STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056153	A. Building B. Wing	09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Napa Post Acute	705 Trancas St. Napa, CA 94558

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 0692 Level of Harm - Actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31424 Based on interview and record review, the facility failed to ensure 1 of 3 sampled resident's (Resident 1) maintained adequate hydration (fluid status in the body) and nutrition (food intake) during his approximate 3. 5 week stay at the facility. Resident 1 was transferred to the facility from Hospital 1 (approximately 90 miles North of the facility) after having his right toe amputated (removed) and his plan of care included post-surgical (after surgery) rehabilitation at the facility, with an ultimate goal of returning home to his wife. Upon admission to the facility, Resident 1 required the assistance of staff for eating and drinking and nursing staff documented he was at risk for dehydration and malnutrition. Although Resident 1 was a Full Code (directs a patient's medical care regarding life-sustaining interventions; full support): 1) Nursing staff and the Registered Dietitian (RD) did not notify Resident 1's physician (Physician F), Nurse Practitioner (NP G), or family when he had a 30.8 (31) pound weight loss 18 days after admission; 2) Nursing staff and the RD did not identify Resident 1's consuming too little fluid, dating back to his admission; 3) Resident 1's severe weight loss was not presented and discussed during the Weight Committee (also known as the Nutritionally at Risk [NAR] Committee; RD and nursing staff monitor/intervene in patient care as it relates to weight loss and weight gain) nor during an IDT meeting (interdisciplinary team of healthcare professionals including nursing, social workers, pharmacy, and dietary staff); 4) Nursing staff did not implement a Change of Condition (COC; clinically important deviation from a patient's baseline in physical, cognitive, behavioral, or functional domains) in response to Resident 1's severe weight loss and failed to document it in his medical record; and, 5) Certified nursing assistants (CNA's) did not consistently and accurately document Resident 1's oral fluid intake in his medical record. These failures: 1) Caused Resident 1 to lose approximately 30.8 pounds during his first 18 days at the facility; (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056153	A. Building B. Wing	09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Napa Post Acute	705 Trancas St. Napa, CA 94558

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 0692 Level of Harm - Actual harm Residents Affected - Some	2) Contributed to Resident 1 ' s approximate 44-pound weight loss (an approximate 27% weight loss) between hospital discharge (on 5/24/23) and hospital ED re-admission (6/18/23), Resident 1 ' s approximate 3.5 week stay at the facility; 3) Caused Resident 1 to become severely dehydrated and severely malnourished, 4) Prevented Physician F and NP G from being aware of Resident 1's decline and therefore, prevented them from evaluating and treating his severe weight loss; 5) Caused Resident 1's family, after observing his condition during a visit, to remove him from the facility AMA (Against Medical Advice) and drive him to Hospital 1; 6) Caused Resident 1 to be admitted into Hospital 1's Intensive Care Unit (hospital department in which dangerously ill patients are under constant observation); 7) Prevented Resident 1's family from being aware of his decline, thereby denying them the opportunity to support and comfort him; 8) Contributed to an exacerbation (make worse) of Resident 1's kidney injury; 9) Contributed to a urinary tract infection and aphasia (loss of ability to understand or express speech); and, 10) Potentially contributed to Resident 1 being placed on Hospice care (End of Life Care). Online review of the Mayo Clinic website revealed dehydration occurs when a person uses or loses more fluid than they take in; the body doesn't have enough water and other fluids to carry out its normal functions; if lost fluids are not replaced, dehydration occurs. One common cause is vomiting and older adults and people with chronic illnesses are most at risk. Severe dehydration requires immediate medical treatment. One complication of dehydration is kidney failure, a potentially life-threatening problem. (https://newsnetwork.mayoclinic.org/discussion/dehydration-can-lead-to-serious-complications/). Findings: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056153	A. Building B. Wing	09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Napa Post Acute	705 Trancas St. Napa, CA 94558

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 0692 Level of Harm - Actual harm Residents Affected - Some	Review of Resident 1's medical records from Hospital 1 (first admission, prior to his stay at the facility) indicated he was admitted on [DATE] and discharged to the facility on [DATE] (six-day hospital stay). The physician Discharge Summary (physician documentation summarizing the hospital stay), dated 5/24/23, indicated, Hospital Course . male with history of . DM2 (diabetes type 2; chronic disease characterized by elevated levels of blood glucose [blood sugar]), CVA (stroke), and dementia (general term for the impaired ability to remember, think, or make decisions that interferes with doing everyday activities) who presents with generalized weakness .1. Right food diabetic ulcer (wound) .right fifth toe amputation (on 5/19/2023) . 2. Fever, positive for group B strep (bacteria) on admission . received ceftriaxone (antibiotic) .3. AKI (Acute kidney injury; an abrupt decrease in kidney function, which encompasses both injury [structural damage] and impairment [loss of function]) present on admission: Baseline serum creatinine (chemical waste product; indicates how well the kidney works; Creatinine is removed from the body entirely by the kidneys) approximately 0.9 mg/dL (milligrams per deciliter - unit of measure showing concentration of a substance), presented (on hospital admission) at 1.3 mg/dL, now (at discharge, 5/24/23) 1.1 mg/dL (normal). Likely . due to dehydration. Received maintenance fluids (intravenous fluids) with normalization of his creatinine . 5. Type 2 diabetes . 6. Physical deconditioning per the family, weak beyond his baseline in the setting of acute (new/current) illness . Discharge details indicated, Follow-Up Plans: Per SNF (skilled nursing facility) orders . Discharge Activity: Ambulates (walks) with Assist (assistance) Discharge Diet: Pureed diet (food with soft, pudding-like consistency; pureed diet continued at the facility) . Wound care: (physician name) from podiatry (medical specialty devoted to the study/diagnosis/treatment of foot and ankle disorders) has been consulting on this patient . Daily dressing changes by nursing at (facility name) . Review of Resident 1's medical records from Hospital 1 (second admission, after his 3.5 week stay in the facility), dated 6/18/2023 at 8:05 p.m., revealed documentation by Physician C titled, Emergency Department Reports, subtitled, History (History of Present Illness). Physician C documented, Family went to go visit Patient (Resident 1) today at (facility name) where the patient has been . since discharge (5/24/2023) to that facility from here (approximately twenty-five days/3.5 weeks). He was noted to be markedly more emaciated (abnormally thin or weak, especially because of illness or lack of food) and nonverbal than he was on their previous visit which was approximately 3 weeks ago. Family elected to sign him out of that facility and bring him here for evaluation. Patient does apparently have a history of being verbal and ambulatory (able to walk) and now is neither . by report, the patient has not been eating much at this post-acute facility for some time . Physician C documented his diagnosis to include acute (new onset) renal failure, dehydration, urinary tract infection, and encephalopathy. Physician C documented Resident 1 was, .clearly quite ill ., and in, critical condition. Physician C documented he was admitting Resident 1 into the Intensive Care Unit. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056153	A. Building B. Wing	09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Napa Post Acute	705 Trancas St. Napa, CA 94558

