

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

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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 07/04/2026
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 0600 Level of Harm - 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 interviews and record reviews, the facility failed to protect one of three resident's sampled for abuse (Resident 1), right to remain free from physical abuse when Certified Nursing Assistant 1 (CNA 1), ignored Resident 1's verbalizations of pain during transfer, requests for CNA 1 to stop cleaning Resident 1, and Resident 1's tears while CNA 1 continued to provide incontinence care. This failure caused Resident 1 to experience pain, feel scared, vulnerable, and treated like an object. A review of Resident 1's admission record indicated Resident 1 was admitted in 11/25 with diagnoses of displaced right femur fracture (a break in her right thigh bone), collapsed vertebrae in thoracic region (occurs when the bone in your mid-back breaks and squashes into a wedge shape and often causes pain, height loss, and hunched posture) , and generalized muscle weakness.A review of Resident 1's Minimum Data Set (MDS-A resident assessment tool) dated 5/16/26, indicated Resident 1 had a BIMS (Brief Interview for Mental Status-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident with a numeric range of 0-7 indicating severe cognitive impairment, 8-12 indicating moderate cognitive impairment and 13-15 indicating cognitively intact) score of 11.During an interview on 7/2/26 at 12:36 p.m. with Resident 1 in Resident 1's room, Resident 1 reported she had fragile loose skin on her upper arms and stated CNA 1 had come into the room Sunday 6/28/26 at 3:15 a.m., did not explain what she was going to do and grabbed Resident 1 by her right arm and yanked her up to sitting and then to standing. Resident 1 stated she cried out in pain multiple times and was crying tears. CNA 1 did not stop and was aggressive while cleaning Resident 1 and it hurt badly. Resident 1 stated CNA1 was dismissive and rough and was more concerned with her task than Resident 1 as a person and Resident 1 felt scared. Resident 1 continued stating there was no reason CNA 1 had to hurt her and CNA 1 should have been gentle. Resident 1 stated that CNA 1 should not be allowed to care for residents if this was how CNA 1 treated people.A review of Resident 2's admission record indicated Resident 2 was admitted in 4/25 with diagnoses of stage 4 pressure ulcer of sacral region (Full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone near the tailbone), and abnormal gait and mobility (deviations from a natural walking pattern, such as limping, shuffling, or imbalance).A review of Resident 2's MDS, dated [DATE], indicated Resident 2 had a BIMS score of 15 indicating she was cognitively intact.During an interview on 7/2/26 at 2:00 p.m. with Resident 2, Resident 1's roommate at the time of the incident and currently, while in Resident 2's room, Resident 2 stated CNA 1 had come into the room on 6/28/26 at 3:15 a.m. to change Resident 1, the curtain between the two beds was drawn at this time. Resident 2 stated she could hear Resident 1 crying out stop you are hurting me at least 3 times. Resident 2 then pulled back the curtain and asked CNA 1, What are you doing, can't you hear her, she said stop, you have to be gentle. Resident 2 stated it was basic decency to (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 - Actual harm Residents Affected - Few	stop what you are doing if it was causing another person pain.During a phone interview on 7/2/26 at 3:15 p.m. with Licensed Nurse 1 (LN 1), LN 1 stated the charge nurse, Licensed Nurse 2 (LN 2), came and told LN 1 that Resident 1 had approached her at around 11:00 a.m. the next morning on 6/29/26, and informed LN 2 that Resident 1 never wanted CNA 1 to care for her ever again. LN 1 then went to Resident 1's room and spoke to Resident 2 who confirmed she had heard Resident 1 crying out in pain the night before when CNA 1 was cleaning Resident 1. LN 1 reported she spoke to Resident 1 later in the morning on 6/29/26 and Resident 1 was still very upset. LN 1 stated if a resident cried out in pain you should stop what you are doing, that is just being respectful. LN 1 further stated every resident had a right to be free from harm.During an interview on 7/4/26 at 10:00 a.m. with LN 2, LN 2 confirmed Resident 1 came to her the morning of 6/29/26 and reported that CNA 1 was rough and mean to her the night before on 6/28/26, and Resident 1 wished for CNA 1 to never care for her again, ever. LN 2 stated she informed LN 1 what Resident 1 had told her and LN 1 reported the incident immediately.During an interview on 7/2/26 at 2:45 p.m. with the Interim Director of Staff Development (IDSD) in her office, IDSD stated if Resident 1 was verbalizing pain she would have expected CNA 1 to stop what she was doing to Resident 1 and notify the Nurse so they could have come and assessed Resident 1.A review of Social Services Progress Notes dated 6/29/26 indicated Resident 1 had cried after the incident on 6/28/26 and explained CNA 1 handled her roughly and CNA 1's tone was curt and dismissive. Resident 1 stated the incident made her feel upset and uncomfortable.A review