

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

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Form Approved OMB  
No. 0938-0391

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>555844                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                        | (X3) DATE SURVEY<br>COMPLETED<br><br>07/31/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Novato Healthcare Center                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1565 Hill Road<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                 |                                                 |
| F 0609<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | <p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on interview and record review the facility failed to report an allegation of abuse for one resident (Resident 1) when Resident 1's Emergency Contact (EC, a trusted person designated to be notified by the facility of a resident's health status) notified the Social Service Director (SSD) of an allegation of misappropriation of Resident 1's property. This failure decreased the facility's potential to ensure the facility provided monitoring of Resident 1's psychosocial health and oversight of Resident 1's protection from further misappropriation of funds. Findings: A review of Resident 1's face sheet indicated admission to the facility on 3/23/26 with a medical history that included severe major depressive disorder with psychotic symptoms (a serious mental health condition/mental disorder in which a person has depression along with loss of touch with reality) and cognitive communication deficit. A review of Resident 1's Minimum Data Set (MDS, a resident assessment tool used to identify resident care needs) dated 6/24/26, showed a Brief Interview for Mental Status (assessment of cognitive status) score of 13 which indicated Resident 1 was able to make and understand decisions independently. During an interview on 7/31/26 at 12 p.m., the Social Services Director (SSD) acknowledged she was informed by Resident 1's EC that money was taken from Resident 1's bank account. The SSD stated she reported the allegation of misappropriation of property to Adult Protective Services (APS) but was unable to state what date she reported the allegation to them. The SSD stated she was aware the allegation had been reported to the police and Ombudsman (an independent, neutral official who helps solve disputes between a resident and the facility) but did not know if the California Department of Public Health (CDPH) had been notified. A review of Resident 1's progress notes between 7/7/26 and 7/24/26 was conducted on 7/31/26. There was no documented evidence found in Resident 1's progress notes that indicated the SSD reported the allegation to the Director of Nursing (DON), Administrator (ADM), or to CDPH. During an interview on 7/31/26 at 1:29 p.m., the DON stated she and the Assistant Director of Nursing (ADON) found out about the allegation of abuse from Resident 1's EC on 7/7/26. The DON stated she reported the event to the ADM, and the ADM called the police on 7/7/26. During an interview on 7/31/26 at 3:30 p.m., the ADM stated he did not know who notified CDPH of the abuse allegation. The ADM stated the policeman who went to the facility to investigate notified him that Resident 1's allegation of abuse was already an open case. A review of the facility's policy and procedure titled Abuse Prevention and Management revised 5/30/24 indicated, ".Allegations of abuse .or reasonable suspicion of a crime are to be reported to the Administrator or designated representative immediately .The Administrator or designated representative will notify law enforcement, by telephone immediately, or as soon as practically possible, but no longer than (2) hours of an initial report AND send a written SOC341 report to the Ombudsman, Law Enforcement, and CDPH Licensing and Certification within (2) hours.</p> |                                                                                 |                                                 |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER<br>REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|--------------------------------------------------------------------------|-------|-----------|

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| F 0610<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | Respond appropriately to all alleged violations.<br><br>Based on interview and record review, the facility failed to investigate an allegation of misappropriation of resident property for one resident (Resident 1). This failure decreased the facility's potential to conduct a thorough investigation of an allegation of abuse and to protect Resident 1 from further misappropriation of funds. Findings: A review of Resident 1's face sheet indicated admission to the facility on 3/23/26 with a medical history that included severe major depressive disorder with psychotic symptoms (a serious mental health condition/mental disorder in which a person has depression along with loss of touch with reality) and cognitive communication deficit. During an interview on 7/31/26 at 1:29 p.m., the Director of Nursing (DON) confirmed Resident 1's Emergency Contact (EC, a trusted person designated to be notified by the facility of a resident's health status) notified her that money was taken from Resident 1's bank account on 7/7/26. The DON reported the event to the Administrator (ADM) who then called the police. The DON stated that the police came to the facility to investigate the allegation. A copy of the facility's own investigation of the abuse allegation and the investigation summary was requested but were not provided. The DON verified the facility had not conducted their own investigation of the allegation of abuse. During an interview on 7/31/26 at 3:30 p.m., the ADM verified he was the facility's Abuse Coordinator. The ADM stated an investigation of the abuse was conducted by the police. The ADM confirmed an investigation summary was not written nor submitted to the California Department of Public Health (CDPH). A review of the facility's policy and procedure titled, Abuse Prevention and Management, revised on 5/30/24 indicated, .When the Administrator or designated representative receives a report of an allegation of resident abuse, the Administrator or designated representative, will initiate an investigation immediately. The administrator or designated representative conducting the investigation will interview individuals who may have information relevant to the allegation or suspected crime. Witnesses include but are not limited to the resident, witnesses to the incident, family, visitors, etc. While the investigation is being conducted, accused individuals may be denied access to the facility or unsupervised access to the resident. The Administrator will inform the resident of the results of the investigation within five (5) working days of the reported incident. The Administrator will provide a written report of the results of all abuse investigations and appropriate action taken, to the California Department of Public Health Licensing and Certification and others that may be required by state or local laws, within five (5) working days of the reported allegation . Documents regarding allegations will be maintained for not less than 5 years. |                                                                                 |                                                 |