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	05/08/2026

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility nurses failed to notify the physician when one resident (Resident 1), out of five sampled residents, did not consume the minimum amounts of fluid and nutrition the Registered Dietitian's (RD) calculated for Resident 1 in April 2026.This failure contributed to Resident 1's hospitalization with a diagnosis of hypovolemia (a critical condition in which there is a low volume of fluid in the body, often caused by dehydration) on 4/30/26.Findings:A review of Resident 1's admission record indicated admission to the facility on [DATE] with diagnoses of Schizoaffective Disorder (a chronic mental health disorder characterized by combinations of hallucinations, delusions, a mood disorder (mania or depression), hypothyroidism (a condition where the thyroid gland does not produce enough hormones to regulate your body's metabolism), and generalized weakness.A review of all of Resident 1's care plans indicated the following goals and interventions: A care plan dated 11/15/21 indicated Resident 1 had an actual or potential nutritional problem related to her disease processes. Interventions required nursing staff to supervise and assist with meals as needed and monitor intake and record q [every] meal. A care plan initiated on 11/15/21 and revised on 2/25/26 indicated Resident 1 had a history of weight refusal. At that time, Resident 1's meal intake was assessed as good (76-100%). Interventions required nursing staff to monitor, document, and report signs of malnutrition and significant weight loss to the physician, and to weigh Resident 1 according to facility protocol. A care plan initiated on 11/27/21 and revised on 6/27/25 indicated Resident 1 was receiving a psychotropic medication (a medication affecting mood, thoughts, emotions, and behavior, used primarily to treat mental health disorders). Resident 1's goal was to remain free of drugˆrelated complications and not experience adverse side effects. Nursing staff were expected to monitor, document, and report to the physician as needed for any side effects or adverse reactions, including refusal to eat, loss of appetite, or weight loss. A review of Resident 1's nutrition assessment completed by the RD, dated 2/25/26, indicated Resident 1 had an estimated daily caloric need of 1888-2265 calories and an estimated fluid need of 1,888-2,265 ml/kcal (milliliter per calorie a unit of measure). This document also indicated Resident 1's nutritional goals were established to have .adequate PO [by mouth] intake to meet >75% of nutrition needs [and] No s/s [signs/symptoms] of dehydration. The RD's instructions for the nursing staff included monthly weights, monitor PO intake, weight changes.A review of Resident 1's weight summary indicated Resident 1's weight on 4/7/26 was 184.2 pounds. There were no other weights obtained for Resident 1 between 7/1/25 and 4/7/26 nor were there any documented refusals from Resident 1 to determine Resident 1's weight was being monitored.A review of Resident 1's nutrition and fluid intake for April 2026 indicated out of 89 meals served to Resident 1, Resident 1:Refused 58 timesConsumed 0-25% of meals: 6 timesConsumed 26-50% of meals: 7 timesConsumed 51-75% of meals: 4 timesConsumed 76-100% of meals: 14 timesThis document further indicated Resident 1 did not meet the daily caloric requirements established in the care plan or her daily goal of consuming 1888-2265 ml of fluid.A review of Resident 1's side effect monitoring for the month of April 2026, indicated nursing staff were expected to monitor Resident 1's side effects of refusal to eat.loss of appetite.weight loss every shift. Further review of this document indicated each shift documented No, which signified nursing (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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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff had not observed any meal refusals, loss of appetite, or weight loss in Resident 1.A review of Resident 1's progress note written by the RD and dated 4/27/26 at 3:52 p.m., indicated Resident 1 had poor PO intake (<50% of meals) and 24 documented meal refusals x 2 weeks.MD [physician], SSD (Social Services Director), nurses aware.A review of Resident 1's psychiatric visit note, dated 4/28/26, indicated the Psychiatric Mental Health Nurse Practitioner (PNP) obtained report from nursing staff who reported that Resident 1 had not been eating and experienced a loss of appetite since she moved to a room at the end of a hallway on 3/5/25. The PNP indicated Resident 1 had refused 25 meals with associated weight loss. The PNP recommended Resident 1 start on an appetite stimulant medication and would defer appetite and weight management to the primary physician.A review of Resident 1's progress note dated 4/30/26 at 3:50 p.m. indicated, Resident noted with altered mental status during routine rounds. Eyes open but unresponsive to name, minimal movement. VS [vital signs] obtained 79/50 [a normal blood pressure is 120/80], P [pulse, normal 60-100] 43 R [respirations, normal 12-20] 10 O2 [oxygen saturation indicated how much oxygen is in the blood, normal 95-100%] fluctuated between 76%-89% RA [room air]. 6L [liters per minute-a unit of air flow measure] oxygen provided via NC [nasal cannula] and fluctuated between 93%-95%. Skin noted cold with temp 96.1 [normal 98.6], warm blanket provided. NP [Nurse Practitioner] notified and ordered to transfer resident to [hospital] for further evacuation (sic). Family notified. 