

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 05/01/2025
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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>46132</p> <p>Based on observation, interviews and record reviews, the facility failed to ensure the dignity of one out of three sampled residents (Resident 2) was protected when Licensed Nurse C (LN C) teasingly pinched Resident 2 on numerous occasions despite Resident 2 requesting multiple times for LN C to refrain from doing so.</p> <p>This failure resulted in Resident 2 feeling disrespected, frustrated, and her dignity was violated.</p> <p>Findings</p> <p>During a concurrent observation and interview on 5/1/25 at 11:12 a.m., Resident 2 stated LN C, a nurse who cared for her, had a habit of pinching her. Resident 2 stated LN C liked to pinch residents and added, LN C also pinched Resident 4. Resident 2 stated LN C would pinch her on her arms and added, she knew the difference between being pinched as necessary when being given an injection versus being pinched when LN C was teasing her. Resident 2 stated LN C would pinch her even when LN C was not administering her an injection. Resident 2 stated she understood that LN C was playful but stated she did not like being pinched. Resident 2 stated she told him multiple times to stop pinching her, but LN C would not stop. Resident 2 stated not only did the pinches hurt but the lack of boundaries felt very disrespectful, and that her dignity was violated. Resident 2 stated she had talked to multiple staff about LN C pinching her and in response, staff would say LN C was just being playful or would disregard the reports and indicate they did not believe her. Resident 2 stated this made her feel really hurt and upset. Resident 2 stated every time he pinched her, she would tell LN C to stop but LN C would just laugh at her and he would continue to pinch her. Resident 2 stated she was bothered staff did nothing to stop LN C from pinching her when she reported it. Resident 2 reiterated she felt frustrated, disrespected and her dignity was violated.</p> <p>During an interview on 5/1/25 at 11:21 a.m., Resident 4 stated LN C would pinch her in the past. Resident 4 stated she would shield her face because LN C had a habit of pinching her cheeks every time he came into her room. Resident 4 stated LN C she let LN C know his pinching behavior was unwelcome.</p> <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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/1/25 at 11:31 a.m., LN B stated LN C had a playful and childlike behavior and was aware of LN C pinching residents. LN B stated LN C was immature and was pinching residents in a playful manner. LN B acknowledged, residents could have felt disrespected and their dignity was disregarded when they were pinched despite indicating they did not want to be pinched or when staff did not stop the pinching from LN C.</p> <p>During an interview on 5/1/25 at 11:58 a.m., the Director of Staff Development (DSD) stated LN C was immature and had been in-serviced (training that is provided to employees while they are actively working in their roles) in the past because of his conduct and professionalism. The DSD stated she was not surprised to hear about this pinching issue as there was a similar incident that happened between LN C and Resident 4. The DSD acknowledged, residents might feel upset and frustrated when they were pinched despite indicating they did not want to be pinched or when staff did not stop the pinching from LN C.</p> <p>During an interview on 5/1/25 at 1:00 p.m., Unlicensed Staff D stated Resident 1 had told him LN C pinched her. Unlicensed Staff D stated he believed Resident 2 but also knew LN C 's pinching was not meant to hurt Resident 2. When asked what he did when Resident 2 told him LN C pinched her, Unlicensed Staff E did not respond.</p> <p>A review of the facility ' s policy and procedure (P&P) titled Attachment F, [NAME] of Rights, undated, indicated .Patients shall have the right .To be treated with consideration, respect and full recognition of dignity and individuality .</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>46132</p> <p>Based on observation, interviews and record reviews, the facility failed to report the result of an investigation for an injury of unknown source (an injury where the source is not observed by anyone and the resident cannot explain how it occurred, and the injury is suspicious due to its location, extent, or the number of injuries) for one out of three sampled residents (Resident 1) when no report was received by the California Department of Public Health (the Department) within five working days of the incident.</p> <p>This failure of timely reporting had the potential to cause a delayed response by enforcement agencies to ensure resident safety.</p> <p>Findings:</p> <p>A review of Resident 1 ' s face sheet (front page of the chart that contains a summary of basic information about the resident) indicated Resident 1 was admitted to the facility in April of 2025 with a diagnosis of contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion) of right and left hand.</p> <p>A review of Resident 1 ' s SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents) communication form, dated 4/21/25, indicated Resident 1 was noted with bruising on her right arm, right arm with purple skin discoloration, swelling and limited mobility compared to baseline (a starting point or initial measurement used for comparison and tracking changes over time). The note also indicated Resident 1 was grimacing and crying but was not able to provide information regarding the cause of injury. Resident 1 was sent to the emergency room for further evaluation and treatment.</p> <p>A review of Interdisciplinary (IDT, a group of health care professionals with various areas of expertise who work together toward the goals of their clients) note, dated 4/22/25, indicated Resident 1 was noted with bruising on her right arm, was transferred to the hospital, and was diagnosed with closed displaced spiral fracture of shaft of right humerus (the bone in the upper arm is broken in a twisting, spiral pattern, and the broken pieces have moved out of alignment).</p> <p>During an interview on 5/1/25 at 11:58 a.m., the Director of Staff Development (DSD) stated a result of the investigation of the injury of unknown source for Resident 1 should have been submitted to the Department within five working days of the incident to notify of the investigation result. The DSD agreed to provide documentation the result of the investigation for Resident 1s injury of unknown origin was submitted to the state within five working days of the incident.</p> <p>During an interview on 5/1/25 at 1:32 p.m. the Infection Preventionist (IP) stated the result of the investigation on injury of unknown origin for Resident 1 should be submitted to the Department within five working days to notify them of corrective actions taken and the investigation result.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 5/2/25 at 10:03 a.m., the Assistant Director of Nursing (ADON) stated the result for Resident 1 ' s injury of unknown origin investigation should have been reported to the Department within five working days.</p> <p>The facility was not able to provide evidence it had submitted the result of the investigation into Resident 1 ' s injury of unknown origin to the Department within five working days of the incident.</p> <p>A review of the facility ' s policy and procedure (P&P) titled Reporting Abuse, revised 1/18/2014, indicated, . the administrator, or his or her designee, shall provide the appropriate agencies or individuals with a written report of the findings of the investigation within 5 working days of the incident .</p>		