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	12/31/2025

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. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure two residents (Resident 2 and Resident 4) out of six sampled residents were free from physical and emotional abuse when:Resident 1 intentionally hit Resident 2 with his pillow.Resident 3 intentionally threw a full bottle of a nutritional supplement at Resident 4 which landed on Resident 4's face.These failures resulted in Resident 2 experiencing physical harm and caused Resident 4 to sustain a bruise to her left lower lip.Findings:1. A review of Resident 1's admission record indicated admission to the facility on [DATE] with diagnoses of Symptomatic Epilepsy (seizure disorder caused by an identifiable injury to the brain) and Paranoid Schizophrenia (a mental health condition where a person has a hard time distinguishing between what is real and what is imagined).A review of Resident 2's admission record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses of Hemiplegia and Hemiparesis (weakness and paralysis on one side of the body) following a cerebral infarction (stroke) affecting the left side, Alzheimer's Disease (progressive brain disorder which gradually destroys memory and thinking skills until a person can no longer perform even simple tasks) and Dementia (a progressive decline in mental abilities).A review of Resident 1's minimum data set (MDS-a federally mandated resident assessment tool), dated 10/10/25, indicated a brief interview for mental status (BIMS- an assessment tool used by facilities to screen and identify memory, orientation, and judgment status of the resident) score of 5 of 15 which indicated severe cognitive (process of acquiring and understanding) impairment. This MDS also indicated Resident 1 had experienced hallucinations (sensory experiences that seem real but are created by the mind without any outside cause).A review of Resident 2's MDS, dated [DATE], indicated a BIMS was not completed because Resident 2 was rarely understood. This MDS also indicated Resident 2 had difficulty focusing attention and exhibited incoherent or disorganized thought processes.A review of Resident 1's Care Plan, dated 8/20/23, indicated Resident 1 had displayed aggressive behavior toward staff. A goal had been placed to eliminate this behavior. To achieve this goal, staff were required to provide psychosocial support to build a positive relationship with Resident 1; and if Resident 1 appeared to be having a bad day, staff were expected to speak calmly and ask how he was or to leave him alone.A review of Resident 1's Progress Note dated 12/14/25at 12:40 a.m., indicated Licensed Nurse 1 (LN 1) entered Resident 1 and Resident 2's room after hearing a shout for help. When LN 1 entered the room, she witnessed Resident 1 strike Resident 2 with a pillow. Resident 1 stated Resident 2 was standing next to my bed bothering me. LN 1 indicated in her note that [Resident 2] is wheelchair bound and is total assist. A review of an Interdisciplinary Team (IDT- a team of healthcare professionals collaborating to create resident centered goals) note dated 12/15/25 at 4:48 p.m., indicated Resident 2 may have wobbled his bedside drawer, which disturbed the privacy curtain, knocking over Resident 1's empty water bottle. Resident 1 stated, I didn't hit him hard. I just pillow touched him to remind him not to touch my stuff.During an interview in Resident 1's room on 12/30/25 at 1:15 p.m., Resident 1 recalled the incident and stated Resident 2 was moving his nightstand and stealing his water. Resident 1 stated he hit Resident 2 with his pillow to make him stop.During an observation in Resident 2's room on 12/30/25 at 2:33 p.m., Resident 2 was lying on his side in bed. Resident 2 made eye contact but would not speak.During an interview in the Administrator's office on 12/30/25, at 3:47 p.m., the Administrator (ADM) stated he substantiated the allegation of resident-to-resident abuse between Resident 1 and Resident 2. During a phone interview on 12/31/25, at 3:10 p.m., Certified Nursing Assistant 1 (CNA 1) stated when he started his shift on 12/14/25, he heard a resident saying Stop followed by soft thuds. Upon locating the room, CNA 1 witnessed Resident 1 strike Resident 2 in the upper body with a pillow multiple times. Resident 2 had his arms up as though to protect himself. CNA 1 stated he was able to remove Resident 1 from Resident 2's bedside with the help of LN 1.2. A review of Resident 3's admission record indicated Resident 3 was admitted to the facility on [DATE] with a diagnosis of End Stage Renal Disease (final stage of kidney failure in which the kidneys have lost 85-90% of their function and can no longer filter out waste or balance fluid effectively enough without medical intervention).A review of Resident 3's MDS, dated [DATE], indicated a BIMS score of 13 of 15 which indicated no cognitive impairment. An MDS dated [DATE] indicated Resident 3 had demonstrated delusional (firmly held beliefs contrary to reality) behaviors and had verbally threatened, screamed at, or cursed at others.A review of Resident 3's Care Plans indicated the following goals and interventions:A care plan dated 7/7/25 indicated Resident 3 was confabulating stories about the staff. The goal was to reduce confabulation statements. To reach this goal, staff were to provide support with active

