

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555844	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/08/2025
NAME OF PROVIDER OR SUPPLIER  Novato Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1565 Hill Road Novato, CA 94947	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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.  (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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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interviews and record reviews, the facility failed to notify one resident (Resident 1) of two sampled residents about a significant medication error that occurred when licensed nurses administered a double-dose of insulin lispro (a fast-acting, man-made insulin (a hormone that regulates blood sugar allowing it to be used by our body as energy) used to treat diabetes) on the morning of 8/19/25 and caused Resident 1 to experience a potentially life-threatening hypoglycemic (a low blood sugar level that can cause harm; a level below 54 milligram per deciliter (mg/dl) is a cause for immediate action) episode, when her blood sugar level went down to 43 mg/dl. This failure denied Resident 1 her right to consent to subsequent treatments and to make informed decisions about her own plan of care. Findings: A review of Resident 1's admission record indicated admission to the facility on 1/7/25 with a diagnosis of Type 1 diabetes (a chronic condition in which the pancreas makes little or no insulin (a hormone the body uses to use sugar (glucose) to produce energy). This record also indicated Resident 1 was her own healthcare decision maker. A review of Resident 1's Medication Administration Record (MAR) dated August 2025, indicated Resident 1 was scheduled to receive 12 units of Insulin Lispro 100 units/ml (milliliter, a unit of measurement) at 7 a.m. and 7:30 a.m. Licensed Nurse A (LN A) administered one dose of 12 units of Insulin Lispro at 6:58 a.m. on 8/19/25. LN B then administered a second dose of 12 units of Insulin Lispro at 8:22 a.m. on 8/19/25, which resulted in Resident 1 receiving two fast-acting insulin doses 1 hour and 24 minutes apart. In addition, LN B gave Resident 1 three units of insulin lispro 100 units/ml on 8/19/25 at 8:22 a.m. for a sliding scale (a set of various insulin doses administered based on the resident's glucose (sugar) reading at the time) order. The MAR indicated Resident 1 received a total of 27 units of a fast-acting insulin on the morning of 8/19/25. A review of Resident 1's SBAR (Situation, Background, Appearance, Review) and Notify Communication Form dated 8/19/25, indicated, The change in condition, symptoms, or signs observed. hypoglycemia, unresponsiveness, altered [abnormal] level of consciousness. Blood Sugar. 43.0 [gm/dl] .Resident became hypoglycemic MD [physician] gave order for glucose gel q [every] 15 min [minutes]. During an interview on 9/8/25 at 3:15 p.m., LN C stated Certified Nursing Assistant D (CNA D) called his attention to check on Resident 1 on the morning of 8/19/25. LN C stated he went to Resident 1's room and checked her blood sugar because CNA D said Resident 1 was not acting like her usual self. LN C stated Resident 1 was in a hypoglycemic episode when he checked Resident 1's blood sugar at 43 gm/dl. LN C stated Resident 1 usually had a high blood sugar reading and 43 gm/dl was low for her. During an interview on 9/8/25 at 3:40 p.m., Resident 1 stated her blood sugar dropped on its own and not the fault of a nurse. During an interview on 9/9/25 at 12:57 p.m. CNA D stated she saw Resident 1 was shaking and was not her normal self on the morning of 8/19/25. CNA D stated she notified LN C. CNA D stated she had not heard any mention of Resident 1 having a medication error. During an interview on 9/10/25 at 1:42 p.m., the Director of Nursing (DON) stated she verified with the Medical Records Director and found LN E entered orders for insulin into the computer for Resident 1 on 8/18/25. The DON acknowledged Resident 1 received 27 units of insulin lispro on 8/19/25. When asked if this was a medication error, the DON stated, Most possibly. When asked if the facility did a medication error report, she stated, Yes. During an interview on 9/11/25 at 12:59 p.m., Resident 1 stated nobody told her she was given a double dose of insulin in error on 8/19/25. Resident 1 stated the facility should have informed her because she did not know what happened. Resident 1 further stated she wanted to be notified of her condition. During an interview on 9/11/25 at 1:13 p.m., the DON stated Resident 1 was informed of the medication error which occurred on 8/19/25 by LN E. During an interview on 9/11/25 at 2:54 p.m., LN E stated had not notified Resident 1 of the medication error that occurred on 8/19/25. A review of the facility's policy and procedure (P&amp;P) titled, Change of Condition Notification, dated 4/1/15, indicated, Purpose. To ensure residents, family, legal representative, and physicians are informed of changes in the resident's condition in a timely manner. The Facility will promptly inform the resident, consult with the resident's attending Physician, and notify the resident's legal representative or an interested family member, if known, when the resident endures a significant change in their condition caused by. A significant change in the resident's physical, mental, psychological status. A review of the facility's P&amp;P titled, Resident Rights-Quality of Life, dated March 2017, indicated, To ensure that each resident receives the necessary care and services to attain on maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.</p>		

