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	09/05/2024

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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39621 Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1) was discharged safely from the facility, when: 1. Resident 1, who was insulin-dependent (Dependent on injectable insulin, a hormone that helps blood sugar enter cells to be used for energy), was discharged from the facility without a glucometer (A small, portable machine that is used to measure how much glucose (a type of sugar) is in the blood), or information on purchasing a home-use glucometer. As a result, Resident 1 refused to administer his insulin for several days, since he could not check his blood sugar levels. 2. Resident 1 was discharged to a Board and Care home (A small, private residential facility that provides housing and personal care for a small group of seniors) which was not licensed by the California Department of Social Services (DCSS- One of 16 departments and offices in the California Health and Human Services Agency whose mission is to serve, aid, and protect needy and vulnerable children and adults) and was a requirement of the facility. These findings had the potential to result in serious harm and jeopardy to Resident 1 ' s health and well-being. Findings: 1. Record review of Resident 1 ' s Face Sheet (Facility Demographic) indicated Resident 1 was admitted to the facility on [DATE], with medical diagnoses including Type 2 Diabetes Mellitus (Diabetes Mellitus is a chronic disease characterized by high levels of blood sugar. In type 2 Diabetes Mellitus, the body does not use insulin properly) and Anxiety Disorder (A disorder that involves persistent and excessive worry that interferes with daily activities). (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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a facility document titled, TRANSFER/DISCHARGE REPORT, dated 7/31/24 (No time documented), indicated one of Resident 1 ' s ordered medications to continue taking after discharge was the following, Insulin Aspart (Fast-acting insulin) Subcutaneous (To be injected under the skin) Solution Per-injector (Using an insulin pen) 100 UNIT/ML(Milliliter). Directions: Inject as per sliding scale (A sliding scale varies the dose of insulin based on blood glucose level): if 200-250 =2units (If the blood glucose level is 200 to 250 mg/dl [milligrams per deciliter], inject 2 units of Aspart insulin); 251-300 =4units; 301-999= 6units BG >300 mg/dl, Notify MD (If the blood glucose level is more than 300 mg/dl, notify the Medical Doctor), subcutaneously at bedtime for DM2 (Type 2 Diabetes Mellitus). Record review of a facility document titled, Discharge Planning Review Form, dated 7/31/24 (no time documented), completed by Licensed Staff A, indicated, Resident [Resident 1] should be monitored for blood sugar every morning and lunch. Resident should administer his insulin as order (Sic) by MD (Medical Doctor). Record review of a nursing note documented by Licensed Staff A, dated 7/31/24 at 4:58 p.m., indicated, Resident verbalized understanding of medication orders .Resident discharged with Home Health care, RN (Registered Nurse), PT (Physical Therapy), Board care home. This note did not indicate Resident 1 was provided a glucometer to check his blood sugar levels at the discharging facility, or information on how to obtain one. This was confirmed by the Director of Nursing (DON) during an interview on 8/21/24 at 12:05 p. m. The DON stated information on arrangements for a glucometer, when needed by a resident after discharge, was required to be documented. During a phone interview with Caregiver B (Staff from the Board and Care home where Resident 1 was discharged on [DATE]), on 8/20/24 at 1:43 p.m., she stated Resident 1 was discharged from the facility without a glucometer. Caregiver B stated Resident 1 refused to take his insulin, as a result of not having a glucometer, for a period of about one week after discharge. Caregiver B stated that approximately one week after discharge from the facility, Resident 1 purchased a glucometer himself at a local pharmacy. During a phone interview with Resident 1 on 8/21/24 at 9:45 a.m., he stated he did not take his insulin for 11 days after discharge from the facility because he was not given a glucometer to check his blood sugar, or notified he needed to purchase one. During an interview with the Director of Nursing (DON) on 8/21/24 at 11:12 a.m., she stated that if a resident preparing for discharge with sliding scale insulin, did not have a glucometer, and neither did the discharging facility, it was the (Skilled Nursing) facility ' s responsibility to provide them with one. During a phone interview on 8/22/24 at 10:50 a.m., Licensed Staff A stated she no longer worked for the facility. Licensed Staff A confirmed she was the discharging nurse for Resident 1 on 7/31/24. Licensed Staff A stated she verbally reminded Resident 1 that he would need to purchase a glucometer upon discharge from the facility, but did not provide it to him, and was unaware if she was required to do so. Licensed Staff A also stated she was too busy and forgot to document any information regarding the glucometer during Resident 1 ' s discharge from the facility. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review of a Social Services note, dated 7/31/24 at 5:56 p.m., indicated, Yesterday SSD (Social Services Director) followed with [Name of Board and Care home Resident 1 was discharge to, on 7/31/24] to discuss the plan for them to come and do an in person assessment to finalize on the plans for DC (Discharge) to their Board and Care .[Caregiver B] said if she can come back around 4:30-5 pm to pick him [Resident 1] up .[Resident 1] was packing and was waiting for her at the lobby and she came to pick him up at 4:45 pm. Record review of licensed Board and Care Homes, accessible through the CDSS on their website (http://www.cdss.ca.gov/), on 8/29/24 at 9:30 a.m., did not indicate the Board and Care home, where Resident 1 was discharged to, on 7/31/24, was licensed. During a phone interview with the Long-Term Care Ombudsman (An advocate for residents of nursing homes) on 8/13/24 at 2:33 p.m., she also stated she searched for this information on the CDSS website and noticed this facility was not licensed. During an interview with the Social Services Director (SSD) on 8/13/24 at 3:12 p.m., she stated she just found out that day (8/13/24) that the Board and Care home Resident 1 was discharged to, on 7/31/24, was not licensed. The SSD stated the placement agent that helped her find this Board and Care home for Resident 1, notified her this was a licensed facility. The SSD also stated she did not know, previous to 8/23/24, how to check for licensed facilities on the CDSS website. During an interview with the Director of Nursing (DON) on 8/21/24 at 10:15 a.m., she stated Board and Care homes for resident discharges, were required to be licensed. Record review of the facility policy titled, Discharge and Transfer of Residents, last revised on 12/21/23, indicated, Drugs which have been dispensed for individual resident use and are labeled in conformance with State and Federal law for outpatient use will be furnished to a resident by the Licensed Nurse upon discharge according to the orders of the resident ' s Attending Physician. This policy did not mention essential medical equipment required for discharge, or the facility requirement to discharge residents to licensed facilities. This information, however, was discussed with the DON during interviews on 8/21/24 at 10:15 a.m., and 11:12 a.m. (above).