

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 06/04/2026
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 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 abuse was reported within the required timeframe for one of three sampled residents reviewed for abuse (Resident 1) when an allegation of abuse was reported to the Department outside of the two-hour timeframe. This failure to report promptly had the potential to delay regulatory oversight and impede timely protective interventions for Resident 1. A review of a facility document titled, Report of Suspected Dependent Adult/Elder Abuse (SOC 341), dated 5/25/26, indicated that Resident 1 was the victim of physical abuse that resulted in a fracture (break) to the second digit (index finger) on the left hand. The date and time of the incident was documented as 5/26/26 at 8:40 a.m. The document further indicated, Patient's [Resident 1] family is alleging abuse and impropriety [behavior, actions, or remarks that are dishonest] related to an unknown occurrence [injury of unknown origin]. A review of a facility document dated 5/25/26 indicated the SOC 341 was faxed to the Department on 5/25/26 at 6:02 p.m. During an interview on 6/4/26 at 11:40 a.m., Licensed Nurse 1 (LN 1) stated allegations of abuse are expected to be reported to the Department within two hours. LN 1 stated the timeliness of reporting is important to ensure that those involved are safe and that appropriate care is provided. During an interview and concurrent document review on 6/4/26 at 1:55 p.m., the Director of Nursing (DON) confirmed the SOC 341 documented that Resident 1's family alleged abuse. The DON also confirmed that the document indicated the time the incident occurred was on 5/25/26 at 8:40 a.m. and that the document was not faxed to the Department until 6:02 p.m. The DON stated if abuse was suspected then it should have been reported within the two-hour timeframe. A review of the facility's policy and procedure titled, Abuse- Reporting Investigations, revised 2018, indicated, To protect the health, safety, and welfare of facility residents by ensuring that all reports of resident abuse. injuries of unknown source. are promptly reported and thoroughly investigated. The facility will report all allegations of abuse and criminal activity as required by law and regulations to the appropriate agencies. Administrator or designed representative will also notify. [Title of the Department] by telephone and in writing (SOC 341) within two (2) hours of initial report. A review of the facility's document titled, Registered Nurse - Job Description, no date, indicated, Report and initiate of alleged abuse or unusual occurrence as outlined within our established policies and procedures. A review of the facility's document titled, LVN (License Vocational Nurse) Staff Nurse - Job Description, no date, indicated, Reports allegations of abuse of unusual occurrence per State and Federal Regulations and facility policy.		

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to communicate postmortem care requirements for one of three sampled residents reviewed for postmortem care (Resident 2) when facility staff did not communicate Resident 2's postmortem care coordination efficiently and timely between internal facility departments and external entities. This failure resulted in a lack of clear direction and coordination with internal facility departments and external entities, which delayed Resident 2's necessary postmortem and cremation procedures. A review of Resident 2's admission record indicated he was admitted to the facility in [DATE] with medical diagnosis which included collapsed vertebra, thoracic region (when the bony block of the mid-back spine weakens and compresses into a wedge shape) and Alzheimer's (a disease characterized by a progressive decline in mental abilities). Resident 2's admission record indicated that a family member was assigned as his responsible party (RP, an individual who manages a resident's care decisions and finances). A review of Resident 2's progress notes titled, Alert Note, dated [DATE] at 2:24 p.m. indicated that Resident 2 was found unresponsive and pronounced dead at 2 p.m. The progress note also indicated that nurse staff attempted to notify Resident 2's RP and the phone number listed was no longer in service. A review of Resident 2's facility provided document titled, Skilled Nursing Visit Note [Name of hospice company], dated [DATE], indicated, Multiple attempts were made to contact patient's [Resident 2] next of kin [RP] - line is disconnected. A review of a facility document titled, Record of Death, indicated that Resident 2's date of death was [DATE]. The document also indicated that Resident 2's body was released to a mortuary on [DATE] at 5:50 p.m. A review of a facility provided email thread dated [DATE] - [DATE] included attempted communication between external entities and facility staff recipients that included the Administrator (ADM), Admissions (Admit), and Social Service (SS). The email thread indicated that communication between external entities and facility staff was initiated on [DATE]. The email thread indicated that an external entity [name of mortuary] required the facility to complete an Indigent application (a formal request used to prove a significant lack of income) for Resident 2 in order to proceed with his postmortem and cremation procedures. On [DATE], the mortuary forwarded the facility ADM and Admit an Indigent application and requested that the facility expedite the completion of the application so the decedent [Resident 2] can be properly cared for. The email thread indicated the mortuary followed up with the ADM and Admit on [DATE], [DATE], [DATE], and [DATE]. The email thread further indicated that the external entities did not receive a reply from facility staff until [DATE]. On [DATE], the Social Service Director (SSD) replied and attached an incomplete Indigent Application to the external entities. A review of a different facility provided email thread between Admit and SSD indicated the previously mentioned email thread that involved the external entities was forwarded to SSD on [DATE]. During an interview on [DATE] at 12:36 p.m., Admit stated she had no responsibilities following the death of a resident. Admit stated the mortuary phoned and emailed the facility with their request to have the Indigent application completed for Resident 2 in early [DATE]. Admit stated communication from the mortuary was directed to her and that she received the Indigent application via email on [DATE]. Admit further stated that she forwarded the application to SSD for completion on [DATE]. Admit confirmed the application was forward to SSD ten days after she received it and stated the application was not the responsibility of the Admissions department. Admit verified there was a delay in communication between the facility departments. During an interview on [DATE] at 1:05 p.m., the SSD stated she received the Indigent application from Admissions on [DATE]. The SSD stated she did not know why there was a delay in receiving the application from Admissions. The SSD further stated on [DATE] she was included on an email thread from Admit that included external entities. The SSD stated the forwarded email discussed that it was the facilities responsibility to contact the PA (Public Administrator- a legally mandated county office that manages the estates of deceased residents who (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pass away without a will or a known executor [person who manages a deceased person's estate]) to evaluate the case. The SSD stated to her knowledge, the PA was not contacted by facility staff until the Indigent application was submitted on [DATE]. During an interview and concurrent document review on [DATE] at 10:30 a.m., the ADM confirmed all email communication between the facility and the external entities in regard to Resident 2 and the Indigent application was provided. The ADM stated SS should had followed up on the phone calls and emails that was directed to Admissions. The ADM further stated, They [SSD and Admit] could have come together to decide how to proceed with the matter. The ADM reviewed the email thread and confirmed SS did not get involved until [DATE]. The ADM stated prior to [DATE] the matter regarding Resident 2 was not brought to his attention. The ADM confirmed based on the email thread there was a delay in getting the application to the correct facility department and having it completed. The ADM further stated there should had been better communication to get the necessary application completed in a timely manner. The ADM stated, If we didn't do it, we didn't do it and that is bad. The evidence [referenced to the email thread] is there. A review of the facility's policy and procedure (P&P) titled, 24 Hour Communication System, dated 2024, indicated, The facility will utilize a 24-hour report system as a means of communicating important aspects of resident's care. A review of the facility's P&P titled, Identifying a Mortuary, dated 2025, indicated, If there is no family/resident representative, the facility staff will contact the Public Administrator's Office/county morgue at the time of the resident's death for mortuary arrangements-referenced on the face sheet. A review of the facility's document titled, Admissions Coordinator - Job Description, no date, indicated, Administrative. Documents all necessary information in an accurate and timely manner. Qualifications. Excellent organizational skills with a detail orientation towards documentation and follow-up. A review of the facility's document titled, Social Service Coordinator - Job Description, no date, indicated, Clinical/Administrative. Communicate needs and plan of care to appropriate staff.		