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	06/17/2026

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the physician and licensed nurses failed to ensure informed consent was provided to one resident (Resident 2) of four sampled residents when Resident 2's informed consent documentation was incomplete and indicated a lethal dose of medication to be administered.This failure resulted in Resident 2 being administered a psychotropic medication without verification of their right to be informed of the risks, benefits, and options of alternative treatment.Findings:A review of Resident 2's hospital Discharge summary dated [DATE] indicated Resident 2 only had two physician's orders for prescribed medications which included amlodipine besylate (medication used to treat high blood pressure) and hydrochlorothiazide (medication used to treat high blood pressure). The hospital also recommended that the skilled nursing facility Resident 2 was to be admitted to avoid the use of sedatives (a substance that depresses the central nervous system, slowing brain activity to induce calmness, relaxation, or sleep) and deliriogenic (a substance or medication that can cause delirium [a sudden state of confusion characterized by disturbances in attention and awareness]) medication when possible.A review of Resident 2's face sheet indicated admission to the facility on 3/16/26 with diagnoses which included encephalopathy (a broad term for any damage or malfunction that affects the brain's structure and overall function), cerebral infarction (also known as stroke; the lack of blood flow to the brain which deprives brain tissue of oxygen and nutrients), cognitive communication deficit (difficulty with communication caused by impaired processes involving attention, memory and learning), major depressive disorder (a mental health condition characterized by persistent sadness or loss of interest that interfere with daily life), severe dementia (a progressive state of decline in mental abilities) with other behavioral disturbance, and insomnia. This document also indicated Resident 2's Responsible Party (RP, a person designated to make decisions when a resident is no longer able to for themselves) was Resident 2's daughter.A review of Resident 2's facility document titled Informed Consent Documentation signed by the physician on 3/16/26 indicated, Medical Provider's Name [Blank- no physician's name written].Medical Provider's Orders.lorazepam 25 mg [milligrams, a unit of measure] [every] 12 hrs [hours] PRN [as needed] for anxiety m/b [manifested by] irritability.If informed consent was obtained, complete the following.On [Blank- no date written] (date), I reviewed the following information regarding the medical intervention described above with the resident or responsible party.After reviewing this information with the resident\responsible party, I obtained informed consent from.[Box not checked next to] The resident.[Box not checked next to] The resident's responsible party (name) [Blank- no name documented].If no informed consent was obtained, complete the following.I have NOT disclosed the risks related to the restraint, psychotropic drug, and/or medical device to the resident based on the following reason.[Box not checked next to] Resident\Responsible Party specifically requested not to be informed.[Box not checked next to] Disclosure would seriously upset the resident and the resident would not be able to rationally weigh the risks of refusing to undergo the recommended treatment.I verified that informed consent was obtained by the physician [Box not checked next to] Yes.[Box not checked next to] No.Person who verified that physician spoke to them regarding informed consent.[Box not checked next to] Resident.[Box not checked next to] Responsible party (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	name.[Blank- no name documented].The verification was obtained via [Box checked next to] Verbal/In person.