

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

Printed: 07/18/2026
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 02/12/2026
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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not provide a safe, hazard free environment for five of eight sampled residents (Resident 3, Resident 23, Resident 61, Resident 81, and Resident 93), when four rooms had damaged wall trims with exposed sharp edges, and Resident 23's wall trim was detached. These failures had the potential to cause harm and injury to the residents, especially those with cognitive impairments who might not recognize the hazards. A review of Resident 3's admission record indicated he was admitted to the facility in December 2025 with medical diagnosis which included chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), and narcolepsy (a chronic sleep disorder). A review of Resident 3's Minimum Data Set (MDS-a federally mandated resident assessment tool) dated 1/02/26, indicated his Brief Interview of Mental Status (BIMS-a cognition [the processes of thinking and reasoning] assessment) score was 15 which indicated his cognition was intact (a score of 1-7 indicates cognition is severely impaired, 8-12 indicates cognition is moderately impaired, and 13-15 indicates cognition is intact). A review of Resident 23's admission record indicated she was admitted to the facility in January 2026 with medical diagnosis which included muscle wasting and atrophy (weakening of muscle mass), and lack of coordination. A review of Resident 23's MDS dated [DATE], indicated her BIMS score was 15 which indicated her cognition was intact. A review of Resident 61's admission record indicated he was admitted to the facility in July 2024 with medical diagnosis which included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body) following a cerebral infarction (stroke). A review of Resident 61's MDS dated [DATE], indicated his BIMS score was 15 which indicated his cognition was intact. A review of Resident 81's admission record indicated she was admitted to the facility in December 2025 with medical diagnosis which included nondisplaced fracture of the sacrum (a crack in the tailbone area) and Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements). A review of Resident 81's MDS dated [DATE], indicated her BIMS score was 15 which indicated her cognition was intact. A review of Resident 93's admission record indicated he was admitted to the facility in February 2026 with medical diagnosis which included hemangioma of intracranial structures (vascular malformations) and history of falling. A review of Resident 93's MDS dated [DATE], indicated his BIMS score was 15 which indicated his cognition was intact. During an observation and concurrent interview on 2/09/26 at 10:52 a.m., in Resident 3's room, approximately six inches (in.- a unit of measure) above the head of his bed, the top layer of the wooden wall trim was observed damaged. The wood was broken and created a sharp, [NAME]-like pointed tip. Resident 3 stated the condition of the wall trim bothered him. Resident 3 further stated he could hurt himself if he came into contact with the sharp edge. Resident 3 stated he informed facility staff and no one had been in to repair it. During an observation on 2/09/26 at 11:07 a.m., in Resident 81's room, approximately five in. above the head of her bed and to the left of the headboard, the top layer of the wooden wall trim was observed damaged. The wood was broken and created a rough-edged pointed tip with a blunt cut edge below it. During an (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	observation on 2/09/26 at 12 p.m. in Resident 23's room, approximately three in. above the head of her bed and to the left of the headboard, the top layer of the wooden wall trim was observed damaged. The wood was broken and created a sharp, splintered pointed tip that protruded approximately one in. from the base layer of wall trim. The base layer of wall trim appeared to be detached down the entire length of the wall with approximately half an inch gap between the base layer of the wall trim and the wall. Resident 23 confirmed the broken wall trim had a very sharp edge. During an observation on 2/09/26 at 2:28 p.m. located in the middle of the room between Resident 61's and 93's designated spaces, the top layer of the wooden wall trim was observed damaged along the wall. Approximately two in. below the damaged area, a walker and wheelchair was stored. The wood was broken and created a rough edge along the underside of the trim and was pointed on top. Resident 61 and Resident 93 confirmed the wall trim was damaged. During a concurrent observation and interview on 2/11/26 at 1:51 p.m., with the Maintenance Director (MTD) in Resident 3's room, the damaged top layer of the wall trim was cut to a blunt, flat edge. The MTD stated he repaired the broken wall trim on 2/09/26. The MTD further stated he did not know how long it had been damaged for. The MTD confirmed the damaged wall trim was located behind Resident 3's head of bed and was sharp prior to the repair. Subsequently, in Resident 61 and Resident 93's room, the MTD verified the top layer of the wall trim was broken and exposed a rough edge. The MTD stated he was unaware of the damage because it was not reported to him. Following, in Resident 23's room, the MTD confirmed the top layer of the wall trim was broken and located near Resident 23's head of bed. The MTD verified the edge was very sharp. Resident 23 stated the entire wall border was coming off the wall. Observed, along the length of the wall, the base layer of the wall border was observed detached from the wall by approximately two to three in. and exposed nails on the opposite side of the wall border that attached to the wall. The MTD was observed to quickly push the detached wall border back into the wall. The MTD confirmed the entire wall border was loose and coming off the wall. Lastly, in Resident 81's room, the MTD confirmed the top layer of the wall trim was broken and located by Resident 81's head of bed. The MTD stated the damaged trim required