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F 0760  Level of Harm - Actual harm  Residents Affected - Few	Ensure that residents are free from significant medication errors.  (continued on next page)

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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interviews and record reviews, the facility failed to ensure one resident (Resident 1) of two sampled residents was free of a significant medication error when a double dose of insulin lispro (a fast-acting, man-made insulin (a hormone that regulates blood sugar allowing it to be used by our body as energy) used to treat diabetes) was administered by licensed nurses on the morning of 8/19/25. This failure resulted in Resident 1 having a hypoglycemic (when blood sugar level reaches a low level) episode in which she became unresponsive. Findings: A review of Resident 1's admission record indicated a diagnosis of Type 1 diabetes (a chronic condition in which the body is unable to produce an adequate amount of insulin). A review of Resident 1's Medication Administration Record (MAR) dated August 2025, indicated Resident 1 was scheduled to receive 12 units of Insulin Lispro 100 units/ml (milliliter, a unit of measurement) at 7 a.m. and 7:30 a.m. Licensed Nurse A (LN A) administered one dose of 12 units of Insulin Lispro at 6:58 a.m. on 8/19/25. LN B then administered a second dose of 12 units of Insulin Lispro at 8:22 a.m. on 8/19/25, which resulted in Resident 1 receiving two fast-acting insulin doses 1 hour and 24 minutes apart. In addition, LN B gave Resident 1 three units of insulin lispro 100 units/ml on 8/19/25 at 8:22 a.m. for a sliding scale (a set of various insulin doses administered based on the resident's glucose (sugar) reading at the time) order. The MAR indicated Resident 1 received a total of 27 units of a fast-acting insulin on the morning of 8/19/25. Based on Resident 1's blood glucose values obtained from the sliding scale orders, Resident 1's average blood glucose level in August 2025 was 192 mg/dl. A review of Resident 1's SBAR (Situation, Background, Appearance, Review) and Notify Communication Form dated 8/19/25, indicated, The change in condition, symptoms, or signs observed. hypoglycemia, unresponsiveness, altered [abnormal] level of consciousness. Blood Sugar. 43.0 [gm/dl]. Resident became hypoglycemic MD [physician] gave order for glucose gel q [every] 15 min [minutes]. During an interview on 9/8/25 at 3:15 p.m., LN C stated Certified Nursing Assistant D (CNA D) called his attention to check on Resident 1 on the morning of 8/19/25. LN C stated he went to Resident 1's room and checked her blood sugar because CNA D said Resident 1 was not acting like her usual self. LN C stated Resident 1 was in a hypoglycemic episode when he checked Resident 1's blood sugar at 43 gm/dl. LN C stated Resident 1 usually had a high blood sugar reading and 43 gm/dl was low for her. During an interview on 9/9/25 at 12:57 p.m. CNA D stated she saw Resident 1 was shaking and was not her normal self on the morning of 8/19/25. CNA D stated she notified LN C. During an interview on 9/10/25 at 1:42 p.m., the Director of Nursing (DON) stated she verified with the Medical Records Director and found LN E entered orders for insulin into the computer for Resident 1 on 8/18/25. The DON acknowledged Resident 1 received 27 units of insulin lispro on 8/19/25. When asked if this was a medication error, the DON stated, Most possibly. When asked if the facility did a medication error report, she stated, Yes. During an interview on 9/10/25 at 2:47 p.m., LN E stated the Assistant Director of Nursing (ADON) gave her orders for insulin to enter into the computer, and she did so on 8/18/25. LN E stated she checked the insulin orders for Resident 1 but may have overlooked a discrepancy on the insulin orders. During an interview on 9/10/25 at 4:06 p.m., the ADON stated he gave orders to LN E to enter into the computer for several residents. The ADON stated he thought what happened was LN E entered the new insulin orders for Resident 1 but did not discontinue the previous insulin orders. The ADON acknowledged LN A and LN B gave insulin doses to Resident 1 which resulted in Resident 1's hypoglycemic episode on 8/19/25. During an interview on 9/12/25 at 8:56 a.m., Physician Assistant F (PA F) stated he was at the facility on the morning of 8/19/25 when