STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555214	A. Building B. Wing	09/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Professional Post Acute Center	81 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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.

41283

Based on observations, interviews, and record reviews, the facility failed to ensure the right one of seven sampled residents, Resident 1, to be free from physical abuse when, Resident 1, who had a history of yelling and screaming due to hallucinations, was slapped on the left side of her face by another resident, Resident 2, who had a care planned intervention to modify her environment by reducing the noise level due to a potential to demonstrate aggressive behavior. Resident 1 and Resident 2 were in rooms close to each other. This failure had the potential to result in physical injuries to Resident 1.

Findings:

A review of Resident 1's Progress Notes, dated 8/25/24, at 5:44 p.m., authored by Licensed Nurse A, indicated, .Resident 1 was yelling in her room when Resident 2 went into the room and slapped Resident 1 on the left cheek. Resident 1 was visibly red on the left cheek following the incident .

A review of Resident 1's Progress Notes, dated 8/25/24, at 11:35 p.m., authored by Licensed Nurse B indicated, Resident 1 being monitored for emotional distress related to being slapped on the left cheek by another Resident 2 .Left cheek with scattered petechiae (Petechiae are pinpoint, round spots that form on the skin. They're caused by bleeding, which makes the spots look red, brown, or purple. The spots often form in groups and may look like a rash) .

A review of Resident 2's Care Plan, initiated on 5/8/23, indicated, Resident 2 has a potential to demonstrate physical behaviors (kicking staff) related to Dementia. The goal for this care plan indicated, The resident (Resident 2) will not harm self or others . One of the interventions for this focused problem indicated, Modify environment: (Specify: .Reduce noise . etc.).

A review of Resident 1's Care Plan, initiated on 6/10/24, indicated, The resident (Resident 1) has a behavior problem related to Hallucinations causing her to yell and scream due to fear.

During an observation on 9/3/24, at 1:10 p.m., Resident 1 was asleep in bed, and seemed comfortable. It was observed that Resident 1's room was very close to Resident 2's room. Resident 2 was observed eating her lunch in her room.

(continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555214	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/03/2024
NAME OF PROVIDER OR SUPPLIER Professional Post Acute Center		STREET ADDRESS, CITY, STATE, ZIP CODE 81 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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and observation on 9/3/24, at 1:40 p.m., with Resident 2, she ambulated independently to the interview room without the use of any assistive device. Resident 2 stated there was a lady close to her room that yells and screams. Resident 2 stated sometimes she would go to that room and just ask the lady (Resident 2) to be quiet because there are people who want to rest. A review of Resident 2's MDS (Minimum Data Set-is part of the federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes), dated 6/25/24, Section C (Cognitive Patterns), indicated her BIMS (Brief Interview for Mental Status) score of 3, (The BIMS assessment uses a points system that ranges from 0 to 15 points: 0 to 7 points suggests severe cognitive impairment. 8 to 12 points suggests moderate cognitive impairment. 13 to 15 points suggests that cognition is intact). Resident 2's BIMS score indicated she had a severe cognitive (relating to or involving the processes of thinking and reasoning) impairment. During an interview on 9/6/24, at 11:15 a.m., with Licensed Nurse A, she stated she was made aware of the incident by Certified Nursing Assistant C. Licensed Nurse A stated Certified Nursing Assistant C informed her that he witnessed Resident 1 was slapped on the left side of her face by Resident 2. Licensed Nurse A stated she checked Resident 1, and she had a fresh red spot on the left side of her face which was not evident during her first assessment at around 4:30 p.m. Licensed Nurse A stated that 5 p.m., the redness appeared which was approximately the size of a quarter. Licensed Nurse A stated that she called it in to CDPH (California Department of Public Health) and also faxed the SOC 341 (Report of Suspected Dependent Adult/Elder Abuse). Licensed Nurse A stated that Resident 1 was non-interviewable. During an interview on 9/6/24, at 4 p.m., with Certified Nursing Assistant C, he stated at around 3:30 p.m., he was walking in the hallway when he saw the call light in a resident's room was on. He stated he entered the room to check the call light and Resident 1 was yelling at that time. Certified Nursing Assistant C stated he saw Resident 2 standing at the side of Resident 1's bed and slapped Resident 1 on the left side of her face. Certified Nursing Assistant C stated he did not have time to prevent the incident from happening and was shocked at what he witnessed. Certified Nursing Assistant C stated Resident 1 also looked shocked and stopped yelling after Resident 2 slapped her. Certified Nursing Assistant C stated he intervened and asked Resident 2 to go out of the room. He stated Resident 2 walked independently back to her room without the use of any assistive device. Certified Nursing Assistant C stated he reported the incident to Licensed Nurse B and Licensed Nurse D, who were doing the change of shift report at that time. When Certified Nursing Staff C was asked if Resident 2's action that he witnessed was intentional or accidental, he stated it was intentional. During an interview on 9/9/24, at 10:26 a.m., with Licensed Nurse B, she stated it was during the change of shift on 8/25/24, when Certified Nursing Assistant C reported the incident between Resident 1 and Resident 2. Licensed Nurse B stated that she reported the incident to Licensed Nurse A. Licensed Nurse B stated that she knew that allegations of abuse should be reported immediately or within 2 hours. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555214	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/03/2024
NAME OF PROVIDER OR SUPPLIER Professional Post Acute Center		STREET ADDRESS, CITY, STATE, ZIP CODE 81 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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow-up interview on 9/9/24, at 10:55 a.m., with Licensed Nurse A, she stated she was aware of the reporting requirements that if it involved abuse, it had to be reported to CDPH immediately or within 2 hours. Licensed Nurse A stated that she was verifying that she called the incident to CDPH on Sunday 8/25/24, at around 9 p.m. and faxed the SOC 341 at around the same time. Licensed Nurse A stated she did not want to make excuses about the delay in reporting the alleged abuse incident. A review of Resident 2's other Care Plans, indicated, 1. Risk for fall care plan, dated, 6/27/24, indicated she was at risk for fall due to self-ambulatory (walk independently), poor safety awareness, and medication side effects. One of the interventions indicated, Provide assistance in transfer and mobility. 2. Risk for elopement/wandering care plan, dated 6/27/24, related to cognitive loss, impaired decision making, and wandering outside the facility. One of the interventions indicated, Frequent visual checks of resident's (Resident 2's) whereabouts. During an interview on 9/9/24, at 2:45 p.m., with the facility Administrator/Abuse Coordinator, she stated the abuse allegation was fully investigated. The Administrator stated she interviewed Certified Nursing Assistant C via phone. The Administrator stated the abuse allegation was substantiated (to establish by proof or competent evidence; verify). The Administrator stated new interventions are in place and was included in the 5-day report submitted to CDPH. The Administrator stated Resident 2 declined to be transferred to another room. The Administrator stated that it was her expectation that allegations of abuse are reported to CDPH immediately or within 2 hours. The Administrator stated she had evidence that the SOC 341 was faxed within 2 hours. The Administrator was informed that the phone call to report the incident was made by a facility staff on 8/25/24, at 9:02 p.m., and the faxed SOC 341 was received by CDPH on 8/25/24, at 9:13 p.m. On 9/12/24, at 10:04 a.m., an email was sent to the facility Administrator to follow-up if she had secured the faxed confirmation she stated that she had, as evidence that the facility faxed the SOC 341 immediately or within 2 hours to CDPH. The Administrator was not able to provide the fax confirmation that the SOC 341 was sent immediately or within 2 hours to CDPH to report the allegation of physical abuse between Resident 1 and Resident 2. A review of a facility policy and procedure (P&P) titled, Abuse, Neglect, Exploitation, and Misappropriation prevention Program, dated, April 2023, indicated, Residents have the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual, or physical abuse, and physical chemical restraint not required to treat a resident's symptoms.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555214	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Professional Post Acute Center	81 Professional Center Parkway San Rafael, CA 94903