maintenance right away. The MTD further stated, Anything could happen, when asked if the broken wall trims were a safety concern. During a concurrent observation and interview on 2/11/26 at 2:30 p.m., in Resident 23's room with the Director of Nursing (DON), she confirmed the top layer of the damaged wall trim was sharp. The DON further stated, The resident [Resident 23] could cut themselves- it's near the patient. The DON verified that the entire wall border was loose from the wall and was a safety issue. The DON stated, It [the wall border] could fall from the wall, and there should be nothing loose from the wall. A review of the facility's document titled, Maintenance Log, dated 11/02/25 thru 12/31/25, and 1/26/26 thru 2/10/26 showed no evidence that the damaged wall trims was reported to maintenance. A review of the facility's document titled, Certified Nursing Assistant, dated 2003, indicated, Report all hazardous conditions and equipment to the Nurse Supervisor/Charge Nurse immediately. A review of the facility's document titled, Charge Nurse, dated 2003, indicated, Ensure that your unit's resident care rooms are maintained in a clean, safe, and sanitary manner. Report hazardous conditions or equipment. A review of the facility's policy and procedures (P&P) titled, Maintenance Service, dated 2001, indicated, The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe manner. maintaining the building in good repair and free from hazards. A review of the facility's P&P titled, Free from Accident Hazards, dated 2001, indicated, Our facility strives to make the environment as free from accident hazards as possible.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to provide services according to professional standards of practice for three of eight sampled residents (Resident 15, Resident 59, and Resident 80) when 72-hour monitoring was not completed following a change of condition (COC). These failures had the potential for Resident 15, Resident 59, and Resident 80 to experience further complications after a COC. A review of Resident 15's admission record indicated she was admitted to the facility in February 2025 with medical diagnosis which included displaced intertrochanteric fracture of the left femur (a serious hip fracture involving the pelvis and thigh bone), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body) following a cerebrovascular disease (conditions that affect blood flow to the brain). A review of Resident 15's Minimum Data Set (MDS-a federally mandated resident assessment tool) dated 1/16/26, indicated her Brief Interview of Mental Status (BIMS-a cognition [the processes of thinking and reasoning] assessment) score was 11 which indicated her cognition was moderately impaired (a score of 1-7 indicates cognition is severely impaired, 8-12 indicates cognition is moderately impaired, and 13-15 indicates cognition is intact). A review of Resident 15's SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a COC among the residents) form, dated 1/31/26 at 12 p.m., indicated, [Resident 15] was noted with wound on R [right] medial [closer to midline of the body] middle finger . A review of Resident 15 ' s care plan initiated on 1/31/26 indicated, Resident [Resident 15] noted with R(right) medial middle finger wound. At risk of complications/infection. A review of Resident 15's progress notes, type, Change in Condition Note X 72 Hours, indicated the COC type s/p [status post] wound to R medial finger, was monitored. However, the progress notes indicated the following:There was no evidence that 72-hour (hr.) monitoring was completed on 1/31/25 for evening shift (PM) and night shift (NOC),There was documented monitoring on 2/01/26 at 10:27 p.m. (PM) but no evidence indicating 72-hr. monitoring was completed day (AM) and NOC shift on 2/01/26,There was documented monitoring on 2/02/26 at 4:17 p.m. (PM), and 10:09 p.m. (PM) but no evidence that 72-hr. monitoring was completed AM and NOC shift on 2/02/26, and;There was no evidence that 72-hr. monitoring was completed on 2/03/26 for AM, PM and NOC shift.A review of Resident 59's admission record indicated he was admitted to the facility in November 2023 with medical diagnosis which included chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), dysphagia (difficulty swallowing), and dementia (a progressive state of decline in mental abilities).A review of Resident 59's MDS dated [DATE], indicated his BIMS score was three which indicated his cognition was severely impaired. A review of Resident 59's SBAR form, dated 12/10/25 at 9 a.m., indicated, Patient [Resident 59] had witnessed fall at 0840 [8:40 a.m.]. Assigned CNA [Certified Nurse Assistant] was doing frequent rounds when they observed patient trying to transfer himself from the bed to his wheelchair. CNA stated patient fell backward onto the floor, hitting his head on the suction machine next the bed. Patient assessed with small lacerations measuring about a cm [centimeter- a unit of measure] each on his forehead, R side of face, and behind ear. A review of Resident 59's progress notes, type Change in Condition Note X 72 Hours, indicated the COC type s/p witnessed fall 12/10, was monitored. However, the progress notes indicated the following:There was no evidence that 72 hr monitoring was completed 12/10/25 for PM and NOC shift,There was monitoring documented on 12/11/25 at 12:31 a.m. (NOC) and 10:57 p.m. (PM) but no evidence that 72 hr. monitoring was completed for AM shift,There was monitoring documented on 12/12/25 at 9:30 p.m., (PM) but no evidence that 72-hr. monitoring was completed for AM and NOC shift, and;There was monitoring documented on 12/13/25 at 1:59 p.m. (AM) and 7:57 p.m., (PM) but no evidence that 72-hr. monitoring was completed for NOC shift.A review of Resident 59's progress notes, type eINTERACT SBAR Summary for Providers, dated 11/29/25 at 5:27 p.m., (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indicated, Pt [Patient-Resident 59] observed on the floor with wife in the room. Wife states that pt was trying to transfer from the bed to the wheelchair and ended up falling down. A review of Resident 59's progress notes, type