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	05/19/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to initiate and update person-centered care plans for two residents (Resident 4 and Resident 5) of eight sampled residents when Resident 4 and Resident 5 ' s care plans did not indicate preferences of their needs. This failure decreased the facility ' s potential to provide consistently communicated personalized care to residents. Cross reference F940. Findings: 1. A review of Resident 4 ' s admission record indicated admission to the facility in July 2021 with a diagnosis which included diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing) with moderate bilateral (affects both eyes) non-proliferative diabetic retinopathy without macular edema (damage to the blood vessels of the retina (a light-sensitive layer of tissue lining the back of the eye) but the macula (part of the retina responsible for central vision) is not affected by swelling or fluid buildup as a result of DM) and legal blindness as defined in the United Stated of America as of 7/31/24. A review of Resident 4 ' s care plan initiated on 6/24/24 indicated, [Resident 4] has impaired cognitive function or impaired thought process .[staff were expected to] Communicate with the resident .regarding residents [sic] capabilities and needs .Communication .Identify yourself at each interaction. Face the resident when speaking and make eye contact . A review of Resident 4 ' s MDS, dated [DATE], indicated Resident 4 scored 14 out of 15 in 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) which indicated she had minimal cognitive impairment. A review of Resident 4 ' s care plan initiated on 4/12/25 indicated, [Resident 4] is at risk of psychological well-being problem r/t [related to] legal blindness .[staff were expected to] Increase communication between resident .about care and living environment . There were no person-centered interventions listed to ensure Resident 4 ' s blindness was included in her dashboard or to ensure any accommodations of her needs based on her blindness such as explaining the location of her personal belongings if/when moved or the location of her lunch tray when it was delivered. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and concurrent observation on 5/14/25 at 11:45 a.m., Resident 4 stated she was blind and that she had to notify or remind staff she was blind when they entered her room. An observation of Resident 4 ' s room showed no posted communication to staff that Resident 4 was blind. Resident 4 further stated, They [the facility] need to hire more regular nurses. It ' s really hard when there are so much registry staff [nurses who work on an as needed or temporary basis via contractual arrangement] they don ' t know your routine. It ' s not consistent care. A review of Resident 4 ' s dashboard (a part of the electronic medical record (EMR) used to summarize and communicate the resident ' s needs and preferences for quick reference) in the facility ' s EMR system on 5/14/25 at 1:13 p.m. indicated no documented evidence Resident 4 was blind. During an interview on 5/15/25 at 11:08 a.m., Licensed Nurse 3 (LN 3) confirmed it was her first day working at the facility and she had not been oriented to the facility nor to her resident assignment. The LN 3 acknowledged she arrived at the facility and has been on her own. During an interview on 5/15/25 at 11:12 a.m., LN 1 acknowledged there currently was no unit supervisor or charge nurse and the facility has had to utilize registry staff more. During an interview on 5/15/25 at 11:36 a.m., LN 2 stated, Knowing your patients is very important .They [the nursing staff and residents] have to depend on registry [nurses] which can add more problems .The needs of the residents are not being met after all of these changes .I worry about our residents getting hurt. During an interview on 5/15/25 at 12:13 p.m., Resident 4 stated, Sometimes staff don ' t even knock or introduce themselves, so I don ' t know when they are there. It ' s very frustrating. During an interview and concurrent record review on 5/15/25 at 1:30 p.m., the LN 4 confirmed the facility no longer used communication boards in the residents ' rooms but had resident needs and preferences noted on each resident ' s dashboard in the EMR. LN 4 stated communication needs were entered into the facility ' s EMR and displayed on the resident ' s dashboard to alert Certified Nursing Assistants and LNs of additional accommodations. LN 4 stated Resident 4 was very verbal and was able to notify people she was blind. 2. A review of Resident 5 ' s admission record indicated admission to the facility in January 2025 with diagnosis which included DM, recurrent severe major depressive disorder (persistent feelings of sadness or loss of interest, along with other symptoms that significantly impact daily life), anxiety disorder (a group of mental health conditions characterized by excessive fear or anxiety that interferes with daily life), and personality disorder (a mental health condition where people have a lifelong pattern of seeing themselves and reacting to others in ways that cause problems). During an interview on 5/14/25 at 12:13 p.m., Resident 5 stated her preferred not to be woken up at 6 a.m. to have his blood glucose level checked. During an interview and concurrent record review on 5/15/25 at 1:30 p.m., LN 4 acknowledged Resident 5 had preferred times he wanted his medication to be administered. The LN 4 stated Resident 5 tended to post notes on his door when he did not want to be disturbed and acknowledged there were no progress notes or documentation of Resident 5 ' s preferences regarding his medication on his care plans. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/19/25 at 1:45 p.m., the Assistant Director of Nursing (ADON) stated having permanent staff working provided better personalized resident care because they were more familiar with the residents ' preferences. A review of the facility ' s policies and procedure titled Accommodation of Residents ' Communication Needs revised March 2017 indicated, To assist residents ' to express or communicate their requests, needs .and/or participate in social conversations .The following are examples of adaptive devices the staff may provide the resident .Communication Boards .Magnifying Glass .Large Print Written Materials .Bells or other Sound Making Devices .Any accommodation identified and provided by facility staff will be reflected in the residents plan of care, and up-dated as appropriate.