

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555844	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/25/2025
NAME OF PROVIDER OR SUPPLIER Novato Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41283</p> <p>Based on observations, interviews, and record reviews, the facility failed to protect one resident (Resident 1) from physical abuse by Resident 2, when Resident 2 struck Resident 1 on the head with a coffee cup which shattered into small pieces.</p> <p>This failure resulted in Resident 1 being sent to the hospital Emergency Department (ED) for evaluation and treatment of a head injury.</p> <p>Findings:</p> <p>A review of Resident 1's Admission Record, indicated he was admitted to the facility on [DATE]. Resident 1's medical diagnoses included Major Depressive Disorder (a serious mood disorder characterized by persistent sadness, loss of interest in activities, and other symptoms that affect daily life) and Dementia (a progressive state of decline in mental abilities).</p> <p>A review of Resident 2's Minimum Data Set (MDS- a federally mandated resident assessment tool) dated 3/21/25, indicated Resident 2 had:</p> <ul style="list-style-type: none"> - Medical diagnoses included which dementia, depression, and schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves); - A Brief Interview for Mental Status (BIMS- an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 8 which indicated moderate cognitive (the mental process involved in obtaining, storing, and using knowledge) impairment; and, - Physical behavioral symptoms directed towards others (e.g. hitting) and verbal behavioral symptoms directed towards others (e.g. cursing at others). <p>A review of Resident 2's medical chart indicated the following various care plans regarding:</p> <ul style="list-style-type: none"> - Resident-to-resident physical altercation (a fight), Resident 2 hit another resident on top of the head with a plastic coffee mug which was initiated on 2/28/25. <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>- Resident 2 had physical aggression (violent behavior) by hitting staff on the head which was initiated on 3/23/25.</p> <p>- Resident 2 had physical aggression towards another resident, hit another resident on the head which was initiated on 4/10/25.</p> <p>A review of Resident 1's progress note dated 4/10/25 at 5:34 p.m. indicated, [Resident 1] was the victim of Resident-to-Resident Physical abuse and had to be sent out to the hospital for further Evaluation since he had a laceration [a deep, jagged wound] on is head.</p> <p>A review of Resident 1's hospital ED document titled Encounter Summary, dated 4/10/25 at 5:14 p.m., indicated, .Reason for Visit .Head Injury .Visit Diagnoses .Closed head injury without loss of consciousness [sudden, temporary loss of awareness of oneself and the surroundings] .Scalp abrasion [a type of wound characterized by the scraping away of the outer layer of skin] .Injury due to physical assault [the act of intentional harm].</p> <p>A review of Resident 2's progress note dated 4/10/25 at 5:38 p.m. indicated, [Resident 2] had an unprovoked [occurred without cause] resident to resident physical altercation. [Resident 2] was sitting in the alcove [a small, recessed section of a room] drinking coffee and was sitting next to [Resident 1] .all of a sudden, [Resident 2] banged his empty cup on [Resident 1's] head hard enough to break it. [Resident 2] was screaming at [Resident 1] and staff immediately separated him .probed [to ask a series of questions to obtain information] [Resident 2] that there was something that happened earlier and [Resident 2] then said, ' oh that was because .[Resident 1] was trying to hold my shirt.' .Reminded [Resident 2] that is the third incident .</p> <p>During an interview on 4/25/25 at 1:45 p.m., Certified Nursing Assistant A (CNA A) stated he witnessed Resident 2 hit Resident 1 in the head without warning and broke his coffee cup on Resident 1's head when both residents were sitting close to each other at the nurse's station. CNA A stated Resident 1 was bleeding from the head. CNA A stated he witnessed a similar incident in the past where Resident 2 broke his coffee cup on another resident's head. CNA A stated he called Licensed Nurse B (LN B) after he had placed himself between Resident 1 and Resident 2 to separate them.</p> <p>During a concurrent observation and interview on 4/25/25 at 2:43 p.m., LN B stated the incident between Resident 1 and Resident 2 happened on 4/10/25 at around 9 a.m. LN B stated there was a CNA assigned to look after Resident 2 because Resident 2 was previously involved in a similar incident, where he broke his coffee cup on another resident's head. LN B stated she applied a gauze (a thin fabric typically applied to wounds to absorb fluid and provide protection to the wound) to Residents 2's head because he got a scrape that was bleeding profusely. LN B stated she called and received orders from Resident 1's physician to transfer him to the ED for evaluation. LN B showed this Surveyor the blue, hard plastic coffee cup was used by Resident 2 that had broken into multiple small pieces.</p> <p>During a concurrent observation of Resident 2 in the facility's Memory Care Unit (an area of the facility provides care to residents with Alzheimer's disease (a disease characterized by a progressive decline in mental abilities) and dementia) and interview on 4/25/25 at 3:05 p.m., Resident 2 was observed seated with residents to his left and right side. Resident 2 then independently walked toward this Surveyor without the use of an assistive device (a device used to assist a person to walk or move). Resident 2 was asked if he had hurt another resident using his coffee cup he stated, Yes, I did [because] he was ' pawing' [to touch or handle clumsily] the front of my shirt.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/28/25 at 1:52 p.m., CNA C stated early on 4/10/25, CNA A took Resident 1 back to his room because he was annoying other residents. CNA C stated at around 9 a.m., Resident 1 came out of his room, sat beside Resident 2 and started watching television. CNA C stated he was walking toward Resident 1 to get his coffee cup when Resident 2 suddenly and without any provocation, hit Resident 1 on the head with a plastic coffee cup. CNA C compared the sound of the impact from the coffee cup to somebody using a hammer. CNA C stated the impact was so hard the coffee cup broke into pieces. CNA C stated he got a towel and placed it on Resident 1's head while CNA A held Resident 2 back from Resident 1 because he was still cursing at Resident 1. CNA C stated LN B assessed Resident 1 and performed first aid. CNA C stated Resident 1 had a medium amount of blood on his head.</p> <p>During an interview on 4/30/25 at 1:55 p.m., the Director of Nursing (DON) stated she had investigated the incident between Resident 1 and Resident 2. The DON stated she spoke to LN B, CNA A, and CNA C. The DON stated CNA A and CNA C both witnessed the incident and reported to her Resident 2 struck Resident 1 on the head. The DON stated one of the CNAs described the impact on Resident 1's head was hard. The DON stated Resident 1 sustained a scrape on his head as a result of the strike.</p> <p>A review of a facility policy and procedure titled, Abuse Prevention and Management, dated 2022 indicated, The facility does not condone any form of resident abuse .and/or mistreatment. The facility develops policies, procedures, training programs and .prevention systems .Abuse is defined as the willful, deliberate infliction of injury .</p>		