of Social Services Progress Notes dated 7/1/26 indicated Resident 1 expressed ongoing emotional distress related to the incident with CNA 1 and felt CNA 1 should have been reported so CNA 1 would not have the opportunity to be mean to others.A review of the Facility's Investigative Report dated 7/1/26 indicated Resident 1 stated she did not want CNA 1 to care for her anymore, never wanted to see CNA 1 in her room, and that CNA 1 was a big woman and Resident 1 did not feel she could protect herself.During an interview on 7/2/26 at 3:47 p.m. with the Director of Nursing (DON) in the conference room, DON stated she would have expected CNA 1 to first explain what she was going to do before doing it and if Resident 1 cried out in pain CNA 1 should have stopped what she was doing, made sure Resident 1 was comfortable, and then should have reported it to the nurse. DON confirmed CNA 1 was suspended following the incident until the facility investigation was completed. DON continued stating she was aware of the emotional distress the incident had caused Resident 1 and had referred Resident 1 for Psychiatric services on 6/29/26.A review of a Facility document titled, Resident Rights, revised 01/2012, indicated, Employees are to treat all residents with kindness, respect, and dignity and honor the exercise of resident's rights.A review of a Facility document titled, Abuse Prevention and Management, dated 6/12/24, indicated, Abuse is defined as the willful, deliberate infliction of injury, unreasonable confinement, involuntary seclusion, and physical or chemical restraint not required to treat symptoms, and/or imposed for the purpose of convenience, intimidation, exploitation, misappropriation of resident property, mistreatment, and injuries of unknown source or punishment with resulting physical harm, pain, or mental anguish. It further indicated, Willful, as related to abuse, is defined as the individual acting deliberately (not inadvertent or accidental) and not that the individual must have intended to inflict injury or harm.		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Physical Therapy (PT-a healthcare specialty that uses movement, exercise, manual therapy, and patient education to reduce pain, restore physical function, and prevent injury) services were provided to seven of eleven sampled residents reviewed for PT services (Resident 3, Resident 4, Resident 5, Resident 6, Resident 7, Resident 8, Resident 9) when the facility had no current Director of Rehab (DOR), no current Physical Therapist (PT), no current Physical Therapy Assistants (PTA) to provide these services to residents with active physician orders. The affected residents did not receive their PT treatment as ordered. For two of the eleven sampled residents (Resident 6 and Resident 9) Occupational Therapy (OT - health profession that focuses on functional tasks like dressing, cooking, bathing, and cognitive problem-solving) orders were added in place of necessary PT services for these residents. This failure decreased the facility's potential to provide residents with appropriate services to maintain or improve their limitations in range of motion, strengthening, functional mobility, and increased risk of falling. This failure resulted in residents feeling frustrated and upset with the lack of progress in their physical rehabilitation. A facility document titled, Census Details Report, dated 7/2/26, was provided when a list of residents requiring any rehabilitation services was requested. The column for PT in this report was empty, indicating there were no current residents with PT services. A review of a facility document titled, Order Listing Report, dated 7/3/26, indicated there were 11 residents with active PT orders. A review of Resident 3's admission record indicated Resident 3 was admitted in 9/25 with the diagnoses of aftercare following surgical amputation (the deliberate removal of all or part of a limb or body part, performed through a bone or joint), acquired absence of right and left leg below the knee, and abnormalities of gait and mobility (difficulty walking and balancing). A review of Resident 3's Minimum Data Set (MDS-a resident assessment tool), dated 6/10/26, indicated Resident 3 had a BIMS (Brief Interview for Mental Status-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident with a numerical scale of 0-7 indicating severe cognitive impairment, 8-12 indicating moderate cognitive impairment, and 13-15 indicating cognitively intact) score of 15. A review of Resident 3's active PT orders, dated 6/19/26, indicated Resident 3 should have received PT 5xwk (5 times a week) for 4 weeks. A review of Resident 3's most recent PT evaluation, dated 6/19/26-7/15/26, indicated Resident 3 required skilled PT services to increase independence with walking, increase lower extremity range of motion (LE ROM) and strength, minimize falls and promote safety awareness, to return to prior level of functional abilities and safely return home. PT evaluation further indicated due to documented physical impairments and associated functional deficits, without skilled therapeutic intervention, the resident is at risk for falls and further decline in function. Resident 3's current Care Plan indicated Resident 3 is at risk for decreased functional mobility without PT