

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

Printed: 07/18/2026
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 11/13/2025
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 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on observation, interview, and record review, the facility failed to ensure dietary staff were trained and had appropriate competencies and skills sets for a census of 162, when: 1. DA 1 was observed not wearing a hair net while working inside the kitchen, 2. DA 2 did not follow the manufacturer's instruction for the use of red bucket test strips, 3. The [NAME] could not verbalize the correct Cool-down Process of Hot food, and; 4. The Dietary supervisor could not provide documentation of last quarter's cool down logs for both the Hot Food cool down process, and Ambient (Shelf stable food that can be safely stored in room temperature) cool down process. These failures reduced the facility's potential to ensure dietary staff were skilled and competent to provide dietary services to the residents. Findings: During a concurrent interview and record review on 9/18/25 at 9:50 a.m. with Registered Dietician (RD) 1, RD 1 confirmed she does not have any records of the competencies and documentations performed by the dietary staff related to: 1. Infection Control - use of hairnets in the kitchen 2. Quaternary ammonia (for kitchen, a cleaning product that kills germs, bacteria, viruses on hard surfaces) 3. Cool Down Process for Hot Food (a process where in the temperature range of hot food 140 F need to go to 41 F within the first 2 hours to prevent bacterial growth) 4. Food temperature logging related to the Cool Down Process for Hot Food and Ambient foods. During a review of the facility's policy and procedure titled, Staff Competency or Skills checks, revised, 8/22/2019, indicated, .Competency evaluation or skills checks will be performed .annually .skills checks will be through written testing and observation .evaluations will be retained in the employee file .		

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review, the facility failed to ensure pureed (cooked food that is blended to the consistency of a cream paste) food was prepared correctly for a census of 162, when temperature of a cold pureed fruit tested at 71.8 F and was warm to taste. This failure had a potential to result in food that does not meet resident nutritional needs. Findings: During an observation on 9/17/25 at 1:55 p.m., two test trays were delivered to the conference room by the Dietary Supervisor (DS) and Registered Dietician (RD) 2 using the food cart. Two test trays consisted of: One Regular meal tray, one pureed meal tray. The temperature was checked by both RD 2 and Nurse Surveyor (NS) side by side. Food temperature test results were as follows: Pureed meal tray: Puree Tacos Casserole 124 F Puree Zucchini - 118.8 F Pureed Tangy Glazed Fruit - 71.8 F The survey team sampled the pureed food and the allegedly cold pureed tangy glazed fruit tasted warm. During an interview on 9/18/25 at 9:50 a.m. with Registered Dietician (RD) 1, RD 1 stated, her expectation for the supposedly cold pureed tangy glazed fruit is to be served cold. She further stated, it needs to be [at] 40 F. During a review of the U.S. Food and Drug Administration Food Code 2022, 3-501.19 titled, Time as Public Health Control, indicated, the food shall have an initial temperature of 41 F or less and may not exceed 70 F. the food shall be monitored to ensure the warmest portion of the food does not exceed 70 F.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, and distribute food in accordance with professional standards for food service safety for a census of 162, when:1. Dietary Aid (DA) 1 was observed not wearing a hair net while inside the kitchen.2. Several various metal sheet pans and metal lids in clean and ready-to-use storage areas: a. Were stacked wet while stored away. b. Had food debris.3. There were bags of food items in the walk-in refrigerator and concerns related to frozen fish patties in the the walk-in freezer. a. The walk-in refrigerator floor was extremely wet b. One bag of carrot strips expired. c. One bag of open corn tortilla was not labeled with an open or use by date. d. One package of opened fish nuggets in a large 2-gallon size zipped bag had freezer burn.4. The oven had black residues at the bottom layer and was dirty.5. DA 2 could not verbalize and perform the proper process of testing for the sanitation (red) bucket. 6. [NAME] was unable to verbalize the correct technique for the cool down process for hot foods.7. Dietary Supervisor (DS) cannot provide any evidence of cooling log temperatures documented for hot and ambient foods. These failures had potential to cause food-borne illnesses in a highly susceptible population who received food from the kitchen.Findings:1. During a concurrent observation and interview with the Dietary Supervisor (DS) on 9/16/25 at 9:20 a.m. at the kitchen's initial tour, Dietary Aid 1 (DA 1) was observed not wearing a hair net. DS confirmed and instructed DA 1 to wear hair net right away. During an interview with Registered Dietician (RD) on 9/18/25 at 9:50 a.m., the RD stated, she was shocked that someone was not wearing a hair net. The RD stated, wearing hair restraints/hair nets is an important part of the kitchen uniform for infection control.During a review of the facility's policy and procedure (P&P) titled, Dietary Department- Infection Control, dated, 2/29/24 indicated, .cover hair, beard and mustache with an effective hair restraint.while in any kitchen and food storage areas.2. During a concurrent observation and interview with DS on 9/16/25 at 9:26 a.m. at the kitchen's initial tour, several metal sheet pans stored at the clean and ready-to-use storage areas were observed stacked wet and had food debris. The metal pans included: 3 of full sheet pans (wet) 1 full sheet of pan (food debris inside) 6 full sheet pans lids/covers (wet) 2 round lids/covers (wet). The DS confirmed the metal sheet pans were wet and had food debris inside. DS stated the dishes, pans and pots needed to be completely air-dried and clean before being stored away. During an interview 9/18/25 at 9:50 a.m. with RD, the RD stated dishes, pans and pots should be dried before being stored away to prevent mold and bacterial growth. During a review of the facility's P&P titled, Pots and Pan Cleaning, revised 6/22/23 indicated, . invert the pots and pans and place them on a drying rack.allow the items to air dry.when items are dry, store them in the proper storage area.3. During a concurrent observation and interview with DS on 9/16/25 at 9:32 a.m. at the kitchen's initial tour, the walk-in refrigerator floor was extremely wet; one bag of carrot strips was expired, one bag of corn tortilla was not labeled with open or use by date. DS confirmed that the refrigerator floor was extremely wet and very slippery; 1 bag of carrots were expired, and 1opened bag of corn tortilla did not have an open or use by date. During a concurrent observation and interview with DS on 9/16/25 at 9:42 a.m., at the kitchen's initial tour, walk- in freezer, one package of opened fish nuggets was not tightly closed and had a freezer burn. DS confirmed the package of fish nuggets was loosely sealed using a large, zipped plastic bag and had ice crystals and freezer burn. DS stated the fish patties need to be fully sealed and free from any freezer burn.During an interview on 9/18/25 at 9:50 a.m. with RD, the RD stated, her expectations were, the walk-in refrigerator, walk - in freezer, and the whole kitchen floor must be always kept clean. RD stated, . the fish nuggets may have been defrosted and then returned to the freezer. RD further stated, the fish patties should have been discarded. During a review of facility's P&P titled, Food Storage and Handling, revised 2/29/24, indicated, .Fresh vegetable storage.label and date all food items. rotate vegetables so that the oldest produce is used first.Foods should be labeled, dated, and in their original containers. if designed for freezing. Foods to (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	be frozen should be stored in airtight containers.4. During a concurrent observation and interview with DS on 9/16/25 at 10 a.m. at the kitchen's initial tour with the DS, the oven was observed to have black residue at the bottom of the oven. DS confirmed that the oven was dirty and needed to be cleaned.During an interview on 9/18/25 at 9:50 a.m. with RD, the RD stated, the oven must be cleaned before and after usage to prevent any food-borne pathogens. During a review of the facility's P&P titled, Oven Convention-Operation and Cleaning, revised 6/22/23, indicated, .Remove spills, spillovers, and burned food deposits from the oven.wash oven interior with a clean damp cloth. During a review of the 2022 US Food and Drug Administration (FDA) Food Code section 4-601.11 the food code indicated, .The Food-contact surfaces of cooking equipment and pans shall be free of encrusted grease deposits and other soil accumulations.5. During a concurrent observation and interview with DA 2 and DS on 9/16/25 at 10:10 a.m., DA 2 was unable to demonstrate the process of checking the concentration range of the red bucket sanitizer. DA 2 performed the test and dipped the strip for less than 5 seconds before reading the result. The DS confirmed that DA 2 was unable to show the process of testing the red bucket sanitizer and the use of the testing strips. DS stated, the test strip must be in the solution 10 seconds before reading the result.During an interview on 9/18/25 at 9:50 am with RD, the RD stated, her expectations were that the dietary aides should be able to perform the test accurately and the red bucket should be checked routinely every shift using the test strips per manufacturer's manual to make sure it is in the correct range.During a review of the facility's policy and procedure titled, Sanitizer Test Instructions, undated, the sanitizer test indicated, .Dip for 10 seconds. Do not shake or swirl. Compare colors immediately.Tape should read between 200-400.6. During a concurrent interview and record review on 9/17/25 at 11 a.m. with Cook, [NAME] was unable to state the correct Cool Down Process for Hot Food. [NAME] stated, .Hot food cool down should go to 90 Fahrenheit (F-temperature measurement) in first 2 hours.During an interview on 9/18/25 at 9:50 a.m. with RD, the RD stated her expectations were for the [NAME] to be aware and familiarize himself with the Cool down process for hot food. The RD further stated, . not knowing the accurate targeted temperatures for cooling procedures for hot food can cause bacterial growth and possible food born illnesses. During a review of facility's P&P titles, Hazardous Foods Cooling Monitor, revised July 2014 indicated, .Hot food should be cooled from 140 F to 70 F within two hours.cooled from 70 F to 41 F or lower within four hours.During a review of the 2022 US FDA Food code section 3-501.14 indicated, .the food provision for cooling provides.with cooling from 135 F to 70 F in 2 hours.The initial 2-hour cool is a critical element of this cooling process.7. During a concurrent interview and record review on 9/17/25 at 2 p.m. with DS, the DS confirmed that they do not have a cool down logbook for hot food and ambient food for the last 3 months. DS further stated, .We don't have that. The facility did not have evidence of cooldown logs to ensure proper cooling technique is performed as per food code.During an interview on 9/18/25 at 9:50 a.m. with RD, the RD stated that the cooling logbook for Hot food and Ambient food has been her concern and is part of her QAPI project. RD confirmed that there was no cooling logbook for hot foods and ambient foods for the last quarter available upon request.During a review of facility's P&P titles, Hazardous Foods Cooling Monitor, revised July 2014 indicated, .record the temperature of food every hour.Record action taken to achieve proper temperature cooling on DS-23-Form A- Cooling Monitor Log.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure five out of 40 sampled residents (Resident 58, Resident 135, Resident 42, Resident 116, Resident 124 and Resident 64) were treated with dignity when: Staff were feeding residents standing up and were not asking permission to wear clothes protector before mealtime during dining observation Resident 64, who needed assistance with feeding was referred to as feeder. Licensed Nurse did not offer Resident 124 privacy during medication pass. These failures resulted in residents feeling rushed and undignified, caused Resident 64 to feel disrespected and had the potential to decrease his self-esteem. Findings: During a review of Resident 58's admission Record (AR), Resident 58 was admitted to the facility 11/20 with admitting diagnosis of unspecified dementia (a group of conditions that cause a decline in cognitive functions, such as memory, thinking, problem-solving, and language.) During a review of Resident 135's AR, Resident 135 was admitted to the facility 10/20 with admitting diagnosis including dementia. During a review of Resident 42's AR, Resident 42 was admitted to the facility 2/25 with admitting diagnosis of osteoarthritis (a common wear and tear that develops when the smooth cartilage cushioning the joints breaks down, causing bones to rub together) of the knee. During a review of Resident 116's AR, Resident 116 was admitted 3/22 with admitting diagnosis including drug induced Parkinsonism (a movement disorder that is caused by taking medication that interferes with dopamine [chemical in the brain that helps you feel good] transmission in the brain.) During an observation on 9/16/25 at 12:20 p.m., at Station 2 Dining area, Certified Nurse Assistant (CNA) 11 was assisting Resident 58 with her lunch meal. CNA 11 was standing while assisting to feed Resident 58. When asked, how she felt while the CNA was standing up when assisting her to feed, Resident 58 replied slowly, Rushed. CNA 11 confirmed he was standing beside Resident 58 during lunch time to initiate her meal. During an observation on 9/17/25 at 12:45 p.m., at Station 2 Dining area, CNA 10 was putting towels around the neck of Resident 42, Resident 58, Resident 116, and Resident 135. CNA 10 did not ask permission if the residents wanted a towel to cover their clothing before putting it on. Resident 135 got upset, he abruptly pulled and removed the towel. Resident 135 threw the towel on the table and stated, I don't need this. During an interview on 9/17/25 at 12:55 p.m. with Resident 116, Resident 116 stated, they should ask me first if I want it [towel] or not. It's ridiculous. During an interview on 9/17/25 at 12:58 p.m. with Resident 42, Resident 42 stated, she did not like the white towel as cloth covering. She further stated, they should use something nicer. During an interview on 9/17/25 at 1:30 p.m. with CNA 10, CNA 10 confirmed that she did not ask permission from the residents before she placed the towel around their necks as a bib. During an interview on 9/19/25 at 10:18 a.m. with the Director of Nursing (DON), DON stated, her (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	expectations were for the staff to sit down and be engaged with the residents while assisting them with their meals. DON further stated that the staff must ask permission or inform the residents first if they want a clothes protector or not. DON stated, The staff must ask permission from the residents before doing anything for them. This is our resident's right to dignity. During a review of an undated facility's Policy and Procedure (P&P), Residents Rights-Quality of Life, indicated, .Residents are offered meals and snacks.Facility staff treats cognitively impaired residents with dignity and sensitivity. 