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 0692 Level of Harm - Actual harm Residents Affected - Some	Continued review of Resident 1's medical records from Hospital 1 (second admission), dated 6/18/2023 at 10:11 p.m., revealed documentation by Physician D (a nephrologist; specialist in kidney function) that indicated, Per (family member) at bedside, reports visiting (at the facility) with other family members today, (and) noticed significant weight loss, was non-verbal, unintelligible when (he, Resident 1) attempted to speak. (Family member) reports (the facility) mentioned that he (Resident 1) hasn't eaten or had water in days; even vomited a few times a few days ago . Physician C documented his impression (diagnosis) included, #AKI, oligoanuris (condition lying between anuria [no urine output] and oligouria [low urine output], when less than 100 cc (cubic centimeters) of urine is produced per day; normal urine output is [PHONE NUMBER] cc each day) . etiology (cause) suspect to be due to . severe volume depletion in the setting of significant caloric and water deprivation; as family mentions days without food/water and significant weight loss . Physician D documented a second impression to include, #Electrolytes (minerals in blood/body fluids that affect how the body functions in many ways including the amount of water in the body and the acidity of blood) . HyperNA (increased sodium concentration in the blood; causes lethargy/confusion/excessive thirst) HyperCl (excessive Chloride level in the blood; sign of dehydration, kidney disease, and too much acid in the blood), Hypo K (low potassium) . suspect related to lack of access to free water and poor nutritional intake . Continued review of Resident 1's medical records from Hospital 1 (second admission), dated 6/19/2023 at 10 minutes after midnight and 6/19/2023 at 4:56 a.m., indicated Physician E documented Resident 1's History and Physical assessment (documentation of physician's thorough medical history and physical exam). Physician E's history and physical indicated, . pt (patient) . admitted in May 2023 (first admission) for R fifth toe infection s/p (status post) amputation . who was discharged to (facility name) . who presents to the (Hospital 1 name) ED from the care home (facility) via private transportation [his family drove him] . They (family) visited him for Father's Day and found him to be in terrible condition: generalized weakness, dehydration, non-verbal, oral thrush (fungal infection of the mouth), and significant weight loss . They were concerned enough to remove him from the care home (facility) and drive him to (Hospital 1's) ED . His weight in the ED was 44 kg (kilograms), whereas upon hospital discharge on May 24th, it had been recorded as 64 kg, representing a 20 kg (44 lbs [pounds]) weight loss in just 3.5 weeks. Labs (laboratory blood work) showed significant AKI, with a serum Cr (creatinine) of 6.2, whereas it had been 1.1 on May 23rd . UA (urinalysis) was positive for UTI (urinary tract infection). He was given 1 L NS (one liter [1000 cc's] normal saline [intravenous fluids]) as well as Rocephin (antibiotic) . He appeared gaunt and weak and was non-verbal. His tongue was white. His abd (abdomen) was scaphoid (abdominal wall is sunken; concave). Continued review of Physician E's History and Physical (dated 6/19/2023 at 10 minutes after midnight and 6/19/2023 at 4:56 a.m.) indicated Physician E's active diagnoses included, AKI. Due to severe dehydration . Severe dehydration. Probably due to significantly reduced oral intake, for whatever reason (not sure if dysphagia [difficulty or discomfort in swallowing] precluded oral intake, or if he was refusing, or if he was being neglected). Aggressive IVFs (aggressive intravenous fluid treatment) . Severe Acute Protein-Calorie Malnutrition; Unintentional Weight Loss . Aphasia. Could be due to TME (toxic-metabolic encephalopathy; encephalopathy caused by toxins (substances that are poisonous [toxic] to humans; can be produced inside the body), AKI, and hypernatremia (elevated blood sodium level) . Acute Encephalopathy on Chronic Dementia. Acute component most likely a TME due to dehydration . Oral thrush . UTI . S/P (status post) R (right) 5th toe amputation May 2023 . Physician E documented Resident 1's code status was, Code: Full and his disposition was, ICU. Expected stay 2 or greater midnights. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056153	A. Building B. Wing	09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Napa Post Acute	705 Trancas St. Napa, CA 94558