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure adequate supervision for one resident (Resident 1) out of a sampled 6 residents when staff were unaware that Resident 1 eloped from the facility.This failure decreased the facility's potential to prevent serious injury, harm, or death to Resident 1.Findings:A review of Resident 1's admission record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses of Aphasia (damage to the brain's language center affecting the ability to communicate) following Cerebral Infarction (stroke), Muscle Weakness, Unsteadiness on feet, and a history of falling.A review of Resident 1's Elopement Evaluation, dated 11/23/25, indicated Resident 1 had a history of elopement and wandering which flagged Resident 1 at risk for exiting the facility unnoticed.A review of Resident 1's Minimum Data Set (MDS-a federally mandated resident assessment tool) dated 11/28/25, indicated Resident 1 completed the activity of walking 50 feet with two turns with supervision or guard assistance. Due to safety concerns, Resident 1 was not assessed to walk 150 feet, walk 10 feet on uneven surfaces, or go up or down on a curb. This MDS also indicated Resident 1 used a walker or wheelchair for mobility. A review of Resident 1's Care Plan, dated 11/23/25, indicated Resident 1 was at risk for wandering/elopement. Resident 1's goal was to maintain safety and staff were expected to implement the following activities to meet this goal:Engage Resident 1 in purposeful activity;Place a wandering device on Resident 1and check the presence of the device every shift;Monitor Resident 1's whereabouts every 15 minutes; and,Identify wandering/elopement de-escalation behaviors.A review of a Situation, Background, Assessment and Recommendation (SBAR- a standardized communication framework used by healthcare professionals to convey critical information accurately) form dated 12/12/25 at 3 p.m., indicated Licensed Nurse 1 (LN 1) was notified Resident 1 was outside the facility. LN 1 had checked the front of the building to search for [Resident 1] and did not find [Resident 1]. [LN 1] went inside and checked [Resident 1's] room and dining room. [Resident 1] was still not found. [LN 1] went outside once again to look for [Resident 1] .and found [Resident 1] walking down the street. LN 1 redirected [Resident 1] back into facility. [Resident 1] was found uninjured.A review of a progress note dated 12/12/25 at 6:15 p.m., the Social Worker (SW) indicated Resident 1 had no recollection of leaving the facility.During a concurrent observation and interview in Resident 1's room on 12/30/25 at 12:06 p.m., Resident 1 did not recall eloping from the facility. Resident 1 stated he was unsure why his room was changed but would like to return to his previous room.During an interview at the nurse's station on 12/30/25 at 12:16 p.m., LN 2 stated Resident 1 was transferred into the alarmed unit (a unit for residents who were at high risk for elopement) on 12/30/25 after breakfast. LN 2 stated he witnessed Resident 1 walk to the alarmed set of closed double doors to peer out the window.During an interview on 12/30/25 at 4 p.m., the Director of Nursing (DON) stated staff should check all residents' wandering devices for placement and functionality daily. This monitoring should be documented on the Medication Administration Record (MAR). It was placed on the MAR to remind staff the residents were wearing a wandering device and needed closer monitoring. The DON reviewed Resident 1's MAR dated November 2025 and confirmed Resident 1 did not have documentation to indicate his wandering device was being monitored.During an interview at the front desk on 12/31/25 at 10:11 a.m., the receptionist stated she witnessed Resident 1 walk out the front doors on 12/12/25. She stated the alarm sounded so she turned off the alarm, checked on Resident 1, and saw that he was walking towards a lounge placed at the left front of the building. When Resident 1's Certified Nursing Assistant (CNA 1) came out of the building, the receptionist went back into the facility to resume her work. During a phone interview on 12/31/25 at 10:45 a.m., CNA 1 stated he was made aware Resident 1 was outside at the front of the facility. CNA 1 went to the front of the facility and attempted to persuade Resident 1 to come back inside but Resident 1 refused. CNA 1 then went back into the facility to inform Resident 1's nurse of his refusal to come back inside. CNA 1 stated he then resumed his work and was informed upon completion that Resident 1 was missing.During a phone interview on 12/31/25at 11:02 a.m., LN 1 stated she was informed Resident 1 was in front of the facility, sitting in a lounge chair by CNA 1. CNA 1 told her he could not persuade Resident 1 to come back inside. LN 1 stated she immediately went toward the front of the building and did not see Resident 1 sitting in a lounge chair. LN 1 then looked in Resident 1's room and the Dining Room and asked LN 3 for assistance in locating Resident 1. LN 1 and LN 3 each drove their own vehicles in opposite directions to search for Resident 1. LN 1 stated Resident 1 was found at a public intersection approximately 0.8 miles from the facility. LN 1 stated she did not inform the Administrator (ADM)