2. A review of the admission Record indicated the facility admitted Resident 64 in 2021 with multiple diagnoses including multiple sclerosis (a disabling disease of the central nervous system causing muscle spasms, pain and mobility problems), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and chronic pain syndrome. Resident 64's medical history indicated that the resident had multiple contractures (permanent shortenings of muscles and/or joints, which limits mobility), including his right hand. A review of Resident 64's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 8/14/25 indicated Resident 64 scored 12 out of 15 on a Brief Interview for Mental Status (BIMS-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident), which indicated he had moderate cognitive impairment. A review of Resident 64's care plan addressing nutritional problem initiated 2/7/22 directed staff to make sure that res [resident] has feeding assistance. During a concurrent observation and interview on 9/16/25, at 1:20 p.m., in Resident 64's room, observed Resident 64's lunch tray on his bedside table, about three feet away from resident's reach. CNA 2 entered the resident's room and explained, Tray is not within reach because he [Resident 64] is a feeder. When CNA 2 was asked what he meant by feeder, CNA 2 explained, [I] Mean he's a feeder, he can't eat by himself. He depends on staff to be helped with feeding. CNA 2 initially did not provide the answer when he was asked if it was appropriate to call the residents a feeder, but after a moment CNA 2 added, Shouldn't call him the feeder. Should have said he needs assistance with feeding. During a concurrent observation and interview with Resident 64 on 9/16/25 at 1:35 p.m., in the resident's room, Resident 64 stated that he was assisted by CNA 2 with his lunch because he could not eat by himself. When Resident 64 was asked how he felt to be called a feeder, Resident 64 replied, Well, I need help with feeding, but I would prefer he called me by my name rather than calling me a feeder. During an interview with DON on 9/18/25, at 12 p.m., the DON stated, Not acceptable to call resident a feeder. All residents must be treated with respect and dignity. The DON stated the expectation was that staff referred to residents who required assistance with feeding in a dignified way. A review of the facility's policy titled, Resident Rights & Quality of Life, dated 3/2017 indicated, Each resident shall be cared for in a manner that promotes and enhances the quality of life, dignity, respect. Facility staff speaks respectfully to residents at all times, including addressing the resident by his or her name. Treats cognitively impaired residents with dignity and sensitivity. 3. During a review of a Resident 124's admission Record, Resident 124 was admitted to the facility in (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	late 2024 with admitting diagnosis of congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling) and dementia (a progressive state of decline in mental abilities). Resident 124's MDS, dated [DATE] indicated, Resident 124 is rarely/never understood During a medication administration observation on 9/18/25 at 10:25 a.m., Licensed Nurse 4 (LN 4) was observed to prepare and administer Resident 124's medication. Resident 124 was sitting in her wheelchair in the common area across the nurses station. Four other residents occupied the same area as they watched television. LN 4 administered and explained all medications out loud to Resident 124 without offering privacy. LN 4 pulled up Resident 124's pants to expose her left knee and applied arthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage) medication while one resident was watching them. During an interview on 9/19/25 at 9:30 a.m. with DON, the DON stated her expectation of the LN was to bring resident back to her room (when giving medications) for privacy and dignity. During a review of facility's policy and procedure titled, Resident Rights-Quality of Life, revised March 2017, indicated Facility staff shall maintain an environment in which confidential clinical information is protected.Facility staff promotes, maintains, and protects privacy, including bodily privacy, when assisting .during treatment procedures.		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on interview and record review, the facility failed to ensure accurate documentation of the residents' wishes regarding their care was maintained for six of 40 sampled residents reviewed for Advance Directives (AD - a written instruction relating to the provision of health care when the individual is incapacitated) when: POLST (Physician's Order for Life-Sustaining Treatment) was not completed for Resident 10, and Advanced Directive were not completed or offered to Residents 13, 15, 18, 110, 122. These failures had the potential for Residents 10, 13, 15, 18, 110, 122 to not have their wishes and treatment preferences honored. Findings: A review of Resident 10's admission Record indicated Resident 10 was admitted to the facility in July 2025 with multiple diagnoses including fracture of left femur (bone of the upper leg), chronic respiratory failure (lungs are unable to exchange oxygen and carbon dioxide effectively), chronic obstructive pulmonary disease (lung disease that blocks air flow making it difficult to breathe) and dementia (impairment of brain functions causing memory loss and impaired judgement). A review of Resident 10's Minimum Data Set (MDS- federally mandated assessment tool), Cognitive Patterns, dated 7/13/25, indicated Resident 10 had a Brief Interview for Mental Status (BIMS- tool to assess cognition) score of 8 out of 15 that indicated Resident 10 had moderate cognitive impairment. A review of Resident 10's Order Summary Report indicated an order dated 7/18/25, DNR [Do Not Resuscitate] . A review of Resident 10's Order Summary Report indicated an order dated 8/5/25, Hospice care via [Name of Hospice Agency] 8/1/2025 . A review of Resident 10's Profile indicated Code Status: (Advance Directives) DNR. During a concurrent interview and record review on 9/17/25 at 12:46 p.m. with the Case Manager (CM), the CM confirmed that Resident 10 does not have a completed POLST in his medical record. The CM stated she will try and locate the POLST for Resident 10. During a subsequent interview on 9/17/25 at 1:16 p.m. with the CM, the CM stated she contacted Resident 10's hospice agency and physician and was unable to locate a POLST. Reviewed with the CM that Resident 10's record indicated his code status was DNR, but the CM acknowledged that the facility did not have the documentation to confirm the code status of DNR. The CM stated it was important for Resident 10 to have a completed POLST in his record, since he was on hospice care. During a subsequent interview on 9/17/25 at 1:47 p.m., with the CM, the CM stated she contacted Resident 10's family who provided the POLST. The CM stated the expectation was the POLST will be in the medical record and the POLST will match the electronic health record. A review of the facility's Policy and Procedure (P&P) titled, Physician Orders for Life-Sustaining Treatment (POLST), dated 6/3/20, indicated .To help ensure that this facility honors residents' treatment wishes concerning resuscitation and life-sustaining treatment . The POLST form is designed to be a portable, authoritative and immediately actionable physician order consistent with the resident wishes and medical condition .A valid POLST is to be honored across treatment settings . (continued on next page)		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a review of Resident 13, Resident 15, Resident 18, resident 110, and resident 122 's medical records on 09/17/25 at 3:29 p.m. for an Advanced Directive (AD, a written statement of a person's wishes regarding medical treatment), the Electronic Health Records (HER) and the paper medical chart were reviewed. There were no documented evidence an Advanced Directive had been completed. During an interview with the Licensed Nurse (LN) 16 on 9/17/25 at 3:35 p.m., confirmed Resident 13, Resident 15, Resident 18, Resident 110, and Resident 122 paper chart records had no completed AD. LN 16 further stated all residents when they are admitted are asked by nursing if they have completed an AD form. If the resident is alert and oriented, or has a Responsible Party (RP) and the Resident has a POLST and a completed Advanced Directive document. LN 16 stated if the resident has a completed AD, a copy of the Advanced Directive document would be requested so that it may be included and become part of the Resident's Clinical Record. If the Resident has no AD, the resident or the RP will be provided the form and also referred to the Social Services Director to assist in completing an Advanced Directive document. During a concurrent interview and record review with the LN 2 on 9/17/25 at 3:40 p.m. LN 2 reviewed the paper charts of Resident 13, Resident 15, Resident 18, Resident 110, and Resident 122 and after reviewing the records she confirmed the residents had no Advanced Directive form completed in the paper medical record chart. During a concurrent interview and record review with the Medical Records Director (MDR) on 9/17/25 at 4 p.m., the MDR stated and confirmed there were no Advanced Directives completed for Resident 13, Resident 15, Resident 18, Resident 110, and Resident 122 from the paper clinical records, nor in the EHR. The MDR stated she had also searched in the overflow medical records section and confirmed there were no Advanced Directives form completed for Resident 13, Resident 15, Resident 18, Resident 110, and Resident 122 in the Overflow records section Interview with the Social Services Designee (SSD), on 9/17//25 at 4:15 p.m., the SSD stated that whenever a resident is admitted , the Licensed Nurses asked the resident or the RP if the resident has an Advanced Directive. If there is an Advanced Directive, then a copy is requested from the resident or RP. The copy of the Advanced Directive becomes part of the resident's medical records. If there is no Advanced Directive the LN will notify the SSD. The SSD meets with the Resident or RP to obtain the Resident's POLST, and an Advanced Directive. If the Resident does not have an AD the Resident or RP will be asked if they would want to complete one. If interested then the SSD stated she would help the resident to complete one. If the Resident does not want to have an Advance Directive then it will be documented that the resident refused to complete an Advanced Directive. During an interview with the Director of Nursing (DON), stated the Licensed Nurses (LNs) upon admitting a resident will ask the resident if alert and oriented or his and her Responsible Part (RP) if the resident has a completed Advanced Directives document. If there are no Advanced Directives the Social Services Department staff will help to complete one. The DON stated if the resident refused to have an AD then it must be documented the resident refused to complete an AD. Review of the facility Policy and Procedure titled, Advance Directive. effective date 7/31/24 indicated, .a. Upon Admission, the Admissions Staff or Designee will provide written information to the resident concerning his or her right to make decisions concerning medical care including the right to accept or refuse medical or surgical and the right to formulate advance directives treatment .c During the Social Service Assessment process, the Director of Social Services or Designee will also (continued on next page)		

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ask the resident if they have a written advance directive .2. Review of the Advance Directive a. The interdisciplinary team will periodically review the Advance Directive, if applicable with the resident or resident representative to ensure that it still reflects the resident's wishes		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than five percent when 22 medication errors were found out of 47 opportunities observed during a medication administration for three of 40 sampled residents (Resident 25, Resident 124, Resident 46) when: 1) Resident 25's prostate (male organ) medication was not given, and the wrong vitamin was administered; 2) Resident 124's medications were crushed, medications were not given, and were not given according to physician orders; and 3) Resident 46's blood pressure medication was not given, scheduled pain medication and morning medication were not given at scheduled time. These failures resulted in medication error rate of 46.81 percent resulting from medications not given in accordance with the prescriber's orders and had the potential to affect the residents' clinical conditions. Findings: 1. During a medication administration observation on 9/18/25 at 8:50 a.m. with Licensed Nurse (LN) 6, LN 6 was preparing 7 medications for Resident 25, including Vitamin b12 1000 mg (mg-a unit of measurement). LN 6 confirmed a total of six pills and one liquid medication was to be administered. LN 6 administered Resident 25's medications without asking his name and not explaining each medication before administration. During a review of Resident 25's Order Summary Report (OSR) indicated, an order for Finasteride (medication that helps reduce the symptoms of an enlarged prostate gland) 5 mg (mg-a unit of measurement). Give 1 tablet by mouth one time a day. The OSR further indicated for an order of Vitamin B Complex one time a day for Supplement. Both Finasteride and Vitamin B complex were schedule to be administered at 9 a.m. as indicated in the Medication Administration Record (MAR). During an interview on 9/18/25 at 10 a.m. with LN 6, LN 6 confirmed that Finasteride was not available in the medication cart and unable to administer to Resident 25. LN 6 further confirmed that the wrong vitamin was administered. During an interview on 9/19/25 at 10 a.m. with Director of Nursing (DON), DON stated, LN 6 should verify resident before administering orders. DON further stated LNs should follow physician orders and if a medication was missed LNs should notify the physician. 2. During a medication administration observation on 9/18/25 at 10:25 a.m. with LN 4, LN 4 was preparing 12 medications for Resident 124. LN 4 confirmed metoprolol (blood pressure) medication was not available to administer. Resident 124 was sitting in her wheelchair in the common area across the nurses station. Resident 124 began coughing when LN 4 administered one medication. LN 4 went back to the medication cart, and crushed all medications all together and mixed it with apple sauce. LN 4 observed pulling up Resident 124's pants to expose her left knee and applied a small amount of arthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage) medication on his glove and on to Resident 25's knee. During a review of Resident 25's Order Summary Report (OSR) indicated, an order Lidocaine External Patch (pain medication) 5% apply to lower back was not given, Metoprolol. 25 mg .Give 0.5 mg tablet one time a day for hypertension (high blood pressure) was not given, Omeprazole Capsule Delayed release (heart burn medication) 40 mg Give 1 capsule by mouth one time a day, Diclofenac (Arthritis medication) External Gel 1% Apply to left knee topically three times a day for L knee arthritic pain 4 gm (gram- unit of measurement), and metoclopramide 10 mg. give 1 tablet by mouth 4 times a day. No documented evidence of an order to crush all medications from the physician for Resident 124. During an interview on 9/23/25 at 4:45 p.m. with Pharmacy Consultant (PC), PC confirmed that omeprazole and metoclopramide should not be crushed. PC stated that there were risks involved where the changes of how the body interacts with the drug would be created where there is a higher acute effect and a reduction of effect duration. PC further stated there should be dosing cards available for nurses knowing the references to the 4.5 inches/4 grams for arthritis medication cream. During an interview on 9/19/25 at 10:00 a.m. with DON, DON stated that LNs should follow physician orders and if medication was missed LNs should notify the physician. 