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 0692 Level of Harm - Actual harm Residents Affected - Some	Continued review of Resident 1's medical records from Hospital 1 (second admission), dated 6/25/23, indicated Nurse Practitioner K documented a Discharge Summary (summary of hospital stay) that indicated, . removed by family from (facility) . found to have (in the ED) acute renal failure . Thought related to severe dehydration. Also with significant malnutrition with weight loss of 20 kg (kilograms) in last month . 1. Acute kidney injury . likely secondary to severe dehydration . 3. Severe dehydration this is likely the result of very poor oral intake . 5. Severe acute protein calorie malnutrition . Discharge planning: Palliative care (comfort measures only) . Confirmed that patient will be receiving services from hospice . Review of Resident 1's facility electronic medical record (EMR; at the facility) Facesheet (a demographic) indicated he was admitted from Hospital 1, and into the facility on [DATE]. Resident 1's facility Facesheet indicated his diagnoses included sepsis (infection; treated at the hospital), aftercare following surgical amputation (his right toe), generalized weakness, difficulty walking, dementia, diabetes type 2, acute kidney failure, Cerebral infarction (history of stroke), blindness in one eye, and dysphagia (difficulty swallowing). Review of Resident 1's facility EMR revealed a nursing care plan (document that contains essential information about a patient's condition, diagnosis, goals, interventions, and outcomes), dated 5/24/2023, that indicated, Nutrition: Resident at nutrition & hydration risk . Goals on the care plan indicated, Maintain po (oral) intake (greater than) 75% (for) most meals . maintain CBW (current body weight) 146# (146 pounds) +/- (plus or minus) 5# (5 pounds) . Adequate fluid intake . No sign/symptoms of dehydration . Nursing interventions included, Assess for signs/symptoms of dehydration . Assist with meals . Encourage adequate fluids as tolerated, monitor % of intake . RD evaluation as needed .Weight as ordered . A second nursing care plan, dated 5/24/2023, indicated, Dehydration: At risk for dehydration .Interventions .Encourage increase p.o. fluid .monitor for s/s (signs/symptoms) of dehydration . provide adequate fluids . A third nursing care plan, dated 6/5/2023 indicated, Resident is in facility for short term placement . Lives in (city name) w/ (with) his wife and support from his adult children . Wife plans for him to return home . Resident 1's facility EMR contained one provider (physician or nurse practitioner) progress note documented by NP G on 6/2/2023 at 1:49 p.m. (nine days after admission) that indicated, .Seen today for initial exam . Here for rehab (rehabilitation) following hospitalization for AKI, R (right) diabetic foot ulcer s/p (status post) partial amputation of the R 5th (toe) . PMH (past medical history) DM II (diabetes type 2) Dementia . Glaucoma (increased pressure within the eyeball, causing gradual loss of sight) - R eye blind .CODE status: FULL . NP G documented her assessment and plan for Resident 1's stay was, Weakness/ambulatory impairment - PT/OT (physical therapy/occupational therapy) - Supportive care Dementia .(medication for treatment listed) .AKI - Resolving: CR (creatinine) 1.1 (normal level) at time of discharge (from hospital, 5/24/23) . DMII - controlled - R foot wound s/p R (sic) - Wound care per nursing - F/u (follow up with) podiatry . During a tour of the facility and concurrent interview on 8/16/2023 at 1:30 p.m., LN H was asked how staff handled residents with weight loss. LN H stated the RD came to the facility three times per week and made recommendations (for nutritional interventions) and the resident would be discussed at the Weight Committee. LN H stated staff monitored resident intake and output and RNA's (restorative nursing assistants; help residents perform tasks that restore/maintain physical function as directed by the established care plan) weighed residents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056153	A. Building B. Wing	09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Napa Post Acute	705 Trancas St. Napa, CA 94558

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 0692 Level of Harm - Actual harm Residents Affected - Some	Review of Resident 1's medical record revealed one assessment from the RD (dated 5/31/2023 - one week after admission) that indicated, E Physical and Mental Functioning . e. Feeds Self . (MDS assessment indicated he required assistance of one staff to eat/drink). RD documented the following data regarding Resident 1: L. Fluid Intake . 1. Consumes 1,500 and over cc/day . M . 5a. Meal Intake % 76% . Under the category titled, S. Nutrition Goals/Monitoring and Evaluation, the RD documented, . Recommendations: Continue with current POC (plan of care) Goals: Maintain CBW (current body weight) 146# (pounds) +/- (plus or minus) 5# (pounds). Maintain po intake (greater than) 75% x (for) most meals. Maintain (+) [positive] hydration status. Eval (evaluation): Resident with dementia and currently tolerating puree texture diet . Will continue to monitor PRN (as necessary) . (Resident 1 ' s facility diet order was CCHO (consistent, constant, or controlled carbohydrate diet - secondary to DM), puree consistency, with thin liquids). During an interview and concurrent record review on 8/16/2023 at 2:20 p.m., the Registered Dietitian (RD) was asked how the facility handled resident weight loss and specifically, Resident 1's weight loss. RD stated residents who were newly admitted to the facility had their weights monitored weekly for four weeks. She stated weekly weights were discontinued until the resident's weight was stable, at which time the resident would be weighed monthly. RD stated interventions to address the weight loss included a root cause analysis (determining the potential causes) including assessing the resident's appetite/food preferences, determining if medications may be a contributing factor, and considering absorption [absorbing nutrients from the small and large intestines] issues. The RD stated additional interventions included discussing the weight loss at the Weight Committee (Registered Dietitian, DON and/or the Assistant DON, and the treatment nurse [nurse who treats wounds]) and calling/faxing the physician if necessary. The RD stated the physician was always faxed to notify him/her and to suggest interventions. During the same interview and concurrent record review on 8/16/2023 at 2:20 p.m., Resident 1's medical record titled, Weights and Vitals Summary indicated Resident 1 was weighed 5/25/23 (the day after admission) and his weight was 148 pounds; his weight on 5/31/23 was 146 pounds; and his weight on 6/12/23 was 117.2 pounds (a 30.8-pound weight loss in approximately eighteen days). The RD stated in addition to the three documented weights, Resident 1 had an undocumented weight obtained on 6/8/23 which was 119 pounds. During the same interview and concurrent record review on 8/16/2023 at 2:20 p.m., RD stated Resident 1's family took him out of the facility on 6/18/23 AMA. When asked why the family took Resident 1 out AMA, RD stated the family wanted to take him because he was declining. When asked if she thought Resident 1 had been declining, RD stated he had a vomiting issue. RD stated she did not remember the details but Resident 1 had been eating well but was vomiting. RD stated Resident 1 was eating everything until he began having nausea and vomiting. She stated Resident 1 stopped eating two days prior to his family taking him to the Emergency Department. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056153	A. Building B. Wing	09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Napa Post Acute	705 Trancas St. Napa, CA 94558