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure sufficient nursing staff for seven residents (Resident 2, Resident 3, Resident 4, Resident 5, Resident 6, Resident 7, and Resident 8) of eight sampled residents when residents ' medications were not administered when scheduled. This failure decreased the facility ' s potential to safely meet the residents ' needs in a manner that promotes their physical well-being. Cross reference F760 and F940. Findings: A review of Resident 2 ' s admission record indicated admission to the facility in January 2025 with a diagnosis which included diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing). A review of a Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 4/9/25, indicated Resident 2 had moderate cognitive (relating to the mental process involved in knowing, learning, and understanding things) impairment. A review of Resident 2 ' s Medication Administration Record (MAR) dated April 2025 indicated the following: · Insulin lispro injection solution 100 U/mL (units per milliliter, a type of measurement) inject as per sliding scale was administered late in 1 out of 30 opportunities. · Insulin glargine Solostar® Subcutaneous Solution Pen-injector 100 U/mL inject 20 units was administered late in 10 out of 60 opportunities and not at all in 3 out of 60 opportunities. · Insulin lispro (1 unit dial) Subcutaneous Solution Pen-injector 100 U/mL inject per sliding scale was administered late in 38 out of 90 opportunities and not at all in 2 out of 60 opportunities. · Insulin lispro Injection Solution 100 U/mL, inject 10 units was administered: late in 45 out of 90 opportunities and not at all in 1 out of 90 opportunities. A review of Resident 2 ' s MAR dated May 2025 indicated the following: · Insulin glargine Solostar® Subcutaneous Solution Pen-injector 100 U/mL inject 20 units was administered late in 7 out of 37 opportunities. · Insulin lispro (1 Unit Dial) Subcutaneous Solution Pen-injector 100 U/mL inject per sliding scale was administered late in 20 out of 55 opportunities. · Insulin lispro Injection Solution 100 U/mL, inject 10 units was administered late in 29 out of 55 opportunities. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of Resident 3 ' s admission record indicated admission to the facility in October 2022 with a diagnosis which included DM with hyperglycemia (too much glucose in the blood). A review of Resident 3 ' s MDS dated [DATE] indicated Resident 3 had no cognitive impairment. A review of Resident 3 ' s MAR dated April 2025 indicated the following: · Basaglar® KwikPen® Subcutaneous Solution Pen-injector 100 U/mL inject 34 units was administered late in 45 out of 60 opportunities. · Admelog® SoloStar® Solution Pen-injector 100 U/mL inject 18 units was administered late in 41 out of 90 opportunities. A review of Resident 3 ' s MAR dated May 2025 indicated the following: · Basaglar® KwikPen® Subcutaneous Solution Pen-injector 100 U/mL inject 34 units was administered late in 12 out of 37 opportunities. · Admelog® SoloStar® Solution Pen-injector 100 U/mL inject 18 units was administered late in 14 out of 55 opportunities and not given at all in 1 out of 55 opportunities. A review of Resident 4 ' s admission record indicated admission to the facility in July 2021 with a diagnosis which included DM with moderate bilateral (affects both eyes) non-proliferative diabetic retinopathy without macular edema (damage to the blood vessels of the retina (a light-sensitive layer of tissue lining the back of the eye) but the macula (part of the retina responsible for central vision) is not affected by swelling or fluid buildup as a result of DM). A review of Resident 4 ' s MDS dated [DATE] indicated Resident 4 had no cognitive impairment. A review of Resident 4 ' s MAR dated April 2025 indicated the following: · Humulin 70/30 Subcutaneous Suspension 100 U/mL inject 25 units subcutaneously in the morning was administered late in 10 out of 21 opportunities. · Humulin 70-30U Kwikpen® inject 30 units subcutaneously in the morning was administered late in 3 out of 8 opportunities. · Insulin lispro 100 U/ml Pen per sliding scale inject subcutaneously before meals and at bedtime was administered late in 33 out of 120 opportunities. A review of Resident 4 ' s MAR dated May 2025 indicated the following: · Humulin 70/30 Subcutaneous Suspension 100 U/mL inject 25 units subcutaneously in the morning was administered late in 5 out of 19 opportunities. · Insulin lispro 100 U/mL Pen per sliding scale inject subcutaneously before meals and at bedtime was administered late in 12 out of 72 opportunities. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of Resident 5 ' s admission record indicated admission to the facility in January 2025 with a diagnosis which included DM. A review of Resident 5 ' s MDS dated [DATE] indicated Resident 5 had no cognitive impairment. A review of Resident 5 ' s MAR dated April 2025 indicated the following: · Insulin glargine Subcutaneous Solution Pen-injector 100 U/mL inject 6 units was administered late in 7 out of 19 opportunities. · Insulin lispro (1 Unit Dial) Subcutaneous Solution Pen-injector 100 U/mL per sliding scale was administered late in 10 out of 55 opportunities. A review of Resident 5 ' s MAR dated May 2025 indicated the following: · Insulin glargine Subcutaneous Solution Pen-injector 100 U/mL inject 6 units was administered late in 2 out of 18 opportunities. · Insulin lispro (1 Unit Dial) Subcutaneous Solution Pen-injector 100 U/mL per sliding scale was administered late in 7 out of 55 opportunities. A review of Resident 6 ' s admission record indicated admission to the facility in January 2025 with a diagnosis which included DM with chronic kidney disease (CKD, a progress condition where the kidneys become damaged and are unable to filter blood effectively). A review of Resident 6 ' s MDS dated [DATE] indicated Resident 6 had no cognitive impairment. A review of Resident 6 ' s MAR dated April 2025, indicated the following: · Insulin degludec FlexTouch® Subcutaneous Solution Pen-injector 200 U/mL inject 36 units was administered late in 16 out of 30 opportunities and was not administered at all in 4 out of 30 opportunities. · Insulin aspart FlexPen® Subcutaneous Solution Pen-injector 100 U/mL inject 15 units and per sliding scale were administered late in 39 out of 90 opportunities. · Insulin lispro (1 unit dial) Pen-injector 100 U/mL per sliding scale was administered late in 4 out of 9 opportunities. A review of Resident 6 ' s MAR dated May 2025 indicated the following: · Insulin degludec FlexTouch® Subcutaneous Solution Pen-injector 200 U/mL inject 36 units was administered late in 11 out of 19 opportunities. · Insulin aspart FlexPen® Subcutaneous Solution Pen-injector 100 U/mL inject 15 units and per sliding scale were administered late in 21 out of 58 opportunities. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of Resident 7 ' s admission record indicated admission to the facility in September 2023 with a diagnosis which included DM. A review of Resident 7 ' s MDS dated [DATE] indicated Resident 7 had severe cognitive impairment. A review of Resident 7 ' s MAR dated April 2025, indicated the following: · Insulin glargine Solostar® Subcutaneous Solution Pen-injector 100 U/mL, inject 30 units was administered late in 18 out of 29 opportunities. · Insulin lispro (1 Unit Dial) Subcutaneous Solution Pen-injector 100 U/mL per sliding scale was administered late in 38 out of 90 opportunities. A review of Resident 7 ' s MAR dated May 2025, indicated the following: · Insulin glargine Solostar® Subcutaneous Solution Pen-injector 100 U/mL, inject 30 units if blood glucose (BG) is greater than 150 mg/dL or 26 units if BG is less than 150 mg/dL was administered too early in 1 out of 19 opportunities and late in 5 out of 19 opportunities. · Insulin lispro (1 Unit Dial) Subcutaneous Solution Pen-injector 100 U/mL was administered late in 16 out of 57 opportunities. A review of Resident 8 ' s admission record indicated admission to the facility in March 2024 with a diagnosis which included severe bipolar disorder (a mental health condition characterized by mood swings that range from the lows of depression to elevated periods of emotional highs) with psychotic features (a mental health condition characterized by symptoms of false beliefs and seeing or hearing things that do not exist), and depression (a mental health condition characterized by symptoms like sadness, loss of interest and low energy). A review of Resident 8 ' s MDS, dated [DATE], indicated Resident 8 had severe cognitive impairment. During a concurrent observation, interview, and record review on 5/14/25 at 11:22 a.m., Licensed Nurse 6 (LN 6) verified Resident 8 ' s MAR on the computer screen was all in red. LN 6 confirmed the red meant Resident 8 ' s morning medications were late to be administered. LN 6 stated she had one full medication cart for Station 3 which had 35 residents, and she had to split another medication cart for Station 4 which had 23 residents. LN 6 stated she had to pass morning medications to approximately 46 residents. LN 6 stated the facility was short staffed on nursing personnel and needed a lot of help. LN 6 stated short staffing increased the risk of medication errors. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 5/14/25 at 11:45 a.m., Resident 4 stated she did not receive her medications on time. Resident 4 stated, Yesterday I did not get my morning medications until 10:30 a.m. and I did not get my insulin until after I ate. It made me feel crappy the whole rest of the day. Resident 4 stated she experienced longer wait times for assistance on the weekends. Resident 4 further stated, It depends if its registry staff [nurses who work on a contracted as needed or temporary basis via contractual arrangement] .Registry [nurses] at night tends to not be as fast. They don ' t seem to care as much. Resident 4 stated the facility was short-staffed a lot of the time, and further added, There have been times where there are only two nurses to cover the floor. It seems to be a problem a lot of the time. Resident 4 stated medications were not given on time when she was assigned to a registry nurse. Resident 4 stated, It ' s really hard when there are so much registry staff. They don ' t know [residents '] routine. It ' s not consistent care. During an interview on 5/14/25 at 2:03 p.m., Resident 3 stated the facility was short staffed. Resident 3 confirmed the facility used registry staff who often times came in late and did not know the resident. During an interview on 5/15/25 at 11:12 a.m., LN 1 stated the station she was assigned to was currently without a Unit Supervisor or Charge Nurse (a nurse responsible for coordinating and overseeing care in the unit to ensure smooth and safe operation). LN 1 stated the facility utilized registry staff more recently and further stated, A lot of staff left and they are just trying to fill in the gaps. During an interview on 5/15/25 at 11:36 a.m., LN 2 stated the facility was short staffed, sometimes with one LN per station. LN 2 stated when the facility was short staffed the residents were split between the two stations. LN 2 further stated, The nurse may have 30 residents each- which is hard. LN 2 stated, There is no Director of Nursing [DON] to run the facility. The Director of Staff Development [DSD just quit prematurely. A lot of staff left, and it ' s been very overwhelming. LN 2 stated the needs of the residents were not being met after all the changes. LN 2 stated, Just last week a registry nurse came in late and could not log in. There was no DON to even call to help her. It delays resident care .I worry about our residents getting hurt. During an interview on 5/15/25 at 3:15 p.m., Resident 4 stated, I feel very off now. I feel very, very tired and a little dizzy. I can tell when my blood sugars are high. Resident 4 confirmed she did not receive her first dose of insulin today until noon, when it should be given in the morning. During an interview on 5/19/25 at 1:08 p.m., the Staff Coordinator (SC) stated residents have requested not to have registry staff as their nursing care providers. The SC stated the residents were used to having in-house staff, and they know the residents needs best. The SC further stated, Residents have shared that they are not comfortable having registry as staff. The SC stated, There are a lot of call offs, and a lot of staff have left or changed their work status from full time to on call. During an interview on 5/19/25 at 1:45 p.m., the Assistive Director of Nursing (ADON) stated, When we have our own staff working and contacting the doctor, following expectations, recognizing changes in resident ' s condition, things go better. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the facility ' s document titled Facility Assessment Tool, dated 2025 indicated, Inform staffing decisions to ensure that there are sufficient number of staff with the appropriate competencies and skill sets necessary to care for the residents ' needs .Diseases/conditions, physical and cognitive disabilities, and behavioral health needs .diabetes .Medication management .Administration of medications .Will always evaluate to ensure staffing meets residents need. A review of the facility ' s policy and procedure titled Diabetic Care, dated 2012, indicated, To ensure that residents with diabetes achieve optimal well-being .A Licensed Nurse will monitor the resident ' s blood glucose per the Attending Physician ' s order and will administer medication as indicated.