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	02/17/2026

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 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 observations, interviews, and record review the facility failed to ensure Resident Rights were honored when:Dignity and respect for residents was not provided when residents complained staff were observed being disrespectful, rude and unprofessional.Access to call lights for assistance and emergencies was not available when the call lights of three resident (Resident 15, Resident 24, and Resident 110) were not within reach on multiple observations.Access to visitors was denied to one resident (Resident 16) when she requested a visit from her daughter and the facility prevented her daughter visitation.Four out of five sampled residents (Resident 39, Resident 41, Resident 42, and Resident 69) were not treated with dignity and respect when staff were overheard speaking in a foreign language throughout the facility.These failures prevented the residents their right to safety, a dignified existence, self-determination, communication with and access to persons and services inside the facility, and residents feeling insecure and wondering if they were being talked about by staff. Findings: 1. Review of Resident 83's medical record document titled admission RECORD, indicated he was admitted [DATE] with diagnoses that included Chronic Ulcer of Right Foot, Cellulitis (Infection of skin and tissue), Dialysis (A treatment for kidney failure that filters waste, toxins, and excess fluid from the blood.), and Diabetes. Review of the Brief Interview of Mental Status (BIMS) score (An assessment that determine how cognitively intact a resident was.) indicated a score of 15 (A score of 12 - 15 indicated a resident was cognitively intact.). During an interview with Resident 83 on 2/3/26 at 10:55 a.m., he stated he had heard night nurses outside his room yell F**k you outside of his room all the time. He stated staff speak Spanish or some foreign language to each other in front of him all the time. He stated the staff are really unprofessional and he has informed nurses, but nothing ever changes so I stopped complaining. He stated it made him feel like staff did not care and it made him mad. During an observation on 2/10/26 at 2 p.m., 2:45 p.m. and 3:30 p.m. Licensed Nurse S was observed to exit through the main lobby and emit a cloud of blue, white vapor out of his mouth and nose, after he inhaled from something he pulled out of his pocket, immediately outside the double doors, where resident and family members enter the facility. During an interview on 2/3/26 at 8 a.m., Activity Director stated staff were never supposed to be on the phone during patient care hours or speak in a foreign language in front of residents or their families. Activity Director stated if a resident had a concern or was upset by something they could fill out a complaint form and report it to Social Services. She stated as Activity Director she assisted Residents at the monthly Resident Council meeting and the most recent complaints were related to staff sitting in patient room, taking their breaks and charging their phone. (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	02/17/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and concurrent record review with Social Services on 2/3/26 at 8:35 a.m., she stated she was responsible for the Grievance from residents or their families. She stated she would document the complaint, investigate and would follow up with a resolution. She stated she would communicate to the Director of Nursing (DON) and Administrator any grievances she received. She stated the Administrator review all of the grievances from the residents at the morning meetings that take place Monday through Friday at 9 a.m She stated most of the grievances were about staff taking a long time to answer call lights and lost items. She stated she had not heard about any grievance that staff behavior was unprofessional. During a concurrent record review of a document titled GRIEVANCE TRACKING LOG, it indicated what resident or family member expressed a grievance on what date, the nature of the grievance, how it was resolved and follow up. The grievance log indicated 25 instances of unprofessional staff behavior from April 2025 through December 2025. Further review indicated 13 were specifically about staff tone, Health Information Portability and Protection Act (HIPPA) documentation and public discussion about private care concerns, inappropriate bedside manners, bad communication, care need expectations, lack of professionalism from staff, and night shift care inconsistency. Social Services stated she had not documented details of each grievance and could not recall specific details. During an interview on 2/3/26 at 1 p.m., with the Director of Nursing, she stated she had not heard about any grievances or complaints from residents or family members about unprofessional staff behavior. She stated Social Services is responsible for management of grievances and complaints. She could not state if the facility reviewed the grievances for any trends to see if there was a larger problem than one or two complaints. During an interview with the Administrator on 2/2/26 at 4:15 p.m. he stated he had to discipline one night nurse (Licensed Nurse S) for unprofessional behavior. He stated Licensed Nurse S was a little rough around the edges and based on no specific issue he moved him to the AM shift so that he could keep an eye on him. Administrator stated he had a disciplinary action documented in his employee file for professionalism. During an observation and interview at 2/10/26 at 2:15 p.m. , the Infection Preventionist observed Licensed Nurse S outside the main entrance of the facility exhaling a cloud of vapor or smoke. She stated he is not supposed to be doing that. She stated that was very unprofessional. During an interview with the Director of Nursing on 2/12/26 at 8:30 a.m., she stated Social Services was responsible for investigating any grievance of complaint from a resident or family member. During an interview with the Administrator on 2/12/26 at 10:35 a.m. he stated he was not aware of any grievances (Complaint) from any resident or family of residents in the facility regarding unprofessional staff behavior. He stated he had not reviewed the grievance log and that the Social Services Director was responsible for grievances and would inform him in the morning meeting if there were any grievances. He stated there was a nurse who worked night shift that had a disciplinary action in his file. Administrator stated his expectation of all staff was that everyone was treated with dignity and respect. During review of an employee file document for Licensed Nurse S titled EMPLOYEE DISCIPLIANRY ACTION FORM, dated 1/16/26 it indicated NATURE OF INFRACTION Complaints from staff of being loud and lack of professionality in the workplace. During a record review of a facility Policy and Procedure titled Grievances/Complaints, Filing, (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	02/17/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	revised April 2025, it indicated Residents and their representative have the right to file grievances, either orally or in writing, to the facility staff. Actions on such issues will be responded to in writing, including a rationale for the response. The administrator will review the findings with grievance officer to determine what corrective actions, if any, need to be taken. 2. During a concurrent observation and interview on 2/2/26 at 10:52 a.m. with Resident 15 in his room, Resident 15 stated, staff moved his call light away from him and this meant he had to yell out for help, but staff did not come. Resident 15's call light could not be visualized near him or his bed. During a concurrent observation and interview on 2/2/26 at 11:00 a.m. with Resident 15 in his room with Unlicensed Staff AA, Unlicensed Staff AA stated he could not find Resident 15's call light and that it was not ok and forced the resident to yell out for help. During a concurrent observation and interview on 2/2/26 at 11:15 a.m. with Resident 24 in his room, Resident 24's call light was seen on the floor on the far side of his bedside table and was not accessible to Resident 24. Resident 24 stated he had a bowel movement and had been waiting for 2 hours to be changed, this has happened frequently and made Resident 24 feel like staff did not want to help him. During a concurrent observation and interview on 2/2/26 at 11:20 a.m. with Resident 110 in his room, Resident 110's call light was seen pinned to the wall to the left of Resident 110 far out of reach. Resident 110 stated he had left sided weakness after his stroke and could not use his left arm. Resident 110 stated he felt like staff pinned the call light away from him on purpose so he could not call for help. During a concurrent observation and interview on 2/2/26 at 11:25 a.m. in Resident 15, Resident 24, and Resident 110's room with Licensed Nurse Z, Licensed Nurse Z confirmed that Resident 15's call light was anchored on the wall near Resident 24's bed and was far out of reach. Licensed Nurse Z confirmed that Resident 24's call light was on the floor on the opposite side of the bedside table and was far out of reach. Licensed Nurse Z confirmed that Resident 110's call light was anchored to the wall far out of reach on Resident 110's left side which was his affected side. Licensed Nurse Z stated that none of the Resident's in the room had access to their call lights and this could have lead to delays in care and could be dangerous in an emergency. During an interview on 2/12/26 at 12:45 p.m. with the Director of Nursing (DON), DON stated call lights should always be in reach for all Residents. DON further stated if anchored out of reach or on the floor residents would be unable to call for assistance and this did not meet her expectation. A review of a facility policy titled, Call System, Residents, revised 09/2022, indicated each resident is provided with a means to call staff directly for assistance from his or her bed and that calls for assistance are to be answered immediately. A review of a facility policy titled, Resident Rights, revised 08/2009, indicated the facility will make every effort to assist each resident in exercising his/her rights to assure that the resident is always treated with respect, kindness and dignity. 3. During a record review of Resident 16 on 2/10/26 the Face Sheet, (some key health information of the resident) dated 2/10/26, it indicated that Resident 16 was admitted to the facility 10/16/23. (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	02/17/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 16 had the diagnosis of Osteoarthritis to knees, heart disease, chronic pain, Glaucoma, Degenerative nerve syndrome and Cognitive impairment. Resident 16's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 1/7/26 indicated Resident 16 needed substantial assistance with Activities of Daily Living. During an interview on 2/10/26 at 2:15 p.m., Social Services stated we are following the guidance of Resident 16's Durable Power of Attorney (DPOA.) The DPOA instructed the facility to prevent Resident 16's daughter from visiting, as the daughter's presence continues to be detrimental to Resident 16's well-being. During an interview on 2/10/26 at 2:30 p.m., Resident 16 voiced her desire to see her daughter. Resident 16 was in her room and sitting in a wheelchair. A Spanish interpreter was on the phone to facilitate the communication. Resident 16 expressed a preference for her daughter, stating that she helps with getting out of bed, cleaning, and feeding. Resident 16 did not mention any negatives. As the interview ended, Resident 16 was pleading and crying Bring back my daughter, I miss my daughter, I need my daughter! During an interview on 2/10/26 at 2:50 p.m., the Administrator stated that Resident 16's documented DPOA requested the facility not allow the daughter to visit because she interfered with staff care and was potentially detrimental to Resident 16's well-being. The Administrator stated the facility was not allowing this daughter to visit and had asked the Ombudsman (patient advocate agency) to work with the family. 4. A review of Resident 39's admission record indicated he was last admitted in 10/18 with the diagnosis of unspecified sequelae of cerebral infarction (long-term health problems caused by a stroke). A review of Resident 39's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 1/13/26, indicated he had no memory impairment. A review of Resident 41's admission record indicated he was last admitted in 4/24 with the diagnosis of acute coronary thrombosis not resulting in myocardial infarction (a condition when a sudden blood clot forms in a heart artery, but it doesn't block blood flow enough to damage the heart muscle or cause a heart attack). A review of Resident 41's MDS, dated [DATE], indicated he had no memory impairment. A review of Resident 42's admission record indicated he was last admitted in 3/25 with the diagnosis of intraspinal abscess (an infection inside the spine that creates a pus-filled pocket which can press on nerves and cause pain) and granuloma (small lump of immune cells that form when the body is trying to block of something it sees harmful like bacteria). A review of Resident 42's MDS dated [DATE], indicated he had no memory impairment. A review of Resident 69's admission record indicated he was last admitted in 8/23 with the diagnosis of other speech and language deficits following cerebral infarction (problems with speaking or understanding language after a stroke). A review of Resident 69's MDS dated [DATE], indicated he had no memory impairment. (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	02/17/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/3/26 at 10:12 a.m., with Resident 39, Resident 39 stated he hears staff speaking foreign languages all the time. Resident 39 stated this makes him uncomfortable because he does not know if they are talking about him. During an interview on 2/3/26 at 10:30 a.m., with Resident 41, Resident 41 stated he hears staff speaking foreign languages usually when multiple staff members are helping one of the other residents he shares his room with. Resident 41 also stated this makes him uncomfortable. During an interview on 2/3/26 at 10:42 a.m., with Resident 42, Resident 42 stated he hears staff speak foreign languages in the hallways and it makes him feel uncomfortable because he does not know what they are saying. During an interview on 2/3/26 at 11:10 a.m., with Resident 69, Resident 69 stated he hears staff speaking foreign languages all the time. Resident 69 also stated it really bothered him especially when staff would speak a foreign language while providing direct care to him. During an interview on 2/3/26 at 11:49 a.m. with Licensed Nurse (LN) A, LN A stated staff occasionally speak foreign languages, and she recalls there has been an in-service addressing the issue. During an interview on 2/5/26 at 11:19 a.m., with the Director of Nursing (DON), the DON stated staff is expected to speak in the same language the resident speaks, especially when around resident care areas. During a review of the facility's in-service records dated 8/27/25 which covered Communication/Foreign Language, the records indicated the objective of the in-service was After 1 hour of in-service the staff are expected to only speak in a language that is recognized and understood by the residents.

