to result in residents utilizing an unstable handrail that could subsequently cause a sudden fall and serious injuries. Findings: During an observation on 8/18/2025 at 4:43 p.m. in the east wing hallway, one handrail on the wall between room [ROOM NUMBER] and 10 had a crack along the seam of the handrail and was not firmly secured to the wall. During a concurrent observation and interview on 8/18/2025 at 5:42 p.m. with the Maintenance Director (MDR) in the east wing hallway, the MDR tugged on the handrail between room [ROOM NUMBER] and 10 and the handrail separated from the wall. MDR stated the handrail should have been secured to the wall and it needed to be reinforced. During a review of the facility's policy and procedure (P&P) titled, Maintenance Service, dated January 2018, the P&P indicated, The maintenance department is responsible for maintaining the buildings, grounds and equipment in a safe and operable manner at all times.</p>