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure six residents (Resident 2, Resident 3, Resident 4, Resident 5, Resident 6, and Resident 7) of seven sampled residents, were free from significant medication errors when the following medications were not administered in accordance with the physician ' s order: 1. Resident 2 ' s insulin lispro (a rapid-acting medication used to treat Diabetes Mellitus (DM -a disorder characterized by difficulty in blood sugar control and poor wound healing)) and insulin glargine (a long acting, steady release medication used to treat DM) were administered late; 2. Resident 2 was administered the wrong dose of nutritional insulin (insulin lispro); 3.Resident 3 ' s Admelog® (a rapid-acting medication used to treat DM) and Basaglar® (a long acting, steady release medication used to treat DM) were administered late and one dose of Admelog® was not administered; 4. Resident 4 ' s insulin lispro and Humulin (an intermediate acting (works for about half of the day to provide coverage overnight or between meals) medication used to treat DM) was administered late; 5. Resident 5 ' s insulin glargine and insulin lispro were administered late and one dose of insulin lispro was not administered; 6. Resident 6 ' s insulin aspart (a rapid-acting medication used to treat DM), and insulin degludec® (an ultra-long acting (works for up to 42 hours longer than long-acting insulin) medication used to treat DM) were administered late and were not administered several times; and, 7. Resident 7 ' s insulin glargine and insulin lispro were administered late and insulin glargine was either not administered or the wrong dose was administered. These failures decreased the facility ' s potential to safely administer medications and increased the potential for six residents to experience wide fluctuations of hypoglycemia (when blood sugar levels are too low) and hyperglycemia (when blood sugar levels are too high). Cross reference F725 and F940. Findings: 1. A review of Resident 2 ' s admission record indicated admission to the facility in January 2025 with a diagnosis which included DM. A review of a Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 4/9/25, indicated Resident 2 had moderate cognitive (relating to the mental process involved in knowing, learning, and understanding things) impairment. A review of Resident 2 ' s order summary report indicated the following active orders as of 5/20/25: (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	· Insulin lispro injection solution 100 Unit/milliliter (U/mL, a unit of measure) inject as per sliding scale (a method of determining the dose to be administered to the resident based on their current blood glucose (BG) level) subcutaneously (injected using a needle under the skin into a layer of fat) at bedtime for DM 2. · Insulin glargine Solostar® Subcutaneous Solution Pen-injector 100 U/mL inject 20 units subcutaneously two times a day for DM, hold if BG is less than 100 milligram/deciliter (mg/dL, a unit of measurement) and notify physician. · Insulin lispro (1 unit dial) Subcutaneous Solution Pen-injector 100 U/mL inject per sliding scale subcutaneously with meals for DM 1. · Insulin lispro injection solution 100 U/mL inject 10 units subcutaneously with meals for DM 2. A review of Resident 2 ' s Medication Administration Record (MAR) dated April 2025 indicated the following: · Insulin lispro injection solution 100 U/mL inject as per sliding scale was administered late in 1 out of 30 opportunities. · Insulin glargine Solostar® Subcutaneous Solution Pen-injector 100 U/mL inject 20 units was administered late in 10 out of 60 opportunities and not at all in 3 out of 60 opportunities. On 4/15/25 at 8:41 p. m., the insulin glargine Solostar® was administered when it was supposed to be held (not given) and the physician notified because Resident 2 ' s BG level was 85 mg/dL. The MAR was blank on 4/27/25 at 9 a.m. which indicated the medication was not given. On 4/30/25 at 9 p.m., a 9 noted which meant Other/See Progress Notes. · Insulin lispro (1 unit dial) Subcutaneous Solution Pen-injector 100 U/mL inject per sliding scale was administered late in 38 out of 90 opportunities and not at all in 2 out of 60 opportunities. The MAR was blank on 4/27/25 at 9 a.m. and 12 p.m. which indicated the medication was not given. · Insulin lispro Injection Solution 100 U/mL, inject 10 units was administered: late in 45 out of 90 opportunities and not at all in 1 out of 90 opportunities. A review of Resident 2 ' s progress notes dated 4/15/25 showed no documented evidence the physician was notified that Resident 2 ' s BG level was 85 mg/dL and that 20 units of insulin glargine was administered when it was not supposed to be. A review of Resident 2 ' s progress notes dated 4/27/25 and 4/30/25 showed no documented evidence of the reason why 20 units of insulin glargine was not administered when it was supposed to be. A review of Resident 2 ' s progress notes dated 4/27/25 showed no documented evidence of the reason why Resident 2 was not administered insulin lispro (1 unit dial) per sliding scale at 7:30 a.m. or 12 p.m. A review of Resident 2 ' s MAR dated May 2025 indicated the following: (continued on next page)

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	555844	A. Building B. Wing	05/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Novato Healthcare Center	1565 Hill Road Novato, CA 94947

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(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 - Many	· Insulin glargine Solostar® Subcutaneous Solution Pen-injector 100 U/mL inject 20 units was administered late in 7 out of 37 opportunities. · Insulin lispro (1 Unit Dial) Subcutaneous Solution Pen-injector 100 U/mL inject per sliding scale was administered late in 20 out of 55 opportunities. · Insulin lispro Injection Solution 100 U/mL, inject 10 units was administered late in 29 out of 55 opportunities. 2. A review of Resident 2 ' s MAR dated April 2025 indicated: · On 1/8/25 the physician ordered a conditional order for Resident 2 ' s order for insulin lispro, inject 10 units. The conditional order indicated, If PO [by mouth] intake is 0-25%- Hold 10 units of nutritional insulin [insulin lispro] dose. If PO intake is 26-74%- Administer 5 units nutritional insulin .If PO intake is 76-100%- Administer 10 units nutritional insulin. Ensure amount eaten of meal .is documented. On 4/20/25 at 12 p.m. the MAR for this order indicated Resident 2 ate 70% of her meal and 5 units of insulin lispro was administered. · On 4/20/25 at 12 p.m. Resident 2 ' s BG was 222 mg/dL. Per Resident 2 ' s insulin lispro (1 unit dial) sliding scale order, Resident 2 should have been given 6 units of insulin lispro; however, a 4 was noted which meant vitals outside parameters so the amount of insulin lispro administered to Resident 2 was not indicated for this specific order. · Based on Resident 2 ' s lispro sliding scale order and the conditional order for nutritional insulin, Resident 2 should have been administered 6 units of insulin lispro per sliding scale and 5 units of nutritional insulin for a total of 11 units of insulin lispro on 4/20/25 at 12 p.m. According to this MAR, Resident 2 was only administered 5 units of insulin lispro. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	· Furthermore, Resident 2 was administered the wrong dose of nutritional insulin (insulin lispro) in 21 out of 90 opportunities on the following dates: 4/1/25 at 8:52 p.m. Resident 2 was given 9 units when she was supposed to receive 5 units; 4/4/25 at 4:31 p.m. she was given 5 units when she was supposed to receive 10 units; 4/5/25 at 5:58 p.m. she was given 9 units when she was supposed to receive 5 units; on 4/6/25 at 8:35 p.m. she was given 8 when she was supposed to receive 5 units; on 4/7/25 at 6:02 p.m. she was given 0 units when she was supposed to receive 10 units; on 4/8/25 at 10:35 a.m. she was given 19 units when she was supposed to receive 10 units; on 4/8/25 at 12:32 p.m. she was given 13 units when she was supposed to receive 5 units; on 4/10/25 at 6 p.m. she was given 20 units when she was supposed to receive 5 units; on 4/11/25 at 5:19 p.m. she was given 15 units when she was supposed to receive 5 units; on 4/12/25 at 10:38 p.m. she was given 22 units when she was supposed to receive 5 units; on 4/13/25 at 10:29 p.m. she was given 13 units when she was supposed to receive 5 units; on 4/14/25 at 9:41 p.m. she was given 0 units when she was supposed to receive 5 units; on 4/16/25 at 2:14 p.m. she was given 0 units when she was supposed to receive 10 units; on 4/22/25 at 6:53 p.m. she was given 9 units when she was supposed to receive 5 units; on 4/23/25 at 10:43 p.m. she was given 10 units when she was supposed to receive 0 units; on 4/24/25 at 6:09 p.m. she was given 9 units when she was supposed to receive 5 units; on 4/28/25 at 11:56 a.m. she was given 0 units when she was supposed to receive 5 units; on 4/29/25 at 9:01 a.m. she was given 8 units when she was supposed to receive 5 units; on 4/29/25 at 1:48 p.m. she was given 6 units when she was supposed to receive 0 units; on 4/30/25 at 9:47 a.m. she was given 7 units when she was supposed to receive 0 units; and on 4/30/25 at 1:57 p.m. she was given 12 units when she was supposed to receive 0 units per physician ' s order. A review of Resident 2 ' s progress notes dated 4/20/25 at 1:27 p.m. indicated, .70% eaten, 5 units given. A review of Resident 2 ' s MAR dated May 2025 indicated the following: · Resident 2 was given the wrong dose of nutritional insulin in 21 out of 90 opportunities on: 5/2/25 at 1:32 p.m. she was given 0 units when she was supposed to receive 5 units; on 5/2/25 at 1:39 p.m. she was given 3 units when she was supposed to receive 10 units; on 5/3/25 at 5 p.m. she was given 0 units when she was supposed to receive 10 units; on 5/5/25 at 10:13 p.m. she was given 18 units when she was supposed to receive 5 units; on 5/6/25 at 9:14 a.m. she was given 15 units when she was supposed to receive 5 units; on 5/6/25 at 12:40 p.m. she was given 12 units when she was supposed to receive 5 units; on 5/9/25 at 9:51 a.m. she was given 13 units when she was supposed to receive 10 units; on 5/9/25 at 1:13 p.m. she was given 19 units when she was supposed to receive 10 units; on 5/10/25 at 8:56 a.m. she was given 6 units when she was supposed to receive 10 units; on 5/10/25 at 11:17 a.m. she was given 9 units when she was supposed to receive 10 units; on 5/10/25 at 6:04 p.m. she was given 28 units when she was supposed to receive 5 units; on 5/14/25 at 5:41 p.m. she was given 19 units when she was supposed to receive 10 units; on 5/15/25 at 10:06 a.m. she was given 22 units when she was supposed to receive 10 units; on 5/15/25 at 12:08 p.m. she was given 13 units when she was supposed to receive 10 units; and on 5/18/25 at 9:02 p.m. she was given 9 units when she was supposed to receive 5 units per physician ' s orders. 3. A review of Resident 3 ' s admission record indicated admission to the facility in October 2022 with a diagnosis which included DM with hyperglycemia. A review of Resident 3 ' s MDS dated [DATE] indicated Resident 3 had no cognitive impairment. (continued on next page)

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(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 - Many	A review of Resident 3 ' s order summary report indicated the following active orders as of 5/20/25: Basaglar® KwikPen® Subcutaneous Solution Pen-injector 100 U/mL inject 34 units subcutaneously two times a day for DM and Admelog® Solostar® Solution Pen-injector 100 U/mL inject 18 units subcutaneously with meals for DM. A review of Resident 3 ' s MAR dated April 2025 indicated the following: · Basaglar® KwikPen® Subcutaneous Solution Pen-injector 100 U/mL inject 34 units was administered late in 45 out of 60 opportunities. · Admelog® SoloStar® Solution Pen-injector 100 U/mL inject 18 units was administered late in 41 out of 90 opportunities. A review of Resident 3 ' s MAR dated May 2025 indicated the following: · Basaglar® KwikPen® Subcutaneous Solution Pen-injector 100 U/mL inject 34 units was administered late in 12 out of 37 opportunities. · Admelog® SoloStar® Solution Pen-injector 100 U/mL inject 18 units was administered late in 14 out of 55 opportunities and not given at all in 1 out of 55 opportunities. On 5/11/25 at 8 a.m., the MAR indicated Resident 3 ' s BG was 229 mg/dL but also had a 9 noted which meant Other/See Progress Notes. A review of Resident 3 ' s progress note dated 5/11/25 at 11:21 a.m. indicated, Admelog SoloStar® Solution Pen-injector 100 U/ml. Inject 18 unit subcutaneously with meals .given too late. During an interview on 5/14/25 at 2:03 p.m., Resident 3 stated that nurses often gave his medications late. Resident 3 stated he was worried about his insulin and blood sugar. Resident 3 stated receiving his insulin late made him feel sick. He stated it was alarming and frustrating because he knew the consequences if he did not receive his medications on time, especially his insulin. During an interview on 5/19/25 at 10 a.m., Licensed Nurse 5 (LN 5) confirmed that omission or late administration of insulin could jeopardize residents ' health and safety. LN 5 further stated the resident could be a high risk for hyperglycemia. LN 5 confirmed Resident 3 ' s blood sugar was checked only once on 4/27/25 at 1:16 p.m. LN 5 stated Resident 3 ' s blood sugar should have been monitored throughout the day since his insulin lispro was unavailable. 4. A review of Resident 4 ' s admission record indicated admission to the facility in July 2021 with a diagnosis which included DM with moderate bilateral (affects both eyes) non-proliferative diabetic retinopathy without macular edema (damage to the blood vessels of the retina (a light-sensitive layer of tissue lining the back of the eye) but the macula (part of the retina responsible for central vision) is not affected by swelling or fluid buildup as a result of DM). A review of Resident 4 ' s MDS dated [DATE] indicated Resident 4 had no cognitive impairment. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of Resident 4 ' s order summary report indicated the following active orders as of 5/20/25: Humulin 70/30 Subcutaneous Suspension 100 U/mL inject 25 units subcutaneously in the morning for DM2; Humulin 70-30 U Kwikpen® inject 30 units subcutaneously in the morning for DM2; and Insulin lispro 100 U/mL Pen per sliding scale inject subcutaneously before meals and at bedtime for DM 2. A review of Resident 4 ' s MAR dated April 2025 indicated the following: · Humulin 70/30 Subcutaneous Suspension 100 U/mL inject 25 units subcutaneously in the morning was administered late in 10 out of 21 opportunities. · Humulin 70-30U Kwikpen® inject 30 units subcutaneously in the morning was administered late in 3 out of 8 opportunities. · Insulin lispro 100 U/ml Pen per sliding scale inject subcutaneously before meals and at bedtime was administered late in 33 out of 120 opportunities. A review of Resident 4 ' s MAR dated May 2025 indicated the following: · Humulin 70/30 Subcutaneous Suspension 100 U/mL inject 25 units subcutaneously in the morning was administered late in 5 out of 19 opportunities. · Insulin Lispro 100 U/mL Pen per sliding scale inject subcutaneously before meals and at bedtime was administered late in 12 out of 72 opportunities. During an interview on 5/14/25 at 11:45 a.m., Resident 4 stated she does not receive her medications on time. Resident 4 stated, Yesterday I did not get my morning medications until 10:30 a.m. and I did not get my insulin until after I ate. It made me feel crappy the whole rest of the day. During a concurrent observation and interview on 5/15/25 at 12:13 p.m., LN 3 was observed to prepare and administer Resident 4 ' s medication, 8 units of insulin lispro 100U/ML Pen according to the ordered sliding scale. During the administration of insulin lispro to Resident 4, Resident 4 stated, Did you hear what happened today? They are getting a late start on medications. LN 3 confirmed she did not have access to the facility ' s electronic medical system and as a result she missed her morning medication pass. LN 3 confirmed Resident 4 did not receive any of her scheduled morning medications, including insulin on 5/15/25. During an interview on 5/15/25 at 3:15 p.m., Resident 4 stated, I feel very off now. I feel very, very tired and a little dizzy. I can tell when my blood sugars are high. Resident 4 confirmed she did not receive her first dose of insulin today until noon, when it should be given in the morning. 5. A review of Resident 5 ' s admission record indicated admission to the facility in January 2025 with a diagnosis which included DM. A review of Resident 5 ' s MDS dated [DATE] indicated Resident 5 had no cognitive impairment. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of Resident 5 ' s order summary report indicated the following active orders as of 5/20/25: Insulin glargine Subcutaneous Solution Pen-injector 100 U/mL inject 6 units subcutaneously at bedtime for DM 2 and Insulin lispro (1 Unit Dial) Subcutaneous Solution Pen-injector 100 U/mL per sliding scale inject subcutaneously with meals for DM 2. A review of Resident 5 ' s MAR dated April 2025 indicated the following: · Insulin glargine Subcutaneous Solution Pen-injector 100 U/mL inject 6 units was administered late in 7 out of 19 opportunities. · Insulin lispro (1 Unit Dial) Subcutaneous Solution Pen-injector 100 U/mL per sliding scale was administered late in 10 out of 55 opportunities. A review of Resident 5 ' s MAR dated May 2025 indicated the following: · Insulin glargine Subcutaneous Solution Pen-injector 100 U/mL inject 6 units was administered late in 2 out of 18 opportunities. · Insulin lispro (1 Unit Dial) Subcutaneous Solution Pen-injector 100 U/mL per sliding scale was administered late in 7 out of 55 opportunities. On 5/6/25 at 5 p.m. the MAR indicated Resident 5 ' s BG was 170 mg/dL. Per the sliding scale, Resident 5 was supposed to receive 1 unit of insulin lispro but a 5 was noted which meant Hold/See Progress Notes so 0 units were given to Resident 5. A review of Resident 5 ' s progress note dated 5/6/25 at 6:10 p.m. indicated no documented evidence Resident 5 was administered any insulin lispro on 5/6/25 at approximately 5 p.m. 6. A review of Resident 6 ' s admission record indicated admission to the facility in January 2025 with a diagnosis which included DM with chronic kidney disease (CKD, a progress condition where the kidneys become damaged and are unable to filter blood effectively). A review of Resident 6 ' s MDS dated [DATE] indicated Resident 6 had no cognitive impairment. A review of Resident 6 ' s order summary report indicated the following active orders as of 5/20/25: · Insulin degludec FlexTouch® Subcutaneous Solution Pen-injector 200 U/mL inject 36 units subcutaneously one time a day for DM 2; · Insulin aspart FlexPen® Subcutaneous Solution Pen-injector 100 U/mL inject 15 units subcutaneously before meals for DM 2; · Insulin aspart FlexPen® Subcutaneous Solution Pen-injector 100 U/mL per sliding scale inject subcutaneously before meals for DM 2; and, · Insulin lispro (1 unit dial) Pen-injector 100 U/mL per sliding scale inject subcutaneously with meals. A review of Resident 6 ' s MAR dated April 2025, indicated the following: (continued on next page)

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(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 - Many	· Insulin degludec FlexTouch® Subcutaneous Solution Pen-injector 200 U/mL inject 36 units was administered late in 16 out of 30 opportunities and was not administered at all in 4 out of 30 opportunities. On 4/6/25, 4/7/25, 4/9/25 and 4/28/25 at 8 a.m., the MAR indicated a 5 was noted which meant Hold/See Progress Notes so 0 units were given to Resident 5. · Insulin aspart FlexPen® Subcutaneous Solution Pen-injector 100 U/mL inject 15 units and per sliding scale were administered late in 39 out of 90 opportunities. The insulin aspart 15 units was not given at all in 10 out of 90 opportunities: 4/5/25 at 7:30 a.m. and 12:30 p.m., 4/6/25 at 7:30 a.m. and 12:30 p.m., 4/8/25 at 7:30 a.m., 4/9/25 at 5 p.m., 4/10/25 at 5 p.m., 4/15/25 at 7:30 a.m., and 4/28/25 at 7:30 a.m. and 5 p.m. The insulin Aspart per sliding scale was not given at all in 1 out of 90 opportunities: 4/5/25 at 12:30 p.m. · Insulin lispro (1 unit dial) Pen-injector 100 U/mL per sliding scale was administered late in 4 out of 9 opportunities. A review of Resident 6 ' s progress notes dated April 2025 showed no documented evidence of a reason to explain why Resident 6 was not administered her insulin nor whether the physician was notified on: · Insulin deglu[DATE] units at 8 a.m. on 4/6/25, 4/7/25, 4/9/25, and 4/28/25. · Insulin aspart 15 units on 4/5/25 at 7:30 a.m. and 12:30 p.m., 4/6/25 at 7:30 a.m. and 12:30 p.m., 4/8/25 at 7:30 a.m., 4/9/25 at 5 p.m., 4/10/25 at 5 p.m., 4/15/25 at 7:30 a.m., and 4/28/25 at 7:30 a.m. and 5 p.m. · Insulin aspart per sliding scale on 4/5/25 at 12:30 p.m. A review of Resident 6 ' s MAR dated May 2025 indicated the following: · Insulin degludec FlexTouch® Subcutaneous Solution Pen-injector 200 U/mL inject 36 units was administered late in 11 out of 19 opportunities. · Insulin aspart FlexPen® Subcutaneous Solution Pen-injector 100 U/mL inject 15 units and per sliding scale were administered late in 21 out of 58 opportunities. During an interview on 5/19/25 at 3:15 p.m., Resident 6 stated, They check my blood sugar after I eat and then they give me my insulin. Resident 6 confirmed that her insulin was administered after she eats her meals. 7. A review of Resident 7 ' s admission record indicated admission to the facility in September 2023 with a diagnosis which included DM. A review of Resident 7 ' s MDS dated [DATE] indicated Resident 7 had severe cognitive impairment. A review of Resident 7 ' s order summary report indicated the following active orders as of 5/20/25: (continued on next page)