[Box checked next to] Telephone (2nd signature required).Date [next to signature of Nurse verifying consent].3/16/23.Date [next to signature of second nurse verifying consent because verification was by telephone].3/16/24.A review of Resident 2's Medication Administration Record (MAR) dated March 2026 indicated Resident 2's first dose of 1 mg lorazepam was administered to her on 3/18/26 at 11:12 a.m. This MAR further indicated licensed nurses administered 1 mg of lorazepam a total of 10 times out of 30 opportunities in March 2026.A review of Resident 2's order summary report dated April 2026 indicated Resident 2 had physician's orders to receive: Lorazepam oral tablet 1 mg [milligram, a unit of measure] Give 1 tablet by mouth every 12 hours as needed [PRN] for anxiety for 14 days m/b [manifested by] irritability.Start Date 4/4/26.End Date 4/17/26. and Lorazepam oral tablet 1 mg Give 1 tablet by mouth every 12 hours as needed for anxiety for 90 days m/b irritability.Start Date 4/5/26.End Date.7/4/26.A review of Resident 2's MAR dated April 2026 and May 2026 indicated licensed nurses administered 1 mg of lorazepam to Resident 2:36 times out of 60 opportunities in April 2026; and,33 times out of 62 opportunities in May 2026.A review of Resident 2's physician's visit notes dated 5/25/26 at 8 a.m. indicated, Patient [Resident 2] lacks medical decision-making capacity.Daughter identified as responsible party [RP] and appropriate surrogate decision maker.In a concurrent interview and record review with the Director of Nursing (DON) on 6/17/26 at 2:20 p.m. the DON stated Resident 2's informed consent documentation for lorazepam 25 mg was invalid because Resident 2's lorazepam orders were for 1 mg. The DON was asked for a copy of Resident 2's informed consent for the 1 mg order of lorazepam. None was provided to the surveyor.A follow-up email regarding this surveyor's request for a copy of Resident 2's informed consent for 1 mg of lorazepam was sent to the facility's Medical Records Director (MDR) on 6/22/26 at 8:52 a.m. The MDR replied that the document would be emailed to the surveyor by noon on 6/22/26. No informed consent was received.In an interview with Licensed Nurse 3 (LN 3) on 7/3/26 at 12:59 p.m., LN 3 stated he was 100% sure Resident 2 had a signed informed consent form for the 1 mg order of lorazepam and acknowledged he had not checked Resident 2's informed consent prior to administering lorazepam to Resident 2. LN 3 stated Resident 2 lacked capacity so Resident 2's RP would have had to sign the consent form.In an interview with the California Department of Public Health's (CDPH) Pharmacy Consultant (PharmD) on 7/15/26 at 5:20 p.m., the PharmD stated a 25 mg dose of lorazepam was unheard of and she could not think of a place where this dose would be clinically appropriate. The PharmD further stated she expected a new consent form to have been obtained since the one on file was inaccurate to begin with regardless if the ordered dose was less than what was indicated on the consent form.A review of the drug manufacturer's guide for lorazepam revised September 2016 indicated, Elderly.patients may be more susceptible to the sedative effects of lorazepam. Therefore.the initial dosage should not exceed 2 mg.The usual range is 2 to 6 mg/day given in divided doses.but the daily dosage may vary from 1 to 10 mg/day. For anxiety, most patients require an initial dose of 2 to 3 mg/day given two times a day or three times a day.For elderly.patients, an initial dosage of 1 to 2 mg/day in divided doses is recommended.lorazepam tablets are available in the following dosage strengths.0.5 mg.1 mg.[or] 2 mg.A review of the facility's document titled Informed Consent Documentation last revised 12/8/20 indicated, Instructions: This form is to be completed by the physician, physician's assistant or nurse practitioner to document that they have obtained informed consent from the resident or a responsible party for orders that they have issued.A review of the facility's policy and procedure titled Informed Consent dated 1/30/26 indicated, If the resident lacks capacity to provide informed consent, the surrogate decision-maker will provide informed consent.It is the Healthcare Practitioner's. responsibility to obtain informed consent.The licensed nurse will confirm that the Healthcare Practitioner obtained informed consent and will document the verification in the Resident's medical record, before administering the first dose.of psychoactive medications.Documenting of the verification of informed consent may be done by.Contacting the.decision-maker.to verify that the Healthcare Practitioner (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	obtained informed consent for the order. The licensed nurse will contact the healthcare practitioner to request the practitioner obtain the informed consent, if the licensed nurse is unable to verify that the Healthcare Practitioner obtained informed consent for the order.