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 0692 Level of Harm - Actual harm Residents Affected - Some	During the same interview and concurrent record review on 8/16/2023 at 2:20 p.m., RD was asked about the interventions implemented to address Resident 1's weight loss and she stated there were, none. RD stated her normal process was to ask for a re-weight (to ensure the weight was accurate) and then document the re-weight. When asked why that was not done for Resident 1, RD stated she did not know. RD stated she had added additional items to his tray such as yogurt, but this was written in her binder and did not show up in the medical record. When asked if the CNAs or nursing staff informed her of Resident 1's weight loss, RD stated she tracked resident weights herself. When asked why Resident 1's medical record did not have an RD progress note (with one exception of the RD assessment on 5/31/2023), RD stated she normally wrote a note. RD stated she was not sure why (his weight loss) was not caught. RD stated the weight loss was missed. Review of a document titled, Weekly Weights 6/4/22 - (facility name), provided by the RD (weight loss tool; not located in Resident ' s EMR), indicated Resident 1 had an 18.49% weight loss. RD stated she assumed that number was incorrect. During the same interview and concurrent record review on 8/16/2023 at 2:20 p.m., RD stated the facility received a call from Adult Protective Services (APS) on 7/18/23 (after Resident 1 had left the facility) regarding Resident 1. RD stated APS was requesting Resident 1's medical progress notes. Review of facility policy titled, Weight Assessment and Intervention, subtitled, Weight Assessment (revised March 2022) indicated, .4. The threshold for significant unplanned and undesired weight loss will be based on the following . a. 1 month - 5% weight loss is significant; greater than 5% is severe . During a telephone interview on 9/11/2023 at 3:31 p.m., Adult Protective Services Social Worker (APS S.W.) stated (an anonymous complainant) had filed a complaint with her department (Adult Protective Services). APS S.W. stated the complaint indicated that Resident 1's family had gone to visit him at the facility and found him in a, bad situation. APS S.W. stated the family was very upset the facility had not communicated (with them) that he had declined (in health status). APS S.W. stated the family took Resident 1 (out of the facility) and brought him to Hospital 1. APS S.W. stated the family had not been able to visit Resident 1 at the facility for three weeks and when they saw him at the facility (on 6/18/2023), they took him straight to Hospital 1. Review of a nursing progress note from Resident 1's medical record (dated 6/18/2032 at 11:50 a.m.), documented by Licensed Nurse A (LN A), indicated, Approx (approximately) 0930 (9:30 a.m.) residents ' family .want the resident to be discharged AMA (against medical advice) . They (family members) said that they are very concerned that the resident seems to be declining and he has lost weight. They want to take him home so they can . take care of him better . During an interview and concurrent record review on 9/14/23 at 2:33 p.m., Certified nursing assistant B (CNA B) stated she had worked with Resident 1 once or twice in the past. When asked how she monitored a resident's intake (oral) and output (urine and stool), CNA B stated she looked at the meal tray and marked down how much they ate and drank. She stated if a resident only drank a little, she would tell (verbally) the nurse. During an interview on 9/14/23 at 2:55 p.m., LN A stated she had some recollection of Resident 1 and he had been her patient when she worked in the morning (morning shift). When asked what she recalled, LN A stated Resident 1's family took him out of the facility AMA. LN A stated she remembered they said, they could take care of him better (than the facility). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056153	A. Building B. Wing	09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Napa Post Acute	705 Trancas St. Napa, CA 94558

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 0692 Level of Harm - Actual harm Residents Affected - Some	During the same interview and concurrent record review on 9/14/23 at 2:55 p.m., LN A stated Resident 1 was a fall risk and therefore, his room was near the nurse's station. LN A stated, he's a feeder (unable to feed himself; requires staff assistance to eat). LN A reviewed the Weights and Vitals Summary (that indicated Resident 1 lost 30.8 pounds between 5/25/23 and 6/12/23) and stated it was a, significant weight loss. When asked if she was aware of Resident 1's weight loss, LN A stated she did not remember. When asked what she would have done if she had been aware, LN A stated she would have called the doctor, notified the RD, and documented a note (in the nurse progress notes). LN A confirmed Resident 1's EMR did not contain a nurses note indicating Resident 1's physician (Physician F) or family were notified of the significant weight loss. LN A confirmed Resident 1's medical record did not contain a Change of Condition (COC) or an SBAR (Situation-Background-Assessment-Recommendation; communication technique between health care team members regarding a patient's condition) nursing note identifying the significant weight loss. During the same interview and concurrent record review on 9/14/23 at 2:55 p.m., LN A confirmed a COC, dated 6/16/23 (four days after his documented significant weight loss), was located in Resident 1's medical record. LN A stated the form was completed due to Resident 1 experiencing nausea and vomiting. LN A stated Resident 1 had emesis (vomiting) three times in an eight-hour period and NP G had been notified. LN A confirmed NP G had ordered medication (Zofran) to treat Resident 1's nausea and vomiting after she was notified. LN A confirmed Resident 1's weight loss was not addressed in the COC dated 6/16/23. Review of facility policy titled, Change in a Resident's Condition or Status, subtitled, Policy Statement (revised February 2021) indicated, Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition . Under subtitle, Policy Interpretation and Implementation, the policy indicated, 1. the nurse will notify the resident's attending physician . when there has been a(an): .d. significant change in the resident's physical/emotional/mental condition . 2. A significant change of condition is a major decline . in the resident's status that: a. will not normally resolve itself without intervention by staff or by implementing standard . interventions . c. requires interdisciplinary review and/or revision to the care plan . 3. Prior to notifying the physician . the nurse will make detailed observations and gather relevant and pertinent information . 4 . a nurse will notify the resident's representative when: .b. there is a significant change in the resident's physical, mental .status .5. Except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring . 8. The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition . During an interview and concurrent record review on 9/14/23 at 3:57 p.m., the Social Worker (SW) stated her memory of Resident 1 was that he lived in a nearby city with his wife, he was at the facility for therapy and nursing care, and the plan for him was to return home with his wife (after discharge from the facility). Review of an IDT progress note (dated 6/12/2023 at 4:46 p.m. - after Resident 1's weight loss was documented in his medical record) indicated the following: Note Text: Psychoactive Medication Review. The IDT note indicated the DON, LN H and the SW were the members present at the meeting. SW reviewed the IDT note and confirmed the meeting was, just (a) psychoactive (medication) review and did not address his weight loss. When asked if she had been aware of Resident 1's significant weight loss, the SW stated she was, not aware at that point. SW stated she had called Resident 1's family member two days after he left the facility AMA and his family member informed SW that Resident 1 was in the Hospital 1's Intensive Care Unit. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056153	A. Building B. Wing	09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Napa Post Acute	705 Trancas St. Napa, CA 94558