Change in Condition Note X 72 Hours, indicated the COC type unwitnessed fall, was monitored. However, the progress notes indicated the following: On 11/29/25, the only documented monitoring was at 11/29/25 at 6:51 p.m., There was monitoring documented on 11/30/25 at 2:20 p.m. (NOC) and 6:08 p.m. (PM) but there was no evidence that 72-hr. monitoring was completed for AM shift, There was monitoring documented on 12/1/25 at 6:24 a.m. (NOC) and 4:51 p.m. (PM) but there was no evidence that 72-hr. monitoring was completed AM shift, There was monitoring documented on 12/02/25 at 2:35 a.m. (NOC) but there was no evidence that 72-hr. monitoring was completed for AM and PM shift, and; There was no evidence that 72-hr. monitoring was completed 12/03/26 for AM, PM and NOC shift. A review of Resident 59's progress notes, type eINTERACT SBAR Summary for Providers, dated 10/9/25 at 5:30 p.m., indicated, Falls. A review of Resident 59's progress notes indicated no evidence that 72-hr. monitoring was completed status post fall on 10/9/25. A review of Resident 80's admission record indicated he was admitted to the facility in October 2025 with medical diagnosis which included encounter for surgical aftercare following surgery on the skin and subcutaneous (under the skin) tissue and cerebral palsy (a neurological [related to the nervous system] disorder that affects movement and posture). A review of Resident 80's MDS dated [DATE], indicated his BIMS score was 15 which indicated his cognition was intact. A review of Resident 80's SBAR form, dated 1/3/26 at 12:28 p.m., indicated, TX [Treatment] nurse reported patient's [Resident 80] right buttock surgical site noted to be re-opened. Measurement of 2.5 cm x 1 cm. A review of Resident 80's progress notes, type Change in Condition Note X 72 Hours, indicated the COC type right buttock re-opened, was monitored. However, the progress notes indicated the following: There was monitoring documented on 1/03/26 at 11:52 p.m. (NOC), but there was no evidence that 72-hr. monitoring was completed for PM shift, There was no evidence that 72-hr. monitoring was completed on 1/04/26 for AM, PM and NOC shift, There was monitoring documented on 1/05/26 at 6:22 a.m. (NOC) but there was no evidence that 72-hr. monitoring was completed for AM and PM shift, and; There was no evidence that 72-hr. monitoring was completed on 1/06/26 for AM, PM and NOC shift. During an interview on 2/11/26 at 11:08 a.m., Licensed Nurse 2 (LN 2) stated that after a COC was initiated for a resident, 72-hour monitoring was required every shift (AM, PM, and NOC). LN 2 confirmed that documentation for this monitoring was in residents' progress notes and emphasized its importance. LN 2 explained the purpose of the 72-hr. monitoring, To make sure something is improving and if it is not improving, what are we supposed to do next. LN 2 stated that any significant changes in a resident typically occurred within the first three days of the COC, and added, The first three days are crucial-we keep a closer eye on them. During an interview and concurrent record review on 2/12/26 at 1:44 p.m., the Director of Nursing (DON) stated she expected 72-hr. monitoring to be completed after a COC. The DON further stated she expected 72-hr. monitoring to be documented every AM, PM and NOC shifts. The DON stated the purpose of 72-hr. monitoring was to assess if the current orders and interventions were effective. The DON stated 72-hr. monitoring followed the progress or decline of the resident. The DON reviewed multiple SBAR reports that pertained to Resident 59. The DON confirmed Resident 59's SBARs reported multiple falls and that 72-hr. monitoring status post COCs were inconsistent. The DON reviewed Resident 15's SBAR dated 1/31/26. The DON confirmed 72-hr. monitoring status post COC was not completed on 1/31/26 for PM and NOC shifts, and on 2/01/26 for AM and PM shifts. The DON also confirmed that no 72-hr. monitoring was documented on 2/03/26. The DON reviewed Resident 80's SBAR dated 1/03/26. The DON confirmed 72-hr. monitoring status post COC was not completed on 1/03/26 for PM shift, on 1/04/26 for PM and NOC shifts, on 1/05/26 for AM and PM shifts, and on 1/06/26 for AM, PM and NOC shifts. A review of the facility's document titled, Nursing Staffing Assignment and Sign-in Sheet, dated 2/2026, indicated AM shift was 7 a.m. to 3:30 p.m., PM shift was 3 p.m. to 11:30 p.m., and NOC shift was 11 p.m. to 7:30 a.m. A review of the facility's document titled, Charge Nurse, dated 2003, (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indicated, Perform routine charting duties as required. A review of the facility's policy and procedures (P&P) titled, Acute Condition Changes- Clinical Protocol, revised 3/2018, indicated, The staff will monitor and document the resident/patient's progress and responses to treatment. A review of the facility's P&P titled, Falls and Fall Risk, Managing, revised 3/2018, indicated, The staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling. A review of the facility's P&P titled, Pressure Injuries/Skin Breakdown-Clinical Protocol, revised 4/2018, indicated, To ensure skin issues are identified promptly, properly classified, treated and monitored appropriately.