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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. Based on interviews and record review, the licensed nurses to notify a resident's Responsible Party (RP, a person designated to make decisions regarding care when the resident is no longer able to) of a change of condition for one resident (Resident 1) of four sampled residents, when Resident 1's RP was not notified of Resident 1's fall on 6/16/26.This failure prevented Resident 1's RP of the knowledge of Resident 1's fall and the ability to make informed decisions regarding the fall incident (e.g. request for updates pertaining to the fall, request for x-rays if needed).Findings:A review of Resident 1's face sheet indicated her RP was also her conservator (a court appointed person chosen by a judge to care for an adult who is mentally or physically disabled and incapable of caring for themself).During a concurrent observation and interview on 6/16/26 at 1:27 p.m. in the facility's memory care unit, Resident 1 was observed sitting on the floor. Two Certified Nursing Assistants (CNA 1 and CNA 2) and Floor Monitor 1 (FM 1) were observed assisting Resident 1 to get up from the floor and sat her on a chair. Licensed Nurse 1 (LN 1) was observed checking Resident 1's vital signs while she was seated in the chair.During an interview with LN 1 on 6/17/26 at 9:10 a.m., LN 1 stated Resident 1 had not fallen yesterday, 6/16/26.During an interview with CNA 1 on 6/17/26 at 10 a.m., CNA 1 stated she witnessed Resident 1 have an assisted fall on 6/16/26. CNA 1 stated an assisted fall was considered a fall.During an interview with CNA 2 on 6/17/26 at 10:08 a.m., CNA 2 stated yesterday she followed Resident 1 when Resident 1 walked out of her room and had to lower Resident 1 to the floor because she started falling. CNA 2 acknowledged CNA 1, FM 1, and herself, assisted Resident 1 from the floor in a sitting position to a standing position, and sat her on a chair. CNA 2 verified Resident 1 had an assisted fall.During an interview with the DON (Director of Nursing) on 6/17/26, at 10:25 a.m., the DON stated an assisted fall was a fall. The DON stated if Resident 1 was found sitting on the floor, Resident 1 had a fall. The DON stated she expected LN 1 to complete a change of condition report, initiated a fall care plan, and notified the family and Resident 1's physician of the change in condition.During an interview with Resident 1's RP on 7/6/26, at 9:53 a.m., the RP stated he was not informed that Resident 1 fell on 6/16/26.A review of the facility's policy and procedure (P&P) titled, Fall Management Program, dated 11/11/25, indicated, Definition of Falls. 'An event in which a person inadvertently comes to rest on the ground, floor, or lower level.'A review of the facility's P&P titled Fall Management Program revised 8/28/25 indicated, After any fall, .The licensed nurse will notify the following individuals regarding the fall as soon as possible.Resident's responsible party.A review of the facility's P&P titled, Change in Condition, dated 8/5/22 indicated, A Licensed Nurse will notify the . legal representative or an appropriate family member when there is an incident/accident involving the resident.A review of Resident 1's progress notes dated 6/16/26 at 1:50 p.m., written by LN1 indicated, Resident [Resident 1] was ambulating [walking] with staff assistance from her room to a chair at the nurse station when she became unsteady and was about to fall. Immediately [sic] intervened and safely prevented the fall by providing support and assistance. no [sic] impact with the floor occurred. Vitals [sic] signs were obtained and were within normal limits.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interview and record review, the facility failed to ensure one resident (Resident 2) of four sampled residents was free from unnecessary psychotropic medications (prescription drugs that alter brain chemistry, affecting mood, perception, thoughts, or behavior) when Resident 2 was prescribed lorazepam (a prescribed medication used to treat anxiety disorders) as needed (PRN) for 90 days.This failure decreased the facility's potential to safely administer psychotropic medications to residents.Findings:A review of Resident 2's face sheet indicated admission to the facility in March 2026 with diagnoses which included encephalopathy (a broad term for any damage or malfunction that affects the brain's structure and overall function), cerebral infarction (also known as stroke; the lack of blood flow to the brain which deprives brain tissue of oxygen and nutrients), cognitive communication deficit (difficulty with communication caused by impaired processes involving attention, memory and learning), major depressive disorder (a mental health condition characterized by persistent sadness or loss of interest that interfere with daily life), severe dementia (a progressive state of decline in mental abilities) with other behavioral disturbance, and insomnia.A review of Resident 2's facility document titled Order Details created on 4/5/26 at 6:31 a.m. by Licensed Nurse 4 (LN 4) indicated the physician communicated with LN 4 via phone to change Resident 2's lorazepam (an antianxiety chemical agent) order from as needed for 14 days to 90 days.A review of Resident 2's order summary report dated April 2026 indicated Resident 2 had a physician's order to receive Lorazepam oral tablet 1 mg [milligram, a unit of measure] Give 1 tablet by mouth every 12 hours as needed [PRN] for anxiety for 90 days m/b [manifested by] irritability.Start Date 4/5/26.End Date 7/4/26.In a concurrent interview and record review with LN 3 on 7/3/26 at 12:59 p.m., the LN 4 stated he sent Resident 2's physician a text message on 4/4/26 at 12:07 a.m. asking to restart Resident 2's lorazepam order. LN 4 stated he still had the text message he sent and read it out loud to the surveyor. LN 4 stated the physician replied to the text message which indicated Resident 2 could receive lorazepam PRN for 90 days. LN 4 stated the physician did not give a rationale and reiterated the text message only indicated the lorazepam was to be given PRN for 90 days.A review of Resident 2's Medication Administration Record (MAR) dated April 2026 indicated licensed nurses administered 1 mg of lorazepam to Resident 2 at least once per day between 4/20/26 through 5/2/26 and between 5/4/26 and 5/21/26.A review of the facility's policy and procedure titled Behavior/Psychoactive Medication Management effective date of 1/30/26 indicated, Any Psychoactive Medication ordered on an as necessary (prn) basis, must be ordered not to exceed 14 days. If the physician feels the medication needs to be continued, he/she must document the reason(s) for the continued usage and write the order for the medication; not to exceed a 90 day time frame.