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 0692 Level of Harm - Actual harm Residents Affected - Some	During an interview and concurrent record review on 9/14/2023 at 4:29 p.m., the DON was asked if she had had any interaction with Resident 1 during his approximately three and a half-week stay at the facility and she stated, no, just rounding (proactive, systematic, nurse-driven, evidence-based intervention that helps anticipate and address patient needs). The DON stated she had not spoken to his family, either. The DON reviewed the Weights and Vitals Summary, documenting weights from 5/25/23, 5/31/23 and 6/12/23, (indicating Resident 1's 30.8-pound significant weight loss) and stated it was a huge weight loss. When asked what staff should have done with this information, the DON stated normally staff would recheck the weight to ensure accuracy, notify the RD for her review and recommendations, notify the DON or ADON (assistant DON), call (notify) the provider (physician or nurse practitioner), notify the family and/or responsible party, document (interventions and actions taken), and write a COC note to document and monitor the issue. When asked if any of these interventions had been taken for Resident 1, the DON stated, Unfortunately, I do not remember and further stated she did not remember if she was notified. The DON confirmed the EMR did not contain evidence Resident 1's weight had been rechecked or that the DON, RD, or ADON had been notified of the weight loss. During the same interview and concurrent record review on 9/14/2023 at 4:29 p.m., the DON confirmed the RD had provided a nutritional evaluation for Resident 1 on 5/31/23 but the medical record did not contain documentation by the RD of Resident 1's significant weight loss. During a concurrent interview and review of Resident 1's medical record on 9/14/23 at 4:45 p.m., the Director of Staff Development (DSD) and the DON reviewed the documents titled, Documentation Survey Report v2 (report generated when the CNA's charted resident's intake/output). The documents indicated that from 5/24/23 (admission) until 6/18/23 (leaving AMA), the CNA's documentation of Resident 1's fluid consumption was both incomplete and reflected he had a low fluid intake; the DSD and DON confirmed this information. The report indicated on 5/25/23, CNA's documented Resident 1 consumed a total of 360 cc of fluid (the RD's assessment indicated he consumed 1500 cc/day) but his fluid intake at night was left blank; on 5/26/23, the CNA's documented he consumed a total of 580 cc. During Resident's stay at the facility, the CNA's failed to document his fluid intake on approximately seven occasions (Day shift: 6:30 a.m. to 2:30 p.m. - on 6/3/2023; Night shift: 10:30 p.m. to 6:30 a.m. - on 5/24/2023, 5/25/23, 5/29/23, 6/1/23, 6/3/23, 6/14/23); the DSD and DON confirmed this trend. During his stay at the facility, the documents indicated Resident 1 consumed between 100 cc - 1110cc of fluid per day. The documentation indicated Resident 1 consumed less than 500cc in twenty-four hours on approximately eight occasions (5/25/23, 5/27/23, 5/29/23, 5/31/23, 6/3/23, 6/9/23, 6/14/23, 6/15/23 and 6/17/2023). The DSD and DON confirmed nursing staff did not document Resident 1's low oral intake trend on their daily nursing notes titled, Nursing - Daily Skilled Charting Form - V 3.0 or on the MAR (Medication Administration Report) from 5/24/23 through 6/18/23. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056153	A. Building B. Wing	09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Napa Post Acute	705 Trancas St. Napa, CA 94558

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 0692 Level of Harm - Actual harm Residents Affected - Some	During a telephone interview on 9/18/2023 at 2:17 p.m., Physician F (Resident 1's doctor and the facility's Medical Director at the time of Resident 1's admission) stated Nurse Practitioner G (NP G, Resident 1's NP during his stay) worked under him (he supervised her work). Physician F was asked about Resident 1's weight loss, poor fluid intake, lack of nurse monitoring of intake, and lack of RD and nurse response to his severe weight loss. When asked if he had been notified Resident 1's weight loss, Physician F stated he did not recall being notified. Physician F stated if a resident who was a Full Code (like Resident 1) had a thirty-one-pound weight loss, he and/or the NP would act on the information. He stated they would recheck the weight for accuracy, assess any medical trends with the resident, call and notify the family, have a Care Conference to discuss the issue, get a written nutritional evaluation, possibly order an appetite stimulant, possibly order intravenous fluids, and order stat (immediate) labs (laboratory tests such as albumin (a simple form of protein that is found in blood serum). Physician F stated if he had known about Resident 1's decline, he would have intervened. When asked if he thought the facility's failure to monitor and intervene in Resident 1's fluid status and weight loss contributed to his diagnosis in Hospital 1 (kidney injury, severe dehydration, severe malnutrition, etc.), Physician F stated yes he would agree. Physician F stated he wanted to review Resident 1 ' s medical record (did not have it in front of him) and would call back. During a follow-up telephone interview on 9/19/2023 at 11:49 a.m., Physician F stated he reviewed Resident 1's medical record and spoke to NP G. Physician F stated NP G told him she was not notified by the facility of Resident 1's thirty-one-pound weight loss. Physician F stated both the RD and Nursing Staff should have notified him (or NP G) of the weight loss so they could have[TRUNCATED]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056153	A. Building B. Wing	09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Napa Post Acute	705 Trancas St. Napa, CA 94558