3. During a medication administration observation on 9/18/25 at 10:40 a.m. with LN 4, LN 4 was observed preparing 13 medications for Resident 46. Resident 46 observed moaning with a painful teary-eyed expression on his face while (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	waiting next to the medication cart. Resident 46 stated he was waiting too long for his pain medication and had a pain scale 8/10 (severe pain). LN 4 communicated to Resident 46 that metoprolol (blood pressure medication) was not available to be administered. LN 4 acknowledged and agreed that all the medications were being administered late while the resident was in pain. LN 4 further confirmed that blood pressure medication was not administered. During an interview with Resident 46 on 9/18/25 at 11 a.m., Resident 46 stated that the dose of his pain medication was due at 9 a.m. when he had requested LN 4 to bring his pain medication. Resident 46 further stated it is frustrating to get my medications late. During a review of Resident 46's Order Summary Report indicated an order for hydrocodone-acetaminophen tablet (pain medication); 10-325 mg. 1 tablet .three times a day [scheduled 9 a.m., 1 p.m., 9 p.m.] for pain management . and an order for Metoprolol Succinate .50 mg. give 150 mg. one time a day for HTN (hypertension). During a review of Resident 46's Medication Admin Audit Report, dated 9/19/25, indicated all medications were administered at 10:47 a.m. and metoprolol was not administered. During an interview on 9/19/25 at 10:39 a.m. with DON, the DON acknowledged that Resident 46's pain medication was administered late. DON further stated LN should have called the doctor to notify of missed dose and get new orders. During a review of the facility's policy and procedure (P&P) titled, Medication-Administration, dated 8/19/25, the P&P indicated, Medications shall be administered according to physician orders. Medications must be administered within one hour before or one hour after the scheduled time . whenever a medication is held for any reason, it must be documented. and the prescribing provider will be notified. Licensed nurse will verify the resident's identity before administering the medication using the right resident: Confirm with two identifiers. Right Medication: Verify against the MAR and pharmacy label. Right Route. Confirm oral. Right Time: Administer within ordered time window. If the resident has difficulty swallowing pills, the Licensed Nurse will notify the physician to discuss the possibility of a different form of medication i.e (crushed, liquid or suspension. If the medication is to be crushed, a physician order is required.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure medications were properly stored and labeled, for a census of 162 when:1. Medications were found at nurses station and at resident bedside unattended,2. Expired and discontinued medications were available for resident use,3. Loose pills were found in the drawers and the back of medication cart,4. Discontinued narcotics found in narcotic cart and Licensed Nurses (LN) are not counting during change of shift,5. Sticky residual found on outside of multiple bottles, and;6. Non medication items were found in medication cart. These deficient practices had the potential for residents to receive unsafe or reduced potency medications from being used past their expiration dates, improper storage, and diversion or misuse of medications from not being securely stored.Findings: 1.During a concurrent observation and interview on 9/16/25 at 11:02 a.m. with Licensed Nurse (LN) 9, a medication cup with cream was found on the bedside table in room [ROOM NUMBER]. LN 9 confirmed the finding and stated the medication should not be left at bedside. LN 9 confirmed the resident cannot self-administer medication.During a concurrent observation and interview on 9/16/25 at 11:58 a.m. with LN 9, a wound cleanser bottle was found on the bedside table in room [ROOM NUMBER]. LN 9 confirmed finding and stated that it was used for wound treatment and should be stored in the treatment cart. LN 9 confirmed the resident cannot self-administer medication.During a concurrent observation and interview on 9/17/25 at 3:14 p.m., medications were observed on station 3 nurse's station unattended. All LNs were observed giving report near their medication carts. Director of Nursing (DON) was prompted to question LN 12 why medications were left unattended at the nurse's station. LN 12 acknowledged the unattended medications and confirmed that she was going to give it to the nursing supervisor to be discontinued. During an interview on 9/23/25 at 4:45 p.m. with Pharmacist Consultant (PC), PC stated that discontinued meds should be stored in a separated location.2. During a concurrent inspection of Medication Cart C in Station 1 and interview on 9/18/25 at 3:45 p.m., LN 13 identified and confirmed the following:1) Discontinued and expired vial of Humulin (a rapid-acting insulin, medication for elevated blood sugar levels)2) Unlabeled Paxlovid medication (medication for COVID) 3) 5 Discontinued pain medication cards in narcotic box 4) 2 Discontinued narcotic patches (pain medication) in narcotic box5) Expired Morphine (pain medication) bottle in narcotic boxDuring an interview on 9/18/25, at approximately 4 p.m., with LN 13 , LN 13 agreed the Paxlovid medication should have a pharmacy label affixed to it to ensure it was used for the right resident. LN 13 stated the discontinued medications should have been removed from the medication cart. LN 13 confirmed the finding and stated the orders were done and discontinued. During an interview on 9/19/25 at 9:30 a.m. with DON, the DON stated expired medications were to be removed from the facility's supply and placed in the locked medication destruction cabinet located in the medication storage rooms to be logged and disposed. During an interview on 9/23/25 at 4:45 p.m. with PC, PC stated Narcotics have their own separated storage area monitored by the DON and ADON (Assistant Director of Nursing). They should still be counted until transfer of custody to the DON or ADON.3. During a concurrent inspection of Medication Cart B in Station 1 and interview on 9/18/25 starting at 4:15 p.m., LN 14 identified and confirmed the following: 1) Artificial tears (medication for dry eyes) opened 12/31/24 2) Sticky liquid bottles stored in medication bottles During a concurrent review of the manufacturer's labeling for Refresh Tears and interview on 9/18/25 at 4:35 p.m., the labeling indicated, Discard 90 days after opening. LN 14 confirmed that the eyedrops should have been discarded. LN 14 further stated sticky residual can compromise other medications in the cart and it can get into LN hands. During an interview on 9/23/25 at 4:45 p.m. with PC, PC stated there is an expectation that med carts are kept clean. PC further stated residual on bottles may interfere with cleanliness expectations. 4. (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent inspection of Medication Cart A in Station 3 and interview on 9/18/25 starting at 4:47 p.m., LN 10 identified and confirmed the following:1) Loose pills 2) Discontinued Lidocaine vial (pain medication) 3) Sticky liquid bottles stored in medication bottlesDuring an concurrent inspection of Medication Cart A and interview on 9/19/25 4:55 p.m. with LN 10, loose pills were found throughout Medication Cart A. LN 10 verified there were multiple loose pills in the back of the cart. LN 10 stated the discontinued medications should have been removed from the medication cart. LN 10 confirmed the finding and stated the medication orders have been completed and discontinued.5. During a concurrent inspection of Medication Cart C in Station 4 and interview on 9/19/25 starting at 10 a.m. with LN 8 identified and confirmed the following: 1) discontinued Lidocaine vial2) Loose pills3) Ensure in Med cart4) Glucometer controlled solution no tops and no open dateDuring ongoing inspection of Medication Cart C on 9/19/25 10:15 a.m. with LN 8, loose pills were found throughout medication cart C. LN 8 verified there were multiple loose pills in the back of the cart. LN 8 stated the discontinued medications should have been removed from the medication cart. LN 8 confirmed the finding and stated the orders have been completed and discontinued. During a review of the manufacturer's manual blood glucose solution with LN 8, the labeling indicated, Use the [Brand name] Dose Control Solution within 90 days (3 months) of first opening LN 8 acknowledged and agreed the vials should have been marked with an opened date.During an interview on 9/23/25 at 4:45 p.m. with PC, PC stated there is an expectation that med carts are kept clean. PC further glucometer machine solution should be dated upon opening.During a review of the facility's policy and procedure (P&P) titled, Medication-Self Administration, dated 8/19/25, the P&P indicated, If the interdisciplinary team and attending physician approve.medications will be placed in a secured drawer or cabinet.During a review of the facility pharmacy P&P titled, Medication labels, revised January 2025, the P&P indicated, Medications are labeled in accordance with facility requirements and state and federal laws. Only the dispensing pharmacy can modify or change prescription labels.During a review of the facility pharmacy P&P titled, Medication Storage in the Facility-bedside medication storage, revised January 2025, the P&P indicated, Bedside medication storage is permitted for residents who are able to self-administer medications, upon the written order of the prescriber and when it is deemed appropriate in the judgment of the facility's interdisciplinary resident assessment team .All nurses and aides are required to report to the charge nurse on duty any medications found at the bedside not authorized for bedside storage and to give unauthorized medications to the charge nurse .During a review of the facility pharmacy P&P titled, Medication Storage in the Facility-controlled medication storage, revised January 2025, the P&P indicated, At each shift change, a physical inventory of all controlled medications .is conducted by two licensed nurses and is documented on thecontrolled medication accountability record .During a review of the facility pharmacy P&P titled, Medication Storage in the Facility, revised January 2025, the P&P indicated, Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal .Medication storage areas are kept clean, well-lit, and free of clutter .During a review of the facility pharmacy P&P titled, Disposal of Medications, . revised January 2025, the P&P indicated, When medications are expired, discontinued by a prescriber, a resident is transferred or discharged and does not take medications with him/her, or in the event of a resident's death, the medications are marked as discontinued or stored in a separate location and later destroyed.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure proper infection control practices were implemented for a census of 162, when: Proper hand hygiene was not implemented during dining observation. Resident 150 has a suprapubic catheter (A suprapubic catheter is a medical device that helps drain urine from your bladder. It enters your body through a small incision in your abdomen) was not on Enhanced Barrier Precautions (EBP an infection control measures in nursing homes and similar settings to prevent the spread of multidrug-resistant organisms.) A shared blood pressure cuff was not cleaned and sanitized in between resident use. LN 4 did not properly wear N95 mask during medication pass. Multiple staff entered residents' rooms on isolation precautions without wearing the required face shields. Staff not wearing proper PPE (personal protective equipment), housekeeping staff were not familiar with chemicals used for disinfecting residents' rooms and it's dwelling time, no high-contact surface disinfection, multiple residents in the hallways were not wearing masks for source control, and no active COVID-19 signs and symptoms screening of visitors and staff upon entry. Resident 89's door was not closed, and the trash can for discarding PPE was placed outside the room. Resident 157's CPAP (Continuous positive airway pressure- machine used for treatment for obstructive sleep apnea, to keep airway open when sleeping) mask was laying uncovered on the nightstand. Resident 10's oxygen tubing was not labeled and dated. These failures had the potential to compromise resident's health and safety and potentially lead to the spread of communicable diseases. Findings: During an observation on 9/16/25 at 12:30 p.m. in the Station 2 Dining area, Certified Nursing Assistant (CNA) 11 assisted Resident 58 with her lunch. He assisted her with eating. When the resident started eating independently, CNA 11 left her and preceded to monitor the hallways. CNA 11 did not perform any hand hygiene before and after assisting Resident 58 with her meal. CNA 11 confirmed he did not perform hand hygiene before and after assisting Resident 58. During an observation on 9/16/25 at 12:40 p.m. in the Station 2 Dining area, CNA 10 was wearing gloves and was assisting Resident 42's lunch meal by removing the plate cover, cutting her food using the fork, and assisting lunch her using the spoon and fork. CNA 10 assisted Resident 42 for few minutes and stood up and went to Resident 116. CNA 10 assisted Resident 116 by opening the plate cover of his lunch, she touched his spoon and fork, removing the covers for his drinks and handed the fork to Resident 116. CNA 10 did not remove her gloves and did not perform hand hygiene in between resident care at lunch. CNA 10 confirmed that she did not perform proper hand hygiene techniques and failed to remove her gloves in between resident care. During an observation on 9/17/25 at 12:45 p.m. in Station 2 Dining Area, Activity Director (AD) was helping Resident 116 clean his hands using the individual packed hand sanitizer wipes. AD changed her gloves before assisting Resident 135. AD did not perform hand hygiene before putting in the new pair of gloves. AD confirmed that she did not perform hand hygiene in between glove use and resident care. During an interview on 9/19/25 at 8:40 a.m. with Infection Prevention Nurse (IP Nurse), IP Nurse stated, her expectations were that hand hygiene must be performed before and after each care of each resident. Further stated, hand hygiene must be performed before and after removing gloves. During a review of the Policy and Procedure titled, Hand Hygiene, undated, indicated, . alcohol- based hand hygiene products can and should be used to decontaminate hands: Before moving from one (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident to another .regardless of glove use. 2. Resident 150 was admitted with Diagnoses of Toxic Encephalopathy (a condition where brain function is impaired due to the accumulation of toxins in the brain), quadriplegia (inability to move all extremities). On 9/19/25 at 10 a.m. Resident 150 was observed to be in bed and has a urinary drainage bag in place and affixed to the side of the bed. The entrance into the room had no signs posting of Enhanced Barrier Precaution EBP, an infection control measure, primarily used in nursing homes, to reduce the spread of multidrug-resistant organisms) nor were there any Personal Protective Equipment (PPE) available for Staff to use. During an interview with Certified Nursing Assistant 1 (CNA1) on 9/19/25 at 10:05 a.m., the CNA 1 confirmed that she is taking care of Resident 150. CNA 1 stated Resident 150 has a foley catheter which is connected to a drainage bag. She stated that all residents with a urinary drainage catheter must be on EBP Precautions when providing care to the resident with a catheter. The CNA 1 also confirmed Resident 150 should have been on EBP. The CNA 1 further stated and confirmed there were no EBP signs posted at the resident's doorway, nor were there any PPE available or set up for use. During an interview with the LN 1 on 9/19/25 at 10:15 a.m., the LN 1 stated Resident 150 has a suprapubic catheter which is connected to a urinary drainage bag. The LN 1 stated and confirmed Resident 150 should have been on EBP precautions. LN 1 stated and confirmed there were no EBP signs posted at the doorway into the room nor were there any PPE set up for staff providing care to Resident 150. The LN 1 stated the Infection Preventionist (IP) sets up the EBP signs and the PPE for staff to use. LN 1 stated the EBP was not set up for Resident 150. LN 1 stated she will inform the IP to set-up the EBP. During an interview with the IP on 9/19/25 at 10:30 a.m. The IP was asked to go and see about Resident 150. The IP confirmed Resident 150 had a catheter in place. The IP confirmed Resident 150 should be on EBP. precautions. The IP confirmed there were no EBP signs and PPE was not set up for Resident 150 with a catheter. The IP stated all residents with catheters should be on EBP precaution and she would set it up for Resident 150. During a record review of facility Enhanced Barrier Precautions Revision date of 10/15/24 version 3.0 indicated: .Process .2. For residents for whom EBP are indicated, EBP is employed when performing the following high-contact resident care activities for those at risk for transmission or acquisition of MDRO's [Multiple Drug Resistant Organisms] .g. Device care or use: central line, urinary catheter .5. Post the appropriate Enhanced Barrier Precautions sign on the resident's room door to inform caregivers of the appropriate tasks requiring the use of PPE . 