STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555227	A. Building B. Wing	04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Marin	100 Thorndale Drive 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	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44968 Based on interviews and records review, the facility failed to report an allegation of abuse to the California Department of Public Health (CDPH) in accordance with Federal requirements for one of two sampled residents (Resident 1). This failure resulted in a delayed investigation of the alleged abuse by CDPH and had the potential for other residents to be at risk of abuse. Findings: On 4/02/24 at 1:42 p.m., CDPH received a Facility Reported Incident regarding a facility staff member being physically aggressive to Resident 1. A review of the Minimum Data Set (MDS - health status screening and assessment tool used for all residents) dated 1/16/24 indicated Resident 1 was admitted to the facility on [DATE] with a diagnosis including but not limited to Dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities); Left eye blindness and Anxiety (intense, excessive, and persistent worry and fear about everyday situations). The MDS indicated Resident 1 had a BIMS score of 3 out of 15 points (Brief Interview for Mental Status - a 15-point cognitive (relating to the mental process involved in knowing, learning, and understanding things) screening measure that evaluates memory and orientation. A score of 00 to 07 is severe cognitive impairment). A review of the facility document titled Nurse's Notes dated 3/30/24 at 11:00 p.m., indicated Unlicensed Staff A reported to Licensed Nurse B that she witnessed Unlicensed Staff C slapping Resident 1's left hand and pushed Resident 1 to bed. The Nurse's Notes indicated the Director of Nursing (DON), Social Service, and Administrator were notified of the incident. The Nurse's Notes indicated the facility had twenty four (24) hours from 11:00 p.m. to call and fax the incident to the ombudsman (an official who investigates complaints against businesses, public entities, or officials) and authorities. During a telephone interview with Unlicensed Staff A on 4/11/24 at 8:52 a.m., when Unlicensed Staff A was asked about the incident with Resident 1 on 3/30/24, Unlicensed Staff A stated she saw Unlicensed Staff C slapped Resident 1's hands twice during transfer when Unlicensed Staff C had Resident 1 hold on to the transfer lift (used for a patient who is unable to assist with transferring in and out of a bed or wheelchair). Unlicensed Staff A stated she reported the incident to Licensed Nurse B. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555227	A. Building B. Wing	04/10/2024

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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 with Licensed Nurse D on 4/10/24 at 3:05 p.m., when Licensed Nurse D was asked what she would do if she received a report of an abuse allegation, Licensed Nurse D stated she would report to the supervisor and ombudsman. She stated she would call the police immediately if the abuse resulted in an injury. When Licensed Nurse D was asked who was responsible for reporting when incident happened after hours, she stated the charge nurse could report to CDPH by leaving a message. When Licensed Nurse D was asked about the time frame of reporting an allegation of abuse, she stated immediately within 24 hours. During an interview with Licensed Nurse E on 4/10/24 at 3:10 p.m., when Licensed Nurse E was asked what she would do when she received a report of staff being rude or rough to residents, she stated she would step in, she would ask what happened and make sure to separate the staff from the resident. Licensed Nurse E stated she would report the incident to the police and ombudsman immediately. When Licensed Nurse E was asked if she would report the incident to CDPH, she stated yes. She stated the nurse was responsible for reporting to CDPH, the ombudsman, and police when an allegation or incident of abuse happened after hours or on the weekend. Licensed Nurse E stated they have a book at the nurses' station with a step by step instructions on who, and how to report abuse. When Licensed Nurse E was asked about the time frame for reporting an allegation of abuse, she stated immediately, within 24 hours. After review of the policy and procedure titled Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating revised on September 2022 with Licensed Nurse E, Licensed Nurse E verified the policy indicated to report an allegation involving abuse within two hours. During an interview with the DON on 4/10/24 at 3:29 p.m., when the DON was asked about her expectations from the nurses for reports of abuse. The DON stated the nurses were expected to report the incident to CDPH immediately. She stated they have a binder at the nurses' station with an algorithm (a process or set of rules to be followed in calculations or other problem-solving operations) for the nurses to follow. The DON stated the incident with Resident 1 happened on p.m. shift on 3/30/24. She stated Licensed Nurse B started the report and was completed on 3/31/24 with the help of the Director of Staff Development (DSD). The DON concurred the facility's policy for reporting an allegation of abuse was not followed. A review of the Facility policy and procedure titled Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating revised on September 2022 indicated, all reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/ misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management.