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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31424 Based on interview, and facility document review, the facility's Quality Assurance and Performance Improvement Committee (QAPI, a data driven and proactive approach to quality improvement; process used to ensure services are meeting quality standards and assuring care reaches a certain level) failed to identify quality deficiencies and subsequently investigate and act upon the deficiencies once identified, as evidenced by: 1 of 3 sampled Residents (Resident 1) experienced a 30.8 (31) pound weight loss during his first 18 days at the facility. Facility staff did not notify Resident 1's physician or nurse practitioner (NP) of the severe weight loss; interventions to address the severe weight loss were not implemented; and Resident 1's family took him from the facility AMA (Against Medical Advice - in an effort to get him help) and transported him directly to Hospital 1's Emergency Department (ED), where he was admitted into the ICU (Intensive Care Unit). Resident 1's weight loss at the facility was documented on a list titled, June 2023 Monthly Weight Variances (list of residents with weight loss/gain), which was presented at the July 2023 QAPI meeting. However; Resident 1's weight loss, it's causes, staff failure to notify the physician, facility failure to implement interventions to address the decline, and his family's need to remove him from the facility in order to get him help were not addressed or discussed during the QAPI meeting. These failures prevented the facility from gaining insight into potential system failures (nursing, dietary, certified nursing staff competency, etc.) that potentially contributed to Resident 1's severe decline (and ultimate hospitalization in the ICU); thereby impairing facility leadership from implementing changes that would address the failures and ultimately prevent similar harm to other residents (Cross Reference F692). Findings: Review of Resident 1's medical records from Hospital 1 (first admission, prior to his stay at the facility) indicated he was admitted on [DATE] and discharged to the facility on [DATE] (six-day hospital stay). The physician Discharge Summary (physician documentation summarizing the hospital stay), dated 5/24/23, indicated, Hospital Course . [AGE] year-old male (with) .1. Right food diabetic ulcer (wound) .right fifth toe amputation (on 5/19/2023) . Discharge details indicated, Follow-Up Plans: Per SNF (skilled nursing facility) orders . Discharge Diet: Pureed diet (food with soft, pudding-like consistency) . Wound care: . Daily dressing changes by nursing at (facility name) . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056153	A. Building B. Wing	09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Napa Post Acute	705 Trancas St. Napa, CA 94558

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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 1's medical records from Hospital 1 (second admission, after his 3.5 week stay in the facility), dated 6/18/2023 at 8:05 p.m., revealed documentation by Physician C titled, Emergency Department Reports, subtitled, History (History of Present Illness). Physician C documented, Family went to go visit Patient (Resident 1) today at (facility name) where the patient has been . since discharge (5/24/2023) to that facility from here . He was noted to be markedly more emaciated (abnormally thin or weak, especially because of illness or lack of food) and nonverbal than he was on their previous visit which was approximately 3 weeks ago. Family elected to sign him out of that facility and bring him here for evaluation Physician C documented Resident 1 was, .clearly quite ill ., and in, critical condition. Physician C documented he was admitting Resident 1 into the Intensive Care Unit. Continued review of Resident 1's medical records from Hospital 1 (second admission), dated 6/19/2023 at 10 minutes post midnight and 6/19/2023 at 4:56 a.m., indicated Physician E documented Resident 1's History and Physical assessment (documentation of physician's thorough medical history and physical exam). Physician E's history and physical indicated, . presents to the (Hospital 1 name) ED from the care home (facility) via private transportation [his family drove him] . They (family) visited him for Father's Day and found him to be in terrible condition: generalized weakness, dehydration, non-verbal, oral thrush (fungal infection of the mouth), and significant weight loss . They were concerned enough to remove him from the care home (facility) and drive him to (Hospital 1's) ED . His weight in the ED was 44 kg (kilograms), whereas upon hospital discharge on May 24th, it had been recorded as 64 kg, representing a 20 kg (44 lbs [pounds]) weight loss in just 3.5 weeks . He appeared gaunt and weak, and was non-verbal. His tongue was white. His abd (abdomen) was scaphoid (abdominal wall is sunken; concave). Continued review of Physician E's History and Physical (dated 6/19/2023 at 10 minutes post midnight and 6/19/2023 at 4:56 a.m.) indicated Physician E's active diagnoses included, . Severe dehydration. Probably due to significantly reduced oral intake, for whatever reason (not sure if dysphagia [difficulty or discomfort in swallowing] precluded oral intake, or if he was refusing, or if he was being neglected) . Severe Acute Protein-Calorie Malnutrition; Unintentional Weight Loss . Aphasia. Could be due to TME (toxic-metabolic encephalopathy; encephalopathy caused by toxins, infection, organ dysfunctionality, or organ failure), AKI (acute kidney injury) . Acute Encephalopathy on Chronic Dementia (group of symptoms affecting memory, thinking and social abilities severely enough to interfere with your daily life). Acute component most likely a TME due to dehydration . Oral thrush . UTI . Physician E documented Resident 1's disposition was, ICU. Expected stay 2 or greater midnights. Review of Resident 1's facility electronic medical record (EMR; at the facility) facesheet indicated he was admitted from Hospital 1, and into the facility on [DATE]. Resident 1's facility facesheet indicated his diagnoses included . aftercare following surgical amputation (his right toe), generalized weakness, difficulty walking, dementia, diabetes type 2, acute kidney failure, Cerebral infarction (history of stroke), blindness in one eye, and dysphagia (difficulty swallowing). Review of Resident 1's facility EMR revealed a nursing care plan (document that contains essential information about a patient's condition, diagnosis, goals, interventions, and outcomes), dated, dated 5/24/2023, that indicated, Dehydration: At risk for dehydration .Interventions .Encourage increase p.o. fluid . monitor for s/s (signs/symptoms) of dehydration . provide adequate fluids . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056153	A. Building B. Wing	09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Napa Post Acute	705 Trancas St. Napa, CA 94558

