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	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Marin	100 Thorndale Drive 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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on interviews and record review, the facility failed to ensure sufficient staff to fulfill the responsibilities of a full-time supervisor of the Skilled Nursing Facility food and nutrition service.This failure had the potential to place residents at risk for impaired nutritional status.Findings:During an interview on 9/24/25 at 2:42 p.m. with Registered Dietician (RD), RD stated she worked at the facility a minimum of eight hours a week, and that the dietary lead (DL) oversaw tray line, menus, snacks, supplements, and meal preferences for skilled nursing residents. RD stated that the DL reported to the General Kitchen Manager (GKM).During an interview on 9/24/25 at 3:28 p.m. with GKM, GKM stated he oversaw assisted living and skilled nursing units. GKM stated that the DL was responsible for skilled nursing and assisted living units and that the DL did work full-time but that time is split between the two different units. GKM stated they do not have a designated full-time staff for just the skilled nursing unit. During an interview on 9/25/25 at 8:31 a.m. with Health Services Administrator (HSA), HSA stated no dietary staff are designated as full-time for skilled nursing. Confirmed the DL oversaw skilled nursing and assisted living and that the GKM oversaw the entire facility. HSA also confirmed that the RD was only part-time. During a review of the facility's Position Description for Dietary Lead [DL], dated with a last revised date of October 1999, the record indicated, . Responsible for monitoring regulatory compliance related to dietary needs for SNF residents.During a review of California Code of Regulations, Title 22, Chapter 3. The regulation 72351(b) stated If a dietician is not employed full-time, a full-time dietetic services supervisor shall be employed to be responsible for the operations of the food service.

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
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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to store food in a safe and sanitary manner when:1. Multiple food items were not discarded after their use-by-date.2. Opened food items were not properly labeled with open and use-by-date.These failures had the potential to cause food-borne illnesses in an already medically fragile population.Findings:1. During a concurrent observation and interview on 9/22/25 at 3:25 p.m. in the main kitchen with the General Kitchen Manager (GKM), kitchen refrigerator 5 was observed with the following items past their use by date: Tuna Salad - use by 9/12/25Pepper Dressing - use by 9/12/25Bag of Turkey - use by 9/14/25Bag of Ham - use by 9/22/25 at 11:53 a.m.The GKM confirmed the items were past their use by date and stated they should have been discarded. During a concurrent observation and interview on 9/22/25 at 3:41p.m. in the main kitchen with the GKM, walk-in freezer 2 was observed with the following items past their use by date:3 bags of vegetable dumplings - use by 9/20/251 bag of bagels - use by 8/31/25The GKM confirmed that the items were past their use by date and stated staff should have disposed of them.During a concurrent observation and interview on 9/22/25 at 3:46 p.m. in the main kitchen with the GKM, walk in fridge 3 was observed with the following item past its use by date: 1 lb. (pound - unit of measurement) container of [NAME] Hummus - use by 8/15/25 GKM stated that expiration dates are supposed to be monitored daily and expired products should have been disposed of. During a concurrent observation and interview on 9/22/25 at 4:42 p.m. in the resident snack room with Certified Nursing Assistant (CNA) 1, resident snack refrigerator was observed with the following item past its expiration date: 1 carton of fat free milk - exp 9/21/25. CNA 1confirmed the date on the carton of milk and stated, it should have been thrown out. During a review of the facility's policy and procedure (P&P) titled, Labeling & Dating, dated 5/2023, the P&P indicated, Policy: All foods will be appropriately . labeled, and dated. Procedure: All foods are labeled, dated, . and use-by dates are monitored and followed.2. During a concurrent observation and interview on 9/22/25 at 3:25 p.m. in the main kitchen with the General Kitchen Manager (GKM), kitchen refrigerator 5 was observed with the following undated items: Container of bushberries - undated The GKM stated they should have had a best by date label on them. During a concurrent observation and interview on 9/22/25 at 3:41p.m. in the main kitchen with the GKM, walk-in freezer 2 was observed with the following undated items: 3 bags of hamburger buns - undated The GKM stated that the hamburger buns should have been labeled with a best by date. During a review of the facility's policy and procedure (P&P) titled, Labeling & Dating, dated 5/2023, the P&P indicated, Policy: All foods will be appropriately . labeled, and dated. Procedure: All foods are labeled, dated,. and use-by dates are monitored and followed.

