

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  056153	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/22/2026
NAME OF PROVIDER OR SUPPLIER  Napa Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review, the facility failed to provide adequate nursing services for 4 residents (Resident 2, Resident 3, Resident 4, and Resident 5) of 5 sampled residents to ensure residents achieved the highest level of physical and emotional well-being when the facility failed to make a sufficient number of nursing staff available to meet residents' needs. This failure had the potential to place residents at greater risk for dehydration, skin breakdown and placed their safety in jeopardy. A review of Resident 2's admission record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses of Acute on Chronic Heart Failure ( a worsening of a clinical condition when the heart cannot pump enough blood to meet the body's needs for oxygen and nutrients), End Stage Renal Disease (kidney function has declined to 15% of normal capacity) and Diabetes Mellitus (DM-disorder characterized by difficulty in blood sugar control and poor wound healing). A review of Resident 2's care plans indicated the following: A care plan, revised on 10/25/22, indicated Resident 2 was at risk for dehydration. Resident 2's goal was to be free from signs and symptoms of dehydration. To meet this goal, the nursing staff was expected to encourage Resident 2 to drink fluids within Resident 2's 1500 mL (Milliliter-a unit of measure)/day fluid restriction as ordered by her physician. A care plan, dated 6/3/25, indicated Resident 2 was at risk for skin breakdown. To meet Resident 2's goal of reducing the risk of skin impairment, the nursing staff were expected to monitor for incontinence [involuntary leakage of urine or stool] and provide pericare [the process of cleaning a resident's genital and anal areas] after each incontinent episode. A review of Resident 2's Minimum Data Set (MDS- a federally mandated resident assessment tool) dated 11/19/25 indicated Resident 2 had a Brief Interview for Mental Status (BIMS- an assessment used to measure cognition (a person's ability to process information and understanding)) score of 15 which indicated Resident 2's cognition was fully intact. A review of Resident 3's admission record indicated Resident 3 was admitted to the facility on [DATE] with diagnoses of Cholecystitis (redness and swelling (inflammation) of the gallbladder), Cystitis (inflammation of the bladder most commonly caused by a bacterial urinary tract infection (UTI)) and Hemiplegia and Hemiparesis (weakness and paralysis on one side of the body) following Cerebral Infarction (stroke) affecting right dominant side. A review of Resident 3's care plans indicated the following: A care plan, dated 4/1/24, indicated Resident 3 was at risk for dehydration. To meet Resident 3's goal of having adequate hydration, nursing staff were expected to offer fluids in between meals and at snack time, provide additional fluid during activities, and a water pitcher was to be left within Resident 3's reach at bedside. A care plan, dated 9/23/24, indicated Resident 3 was at risk for skin breakdown and pressure ulcer development. To meet this goal, the nursing staff were expected to assist Resident 3 to turn and reposition. A care plan, revised on 10/3/25, indicated Resident 3 was at risk for falls. To minimize Resident 3's risk for falls, the nursing staff were expected to anticipate and meet Resident 3's needs, and educate/remind [Resident 3] to</p> <p>(continued on next page)</p>		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>call [via the call light system] for assistance with all transfers.A review of Resident 3's MDS dated [DATE] indicated Resident 3 had a BIMS score of 15 which indicated Resident 3's cognition was fully intact.A review of Resident 4's admission record indicated Resident 4 was admitted to the facility on [DATE] with a diagnosis of Metabolic Encephalopathy (syndrome of brain dysfunction caused by chemical imbalance in the blood due to organ failure).A review of Resident 4's care plans indicated the following:A care plan, dated 9/15/24, indicated Resident 4 was at risk for dehydration. To meet Resident 4's goal of adequate hydration, the nursing staff were expected to encourage increased fluid intake, offer fluids in between meals and at snack time, provide additional fluid during activities, and a water pitcher to be left within Resident 4's reach at bedside.A care plan, dated 9/15/24, indicated Resident 4 was at risk for skin breakdown. To meet the goal of adequate hydration to prevent skin breakdown, the staff would encourage fluids.A care plan, dated 9/15/24, indicated Resident 4 was at risk for falls. To minimize Resident 4's risk of falls, the staff were expected to educate and remind Resident 4 to call for assistance with all transfers and to keep the call light within reach.A review of Resident 4's MDS dated [DATE] indicated Resident 4 had a BIMS score of 15 which indicated Resident 4's cognition was fully intact.A review of Resident 5's admission record indicated Resident 5 was admitted to the facility on [DATE] with a diagnosis of Hemiplegia and Hemiparesis following Cerebral Infarction affecting the left non-dominant side. A review of Resident 5's care plans indicated the following:A care plan, dated 8/9/23, indicated Resident 5 was at risk for dehydration. To meet Resident 5's goal of adequate hydration, the staff were expected to encourage increased fluid intake, offer fluids in between meals and at snack time, provide additional fluid during activities, and a water pitcher was to be left within Resident 5's reach at bedside.A care plan, dated 8/12/23, indicated Resident 5 had bowel incontinence. To meet the goal of maintaining comfort and dignity daily, the nursing staff were expected to encourage fluid during daytime hours, encourage use of call light for toileting assistance, provide incontinence care during rounds, upon request or as needed. A care plan, dated 2/26/25, indicated Resident 5 was at risk for skin breakdown. To meet the goal of adequate hydration to prevent skin breakdown, the staff would encourage fluids and keep the skin