3.During a concurrent observation and interview on 9/20/25 at 9:20 a.m. with Licensed Nurse 4 (LN 4), LN 4 was observed checking Resident 140's blood pressure with a blood pressure cuff that was shared between residents. LN 4 placed the blood pressure cuff on Resident 140's arm and checked the resident's blood pressure. LN 4 exited the room with the blood pressure cuff unit in the hallway. LN 4 proceeded to use the same blood pressure cuff on Resident 124. LN 4 acknowledged he did not sanitize the blood pressure cuff in between residents and stated that the blood pressure cuff should have been sanitized in between resident use. During an interview on 9/19/25 at 2:00 p.m., with Infection Prevention Nurse (IP), IP stated that blood (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	pressure cuffs should be sanitized in between residents. IP further stated there is a risk of spreading infection when medical equipment is not sanitized after use. During a review of the facility's policy and procedure (P&P), titled Cleaning & disinfection of Resident Equipment, revised January 1, 2012, indicated Reusable items are cleaned and disinfected or sterilized between residents. 4. During a concurrent observation and interview on 9/20/25 at 9:20 a.m. with Licensed Nurse 4 (LN 4), LN 4's N 95 mask was observed under his nose and covering only his mouth. LN 4's N95 mask was not properly worn when administering medications to Resident 140, Resident 124, and Resident 46. LN 4 acknowledged that his mask was not properly worn during medication pass and further confirmed the risk and prevention of becoming Covid positive during a facility outbreak. During an interview on 9/19/25 at 2:00 p.m., with Infection Prevention Nurse (IP), IP stated that the N95 should fit over the nose and mouth. During a review of CDC document titled How to Use Your N95 Respirator. dated March 2025, (https://www.cdc.gov/niosh/ppe/php/n95-use/index.html), indicated N95 respirators must form a seal to the face to work properly. This is especially important for people at increased risk for severe disease. 5. During a review of Resident 7 admission Record indicated Resident 7 was admitted [DATE] with multiple diagnoses that included wedge compression fracture (broken bone) and muscle weakness. During an observation on 9/16/25 at 1:30 p.m. outside of Resident 7's room, a sign was posted on the door which indicated, Droplet Precautions.Contact Precautions. Another sign indicated instructions on the use of gowns, mask or respirators, goggles or face shield and gloves for PPE. Right next to Resident 7's room, a plastic bin was observed to contain blue gowns, gloves and masks available for staff to use. During a concurrent observation and interview on 9/16/25 at 1:40 p.m., Licensed Nurse 3 (LN 3) entered Resident 7's room wearing only a blue gown and gloves. LN 3 confirmed that she did not wear a face shield. LN 3 further stated that face shields were provided yesterday but not available for her to use on her current shift. During a review of Resident 7's Order Summary Report (OSR), dated 9/18/25, indicated, Airborne + Droplet precaution and isolation .Covid 19 positive. During a concurrent observation and interview on 9/17/25 at 9:06 a.m. LN 10 entered Resident 126's room wearing a gown, gloves, and mask. LN 11 was also in the same room wearing a gown, gloves and mask. Both LN 10 and LN 11 confirmed that they were not wearing face shields while in the room. On Resident 126's door, there was a sign for contact, droplet and airborne precautions. During a concurrent observation and interview on 9/17/25 at 12:45 p.m. Certified Nursing Assistant (CNA) 8 entered Resident 126's room wearing a gown, gloves, and mask. At 1:01 p.m. CNA 8 confirmed that she was not wearing a face shield and stated she had been told to wear a face shield only when a resident was coughing. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 126's OSR, dated 9/19/25, the OSR indicated Airborne+Droplet precaution and isolation.Covid 19 positive. During a concurrent observation and interview on 9/17/25 at 12:47 p.m. CNA 9 entered Resident 68's room wearing a gown, gloves, and mask. CNA 9 confirmed that she did not wear a face shield while inside the room. On Resident 68's door, there was a sign indicating droplet and contact precautions. During a review of Resident 68's OSR, dated 9/19/25, the OSR indicated Airbrone+droplet precaution and isolation.Covid 19 positive. During a review of the facility's droplet precaution signage indicated .everyone must.make sure their eyes, nose and mouth are fully covered before room entry. During an interview on 9/19/25 at 1:00 p.m. with IP, IP stated that for droplet, contact and airborne precautions, the required PPE included a mask, gown, gloves, and face shield. IP stated the PPE was to be worn before entering the room and used every time staff entered the room. The IP further stated that if staff did not wear the proper PPE, it could result in the spread of infection. During a concurrent interview and record review of the facility's Respiratory Virus Prevention & Control Plan (RVPC), revised 3/31/25, the RVPC indicated, .isolation, transmission-based precaution, and cohorting.SARS-CoV-2 (Covid). Eye Protection: Yes. The Regional Clinical Consultant (RCC) stated the RVPC was what they used as the policy and procedure for respiratory outbreak. 6. During a review of an unlabeled and undated facility document (covid-19 positive residents), indicated, there were 28 residents who became positive with COVID-19 from one resident in one room to 21 rooms with COVID-19 positive residents from 9/13/25 to 9/19/25, a span of six days. During an observation on 9/19/25, at 9:25 a.m., by the front lobby, no screening for signs and symptoms of COVID-19, no temperatures taken to this surveyor, no staff performing disinfection on high-contact surfaces (door knobs, hallway rails, nurse stations, faucet handles, etc.) and some residents in the lobby not wearing masks for source control. During an observation on 9/19/25, at 10:22 a.m., by room [ROOM NUMBER], a contact precaution stop sign was posted on the door, which indicated, .EVERYONE MUST.clean their hands, including before entering and when leaving the room.put on gown before room entry. Housekeeper (HK) 1 was observed entering the room without performing hand hygiene (HH), and without wearing a gown. HK 1 was also observed leaving the room without performing HH. During an interview on 9/19/25, at 10:30 a.m., when asked about the disinfecting chemicals being used, HK 1 stated, (chemical brand name) was used for bathroom only. HK 1 pointed to a red bucket with rags (clothing) on it but stated did not know the chemical on the bucket. HK1 was not familiar with the chemicals' dwell time (drying time/kill time). During an observation on 9/19/25, at 10:35 a.m., by room [ROOM NUMBER] hallway, no staff performing disinfection on high-contact surfaces and some residents in the hallway not wearing masks for source control. During an interview on 9/19/25, at 10:45 a.m., [NAME] President (VP) 1 stated, it was expected staff should wear Personal Protective Equipment (PPE, gown, gloves, mask) before entering the room. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/19/25, at 10:47 a.m., the Housekeeping Supervisor (HKS) acknowledged housekeeping staff should know what chemicals were used and its dwell time. HKS was not familiar with the chemical's dwell time used to disinfect the floor. During an observation on 9/19/25, at 10:53 a.m., by room [ROOM NUMBER] and 403 hallway, no staff performing disinfection on high-contact surfaces and several residents in the hallway not wearing masks for source control. During an observation on 9/19/25, at 11:36 a.m., by hallway 1, no staff performing disinfection on high-contact surfaces and several residents in the hallway not wearing masks for source control. During a review on 9/19/25 of facility records, the following indicated: -No documented screening and contact tracing done for staff and residents. -No documented current PPE competency for staff including licensed nurses, housekeeping staff, and rehabilitation staff. -No documented line-listing (screening/infection report) done for residents on 9/18/25, and 9/19/25. -No documented line-listing done for staff from 9/13/25 to 9/19/25. -No documented surveillance monitoring, no in-services on PPE donning/doffing on multiple precautions, and no in-services on COVID-19 for housekeeping staff. -No documented extensive (at least 2x/week) COVID-19 testing for staff and residents During an interview on 9/19/25, at 11:45 a.m., with the Infection Preventionist (IP), the IP stated one resident who was in a single room became positive on 9/13/25 from a staff. Furthermore, the IP acknowledged no contact tracing was done. The IP also stated surveillance monitoring was done weekly, not every shift every day. The IP stated expectations for all staff to perform proper hand hygiene, follow the PPE requirements on precaution signs posted, and proper donning and doffing of proper PPE. During an interview on 9/19/25, at 12:45 p.m. and 1:30 p.m. respectively, VP1 stated, since the facility had a COVID-19 positive resident on 9/13/25 and the facility was in a COVID-19 outbreak, the expectation was for staff to have competency validation done and line listing done. During a review of a facility policy and procedure titled, Respiratory Protection Program (RRP), revised September 9, 2021, indicated, .The employee is responsible for being aware of the respiratory protection requirements for their work areas. During a review of facility policy and procedure titled, Guidance for Infection Prevention and Control for Residents with Suspected or Confirmed COVID-19, revised September 16, 2020, indicated, Preventing exposure and transmission of SARS-CoV-2 [COVID-19]. is paramount at nursing centers. Provide education and training to staff to minimize their exposure to pathogens. All staff will be screened for signs and symptoms of SARS-CoV-2 [COVID-19] infection prior to starting their shift. Universal masking for HCP [health care personnel] is in place. Verify staff members can correctly don and doff Personal Protective Equipment [PPE]. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of facility policy and procedure titled, NOVATO HEALTHCARE CENTER RESPIRATORY VIRUS PREVENTION & CONTROL PLAN, revised March 31, 2025, indicated, .During outbreaks, uninfected residents will wear masks for source control when outside of their rooms.In the event of an outbreak, active daily symptom screening of staff and visitors to the facility.[including] Taking temperatures to monitor for fever. Documenting signs or symptoms.Documenting close contact to someone with COVID-19.Documenting if they have a positive COVID-19 or Influenza Test.The facility receptionist or designee will.actively monitor those who enter the facility for signs and symptoms of respiratory illness. in the event of an outbreak, active daily monitoring [line listing] of residents will be conducted to identify signs or symptoms of respiratory illness.using a line list.The Infection Preventionist will conduct contact tracing to determine potential exposures.In the setting of an outbreak, it's essential that the facility institutes source control masking broadly.Increase the frequency of environmental cleaning and disinfection with focus on high-contact surfaces. 7. A review of Resident 89's admission Record indicated Resident 89 was admitted to the facility in May 2025 with multiple diagnoses including hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke-blood supply to the brain is interrupted causing brain tissue death), dysphagia (difficulty swallowing food and liquids), dementia (a condition characterized by impairment of memory and judgement), and Parkinsons disease (disorder of the nervous system that affects movement, often including tremors). During an observation on 9/16/25 at 10:20 a.m. of Resident 89's room, observed isolation signs on door indicating Contact Precautions, Droplet Precautions, Sequence for Putting on Personal Protective Equipment (PPE), and How to Safely Remove Personal Protective Equipment (PPE). Observed the door was closed and a covered trash can for PPE was outside of the room in the hallway. A review of the sign for Contact Precautions indicated . Providers and Staff Must Also .Discard gloves before room exit .Discard gown before room exit . A review of the sign for Droplet Precautions indicated . Everyone must .Remove face protection before room exit . A review of the sign for How to Safely Remove Personal Protective Equipment (PPE) indicated .Remove all PPE before exiting the patient room . leaving the patient room .closing the door. During a concurrent observation and interview on 9/16/25 at 11:18 a.m. with Resident 89, observed Resident 89 sitting in wheelchair in her room with the door open. Resident 89 had a surgical disposable mask on and had a moist cough. Resident 89 stated she was in isolation for COVID-19 (contagious viral disease caused by the coronavirus) since yesterday (9/15/25). Resident 89 asked if the door should be closed. During an interview on 9/16/25 at 11:24 a.m. with Medical Doctor (MD) 1, MD 1 stated there is a COVID-19 outbreak in the facility. MD 1 stated they are following county guidelines. When asked regarding isolation precautions including keeping door closed and trash can placement outside of room, MD 1 stated the facility staff are better able to answer those questions. During an interview on 9/16/25 at 11:26 a.m. with the Case Manager (CM) the CM stated the door should be kept closed for a resident on COVID-19 isolation. When asked if trash cans for PPE removal should be kept outside a COVID-19 isolation room, CM stated was not sure and would check the (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	policy. During an interview on 9/16/25 at 11:28 a.m. with the Administrator (ADM), reviewed that Resident 89 is on isolation for COVID-19 and door was open and trash can was outside the room. The ADM stated the door should have been closed. The ADM stated he would check the policy regarding the trash can outside the room. During a subsequent interview on 9/16/25 at 11:34 a.m. with the ADM, the ADM stated he checked the policy and the trash cans should be in the room. During an interview on 9/16/25 at 12:26 p.m. with Certified Nursing Assistant (CNA) 13 , CNA 13 stated the doors for COVID-19 isolation rooms should be shut. During an interview on 9/19/25 at 8:26 a.m. with the Infection Preventionist (IP), the IP stated the door of an isolation room should be closed and trash cans should be inside the room for removal of PPE prior to exiting the room. The IP stated, Do not want to bring germs out of the room. A review of the facility's Policy & Procedure (P&P) titled Guidance for Infection Prevention and Control for Residents with Suspected or Confirmed COVID-19, revised 9/16/20, indicated .Purpose Preventing exposure and transmission of SARS-CoV-2, the virus that causes COVID-19, is paramount at nursing centers, where many Residents are more vulnerable to complications from the novel disease because of chronic health problems and weakened immune systems .The guidelines will be followed to minimize the exposure and transmission of SAR-CoV-2, the virus that causes COVID-19 to other Residents and the healthcare personnel (HCP) caring for them . Room Placement .COVID-19 positive .the Resident should be placed in a single room with the door closed . Healthcare Personnel (HCP) .Provide education and training to staff to minimize their exposure to pathogens while performing care for Residents .Verify staff members can correctly don and doff Personal Protective Equipment .Personal Protective Equipment (PPE) .Gowns .Disposable isolation gowns are worn when entering a Resident room and discarded before leaving the room .Gloves .Gloves should be donned when entering the Resident room and doffed upon leaving the room . 