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	08/08/2025

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (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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(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 - Few	Based on interview and record review the facility failed to ensure one out of three sampled residents (Resident 1), was free from a significant medication error (an error in administering prescribed medication, which causes the resident discomfort or jeopardizes their health and safety), when the facility did not acquire nor administer Resident 1's antibiotic (a medicine that fights infection) per physician's orders.This failure could result in worsening of Resident 1's medical condition. Findings:A review of Resident 1's hospital discharge form, printed 7/12/25, indicated Resident 1 had a complicated medical history and had been admitted to the hospital with a spinal infection and abscess (a localized collection of pus surrounded by inflamed tissue) which was being treated for lumbosacral-spine-osteomyelitis, (a bone infection of the lower part of the spine).In a concurrent interview and record review on 8/1/25 at 8:57 a.m. with the Director of Business Development (DBD), Resident 1's admission communications were reviewed. The DBD stated she was involved in the admitting process for Resident 1 and confirmed admission communications, prior to Resident 1's admission to the facility, indicated Resident 1 needed an antibiotic, Ceflozane Sulfate Tazobactram Sodium (CSTS) of 3 grams (g-a metric unit) to be given intravenously (IV- an administration of medications or fluids directly into the blood stream via a vein) every eight hours for Resident 1's osteomyelitis until 8/20/25. In an interview and concurrent record review on 8/8/25 at 10:43 a.m. with the Director of Nursing (DON), Resident 1's clinical admission progress note, dated 7/12/25, Resident 1's skilled nursing admission orders, dated 7/12/25, and Resident 1's medication administration records (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), for July 2025, were reviewed. The DON confirmed Resident 1's Clinical admission Progress Note, dated 7/12/25, indicated Resident 1 was admitted from a hospital to the facility on 7/12/25 at 1:53 p.m. The DON confirmed Resident 1 arrived at the facility with the Skilled Nursing admission Orders which included an active medication order for the antibiotic CSTS of 3g to be given via IV every eight hours. The DON confirmed, that even if Resident 1 had received a dose of the antibiotic CSTS immediately prior to leaving the hospital, Resident 1 would have been due for a dose at the facility no later than 10 p.m. on 7/12/25. The DON confirmed that Resident 1's MAR indicated he did not receive CSTS on 7/12/25, or on 7/13/25 at 8 a.m. or at 4 p.m.In a concurrent interview and record review on 8/8/25 at 12:15 p.m. with LN 5 and the DON, Resident 1's medication administration note, dated 7/13/25 at 10:38 a.m., was reviewed. LN 5 confirmed she was the author of the administration note which indicated Resident 1 had not received the prescribed medication and that she that she had spoken with the pharmacy who informed her Resident 1's CSTS would not be delivered that day until around 5:30-6 p.m. (after the next prescribed administration was due). The DON confirmed it would be her expectation that the doctor would be notified if the medication could not be administered as prescribed. LN 5 verified the absence of documentation indicating Resident 1's doctor had been notified that Resident 1 would not be administered the prescribed CSTS.A review of the facility's policy titled, Medication - Administration, revised 1/2012, indicated the policy purpose was, To ensure the accurate administration of medications for residents in the Facility and, Medication will be administered directed by a Licensed Nurse and upon the order of a physician or licensed independent practitioner and Medications and treatments will be administered as prescribed to ensure compliance with dose guidelines.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the medical records were accurately documented for one out of three sampled residents (Resident 1), when Resident 1's medication administration record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) indicated, inaccurately, that Resident 1 was not administered a prescribed medication due to being in the hospital. This failure caused Resident 1's medical records to be inaccurate.Findings:A record review of Resident 1's SNF [Skilled Nursing Facility]/NF [Nursing Facility] to Hospital Transfer Form, dated 7/13/25, indicated Resident 1 was admitted to the facility on [DATE] and discharged from the facility to the hospital on 7/13/25 at 7:15 p.m.In a concurrent interview and record review on 8/8/25 at 1:30 p.m., with the Director of Nursing (DON), Resident 1's MAR, dated July 2025, Resident 1's SNF/NF to Hospital Transfer Form, dated 7/13/25, and facility policy titled, Completion and Correction, dated 1/2012, were reviewed. The DON confirmed Resident 1's MAR entry on 7/13/25 at 4 p.m. indicated Resident 1 did not receive a prescribed dose of Ceflozane Sulfate Tazobactram Sodium (CSTS, an antibiotic mediation that treats an infection) because Resident 1 was hospitalized (admitted to the hospital for treatment). The DON confirmed Resident 1's Transfer Form indicated Resident 1 was transferred to hospital on 7/13/25 at 7:15 p.m. The DON confirmed Resident 1 was still at the facility at 4.p.m. on 7/13/25 and the MAR entry was inaccurate. The DON stated that it was her expectation that entries in the medical record be accurate and confirmed that the facility policy titled, Completion and Correction, indicated that entries into the medical record will be, Complete, legible and accurate.