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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. Based on observation, interview, and record review, nurses failed to prevent an avoidable accident for one resident (Resident 1) of four sampled residents when staff/nursing supervision did not ensure Resident 1 used her walker while walking from her room to the nurse's station.This failure had the potential to result in an injury due to Resident 1 experiencing a staff-assisted fall on 6/16/26 in the memory care unit.Findings:A review of Resident 1's face sheet indicated admission to the facility in November 2024 with diagnoses which included toxic encephalopathy (a malfunction in the brain caused by exposure to harmful substances), muscle weakness, lack of coordination, and long term and current use of anticoagulants (medication used to prevent blood from clotting which increases the risk of excessive and internal bleeding).A review of Resident 1's care plan regarding a risk for falls related to deconditioning, psychoactive drug use, dementia, poor impulse control, and muscle weakness initiated on 11/11/24 indicated, Goal.The resident will be free of falls through the review date.Interventions/ Tasks [nurses were expected to implement include] Anticipate and meet the resident's needs.Follow facility protocol.Per IDT [Interdisciplinary Team, a collaborative group of healthcare professionals that assess and manage a resident's medical, functional, and social needs] review on 6/10/25.reminded [Resident 1] to use her walker however resident is not likely to remember due to dx [diagnosis] of dementia. Staff to.anticipate resident's needs. [NAME] to be placed close to bed for visual reminder to use.The resident needs a safe environment.During a concurrent observation and interview on 6/16/26 at 1:27 p.m. in the facility's memory care unit, Resident 1 was observed walking independently without the use of any assistive device (walker). Within minutes Resident 1 was observed sitting on the floor. Two Certified Nursing Assistants (CNA 1 and CNA 2) and Floor Monitor 1 (FM 1) were then observed assisting Resident 1 get up from the floor and sat her on a chair. Licensed Nurse 1 (LN 1) was observed checking Resident 1's vital signs while she was seated in the chair.A review of Resident 1's progress note dated 6/16/26 at 1:50 p.m., written by LN 1 indicated, Resident [Resident 1] was ambulating [walking] with staff assistance from her room to a chair at the nurse station when she became unsteady and was about to fall. Immediately [sic] intervened and safely prevented the fall by providing support and assistance. no [sic] impact with the floor occurred. Vitals [sic] signs were obtained and were within normal limits.A review of Resident 1's progress notes dated 6/16/26 after 1:50 p.m. showed no documented evidence Resident 1 made contact with the floor, a licensed nurse conducted a post-fall assessment, a licensed nurse interviewed staff regarding the incident, a post-fall evaluation was completed, Resident 1's fall risk care plan was updated, and the physician, Director of Nursing (DON), and/or Administrator was notified of the fall.During an interview with LN 1 on 6/17/26 at 9:10 a.m., LN 1 stated Resident 1 had not fallen yesterday, 6/16/26.During an interview with CNA 1 on 6/17/26 at 10 a.m., CNA 1 stated she witnessed Resident 1 have an assisted fall on 6/16/26. CNA 1 stated an assisted fall was considered a fall.During an interview with CNA 2 on 6/17/26 at 10:08 a.m., CNA 2 stated she followed Resident 1 when Resident 1 walked out of her room and had to lower Resident 1 to the floor because she started falling. CNA 2 acknowledged CNA 1, FM 1, and herself, assisted Resident 1 from the floor in a sitting position to a standing position, and sat her on a chair. CNA 2 verified Resident 1 had an assisted fall.During an interview with the DON on 6/17/26, at 10:25 a.m., the DON stated an assisted fall was a fall. The DON stated if Resident 1 was found sitting on the floor, Resident 1 had a fall. The DON stated she expected LN 1 to complete a change of condition report, initiated a fall care plan, and notified the family and Resident 1's physician of the change in condition.During an interview with LN 3 on 7/3/26 at 12:59 p.m., LN 3 stated if a resident was found sitting on the floor, then the resident had a fall. LN 3 added that the charge nurse should assess the resident