8. A review of Resident 157's admission Record indicated Resident 157 was admitted to the facility June 2025 with multiple diagnoses including Alzheimers disease (a progressive disease that destroys memory and other mental functions), obstructive sleep apnea (intermittent airflow blockage during sleep) and chronic kidney disease (loss of kidney function that filters waste from the body). A review of Resident 157's Minimum Data Set (MDS- federally mandated assessment tool), Cognitive Patterns, dated 7/2/25, indicated Resident 157 had a Brief Interview for Mental Status (BIMS- tool to assess cognition) score of 0 out of 15 that indicated Resident 157 had severe cognitive impairment. A review of Resident 157's orders, indicated an order dated 7/26/25 .CPAP: Min [minimum] Pressure 8/ max [maximum] pressure 15. Clean mask with soap and water daily and PRN [as needed] soiling at bedtime . During an observation on 9/16/25 at 10:20 a.m. of Resident 157, observed Resident 157's CPAP machine and mask on nightstand. The mask was laying uncovered, not in bag on top of the nightstand. During an interview on 9/18/25 at 2:07 p.m. with the Director of Nursing (DON), reviewed that Resident 157's CPAP mask was uncovered on the nightstand. The DON stated the CPAP mask should (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	have been in a bag to keep it clean. During a concurrent observation and interview on 9/18/25 at 3:42 p.m. with LN 14 confirmed that Resident 157's CPAP mask was laying uncovered on nightstand. LN 14 stated the CPAP mask should be in a bag to protect it and keep it clean. During an interview on 9/19/25 at 8:26 a.m. with the Infection Preventionist (IP), reviewed that CPAP mask was observed in a resident's room laying uncovered on a nightstand. The IP stated the CPAP mask should be in a bag to protect from germs and keep it clean. 9. A review of Resident 10's admission Record indicated Resident 10 was admitted to the facility in July 2025 with multiple diagnoses including fracture of left femur (bone of the upper leg), chronic respiratory failure (lungs are unable to exchange oxygen and carbon dioxide effectively), chronic obstructive pulmonary disease (lung disease that blocks air flow making it difficult to breathe) and dementia (impairment of brain functions causing memory loss and impaired judgement). A review of Resident 10's MDS, dated [DATE], indicated Resident 10 had a BIMS score of 8 out of 15 that indicated Resident 10 had moderate cognitive impairment. A review of Resident 10's orders indicated an order dated 7/21/25, .Administer oxygen at 2 L [liters] per minute via nasal cannula to maintain O2 [oxygen] saturation between 88-92% [level of oxygen in the blood] . During an observation on 9/16/25 at 10:20 a.m., of Resident 10's room, observed oxygen concentrator (machine to supply oxygen) with humidifier. Observed oxygen tubing was not labeled with the date changed. During a concurrent observation and interview on 9/17/25 at 9:29 a.m. with Resident 10, observed Resident 10 with oxygen via nasal cannula. Observed oxygen tubing was not labeled with date changed. Resident 10 stated he does not know when the tubing was changed that he does not pay attention. During a concurrent observation and interview on 9/17/25 at 9:35 a.m. with LN 15, LN 15 confirmed that Resident 10's oxygen tubing was not labeled with date changed. LN 15 stated the tubing should be labeled with date changed. LN 15 stated that the tubing should be changed every night shift. During an interview on 9/18/25 at 2:07 p.m. with the Director of Nursing (DON), reviewed that Resident 10's oxygen tubing was not labeled with the date changed The DON stated the oxygen tubing should be labeled with the date changed. A review of the facility's Policy & Procedure (P&P) titled Oxygen Therapy, revised 11/17, indicated .To ensure the safe storage and administration of oxygen in the facility .Oxygen tubing, mask, and cannulas will be changed no more than every seven (7) days and as needed. The supplies will be dated each time they are changed . A review of the facility's P&P titled Infection Control - Policies & Procedures, revised 1/1/12, indicated .To provide infection control policies and procedures required for safe and sanitary environment .Establish guidelines for the availability and accessibility of supplies and equipment necessary for standard precautions .		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, and record review, the facility failed to ensure the needs were accommodated for two of 40 sampled residents (Resident 120 and Resident 140), when Resident 120's bed control remote (a handheld device that is connected by a cable to a bed and allows a person to adjust the position of a bed, elevate the head or feet) was not accessible to the resident and Resident 140's call light (a device used to contact staff for assistance) was not within the resident's reach. These failures resulted for Resident 120 and Resident 140 to experience frustration and anxiety when the residents were not able to reach bed control and a call for assistance. Findings: A review of the admission record indicated the facility admitted Resident 120 in 2017 with multiple diagnoses which included left hemiplegia (paralysis on his left side of the body). Resident 120's medical records indicated that left side was his dominant side. A review of Resident 120's care plan titled, The resident has an ADL [activities of daily living, tasks as bathing, toileting, feeding, a person performs daily to care for himself] self-care performance deficit, dated 1/24/22, indicated, Resident 120 was dependent on staff for bed mobility, turning, transfer, and personal hygiene. During a concurrent observation and interview on 9/16/25 at 10:55 a.m., in Resident 120's room, Resident 120 was lying flat on his back. Resident 120 had slow speech but responded to all questions appropriately. Resident 120 was noted to turn his head from side to side, fumbling with his right hand through his bed and cover sheet on both sides of the bed. Resident 120 stated, I need to raise my head up, I can't see well when I'm flat, and I don't have my remote, can't find it. The bed control remote was observed hanging all the way down under the bed, close to resident's feet on the left side of the bed and the resident was unable to see and reach it. During a concurrent observation and interview on 9/16/25, at 10:58 a.m., a Certified Nursing Assistant (CNA) 7 entered the Resident 120's room. CNA 7 found the bed control and handed to the resident. CNA 7 confirmed bed control was not within the resident's reach. CNA 7 explained that Resident 120 was able to use bed remote control when he needed to elevate or lower his head if the remote was on the right side of the bed. CNA 7 added, He [Resident 120] has paralysis on his left. He can reach over with his right hand if its within reach. CNA 7 stated, to accommodate the resident so he is able to reach the bed control, the control should be clipped to the right side bed rail. During an interview with Director of Nursing (DON) on 9/18/25, commencing at 12 p.m., the DON stated if the resident had the ability to use bed control and it was safe, it should be within his reach. The DON added, If resident has limited mobility, especially paralyzed on one side, the remote control and call light should be within his reach and on the side that is functional. Nurses and CNAs have responsibility to make sure the bed control remote is reachable before they leave the room. A review of the admission record indicated that the facility admitted Resident 140 earlier this year with multiple diagnoses, including stroke, dementia (a progressive state of decline in mental abilities), and muscle weakness. A review of Resident 140's 'Risk for falls' care plan dated 1/30/25, indicated the resident needed a safe environment and the care plan goal indicated, the resident will be free from falls and injuries. The nursing interventions directed staff to anticipate and meet the resident's needs, to be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. During a concurrent observation and interview on 9/16/25 at 12 p.m., Resident 140 was observed sitting on the edge of the bed. Resident 140 was alert and able to carry a small conversation. Resident 140 explained that the resident in next bed was her husband, and she helped the staff to assist with his care. When Resident 140 was asked how she called staff if she needed assistance, the resident replied, I don't call, I go look for them. I don't have the call bell. Resident 140 looked around and could not find the call light. Resident 140's call light was observed on the floor behind the nightstand, about three feet from the resident's bed. During a concurrent observation and interview on 9/16/25, at 12:10 p.m., CNA 5 entered Resident 140's room. CNA 5 found both call lights behind the nightstand, pulled them out and put on each resident's bed. CNA 5 confirmed that both call lights were not within resident's reach and acknowledged that Resident 140 (continued on next page)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	would not be able to use the call light when she needed help or in case of emergency. During an interview with DON on 9/18/25, commencing at 12 p.m., the DON stated the expectation was that call lights should always be accessible to residents. The DON added the call light was important because it allowed residents to call for assistance and communicate their needs. The DON added nurses and CNAs were responsible to make sure the call lights were reachable before they leave the room. A review of the facility's policy titled, Resident Rights - Accommodation of Needs, dated 1/2012 indicated, . the purpose of the policy was to ensure that the facility staff provides an environment and services that meet resident's individual needs. The policy indicated, Residents' individual needs and preferences are accommodated to the extent possible. Facility staff attitude and behavior are directed towards assisting the residents in maintaining independence, dignity and well-being. A review of the facility's policy titled, Communication - Call System, dated 1/2012, indicated, The facility will provide a call system to enable residents to alert the nursing staff from their rooms and toileting/bathing facilities. Call cords will be placed within the resident's reach in the resident's room. When the resident is out of bed, the cord will be clipped to the bedspread in such a way as to be available.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure two of 40 sampled residents (Resident 97 and Resident 172) received necessary care and services to maintain good nutrition, grooming, and personal hygiene when: Resident 97 had long, thick toenails. Resident 172 was not provided assistance with eating and personal care. These failures reduced the facility's potential to provide Activities of Daily Living (ADL) care for Resident 97 and Resident 197, and had the potential to negatively affect their self-esteem, comfort, and personal hygiene. Findings: During a review of Resident 97's admission Record (AR), the AR indicated Resident 97 was admitted on [DATE] with multiple diagnoses which included frontotemporal neurocognitive disorder (group of rare brain disorder leading to changes in personality and behavior, problems with language or difficulty with movement), dementia with psychotic disturbances (a progressive state of decline in mental abilities) and type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During an observation on 9/16/25 at 11:22 a.m. in the Station 2 hallway, Resident 97 was observed walking up and down the hallway with no socks on, and Resident 97's toenails were noted to be long and thick. During a review of Resident 97's Care Plan Report (CPR), the CPR indicated, Resident 97 had an ADL (Activities of Daily Living-routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) self-care performance deficit, with interventions that included: Check nail length and trim and clean on bath day and as necessary, and report any changes to the nurse. During a review of Resident 97's Order Summary Report (OSR), dated 9/18/25, the OSR indicated, Resident 97 had an order for 'Podiatry service as clinically indicated,' with an order date of 9/13/24. During an interview on 9/18/25 at 2:14 p.m. with Social Services Designee (SSD), SSD stated the podiatrist (medical doctor who specializes in diagnosing and treating conditions of the foot) came once a month and that residents were to be seen every 60-90 days, and as needed if they required care earlier than their due date. During a concurrent observation and interview on 9/18/25 at 2:43 p.m. with Director of Nursing (DON), DON described Resident 97's toenails as long, pointy and thick. The DON stated the expectation for residents with long toenails, especially those with DM, was to be referred to and seen by podiatry as soon as possible. The DON further stated that long, thick toenails could potentially result in skin issues of the foot and pain. During an interview on 9/19/25 at 8:24 a.m. with Certified Nursing Assistant (CNA) 4, CNA 4 stated that CNAs were to check nails daily and document on shower days, and report concerns to nurses. CNA 4 added that only the podiatrist cut toenails, and long or thick nails extending beyond the toes were to be reported. During an interview on 9/19/25 at 12:12 p.m. with SSD, SSD stated that there was no evidence in Resident 97's clinical record that he had been seen by the podiatrist. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Grooming Care of the Fingernails and Toenails, dated 10/21/21, the P&P indicated, fingernails are trimmed by CNAs.this includes all toenails except for high-risk residents.high risk Residents and Residents with hypertrophic (abnormally thick), myotic (infected with fungus) and keratotic (build up of keratin-protein that makes up nails.) toenails are referred to a podiatrist. 2. A review of the admission record indicated the facility admitted Resident 172 earlier this year with multiple diagnoses, which included dementia (a progressive state of decline in mental abilities), communication deficit, and dysphagia (difficulty swallowing). A review of Resident 172's Minimum Data Set (MDS-a federally mandated resident assessment tool) dated 8/2/25 indicated the resident was cognitively intact and did not have behaviors of rejection of care. The MDS assessment indicated that Resident 172 was incontinent of bladder and bowel (a condition where there is an involuntary loss of urine and stool). A review of Resident 172's physician notes dated 9/8/25 indicated the resident's condition changed and in August 2025 the resident was noted to have both hands tremors (involuntary, shaking movements) and left facial jaw movements, the resident was not able to feed herself and was provided one-on-one help with meals. The physician documented that facility's staff reported that resident was eating good with one-on-one assistance. The physician note contained the following, Family visited her [Resident 172] in early August [2025] and noted that resident was left in her room not attended. She made a grievance with facility administrator, as a result patient was provided shower. A review of Resident 172's care plan addressing self-care performance deficit dated 5/11/25 indicated Resident 172 was dependent on staff for bed mobility, bathing, toileting, and personal hygiene. The nursing interventions included providing personal hygiene and sponge bath as needed, oral care, clean up assistance after resident ate, and encouraging the resident to use call bell when the resident needed assistance. A review of Resident 172's care plans addressing bladder and bowel incontinence, dated 5/11/25, indicated staff to check the resident every 2 hours and more often as needed, clean peri-area with each incontinence episode, and change briefs and clothing after incontinence episodes. A review of nursing progress notes written by Licensed Nurse (LN 8) dated 8/10/25 indicated the resident was provided breakfast at 8:32 a.m. LN 8 documented the resident was still eating her breakfast one hour later when LN 8 administered resident's medication at 9:39 a.m. LN 8 indicated, Resident family came @ [at] 11:30 and stated that she [Resident 172] was dirty and wet, and her eye was crusted over, her breakfast was still there, her hands were dirty, her room had a foul smell.and was concerned for