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	02/17/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview and record review, the facility failed to ensure residents had a safe, sanitary, homelike environment when: Patient care areas and laundry processing were observed to have broken and cracked floor tiles, exposed and unsealed medication cart work surfaces, unsealed cement on floors, exposed plaster, rusty and non-functioning equipment, and unsealed woodwork.These failures resulted in an environment for residents and staff that did not appear homelike, increased the risk of cross contamination and the spread of contagious disease.Cross Reference F880Findings: During an observation on 2/9/26 at 10:30 a.m. the floors and door jambs in resident rooms 56, 58, 59, 60, 61, 62 were observed to have chipped and cracked floor tiles, chipped paint on the doors and door jambs. The hand-washing sink in the east nursing station was observed to have exposed and damaged plaster in the entire area behind the faucet. The corner wall of the east nursing station where staff exited and entered the station was observed to have exposed plaster on the entire area around the alcohol-based hand sanitizer gel dispenser.During an observation on 2/10/2026 at 2:40 p.m., the hand-washing sink in the west nursing station was observed to have cracked, exposed plaster across the area behind the faucet and handles.During an observation on 2/10/2026 at 2:58 p.m. the clean utility room near the west nursing station was observed to have a grey black sticky substance on the high touch areas. An observation of scratched, chipped and worn paint indicated high use.During an observation and interview on 2/10/2026 at 2:47 p.m. at the west nursing station hand washing sink, Licensed Nurse QQ stated the water was too hot to wash her hands. She stated she could not hold her hands under the hot water without adjusting the temperature. She stated she did not know if exposed plaster could be sanitized. She stated it did not look like anyone cared.During an interview and observation on 2/10/2026 at 2:54 p.m., at the west nursing station hand washing sink, Administrator stated the exposed plaster behind the faucet was not good. He stated he was unsure if the exposed plaster could be disinfected and stated it needed to be repaired.During an interview and observation 2/10/2026 at 3:19 p.m., at the west nursing station, Licensed Nurse Q observed the medication cart and stated she observed a crack and open area on the surface of the medication cart. She stated she observed wood in the area of missing surface. She stated she was unsure if the crack and exposed wood could be disinfected.During an observation and interview on 2/11/26 at 8:45 a.m., with Housekeeping Director and Infection Preventionist, the room where dirty laundry was washed, was observed to have one out two functioning washing machines. The functioning washing machine on the left was observed to have a heavy band of white, rusty, powdery material that resembled corrosion. Housekeeping Director stated dirty laundry is brought outside the room with the washing machines to be sorted. An observation of the door that led to the outside dirty laundry area indicated to the left of the door was a red hose and spigot. The hose was plumbed inside the washing room and was fed through a hole in the wall to the outside dirty laundry sorting area. Close observation of the hole in the wall where the red hose exited the facility indicated a gap between the hose and the wall that let sunlight through to the inside of the washing room. Outside the doorway in the facility back parking lot the red hose was hanging up, and a steady drip of water was observed to have accumulated a pool of water on the cement in front of the doorway. The Infection Preventionist and the Housekeeping Director could not explain why the hose was plumbed in this manner or if it met California plumbing code. They stated the functioning washing machine was observed to have rust and corrosion on the lower left area where the machine was closest to the floor. They stated the Administrator was aware one out of two washing machines were not working and aware of the age and condition of the one remaining functioning washing machine. They stated they did (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	02/17/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not hear what the follow up was for the washing machines. An observation of the ceiling in the room with the washing machines indicated a ceiling mounted metal box that had been painted white. Observations indicated the surface was rough, appeared rusty and had been painted over. Infection preventionist and Housekeeping Director stated they did not know if you could disinfect rust or corrosion. An observation of the ceiling in the area that contained three laundry dryers indicated two out of three dryers were functional. The room had broken floor tiles, scratched walls that exposed unpainted and unsealed plaster where laundry carts were moved, and a ceiling with a large rough area of exposed plaster. Observation in the room indicated a folding table where clean resident laundry was folded had exposed unsealed wood edges and the white laminate surface had cracks and what appeared to be bubble that interrupted the smooth laminate. Infection preventionist and Housekeeping director stated they did not know if exposed plaster, chipped paint, or unsealed wood could be disinfected or sanitized. They stated Administrator was aware of the chipped floor tiles, exposed plaster and non-functional dryer but they did not hear about what the follow up plan was.During an observation and interview on 2/11/2026 at 9:50 a.m. with the Infection Preventionist, the utility room on the east nursing station was observed to have chipped paint on the door jambs in high touch areas, exposed plaster on the walls where carts had gouged through the paint and had exposed plaster. Infection preventionist stated the chipped paint, exposed plaster and unsealed wood could not be disinfected and the risk was cross contamination in infection.During the observation and concurrent interview with the Infection Preventionist of the west utility room door, it appeared to have black, grey sticky area around the high use door handle and door jamb. Scratches and worn paint exposed a wood surface in patches. Inside the utility room a large rectangle of exposed and unsealed concrete was observed on the tile floor in front of the hand-washing sink. Exposed plaster on the walls and chipped paint was observed inside the room. The infection preventionist stated exposed concrete, chipped floor tiles, exposed plaster could not be disinfected. She stated it looked dirty and if residents or family were looking at it, they would think it was dirty.During an interview on 2/12/26 at 8:30 a.m. in the Administrator's office, the Director of Nursing stated for environmental issues like chipped floor tiles and chipped paint and exposed plaster or wood, and for broken medication cart surfaces, staff were supposed to communicate the needed repairs to maintenance by documentation of the needed repairs in the maintenance binder located at the nursing stations. She stated the maintenance staff would fix the issues. She stated she knew about the medication cart and the top had just been ordered but had not arrived yet.During a concurrent observation and interview on 2/12/26 at 9 a.m., Administrator, Director of Nursing and Maintenance Director observed the shower room in the northwest hallway. The overhead light was observed not to turn on. Maintenance Director stated it needed to be replaced. During an observation in the northwest hallway, resident rooms 5, 6, 9, 10 were observed to have chipped paint on the door jambs, doors with chipped paint and black, grey streak, chipped and missing part of floor tiles and based boards with exposed wood. Maintenance Director stated the floor tiles had been ordered and were available to repair floors, but it was difficult to get the time to complete the repairs because the rooms were always full of residents.A review of the facility Policy and Procedure titled Maintenance Service, revised 12/2009, indicated Functions of maintenance personnel include, but are not limited to: a. maintaining the building in compliance with current federal, state, and local laws, regulations, and guidelines. b. maintaining the building in good repair and free from hazards. The maintenance director is responsible for developing and maintaining a schedule of maintenance service to assure that the buildings, grounds, and equipment are maintained in a safe and operable manner. 7. Maintenance personnel shall follow established infection control precautions in the (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	02/17/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	performance of their daily work assignments.SEE PHOTOS