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the medication error rate was not greater than five percent when six identified medication errors out of 27 opportunities were observed for three of five sampled residents (Resident 2, Resident 16 and Resident 21).These failures resulted in an overall facility medication error rate of 22.22% and had the potential to result in negative health outcomes for Resident 2, Resident 16 and Resident 27. Based on observation, interview, and record review, the facility failed to ensure the medication error rate was not greater than five percent when six identified medication errors out of 27 opportunities were observed for three of five sampled residents (Resident 2, Resident 16 and Resident 21).These failures resulted in an overall facility medication error rate of 22.22% and had the potential to result in negative health outcomes for Resident 2, Resident 16 and Resident 27.Findings:1. During a review of the Record of Admission, the Record of Admission indicated Resident 21 was admitted to the facility on [DATE] with diagnoses that included Parkinson's disease (nerve disorder of the brain which causes tremors, abnormal movement, and loss of balance).During an observation on 9/24/25 at 8:13 a.m. with Licensed Vocational Nurse (LVN) 4, LVN 4 was observed preparing and administering Resident 21's morning medications. LVN 4 administered one tablet of Losartan (medication to treat high blood pressure) 25 mg (milligrams- unit of measurement) which Resident 21swallowed with sips of water.During a record review on 9/24/25 at 12:06 p.m. the physician's order dated 9/17/25 indicated Losartan 50 mg with Hydrochlorothiazide 12.5 mg (combination high blood pressure medication with a diuretic medication to increase urine output) every morning.During an interview and review of Resident 21's medications on 9/24/25 at 12:21 p.m. with LVN 4, LVN 4 confirmed she did not administer Losartan 50 mg with Hydrochlorothiazide and instead administered the wrong medication.During an interview on 9/25/25 at10:28 a.m. with the pharmacist, (Pharm) 1 stated it was important for Resident 21 to receive the diuretic portion of the mediation in the morning so that Resident 21's blood pressure was managed, and his urine output was increased during the daytime. Pharm 1 confirmed, LVN 4 administered the wrong medication during the morning medication pass.During a review of the facility's Policy and Procedure titled, Administering Medications (P&P) dated April 2019, the P&P indicated, Medications are administered in a safe and timely manner and as prescribed.the individual administering the medication checks the label to verify the right. medication, right dosage. prior to giving the medication.2. During a review of the Record of Admission, the Record of Admission indicated Resident 21 was admitted to the facility on [DATE] with diagnoses that included Parkinson's disease (nerve disorder of the brain which causes tremors, abnormal movement, and loss of balance).During an observation on 9/24/25 at 8:13 a.m. with Licensed Vocational Nurse (LVN) 4, LVN 4 was observed preparing and administering Resident 21's morning medications. LVN did not administer Aspirin (medication to prevent blood clotting) to Resident 21 during the observation.During a record review on 9/24/25 at 12:06 p.m., the physician's order dated 9/13/25 indicated, Aspirin 81 mg chewable tablet every morning for blood clot prevention.During an interview with LVN 4 on 9/24/25 at 12:21 p.m., LVN 4 confirmed she did not administer Aspirin to Resident 21.During an interview with the Director of Staff Development (DSD) on 9/24/25 at 4:12 p.m., DSD stated, LVN 4 did not follow physician's orders and should have administered Resident 21's Aspirin to prevent blood clotting.During a review of the facility's Policy and Procedure (P&P) titled, Administering Medications, dated April 2019, the P&P indicated, Medications are administered in a safe and timely manner and as prescribed. medications are administered in accordance with prescriber's orders 3. During a review of the Record of Admission, the Record of Admission indicated, Resident 16 was admitted to the facility on [DATE] with diagnoses that included hypertension (high blood pressure) and fracture of the humerus (arm).During an observation on 9/24/25 at 8:35 a.m. with Licensed Vocational Nurse (LVN) 4 was observed preparing and administering Resident 16's morning medications. LVN 4 administered one (continued on next page)

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	tablet of Lisinopril (medication to reduce blood pressure) which Resident 16 swallowed with sips of water.During a record review on 9/24/25 at 12:46 p.m., the physician's order dated 9/17/25 indicated, Hold Lisinopril . if SBP (systolic blood pressure- the top number in a blood pressure reading which measures the pressure the blood is pumping in the blood vessels) is less than 110.During a record review on 9/24/25 at 12:52 p.m., Resident 16's Medication Administration Record indicated Resident 16's SBP was 107 prior to the resident receiving Lisinopril during the morning medication administration observation on 9/24/25.During an interview on 9/24/25 at 4:12 p.m. with the Director of Staff Development (DSD), the DSD stated LVN 4 should have checked Resident 16's blood pressure to ensure it was within parameters prior to administering the resident's blood pressure medications. DSD stated he would expect LVN 4 to hold Resident 16's blood pressure medications when her SBP was 107 as the physician instructed.During an interview on 9/25/25 at 10:28 a.m. with the pharmacist (Pharm) 1, Pharm 1 stated LVN 4 should have followed the physician's order and held Lisinopril when Resident 16's SBP was 107. Pharm 1 stated, Resident 16 was at risk for symptoms of low blood pressure from receiving blood pressure medications which were not indicated.During a review of the facility's Policy and Procedure (P&P) titled, Administering Medications, dated April 2019, the P&P indicated, Medications are administered in a safe and timely manner and as prescribed. the following information is checked/verified for each resident prior to administering medications: vital signs if necessary. 