her well-being. The nursing progress note indicated the Certified Nursing Assistant (CNA) who was assigned to Resident 172 was sent to lunch at 11:10 a.m., and did not return back until 1:07 p.m., (two hours later). LN 8 documented that IDT (Interdisciplinary Team, a group of healthcare disciplines who discuss resident care needs and concerns and usually consists of Director of Nursing, Administrator, Social Services) was notified regarding issues with Resident 172's hygiene and feeding. During a concurrent interview and record review on 9/18/25, at 3:04 p.m., LN 8 stated Resident 172 was able to voice her needs and requests and had no behaviors of rejection of care, except occasional refusals to get out of bed. LN 8 stated Resident 172's functional abilities declined in the summer and (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident required one-on-one assistance with feeding due to risks for aspiration (the entry of foreign material into the windpipe or lungs). LN 8 stated the resident was eating her breakfast unassisted on 8/10/25 when she administered her medications around 9:30 a.m., and was still working on her breakfast at 11:30 a.m., when the resident's daughter came. LN 8 stated that Resident 172's daughter was very upset that the resident was not assisted with feeding, had food all over her, and was soiled. LN 8 agreed that eating food that was sitting in resident's room for several hours was unsafe and could cause food poisoning. During an interview with CNA 6 on 9/19/25, at 11:15 a.m., CNA 6 stated Resident 172 had difficulties with communication but was able to verbalize her needs. CNA 6 stated the resident's condition worsened later in the summer and the resident became more dependent on staff with turning, hygiene and cleaning. CNA 6 stated that Resident 172 was at risk for aspiration and required one-on-one assistance with feeding and to have her head of bed elevated 30 minutes after the feeding. CNA 6 stated that resident's family visited the resident on weekends and voiced her concerns with mother's personal care. CNA 6 explained, One time daughter complained that she found her mother not assisted with feeding. mother was very messy, soaking wet and soiled. During an interview with Regional MDS Director (RMDS) on 9/19/2025 at 11:23 a.m., confirmed that he was in the facility on 8/10/25 and discussed Resident 172's daughter's concerns with her mother's care. RMDS stated he met the resident's daughter in her mother's room, emotional and upset. RMDS stated the daughter was very concerned with her mother's wellbeing, and stated that her mother was not cared for and not cleaned that day. Was soiled and wet. Upset that resident was not supposed to eat by herself and was not assisted with feeding and attempted to eat by herself. During a concurrent interview and record review with DON on 9/18/25, at 12:15 p.m., the DON reviewed Resident 172's nursing progress note dated 8/10/25. The DON stated, We are responsible that residents receive quality care. The DON added the expectation for staff was to provide personal care, clean, and change the resident every two hours or more often as needed, especially for residents that are dependent on staff assistance. A review of the facility's 'Dining Program' policy dated 1/30/25 indicated the purpose of the policy was To ensure that the facility serves meals.provides residents with adequate supervision and/or assistance with meals.Process: Nursing staff will provide assistance as needed to those residents who have difficulty or are unable to feed themselves.Residents will be monitored by nursing staff.to ensure assistance if needed. A review of the facility's policy titled, Incontinence Care, dated 9/2014, indicated, Residents who are incontinent of urine, feces, or both, will be kept clean, dry and comfortable.Incontinence care is provided when the resident is wet or soiled.		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of 40 sampled residents (Resident 14) was offered activities that met their interests and preferences. This failure had the potential to affect the resident's physical, mental, and psychosocial well-being. During a review of Resident 14's admission Record (AR), the AR indicated Resident 14 was admitted on [DATE] with multiple diagnoses which included dementia (a progressive state of decline in mental abilities). During an observation on [DATE] at 11:25 a.m., 1:20 p.m., and 2:45 p.m. respectively, Resident 14 was in her room, sitting up on the bed with no activity. During an observation on [DATE] at 8:55 a.m., 11:22 a.m., and 1:23 p.m. respectively, Resident 14 was in her room, sitting up on the bed with no activity. During a review of Resident 14's Activity Progress Note (APN), dated [DATE], the APN indicated, Resident 14's activity preference included independently reading books, newspapers, and magazines and listening to music in a group setting. During a review of Resident 14's Care Plan Report (CPR), the CPR indicated, .Resident enjoys reading and conversation.engage in conversation daily.provide reading material and inquire about what she is reading. The CPR also indicated, .Resident has impaired cognitive function .provide a program of activities that accommodates the resident's abilities. During a concurrent interview and record review on [DATE] at 10:48 a.m. with Activities Director (AD), Resident 14's Activity Lookback Report (ALR) was reviewed and showed no plan of care (POC) for activities was documented for Resident 14 in the clinical record for the last 16 days. The AD stated the POC was where staff documented activities completed by residents each day and confirmed there was no documented evidence of activities done by Resident 14. During an interview on [DATE] at 9:03 a.m. with Director of Nursing (DON), DON stated that despite the outbreak, activities should still be provided for residents, such as 1:1 room visit. The DON further stated that if activities were not provided, it could result in a decline in the residents' psychosocial wellbeing. During a review of the facility's policy and procedure (P&P) titled, Room Visit Program, revised 11/13, the P&P indicated, .the facility will provide recreational opportunities for residents who are not physically able or choose not to leave their room.residents will be visited in their room on a regularly scheduled basis.activities staff will provide the residents with supplies/equipment for the activities specified in the Activities Care Plan.activity staff will document the activity, level of participation, and response to approaches.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to prevent one of forty sampled residents (Resident 157) from developing a facility acquired pressure injury (injury to the skin and underlying tissue due to prolonged pressure). This failure resulted in Resident 157 developing pressure injuries to right and left heels causing decreased mobility and increased risk for infection. A review of Resident 157's admission Record indicated Resident 157 was admitted to the facility June 2025 with multiple diagnoses including Alzheimer's disease (a progressive disease that destroys memory and other mental functions), obstructive sleep apnea (intermittent airflow blockage during sleep) and chronic kidney disease (loss of kidney function that filters waste from the body). A review of Resident 157's Minimum Data Set (MDS- federally mandated assessment tool), Cognitive Patterns, dated 7/2/25, indicated Resident 157 had a Brief Interview for Mental Status (BIMS- tool to assess cognition) score of 0 out of 15 that indicated Resident 157 had severe cognitive impairment. A review of Resident 157's MDS, Functional Abilities indicated Resident 157 was dependent for bed mobility. Further review of Resident 157's MDS, Skin Conditions, indicated Resident 157 did not have any pressure injuries upon admission but was at risk of developing pressure injuries. A review of Resident 157's Care Plan, initiated 6/27/25, .The resident has potential for pressure ulcer development r/t [related to] disease immobility .Goal .The resident will have intact skin .through review date .09/24/2025 . Interventions .Follow facility policies/protocols for the prevention/treatment of skin breakdown .If the resident refuses treatment, confer with the resident, IDT [Interdisciplinary Team] and family to determine why and try to alternative methods to gain compliance. Document alternative methods . Monitor/document/report PRN [as needed] any changes in skin status .The resident needs to .turn /reposition at least every 2 hours, more often as needed or requested . A review of Resident 157's Order Summary Report indicated an order on 8/17/25 for low air loss mattress (LAL-pressure relief mattress), an order on 8/4/25 to offload (reducing pressure to the affected area to promote healing) to right heel every shift, and an order on 8/9/25 for offloading boots (designed to offload the heels). A review of Resident 157's SBAR [Situation, Background, Assessment, Recommendation] Communication Form, dated 8/2/25, indicated .CNA [Certified Nursing Assistant] notice resident foot had a pressure injury sore on the bottom of right foot 6 cm [centimeters] circular wound stage 3 [wound that extends through all layers of the skin] discoloration of the heel . A review of Resident 157's Wound Assessment and Plan [WAP], dated 8/8/25, indicated .Wound Location: Left Heel Wound Type: Pressure Injury Pressure Injury Stage Upon Completion of Visit: Unstageable [pressure injury where the depth cannot be determined] (Depth Obscured) Healing Status: Initial Wound Onset Date: 08/02/2025 Wound Measurement: 1.5cm [centimeter] Length X 2cm X UTD [Unable to Determine] cm Depth . Resident 157's WAP also indicated .Wound Location: Right heel Wound Type: Pressure Injury Pressure Injury Stage Upon Completion of Visit: Unstageable (Depth Obscured) Healing Status: Healing Wound Onset Date: 08/02/2025 Wound Measurement: 5cm X 6cm X UTD cm Depth . A review of Resident 157's Wound Assessment and Plan, dated 8/8/25, indicated Treatment Order .offloading per facility protocol with heel float by bridge [use pillows or other device under calves to elevate heels off bed] and offloading boots bilaterally[both] .Preventative Wound Recommendations: Air mattress .LAL . During an observation on 9/16/25 at 10:20 a.m. at Resident 157's room, observed Resident 157 lying on his back. Observed offloading boots bilateral feet and low air loss mattress. During an interview on 9/18/25 at 10:29 a.m. with Licensed Nurse (LN) 3, LN 3 stated Resident 157 had unstageable pressure injuries on right and left heels that started 8/2/25. LN 3 stated Resident 157 developed the pressure injuries because there was pressure on his heels when in bed. LN 3 acknowledged that these were facility acquired pressure injuries. LN 3 stated a low air loss mattress and offloading boots were ordered after the pressure injuries occurred. LN 3 stated prior to the development of the pressure injuries, pillows were used to elevate the heels. When asked what could have been done to prevent pressure injuries, LN 3 stated could have used a low air loss mattress (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sooner and could have used offloading boots instead of pillows. During an interview on 9/18/25 at 2:07 p.m. with the Director of Nursing (DON), the DON stated, Resident 157 developed pressure injuries on his heels because he had a tendency to rub his heels on the mattress. The DON stated Resident 157 would also push down on his heels when he was in the wheelchair and would move his heels up and down in the wheelchair. During a concurrent observation and interview on 9/18/25 at 3:42 p.m. with Licensed Nurse (LN) 14, observed with LN 14 Resident 157 in bed lying on his back with offloading boots on both feet. LN 14 stated Certified Nursing Assistant (CNA) had noticed wounds, but skin had been broken down before it was reported. LN 14 stated Resident 157's wounds were caused by CNA's improper care. LN 14 stated Resident 157 needed pillow under his calves to float his heels and needed to be turned every two hours. LN 14 stated CNAs are still not turning him every two hours. LN 14 stated Resident 157's skin breakdown was caused by lack of care by the CNAs not turning him. LN 14 stated Resident 157's turning was not documented in chart. LN 7 stated Resident 157 should have a turning schedule. During an interview on 9/18/25 at 3:37 p.m. with CNA 12, CNA 12 stated she had not worked with Resident 157 before and was not made aware he had wounds to his heels. CNA 12 stated she did receive any report or instruction regarding pressure relief for his heel wounds. During an interview on 9/19/25 at 10:35 a.m. with the Wound Medical Doctor (WMD), the WMD stated Resident 157's wounds were pressure injuries on his right and left heel. The WMD stated the wounds were unstageable with mostly eschar (collection of dead tissue within a wound). The WMD stated Resident 157 was not admitted with pressure injuries and the onset was 8/2/25. The WMD stated the wounds developed due to immobility and could have used pillows under calves to prevent heels from touching the mattress. WMD stated use of low air loss mattress may have helped prevent development of the pressure injuries. A review of the facility Policy and Procedure (P&P) titled Pressure Injury Prevention, revised 6/27/24, indicated .Based on the risk score, develop a plan of care for the resident's risk factors .Implement interventions .Pressure redistributing devices for bed and chair .Repositioning and turning .Heel and elbow protectors .off-loading pressure from heels .Risk Factors to consider when implementing a plan of care .Comorbidities such as diabetes [too much sugar in the blood], end stage renal disease [kidneys lose the ability to filter waste from the body], cancer, vascular disease [condition that affects blood vessels and impacts blood flow], stroke .Cognitive impairment to the degree that it affects communication and active participation in the plan of care .Resident's choice not to follow with the recommended treatment plan. (Note: Attempt to identify reasons for resident's non-adherence when possible and develop alternatives) . Staff will observe for any signs of potential or active pressure injury daily .		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of 40 sampled residents' (Resident 9) weight was not maintained when Registered Dietician's (RD) recommendation for therapeutic diet was not followed. This failure resulted in Resident 9's significant weight loss and had the potential to place the resident at risk for further weight loss. Findings: During a review of Resident 9's admission Record (AR), the AR indicated Resident 9 was admitted on [DATE] with multiple diagnoses which included type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), dementia (a progressive state of decline in mental abilities), gastro-esophageal reflux disease (GERD-digestive condition where stomach acid flows back up causing discomfort). During a review of Resident 9's Nutritional Risk Assessment (NRA), dated 6/2/25, the NRA indicated Resident 9 had lost 9.9% or 20.6 pounds (lbs.-unit of measurement) in three months. Resident 9's NRA indicated, Resident 9 liked supplements and was agreeable to increasing them. The NRA indicated the following dietary recommendations: discontinue (dc) house supplement 4 oz (ounces-unit of measurement) daily and 4 oz twice daily; add NAS (no added sugar) house supplement 4 oz twice daily and record % intake. During a review of Resident 9's Nutrition/Dietary Note (NDN), dated 8/15/25, NDN indicated, Resident 9 had experienced weight loss of 7.7% (14lbs) in 1 month, 12% (22.8lbs) in 3 months, and 19.6% (40.6 lbs.) in 6 months, which were significant. The RD's (Registered Dietician) recommendations included discontinuing the 4 oz house supplement once daily and adding NAS house supplement 4 oz three times daily and record % intake. During a review of Resident 9's Order Summary Report (OSR), printed on 9/19/25, the OSR indicated Resident 9 had an order of 4oz house supplement/milk shake in the afternoon for supplement, record % intake with an order date of 5/22/25. During an interview on 9/19/25 at 9:26 a.m. with RD, RD stated Resident 9 had been losing weight and had lost 11% in the last three months. RD stated that when she reviewed the care plan, she realized that nobody had entered her recommendations into the orders. The RD stated that once she made a recommendation in her dietary note, it did not require approval from the physician to be carried out. RD further stated that if the dietary recommendations were not followed, it could contribute to the residents' weight loss and cause residents to feel unhappy or ignored. During a review of the facility's policy and procedure (P&P) titled, Evaluation of Weight and Nutritional Status, revised 1/30/25, the P&P indicated, .facility will maintain acceptable nutritional status for residents per professional standards by implementing interventions for maintaining or improving nutritional status. any resident weight that varies from previous reporting period by 5% in 30 days, 7.5% in 90 days, 10% in 180 days. is considered insidious weight loss. once weight loss is identified, the IDT will. identify and implement appropriate interventions. update and revise the care plan.		