

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555595	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/09/2026
NAME OF PROVIDER OR SUPPLIER Smith Ranch Skilled Nursing & Rehabilitation Cente		STREET ADDRESS, CITY, STATE, ZIP CODE 1550 Silveira 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 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** Based on interview and record review, the facility failed to ensure an allegation of verbal abuse was timely reported to the Department or was investigated for one of three sampled residents (Resident 1).This failure delayed state agency awareness and oversight of an alleged abuse incident and caused Resident 1 unnecessary anxiety. Cross reference F610. A review of Resident 1's admission Record (a facility demographic) indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis (hemiparesis is weakness on one side of the body, while hemiplegia is complete paralysis or loss of movement on one side), memory deficit following cerebral infarction (occurs when an artery supplying oxygen to the brain is blocked, causing tissue damage critical for memory), schizoaffective disorder (a mental health condition marked by a mix of schizophrenia symptoms, such as seeing or hearing things that are not there, and mood disorder symptoms, such as depression), and bipolar disorder (a lifelong mental health condition characterized by dramatic shifts in mood, energy, and activity levels).A review of Resident 1's Minimum Data Set (MDS-a standardized, comprehensive assessment tool used in Medicare and Medicaid-certified nursing facilities) indicated Resident 1's cognitive ability (the mental processes involved in acquiring, processing, storing, and retrieving information) was moderately impaired.During a record review of facility Progress Notes dated 4/13/26 at 2:27 p.m., it indicated Resident 1 entrance to the facility on 4/09/26 followed an unwitnessed fall with a loss of consciousness. This accident was reportedly due to Resident 1's family member administering twice the amount of insulin (a vital hormone medication that regulates blood sugar levels; insulin overdose is a medical emergency that causes dangerously low blood sugar) Resident 1 was prescribed.A review of an online communication to the Department dated 6/01/26 from an external entity indicated Resident 1 had received a verbal death threat from her family member.During an interview on 6/09/26 at 10 a.m., Resident 1 stated she had been scheduled for discharge on [DATE] but had decided to remain in the facility longer. Resident 1 further stated her family member was angry about this and threatened to kill her. Resident 1 added her family member was serious about the threat. Additionally, Resident 1 mentioned her family member, whom she resided with prior to admission to the facility, had verbally and physically abused her in the past. Resident 1 stated the thought of discharging her to the care of her family member made her anxious.During an interview on 6/09/26 at 10:30 a.m. with the facility Nurse Case Manager (NCM), she stated she learned of the death threat to Resident 1 from the facility Social Worker (SW), but stated because the situation was not internal, she believed it did not have to be reported to any outside agencies.During an interview on 6/09/26 at 10:48 a.m. with the facility SW, she stated Resident 1's caregiver had told her that Resident 1 had received a death threat from her family member, but SW had not reported the threat to local law enforcement, the Ombudsman, or to the Department. During an interview on 6/09/26 at 11 a.m. with the facility Administrator (ADM), he stated no SOC-341 (the official form used by those required to report crimes against vulnerable adults) was prepared or sent to any outside agencies or the Department , and no internal investigation was conducted related to the death threat made to Resident 1.A review of facility Policy and (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procedure titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, dated 3/2022, indicated, If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The state/licensing/certification agency .b. The local/state ombudsman.d. Adult Protective Services e. Law enforcement officials.all allegations are thoroughly investigated.within five business days of the incident, the administrator will provide a follow-up investigation report.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement comprehensive, person-centered nursing care plans for one of three sampled residents (Resident 1), after Resident 1 received verbal threats of violence/death from a family member. This failure had the potential to result in Resident 1's physical harm and/or continued psychological distress. A review of Resident 1's admission Record (a facility demographic) indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis (hemiparesis is weakness on one side of the body, while hemiplegia is characterized by complete paralysis or loss of movement on one side), memory deficit following cerebral infarction (when an artery supplying oxygen to the brain is blocked, depriving the it of oxygen and causing tissue damage critical for memory), and bipolar disorder (a lifelong mental health condition characterized by dramatic shifts in mood, energy, and activity levels). A review of Resident 1's Minimum Data Set (MDS-a standardized, comprehensive assessment tool used in Medicare and Medicaid-certified nursing facilities) indicated Resident 1's cognitive ability (the mental processes involved in acquiring, processing, storing, and retrieving information) was moderately impaired. A review of an online communication to the Department dated 6/01/26 from an external agency indicated Resident 1 had received a verbal death threat from her family member. During an interview on 6/09/26 at 10 a.m., Resident 1 stated she had been scheduled for discharge on [DATE] but had decided to remain in the facility longer. Resident 1 further stated her family member was angry about this and threatened to kill her. Resident 1 added her family member was serious about the threat. Additionally, Resident 1 mentioned her family member, whom she resided with prior to admission to the facility, had verbally and physically abused her in the past. Resident 1 stated the thought of discharging her to the care of her family member made her anxious. During a record review on 6/09/26 of Resident 1's nursing care plans, no updated content to address safety or psychosocial concerns was found following death threats made to Resident 1. During an interview on 6/09/26 at 10:30 a.m. with the facility Nurse Case Manager (NCM), she stated she learned of the death threat to Resident 1 from the facility Social Worker (SW). The NCM stated she was not sure if care plans for the protection and/or psychosocial needs of Resident 1 had been created or updated. During an interview on 6/09/26 at 10:48 a.m. with the facility SW, she stated no care plan had been initiated to ensure Resident 1's physical or psychological safety while in the facility or upon discharge, and that the facility was, working on this with the Ombudsman [assist residents in long-term care facilities with issues related to day-to-day care, health, safety, and personal preferences] on it. A review of facility Policy and Procedure titled, Care Plans, Comprehensive Person-Centered, dated 3/2022, indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. assessments of residents are ongoing and care plans are revised as information about the residents and the resident's conditions change.		