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	09/04/2024

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39621 Based on interview and record review, the facility failed to become aware one of three sampled residents (Resident 1) had not received his early-morning Physician-prescribed insulin (An injected hormone that is essential for allowing the body to use sugar (glucose) for energy) most days of every month, for more than a year, until Resident 1 noticed this issue himself and reported it to Administration. As a result, Administration did not intervene until notified by Resident 1, which allowed daily significant medication administration errors to occur for Resident 1 for a period of one year, with a few exceptions. This finding had the potential to result in serious consequences for Resident 1, including uncontrolled blood glucose levels and death. Findings: Record review of the facility Face Sheet (Facility Demographic) indicated Resident 1 was admitted to the facility on [DATE], with medical diagnoses including Type 2 Diabetes Mellitus (A chronic condition that causes high blood sugar levels due to a lack of insulin or insulin resistance) with Hyperglycemia (High blood glucose levels), and Long Term (Current) Use of Insulin. Record review of a report received by the DEPARTMENT on 7/15/24, indicated Resident 1 was not receiving his nightly insulin for diabetes treatment, and specifically mentioned Licensed Nurse A as the staff member not administering this medication. Record review of Resident 1 ' s Physician Orders for June of 2024, indicated, HumuLIN R (A short-acting insulin that starts to work in 30 minutes and lasts for several hours to control blood glucose levels) Injection Solution 100 UNIT/ML (Milliliter) (insulin Regular (Human)) Inject as per sliding scale (A sliding scale varies the dose of insulin based on blood glucose level) .subcutaneously (To be injected in the fatty issue beneath the skin) before meals for diabetes. This order was started on 6/29/23, according to this document. Record review of Resident 1 ' s Medication Administration Record (MAR) for June 2024, indicated at 6 a.m. Humulin insulin was only administered to Resident 1 twice during the month of June, by Licensed Staff B. On both occasions, Resident 1 had blood glucose levels that were above the normal ranges (A normal fasting blood glucose level for someone without diabetes is between 70 and 99 milligrams per deciliter (mg/dL)), for example, on 6/01/24, he received six units of Humulin insulin for a blood glucose of 300 mg/dl, and on 6/14/24, he received four units of Humulin insulin for a blood glucose of 236 mg/dl. This MAR did not indicate Resident 1 ' s Humulin insulin was held or refused, as this was not documented. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with Resident 1 on 8/27/24 at 12:01 p.m., he stated he had recently noticed that when a night shift registry Licensed Nurse (Licensed Staff B) was assigned to care for him, Licensed Staff B would check his blood glucose in the morning, at around 6:50 a.m., and administer insulin, but when the regular night shift Licensed Nurse (Licensed Staff A) was assigned to care for him, she would check his blood sugar but NOT administer his insulin. Resident 1 stated that on one occasion, he asked Licensed Staff B why he was administering early morning insulin, but nobody else was doing it. Resident 1 stated that Licensed Staff B told him he was just following Physician Orders. Resident 1 stated he notified the Director of Nursing (DON) and Administrator about it, and they confirmed Licensed Staff A was not administering his early morning insulin. Resident 1 stated that after he notified Administration about this issue, his insulin schedule was changed so that now, the morning shift nurse, was responsible for administering this insulin, and the problem was resolved; however, he feared for other residents, and thought they might also be experiencing an omission of prescribed medications during the night shift. During a phone interview with Licensed Staff A on 9/03/24 at 4:50 p.m., she confirmed she was not administering Resident 1 ' s 6 a.m., Humulin insulin. Licensed Staff A stated that Resident 1 did not want to be woken up in the morning, and breakfast was not delivered until 7:30 a.m., so she did not want to wake up Resident 1 for his insulin, and felt that giving the insulin between 6 a.m., and 7 a.m., was too early. Licensed Staff A stated she did check Resident 1 ' s blood glucose levels every shift and wrote it on a piece of paper that was passed on to the morning shift nurse. Licensed Staff A stated her shift ran from 11 p.m. at night to 7 a.m., the following morning, therefore, the administration of 6 a.m. insulin was her responsibility. Licensed Staff A confirmed she failed to inform the DON she was not administering Resident 1 ' s morning insulin. During a concurrent interview and record review with the DON on 9/04/24 at 11:52 a.m., Resident 1 ' s MARs were reviewed since the Humulin insulin order was started, (June of 2023). It was noticed that since July of 2023, Resident 1 was not administered his morning insulin daily as prescribed on most days. This early-morning insulin was only documented as administered a few days per month when Licensed Staff B worked at the facility. This trend continued until July of 2024, when finally, on 7/13/24, the timing of the insulin was changed to 7 a.m., and later to 7:30 a.m., starting on 7/16/24. From then on, Resident 1 was administered his morning insulin daily. During this interview, the DON was asked who was responsible for auditing medical records to ensure the documentation was complete and accurate in the residents ' charts. The DON stated this was the Medical Record Department ' s responsibility. The DON stated she was unaware of this issue with Resident 1 ' s early morning insulin, until he notified her in July of 2024. During an interview with the Medical Record Director by phone, on 9/04/24 at 11:55 a.m., she was asked if she was responsible for auditing medical records to ensure they were complete and accurate. The Medical Records Director responded, Yes, part of it. The Medical Records Director stated she pulled out a document daily that indicated all the residents ' undocumented medications from the facility ' s computerized charting system, and gave it to the DON, but she was unable to remember any specific issues with Resident 1 ' s MARs. Record review of a facility document titled, CORRECTIVE ACTION MEMO, indicated Licensed Staff A received disciplinary action on 7/15/24, for not checking Resident 1 ' s blood sugar levels, not documenting when this service was refused, and not notifying the DON about it. This document did not mention the omission of the daily early-morning insulin for Resident 1. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility policy titled, Medical Record Department Tasks, last revised on 1/1/2012, indicated, The Director of Medical Records will also determine an audit schedule to be carried out by Medical Records Department Staff based on the Facility ' s needs. Record review of the facility policy titled, Medication-Administration, last revised on 1/1/2012, indicated, Medication will be administered directed by a Licensed Nurse and upon the order of a physician or licensed independent practitioner .Whenever a medication is held for any reason, the hour it was held must be initialed and circled in the Medication Administration Record (MAR) by the responsible Licensed Nurse. The Licensed Nurse will document on the back of the MAR, noting the time and reason the medication was held . If resident is refusing to take medication, time of refusal must be circled in the Medication Administration Record (MAR) and initialed by the Licensed Nurse who is passing meds .Licensed Nurse will notify M.D. (Medical Doctor) and document in the medical record.