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	05/14/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 46132 Based on interviews and reviews, the facility failed to notify the physician of a significant change for one out of two sampled residents (Resident 12), when Resident 12's unintentional weight loss was not reported to the physician. This failure could result in missed opportunity to provide timely intervention. Findings: A review of Resident 12's face sheet (front page of the chart that contains a summary of basic information about the resident) indicated Resident 12 was admitted to the facility in July 2019 with diagnoses including dementia (a progressive state of decline in mental abilities) and dysphagia (difficulty swallowing). A review of Resident 12's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 4/10/25, indicated Resident 12 was dependent on staff for feeding assistance. The MDS also indicated Resident 12 had lost weight but was not on a physician prescribed weight loss regimen. A review of Resident 12's Weights and Vitals Summary indicated Resident 12 weighed 97.3 pounds (lbs. a unit of weight) on 4/4/25 and 92.1 lbs. on 5/6/25. Resident 12 lost 5.2 lbs. or 5.18 percent (%) of her body weight from 4/4/25-5/6/25. During an interview on 5/14/25 at 11:26 a.m., Licensed Nurse C (LN C) stated 5 lbs. weight change in a month was considered a significant weight change and a change of condition (COC, any alteration in a person's physical, cognitive, or behavioral status that is different from their usual baseline). LN C stated COC and significant weight change should be reported to the physician regardless of whether the resident was on hospice (compassionate care for people who are near the end of life provided at the person's home or within a health care facility) or not. LN C stated not reporting a significant weight change to the physician would put the resident at risk for further weight fluctuations which could negatively affect the resident's health. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 5/14/25 at 11:53 a.m., with LN D, Resident 12's Weights and Vitals Summary was reviewed. LN D verified Resident 12 had a weight loss of 5.2 lbs. from 4/4/25-5/6/25 and stated this should have been reported to the physician. LN D stated weight change of 5 lbs. in a month was considered a COC and as such should have been reported to the physician. LN D stated that the COC should have also been documented. LN D stated the reporting of weight changes was important to ensure interventions could be put in place to prevent further weight changes which could be detrimental to residents' medical status. During a concurrent interview weight and record review on 5/14/25 at 12:55 p.m. with the Infection Preventionist (IP), Resident 12's medical records were reviewed including the nutrition care plan (CP, a detailed, written document that outlines a resident's individual needs, goals, and how their care will be managed) and Weights and Vitals Summary was reviewed. The IP verified Resident 12 weighed under 100 lbs., had lost 5.2 lbs. from 4/4/25-5/6/25, and there was no indication the physician had been notified of Resident 12's weight loss from 4/4/25-5/6/25. The IP stated a weight loss of 5 lbs. in a month was considered a significant weight loss and a COC which should be reported to the physician despite Resident 12 being on hospice services. The IP verified Resident 12 had no CP indicating to discontinue weight monitoring and nor instructing staff not to report significant weight loss to the physician. The IP stated even though Resident 12 was on hospice, the facility still had to report significant weight loss to the physician to ensure prompt intervention if needed to stop weight loss if possible. The IP stated not reporting weight loss to physician could lead to further weight loss and could have a negative impact on residents' medical status. A review of the facility's policy and Procedure P&P titled Evaluation of Weight and Nutritional Status, revised 1/30/25, the P&P indicated, . the residents attending physician will be notified when there is a weight variance of 5 pounds in 1 month or a weight variance of 3 pounds in one month if a resident weigh 100 pounds or less .