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(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 - Many	· Insulin glargine Solostar® Subcutaneous Solution Pen-injector 100 U/mL inject 30 units subcutaneously in the morning for DM. · Insulin lispro (1 Unit Dial) Subcutaneous Solution Pen-injector 100 U/mL inject subcutaneously before meals for DM 2. A review of Resident 7 ' s MAR dated April 2025, indicated the following: · Insulin glargine Solostar® Subcutaneous Solution Pen-injector 100 U/mL, inject 30 units was administered late in 18 out of 29 opportunities. Resident 7 was not administered insulin glargine 30 units on 4/25/25 and 4/26/25 at 9 a.m. · Insulin Lispro (1 Unit Dial) Subcutaneous Solution Pen-injector 100 U/mL per sliding scale was administered late in 38 out of 90 opportunities. A review of Resident 7 ' s progress notes dated 4/25/26 and 4/26/25 showed no documented evidence of a reason to explain why Resident 7 was not administered 30 units of insulin glargine nor whether the physician was notified that it was not administered. A review of Resident 7 ' s MAR dated May 2025, indicated the following: · Insulin glargine Solostar® Subcutaneous Solution Pen-injector 100 U/mL, inject 30 units if BG is greater than 150 mg/dL or 26 units if BG is less than 150 mg/dL was administered too early in 1 out of 19 opportunities and late in 5 out of 19 opportunities. · Resident 7 ' s BG was 135 mg/dL and she was administered 30 units of insulin glargine on 5/11/25 at 11:06 a.m. when she was supposed to be given 26 units. · Resident 7 ' s BG was 105 mg/dL and she was administered 30 units of insulin glargine on 5/16/25 at 9:43 a.m. when she was supposed to be given 26 units. · Insulin lispro (1 Unit Dial) Subcutaneous Solution Pen-injector 100 U/mL was administered late in 16 out of 57 opportunities. A review of the facility ' s meal service times indicated: Station 1: Breakfast 7:00-7:40 a.m., Lunch 12:30-12:55 p.m., Dinner 5:00- 5:25 p.m. Station 2: Breakfast 7:40-8:00 a.m., Lunch 12:55-1:15 p.m., Dinner 5:25-6:00 p.m. Station 3: Breakfast 8:00-8:15 a.m., Lunch 12:55-1:10 p.m., Dinner 6:00-6:30 p.m. Station 4: Breakfast 8:15-8:30 a.m., Lunch 1:10-1:30 p.m., Dinner 6:30-6:50 p.m. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 5/15/25 at 11:12 a.m., LN 1 stated medication should be given no more than one hour before and no later than one hour after it was scheduled. LN 1 stated a progress note should be made if the medication was given late. LN 1 stated, Giving insulin on time is pretty important .If you don ' t give insulin on time, it could be a risk for diabetic coma due to their blood sugar increasing. During an interview on 5/15/25 at 11:36 a.m., LN 2 stated, The insulin coverage is to reflect the resident ' s blood sugar. If given too late, it can push the resident into a hypoglycemic episode. LN 2 further stated, If the resident is receiving a sliding scale, the coverage would be wrong if it was given two hours late. LN 2 confirmed not receiving insulin timely could result in blood sugar fluctuations which could be fatal to the resident. During an interview on 5/15/25 at 1:23 p.m., the Medical Doctor (MD) stated, I expect it [insulin] to be given as ordered. If it ' s to be given with a meal, I expect it to be given with a meal or maybe two to three minutes after a meal. If given past a meal, that would not be acceptable unless there was another blood sugar check. The MD also stated he expected to be notified if insulin was administered late. During an interview on 5/15/25 at 1:30 p.m., LN 4 stated insulin should be given as ordered. LN 4 further stated, It ' s not acceptable to give insulin hours after a meal. LN 4 confirmed Resident 2, Resident 4, and Resident 5 received the insulin more than an hour past the scheduled administration parameters on multiple occasions. LN 4 stated giving insulin not as ordered could cause the resident to become hypoglycemic or hyperglycemic. In a telephone interview on 5/19/25 at 12:50 p.m., the Pharmacist (PharmD) stated if insulin was administered after the resident ate their meal, it could cause the resident to become hypoglycemic. The PharmD further stated it was best practice to administer the medication per the physician ' s orders. During an interview on 5/19/25 at 1:45 p.m., the Assistant Director of Nursing (ADON) stated when a resident ' s medication was unavailable the doctor should be notified. The ADON stated it should be noted in the resident ' s progress notes as, MD contacted, or MD aware. The ADON stated, Policy is, it [the medication] should be ordered before it runs out. The ADON would neither confirm nor deny Resident 3, Resident 6, and Resident 7 ' s insulin orders were administered late. The ADON stated, What nurses are doing is passing the medication, and then sitting down and documenting them as administered at a different time. The ADON confirmed they should be documented when given. The ADON confirmed there was no way of knowing if the medication was given as documented or as scheduled. The ADON confirmed this practice could lead to medication errors. The ADON stated medication auditing started approximately two weeks ago. The ADON stated, Prior to that, I ' m not sure who did audits or if they were completed- the DON usually took care of that. A review of the facility ' s policy and procedure (P&P) titled, Medication - Administration, dated 2012 indicated, Administration of medications .Medications and treatments will be administered as prescribed to ensure compliance with dose guidelines .Medications may be administered one hour before or after the scheduled medication administration time .Nursing staff will keep in mind the seven ' rights ' of medication when administering medication .The right amount .The right time . (continued on next page)

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	555844	A. Building B. Wing	05/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Novato Healthcare Center	1565 Hill Road Novato, CA 94947

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the facility ' s P&P titled, Pharmacy Services for Nursing Facilities, dated August 2014 indicated, . Administration of medications must be documented at the time of administration to the resident. Do not wait until the end of the med pass or shift to initial medication administration records .Medications ordered as AC (before meals), PC (after meals) and with meals (at least 100 calories) do not have an hour leeway for administration .Document medications withheld .or given at a time other than scheduled .Document ax explanatory note per facility policy similar to PRN [as needed] documentation . According to American Medical Directors Association ' s Diabetes Management in the Long-Term Care Setting, dated 2010, The chronic hyperglycemia of diabetes is associated with multiple organ dysfunction and failure, especially affecting the eyes, kidneys, nerves, heart and blood vessels .Elderly people with diabetes may also have hypoglycemia, which when untreated may cause falls or permanent neurological impairment.