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on observation, interview, and record review, the facility failed to ensure adequate pain management was provided, consistent with professional standards of practice for one of 40 sampled residents (Resident 46), when the pain medication was not administered, administered later than the scheduled time, ongoing pain assessments every shift were not completed accurately, and the resident was not monitored for side-effects of pain medication. These failures resulted in Resident 46 experiencing uncontrolled pain and suffering, affected resident's simple movements causing frustration, and had the potential to increase his feeling of depression. Findings: A review of the admission Record indicated the facility admitted Resident 46 in 2022 with multiple diagnoses, which included left leg below knee amputation (BKA), chronic pain syndrome, and phantom limb syndrome with pain (a condition when the individual experience persistent pain, sensations, or movement in a limb that has been amputated or lost). A review of Resident 46's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 9/11/25 indicated the resident was cognitively intact. The MDS assessment indicated the resident had no disorganized thinking or delusions. A review of Resident 46's clinical record indicated the following physician orders:- Assess for pain every shift and chart intensity of pain using 1-10 numeric pain scale. 0=no pain, 1-4=mild pain, 5-7=moderate pain, 8-9=severe pain, ordered 10/3/22. - Hydrocodone-Acetaminophen (Norco, strong narcotic pain medication), 10-325 mg (milligram, unit of measurement), 1 tablet by mouth three times a day for pain management. Hold medication if respiration rate is less than 12 breath per minute, ordered 8/5/25. During a concurrent observation and interview on 9/16/25, at 10:45 a.m., Resident 46 was observed in bed. Resident 46 stated the facility was not managing his pain adequately and he experienced issues with his pain medications on multiple occasions. Resident 46 stated that he had chronic pain issues related to his left leg amputation and received routine Norco scheduled three times a day. Resident 46 added, Even if its scheduled, I have to wait. Yesterday I did not receive my noon Norco. Waited for an hour, then went and asked [the nurse], and she said she will bring my Norco in 10 minutes. The resident stated that he waited and still did not receive Norco in 10 minutes as promised. Resident 46 stated he was in a lot of pain and had to self-transfer himself to wheelchair, which increased his pain and went looking for his nurse. Resident 46 stated, This time she said, I don't have time. I waited and waited and never received my Norco. Resident 46 stated that when afternoon shift nurse came, he explained what happened and he eventually received his pain medication almost at 5 p.m., instead of 1 p.m. Resident 46 stated he felt upset and frustrated, feel like they don't care about me and my needs when he does not receive his pain medications on time. Resident 46 added, I have chronic pain, always in pain. Pain medication helps, but if I don't receive it on time, my pain gets to 10. It takes long time to get a relief. A review of Resident 46's care plan dated 10/13/22 indicated that the resident was at risk for pain related to his diagnosis of left leg BKA and phantom limb pain. A care plan goal indicated that the resident will not have an interruption in normal activities due to pain and will have a decrease in behaviors of inadequate pain control manifested by irritability and agitation. The interventions to pain management included monitoring and recording any complaint of pain, location, duration, quality, aggravating and relieving factors, administering pain medications as ordered, to anticipate the resident's need for pain relief and respond immediately to any complaint of pain, and monitor/document for side effects of pain medications and effectiveness. During an interview with Certified Nursing Assistant (CNA) 2 on 9/16/25, at 11:20 a.m., CNA 2 stated, Resident 46 was alert and independent with his activities. CNA 2 stated Resident 46 was always complaining of pain, and sometimes would get irritable and started yelling at the staff if he was in pain. During an interview with Licensed Nurse (LN) 7 on 9/16/25, at 12:45 p.m., LN 7 stated, Resident 46 was alert and was able to verbalize when he was in pain and where his pain was. LN 7 stated she assessed the resident for presence of pain once a day during morning medication administration. LN 7 stated Resident 46 had frequent complaints of pain and had (continued on next page)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Norco scheduled three times a day. LN 7 was asked if the pain was controlled with Norco and where the staff documented the effectiveness of pain medication, and no answer was provided. A review of Resident 46's Medication Administration Record (MAR) for 9/15/25 indicated the dose of Norco scheduled to be administered at 1 p.m., was not administered. The space where nurses were required to document resident's respirations, the nurse documented 'X.' During an observation and interview with Resident 46 on 9/18/25, at 10:15 a.m., the resident was in bed. Resident was moving his left leg (stump) up and down in bed and had a painful expression on his face. Resident 46 stated he had severe pain at 8 out of 10 and had not received Norco, scheduled at 9 a.m. Resident 46 added, If I knew that I won't receive Norco by 10 a.m., I'd ask my night shift nurse to give me Norco ordered as needed but I didn't want to take it too close to 9 a.m. dose. The resident stated when the pain was severe, his left leg would start jerking and the pain shoots up through entire body. During an interview and record review with LN 4 on 9/18/25 at 10:30 a.m., LN 4 validated that Resident 46's Norco scheduled at 9 a.m. was not administered. LN 4 stated he did not have chance to assess Resident 46's pain yet. LN 4 stated that the resident's medications scheduled for 9 a.m., should be administered between 8 a.m. and 10 a.m. LN 4 validated that Resident 46 will not receive his Norco as prescribed by physician. A review of the Medication Administration Audit Report for 9/18/25 indicated that Resident 46's Norco scheduled at 9 a.m. was not administered until 10:45 a.m. During a concurrent interview and record review with Director of Nursing (DON) on 9/18/25, commencing at 12 p.m., the DON stated the expectation was that staff follow physician's order. The DON acknowledged that Resident 46's Norco 1 tablet was not administered on 9/15/25 at 1 p.m. The DON explained that there should be a progress note indicating why the Norco was not administered. The DON searched the resident's progress notes and was unable to find any documentation explaining why the Norco was not administered. A review of the 'Medication -Administration' policy dated 1/2012 indicated, Medications and treatments will be administered as prescribed. Medications may be administered one hour before or after the scheduled medication administration time. During a continued interview and record review on 9/18/25, commencing at 12 p.m., the DON stated resident's pain assessment should be done every shift and assessed at its worst so the physician could see if the medication was effective. The DON reviewed Resident 46's shift pain assessment from 9/1/25 through 9/17/25, indicated, the resident's pain was not assessed on 9/15/25 am shift. The DON stated, Resident 46's highest pain level was not assessed and not documented. The DON reviewed nursing progress notes and was unable to find the documentation if Resident 46's pain medications were effective. The DON added, Expectation is that nurses document that resident's pain is controlled with Norco, but nothing documented. The DON stated, the resident should be monitored for adverse effects of Norco. The DON searched Resident 46's clinical records and acknowledged that there was no documented evidence the facility monitored Resident 46 for adverse effects of Norco. During an interview with DON on 9/19/25, at 12:30 p.m., the DON stated, the facility's process of pain management included assessing resident's pain on admission and quarterly in addition to pain assessment every shift. The DON acknowledged Resident 46's clinical records indicated, pain assessments were not conducted quarterly and not addressed during resident's care conference on 8/12/25. Discussed with the DON regarding Resident 46's medications, including pain medication administered one hour and 45 minutes later than scheduled time. The DON stated, Expectation is to follow physician order and the facility's policies. If it's scheduled at 9 a.m., we have one hour window, can administer from 8 to 10 a.m. Having resident sitting and waiting for his pain medication is not acceptable. A review of facility's policy titled, Medication -Administration, dated 1/2012 indicated, Medications and treatments will be administered as prescribed. Medications may be administered one hour before or after the scheduled medication administration time. A review of the facility's policy titled, Pain Management, dated 5/2023 indicated, A pain assessment will be completed for each resident upon admission, quarterly, when there is a new onset of pain, exacerbation of pain. The interdisciplinary team will review the pain assessment and develop a resident centered care plan for pain management. The goal for pain (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Novato Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1565 Hill Road Novato, CA 94947	
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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	management will be resident centered and determined by the residents acceptable level of pain. The licensed nurse will administer pain medications as ordered. the licensed nurse will reevaluate the residence level of pain within one hour. and document. each shift. Residents receiving medications for pain management will be monitored for side effects.		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on observation, interview, and record review, the facility failed to ensure Licensed Nurse (LN) 17 had the specific skill sets and competencies necessary to care for residents' needs when LN 17 did not have a competency evaluation done before providing care to residents. This failure resulted in Resident 37 and Resident 46 receiving their medications late, which caused pain and discomfort. During a review of Resident 37's admission record, the admission record indicated, Resident 37 was admitted to the facility July 2023 with multiple diagnoses which included Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements). During a review of Resident 37's active orders dated 8/15/25, the orders indicated .Carbidopa -Levodopa (Combination medication used to treat the symptoms of Parkinson's disease. It helps manage motor symptoms such as stiffness, tremors, and difficulty with movement) .Give 2 tablet by mouth every 4 hours for Parkinson's Disease. During a concurrent observation and interview on 9/16/25 at 1:15 p.m. in Resident 37's room, Resident 37 stated she received her morning dose of Carbidopa-Levodopa 1 1/2 hours late. Resident 37 further stated she received her medications late whenever registry (staff who are licensed and provided by a staffing agency to work in healthcare facilities temporarily or on a day-to-day basis) nurses were working. Resident 37 further stated her Parkinson's medications need to be given on time because her speech and movement were affected when she received her medications late. Occupational Therapist (OT) 1 confirmed Resident 37 occasionally received her Parkinson's disease medications late when registry nurses were working. OT 1 acknowledged Resident 37's speech and movement were affected and caused discomfort when Resident 37 received her medications late. During an interview on 9/16/25 at 1:29 pm with LN 17, LN 17 confirmed she was a registry staff. LN 17 acknowledged she administered Resident 37's morning dose of Carbidopa-Levodopa 1 1/2 hours late. During a review of Resident 37's Medication Administration Record (MAR), dated 9/16/25, the MAR indicated, LN 17 administered Resident 37's 8:00 a.m. dose of Carbidopa-Levodopa at 9:32 a.m. During a review of Resident 46's admission record, the admission record indicated, Resident 46 was admitted to the facility March 2011 with multiple diagnoses which included Chronic Pain. During a review of Resident 46's active orders dated 8/5/25, the orders indicated .hydrocodone-acetaminophen (combination pain medication used to treat moderate to severe pain) Give 1 tablet by mouth three times a day for Pain Management. During an interview on 9/16/25 at 10:45 a.m. with Resident 46, Resident 46 stated he received his medications chronically late when registry staff were working. Resident 46 further stated he did not receive his noon dose of hydrocodone-acetaminophen on 9/15/25. Resident 46 further stated he had severe pain when he did not receive his medication. During a review of Resident 46's Medication Administration Record (MAR), dated 9/15/25, the MAR indicated, LN 17 administered Resident 46's 1:00 p.m. dose of Hydrocodone-Acetaminophen at 4:07 p.m. During an interview on 9/18/2025 at 9:10 AM with Director of Staff Development (DSD), DSD stated registry staff should be checked off on skills and competencies before providing care to residents. DSD further stated she was unable to locate a competency checklist for LN 17 proving that LN 17 had the skills and competencies to provide resident care. During an interview 09/18/25 at 11:03 a.m. with Director of Nursing (DON), DON stated the expectation is for registry nurses to be signed off on competencies before providing resident care. DON further stated there was a risk for medication errors and resident complaints when registry nurses skills and competencies were not validated before providing resident care. During a review the facility's policy and procedure (P&P), titled Staff Competency Validation, dated 6/4/24, the P&P indicated, .Competency validation is completed to evaluate an individual's performance. meet standards set by regulatory agencies. Competency validation is a determination based on an individual's satisfactory performance of each specific element of his/her job description, and of the specific requirements for the area in which he or she is employed. During a review of a facility (continued on next page)		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	document, titled License Nurse Registry Education and Acknowledgement, updated 7/29/25, the facility document indicated, .the orientation packet is reviewed by the staff prior to the start of shift.job expectations.administer medications in a timely manner as prescribed by the Healthcare provider.During a review of the facility P&P titled Medication-Administration, dated 8/19/25, the P&P indicated, .medications must be administered within one hour before or one hour after the scheduled time.