4:10 p.m., [Resident 1] picked up by [ambulance service].A review of Resident 1's emergency room notes, dated 4/30/26, indicated Resident 1 was treated for diagnoses of hypotension (low blood pressure), shock (a life threatening, critical condition characterized by decreased blood flow to tissues, resulting in cellular deprivation of oxygen and potential organ failure), sepsis secondary to UTI (life threatening emergency where a kidney or bladder infection spreads, causing the immune system to damage its own tissue) and hypovolemia (a dangerous reduction of fluids in the body).A review of Resident 1's hospital progress notes, dated 4/30/26, at 6:11 p.m., the Critical Care MD indicated Resident 1, amongst her other diagnoses, had experienced .severe AKI [Acute Kidney Injury-causing waste to build up in the blood] with oliguria [abnormally low urine output], combined septic shock and hypovolemia with poor oral intake for many days prior, likely profoundly dehydrated which is c/w [consistent with] her very dry mucous membranes.During an interview in the hallway on 5/8/26, at 9:45 a.m., Certified Nursing Assistant 1 (CNA 1) stated night shift nursing staff were responsible for filling water pitchers, but it was everyone's responsibility to ensure the water in each resident's pitcher was fresh.During an observation in the hallway of six residents on 5/8/26 at 9:57 a.m., five residents' water pitcher was approximately half full and were at room temperature to touch. One resident had no water pitcher.During an interview on 5/8/26 at 12:38 p.m., the Director of Nursing (DON) stated nursing staff were expected to document physician notification in the progress notes. The DON reviewed Resident 1's progress notes for evidence the physician had been notified of Resident 1's repeated meal refusals and poor fluid intake. The DON confirmed she was unable to locate any documentation or physician orders indicating the physician had been informed. During an interview on 5/8/26 at 12:54 p.m., the RD stated Resident 1's weight loss was discussed after Resident 1's weight loss became apparent to her on 4/27/26. The RD acknowledged she did not call the MD or the family despite her progress note indicating otherwise. The RD explained items raised about Resident 1's weight loss during the morning leadership meeting were assigned to specific leaders for follow up, and she was unsure who had been responsible for notifying the physician, though she assumed it would be nurses. During an interview on 5/8/26at 1:18 p.m., Licensed Nurse 1 (LN 1) stated she found Resident 1 unresponsive during her first resident rounding. LN 1 stated she received no outstanding or concerning matters during change of shift report. LN 1 stated she had noticed Resident 1 was exhibiting minor changes days prior to her change of condition, such as talking less. LN 1 further stated she found out Resident 1 hadn't eaten for a few days after sending Resident 1 to the hospital. LN 1 stated licensed nurses were responsible for calling the MD for anything concerning, including refusing to eat and significant weight loss. LN 1 added nurses should (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	then document the MD notification in the progress notes of the resident's chart.During an interview in the hallway on 5/8/26 at 1:30 p.m., the DON stated she would be concerned for a resident if she had not eaten or had poor intake for two to three days and expected nurses to have notified the MD. The DON explained early notification would allow her to ensure the resident received appropriate care and monitoring.During a phone interview on 5/8/26 at 1:48 p.m., the Social Service Director (SSD) stated she had been assigned to contact the PNP on 4/27/26 to request an evaluation of Resident 1 during the next visit regarding Resident 1's meal refusals. The SSD stated the PNP saw Resident 1 the following day. The SSD stated she was aware the PNP made recommendations but was unsure whether the PNP planned to notify Resident 1's MD.A phone call was placed on 5/8/26 at 1:57 p.m. to the MD and a message was left requesting for a return call. The MD never returned the call.During a concurrent interview and record review on 5/8/26 at 2:41 p.m., the RD stated nutrition assessments were completed quarterly, with Resident 1's most recent completed on 2/25/26. The RD had calculated that Resident 1 required 1,888-2,265 calories per day and 1888-2265 ml of fluid intake per day. Upon reviewing Resident 1's April 2026 meal and fluid intake documentation, the RD confirmed Resident 1 was not meeting the estimated daily nutritional or fluid needs required to maintain physical well-being.During a phone interview on 5/8/26 at 2:59 p.m., the Nurse Practitioner (NP) called in lieu of the MD and stated he saw Resident 1 often during his rounds at the facility. The NP stated he ordered laboratory tests after learning of Resident 1 had weight loss; however, the labs were not obtained before Resident 1 was transferred to the hospital. The NP stated he was unaware Resident 1 had refused numerous meals throughout most of April or that Resident 1 had demonstrated a poor appetite during other meals. The NP stated he would like to be notified immediately after two days of poor intake so next steps can be taken. The NP further stated the nursing department would have to investigate this breakdown in communication.A review of the facility's policy and procedure (P&P) titled Change in a Resident's Condition or Status, revised February 2023, indicated, Our facility notifies the .attending physician.of changes in the resident's medical/mental condition. The nurse will notify the resident's attending physician when there has been a.refusal of treatment two (2) or more consecutive times. A significant change of condition is a major decline.in the resident's status that.will not normally resolve itself without intervention by staff.A review of facility's P&P titled Calorie Counts, revised April 2007, indicated, This facility will provide accurate daily caloric intake assessments as necessary for nutritional evaluation.Direct care staff will notify nursing staff of any ?poor intake', defined as consumption of 25 percent or less of a meal or snack.nursing staff will document poor intake in progress notes. Three or more episodes of poor meal intake in a two day period will be reported to the Dietitian.A review of facility's P&P titled Resident Hydration and Prevention of Dehydration, revised October 2017, indicated, This facility will strive to provide adequate hydration and to prevent and treat hydration . Minimum fluid needs will be calculated and documented using current standards of practice. Nurses will assess for signs and symptoms of dehydration during daily care . Nurses' aides will provide and encourage intake of bedside snack and meal fluids on a daily and routine basis as part of daily care.Intake will be documented in the medical records. Aides will report intake of less than 1200 ml/ day to nursing staff . If potential inadequate intake and or signs and symptoms of dehydration are observed, intake and output monitoring will be initiated and incorporated into the care plan. The physician will be notified.