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop, implement, and/or maintain an effective training program for all new and existing staff members. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure registry staff (nurses who work on a contracted as needed or temporary basis via contractual arrangement) were effectively trained prior to independently providing services to residents for a census of 174 residents. This failure decreased the facility ' s potential to provide person-centered care and reduce the potential of adverse events. Cross reference F725 and F760. Findings: A review of Resident 4 ' s admission record indicated admission to the facility in July 2021 with a diagnosis which included DM with moderate bilateral (affects both eyes) non-proliferative diabetic retinopathy without macular edema (damage to the blood vessels of the retina (a light-sensitive layer of tissue lining the back of the eye) but the macula (part of the retina responsible for central vision) is not affected by swelling or fluid buildup as a result of DM). A review of Resident 4 ' s MDS dated [DATE] indicated Resident 4 had no cognitive impairment. A review of Resident 4 ' s MAR dated April 2025 indicated the following: · Humulin 70/30 Subcutaneous Suspension 100 U/mL inject 25 units subcutaneously in the morning was administered late in 10 out of 21 opportunities. · Humulin 70-30U Kwikpen® inject 30 units subcutaneously in the morning was administered late in 3 out of 8 opportunities. · Insulin lispro 100 U/ml Pen per sliding scale inject subcutaneously before meals and at bedtime was administered late in 33 out of 120 opportunities. A review of Resident 4 ' s MAR dated May 2025 indicated the following: · Humulin 70/30 Subcutaneous Suspension 100 U/mL inject 25 units subcutaneously in the morning was administered late in 5 out of 19 opportunities. · Insulin Lispro 100 U/mL Pen per sliding scale inject subcutaneously before meals and at bedtime was administered late in 12 out of 72 opportunities. (continued on next page)

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 5/14/25 at 11:45 a.m., Resident 4 stated she did not receive her medications on time. Resident 4 stated, Yesterday I did not get my morning medications until 10:30 a.m. and I did not get my insulin until after I ate. It made me feel crappy the whole rest of the day. Resident 4 stated she experienced longer wait times for assistance on the weekends. Resident 4 further stated, It depends if its registry staff [nurses who work on a contracted as needed or temporary basis via contractual arrangement] .Registry [nurses] at night tends to not be as fast. Resident 4 stated the facility was short-staffed a lot of the time, and further added, There have been times where there are only two nurses to cover the floor. It seems to be a problem a lot of the time. Resident 4 stated medications were not given on time when she was assigned to a registry nurse. Resident 4 stated, It ' s really hard when there are so much registry staff. They don ' t know [residents '] routine. It ' s not consistent care. During an interview on 5/15/25 at 10:57 a.m. with the Administrator (ADM) and Nurse Consultant (NC), the NC stated the new Director of Nursing (DON) will start working at the facility on 5/20/25. The ADM stated the Assistant Director of Nursing (ADON) will return to the facility on 5/19/25 and the Director of Staff Development (DSD) and Staffing Coordinator (SC) were both working off-site from the facility. During an interview on 5/15/25 at 11:08 a.m., LN 3 confirmed it was her first day working at the facility and she had not been oriented or provided training to the facility nor to her resident assignment. The LN 3 stated she had been instructed to read over some documents and sign paperwork prior to picking up a shift at the facility via her staffing agency. LN 3 acknowledged she arrived at the facility and has been on her own. During an interview on 5/15/25 at 11:12 a.m., LN 1 stated the station she was assigned to was currently without a Unit Supervisor or Charge Nurse (a nurse responsible for coordinating and overseeing care in the unit to ensure smooth and safe operation). LN 1 stated the facility utilized registry staff more recently and further stated, A lot of staff left, and they are just trying to fill in the gaps. During an interview on 5/15/25 at 11:36 a.m., LN 2 stated the facility was short staffed, sometimes with one LN per station. LN 2 stated when the facility was short staffed the residents were split between the two stations. LN 2 further stated, The nurse may have 30 residents each- which is hard. LN 2 stated, There is no DON to run the facility. The DSD just quit prematurely. A lot of staff left, and it ' s been very overwhelming. LN 2 stated the needs of the residents were not being met after all the changes. LN 2 stated, Just last week a registry nurse came in late and could not log in. There was no DON to even call to help her. It delays resident care .I worry about our residents getting hurt. During an interview on 5/15/25 at 12:13 p.m., LN 3 confirmed she was not provided access to the facility ' s electronic medical record (EMR) system. LN 3 stated she reported her concern to the facility ' s receptionist, SC, and someone whom she thought was a Nurse Supervisor before having to call the facility ' s information technology department herself. LN 3 acknowledged her shift started at 7 a.m. and she did not obtain EMR access until approximately 11 a.m. which resulted in her having had to pass morning medications late for the residents she was assigned to. (continued on next page)

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 5/15/25 at 1:30 p.m., LN 4 stated registry nurses were utilized daily and the facility had been dependent on registry nurses for years. LN 4 stated registry staff normally communicated with the DSD and prior to their first time working at the facility, they were supposed to receive a quick facility orientation so knew where things were located. LN 4 further stated in case of an emergency, registry staff could reach out to the Case Manager, the Infection Preventionist, ADM, or DSD. During an interview on 5/15/25 at 3:15 p.m., Resident 4 stated, I feel very off now. I feel very, very tired and a little dizzy. I can tell when my blood sugars are high. Resident 4 confirmed she did not receive her first dose of insulin today until noon, when it should be given in the morning. During a telephone interview on 5/15/25 at 4:25 p.m., the DSD stated prior to the recent changes in management, the staffing agency provided the registry staff questionnaires and quizzes that registry staff were required to complete. The DSD added registry staff were given a packet of documents that needed to be signed prior to their first shift; however, to her knowledge, the packet had not been used for at least over a year is not offered to new registry staff who pick up shifts. The DSD acknowledged the facility did not have a proper system to ensure registry staff are provided orientation or training. The DSD stated facility staff usually provided the registry staff orientation to the floor, so they knew where things were located. The DSD also stated the SC, ADM, DSD, and DON all had the ability to provide registry staff access to the EMR. The DSD explained that once a registry staff was scheduled to work a shift, the SC would request EMR access for the registry staff from the DON and ADM; however, while the facility did not have a DON, the DSD assisted in setting it up. The DSD further stated the process of obtaining EMR access for registry staff was made more difficult if the registry staff was scheduled at the last minute. When this happened, the DSD usually did not receive the email request until past her working hours or the following morning. The DSD acknowledged this was not an efficient way to communicate and set up the registry staff for success. The DSD added if the registry staff did not have access to the EMR by the time their shift started, resident care would be delayed. During an interview on 5/19/25 at 10 a.m., LN 5 stated insulin tended to be administered late many times when registry staff was utilized because they did not have access to the EMR. LN 5 stated it occurred more often on the afternoon shift. During an interview on 5/19/25 at 1:08 p.m., the Staff Coordinator (SC) stated residents have requested not to have registry staff as their nursing care providers. The SC stated the residents were used to having in-house staff, and in-house staff knew residents ' needs best. The SC further stated, Residents have shared that they are not comfortable having registry as staff. The SC stated, There are a lot of call offs, and a lot of staff have left or changed their work status from full time to on call. During an interview on 5/19/25 at 1:45 p.m., the Assistive Director of Nursing (ADON) stated, When we have our own staff working and contacting the doctor, following expectations, recognizing changes in resident ' s condition, things go better. (continued on next page)

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the facility ' s document titled Facility Assessment Tool, updated 3/14/25 indicated, .Use this assessment to make decisions about the facility ' s direct care staff member needs and their capabilities to provide services to the resident in the facility .All personnel, including .nursing, and other direct care staff (both employees and those who provide services under contract) .[Ensure documentation of] their education and/or training and any competencies related to resident care .The Facility Assessment will be used to . Inform staffing decisions to ensure that there are sufficient number of staff with the appropriate competencies and skill sets necessary to care for the residents ' needs .[and] Develop and maintain a plan to maximize recruitment and retention of direct care staff .