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 41283 Based on observations, interviews, and record reviews, the facility failed to ensure that an alleged violation of physical abuse to one of seven sample residents, Resident 1, was reported to the State Survey Agency immediately, but not later than 2 hours after the allegation of physical abuse was made, when Certified Nursing Assistant C witnessed Resident 2 slapped Resident 1 on the left side of her face on 8/25/24, at 3:30 p.m., and Licensed Nurse A reported the incident to the State Survey Agency via voicemail on 8/25/24, at 9:02 p.m., followed by a fax transmitted to the State Survey Agency on 8/25/24, at 9:13 p.m. The physical abuse allegation was reported by Licensed Nurse A to the State Survey Agency more than 5 hours after Certified Nursing Assistant C's allegation was made. This failure had the potential to result in further escalation and recurrence of physical abuse of Resident 1 by Resident 2 pending an investigation and identification of new measures to protect Resident 1 from Resident 2. Findings: A review of Resident 1's Progress Notes, dated 8/25/24, at 5:44 p.m., authored by Licensed Nurse A, indicated, .Resident 1 was yelling in her room when Resident 2 went into the room and slapped Resident 1 on the left cheek. Resident 1 was visibly red on the left cheek following the incident . A review of Resident 1's Progress Notes, dated 8/25/24, at 11:35 p.m., authored by Licensed Nurse B indicated, Resident 1 being monitored for emotional distress related to being slapped on the left cheek by another Resident 2 .Left cheek with scattered petechiae (Petechiae are pinpoint, round spots that form on the skin. They're caused by bleeding, which makes the spots look red, brown, or purple. The spots often form in groups and may look like a rash) . A review of Resident 2's Care Plan, initiated on 5/8/23, indicated, Resident 2 has a potential to demonstrate physical behaviors (kicking staff) related to Dementia. The goal for this care plan indicated, The resident (Resident 2) will not harm self or others . One of the interventions for this focused problem indicated, Modify environment: (Specify: .Reduce noise . etc.) A review of Resident 1's Care Plan, initiated on 6/10/24, indicated, The resident (Resident 1) has a behavior problem related to Hallucinations causing her to yell and scream due to fear. During an observation on 9/3/24, at 1:10 p.m., Resident 1 was asleep in bed, seemed comfortable. It was observed that Resident 1's room was very close to Resident 2's room. Resident 2 was observed eating her lunch in her room. During a concurrent interview and observation on 9/3/24, at 1:40 p.m., with Resident 2, she ambulated independently to the interview room without the use of any assistive device. Resident 2 stated there was a lady close to her room that yells and screams. Resident 2 stated sometimes she would go to that room and just ask the lady (Resident 2) to be quiet because there are people who want to rest. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555214	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/03/2024
NAME OF PROVIDER OR SUPPLIER Professional Post Acute Center		STREET ADDRESS, CITY, STATE, ZIP CODE 81 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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 2's MDS (Minimum Data Set-is part of the federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes), dated 6/25/24, Section C (Cognitive Patterns), indicated her BIMS (Brief Interview for Mental Status) score of 3, (The BIMS assessment uses a points system that ranges from 0 to 15 points: 0 to 7 points suggests severe cognitive impairment. 8 to 12 points suggests moderate cognitive impairment. 13 to 15 points suggests that cognition is intact). Resident 2's BIMS score indicated she had a severe cognitive (relating to or involving the processes of thinking and reasoning) impairment. During an interview on 9/6/24, at 11:15 a.m., with Licensed Nurse A, she stated she was made aware of the incident by Certified Nursing Assistant C. Licensed Nurse A stated Certified Nursing Assistant C informed her that he witnessed Resident 1 was slapped on the left side of her face by Resident 2. Licensed Nurse A stated she checked Resident 1, and she had a fresh red spot on the left side of her face which was not evident during her first assessment at around 4:30 p.m. Licensed Nurse A stated that 5 p.m., the redness appeared which was approximately the size of a quarter. Licensed Nurse A stated that she called it in to CDPH (California Department of Public Health) and also faxed the SOC 341 (Report of Suspected Dependent Adult/Elder Abuse). Licensed Nurse A stated that Resident 1 was non-interviewable. During an interview on 9/6/24, at 4 p.m., with Certified Nursing Assistant C, he stated at around 3:30 p.m., he was walking in the hallway when he saw the call light in a residnet's room was on. He stated he entered the room to check the call light and Resident 1 was yelling at that time. Certified Nursing Assistant C stated he saw Resident 2 standing at the side of Resident 1's bed and slapped Resident 1 on the left side of her face. Certified Nursing Assistant C stated he did not have time to prevent the incident from happening and was shocked at what he witnessed. Certified Nursing Assistant C stated Resident 1 also looked shocked and stopped yelling after Resident 2 slapped her. Certified Nursing Assistant C stated he intervened and asked Resident 2 to go out of the room. He stated Resident 2 walked independently back to her room without the use of any assistive device. Certified Nursing Assistant C stated he reported the incident to Licensed Nurse B and Licensed Nurse D, who were doing the change of shift report at that time. When Certified Nursing Staff C was asked if Resident 2's action that he witnessed was intentional or accidental, he stated it was intentional. During an interview on 9/9/24, at 10:26 a.m., with Licensed Nurse B, she stated it was during the change of shift on 8/25/24, when Certified Nursing Assistant C reported the incident between Resident 1 and Resident 2. Licensed Nurse B stated that she reported the incident to Licensed Nurse A. Licensed Nurse B stated that she knew that allegations of abuse should be reported immediately or within 2 hours. During a follow-up interview on 9/9/24, at 10:55 a.m., with Licensed Nurse A, she stated she was aware of the reporting requirements that if it involved abuse, it had to be reported to CDPH immediately or within 2 hours. Licensed Nurse A stated that she was verifying that she called the incident to CDPH on Sunday 8/25/24, at around 9 p.m. and faxed the SOC 341 at around the same time. Licensed Nurse A stated she did not want to make excuses about the delay in reporting the alleged abuse incident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555214	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Professional Post Acute Center	81 Professional Center Parkway San Rafael, CA 94903