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	02/17/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, one of two residents sampled for tube feeding (Resident 140), who was at risk for constipation, had no bowel movement (BM) for five days and was not given bowel care medications as indicated on the care plan. This failure contributed to Resident 140 developing a fecal impaction (a severe, solid, or hard mass of stool stuck in the rectum or colon, typically resulting from chronic, untreated constipation).During an electronic medical record (eMR) review on 2/3/26 at 3:30 p.m., Resident 140's face sheet indicated an admission date of 1/9/26, age in his 70s, and medical diagnoses that include traumatic subdural hemorrhage (a type of bleeding near the brain that can happen after a head injury), broken facial bones, aphasia (language disorder resulting from brain damage that impairs speaking, writing, reading, and comprehension while leaving intelligence intact), dysphagia (difficulty swallowing), and a gastrostomy (the surgical creation of an opening (stoma) into the stomach to insert a feeding tube (G-tube) for direct nutrition). Review of Resident 140's Constipation Risk assessment dated [DATE] indicated Resident 140 was at high risk for constipation. Review of Resident 140's care plan dated 1/10/26 revealed a focus area Bowel: At risk for complications with bowel regimen due to constipation, with the goal, Will have satisfactory bowel movements every 1 to 3 days as evidenced by soft, formed stools, and interventions that included administering medications per physician order. Review of Resident 140's physician orders revealed no bowel care medications such as laxatives (increase muscle contractions in the intestines) or stool softeners (increase water absorption into the colon to soften stool) were ordered except MiraLax (a laxative) ordered 1/26/26 to be given once every 24 hours as needed for constipation. Review of Resident 140's medication administration record indicated MiraLax was administered on 1/26/26 and 1/27/26 by Licensed Nurse Q. Review of Resident 140's documentation of bowel movements indicated Resident 140 had a small putty-like BM on 1/21/26 and no subsequent BMs were documented. During an interview on 2/3/26 at 11 a.m., Licensed Nurse Q reviewed Resident 140's eMR and verified Resident 140 had not had a bowel movement for five days when she obtained an order from the doctor for Miralax on 1/26/26. Licensed Nurse Q stated she obtained the order for Miralax because Resident 140 did not have orders for any bowel care medications. Licensed Nurse Q verified she administered the Miralax to Resident 140 on 1/26/26. When queried, Licensed Nurse Q stated not having a bowel movement for five days was a big deal. Licensed Nurse Q stated the potential outcome to the resident included a lot of pain, fissures, hemorrhoids, bowel obstruction, or a gassy formation that could cause delirium. Licensed Nurse Q stated Resident 140 re-admitted from the hospital on 1/21/26 and then was transferred back to the hospital on 1/27/26 when he became unresponsive. During a phone interview on 2/4/26 at 9:21 a.m., Resident 140's family member stated that when Resident 140 was re-admitted to the hospital (on 1/27/26), he was constipated and the nurses were pulling fecal matter out of his stomach from his G-tube. During a medical record review on 2/11/26 at 10:30 a.m., Resident 140's hospital records revealed a hospitalist (a physician who specializes in the care of patients solely while they are admitted to the hospital) progress note dated 1/30/26 indicated, . found to have bowel obstruction . Bowel obstruction vs ileus (a temporary condition where the intestine cannot push food and waste out of your body) - no BM since 1/21 . Review of Resident 140's Critical Care Consult Note dated 1/30/26 indicated that the G-tube output was black/feculent in appearance, belly distended and tense, no reported BM from nursing. Review of Resident 140's abdomen x-ray dated 1/30/26 indicated, Large amount of gas and fecal material within the colon suggesting an ileus. During an interview on 2/12/26 at 1 p.m., Director of Nursing (DON) stated it was her expectation that the nurses monitor for their residents' last bowel movement, and if a (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	02/17/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident had gone beyond three days, the nurse should initiate bowel care. DON stated the residents' last BM was on the eMR, there was an alert with the date of the last BM. DON verified the nurses did not have to go looking for documentation of the last BM, it was easy to see. DON stated it was her expectation that if a resident was at risk for constipation, the nurse should have called and notified the doctor to get orders for bowel care. DON stated routine bowel care should be obtained when the care plan for constipation was developed. Review of facility policy and procedure Bowel (Lower Gastrointestinal Tract) Disorders - Clinical Protocol, last revised 9/2017, indicated, As part of the initial assessment, the staff and physician will help identify individuals with previously identified lower gastrointestinal tract conditions and symptoms.Examples of lower gastrointestinal tract conditions and symptoms include: .Alteration in bowel movements . In addition, the nurse shall assess and document/report the following: . Presence of fecal impaction . Abdominal assessment . Onset, duration, frequency, severity of signs and symptoms; all current medications .