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to safely obtain, prepare and serve food to a census of 70 residents receiving food from the kitchen when dietary staff:Used damaged/worn food preparation equipment;Stored frozen meats improperly;Served unpasteurized, uncooked eggs to four residents (Residents 25, 34, 53 and 81);Did not practice appropriate hand hygiene and wore unapproved jewelry during food preparation, and;Used cracked and worn implements to transport and serve resident food.These failures could have led to foodborne illnesses in residents. Additionally, those with weakened immune systems or health conditions faced a higher risk of serious complications.During a concurrent observation and interview on 2/09/26 at 8:58 a.m. with the Dietary Manager (DM), an initial tour of the kitchen was conducted. Several brightly colored plastic cutting boards were observed to have deep scratches and cuts. The colored material coating on the boards was excoriated, showing approximately a ten-inch round area of white material underneath. The DM stated all the cutting boards should have been changed out, since the plastic material that became dislodged could have contaminated resident food during preparation. The DM also stated cutting boards in this condition might be more difficult to clean.During a review of 2022 Food Code section 4-501.12, indicated, Cutting surfaces such as cutting boards and blocks that become scratched and scored may be difficult to clean and sanitize. As a result, pathogenic microorganisms transmissible through food may build up or accumulate. These microorganisms may be transferred to foods that are prepared on such surfaces.During a concurrent observation and interview on 2/09/26 at 9:15 a.m. with the DM, a box containing chicken cutlets was seen in the kitchen walk-in freezer; with the meat stored in a plastic bag that was open to air. Additionally, in the walk-in freezer, a large frozen beef roast was stored directly on top and touching loose boxed breadsticks. The DM stated the chicken should have been stored in closed bags to prevent freezer burn, and cross-contamination from beef drippings or particles could have fallen on other foods directly below. The DM removed the chicken cutlets and the breadsticks from the freezer to discard.A review of the undated facility policy and procedure (P & P) titled, Food Preparation and Service, indicated, food preparation staff adhere to proper hygiene and sanitary practices to prevent the spread of foodborne illness.appropriate measures are used to prevent cross-contamination. These include: storing raw meat separately and in drip-proof containers, and in a manner that prevents cross-contamination from other foods.During a concurrent observation and interview on 2/10/25 at 10:30 a.m., with DM in the kitchen, a box containing trays of eggs was observed in the walk-in refrigerator. Upon inspection of the outside box and of the unstamped eggshells themselves (pasteurized eggs are commonly stamped p), it was discovered that the eggs were not pasteurized, and approximately half of the eggs were already used. The DM stated the facility did not serve sunny-side up eggs (eggs cooked on one side, not flipped over), but did serve over-easy (eggs flipped to cook the tops lightly, usually preserving a liquid, uncooked yoke). The DM stated there were residents that regularly requested their eggs cooked over-easy, and the unpasteurized eggs were used for that purpose.During an interview on 12/12/26 at 12:30 p.m., Resident 25, Resident 34, Resident 53, and Resident 81 were asked if they had received fried eggs in the last week with uncooked or runny yokes. All four residents replied they had recently received eggs cooked this way, as that was their preference.During a concurrent interview and record review with the Registered Dietitian (RD) on 12/12/26 at 12:45 p.m., the RD presented documentation showing the facility usually ordered pasteurized eggs from their food supplier. The RD confirmed the facility had been out of pasteurized eggs for several days but would be able to resume serving them in two days. The DM stated until pasteurized eggs were again available, residents would receive fried eggs with the yokes completely cooked to avoid salmonella infections.A review of the undated facility P & P titled, Food Preparation and Service, indicated, only pasteurized shell eggs are cooked and served when: residents request undercooked, soft-served or sunny side up eggs and preparing foods (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	that will not be thoroughly cooked.unpasteurized eggs are cooked until all parts of the egg (yolk and whites) are completely firm.During a concurrent observation and interview on 2/11/25 at 12 p.m. with DM, and the Dietary Aide (DA) in the kitchen, tray-line food service was taking place. The DA was placing food items on trays and dropped her pen on the ground. With gloved hands, DA picked up the pen and placed it in her pocket. The DA did not wash her hands and/or put on clean gloves but resumed touching resident food items to be served at lunch. The DA was also seen to be wearing gold hoop earrings that were not covered or secured by a hairnet. The DM stated he would have expected the DA to have removed her gloves, wash her hands and put on a new pair of clean gloves after picking up anything from the floor, to avoid any germs or dirt from coming into contact with resident food. During an interview on 2/11/26 at 3:20 p.m., the Infection Prevention Nurse (IPN) stated that failure to wash hands and change dirty gloves when handling resident food could lead to food-borne illnesses for this vulnerable population.A review of facility P & P titled, Dress Code and Personal Hygiene, dated 5/2019, indicated, all personnel are trained and in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections.Jewelry should be limited to watches and wedding rings.During a concurrent observation and interview on 2/11/25 at 12:15 p.m., with the DM in the kitchen, tray-line process continued and staff were observed placing hot food on plates, then into purple heat insulating containers for transport to the dining room. Several of the insulating lids were observed to be worn and crumbling around the edges, and one lid had a thin one-inch crack along the edge. The DM stated plate insulators in this condition should have been replaced, and he removed them from the ready-for-use rack for disposal. The DM stated if pieces of the plastic broke off, they could land in resident foods and be ingested accidentally.A review of 2022 Food Code, Annex 4, Table 3., indicated, Illness and injury can result from foreign objects in food. These physical hazards can result from contamination or poor procedures at many points in the food chain.A review of facility P & P titled, Sanitation, dated 11/2022, indicated, plastic ware, china and glassware that cannot be sanitized or are hazardous because of chips, cracks or loss of glaze are discarded. Damaged or broken equipment that cannot be repaired is discarded.		

