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	05/04/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify a resident representative of a decline in condition for one of three sampled residents, Resident 1, when Resident 1 was transferred to the hospital and Resident 1's family member (FM) was not informed. This failure caused FM to feel angry and confused when she learned Resident 1 was hospitalized from hospital staff who had called from the intensive care unit (ICU) to inform her Resident 1 was in critical condition and being intubated (a procedure where a breathing tube is inserted into the airway to bring oxygen to the lungs).During a phone interview on 5/4/26 at 8:58 a.m., FM stated she was the primary contact for the facility staff to call whenever there was a change in Resident 1's condition. FM stated on the night of 4/30/26, around 9 p.m. she received a phone call from staff at the local acute care hospital. FM stated the hospital staff told her Resident 1 was in the ICU in critical condition, they needed to intubate her and they needed information from FM about Resident 1 fast. FM stated the hospital staff told her, Just so you know, we could lose her [Resident 1] when we intubate. FM stated to get a call like that when she did not even know Resident 1 was in the hospital made her feel angry, confused, and she wondered how long Resident 1 had been in the hospital. FM stated facility staff should have definitely called her to tell her Resident 1 was sent to the hospital. FM stated the hospital ICU doctor told her Resident 1 was dehydrated, septic (occurs when infections trigger extreme inflammation, leading to low blood pressure, organ failure, and high mortality (25-60%) if not treated immediately), and had a urinary tract infection.Review of Resident 1's face sheet indicated Resident 1 was admitted on [DATE] with medical diagnoses that included abnormality of gait and mobility, muscle weakness, and need for assistance with personal care, among others. Resident 1's face sheet indicated FM was Responsible Party and Emergency Contact #1, and Resident 1's code status (a patient's preferences for life-saving interventions if their heart or breathing stops) indicated she was to receive full treatment. Resident 1's nurse progress note written by Licensed Nurse A, dated 4/30/26 at 10:34 p.m., indicated that at 3:40 p.m., Resident 1's mental status became altered, she was not responding to her name, and her vital signs (blood pressure, pulse, breathing rate, temperature, and the percentage of oxygen in the blood) had become unstable. Further review of Resident 1's nurse progress note indicated Resident 1's nurse practitioner ordered Resident 1 to be transferred to the local acute care hospital and family was notified.During an interview on 5/4/26 at 1:46 p.m., Director of Nursing (DON) stated she recalled speaking with Licensed Nurse (LN) A on 4/30/26 about Resident 1. DON stated LN A informed her Resident 1's vital signs were unstable and she needed to go to the hospital. DON stated she called the nurse practitioner for LN A while LN A attended to Resident 1. DON stated the next day (5/1/26) she spoke with FM who was upset that she had not been informed of Resident 1's transfer to the hospital. DON stated she did not ask LN A about her progress note that indicated she had informed Resident 1's family of the transfer to the hospital.During a phone interview on 5/4/26 at 1:59 p.m., LN A stated that on 4/30/26 when Resident 1 was sent to the hospital, she did not notify Resident 1's family. LN A stated LN B notified Resident 1's family of her transfer to the hospital.During an interview on 5/4/26 at 2:19 p.m., LN B stated that on 4/30/26 when Resident 1 (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

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was sent to the hospital, she did not notify Resident 1's family. LN B stated she was on overtime, so she stayed long enough to complete some paperwork, but then told LN A that she did not call Resident 1's family. LN B stated, When I said I didn't call, maybe she (LN A) thought I said I did call. During an interview on 5/4/26 at 2:22 p.m., DON stated it was her expectation that when a resident was sent to the hospital, the nurse should call the resident's family and tell them. DON stated it was the responsibility of the floor nurse to notify the family of the transfer. DON stated it was important to notify the family so that the family is updated on the resident's care and the resident's situation.Review of facility policy and procedure Change in a Resident's Condition or Status, last revised 2/2023, indicated, Unless otherwise instructed by the resident, a nurse will notify the resident's representative if the resident is not self RP [responsible party] when: . it is necessary to transfer the resident to a hospital/treatment center.