STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555844	A. Building B. Wing	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Novato Healthcare Center	1565 Hill Road Novato, CA 94947

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 36790 Based on observations, interviews and record reviews, the facility failed to implement the interventions to reduce the risk of elopement (leaving the facility without knowledge of the staff) for one out of one sampled resident (Resident 1), who left the facility, undetected, and was found by the local Police Department. This failure had the potential to result in serious injuries, including bruises, lacerations, head injury and broken bones. Findings: During on observation on 7/17/24 at 4 p.m., Resident 1 was sitting in a chair in the hall outside of his room with the Staff person who was monitoring him. Resident 1 asked if he could go home and wanted to know when. Resident 1 had a wander guard bracelet on his right wrist. During a review of the medical records on 7/17/24, Resident 1's Elopement Evaluation, dated 6/28/24, was done on the day of his admission and had a score of six, when a score greater than one indicated a risk for elopement The evaluation section of what to do to prevent elopement was left unmarked. Review of Resident 1's care plan, starting 6/28/24, had a plan for deficiency in Ability to Care for Self, a Cognitive Deficit plan to support Resident 1 and a plan for Risk of becoming Malnourished. During a review of Resident 1's medical records on 7/17/24, Resident 1's Change of Condition note, dated 7/1/24, documented that in the afternoon of 7/1/24, Resident 1 was seen leaving through the facility's front door and told staff he was going to the highway to get home. A Nurse and CNA coaxed him back by agreeing to help him make his phone call. The Doctor was notified and an order to adjust his medication was made. Resident 1's care plan, started 6/28/24, and had the focus of Resident 1 being an elopement risk added on 7/1/24. Interventions included: Have resident wear a wander guard, do every 15-minute checks, notify doctor and notify Responsible Party. During a review of Resident 1's medical records on 7/17/24, a Progress Note, dated 7/1/24 at 10 p.m., documented, Resident was seen outside the parking lot, the nurse was able to redirect and able to go back inside the room, still on q (every) 15-minute monitoring. During a review of Resident 1's medical records on 7/17/24, a Change for Condition note, dated 7/3/24, indicated Resident 1 had a loss of consciousness and was sent to the hospital. Resident was in the hospital from 7/3/24 to 7/6/24. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's medical records on 7/17/24, Resident 1's Progress Notes, dated 7/6/24, indicated Resident 1 returned to the facility around 12:20 p.m., and the Clinical Admission note on 7/6/24 at 12:21 p.m., included: Alert and oriented times 3, alert (some forgetfulness) and mood is pleasant no unwanted behaviors witnessed. Other admission assessments were observed to be present in the electronic records and dated 7/6/24. During a review of Resident 1's medical records on 7/17/24, a Nurse Progress Note, dated 7/6/24 at 12:33 p. m., documented Resident 1 was angry that he was discharged from the hospital before the weekend. A Nurse Progress Note, dated 7/6/24 at 12:35 p.m., documented: Resident is ambulating with walker from room to nurse station to call his wife. Resident denies any concerns or current needs, Will continue to monitor. During a review of the medical records on 7/17/24, Resident 1's Elopement Evaluation, dated 7/6/24, timed at 14:33 (2:33 p.m.), was done for this readmission and had a score of six, when a score greater than one indicated a risk for elopement. The evaluation section of what to do to prevent elopement was left unmarked. During a review of Resident 1's medical records on 7/17/24, a Nurse Progress Note, dated 7/6/24 at 15:29 (3:29 p.m.), indicated Resident 1 was agitated, uncooperative and cursing. Nurse tried to de-escalate the resident, but resident walked away. After making a call from the nursing station, he cursed the nurse and walked to his assigned room. During a review of Resident 1's medical records on 7/17/24, a Nurse Progress Note, dated 7/6/24 at 17:33 (5:33 p.m.), indicated, Resident was readmitted to hospital at this time, transport by police. During a review of Resident 1's medical records on 7/17/24, a Change of Condition note, dated 7/6/24 at 17:34 (5:34 p.m.), documented Resident 1 did an, Elopement from facility through back door. During a review of Resident 1's medical records on 7/17/24 at 17:36 (5:36 p.m.), indicated, Resident was last seen by PM shift CNA around 4:45 p.m. inside the facility on Unit 1. At around 5:20 p.m. Police called to inform staff that resident was found at (a busy street) on the ground and sent to [local hospital]. During a review of Resident 1's medical records on 7/17/24, Resident 1's Elopement Evaluation, dated 7/6/24 timed at 18:15 (6:15 p.m.), was done after the elopement and had a score of eight. The evaluation section of what to do to prevent elopement was left unmarked. During an interview on 7/17/24 at 4:05 p.m., Licensed staff stated she did not check his Wander Guard and did not document on the medical records about the Wander Guard. During an interview on 7/17/24 at 4:15 p.m., the Assistant Director of Nursing (ADON) stated Resident 1 had been on 1:1 staffing since his elopement on 7/6/24. The ADON stated he had a Wander Guard after the first time he went outside of the facility. The ADON stated that the Wander Guard company had a recall on the bracelets, so the facility initiated 15 min checks on residents who needed Wander Guards. ADON stated the back door at the end of Resident 1's hall did not alarm when opened unless a resident with a Wander Guard was close to the doorway. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/17/24 at 4:15 p.m., the ADON stated the staff on duty for Resident 1 on 7/6/24, were a Registry Nurse and a Registry CNA and would not have known about Resident 1's prior elopement attempt. When asked how the Registry staff could know he was an elopement risk, the ADON stated it would be during the morning Huddle when this would be discussed. During an interview on 7/17/24 at 4:15 p.m., the ADON was asked for documentation of the Wander Guard and documentation of every 15-minute checks. The ADON concurred with the Licensed Staff that the Wander Guard was not documented regularly. The ADON located the every 15-minute check sheets for 7/8/24, 7/14/24, and 7/15/24. No documentation for close monitoring was available for 7/1/24 to 7/3/24, between his elopement event and hospitalization , and there was none for 7/6/24, when he returned to the facility. During a review of the Facility's policy, Wandering and Elopement, dated 1/31/23, indicated, The Resident's risk for elopement and preventative interventions will be documented in the resident's' medical record and will be reviewed and re-evaluated by the IDT upon admission, readmission, quarterly and upon change in condition .