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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 1's facility EMR contained one provider (physician or nurse practitioner) progress note documented by NP G on 6/2/2023 at 1:49 p.m. (nine days after admission) that indicated, .Seen today for initial exam . Here for rehab (rehabilitation) following hospitalization for .diabetic foot ulcer s/p (status post) partial amputation of the R 5th (toe) . CODE status: FULL . NP G documented her assessment and plan for Resident 1's stay was, .PT/OT (physical therapy/occupational therapy) - Supportive care Dementia . (medication for treatment listed) .AKI - Resolving . Review of Resident 1's facility medical record revealed one assessment from the RD (dated 5/31/2023 - one week after admission) that indicated, E Physical and Mental Functioning . e. Feeds Self . (MDS assessment indicated he required assistance of one staff to eat/drink). RD documented the following data regarding Resident 1: L. Fluid Intake . 1. Consumes 1,500 and over cc/day . M . 5a. Meal Intake % 76% . Under the category titled, S. Nutrition Goals/Monitoring and Evaluation, the RD documented, . Goals: Maintain CBW (current body weight) 146# (pounds) +/- (plus or minus) 5# (pounds). Maintain po intake (greater than) 75% x (for) most meals. Maintain (+) [positive] hydration status. Eval (evaluation): Resident with dementia and currently tolerating puree texture diet . Will continue to monitor PRN (as necessary) . During the same interview and concurrent record review on 8/16/2023 at 2:20 p.m., Resident 1's medical record titled, Weights and Vitals Summary indicated Resident 1 was weighed 5/25/23 (the day after admission) and his weight was 148 pounds; his weight on 5/31/23 was 146 pounds; and his weight on 6/12/23 was 117.2 pounds (a 30.8 pound weight loss in approximately eighteen days). RD stated Resident 1's family took him out of the facility on 6/18/23 AMA. She stated Resident 1 stopped eating two days prior to his family taking him to the Emergency Department. RD was asked about the interventions implemented to address Resident 1's weight loss and she stated there were, none. RD stated she was not sure why (his weight loss) was not caught. RD stated the weight loss was missed. Review of a document titled, Weekly Weights 6/4/22 - (facility name) indicated Resident 1 had an 18.49% weight loss. RD stated she assumed that number was incorrect. During the same interview and concurrent record review on 8/16/2023 at 2:20 p.m., RD stated the facility received a call from Adult Protective Services (APS) on 7/18/23 (after Resident 1 had left the facility) regarding Resident 1. RD stated APS was requesting Resident 1's medical progress notes. Review of facility policy titled, Weight Assessment and Intervention, subtitled, Weight Assessment (revised March 2022) indicated, .4. The threshold for significant unplanned and undesired weight loss will be based on the following . a. 1 month - 5% weight loss is significant; greater than 5% is severe . During a telephone interview on 9/11/2023 at 3:31 p.m., Adult Protective Services Social Worker (APS S.W.) stated (an anonymous complainant) had filed a complaint with her department (Adult Protective Services). APS S.W. stated the complaint indicated that Resident 1's family had gone to visit him at the facility and found him in a, bad situation. APS S.W. stated the family was very upset the facility had not communicated (with them) that he had declined (in health status). APS S.W. stated the family had not been able to visit Resident 1 at the facility for three weeks and when they saw him at the facility (on 6/18/2023), they took him straight to Hospital 1. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056153	A. Building B. Wing	09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Napa Post Acute	705 Trancas St. Napa, CA 94558

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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a nursing progress note from Resident 1's medical record (dated 6/18/2032 at 11:50 a.m.), documented by Licensed Nurse A (LN A), indicated, Approx (approximately) 0930 (9:30 a.m.) residents family .want the resident to be discharged AMA (against medical advice) . They (wife and daughter) said that they are very concerned that the resident seems to be declining and he has lost weight. They want to take him home so they can . take care of him better . During the same interview and concurrent record review on 9/14/23 at 2:55 p.m., LN A reviewed the Weights and Vitals Summary (that indicated Resident 1 lost 30.8 pounds) and stated it was a, significant weight loss. LN A confirmed Resident 1's medical record did not contain a Change of Condition (COC) or an SBAR (Situation-Background-Assessment-Recommendation; communication technique between health care team members regarding a patient's condition) nursing note identifying the significant weight loss. Review of facility policy titled, Change in a Resident's Condition or Status, subtitled, Policy Statement (revised February 2021) indicated, Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition . Under subtitle, Policy Interpretation and Implementation, the policy indicated, 1. the nurse will notify the resident's attending physician . when there has been a(an): .d. significant change in the resident's physical/emotional/mental condition . During an interview and concurrent record review on 9/14/23 at 3:57 p.m., the Social Worker (SW) reviewed an IDT progress note (dated 6/12/2023 at 4:46 p.m. - after Resident 1's weight loss was documented in his medical record) indicated the following: Note Text: Psychoactive Medication Review. The IDT note indicated the DON, LN H and the SW were the members present at the meeting. SW reviewed the IDT note and confirmed the meeting was, just (a) psychoactive (medication) review and did not address his weight loss. SW stated she had called Resident 1's wife two days after he left the facility AMA and his wife informed SW that Resident 1 was in the Hospital 1's Intensive Care Unit. During an interview and concurrent record review on 9/14/2023 at 4:29 p.m., the DON reviewed the Weights and Vitals Summary (indicating Resident 1's 30.8 pound significant weight loss) and stated it was a huge weight loss. When asked what staff should have done with this information, the DON stated normally staff would recheck the weight to ensure accuracy, notify the RD for her review and recommendations, notify the DON or ADON (assistant DON), call (notify) the provider (physician or nurse practitioner), notify the family and/or responsible party, document (interventions and actions taken), and write a COC note to document and monitor the issue. When asked if any of these interventions had been taken for Resident 1, the DON stated, Unfortunately, I do not remember and further stated she did not remember if she was notified. The DON confirmed the medical record did not contain evidence Resident 1's weight had been rechecked or that the DON, RD, or ADON had been notified of the weight loss. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056153	A. Building B. Wing	09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Napa Post Acute	705 Trancas St. Napa, CA 94558