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 47563 Based on interviews and record reviews, the facility failed to establish and implement an appropriate abuse policy and procedure (P&P) when: 1. the facility's P&P titled Reporting Abuse was not revised to reflect current reporting guidelines, and 2. staff were not able to correctly state whom to report or the time frames to report abuse allegations. These failures could put all 174 residents of the facility at risk for abuse without timely interventions. Findings: 1. A review of the facility's P&P titled Reporting Abuse , revised 1/8/2014, indicated, .If the reportable incident results in serious bodily injury, a telephone report shall be made to the local law enforcement agency immediately and no later than 2 hours of the observation, knowledge or suspicion of the physical abuse. In addition, a written report shall be made to the local ombudsman, the California Department of Public Health and the local law enforcement agency within 2 hours of the observation, knowledge or suspicion of the physical abuse .If the reportable incident does not result in serious bodily injury, the Administrator or his/her designee, will make a telephone report to the local law enforcement agency within 24 hours of the observation knowledge or suspicion of the physical abuse. In addition, a written report shall be made to the local ombudsman, the California Dept of Public Health and the local law enforcement agency within 24 hours of the observation, knowledge or suspicion of the physical abuse .If the suspected abuse is allegedly caused by a resident who has been diagnosed with dementia, and a license nurse reasonably determines that there is no serious bodily injury, the administrator, or his/her designee, shall report to the Ombudsman or law enforcement agency telephone report shall be made to the local law enforcement agency by telephone as soon as practically possible and write a written report within 24 hours of the observation, knowledge or suspicion of the abuse . A review of the All Facilities Letter (AFL, information contained may include changes in requirements in healthcare, enforcement, new technologies, scope of practice, or general information that affects the health facility) 21-26, dated 7/26/21, indicated, . Pursuant to Title 42 CFR section 483.12(c)(1) . facilities must report any instance of suspected or alleged abuse neglect, exploitation, and/or mistreatment of elders or dependent adults to their local law enforcement agency, LTC ombudsman, and [the state]. When to Report . for incidents that involve abuse or result in serious bodily injury, facilities must: Call local law enforcement immediately, but no later than two hours after the allegation is made. File a written or electronic report to the LTC ombudsman, local law enforcement, and [the state] within two hours . for any other reasonable suspicion that does not result in abuse or serious bodily injury, facilities must: Call local law enforcement as soon as possible, but no later than 24 hours after the allegation is made. File a written or electronic report to the LTC ombudsman, local law enforcement and DO within 24 hours . (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During an interview on 5/14/25 at 11:13 a.m. Unlicensed Staff A stated abuse allegations should be reported only to the ombudsman and state within 24 hours. During an interview on 5/14/25 at 11:26 a.m., Licensed Nurse (LN) C stated all abuse allegations should be reported to CDPH, ombudsman and the police right away within 24 hours if there was no injury and within 2 hours if there was an injury. LN C stated it was important abuse allegations were reported right away to provide timely action for residents' safety and to investigate timely while the incident was still fresh. During an interview on 5/14/25 at 11:48 a.m., LN E stated abuse allegations should be reported immediately within 24 hours. LN E stated it was important abuse allegations were reported timely to ensure residents safety. During an interview on 5/14/25 at 11:53 a.m., LN D stated abuse allegations should be reported within 24 hours if there was no injury. LN D stated it was important to report abuse allegations timely to stop the abuse from occurring again and to provide safety for the residents. During an interview on 5/14/25 at 12:25 p.m., the Infection Preventionist (IP) stated abuse allegations should be reported to the ombudsman, CDPH and the local police immediately within 2 hours if the abuse results in injury and within 24 hours if the abuse did not result in injury. The IP stated it was important to report abuse allegations timely to protect residents' and ensure residents' safety.