intervention, falls, increased deconditioning. PT was to evaluate and treat as indicated. During a concurrent observation and interview on 7/2/26 at 1:30 p.m. with Resident 3 in his room, Resident 3 had bilateral Above the knee Amputations (AKA-above-the-knee amputation), with prosthetic legs attached. Resident 3 stated his PT was renewed but he had not received any sessions since the last PT quit on 6/12/26. Resident 3 stated he really needed the PT to practice stairs and for strength training with use of new prosthetics. Resident 3 stated PT was the main reason he came to the facility, his progress had stalled, and he had no idea how long he would be without this needed therapy. A review of Resident 4's admission record indicated Resident 4 was (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	admitted in 5/26 with the diagnoses of Displaced comminuted Fracture of the left patella (kneecap is shattered into three or more pieces that have moved out of proper alignment), difficulty walking, and osteoarthritis (a degenerative joint disease where the protective cartilage that cushions the ends of your bones gradually wears away, causing pain, stiffness, and bone-on-bone friction in joints like the hands, knees, hips, and spine).A review of Resident 4's MDS, dated [DATE], indicated Resident 4 had a BIMS score of 15 with no cognitive impairment.A review of Resident 4's active PT orders dated 6/19/26 indicated Resident 4 should have received PT 5xwk for 4 weeks.A review of Resident 4's most recent PT evaluation, dated 5/21-6/15/26 indicated Resident 4 presented with balance deficits, decreased functional capacity, decreased safety awareness, pain and strength impairments and in consideration of history, personal factors, and functional limitations documented in this eval, patient requires skilled PT services to increase functional activity tolerance, increase independence with gait, increased LE ROM and strength, minimize falls and promote safety awareness, in order to return to prior level of functional abilities and safely return home. Due to the documented physical impairments and associated functional deficits, without skilled therapeutic intervention, the patient is at risk for falls and further decline in function.A review of Resident 4's current Care Plan indicated Resident 4 had impaired balance, limited mobility, limited ROM and PT/OT was to evaluate and treat as ordered. The Care Plan further indicated Resident 4 was at risk for Pressure Injury related to decreased mobility due to the fracture of her left patella.During an interview on 7/3/26 at 1:45 p.m. with Resident 4 in her room, Resident 4 stated she had not received PT for at least a few weeks, possibly one month. Resident 4 further stated her PT stopped suddenly and no facility staff came to discuss this with her. Resident 4 was concerned as she was spending more time in bed due to continued trouble walking. A review of Resident 5's admission record indicated Resident 5 was admitted in 5/26 with diagnoses of Peripheral Neuropathy (damage to the nerves outside your brain and spinal cord, it disrupts the communication network between your brain and the rest of your body, leading to symptoms like numbness, tingling, weakness, or burning pain, most commonly in the hands and feet), muscle weakness, and difficulty walking.A review of Resident 5's most recent MDS, dated [DATE], indicated Resident 5 had a BIMS score of 12 with moderate cognitive impairment.A review of Resident 5's active PT orders dated 6/4/26 indicated he should have received PT 3xwk (3 times a week) for 4 weeks.A review of Resident 5's most recent PT evaluation, dated 6/4/26-6/29/26, indicated Resident 5 required skilled PT services to increase independence with walking, increase LE ROM and strength, minimize falls and promote safety awareness, in order to return to prior level of functional abilities and safely return home. Due to documented physical impairments and associated functional deficits, without skilled therapeutic intervention the patient is at risk for falls and further decline in function.A review of Resident 5's current Care Plan indicated Resident 5 had a self-care deficit related to physical deconditioning. PT/OT was to evaluate and treat as ordered as Resident 5 was at risk for decreased functional mobility, falls, and further deconditioning without PT intervention.During an interview on 7/4/26 at 11:00 a.m. with Resident 5 in his room, Resident 5 stated he had not received his PT for 1.5 weeks and wanted to go home, but there was no current PT to assess him again to see if it was safe. Resident 5 further stated he was depressed and if he was not going to receive his PT he wanted to leave. Resident 5 stated the facility had told him if he left against medical advice he would not be allowed to return and he did not want this to be a consequence in case he ever needed to return.A review of Resident 6's admission record indicated Resident 6 was admitted in 3/26 with the diagnoses of aftercare for left artificial hip joint surgery (left hip replacement), and abnormalities of gait and mobility.A review of Resident 6's MDS dated [DATE], indicated Resident 6 had a BIMS of 15 and was cognitively intact.A review of a facility (continued on next page)		

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