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	02/17/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide adequate supervision and monitoring for one out of two sampled Residents (Sampled Resident 60) when Resident 60 left the facility unnoticed by staff (eloped) on 12/27/25.This failure contributed to Resident 60 being found outside the facility by the police and had the potential to lead to injuries for Resident 60. Review of Resident 60's medical record document titled admission RECORD, indicated he was admitted [DATE], with diagnoses that included Heart Disease, Encounter for Aftercare Following Surgery on the Circulatory System, Muscle Weakness, Need for Assistance with Personal Care, and Unspecified Psychosis (A person's thoughts and perceptions are disrupted and they may have difficulty recognizing what is real and what is not.).During an observation on 2/2/26 at 9 a.m., the front doors of the facility faced north onto a busy street with consistent traffic.During an interview with Resident 60's Public Guardian I (A court-appointed official or agency that acts as a legal conservator for adults unable to manage their own personal care or finances due to severe cognitive impairment, dementia, or disability) on 2/3/26 at 1:56 p.m., she stated someone from the facility had informed her that Resident 60 had eloped on the weekend. She stated the person who had informed her stated a licensed nurse had observed Resident 60 in his room with the door shut and Didn't know he had actually gone missing. She stated the police had been notified and was found by the police.On 2/3/26 at 5:06 p.m., the Infection Preventionist Nurse (IP) stated she had spoken with Resident 60's Public Guardian I after he eloped. The IP stated she remembered seeing a text chain on the text system the facility utilized to communicate important things. She stated she received it on the weekend, and it was about Resident 60 missing, and everyone had looked for him and the police were called.During an interview with Licensed Nurse Q on 2/4/26 at 11:58 a.m., she stated she knew that Resident 60 had eloped and stated she was at lunch when he went missing. She stated he did not have a Wander alarm (wireless monitoring system, usually in form of a bracelet that a resident wears, and an alarm will sound if the resident approaches a door sensor) on at that time. She stated if a wander alarm was recommended on the assessment of wandering and elopement, it should have been put on right away and it Would have prevented his elopement. She stated the police brought him back and stated that Resident 60 had walked for quite some time and he kept saying he wanted to go home. Nurse Q stated it was very risky to walk the street in front of the facility because it was very busy and full of cars. She stated he could have fallen or got hit by a car.During an interview on 2/5/26 at 11:15 a.m. with Administrative Staff T, she stated she was aware of the elopement of Resident 60. She stated she remembered looking at the group text used by the facility to communicate important information like an elopement. She reviewed the text history, and it indicated 12/27/2025 at 11:53 a.m. the text indicated Resident 60 was missing and police returned him to the facility at 1:27 p.m A request for a copy of the group chat text made and not received at the conclusion of the survey.During an interview with the Director of Nursing (DON) on 2/12/26 at 8:30 a.m., she stated Resident 60's original elopement wandering assessment score was an 8 and it was not considered high risk. She stated a score of more than 10 was a high risk. She stated the risk assessment dated [DATE], recommendation for a Wander alarm was a mistake. She stated the nurse that had been assigned to Resident 60 observed him in his room after morning medication administration and did not notice that he walked out of his room and out of the facility. She stated, there was not enough supervision of Resident 60 to prevent him from eloping.During an interview with Administrator on 2/12/26 at 10:35 a.m., he stated Resident 60 had eloped. He stated staff did not see Resident 60 exit his room and leave the facility. He stated, The facility did not supervise (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	02/17/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 60 close enough to prevent him from leaving the facility.A review of the facility Policy and Procedure titled Wandering and Elopements, revised March 2019, indicated If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety.A review of a document titled ELOPEMENT AND WANDERING RISK OBSERVATION/ASSESSMENT, (An assessment based on 36 questions regarding wandering and elopement behaviors, history, and expressions of wanting to leave made by residents.) dated 12/27/25, indicated a score of 8 (0 -9 was low risk, and 10-30 was high risk). It also indicated: Based on Elopement and Wandering Risk Observation/Assessment Findings: a. Yes, a wander alarm IS indicated.A review of a facility document titled Investigation Report: Elopement, dated 12/28/25, indicated Date of Incident: 12/27/25, Time of Incident: Approximately 11:45 a.m. The resident was medically cleared and returned to the facility via BLS transport at approximately 1500 (3 p.m.) hours. Conclusion: This event was determined to be an elopement related to resident disorientation and believe of discharge status.Record review of a document titled CARE PLAN REPORT, dated 12/26/25, indicated a focus titled Falls: Resident is at risk for fall with or without injury related to unsteady gait.dementia.Muscle weakness. Interventions/Tasks.Keep within supervised view as much as possible.Record review of a document titled CARE PLAN REPORT, dated 1/2/26, indicated a focus titled Elopement: Resident is at risk for elopement/exit seeking/wandering. Intervention/Tasks.Wander alarm as Ordered. No intervention for supervision or monitoring was indicated.