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. Based on observation and interview, the facility failed to ensure laundry equipment was safely maintained for a census of 71 residents when the inside of one of two laundry dryers was visibly contaminated with debris (pieces of waste). This failure had the potential to expose resident's linens and laundry to unsanitary conditions and damage. During a concurrent observation and interview on 2/11/26 at 12:20 p.m., the Housekeeping Supervisor (HS) removed dry linens from one of two operated laundry dryers. The inside of the dryer cylinder was observed with debris that was melted, hardened, and adhered throughout the inside of the cylinder that was in direct contact with laundry. The HS stated the inside of the dryer cylinder did not get cleaned. The HS further stated the items inside the dryer cylinder appeared to be melted plastic bags and bandages. The HS stated he could not ensure that laundry that came out of the dryer was clean. During an interview on 2/11/26 at 1:51 p.m., the Maintenance Director (MTD) stated it was hard to know what the debris inside the dryer cylinder was. The MTD described the inside of the dryer cylinder with sticky parts. The MTD confirmed that he would not put his clothes inside that dryer cylinder. During an interview on 2/11/26 at 3 p.m., the Infection Preventionist (IPN) was shown photographs that were taken of the inside of the dryer cylinder. The IPN stated the dryer cylinder required to be thoroughly cleaned. The IPN confirmed debris was inside the dryer cylinder. The IPN further stated she would not put her clothes in the dryer cylinder. A review of the facility's document titled, Tumble Dryers, dated 2017, indicated, Daily. Check cylinder for foreign objects to avoid damage to clothing and equipment. A review of the undated facility document titled, JOB DESCRIPTION: Laundry Worker, indicated, Responsibilities include cleaning and sanitizing the work area including; machines. Reports observations concerning structural and equipment wear. Ensures that established sanitation and safety standards are maintained. A review of the facility policy and procedure titled, Laundry and Linen Services, revised 1/2014, indicated, Follow manufacturer's instructions for all laundry processing materials (equipment). Clean linen will remain hygienically clean through measures designed to protect it from environmental contamination.		

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NAME OF PROVIDER OR SUPPLIER Smith Ranch Skilled Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1550 Silveira Parkway San Rafael, CA 94903	
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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to submit Level I Preadmission Screening and Resident Reviews (PASRR) by the 31st day after admission for two of four sampled residents (Residents 4 and 5), who stayed longer than 30 days. This failure had the potential to result in Resident 4 and Resident 5 losing their eligibility for specialized medical services if diagnosed with a serious mental illness, intellectual disability, developmental disability, or related condition(s). A review of Resident 4's admission record indicated she was originally admitted to the facility on [DATE] and most recently readmitted to the facility on [DATE] from a general acute care hospital (GACH), with medical diagnoses which included anxiety disorder (mental health condition marked by intense, persistent, and excessive worry or fear about everyday situations, leading to significant distress and impairment in daily life); obsessive compulsive disorder (a mental health condition where a person gets caught in a cycle of unwanted, intrusive, and upsetting thoughts [obsessions] that create intense anxiety); depression (a serious mood disorder causing persistent sadness, loss of interest, and significant impairment in daily life); and bipolar disorder (a mental illness causing extreme shifts in mood, energy, and activity). A review of Resident 4's GACH Discharge summary dated [DATE], indicated she was hospitalized from [DATE] to 4/09/25 for the treatment of sepsis (the body's extreme, life threatening response to an infection), stercoral colitis (severe, dangerous form of inflammation in the large intestine caused by long term, extreme constipation), and hyperkalemia (a medical condition where there is too much potassium in the blood). This document indicated Resident 4 was transferred back to the nursing facility on 4/09/25. A review of a letter from the California Department of Health Care Services (CDHS) dated 4/01/25 indicated that a Level I PASRR was completed for Resident 4, and no Level II Mental Health Evaluation was required. This letter also indicated that if Resident 4 stayed in the nursing facility for more than 30 days after GACH discharge, a new Level I PASRR screening was required to be submitted on the 31st day. A review of Resident 4's nursing care plan, initiated on 4/09/25, indicated a risk for altered psychosocial well-being due to facility placement, fear, sadness, isolation, and non-adherence. The care plan noted Resident 4 was admitted with antipsychotic medication (Abilify, an atypical antipsychotic medication used to treat serious mental health conditions) for bipolar disorder, posing a risk of adverse drug reactions. On 4/22/25, the care plan recorded suicidal ideation. The interdisciplinary team (IDT) recommended plastic utensils. The care plan also recorded an increase of Bupirone (an anti-anxiety medication) to 10 milligrams (MG) twice a day for Resident 4. During an interview on 2/12/26 at 8:51 a.m., the admission Director (LN 1) stated she processed the residents' PASRR Level I and II screenings. LN 1 confirmed that Resident 4's PASRR Level I screening letter from CDHS, dated 4/01/25, was obtained for readmission on [DATE]. LN 1 mentioned that at that time, the facility lacked a system to catch the 30-day PASRR screenings requiring resubmission on the 31st day after admission, however, the facility now had a system to ensure timely resubmissions for Resident Review PASRR screenings. LN 1 acknowledged the facility should have resubmitted Resident 4's PASRR Level I screening on the 31st day after admission, as instructed by the CDHS letter dated 4/01/25. (continued on next page)		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/12/26 at 3:37 p.m., the Director of Nursing (DON) stated that PASRR screenings were required to be performed before residents were admitted to the facility and when residents already in the facility experienced a change in condition. The DON acknowledged that Resident 4 had a change in condition that required hospitalization on 3/28/25 and was readmitted to the facility on [DATE]. The DON stated that the purpose of PASRR screenings was to assess every resident for severe mental illness, intellectual disability, developmental disability, or related conditions. The DON stated she began her role at the facility on 1/21/26 and was unsure why Resident 4's Level I screening had not been resubmitted the previous year, even though Resident 4 remained in the facility for more than 30 days after her readmission on [DATE]. The DON acknowledged that the facility should have submitted a new Level I PASRR screening on the 31st day following Resident 4's readmission on [DATE], as instructed by the letter from CDHS dated 4/01/25. 