4. During a review of the Record of Admission, the Record of admission indicated, Resident 16 was admitted to the facility on [DATE] with diagnoses that included hypertension (high blood pressure) and fracture of the humerus (arm).During an observation on 9/24/25 at 8:35 a.m. with Licensed Vocational Nurse (LVN) 4 was observed preparing and administering Resident 16's morning medications. LVN 4 administered one tablet of Norvasc (medication to reduce blood pressure) which Resident 16 swallowed with sips of water.During a record review on 9/24/25 at 12:46 p.m., the physician's order dated 9/17/25 indicated, Hold . Norvasc if SBP (systolic blood pressure- the top number in a blood pressure reading which measures the pressure the blood is pumping in the blood vessels) is less than 110.During a record review on 9/24/25 at 12:52 p.m., Resident 16's Medication Administration Record indicated Resident 16's SBP was 107 prior to the resident receiving Norvasc during the morning medication administration observation on 9/24/25.During an interview on 9/24/25 at 4:12 p.m. with the Director of Staff Development (DSD), the DSD stated LVN 4 should have checked Resident 16's blood pressure to ensure it was within parameters prior to administering the resident's blood pressure medications. DSD stated he would expect LVN 4 to hold Resident 16's blood pressure medications when her SBP was 107.During an interview on 9/25/25 at 10:28 a.m. with the pharmacist (Pharm) 1, Pharm 1 stated LVN 4 should have followed the physician's order and held Norvasc when Resident 16's SBP was 107. Pharm 1 stated, Resident 16 was at risk for symptoms of low blood pressure from receiving blood pressure medications which were not indicated.During a review of the facility's Policy and Procedure (P&P) titled, Administering Medications, dated April 2019, the P&P indicated, Medications are administered in a safe and timely manner and as prescribed. the following information is checked/verified for each resident prior to administering medications: vital signs if necessary. 5. During a review of the Record of Admission, the Record of Admission indicated, Resident 16 was admitted was admitted to the facility on [DATE] with diagnoses that included hypertension (high blood pressure) and fracture of the humerus (arm).During an observation on 9/24/25 at 8:35 a.m. with Licensed Vocational Nurse (LVN) 4 was observed preparing and administering Resident 16's morning medications. LVN 4 did not administer Duloxetine (medication used to reduce pain) during the observation.During a record review on 9/24/25 at 12:46 p.m., the physician's order dated 9/11/25 indicated, Duloxetine 60 mg 1 capsule daily for neuropathic pain (nerve pain associated with abnormal sensations).During an interview on 9/24/25 at 4:12 p.m. with the Director of Staff Development (DSD), the DSD stated LVN 4 should have administered Resident 16's Duloxetine with the morning medications as ordered by the physician.During an interview on 9/25/25 at 10:28 a.m. with the pharmacist (Pharm) 1, Pharm 1 stated Resident 16 was at risk for (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	unrelieved pain as a result of not receiving Duloxetine with her morning medications on 9/24/25.During a review of the facility's Policy and Procedure (P&P) titled, Administering Medications dated April 2019, the P&P indicated, Medications are administered in a safe and timely manner and as prescribed. medications are administered in accordance with prescriber's orders 6. During a review of the Record of Admission, the Record of Admission indicated Resident 2 was admitted to the facility on [DATE] with diagnoses that included hypertension (high blood pressure) and osteoporosis (decrease in bone mass with age).During an observation on 9/24/25 at 8:23 a.m. with Licensed Vocational Nurse (LVN) 4, LVN 4 was observed preparing and administering Resident 2's morning medications. LVN 4 prepared Vitamin B 12 (medication to treat vitamin B12 deficiency) in a pill cup with eight other medications. The instructions on the Vitamin B 12 bottle indicated, Place one tablet under the tongue for 30 seconds before swallowing. LVN 4 did not instruct Resident 2 to allow the tablet to dissolve under her tongue. LVN 4 handed Resident 2 the pill cup and the resident swallowed the Vitamin B 12 tablet whole with a sip of water.During a record review on 9/24/25 at 12:27 p.m., the physician's order dated 9/19/25 indicated, Vitamin B 12 dissolve 1 tablet under tongue every day for B 12 deficiency.During an interview with LVN 4 on 9/24/25 at 12:36 p.m., the instructions on the bottle of Vitamin B were reviewed. LVN 4 confirmed she did not instruct Resident 2 to dissolve the Vitamin B tablet under her tongue as the instructions indicated.During an interview on 9/25/25 at 10:28 a.m. with the pharmacist (Pharm) 1, Pharm 1 stated LVN 4 should have instructed the resident to dissolve Vitamin B 12 under her tongue for better absorption of the medication.During a review of the facility's Policy and Procedure (P&P) titled, Administering Medications, dated April 2019, the P&P indicated, Medications are administered in a safe and timely manner and as prescribed. The individual administering the medication checks the label to [NAME] the. right method (route) of administration before giving the medication.