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	02/17/2026

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 0841 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Designate a physician to serve as medical director responsible for implementation of resident care policies and coordination of medical care in the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure effective participation and oversight of resident medical care by Physician R when,The infection Prevention and Control Program for a census of 116 was not provided oversight by Physician R for antibiotic stewardship and monitoring of infectious diseases in the facility designed to slow and prevent the spread of Clostridium Difficile (C. diff- a highly contagious bacteria that causes severe diarrhea), and prevention of water borne illness related to positive Legionella (a type of bacteria found in water that causes Legionnaires Disease a severe pneumonia) results.(Cross reference F 880).Physician R did not ensure resident care policies for informed consent were implemented according to facility policy for two of five residents (Resident 10 and Resident 12) sampled for psychotropic medications, andPhysician R did not ensure adequate diagnostic evaluation for a new diagnosis of Schizophrenia (a mental illness that is characterized by disturbances in thought) for two of five residents (Resident 2 and Resident 10) sampled for freedom from chemical restraint.These failures put residents at risk for negative outcomes related to severe infectious diseases, improper diagnoses of a serious mental illness, and psychotropic (any medication that affects brain activity associated with mental processes and behavior) medications. add F880 language 2. A review of Resident 12's informed consent form dated 3/16/25 for psychotropic medication Risperidone for visual hallucination was not signed by the resident's representative and verbal consent is not indicated. A review of Resident 12's informed consent form dated 9/11/25 for psychotropic medications Mirtazapine for depression and Risperidone for visual hallucination, was not signed by the resident's representative and verbal consent was not indicated. During an interview on 2/12/26 at 11:25 a.m. with Resident 10's representative, the representative stated she had never heard from the medical doctor at the facility and had not signed any forms concerning psychotropic medications. The resident representative further stated she felt she was not kept in the loop and expected the facility would communicate more. During an interview on 2/17/26 at 9:04 a.m. with Resident 12's representative, the representative stated she had not spoken to anyone about psychotropic medications and if she had she would have told them she did not want Resident 12 to take these psychotropic medications because she felt they made Resident 12 less functional. During an interview on 2/12/26 at 12:45 p.m. with the Director of Nursing (DON), DON stated her expectation for informed consent was Physician R would reach out to the resident representatives for education and treatment planning prior to notifying the nurses to obtain confirmation and signature. DON further stated she was surprised that the resident representatives had not heard from Physician R. During an interview on 2/13/26 at 9:45 a.m. with Physician R, Physician R stated he could not do all the education and depended on the nurses to do the teaching and notify him if the representatives had concerns. (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	02/17/2026

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 0841 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of a facility policy titled, Psychotropic: Medication Use, revised 02/25, indicated prior to initiating the use of, increasing the dose, or switching to a different psychotropic medication, the staff and physician will review non pharmacological alternatives, indications and rationale for recommendation, the potential risks and benefits (including possible side effects, adverse consequences, and black box warnings) and the resident or resident's representative's rights to accept or decline the treatment. 3 a. A review of Resident 10's admission record indicated she was admitted in 12/22 with diagnoses of Dementia (a progressive state of decline in mental abilities), Major Depressive disorder (MDD-a mood disorder that causes a persistent feeling of sadness and loss of interest), and unspecified psychosis. A review of Resident 10's Minimum Data Set (MDS-a resident assessment tool) dated 12/22/25 indicated severe cognitive impairment. A review of Resident 10's Physician Order Summary indicated a psychotropic medication, Seroquel, prescribed for schizoaffective disorder (a chronic mental health disorder blending Schizophrenia symptoms with mood disorder episodes), manifested by visual hallucinations. A review of Resident 10's CHE Behavioral Health Services Psychiatry note dated 9/13/23 indicated active diagnoses of Dementia and MDD with no reported auditory hallucinations. A review of Physician R's SOAP note (physician progress notes) dated 10/12/23 indicated no new diagnosis of schizoaffective disorder with active diagnoses of Dementia and MDD. A review of a fax sent to Physician R by facility staff on 10/16/2023 indicated Resident 10 was taking Seroquel without an assigned diagnosis and facility staff asked to have Physician R update Resident 10's diagnoses list. A review of Resident 10's diagnoses list indicated the diagnosis of schizoaffective disorder was added on 10/16/23 by Physician R. A review of Resident 10's CHE Behavioral Health Services Psychiatry note dated 12/27/23 indicated active diagnoses of Dementia and MDD with no recent hallucinations and recommended a decrease in Seroquel dose. No new diagnosis of Schizoaffective is mentioned. A review of Physician R's SOAP note (physician progress notes) dated 12/02/23 indicated no new diagnosis of schizoaffective disorder, and confirmed active diagnoses of Dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. A review of the most recent CHE Behavioral Health Services Psychiatric note dated 12/24/25 indicated an active diagnosis of Dementia without behavioral disturbance, MDD manifested by auditory hallucinations, sadness, insomnia and tearfulness with no new medication recommendations. During an interview on 2/12/26 at 11:25 a.m. with Resident 10's representative, she stated, Resident 10 had no history of schizoaffective disorder, and she had never spoken to a medical doctor from the facility about this diagnosis. During an interview on 2/12/26 at 12; 45 p.m. with the Director of Nursing (DON), DON stated a (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	02/17/2026

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 0841 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	diagnosis of a serious mental illness should not be added for medication alone, it should be properly diagnosed first by a behavioral health provider, if not this could lead to residents inappropriately being labeled as having a serious mental illness. During an interview on 2/13/26 at 9:45 a.m. with Physician R, Physician R stated, for a diagnosis of schizoaffective disorder we refer residents to psychiatric services to evaluate, if psychiatry did not confirm the diagnosis, then it should have been removed. Physician R further stated he may have added the diagnosis of schizoaffective disorder for Resident 10 because it was likely based on evolving symptoms. During an interview on 2/13/26 at 10:40 a.m. with Nurse Practitioner KK, she stated residents with a diagnosis of schizoaffective disorder usually have a history prior to coming to the facility and she would have expected a diagnosis of serious mental illness to be evaluated by the physician applying the diagnosis. A review of a facility policy titled, Schizophrenia and Related Disorders-Clinical Protocol, revised 03/2025, indicated The practitioner will not newly diagnose a resident with a serious mental illness without evidence based criteria that are documented in the residents record.the presence and duration of symptoms, behaviors, and disturbances consistent with current Diagnostic and Statistical Manual of Mental Health Disorders criteria for Schizophrenia. 3b. Review of Resident 2's electronic medical record (eMR) revealed a face sheet that indicated Resident 2 was admitted to the facility on [DATE], his age was in his 60s, and his medical diagnoses included cerebral infarction (blockage in the blood vessels to the brain) with right sided weakness, epilepsy (a seizure disorder), diabetes (a chronic illness that effects the way blood sugar is metabolized), anxiety, and psychotic disorder with delusions (a psychiatric condition characterized by one or more persistent, often non-bizarre, false beliefs). Further review of Resident 2's medical diagnoses indicated that on 2/6/24 a schizophrenia diagnosis was entered. Review of Resident 2's behavioral health note, dated 11/29/23, written by Nurse Practitioner (NP) LL indicated she recommended starting Risperdal (an antipsychotic medication) 0.25 mg daily to help manage his delusions and paranoia. Further review of this behavioral health note revealed no indication Resident 2 had a diagnosis of schizophrenia. Review of Resident 2's physician progress notes and behavioral health notes for November 2023 through May 2024 revealed no mention of a schizophrenia diagnosis. During a phone interview on 2/11/26 at 1:30 p.m., Nurse Practitioner (NP) KK verified Resident 2 was a patient seen by her behavioral health group. NP KK reviewed Resident 2's medical record and stated Resident 2 was originally seen by NP LL, and he was prescribed Risperdal. NP KK verified NP LL's progress notes did not mention schizophrenia at the time the Risperdal was prescribed but stated the diagnosis of schizophrenia was based on his symptoms of delusions, his BIMS score of 3, and the fact that his symptoms improved on the Risperdal. NP KK verified Resident 2's progress note written by NP LL in December 2024 was the first documentation of schizophrenia as a diagnosis. During a record review on 2/11/26 at 2:30 p.m., a fax dated 2/6/24 sent to Physician R by MDS Nurse NN regarding Resident 2 indicated, Hi Doctor. Res[ident] on antipsychotic [medication] 'Risperdal' and no [diagnosis] of schizophrenia? Can we [please] update [medical] diagnosis Y[es] or N[o]. Thank you. Further review of the fax indicated Physician R responded Yes with an undated signature. During a phone interview on 2/11/2026 at 2:58 p.m., Physician R reviewed Resident 2's chart. Physician R stated he based his diagnosis of schizophrenia on Resident 2's behavior. Physician R verified (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	02/17/2026

