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	11/20/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one resident (Resident 3) of four sampled residents was free from abuse when he was struck in the face by Resident 4.This failure resulted in Resident 3 sustaining a painful, sightly swollen, reddened area to his left eyebrow.A review of Resident 3's admission record indicated he was last admitted on [DATE] with the diagnoses of pressure ulcers and heart failure.A review of Resident 3's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 11/15/23, indicated Resident 3 had fully intact cognition (no issues with thinking or memory).A review of Resident 4's admission record indicated he was admitted on [DATE] with the diagnosis of Alzheimer's disease (a disease characterized by a progressive decline in mental abilities).A review of Resident 4's MDS, dated [DATE], indicated Resident 4 had severe memory impairment.A review of Resident 3's Situation, Background, Assessment, Recommendation (SBAR- a communication tool used by healthcare workers when there is a change of condition among the residents) Form, dated 11/13/25 at 9:50 a.m. and documented by Licensed Nurse 2 (LN 2), indicated Resident 3 reported he was hit by Resident 4 around 9 a. m. on his left arm & left upper eyebrow. LN 2 had documented Resident 3 had reported mild pain to his left upper eyebrow and upon assessment LN 2 observed mild redness to Resident 3's left upper eyebrow.A review of Resident 3's nursing progress note dated 11/14/25 at 10:18 p.m. indicated Resident 3 was offered an ice pack for his affected eye to reduce swelling.A review of Resident 4's Behavior Monitoring documentation between 11/5/25 through 11/13/25 indicated Resident 4 hit and kicked others on 11/5/25; Resident 4 hit, kicked, and scratched others on 11/6/25; and Resident 4 kicked and scratched others on 11/7/25.During an interview on 11/20/25 at 11:40 a.m., Resident 3 stated Resident 4 approached his bedside and complained about his television (TV) noise, so he turned off the TV. Resident 3 stated Resident 4 returned to his own bed when a staff member entered the room but when the staff member left the room, Resident 4 returned to Resident 3's bedside grabbed his left arm and punched his left eye area. Resident 3 stated his head still hurt, and his eyesight was blurry.During an interview on 11/20/25 at 2:20 p.m., the Assistant Director of Nursing (ADON) stated no staff witnessed Resident 4 hit Resident 3, but an assessment by a licensed nurse confirmed Resident 3 had an injury to his left eye area.During an interview on 11/20/25 at 2:50 p.m., LN 2 stated a Certified Nursing Assistant (CNA) asked her to check Resident 3 because he reported he was hit by Resident 4. LN 2 stated Resident 3 had redness and pain to his left eyebrow area. LN 2 stated hitting a resident was considered abuse.A review of the facility's policy titled, Abuse Prevention and Management revised 6/12/24, stipulated, Physical abuse is defined as.hitting.the facility identifies, corrects, and intervenes in situations in which abuse.is more likely to occur.and the facility conducts mandatory staff training.on understanding resident behavioral symptoms that may increase the risk of abuse.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility failed to ensure an allegation of verbal abuse was reported within the required timeframe for two residents (Resident 1 and Resident 2) of four sampled residents when the allegation was reported to the California Department of Public Health (the Department) the following day. This failure of timely reporting had the potential to cause a delayed response by enforcement agencies to ensure resident safety.A review of Resident 1's facility document titled, SBAR [Situation, Background, Assessment, and Recommendation- a tool used in healthcare settings to convey information quickly and clearly] Communication Form, dated 11/10/25 at 2:35 a.m. and signed by Licensed Nurse 1 (LN 1), indicated Resident 1 was involved in a verbal altercation with his roommate, Resident 2.A review of Resident 2's SBAR Communication Form, dated 11/10/25 at 2:35 a.m. indicated LN 1, another nurse, and 2 Certified Nurse Assistants overheard Resident 2 yelling.A review of a nursing progress note dated 11/11/25 at 5:55 p. m. indicated the Interdisciplinary Team (IDT- a group of professional and direct care staff that develop a plan for the care and treatment for a patient) met to discuss an incident on 11/10/25 of a verbal altercation between Resident 1 and his roommate Resident 2.A review of a facility document, dated 11/11/25 and received by the Department on 11/11/25 at 1:16 p.m., indicated an allegation of suspected dependent adult/elder abuse had been made related to a resident-to-resident verbal altercation between Resident 1 and Resident 2 on 11/10/25.During an interview on 11/20/25 at 9:55 a.m., the Administrator (ADM) stated the facility report concerning an allegation of verbal abuse between Resident 1 and Resident 2 was not sent to the Department within the required two-hour time frame. The ADM stated the incident occurred on 11/10/25 and it was not reported until 11/11/25.During an interview on 11/20/25 at 10:22 a.m., the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) both stated the allegation of verbal abuse between Resident 1 and Resident 2 was not reported to the Department within the required two-hour time frame.A record review of the facility's policy titled, Abuse Prevention and Management, dated 6/12/24 indicated, for all allegations of abuse, The Administrator or designated representative will.send a written. report to. CDPH Licensing and Certification within two hours.