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46132 Based on interviews and record reviews, the facility failed to ensure five out of five sampled residents (Resident 7, 8, 9 10 and 11) baseline care plans (BCP, a document created within 48 hours of a resident's admission to a nursing home, outlining the initial care needed to ensure residents' safety and well-being, focusing on basic needs and resident-specific information) was completed within 48 hours of admission or that a copy of the BCP was given to those residents or the resident representatives. These failures could compromise the residents' care and could have resulted in health complications. Findings: A review of Resident 7's BCP-V2 form indicated an admitted [DATE] and completed by the Dietary Manager (DM) on 5/9/25. The signature of the resident and the resident representative was left blank. A review of Resident 8's BCP-V2 form indicated an admitted [DATE] and completed by the Director of Rehabilitation (DOR) services on 5/8/25. The signature of the resident and the resident representative was left blank. A review of Resident 9's BCP-V2 form indicated an admitted [DATE] and completed by the DOR on 5/8/25. The signature of the resident and the resident representative was left blank. A review of Resident 10's BCP-V2 form indicated an admitted [DATE] signed by DOR 5/8. The signature of the resident and the resident representative was left blank. A review of Resident 11's BCP-V2 form indicated an admitted [DATE] and completed by the Social Services Director on 5/9/25. The signature of the resident and the resident representative was left blank. During a concurrent interview and record review on 5/14/25 at 12:45 p.m. with the Infection Preventionist (IP), BCP for Residents 7,8,9,10,and 11 were reviewed. The IP verified the BCPs for Resident 7, Resident 8, Resident 9, Resident 10 and Resident 11 were not completed within 48 hours of their admissions to the facility nor was there any indication a copy had been given to the residents or the resident representatives. The IP stated it was important to ensure BCPs were done timely to ensure residents receive appropriate care as soon as they are admitted to the facility. A review of the facility's policy and procedure titled Comprehensive Person-Centered Care Planning , revised 11/2018, indicated, .Baseline care plan . The baseline care plan must be completed within 48 hours from the resident's admission . A copy of the baseline care plan summary will be provided to the resident and/or resident representative .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 46132 Based on observation, interviews and record reviews, the facility failed to ensure one resident out of two sampled residents (Resident 12) who was dependent on staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) received services to maintain grooming and personal hygiene when Resident 12 was not provided showers as scheduled. This failure could result in discomfort, skin impairment and body odor. Findings: A review of Resident 12's face sheet (front page of the chart that contains a summary of basic information about the resident) indicated Resident 12 was admitted to the facility in July 2019 with diagnoses including dementia (a progressive state of decline in mental abilities) and dysphagia (difficulty swallowing). A review of Resident 12s Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 4/10/25, indicated Resident 12 was dependent on staff for provision showers/baths and personal hygiene. During an observation on 5/14/25 at 11:17 a.m., Resident 12 was in bed, asleep and her hair appeared oily and greasy. During an interview on 5/14/25 at 11:26 a.m., Licensed Nurse (LN) C stated it was the facility's policy to ensure residents were provided with showers three times a week. LN C verified if a resident was enrolled in hospice (compassionate care for people who are near the end of life provided at the person's home or within a health care facility), the facility still had the responsibility to provide showers as scheduled. LN C stated not providing showers as scheduled could result in skin breakdown and offensive odor. During a concurrent interview and record review on 5/14/25 at 12:55 p.m., with the Infection Preventionist (IP), Resident 12's ADL care plan (CP, a detailed, written document that outlines a resident's individual needs, goals, and how their care will be managed) and point of care (POC- is the recording and documenting of patient information directly at the bedside or point of care) shower documentation for dates 4/10/25 through 5/14/25 were reviewed. The IP confirmed the facility's policy was to ensure residents receive showers three times a week. The IP verified Resident 12's ADLs CP indicated Resident 12 was dependent on staff for showers and the CP did not indicate she should not be receiving showers three times a week. The IP verified Resident 12's POC shower documentation from 4/10/25 through 5/14/25 indicated Resident only received one shower on 4/25. The IP acknowledged Resident 12 was enrolled in hospice services, and added Resident 12 should still be receiving showers from staff three times a week. The IP stated not receiving showers as scheduled could result in skin impairment and skin infections. A review of Resident 12's weekly skin evaluation forms, for dates 4/10/25 through 5/14/25, indicated Resident 12 received showers on 4/11/25, 4/28/25, 5/2/25, 5/8/25, 5/12/25, and 5/14/25. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure titled Showering and Bathing, revised 1/1/2012, indicated, .a tub or shower bath is given to the residents to provide cleanliness, comfort and prevent body odors . residents are given tub or shower baths unless contraindicated .