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 0841 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	he consulted with the behavioral health consultants when he responded yes to the fax from MDS Nurse NN but was unable to find documentation of the clinical rationale. During an interview on 2/11/2026 at 5:25 p.m., Psychologist MM verified he was Resident 2's psychologist. Psychologist MM reviewed Resident 2's medical record and stated Resident 2 did have a delusional disorder mentioned in his progress notes but stated that diagnosis was not interchangeable with schizophrenia. Psychologist MM verified his progress notes did not mention a diagnosis of schizophrenia. Psychologist MM stated he may have discussed with Physician R the new diagnosis of schizophrenia in February 2024. Psychologist MM stated he recalled he referred Resident 2 to NP LL, for prescribing of psychiatric medications, but she left the practice shortly after she started seeing Resident 2 as consultant. During an interview on 2/12/26 at 8:49 a.m., MDS Nurse NN stated the reason she sent the fax to Physician R was that when she completed the MDS (minimum data set, an assessment tool) for Resident 2, the system triggered a note that they needed the right diagnosis entered for the medication. MDS Nurse NN stated she asked Physician R since he was the medical director and she knew he would answer her request. MDS Nurse NN verified that Risperdal was a new medication for Resident 2 that was started at the facility. MDS Nurse stated she was not aware of any documentation that a clinician diagnosed Resident 2 with schizophrenia in February 2024 or prior to that time. During an interview on 2/12/2026 at 10:20 a.m., MDS Nurse OO stated there was no documentation in Resident 2's record that a clinician diagnosed Resident 2 with schizophrenia at the time MDS Nurse NN entered the diagnosis in the eMR in February 2024 or prior to that time. Review of facility policy Schizophrenia and Related Disorders - Clinical Protocol, last revised 3/2025, indicated, 1. The practitioner will not newly diagnose a resident with a serious mental illness without evidence-based criteria that are documented in the resident's medical record. 2. The rationale for the diagnosis will be based on a comprehensive assessment of the resident's physical, behavioral, mental status, psychosocial status, and comorbid conditions. Documentation will include: a. the findings from the comprehensive assessment; b. the presence and duration of symptoms, behaviors, and disturbances consistent with current Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria for schizophrenia; c. that the symptoms, behaviors, and disturbances are not attributable to substances, medications, or other conditions; and d. the effect the disturbance is having on the resident's function, self-care, or interpersonal relationships, in comparison to before the onset of the disturbance.

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	02/17/2026

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 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on interview and record review, the facility Quality Assurance Performance Improvement Committee failed to identify multiple quality of care issues. This failure resulted in a systemic breakdown of the infection control and prevention program which potentially could have led to harm of vulnerable residents, and other poor outcomes for residents in the care of the facility.During an interview on 2/12/26 at 2:25 p.m., the Administrator stated the Quality Assurance Performance Improvement (QAPI) Committee met monthly. The Administrator stated the QAPI committee developed performance improvement projects based on information they got from department heads, grievances, the resident council, monthly all-staff meetings, and an anonymous suggestion box. The Administrator stated QAPI was the umbrella for all of those sources of information so if something was an ongoing struggle then it would go to QAPI for monitoring. The Administrator stated a performance improvement project for infection prevention was started on 2/3/26, the day after the survey began. The Administrator verified no other quality of care issues found by the survey team were captured by the QAPI committee as areas of improvement. Review of facility document Quality Assurance and Performance Improvement Plan, dated 2026, indicated, [Facility] will put in place systems to monitor care and services, drawing data from multiple sources. The QAPI team at [facility named] will decide what data to monitor routinely. Examples of areas to consider included clinical care areas, such as infections, and medications, such as those requiring close monitoring and antipsychotics.

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	02/17/2026

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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record reviews, the facility failed to develop and maintain an effective infection prevention and control program and a system for preventing, identifying, reporting, investigating, and controlling infections, including establishing policies and procedures, when A. facility staff could not prevent a C-Diff (C. diff- a highly contagious bacteria that causes severe diarrhea) outbreak, B. facility did not follow water management requirements for Legionella (a type of bacteria naturally found in freshwater, that becomes a health concern when it grows in man-made water systems; people get sick (severe pneumonia) by inhaling mist that contains the bacteria), and C. and open sewage pipe was observed in a communal shower room which also stored medical equipment.These failures had the potential to cause the spread of infection among a vulnerable resident population and resulted in harm to at least 8 residents who were confirmed positive for C. Diff. between 11/12/25 and 1/24/26, and three residents (Resident 31, Resident 60, Resident 102) who were identified with active C.Diff. on 2/2/26. On 2/4/26 at 3:25 p.m., the Administrator was notified verbally by the nurse surveyor in his office of an IMMEDIATE JEOPARDY (IJ) (Immediate Jeopardy is a situation in which entity noncompliance has placed the health and safety of recipients in its care at risk for serious injury, serious harm, serious impairment or death. (State Operations Manual, Appendix Q), was identified, under S483.80 Infection Control, due to the facility's failure to maintain an effective infection control program which had resulted in three sampled residents (Resident 31, Resident 60, and Resident 102) who were in Isolation for active infection of Clostridium Difficile (Cdiff) on the day of entrance 2/2/26. The Administrator was informed that the survey team's findings were: 1. Eight residents were confirmed positive for C. Difficile between 11/12/25 through 1/24/26. 2. The Infection Preventionist (IP) was unable to describe the facility's surveillance program to monitor communicable diseases. 3. The IP was unable to provide a tracking log for communicable diseases. 4. Bedside care staff were unable to verbalize the appropriate disinfectant to use for shared care equipment to prevent the spread of C. Difficile. 5. Staff failed to use an appropriate blood pressure cuff for contact isolation. 6. The facility did not have a policy and procedure for C. Difficile. 7. The hand-washing station at the nurses station next to a room with a resident with C. Difficile was not fully stocked and did not have warm water. 8. Two residents with C. Difficile had a shared bathroom with residents who did not have C. Difficile. 9. Staff were observed providing direct care to a resident on contact precautions without gowns.On 2/5/2026 at 10:30 a.m. the Administrator and Director of Nursing were notified the facility plan of removal of IJ draft #1 was not acceptable and were informed of needed revisions. On 2/5/26 at 2:17 p.m., the Administrator provided plan of removal of IJ draft #2.On 2/5/26 at 3:29 p.m., the Administrator was notified plan of removal of IJ draft #2 was rejected.On 2/5/2026 at 3:45 PM the survey team left the facility, and the Administrator was notified to send the plan of removal for IMMEDIATE JEOPARDY via email. On 2/5/2026 at 5:50 p.m. the facility emailed plan of removal of IJ draft #3.On 2/6/2026 at 12:15 p.m. the plan of removal of IJ draft #3 was accepted via email. Draft #3 included facility actions that included: 1. The C. Diff policy and procedure was updated to include the use of bathroom, frequency of cleaning and disinfecting of equipment, rooms, and bathrooms. 2. The IP was trained on the infection surveillance program/monitoring and tracking as well as the facility's Infection Control and Prevention Program. 3. The IP completed in-services with all Licensed Nurses and Certified Nursing Assistants on the policy and procedure for C.diff, including appropriate use of personal protective equipment. 4. The IP or designee will be responsible for ensuring every isolation room has its own dedicated vital signs equipment and cleaning solution. 5. All 116 residents' medical records (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	02/17/2026

