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	03/04/2026

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 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 observation, interviews and record reviews, the facility failed to ensure professional standards of quality were delivered for one out of four sampled residents (Resident 1) when Resident 1 was left to self-administer his medications despite not having a medication self-administration assessment completed.This failure creates risks of medication errors such as overdose or missed doses, adverse drug interactions, and potential resident injury.Findings:A review of Resident 1's Face Sheet (front page of the chart that contains a summary of basic information about the resident) indicated an admission date to the facility in 1/2019 with diagnoses of Hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), Hemiparesis (a neurological condition characterized by partial weakness, reduced strength, or impaired motor function on one side of the body) and Dysphagia (difficulty swallowing).A review of Resident 1's admission/readmission data tool, dated 8/14/24, indicated Resident 1 did not want to self-administer medications.A review of Resident 1's Brief Interview for Mental Status (BIMS, an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident), dated 2/6/26, Resident 1's score was 14 indicating intact cognition (mental action of acquiring knowledge and understanding through thought, experience, and the senses).During a concurrent observation and interview on 3/4/26 at 8:53 a.m., Resident 1 was noted to have a medicine cup labeled 18B containing three pills on top of his overbed table. Resident 1 verified he was occupying 18C bed while the medicine cup was labeled for 18B. Resident stated he was not even sure if these medications were for him. Resident 1 verified no nursing staff had assessed whether it was safe for him to take the medications without staff supervision. When asked if Resident could identify the three pills, Resident stated he believed he could identify two white pills and added, I am not sure . I don't know what the orange pill is. Resident 1 stated he had not requested to self-administer medications and had not requested staff to leave medications at his overbed table. Resident 1 stated he did not take the medications because he had a hard time taking the medications without assistance.During an interview on 3/4/26 at 9:00 a.m., Licensed Nurse (LN) A verified there was a medicine cup labeled 18B with three pills on top of Resident 1's overbed table. LN A verified 18B was occupied by another resident while Resident 1 occupies the 18C bed. LN B stated she was not sure what the medications were inside the medication cup. LN B stated she was not even sure if Resident 1 was safe to self-administer medications. LN B stated the facility policy indicated LNs were not allowed to leave medications at bedside and allow residents to self-administer medications unless there was an assessment that indicated a resident was safe to self-administer medications. LN B stated allowing residents to self-administer medications without proper assessment was a safety risk for the residents and could be a risk for choking episodes.During an interview on 3/4/26 at 9:06 a.m., LN B stated staff were supposed to watch the residents take their medications. LN B stated the Interdisciplinary team (IDT, a group of health care professionals with various areas of expertise who work together toward the goals of their clients) had to assess residents for safe medication self-administration before a resident was allowed to take medications without supervision. LN B stated allowing residents to self-administer medications without assessment was a safety risk.During a concurrent interview and record review on 3/4/26 at 10:00 a.m. with the interim Director of Nursing (IDON), Resident 1's Physician Order (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 03/04/2026
NAME OF PROVIDER OR SUPPLIER Professional Post Acute Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Summary (POS, a healthcare professional's written instruction specifying the care, services, treatment and medications a patient should receive), for 2/2026, and Resident 1's admission/readmission data tool, dated 8/14/24, were reviewed. The IDON verified the admission/readmission data tool dated 8/14/24 indicated Resident 1 did not want to self-administer medications. The IDON verified there was no assessment completed for Resident 1 that would indicate he was safe to self-administer medications. The IDON stated since there was no assessment to check whether Resident 1 was safe to self-administer medications, staff should not allow Resident 1 to self-administer medications. The IDON stated since Resident 1 had not been assessed to safely to self-administer medications, allowing Resident 1 to self-administer medications could result in accidents such as choking. The IDON stated this was a safety issue which could hurt Resident 1.A review of the facility's Policy and Procedure (P&P) titled Administering Medications, revised 4/2019, the P&P indicated .medications are administered in a safe and timely manner and as prescribed.resident may self-administer their own medication only if the attending physician in conjunction with the interdisciplinary care planning team has determined they have the decision making capacity to do so safely.A review of the facility's P&P titled Self-Administration of Medication revised 12/2016, the P&P indicated .residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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, interviews and record reviews, the facility failed to ensure medications were in locked compartments and only accessible for authorized persons for one out of three sampled residents (Resident 1) when medications were left on Resident 1's bedside table.This failure put the residents at high risks for unauthorized access to the medications, ingestion by the wrong resident with possible adverse reactions.Findings:A review of Resident 1's Face Sheet (front page of the chart that contains a summary of basic information about the resident) indicated an admission date to the facility in 1/2019 with diagnoses of Hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), Hemiparesis (a neurological condition characterized by partial weakness, reduced strength, or impaired motor function on one side of the body and Dysphagia (difficulty swallowing).During a concurrent observation and interview on 3/4/26 at 8:53 a.m., Resident 1 was noted to have a medicine cup labeled 18B containing three pills on top of his overbed table. Resident 1 stated he was not sure if these medications were for him and added he was not sure of when these medications were left on his overbed table. Resident 1 stated staff left medications at his overbed table all the time. Resident 1 stated he did not request staff to leave medications at his table.During a concurrent observation and interview on 3/4/26 at 9:00 a.m., Licensed Nurse (LN) A verified there was a medicine cup labeled 18B with three pills on top of Resident 1's overbed table. LN A stated staff should not be leaving medications at residents' bedside because anyone could grab the medication leading to accidental ingestion of medications not meant for them, causing allergic reaction, choking incidents or hospitalization.During an interview on 3/4/26 at 9:06 a.m., LN B stated staff should not leave medications at bedside because they were supposed to watch the resident take the medications. LN B stated leaving medications at a resident bedside was a safety risk.During an interview on 3/4/26 at 10:00 a.m., the Interim Director of Nursing (IDON) stated staff should not leave medications at Resident 1's bedside. as it was not allowed per facility policy. The IDON added, other residents that wander could grab the medications left at bedside and ingest them even though they were not prescribed to them. The IDON stated this was a safety issue and could hurt the residents.A review of the facility's Policy and Procedure (P&P) title Administering Medications, revised 4/2019, the P&P indicated .medications are administered in a safe and timely manner and as prescribed.A review of the facility's P&P titled Self-Administration of Medication revised 12/2016, the P&P indicated .self-administered medications must be stored in a safe and secured place which is not accessible by other residents.staff shall identify and give to the charge nurse any medications found at bedside that are not authorized for self-administration.