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure two of 40 sampled residents (Resident 64 and Resident 3) were free from unnecessary psychotropic medications (medications intended to control behavioral symptoms, including mind, emotions, and behavior) use, when: Resident 64 was prescribed Fluoxetine (an antidepressant medication) without specific manifested behavior of depression, and without monitoring for adverse effects (unwanted, uncomfortable, or dangerous effects). In addition, the facility failed to obtain an informed consent (voluntary agreement to accept treatment after receiving education regarding the risks and benefits, and alternatives ordered) before starting the antidepressant medication. Resident 3's diagnoses did not include depression for the anti-depression medication, and medication change ordered by the behavioral health provider was not implemented. Additionally, the reason for denial of the order was not documented in the medical record. These failures placed Resident 64 and Resident 3 at risk for experiencing adverse effects related to the use of psychotropic medications including, but not limited to increased sedation, headache, and dizziness, which may impair resident's abilities to function at their highest level of physical, mental, and psychosocial well-being. Findings: A review of the admission Record indicated the facility admitted Resident 64 in 2021 with multiple diagnoses including multiple sclerosis (a disabling disease of the central nervous system causing muscle spasms, pain and mobility problems), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and chronic pain syndrome. A review of Resident 64's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 8/14/25 indicated Resident 64 scored 12 out of 15 on a Brief Interview for Mental Status (BIMS, an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident), which indicated he had moderate cognitive impairment. A review of Resident 64's clinical record contained a physician order dated 9/3/25 to administer fluoxetine HCL 20 mg, 1 capsule by mouth one time a day for depression for 7 days and then increase the dose to 2 capsules (40 mg) by mouth one time a day for depression. A review of the Medication Administration Record (MARs) indicated that Resident 64 continuously received Fluoxetine 20 mg every day from 9/4/25 through 9/10/25 and fluoxetine 40 mg from 9/11/25 to 9/18/25. A review of Resident 64's clinical records indicated, had no documented evidence that the resident was monitored for manifested behaviors of depression and for adverse effects of fluoxetine. A review of Resident 64's clinical record contained an unsigned and undated document titled Resident informed Consent to Physical Restraint, Psychotropic Drug or Medical Device. The document indicated that fluoxetine was ordered for depression m/b [manifested by], but did not contain any specific manifested behaviors of depression. The document did not indicate that the physician reviewed and discussed with the resident or responsible party (a legally authorized person designated to make medical decisions on resident's behalf) the reason for treatment with antidepressant, side effects and risks of proposed treatment, and did not obtain the informed consent. During a concurrent observation and interview with Resident 64 on 9/19/25, at 11:35 a.m., Resident 64 was in bed calm and pleasant. When Resident 64 was asked about antidepressant medications he (continued on next page)		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was taking, the resident stated, They say that I have depression. I don't know if I have it or not. Multiple sclerosis is really bad disease that robbed me of many things I was hoping to do when I retire and here, I am bedridden, unable to care for myself. You have to learn to live with this disease. Resident 64 stated he was taking antidepressant medications because they helped him to sleep. During a concurrent interview and record review on 9/18/25, at 12:13 p.m., the Director of Nursing (DON) acknowledged that the informed consent for Resident 64's fluoxetine was not obtained. The DON stated that the physician or nurse practitioner were always responsible to notify resident or RP regarding the new order for all antipsychotics and were responsible for discussing risks and adverse effects. The DON stated that the order for fluoxetine did not indicate what the exact behavior manifestation of depression was and added that the order should have been clarified with physician, but it was not done. The DON confirmed that Resident 64 was not monitored for adverse effects of fluoxetine. A review of the facility's policy titled, Behavior/Psychoactive Medication Management, dated 4/2025, indicated that psychotropic medications were also referred as psychoactive medications, and included antidepressants used to treat depression. The policy further indicated, Any order for psychoactive medications must include a specific behavior manifestation. The residents will be observed and/or monitored for side-effects, and adverse consequences. Facility must obtain a resident's written informed consent for treatment using psychoactive drugs . 2. During a review of Resident 3's admission Record (AR), the AR indicated Resident 3 was admitted on [DATE] with multiple diagnoses which included schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior) and Alzheimer's disease (a disease characterized by a progressive decline in mental abilities.) Resident 3's AR did not indicate a diagnosis of depression. During a review of Resident 3's Order Summary Report OSR, the OSR indicated an active (current) order of .citalopram hydrobromide tablet 40mg, give 1 tablet by mouth once a day for depression m/b (manifested by) increased irritability. ordered 6/3/25. During a review of Resident 3's Behavioral Health Note (BHN), dated 9/1/25, the BHN indicated, .Plan for Medication: decrease [brand name for citalopram] 40 mg (milligram-unit of measurement) qd (everyday) to [brand name for citalopram] 20mg daily. No documented evidence the medication dosage change ordered was implemented. During an interview on 9/19/25 at 9:03 a.m. with Director of Nursing (DON), DON stated that for [name of behavioral health provider] medication changes, the attending physician needed to be informed, and if the physician refused, the reason had to be documented in the clinical record. There was no documented evidence in Resident 3's chart that the physician was notified of the change or that the reason for denying the medication change was documented. During a review of the facility's policy and procedure (P&P) titled, Behavior/Psychoactive Management, dated 5/22/25, the P&P indicated, .the behavior management/psychoactive review committee will review the following and make recommendations based on the resident's need.continued use of psychoactive medication.this information may be documented in the resident's medical record using the behavior management/psychoactive review.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observation, interview, and record review, the facility failed to ensure 1 resident in a census of 162 (Resident 46) was free from significant medication error when: 1) Licensed Nurse (LN) administered resident's pain medication late and not in accordance with the physician's orders and;2) LN did not administer blood pressure medication. These failures decreased the facility's potential to ensure residents are able to attain or maintain their highest practicable physical, mental, and psychosocial well-being. Findings: During a review of Resident 46's admission Record, Resident 46 was admitted to the facility in March 2011 with diagnoses which included acquired absence of left leg below knee, hypertension (HTN-high blood pressure), and chronic pain syndrome. Resident 46's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 9/11/25, indicated, Resident 124 had intact cognition. During an observation of medication administration on 9/18/25 at 10:40 a.m., Licensed Nurse 4 (LN 4) was observed to administer Resident 46's oral pain medication, hydrocodone/acetaminophen 10-325 mg (Milligrams, unit of measure for weight) while Resident 46 observed moaning with a painful teary eyed expression on his face while waiting next to the medication cart. Resident 46 stated he was waiting too long for his pain medication and had a pain scale 8/10 (severe pain). LN 4 communicated to Resident 46 that metoprolol (blood pressure medication) was not available to be administered. LN 4 acknowledged and agreed that the medication was being administered late while the resident was in pain. LN further confirmed that blood pressure medication was not administered. During an interview with Resident 46 on 9/18/25 at 11:00 a.m., Resident 46 stated that the dose of his pain medication was due at 9 a.m. when he had requested LN 4 to bring his pain medication. Resident 46 further stated it is frustrating to get my medications late. During a review of Resident 46's reconciliation of the observation of medication administration with Resident 46's Order Summary Report indicated an order for hydrocodone-acetaminophen tablet (pain medication); 10-325 mg .1 tablet .three times a day [scheduled 9 a.m., 1 p.m., 9 p.m.] for pain management . and an order for Metoprolol Succinate (blood pressure medication) .50 mg.give 150 mg.one time a day for HTN(hypertension). During a review of Resident 46's Medication Admin Audit Report, dated 9/19/25, indicated hydrocodone was given at 10:47 a.m., and metoprolol was not administered. During an interview on 9/19/25 at 10:39 a.m. with Director of Nursing (DON), the DON acknowledged that Resident 46's pain medication was administered late. DON further stated LN should have called the doctor to notify of missed dose and get new orders. During a review of the facility's policy and procedure (P&P) titled, Medication-Administration, dated 8/19/25, the P&P indicated, Medications shall be administered according to physician orders .Medications must be administered within one hour before or one hour after the scheduled time .whenever a medication is held for any reason, it must be documented.and the prescribing provider will be notified.		

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observation, interview, and record review, the facility failed to keep a bed control remote (a handheld device that is connected by a cable to a bed and allows a person to adjust the position of a bed, elevate the head or feet) in a safe operating condition for one of 40 sampled residents (Resident 140), when the insulation (a protective barrier) around the electrical cord was broken exposing wires. This failure had the potential to result in serious risks to Resident 140's safety. Findings: A review of the admission record indicated that facility admitted Resident 140 earlier this year with multiple diagnoses, including stroke, dementia (a progressive state of decline in mental abilities), and muscle weakness. During an observation on 9/16/25 at 12 p.m., Resident 140 was observed sitting on the edge of the bed. Resident 140 was alert and able to carry a small conversation. During further observation, Resident 140 grabbed the bed control remote from the floor and pointed to it. The part of the cord closer to the remote was observed to be ripped with wires exposed. Observed tape wrapped around the exposed wires, but the tape was not holding. Resident 140 stated, It's gone, been broken for long time. I'm scared to use it. During a concurrent observation and interview on 9/16/25, at 12:10 p.m., a Certified Nursing Assistant (CNA) 5 entered Resident 140's room. CNA 5 bent down, picked up the remote control from the floor, and attempted to place it on resident's bed. Resident 140 stated, It's not good, not safe, look at those wires. CNA 5 did not provide any answer when asked if it was safe for use before leaving the room. During a concurrent observation and interview on 9/16/25, at 12:18 p.m., Licensed Nurse (LN) 7 acknowledged the remote's insulation was broken and wires were exposed. LN 7 stated the remote was not safe to use and should be replaced. During a concurrent observation and interview with [NAME] President (VP) 1 on 9/16/25, at 12:25 p.m., the VP 1 observed the remote control with exposed wires and stated, Not safe for resident's use. VP 1 validated that exposed wires created risks for resident's injury and had the potential to cause fire. A review of the facility's policy titled, Maintenance Service, dated 1/2012 indicated the purpose of the policy was To protect the health and safety of residents, visitors, and Facility Staff. The policy indicated, The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times.		

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation, interview, and record review, the facility failed to ensure call lights were accessible for two of forty sampled residents (Resident 138, Resident 10) when: 1. Resident 138's call light was shut in the nightstand drawer, and 2. Resident 10's call light was on the floor behind the nightstand. These failures had the potential for Resident 138 and Resident 10 to have unmet care needs leading to increased risk for falls and injuries. Findings: 1. A review of Resident 138's admission Record, indicated Resident 138 was admitted to the facility May 2025 with multiple diagnoses including fracture of left wrist, fracture of right hand metacarpal (bones of the hand that connect wrist to the fingers), diabetes (too much sugar in the blood), cognitive impairment (memory and thinking problems), and generalized muscle weakness. A review of Resident 138's Minimum Data Set (MDS- federally mandated assessment tool), Cognitive Patterns, dated 8/12/25, indicated Resident 138 had a Brief Interview for Mental Status (BIMS- tool to assess cognition) score of 8 out of 15 that indicated Resident 138 had moderate cognitive impairment. A review of Resident 138's Care Plan, .The resident is at high risk for falls r/t [related to] Confusion, Deconditioning, Psychoactive drug use ., initiated on 5/25/25, indicated .Interventions .Be sure The resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance .During a concurrent observation and interview on 9/16/25 at 10:20 a.m. while conducting initial tour, observed Resident 138 lying in bed with call light in closed drawer of nightstand. When asked if able to reach call light, Resident 138 looked around for it but was not able to reach it. During a concurrent observation and interview on 9/16/25 at 10:26 a.m. with CNA 13, CNA 13 confirmed that Resident 138's call light was in the nightstand drawer and not accessible to the resident. The CNA 13 stated the call lights should be in the bed with the resident. 2. A review of Resident 10's admission Record indicated Resident 10 was admitted to the facility in July 2025 with multiple diagnoses including fracture of left femur (bone of the upper leg), chronic respiratory failure (lungs are unable to exchange oxygen and carbon dioxide effectively), chronic obstructive pulmonary disease (lung disease that blocks air flow making it difficult to breathe) and dementia (impairment of brain functions causing memory loss and impaired judgement). A review of Resident 10's MDS Cognitive Patterns, dated 7/13/2025, indicated Resident 10 had a BIMS score of 8 out of 15 that indicated Resident 10 had moderate cognitive impairment. A review of Resident 10's Care Plan, .The resident is High risk for falls r/t Deconditioning, Incontinence, Psychoactive drug use . initiated on 7/8/25, indicated .Interventions .Be sure The resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance . During a concurrent observation and interview on 9/17/25 at 9:29 a.m. with Resident 10, observed Resident 10 in bed and his call light laying on the ground behind the nightstand next to the bed. Resident 10 when asked if he had a call light, Resident 10 stated that he could not find it. During a concurrent observation and interview on 9/17/25 at 9:35 a.m. with Licensed Nurse (LN) 15, LN 15 confirmed Resident 10's call light was on the floor, behind the nightstand, and inaccessible to Resident 10. LN 15 stated call light should be clipped to the bed. LN 15 stated Resident 10's call light was missing the clip, to be able to clip it to the bed. LN 15 stated the expectation is that the resident is able to access his call light. A review of the facility's Policy and Procedure (P&P) titled Communication-Call System, revised 1/1/12, indicated .Purpose To provide a mechanism for residents to promptly communicate with Nursing Staff .The facility will provide a call system to enable residents to alert the nursing staff from their rooms and toilet/bathing facilities .Call cords will be placed within the resident's reach in the resident's room .		