2. A review of Resident 5's admission Record, dated 2/12/26, indicated Resident 5 was admitted to the facility on [DATE], with diagnoses including paranoid schizophrenia (a chronic mental health condition characterized by intense, irrational suspicion, persecutory delusions, and auditory hallucinations), lack of expected normal physiological development in childhood, and adult failure to thrive. A review of Resident 5's Minimum Data Set (MDS, a federally mandated, standardized clinical assessment tool used in Medicare/Medicaid-certified nursing homes to evaluate resident health, functional capabilities, and care needs) dated 11/08/25, indicated Resident 5 had severe cognitive impairment. The MDS also indicated Resident 5's active diagnoses included schizophrenia. A review of Resident 5's PASRR Level I Screening, dated 4/30/24 [completed by a GACH], indicated Resident 5's screening was, negative, and did not require a PASRR Level II screening due to, 30-Day Exempted Hospital Discharge. A review of Resident 5's Physician's Progress Notes, dated 1/28/26, indicated Resident 5 had displayed alertness, but was unaware of the time, date, or of her current location. According to these notes, Resident 5 described that she was lonely. During an observation on 2/09/26 at 10:48 a.m., outside of the nurse's station, Resident 5 was seen sitting in a wheelchair, periodically yelling out and crying for approximately ten minutes, after which time staff were able to calm her. A review of correspondence to the facility from DHCS, dated 2/10/26, with the subject, Notice of PASRR Level I Screening Results, indicated Resident 5 required a Level II PASRR screening due to, Required for SMI [serious mental illness]. During an interview on 2/12/26 at 3:45 p.m., the DON acknowledged a PASRR Level I was not initiated when Resident 5 remained in the facility for longer than 30 days, and this process should have been re-started to confirm Resident 5's appropriate placement and the need for specialized services. The DON further confirmed that the Level I PASRR screening was not re-started until 2/10/26, although the resident had been in the facility since 4/30/24. A review of the facility policy and procedure titled, California Preadmission Screening and Resident Review (PASRR), dated 7/01/20, indicated, Resident Review (RR) (Status Change) . is selected if the resident has already been admitted to the facility and the facility is updating the existing PASRR on file for either of the following reasons: a. The resident has exceeded the 30-day exempted hospital (continued on next page)		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	discharge. A level I screening should be conducted on the individual's 31st day in the facility. b. There is a significant change in the resident's physical or mental condition.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to initiate a change in condition process, and appropriately monitor and document a resident's response to treatment for one of eight sampled residents (Resident 71) after he suffered a hypertensive crisis (a medical emergency characterized by rapid, severe increase in blood pressure above 180/120 millimeters of mercury [mmHg, unit of measurement for blood pressure]). As a result, Resident 71 experienced another acute hypertension episode one week later, which could have been prevented with close supervision. This posed risks of severe harm, such as a heart attack, stroke, or organ damage to Resident 71. A review of Resident 71's admission record, dated 2/12/26, indicated he was originally admitted to the facility on [DATE], with diagnoses including hypertensive heart disease (heart damage caused by chronic, long-term high blood pressure), heart failure (a chronic condition where the heart cannot pump enough oxygen-rich blood to meet the body's needs), atrial fibrillation (an irregular and usually rapid heart rate where the upper chambers quiver instead of beating effectively), and generalized anxiety disorder (chronic, excessive, and uncontrollable worry about everyday events, lasting for at least six months). A review of Resident 71's Minimum Data Set (MDS, an assessment tool), dated 1/20/26, indicated Resident 71 was severely cognitively impaired. A review of Resident 71's progress notes dated 1/12/26 at 10:23 p.m., indicated Resident 71's blood pressure was 190/152, with a heart rate of 114 beats per minute (a normal blood pressure is no greater than 120/80, and a normal heart rate is 60 to 100 beats per minute) on 1/12/26 at 7:02 p.m. The progress note further indicated, Writer provided PRN [as needed] hydralazine [a medication to treat high blood pressure] at 19:02 [7:02 p.m.], blood pressure taken three times, all showing BP [blood pressure] of 196/152 HR [heart rate] 102. [Physician] was texted and informed. New orders by Dr [doctor] was placed-new orders for metoprolol tartrate [used to treat high blood pressure, heart failure, and to improve survival after heart attacks] 12.5 mg [milligram-a unit of measure] PO [by mouth] for one time. New vitals were assessed one hour later, BP 151/65, HR 67. A review of Resident 71's medical records did not indicate a change of condition was initiated following this episode of hypertension and new medication orders on 1/12/26, even after Resident 71's blood pressure remained elevated. A review of Resident 71's nursing progress notes dated 1/19/26 at 12:19 a.m., indicated Resident 71's blood pressure was 158/70 at 6:40 p.m., and rechecked, with no time noted, for a reading of 163/88. According to this progress note, Resident 71's physician was notified and PRN hypertensive medications were administered. No further notes were documented of treatment results, and no change of condition documentation or ongoing monitoring was initiated. During an interview on 2/12/26 at 3:45 p.m., the Director of Nursing (DON) stated licensed nursing staff should have initiated a change of condition in Resident 70's medical record, periodically monitored his blood pressure and heart rate, and documented his response to medications. The DON stated change of condition documentation involved closely monitoring a resident's new or abnormal medical issues, such as changes in vital signs, consciousness, and symptoms related to cardiovascular or respiratory problems. The DON further stated she would expect licensed nursing staff to closely monitor Resident 71's change of condition because new medications were ordered and hypertension did not completely resolve. A review of facility policy and procedure titled, Acute Condition Changes - Clinical Protocol, dated 3/2018, indicated, the staff will monitor and document the resident/patient's progress and responses to treatment, and the physician will adjust treatment accordingly. the physician will help the staff monitor a resident/patient with a recent acute change of condition until the problem or condition has resolved or stabilized.