and initiate 72- hour charting if the fall was witnessed. LN 3 stated a change of condition report should be made and the fall should be reported to the DON, physician, and family.A review of the facility's policy and procedure (P&P) titled, Fall (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Management Program, dated 11/11/25, indicated, Definition of Falls. ?An event in which a person inadvertently comes to rest on the ground, floor, or lower level.'A review of the facility's P&P titled Fall Management Program revised 8/28/25 indicated, Post-Fall Assessment, Evaluation and Documentation.After any fall, the licensed nurse is responsible for confirming that the resident is safe and stable prior to continuing with post-fall protocols. The resident should be immediately assessed by the licensed nurse for changes in condition and/or injury post fall. Following a resident fall, the licensed nurse will interview staff regarding the incident and complete a Post-Fall Evaluation. Participants in the Post-Fall Evaluation will include individuals who are able to provide information related to the fall.Once the Post-Fall Evaluation is completed the licensed nurse will update the care plan with recommendations. The Post-Fall Evaluation form and documentation of the post-fall investigation will go to the IDT meeting for review and updating of the care plan, as appropriate.The licensed nurse will notify the following individuals regarding the fall as soon as possible.Resident's attending physician.DON and/or Administrator regarding.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, interview, and record review the facility failed to maintain an effective pest control program when flies were observed in the facility's residential areas. This failure had the potential to negatively impact the health and wellness of the residents through the inhalation or ingestion of the flies' droppings and other body parts. Findings:During an observation on 6/17/26 at 12:22 p.m. at the facility's secured unit doorway, a fly flew into the surveyor's face upon entry and continued to buzz around the doorway area.During a concurrent observation and interview on 6/17/26 at 1225 p.m. in Resident 1's room, Resident 1 was sitting up in bed eating his cold breakfast tray. The window screen in Resident 1's room was torn, leaving a wide opening to the outside grounds. Resident 1 stated flies came in his room, and they bothered him when they buzzed around his head.During a concurrent observation and interview on 6/17/26 at 1234 p.m., Resident 2 was observed sleeping in bed. Two flies were seen flying around the room and temporarily landing on Resident 2's oxygen concentrator and bedsheets. Licensed Nurse 1 (LN 1) was brought into the room and confirmed the presence of flies. LN 1 stated the sliding door to the outside garden area is usually open. LN 1 also stated the sliding door to the outside garden area was usually open and was difficult to keep closed.During an observation on 6/17/26 at 1258 p.m. in the dining room, the surveyor observed the sliding glass door slightly open with no screen in place. Directly across from the dining room, a resident room window was open. The window screen in the room not properly seated in the window frame, leaving a corner popped out.During a concurrent observation and interview on 6/17/26 at 1:10 p.m., Certified Nursing Assistant 1 (CNA 1) stated flies did enter the facility, especially through the door leading to the garden area. The surveyor and CNA 1 observed one to two flies flying in and out of the fully open sliding glass door. CNA 1 stated it was difficult to keep the door closed because residents frequently used it to access the garden area.During a concurrent observation and interview on 6/17/26 at 1:52 p.m., the Administrator (ADM) toured the secured unit. The ADM confirmed the presence of flies in the area and noted torn and missing screens on windows and sliding doors.During an interview on 6/17/26 at 2:29 p.m., the Assistant Director of Nursing (ADON) stated flies can be harmful to residents. The ADON stated, Flies leave germs that can get in the food, and if the resident has an open wound, it can become infected or infested with maggots.A review of the facility's policy titled Pest Control, dated 1/1/12, indicated, [the] facility is free of insects.that could compromise the health, safety, and comfort of residents.Windows are screened at all times.