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on interview and record review, the facility failed to ensure housekeeping staff donned personal protective equipment (PPE - clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) when handling 14 out of 15 resident's soiled laundry. This failure had the potential to negatively impact the residents.Findings:During an interview on 9/24/25 at 8:03 a.m. with the Housekeeper, the Housekeeper stated the resident's soiled laundry was transported in a clear plastic bag to the laundry room and was removed from the clear plastic bag and placed in the washer machine. The Housekeeper stated she does not don a gown during handling of the resident's soiled laundry. During an interview on 9/24/25 at 3:06 p.m. with the Infection Preventionist (IP), the IP stated housekeeping staff should don proper PPE which includes a mask, gloves and a gown during the handling of resident soiled laundry for infection prevention and control practices. During an interview on 09/25/2025 at 8:21 a.m. with the Housekeeper Director (HSD), the HSD stated the housekeeping staff should don proper PPE when handling the resident's soiled laundry to prevent cross contamination. During a review of the facility's policy and procedure titled, Laundry and Bedding, Soiled, dated September 2022, indicated, Soiled laundry/bedding shall be handled, transported and processed according to best practices for infection prevention and control . Handling 1. All used laundry is handled as potentially contaminated using standard precautions .

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record reviews, the facility failed to transmit the Minimum Data Set (MDS - an assessment care - planning tool) to the Centers for Medicare and Medicaid Services (CMS) within 14 days after the completion for two of 15 sampled residents (Resident 1 and Resident 6).This failure resulted in the delay of information to CMS for payment and quality measure purposes and for potential changes in Resident 1 and Resident 6's condition to be missed or go unaddressed.1 Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE], with a diagnosis that included pneumonia. During a record review on 9/24/25 at 3:47p.m. Resident 1's quarterly MDS assessment was reviewed. The quarterly MDS was initiated on 8/6/25 and completed (signed by the Director of Nurses (DON)) on 8/24/25. The MDS was not transmitted to CMS until 9/23/25 (29 days after it was completed). During a concurrent interview and record review of Resident 1's quarterly MDS with the Director of Staff Development (DSD) on 9/24/25 at 4:41p.m., the DSD confirmed Resident 1's MDS was not transmitted until 9/23/25 and should have been transmitted within 14 days. During a review of the facility's policy and procedure (P&P) titled, MDS Completion and Submission Timeframes, dated July 2017, the P&P indicated, .2. Timeframes for completion and submission of assessments is based on the current requirements published in the Resident Assessment Instrument Manual. During a review of the MDS Manual, Centers of Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual - Chapter 5, dated October 2024, indicated, .Transmitting Data. Assessment Transmission. MDS Assessments must be submitted within 14 days of the MDS Completion Date (Z0500B + 14 days). 2. During a review of Resident 6's Record Of Admission, the record indicated that Resident 6 was admitted to the facility on [DATE] with a history of diagnoses that included: essential (primary) hypertension (a chronic condition of persistently high blood pressure), Hypothyroidism (condition where the thyroid gland does not produce enough thyroid hormone), and a need for assistance. During a concurrent interview and record review on 9/23/25 at 1:32 p.m. with Licensed Vocational Nurse (LVN) 1, Resident 6's MDS 3.0 Nursing Home Quarterly, dated 8/20/25 was reviewed. The record indicated that Resident 6's Quarterly MDS was completed on 8/12/25 and section Z0500B was signed off by the Director of Nursing (DON) on 8/20/25. LVN1 stated that they had 30 days to submit the completed MDS to CMS after the DON signed it off. During a concurrent interview and record review on 9/24/25 at 8:16 a.m. with Director of Staff Development (DSD), Resident 6's MDS 3.0 NH [Nursing Home] Final Validation Report, dated 9/19/25 was reviewed. The record indicated that Resident 6's MDS was submitted on 9/19/25 at 7:10 p.m. DSD confirmed the MDS section Z0500B was signed off on 8/20/25 and stated that the MDS should have been submitted before 9/19/25. DSD stated it should have been submitted within 14 days. During a review of the facility's policy and procedure (P&P) titled, MDS Completion and Submission (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timeframes, dated July 2017, the P&P indicated, .2. Timeframes for completion and submission of assessments is based on the current requirements published in the Resident Assessment Instrument Manual. During a review of the MDS Manual, Centers of Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual - Chapter 5, dated October 2024, indicated, .Transmitting Data. Assessment Transmission. MDS Assessments must be submitted within 14 days of the MDS Completion Date (Z0500B + 14 days).