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure safe medication storage and administration for one of eight sampled residents (Resident 53) when nursing staff left a medication at Resident 53's bedside, without an assessment, and physician order for self-administration of medications. This failure had the potential to result in serious medication errors, overdoses and theft. In addition, leaving medication unattended risked consumption by other residents, accidental ingestion, or misuse. A review of Resident 53's admission record (facility demographic), dated 2/12/26, indicated Resident 53 was admitted to the facility on [DATE], with medical diagnoses which included psoriatic arthritis mutilans (a rare, severe, and destructive condition causing painful, stiff, and swollen joints, often accompanied by scaly skin patches), generalized anxiety disorder (a chronic, excessive, and uncontrollable worry about everyday events), and venous insufficiency (a condition in which leg vein valves are damaged or weak, causing blood pooling). A review of Resident 53's Minimum Data Set, (MDS, an assessment tool), dated 12/26/25, indicated Resident 53's mental acuity was intact, with little or no cognitive impairment. A review of Resident 53's physician order summary report dated 2/12/26, indicated Resident 53 was ordered, hydrocortisone cream [a steroid ointment used to relieve skin irritation, inflammation, redness, and itching] 2.5%, apply to affected area topically as needed for rashes, use only for visible redness. During a concurrent interview and observation on 2/09/26 at 11:01 a.m., in Resident 53's bedroom, Resident 53 was observed lying in bed, with his bedside table positioned over him. The bedside table contained several personal items on it, including a small white medicine cup containing white cream. Resident 53 stated the cream was hydrocortisone for his rash, left by the nurse for self-application. During a concurrent interview and record review on 2/10/26 at 12:50 p.m., with the Director of Nursing (DON), clinical documentation was reviewed after a resident medication self-administration assessment for Resident 53 was requested. During a concurrent interview and record review with the Director of Nursing (DON) on 2/10/26 at 12:50 p.m., the clinical documentation for Resident 53 was reviewed, following a request for an assessment for self-administration of medications. The DON stated there was no assessment of this kind in Resident 53's medical record, but provided a facility document titled, Patient Clinical Evaluation, dated 8/02/20, which indicated Resident 53 did not wish to self-administer his own medications. The DON stated that after asking Resident 53 if he wanted to administer his own medications, he still preferred the nursing staff to do it. The DON stated that residents wanting to take medicine unsupervised were required to undergo a thorough assessment. The DON added that if medications were left at the bedside, residents without cognitive ability or proper instructions might take or apply medications late, incorrectly, or not at all. A review of facility policy and procedure titled, Self-Administration of Medications, dated 2/2021, indicated if it is deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical record and the care plan. If the team determines that a resident cannot safely self-administer medications, the nursing staff administers the resident's medications. Any medications found at the bedside that are not authorized for self-administration are turned over to the nurse in charge.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a medication was labeled and stored safely when it was found in an unlocked area accessible by four residents (Resident 21, Resident 31, Resident 55 and Resident 71). This violated professional standards of nursing practice and state and federal regulations. This failure had the potential to result in medication errors potentially requiring medical intervention, theft, diversion and/or accidental ingestion by residents. During an observation on 2/09/26 at 10:30 a.m., in the common bathroom shared by the residents in room [ROOM NUMBER] and the residents in room [ROOM NUMBER], a bottle of medicine was found inside an unlocked, plastic chest of drawers containing various personal care items. The manufacturer's label in the medication bottle indicated, Senakot [Senna Docusate, a stimulant laxative and a stool softener to treat occasional constipation], 17.2 milligrams(mg, a unit of measurement), extra strength, 36 tablets. This information was on the bottle, but did not have a label affixed identifying the specific resident the medication belonged to, an opened date, or a use-by date. During a concurrent interview and observation on 2/10/26 at 9:30 a.m. with the Director of Nursing (DON), the medication bottle was found in the same location as the day prior, in the bathroom shared by four residents (Resident 21, Resident 31, Resident 55, and Resident 71). The DON stated she thought the Senakot medication belonged to Resident 21 but could not be certain as there was no label on the bottle. The DON stated the bottle should be stored securely and separately from personal care items accessible to other residents who used the shared, unlocked bathroom. A review of the undated facility policy and procedure titled, Medication Labeling and Storage, indicated, the facility stores all medications and biologicals in locked compartments under proper temperature, humidity, and light controls. Only authorized personnel have access to keys. the nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts and boxes) containing medications and biologicals are locked when not in use.