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have policies on smoking. 46132 Based on observation, interview and record review, the facility failed to ensure their smoking policy was implemented in a safe manner and was operationalized as per the set regulations regarding smoking, and protection for four out of four sampled smoking residents when: 1. Resident 3 was not wearing a smoking blanket/apron (protective covering, typically made from flame-retardant fabric, used to shield smokers from burns and protect their clothing from hot ashes and cigarettes) while smoking, 2. Resident 4 was not supervised by staff while smoking, 3. Resident 6 kept his own cigarettes, and 4. Residents were not following the facility's smoking schedule. These failures had the potential to endanger the health and safety of smoking residents. Findings: 1. A review of Resident 3's face sheet (front page of the chart that contains a summary of basic information about the resident) indicated Resident 3 was admitted to the facility in September 2022 with diagnoses which included nicotine dependence (ND, a state of substance dependence on nicotine), lack of coordination, and muscle weakness. A review of Resident 3's Brief Interview for Mental Status (BIMS, an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident), dated 4/22/25, indicated Resident 3's score was 15, indicating no identified cognition issues. During a concurrent observation and interview on 5/14/25 at 11:00 a.m., Unlicensed Staff F verified Resident 3 was smoking and was not wearing a smoking apron/smoking blanket. During a concurrent observation and interview on 5/14/25 at 11:02 a.m., Residents 3 was sitting in her wheelchairs while smoking. There was 1 fire extinguisher and a smoking apron/blanket inside a locked glass case. Resident 3 stated she did not know where to find the key in case they need to use the fire extinguisher or the smoking blanket/apron. Resident 3 stated no one uses the smoking apron/blanket, and added, staff used to put the smoking apron/blanket on residents, but not recently. During a concurrent observation and interview on 5/14/25 at 11:06 a.m., in the designated smoking area with Resident 3 nearby. Resident 5 stated staff did not accompany residents to smoke, she had not seen any residents who smoked wearing the smoking blanket/apron and added, she smokes at times when Resident 3 smokes too and has not seen Resident 3 wear the smoking apron. (continued on next page)

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/14/25 at 11:17 a.m., Unlicensed Staff B verified Residents 3 was smoking without staff supervision and not wearing a smoking apron/blanket. Unlicensed Staff B stated it was important to offer residents smoking blanket/apron to ensure residents don't accidentally burn themselves while they were smoking. During a concurrent interview and smoking schedule record review on 5/14/26 at 11:26 a.m., Licensed Nurse (LN) C LN C stated CP should be followed because it directs staff on how to provide safe care to the residents. During an interview and concurrent record review on 5/14/25 at 12:25 p.m., with the Infection Preventionist (IP), Resident 3's tobacco use . Care Plan (CP, a detailed, written document that outlines a resident's individual needs, goals, and how their care will be managed), initiated 12/6/22, was reviewed. The IP verified Resident 3's CP indicated Resident 3 was to utilize a smoking apron when smoking, and added, the CP was active and was expected to be followed for Resident 3's safety. 2. A review of Resident 4's face sheet indicated Resident 4 was admitted to the facility in June 2023 with diagnoses including tremors (an involuntary, rhythmic shaking movement of a body part, most commonly the hands), schizophrenia (a mental illness that is characterized by disturbances in thought) and tobacco use. A review of Resident 4's BIMS, dated 3/10/25, score was 10, indicating moderately impaired cognition. During a concurrent observation and interview on 5/14/25 at 11:00 a.m., Unlicensed Staff F verified two residents, Resident 3 and Resident 4, were smoking unattended by staff. Unlicensed Staff F acknowledged staff should be present when residents smoke. Unlicensed Staff F stated the facility's smoking policy was not strictly enforced. During a concurrent observation and interview on 5/14/25 at 11:06 a.m., Resident 6 was seen pushing Resident 5 in a wheelchair towards the designated smoking area. Resident 5 stated staff did not accompany residents to smoke. Resident 6 stated staff did not accompany him when he smokes. During an interview on 5/14/25 at 11:17 a.m., Unlicensed Staff B verified Residents 3,4, 5 and 6 were actively smoking with no staff supervision in the designated smoking area. Unlicensed Staff B stated residents smoked unattended by staff often and disclosed, the facility's smoking policy was not being followed. Unlicensed Staff B added, it was important that residents were monitored while smoking to ensure they were safe. During a concurrent interview and smoking schedule record review on 5/14/26 at 11:26 a.m., Licensed Nurse (LN) C LN C stated CP should be followed because it directs staff on how to provide safe care to the residents. LN C stated a lot of times residents smoke unattended by staff. LN C stated it was important that staff were present when resident smokes to ensure their safety. LN C stated she did not know if there was a specific staff/department responsible to accompany residents on the smoking schedule. During an interview on 5/14/25 at 11:53 a.m., LN D stated residents smoked unsupervised and added, there was no specific staff/department designated to accompany residents while smoking. LN D stated it was important that residents were monitored while smoking to ensure their safety. (continued on next page)