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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	were reviewed by the Director of Nursing (DON) and IP to determine whether they have had any change of conditions that would indicate C.diff infection. 6. The Medical Director will be responsible for providing solutions and measures to prevent the spread of infections.On 2/7/26 at 11:45 a.m., validation of the removal of the IMMEDIATE JEOPARDY (IJ) under S483.80 Infection Prevention was conducted in the presence of Administrator after interviews, observations, and record review confirmed the facility implemented the removal plan. Findings: A. During an observation and interview on 2/3/26 at 3:40 p.m., Housekeeper P on the East Wing stated that when he cleaned the rooms of residents with C. Diff he used Clorox and he held up a spray bottle of Clorox disinfectant spray. During an interview on 2/3/26 at 4 p.m., Licensed Nurse N stated residents with C. Diff should have their own dedicated vital signs equipment. During an interview on 2/3/26 at 4:10 p.m., Unlicensed Staff II explained the isolation precautions for a resident with C-Diff. The staff member said they must gel in, wear a gown, gloves, and mask, dispose of the gown and gloves in the room's trash cans, and wash hands with soap and water. The portable blood pressure device should be sanitized with wipes that have a lavender top. During an observation and concurrent interview on 2/3/26 at 4:10 p.m., Unlicensed Staff JJ noted that designated equipment should be used in the C-Diff isolation room. However, the portable blood pressure device is often brought into the room and cleaned with the provided lavender-topped Medline MicroKill One germicidal alcohol wipes, rather than the blue topped Medline MicroKill Bleach disinfection solution for C-Diff. During an observation and interview on 2/3/26 at 4:20 p.m. Unlicensed Staff J was observed to exit Resident room [ROOM NUMBER] and did not engage in hand hygiene. He stated he was supposed to wash his hands with soap and water and he forgot. He stated the risk to residents if he did not wash his hand was the spread of infection. During a concurrent observation and interview on 2/3/26 at 4:20 p.m. in west hallway with Unlicensed Staff BB, Unlicensed Staff BB stated for Resident's that are on isolation precautions she checked their vital signs using the shared vitals equipment tower and would then disinfect using the violet topped wipes. Unlicensed Staff BB reviewed the active ingredients list on violet topped wipes and concurred it lists ethyl alcohol as the active ingredient and the container did not indicate that it was effective against Clostridium Difficile (C. diff- a highly contagious bacteria that causes severe diarrhea). Unlicensed Staff BB further stated she could not recall receiving infection control education when she started working at the facility in 09/2025, only what she had learned in school for certification. During an interview on 2/3/26 at 4:30 p.m. with Unlicensed Staff PP he stated If a resident was on precautions for C.diff it would mean they were on isolation and stated residents were supposed to have dedicated equipment that stays in the room. During an interview on 2/3/26 at 4:41 p.m. in the east hallway with Unlicensed Staff D, Unlicensed Staff D stated she used the shared vitals equipment tower for Resident 31 who is on Isolation Precautions and disinfected the vitals tower using the blue top bleach wipes in Resident 31's room. (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	02/17/2026

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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Unlicensed Staff D further stated that Resident 31 used to have her own vitals equipment in her room but it had broken. During an observation and interview on 2/3/26 at 4:30 p.m., Housekeeping Supervisor removed a bottle of Clorox disinfectant spray from the housekeeping cart for the [NAME] Wing and stated it was the product the housekeeper used to clean rooms for residents with C. Diff. During an observation and interview on 2/3/26 at 4:45 p.m. with Housekeeping Supervisor and IP, Housekeeping Supervisor stated she just found out the Clorox product the housekeepers were using was not effective against C. Diff and they were now in-servicing the housekeeping staff to use the blue-top bleach wipes. Housekeeping Supervisor held up a container of the bleach wipes. The label indicated, Kills C. Diff spores in 3 minutes. When asked if she reviewed the products the housekeeping staff used, IP stated she was not involved with which products the housekeeping department ordered. During an observation on 2/4/26 at 11:15 p.m. in Contact Precautions room [ROOM NUMBER] for Resident 60, no blood pressure cuff was observed hanging or in the drawers of the bedside table. No blood pressure cuff was observed in the bathroom. During an interview on 2/4/26 at 11:30 a.m. in east hallway with Unlicensed Staff CC, Unlicensed Staff CC stated she was educated today by the DON to use the blue top bleach wipes to disinfect the shared vitals equipment tower but that Residents who are on isolation precautions should have their own equipment. During an interview on 2/4/26 at 11:35 a.m., Unlicensed Staff GG stated she had a resident with C. Diff on her assignment, Resident 31, and stated she used the same vital signs tower to take all her residents' vital signs including the resident with C. Diff. Unlicensed Staff GG stated she cleaned the vital signs equipment with the container of disinfecting wipes with the violet top after use in between residents. During an interview on 2/4/26 at 11:43 a.m., Licensed Nurse Z verified she had a resident with C. Diff on her assignment, Resident 31. Licensed Nurse Z stated residents with C. Diff should have dedicated vital signs equipment. During an interview on 2/4/26 at 11:50 a.m. in the east hallway with Unlicensed Staff DD, Unlicensed Staff DD stated for Residents on isolation precautions she would use the shared vitals equipment tower and disinfect with the blue top bleach wipes and allow to sit for 3 minutes. Unlicensed Staff DD further stated she had not received any additional infection control education this morning when she started her shift. During a concurrent observation and interview on 2/4/26 at 12:15 p.m. with Licensed Nurse EE and Resident 31 inside Resident 31's room, no dedicated vitals equipment is observed, Licensed Nurse EE confirms this. Resident 31 stated she used to have her own equipment but it broke and staff clean the shared vitals equipment after use using the blue top bleach wipes. After exiting Resident 31's room Licensed Nurse EE went to wash her hands at the nurses station in east hallway. Licensed Nurse EE concurred the water from sink remained very cold after 4 minutes of running and there were no paper towels in the dispenser. At this time the vitals tower in east hallway is observed with the violet top disinfectant present in basket. Licensed Nurse EE stated staff should be using the blue top bleach wipes now because the violet top disinfectant does not kill C-Diff. Licensed Nurse EE could not verbalize if the BP cuff on vitals tower was able to be properly disinfected due to its porous Velcro (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	02/17/2026