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure infection prevention measures were provided for one of eight sampled residents (Resident 59) when: 1: Resident 59's portable oxygen concentrator (an oxygen delivery device) filter cabinet was dusty, 2: Resident 59's nasal cannula (a tube that delivers oxygen directly into the nostrils) was not labeled, and; 3: Resident 59's suctioning machine (a medical device used to remove fluids from the airway) was stored close to the floor and the yankauer (a suctioning tool that goes inside the mouth) was not covered during storage. These failures increased Resident 59's risk of infection. A review of Resident 59's admission record indicated he was admitted to the facility in November, 2023, with medical diagnosis which included chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), dysphagia (difficulty swallowing), and dementia (a progressive state of decline in mental abilities). A review of Resident 59's Minimum Data Set (MDS-a federally mandated resident assessment tool) dated 1/01/26, indicated his Brief Interview of Mental Status (BIMS-a cognition [the processes of thinking and reasoning] assessment) score was three which indicated his cognition was severely impaired (a score of 1-7 indicates cognition is severely impaired, 8-12 indicates cognition is moderately impaired, and 13-15 indicates cognition is intact). A review of Resident 59's order summary report indicated the following active orders as of 2/12/2026, Oxygen: Change oxygen tubing to include NC (nasal cannula) every week and PRN (as needed). Date tubing. A review of Resident 59's order listing report indicated the order for, Trach [a surgically created opening in the neck]: Suction trach for increased secretions as needed, was discontinued on 1/15/26. During an observation on 2/09/26 at 9:52 a.m., in Resident 59's room, Resident 59 was observed with an oxygen concentrator and NC in use. Resident 59's NC was observed without a label [to indicate the date it was changed]. The oxygen concentrator that delivered oxygen to Resident 59 was observed with light gray, dusty debris covering approximately 80% of the filter cabinet's internal surfaces and what appeared to be the filter. A label on the oxygen concentrator labeled, Concentrator Data, indicated the last date of service was 8/26/25. Subsequently, a suctioning device was observed to the left of Resident 59's bed and along the wall, approximately 12 inches (in.- a unit of measure) from the floor and set on top of a styrofoam box. A canister attached to the suctioning machine that collected suctioned fluids was approximately 700 ml (milliliter- a unit of volume) full of cloudy, yellow fluid. The yankauer was observed attached to the suctioning device, uncovered, and approximately eight in. from the floor. During an interview on 2/09/26 at 10:32 a.m., Licensed Nurse 2 (LN 2) confirmed Resident 59's oxygen concentrator and NC were currently in use. LN 2 further confirmed Resident 59's NC was not labeled, and stated the label indicated when the NC was last changed. LN 2 stated the filter cabinet of the oxygen concentrator was dirty, and described it as, dusty. LN 2 stated the oxygen concentrator was an issue for infection control reasons. LN 2 further stated, It [oxygen concentrator] converts the room air into oxygen for the resident. If it's dusty, it's not filtering the air well enough and could be an infection control concern. LN 2 verified Resident 59's suctioning machine was in use and stored close to the floor. LN 2 confirmed the canister was approximately 700 ml full of yellow fluid. LN 2 confirmed the yankauer was not covered and was close to the floor. LN 2 stated the yankauer was required to be changed weekly and covered when not in use because it went inside Resident 59's mouth. LN 2 further stated the uncovered yankauer was an infection control concern. During an interview on 2/11/26 at 1:51 p.m., the Maintenance Director (MTD) stated a rental company managed the oxygen concentrators provided to the facility. The MTD was shown a photo of Resident 59's oxygen concentrator and stated the date on the Compressor Data label indicated the last date of service. The MTD stated it was nursing staff's responsibility to assess the oxygen concentrators and report to him if the filters were dirty. The MTD stated he did not recall the dirty oxygen concentrator being reported to him. The MTD confirmed Resident 59's oxygen concentrator filter cabinet had debris. During an interview on 2/11/26 at 3 p.m., the Infection Preventionist (IPN) stated if an oxygen (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	concentrator was dirty, it could cause a bacterial infection in the lungs of the resident. The IPN further stated, It is really a cause for concern, when shown a photo of Resident 59's oxygen concentrator. The IPN confirmed the filter cabinet was dirty. The IPN stated she expected a resident's NC to be changed on a weekly basis and the NC to be labeled and dated when changed. The IPN further stated a NC could harbor debris and any type of infection. Subsequently, the IPN reviewed the photo's taken of Resident 59's suctioning machine and yankauer and confirmed the machine should have been stored on Resident 59's bedside table. The IPN confirmed Resident 59's yankauer should have been stored in a place bag. The IPN further stated if the yankauer was uncovered it could fall on the floor and, it has the potential to harbor bacteria and cause an infection- it goes in someone's mouth. During an interview on 2/12/26 at 1:44 p.m., the Director of Nursing (DON) stated respiratory devices should be changed weekly or as needed. The DON stated she expected the NC to be labeled and dated when changed. The DON further stated, The purpose is for infection control. The DON stated she expected nursing staff to monitor the oxygen concentrator to ensure it was clean and free from dust, debris, or any fluids. The DON confirmed that a yankauer needed to be covered for infection control purposes. The DON further stated that she expected a suctioning machine to be stored at the resident's bedside, preferably on a flat clean surface and far from an area where is would contact debris. The DON stated, It [suctioning machine] is not appropriate to be close to the floor. A review of the facility's document titled, User Manual: Perfecto2 Series, dated 2009, indicated, NEVER block the air openings.Keep the openings free from lint, hair and the like.Remove the filter and clean at least once a week.A review of the facility's undated policy and procedure (P&P) titled, [Name of facility] Oxygen Concentrator Filters Policy, indicated, Proper maintenance of filters prevents dust accumulation, reduces infection risk.Disposable/internal filters: Must be replaced.if visibly dirty.Any visibly contaminated or damaged filter must be replaced immediately.Failure to follow this policy may result in.increased infection risk. A review of the facility's P&P titled, Oxygen Administration, revised 10/2010, indicated, Oxygen tubing.will be changed and labeled every seven days and as needed.A review of the facility's P&P titled, Suctioning, revised 8/2014, indicated, The purpose of this procedure is to help prevent nosocomial [an infection acquired in a healthcare facility] infections.Use fresh sterile suction catheter [yankauer] for each episode suctioning.After completing a single episode of suctioning, wrap the suction catheter around a gloved hand.discard both into a designated trash receptacle.		