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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and review of Resident 1's medical record on 9/14/23 at 4:45 p.m., the Director of Staff Development (DSD) and the DON reviewed the documents titled, Documentation Survey Report v2 (report generated when the CNA's charted resident's intake/output). The documents indicated that from 5/24/23 (admission) until 6/18/23 (leaving AMA), the CNA's documentation of Resident 1's was both incomplete and reflected he had a low fluid intake; the DSD and DON confirmed this information. The documentation indicated Resident 1 consumed less that 500cc on approximately eight occasions. The DSD and DON confirmed nursing staff did not document Resident 1's low oral intake trend on their daily nursing notes titled, Nursing - Daily Skilled Charting Form - V 3.0 or on the MAR (Medication Administration Report) from 5/24/23 through 6/18/23. During a telephone interview on 9/18/2023 at 2:17 p.m., Physician F (Resident 1's doctor and the facility's Medical Director at the time of Resident 1's admission) stated Nurse Practitioner G (NP G, Resident 1's NP during his stay) worked under him (he supervised her work). Physician F was asked about Resident 1's weight loss, poor fluid intake, lack of nurse monitoring of intake, and lack of RD and nurse response to his severe weight loss. When asked if he had been notified Resident 1's weight loss, Physician F stated he did not recall being notified. Physician F stated if a resident who was a Full Code (like Resident 1) had a thirty-one pound weight loss, he and/or the NP would act on the information. Physician F stated if he had know about Resident 1's decline, he would have intervened. When asked if he thought the facility's failure to monitor and intervene in Resident 1's fluid status and weight loss contributed to his diagnosis in Hospital 1 (kidney injury, severe dehydration, severe maturation, abnormal lab values, etc.), Physician F stated yes he would agree. During a telephone interview on 9/20/23 at 11 a.m., LN I was asked about her work with Resident 1. LN I stated she remembered Resident 1, his room was near the nurses station, and she was present when his wife and family came to the facility and took him out AMA. LN I stated Resident 1's wife showed up (at the facility) and was very upset. LN I stated Resident 1's wife said her husband was not improving, therapy was not working, and he would be better off at home. During a telephone interview on 9/20/23 at 2:40 p.m., the DON was asked if Resident 1's 31 pound weight loss was discussed in the Weight Committee. The DON stated, no and stated she did not find any notes (documentation) on him. Review of facility policy titled, Nutritionally At Risk (NAR) Committee (also known as the Weight Committee), undated, indicated the purpose of the committee was, monitoring and intervening in the care of patients as it relates to weight loss . Under the subtitle, Procedure, the policy indicated, The committee will identify, prevent, and reduce the risk factors associated with nutritional disorders . Under the subtitle, Criteria for NAR monitoring, the policy indicated, Significant weight loss . -(minus) 5% in 1 month . Under subtitle, Key Components and Procedures for NAR Monitoring, the policy indicated, . 5. Every resident will be discussed each week until discontinued from the NAR monitoring. Review of facility policy titled, Weight Assessment and Intervention, subtitled, Weight Assessment, subtitled, Evaluation (revised March 2022) indicated, 1. Undesirable weight change is evaluated by the treatment team whether or not the criteria for significant weight change has been met . Under subtitle, Interventions, the policy indicated, 1. Interventions for undesirable weight loss are based on careful considerations of the following: .b. Nutrition and hydration needs of the resident; c. Functional factors that may inhibit independent eating . e. Chewing and swallowing abnormalities . g. The use of supplementation . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056153	A. Building B. Wing	09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Napa Post Acute	705 Trancas St. Napa, CA 94558

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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephone interview 9/21/2023 at 10:40 a.m., Administrator was asked if he was aware of Resident 1's weight loss prior to the Department's investigation (first onsite visit was 8/16/2023 - approximately two months after Resident 1 left the facility AMA) and he stated, Not off the top of my head. Administrator stated QAPI (members) go over residents on the weight list (Monthly Weight Variances list), review them together (not individually), discuss what was done for them; Administrator stated they did not go in-depth. Review of the document titled, June 2023 Monthly Weight Variances, indicated, . (Resident 1's room number and name) [-30.8# (minus 30.8 pounds)/20.8% (percent of weight loss) x < (in less than) 1month) - Add items to meal trays, po (oral) intake excellent, fluids given .). During the same telephone interview on 9/21/2023 at 10:40 a.m., Resident 1's thirty-one pound weight loss and his leaving AMA was discussed with the administrator. Administrator stated staff ususally put interventions in place. When asked why Resident 1's physician was not notified of his weight loss, Administrator stated usually the RD called (the doctor). When asked about why the IDT team did not discuss Resident 1's severe weight loss, Administrator stated he was not aware they hadn't. He stated a Change of Condition (COC) should have been done. During the same telephone interview on 9/21/2023 at 10:40 a.m., Administrator was asked if the QAPI team had done a Root Cause Analysis (RCA; method of problem-solving used to identify the underlying causes of problems) to determine the cause(s) of Resident 1's severe weight loss and Administrator stated, Doesn't look like it. When asked why a RCA was not conducted, Administrator stated he could look through the QAPI notes. When asked if the QAPI team had done an RCA after the SW learned Resident 1 was admitted directly into Hospital 1's ICU, Administrator stated, no, and stated the SW had not notified him of the information. When asked if the QAPI team had done an RCA to determine the cause of Resident 1's family removing him from the facility AMA, Administrator stated they discussed it during the morning meeting stand up (department heads connect at the start of the day to share relevant and time-sensitive information) but no documentation was recorded for that meeting. Administrator stated he was aware APS called the facility and requested medical records. When asked if an RCA should have been done about that, Administrator stated something should have been done on 6/12/2023 (when the facility discovered Resident 1's 30.8 pound weight loss). When asked why Resident 1's physician was never brought into this process, Administrator stated he should have been brought in on 6/12/2023. During the same telephone interview on 9/21/2023 at 10:40 a.m., Administrator was asked if the QAPI team had identified other issues of weight loss at the facility. Administrator stated they had not identified concerns and stated, we do pretty good with weights. Review of facility policy titled, Quality Assurance and Performance Improvement (QAPI) Program, (Revised February 2020) indicated, This facility shall develop, implement, and maintain an ongoing, facility-wide, data-driven QAPI Program that is focused on indicators of the outcomes of care and quality of life for our residents. Under subtitle, Implementation, the policy indicated, . 2. The QAPI plan describes the process for identifying and correcting quality deficiencies. Key components of this process include: a.Tracking and measuring performance; . c. Identifying and prioritizing quality deficiencies; d.Systematically analyzing underlying causes of systemic quality deficiencies; e. Developing and implementing corrective action or performance improvement activities; and f. Monitoring or evaluating the effectiveness of corrective action/performance improvement activities, and revising as needed .