clean and dry.A review of Resident 5's MDS dated [DATE] indicated Resident 5 had a BIMS score of 15 which indicated Resident 5's cognition was fully intact.During a concurrent observation and interview on 1/21/26 at 1:12 p.m., in Resident 2's room, Resident 2 stated, [The] Fresh water is not fresh. The water on the table is from last evening. Who drinks water that has been sitting for a long time? It's gross! You have to ask for it [fresh water]. Upon observation the water in the clear water bottle was less than half full, did not contain ice and temperature was room temperature. Resident 2 stated she needed assistance for toileting and that the average time for a call light to be answered was 30 minutes, especially during the night shift [11 p.m. -7 a.m.] Resident 2 further stated she has had to sit in her own bowel movement for a long time to the point that it burned her skin causing pain. Resident 2 stated she gathered several complaints from other residents to bring to the monthly Resident Council meetings regarding the lack of Certified Nursing Assistants (CNAs) to help with care of the residents.During a concurrent observation and interview on 1/21/26 at 1:44 p.m., Resident 3 stated, The call lights are bad on [the swing shift]. I put the call light on at 9:30 p.m., they [staff] answered at 10:30 p.m. This is not unusual. Resident 3 stated he had an incontinent bowel movement at that time and has had the same experience an additional 2 or 3 times in the past few months. Resident 3 added, It is not a nice feeling. My skin turns red and burns my groin. It makes me feel like, I have no dignity. Upon observation Resident 3's water bottle was nearly full and placed on the far corner of his overbed tray table. Resident 3 was unable to reach his water bottle and stated</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>he needed to call his CNA for help.A review of the Resident Council Meeting Minutes dated January 2025 to January 2026 indicated the following resident requests:March 2025: CNAs going in to [residents'] room to sleep or charge phones.May 2025: When are we getting [facility] CNAs rather than registry?September 2025: NOC [night shift] shift CNAs do not answer call lights.December 2025: Hire more CNAs.January 2026: Need to have CNAs to help.During an observation on 1/22/26 at 11:29 a.m., while in the facility conference room, this surveyor heard a call light sound from the room directly across from the conference room. This surveyor observed the call light above entryway of the room was illuminated. One staff member entered threshold of door, took a pair of latex gloves and left. The staff member did not enter room or address the resident's need. This surveyor witnessed several different facility staff pass by the room without stopping to check in with the resident whose call light had been on for 20 minutes. The surveyor observed the resident's call light was answered by a staff member at 11:48 a.m.During a concurrent observation and interview on 1/22/26 at 11:49 a.m., Resident 4 stated she was dependent on nursing staff to assist her with brief changes as she was unable to walk to the bathroom. Resident 4 stated she removes her own brief when it becomes soiled because it takes too long for the staff to respond to her call light. She stated it took about 15 minutes for call lights to be answered which was too long if you have to do #2 [bowel movement]. Upon observation two water bottles were at Resident 4 bedside. One bottle was empty. The other bottle contained 10 milliliters (mL, a unit of volume) of room temperature water. Resident 4 stated the water on her table was from last evening and further stated residents only received additional water if they asked staff for it.During a concurrent observation and interview on 1/22/26 at 12:10 p.m., in Resident 5's room, this surveyor observed a water bottle half full of room temperature water. Resident 5 stated the water bottle was only changed and filled once per day. Resident 5 stated the water bottle present on the table was brought to him last night. Resident 5 stated the water tasted bad when it's warm. I won't drink it like that. Resident 5 stated, [It] sometimes took staff an hour to answer [the call light] Especially the graveyard shift. They don't answer because they don't like to change you [resident briefs]. Resident 5 stated he has had to sit in his own bowel movement and urine on several occasions. He stated he had lost count how many times this has happened. Resident 5 further stated, I don't like it at all, makes me feel bad but I'm used to it now.During an interview on 1/22/26at 12:21 p.m., CNA 1 stated it was important for the residents to have water throughout the day in order to stay hydrated. CNA 1 further stated it was important to answer call lights quickly, within five minutes, because you don't know what the residents need.During an interview on 1/22/26 at 1:21 p.m., the Director of Nursing (DON) stated the expectation was for the nursing staff to refresh the ice and refill the water for the residents every shift. The nursing staff were expected to offer and encourage sips of water with every care intervention. The DON further stated call lights were everyone's responsibility, including leaders of the facility noting there were several people working in the building at any given time, so wait times for a call light to be answered should not be long. The DON stated residents left in soiled briefs was unacceptable. During an interview on 1/22/26at 1:45 p.m., the Administrator in Training (AIT) stated the facility did not have any staffing waivers on file. A review of the facility's policy titled Staffing, dated 2001, indicated, The facility provides adequate staffing to meet needed care and services for our resident population. Our facility maintains adequate staffing on each shift to ensure that our residents' needs and services are met. Licensed registered nursing and licensed nursing staff are available to provide and monitor the delivery of resident care services. Certified Nursing Assistants are available on each shift to provide the needed care and services of each resident as outlined on the resident's comprehensive care plan.</p>		