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and concurrent record review on 5/14/25 at 12:25 p.m., with the IP, Resident 4's CP titled The resident is a smoker . , dated 7/14/23, was reviewed. The IP verified Resident 4's CP indicated Resident 4 requires supervision while smoking and added, the CP was active and was expected to be followed for Resident 3's safety. 3. A review of Resident 6's face sheet indicated Resident 6 was admitted to the facility in October 2024 with diagnoses including tobacco use and chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing). A review of Resident 6's BIMS, dated 1/25/25, Resident 6's score was 9, indicating moderately impaired cognition. A review of Resident 6's CP titled The resident is a smoker ., dated 1/13/25, both did not indicate Resident 6 was allowed to keep his own cigarettes. During a concurrent observation and interview on 5/14/25 at 11:06 a.m., Resident 6 was seen pushing Resident 5 in a wheelchair towards the designated smoking area joining Resident 3. Resident 6 stated he kept his own cigarettes showed he had a pack of cigarettes in his possession. Resident 3 and Resident 5 confirmed Resident 6 keeps his cigarettes. Resident 6 stated he also kept his lighter but lost it. An interview on 5/14/25 at 11:26 a.m., LN C stated she also knew some residents kept their own cigarette/smoking paraphernalia. LN C stated allowing residents to keep their own cigarettes/smoking paraphernalia was a safety risk due to possible access by confused residents which could lead to accidents and ingestion. During an interview and concurrent record review on 5/14/25 at 12:25 p.m., with the IP, Resident 6's CP titled The resident is a smoker ., dated 1/13/25, and Resident 6's smoking assessment, dated 5/14/25, were reviewed. The IP verified neither document indicated Resident 6 should be allowed to keep his cigarettes and lighter. The IP stated Resident 6 should not be keeping smoking materials on himself. The IP verified there were no safety measures in place to ensure Resident 6 was safe to keep his cigarette on himself. The IP stated Resident 6 keeping a lighter was a safety risk. The IP added it was important to follow residents smoking care plan to ensures residents safety and prevents accidents, burns and fires. 4. During a concurrent observation and interview on 5/14/25 at 11:00 a.m., Unlicensed Staff F verified two residents, Resident 3 and Resident 4, were smoking Unlicensed Staff F stated residents were supposed to smoke only at designated times but many residents did not follow the schedule and the facility's smoking policy was not strictly enforced. During a concurrent observation and interview on 5/14/25 at 11:02 a.m., Residents 3 and Resident 4 were sitting in their wheelchairs while smoking. Resident 3 stated residents smoked whenever they wanted to. Resident 3 stated the residents really did not have to follow the facility's smoking policy. Resident 4 was observed nodding his head while Resident 3 was talking. Resident 4 and indicated he agreed to what Resident 3 was saying. (continued on next page)

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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 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 5/14/25 at 11:06 a.m., Resident 6 was seen pushing Resident 5 in a wheelchair towards the smoking area. Resident 5 stated residents smoked when they wanted to and did not have to follow the smoking schedule set by the facility. Resident 6 stated he does not follow a smoking schedule and smoked when he wanted and staff has allowed him to smoke anytime he wants. During a concurrent interview and record review on 5/14/26 at 11:26 a.m., with LN C, the facility's smoking schedule was reviewed. LN C verified the facility's smoking schedule indicated smoking times of 7:00 a.m. to 7:30 a.m., 9:30 a.m. to 10:00 a.m., 2:00 p.m. to 2:30 p.m., 4:30 p.m. to 5:00 p.m. and 7:30 p.m. to 8:00 p.m. LN C stated residents should follow this schedule unless specified on their CP. LN C stated the CPs should be followed because it directs staff on how to provide safe care to the residents. LN C stated if residents were seen smoking at 11 a.m., then it meant the facility smoking schedule was not followed. LN C stated unfortunately the facility smoking schedule was not strictly enforced and a lot of times residents smoked whenever they wanted to. During an interview on 5/14/25 at 11:53 a.m., LN D stated facility smoking schedule was not being followed as residents smoked whenever they wanted. A review of the facility's policy and procedure titled Smoking Residents revised 7/27/2023, indicated, . Smoking by residents is allowed .with the following safety measures fire retardant blanket (smoking blanket) . the facility may develop a smoking schedule to ensure a safe environment . the IDT will develop an individualized plan of care for safe storage, use of smoking materials, assistance and/or required supervision for residents who smokes . smoking residents will be informed of the designated smoking areas and/or any set smoking schedules .