Resident 1 had a hypoglycemic episode and notified the attending physician. PA F stated it was unfortunate, and it was a medication error. A review of a facility document titled, Medication Error Report Form, dated 8/19/25, indicated, . [Resident 1]. Medication Involved in Error: Lispro [insulin]. Dates Medication Was Administered in Error: 8/19/25. Type of Error: Double dose given . Cause of Error: Transcription error. Describe Any Adverse Reaction: Hypoglycemia. Describe event . Two orders were placed for Lispro 12 units. The [LN] who placed duplicate order failed to D.C. [discontinue] the prior order. A review of a facility policy and procedure titled Medication Administration dated 8/19/25, indicated, The facility shall ensure residents receive the correct medications in a timely, safe, and documented manner.</p>		

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<p>F 0790</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide routine and 24-hour emergency dental care for each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interviews and record reviews, the facility failed to assist one resident (Resident 2) of two sampled residents, to obtain dental care to be conducted in a timely manner, after the facility received a letter from a local oral surgery clinic which indicated Resident 2 had to be referred to a hospital to receive the procedure he needed. This failure decreased the facility's potential to ensure residents received the necessary care and increased Resident 1's potential to experience oral pain and discomfort which could negatively affect his health and well-being. Findings:A review of Resident 2's admission record indicated admission to the facility on [DATE] with diagnosis which included heart failure (a chronic condition in which the heart is unable to pump blood as well as it should) and chronic kidney disease (a condition where the kidneys are unable to filter waste from the blood).A review of Resident 2's care plan initiated on 1/27/24 indicted, The resident has oral/dental problems r/t [related to] poor oral hygiene, has likely cavities. The care plan indicated licensed nurses or a social worker were expected to Coordinate arrangements for dental care, transportation as needed/as ordered.A review of Resident 2's referral, dated 5/29/25, to a local oral surgery clinic indicated, Please re-evaluate for full mouth extractions [the removal of all of Resident 2's teeth].A review of a letter dated 8/8/25 from the local oral surgery clinic indicated, [Resident 2] was seen in our office for a consultation on June 23, 2025. [Resident 2] was referred to our office for full mouth extractions. After review of [Resident 2's] medical history, it has been decided that he be referred to a hospital with an oral surgery department.A review of Resident 2's progress note dated 9/4/25 at 3:58 p.m., written by a social worker indicated, SS [Social Services] called Denti-Cal [California's Medi-Cal dental program which offers dental benefits to eligible low-income individuals] office in regard to [Resident 2's] teeth extractions. As [Resident 2] was denied by Denti-Cal prior and also [local oral surgery clinic] and [hospital name] declined the services as well. Informed Ombudsman [a neutral, independent intermediary who investigates complaints to ensure fairness, accountability, and resolution of issues for the public] and [Resident 2's Responsible Party (RP, a person assigned to make healthcare decisions for Resident 2)].During an interview on 9/24/25 at 4:05 p.m., the Social Services Director (SSD) stated Resident 2 did not have dental pain, but his RP was adamant to have his dental extractions done. The SSD stated Licensed Nurse C (LN C) called the hospital to request if Resident 2's procedure could be done because it was now a nurse's responsibility to find a location to conduct Resident 2's procedure. The SSD stated she would look for a progress note written by LN C regarding when LN C contacted the hospital and the hospital's response. During an interview on 9/25/25 at 4:30 p.m., the Administrator (ADM) stated he would look for a referral to the hospital which was declined. During a telephone interview on 9/26/25 at 9:50 a.m. with the ADM, SSD, and the facility's social worker, the ADM stated he was unable to find any documentation that a formal referral was sent to the hospital. The ADM stated the SSD or the facility's social worker were responsible for arranging the appointment for Resident 2's dental care needs. A review of the facility's policy and procedure titled, Oral Healthcare and Dental Services, dated 7/14/17, indicated, .Assisting Residents with Dental Appointments.The Social Service Staff/Designee is responsible for assisting with arranging necessary dental appointments.All requests for routine and emergency dental service should be directed to the Social Service Staff/Designee to ensure that appointments are made in a timely manner. Social Service will document extenuating circumstances that led to delayed referrals.</p>		