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0609

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

During an interview on 9/9/24, at 2:45 p.m., with the facility Administrator/Abuse Coordinator, she stated the abuse allegation was fully investigated. The Administrator stated she interviewed Certified Nursing Assistant C via phone. The Administrator stated the abuse allegation was substantiated (to establish by proof or competent evidence; verify). The Administrator stated new interventions are in place and was included in the 5-day report submitted to CDPH. The Administrator stated Resident 2 declined to be transferred to another room. The Administrator stated that it was her expectation that allegations of abuse are reported to CDPH immediately or within 2 hours. The Administrator stated she had evidence that the SOC 341 was faxed within 2 hours. The Administrator was informed that the phone call to report the incident was made by a facility staff on 8/25/24, at 9:02 p.m., and the SOC 341 was received by CDPH on 8/25/24, at 9:13 p.m.

On 9/12/24, at 10:04 a.m., an email was sent to the facility Administrator to follow-up if she had secured the faxed confirmation she stated that she had, as evidence that the facility faxed the SOC 341 immediately or within 2 hours to CDPH. The Administrator was not able to provide the fax confirmation that the SOC 341 was sent immediately or within 2 hours to CDPH to report the allegation of physical abuse between Resident 1 and Resident 2.

A review of a facility policy and procedure (P&P) titled, Abuse, Neglect, Exploitation, and Misappropriation prevention Program, dated, April 2023, the P&P Policy Statement indicated, Residents have the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual, or physical abuse, and physical chemical restraint not required to treat a resident's symptoms. The P&P Policy Interpretation and Implementation indicated,

6. Provide staff orientation and training/orientation programs that include topics such as abuse prevention, identification and reporting of abuse, stress management, and handling verbally or physically aggressive behavior.

8. Investigate and report any allegations within timeframes required by federal requirements.

* The State Operations Manual (SOM) Appendix PP, Guidance to Surveyors for Long Term Care Facility, dated 2/3/23, indicated the federal reporting requirements:

S483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

S483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials(including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555214	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41283 Based on observations and interviews, the facility failed to ensure a safe and functional environment to three of seven sampled residents (Resident 3, 4, and 5) in room [ROOM NUMBER], when the sliding door and screen door locking mechanisms were broken. This failure had the potential to result in harm to these residents in case of a violent break-in situation or when accidentally left open during extreme weather patterns, jeopardizing their health and safety. Findings: On 7/17/24, at 8:38 a.m., the California Department of Public Health (CDPH) received a complaint that included an allegation that door locks inside one of the resident rooms were broken and not able to be locked. During a concurrent observation and interview on 9/3/24, at 2 p.m., with the facility's Maintenance Supervisor in room [ROOM NUMBER], 2, and 3, it was observed that the original sliding door locking mechanisms were broken and not able to lock. It was also observed that the screen door in room [ROOM NUMBER] was not locking because it was bent and not able be locked, (A picture of the bent locking system was taken). When the Maintenance Supervisor was asked if he knew about room [ROOM NUMBER]'s sliding door and screen door was not able to be locked, he stated that this was the first time that he knew about it. The Maintenance Director was asked to try and lock both the sliding door and screen door inside room [ROOM NUMBER], and he was not able to lock it and he stated that it was broken. The Maintenance Supervisor and this surveyor also checked the original sliding door locking mechanism in room [ROOM NUMBER] and 2, and these were not able to lock. During an observation on 9/3/24, at 2:35 p.m., with the facility Administrator, she was able to show that room [ROOM NUMBER] and 2 had makeshift locking systems that locked the sliding doors inside the rooms. The makeshift lock in room [ROOM NUMBER] was missing a part and the sliding door was not able to be locked. The Administrator was observed trying to locate the missing part under the bed of the resident in 3C and was not able to find the missing piece. A review of a facility policy and procedure (P&P) titled, Quality of Life- Homelike Environment, undated, the P&P indicated on the policy statement, Residents are provided with a safe, clean, comfortable, and homelike environment and encourage to use their personal belongings to the extent possible.