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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	surfaces. During an interview on 2/10/2026 at 3:02 p.m., Unlicensed Staff J stated the way to clean a blood pressure cuff that would come out of a contact precautions room for C.diff would be to use bleach wipe on the blood pressure cuff for 3 minutes and let it air dry. During an observation and interview on 2/4/26 at 11:58 p.m. Licensed Nurse Q observed Contact Precautions room [ROOM NUMBER] for Resident 60 and stated she did not see any dedicated vital sign equipment in the room. She stated staff had to take one of four shared vital sign rolling towers into the room to take vital signs and then wipe it down with a bleach wipe when you brought it out of the room. She stated Resident 60 shared a bathroom in two residents in room [ROOM NUMBER]. She stated the resident in room [ROOM NUMBER] were not on isolation precautions. During an observation and interview on 2/4/26 at 12:50 p.m. DON observed that Resident 60's room [ROOM NUMBER] was a clostridium difficult contact precautions room and he shared a bathroom with room [ROOM NUMBER], who were two residents in a non isolation. She stated the residents in room [ROOM NUMBER] did not have C.diff. She stated sharing a bathroom was not an infection risk. She stated Resident 60 would not take a shower because he had Cdiff and would have to take a bed bath. She said the bathroom between room [ROOM NUMBER] and room [ROOM NUMBER] would have to be cleaned every time Resident 60 used it. She was unable to explain how that would be monitored and who would clean the bathroom. DON stated you could put a commode (portable toilet) in Resident 60's room and not have him use the bathroom. She could not describe how the commode would be emptied by staff after use if they did not use the shared bathroom between room [ROOM NUMBER] and room [ROOM NUMBER]. She stated the blood pressure cuff and reuseable vital signs Tower would be used in a contact precautions room. She stated staff wiped it with a bleach wipe inside the contact precaution room. An observation in room [ROOM NUMBER] did not indicate a bleach wipe cannister immediately available for staff to sanitize and disinfect the reusable vistal sign equipment. She stated staff had to ask the licensed nurse to get the wipes out of their medication carts. DON stated staff used reuseable stethoscopes in contact precaution rooms. She went into the west nursing station and opened a drawer and stated these are the stethoscopes used in contact precaution rooms. She stated staff wipe them with a bleach wipe before returning them to the drawer. She stated there were only a couple of vital sign towers in the facility and the facility could not leave them in the isolation rooms and be a dedicated contact precaution vital sign tower. During an interview on 2/4/26 at 12:59 p.m. Licensed Nurse Q, she stated she thought the infection preventionist had purchased a new vital sign tower and was not sure if the vital sign tower goes into the contact precautions rooms or not. During an interview on 2/4/26 at 1:15 p.m., Infection Preventionist stated a person in a contact precautions room should be the last person on the unit to take a shower in the shower room. She stated expectations were staff are supposed to communicate to housekeeping to come in and disinfect the shower afterwards, She stated there was no documentation about that communication and there's no way to tell If the shower has been disinfected after the last person took a shower or not. Infection Preventionist stated that room [ROOM NUMBER] and room [ROOM NUMBER] shared a bathroom and staff would have been cleaning the bathroom after each use with bleach wipes. She stated staff have to get the bleach wipes from the nurse's station because they are not left in the room. She could not state how staff would know when to go in and clean up the bathroom after use if the residents are independently using the bathroom. She stated the facility would set up a bedside commode and put a sign on the door not to use the bathroom, and she could not answer how staff were supposed to empty a commode that had been used if the bathroom was off limits. (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	02/17/2026

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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 2/4/26 at 3:20 p.m., DON stated she was not concerned about a Cdiff resident sharing a bathroom with non Cdiff residents. She stated there was no process to have staff clean the bathroom with bleach wipes every time a resident used it to reduce the risk of cross contamination. DON stated that they would put a commode in the contact precautions room. She did not respond when asked where staff would empty the commode if the bathroom was not being used. She did not respond when asked if there was an infection risk for non-contact precautions residents to share a bathroom with a contact precautions resident if they used the bathroom to brush their teeth. She stated she did not know if housekeeping was using disinfecting solution in their cleaning buckets that would eliminate Cdiff and would have to ask them. During a phone interview on 2/5/26 at 10:47 a.m., Medical Director stated the Infection Control Safety Committee Meetings were monthly and he attended the January 2026 meeting. When queried, Medical Director stated the committee told him they needed to do more hand hygiene surveillance and he told them to follow through on that. Medical Director verified he acted as a consultant for the facility when he came to the facility to do his rounds and the staff asked him questions. Medical Director stated he was also available by phone. Medical Director verified he was concerned about the eight residents who had tested positive for C. Diff and verified he was concerned it was an outbreak. Medical Director stated he advised the facility staff to keep doing proper hand hygiene and follow the C. Diff guidelines, but stated he could not supervise the nurses, he could only make sure they did what was needed for the residents' medical care. During an interview and observation on 2/10/26 at 7:15 a.m., Unlicensed Staff G stated the resident in room [ROOM NUMBER]B was originally in room [ROOM NUMBER]C but then she was positive for Clostridium difficile and move to 1B on February 9th 2026. He looked at the contact precautions signage next to the door on 1B and stated in contact precautions you were supposed to wear PPE, and do hand hygiene. He stated he did not know he was supposed to use soap and water for 20 seconds for contact precautions. He stated there was no difference between the contact precautions room [ROOM NUMBER]B and the Transmission-based precaution room [ROOM NUMBER]. During an observation and interview on 2/10/26 at 8:55 a.m. Nurse Practitioner U was observed to walk out of room [ROOM NUMBER] towards the west nursing station. She stated she was walking to the nursing station to wash her hands with soap and water. She stated she did not wash her hands in room [ROOM NUMBER] bathroom because it was considered dirty and contaminated and the hand hygiene sink in the west nursing station had the lowest risk of infection. She was not able to state what the facility Policy and Procedure was for hand hygiene was after providing direct care in a contact precaution room. During a review of Resident 102's medical records on 2/3/26, it was noted in a Change of Condition report dated 11/6/25, that the resident had experienced several loose stools. The physician was notified and subsequently ordered a stool specimen to test for Clostridium difficile (C-Diff). The specimen was collected on 11/6/25. The results, dated 11/6/25, indicated that Resident 102's specimen was positive for C-Diff. Medical orders dated 10/21/25 included an order for Vancomycin 125 mg to be administered orally four times a day for C-Diff, starting on 11/6/25. A bed transfer report dated 11/10/25 indicated that Resident 102 was moved to an isolation room on 11/10/25, several days after the positive C-Diff report. During a review of Resident 31's medical records on 2/3/26, Resident 31's MD orders for 12/19/25 to 2/28/26 included order Stool sample for possible C-diff. one time only for 3 days, ordered 1/10/26. Resident 31's laboratory report dated 1/13/26 indicated the stool specimen was collected on 1/11/26 (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	02/17/2026

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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	and resulted on 1/13/26 showing Resident 31 was positive for C-diff. MD orders also included: Enteric precautions (isolation) for c-diff infection every shift, ordered 1/14/26, and Vancomycin HCL oral Suspension 50 mg/ml Give 5 ml by mouth every 6 hours for positive C. Diff for 14 days ordered 1/13/26 started 1/14/26. Nurse Progress note dated 1/14/26 indicated Resident 31 was moved to the isolation room [ROOM NUMBER]/14/26 due to the laboratory report. During a review of Resident 7's medical records on 2/3/26, it was noted in the CNA task sheet that Resident 7 had loose stools between 1/22/26 and 1/23/26. Resident 7's MD orders dated 1/1/26 to 1/3126 included: Labs-test of c-diff one time only for 1 day please collect sample .date 1/22/26. Resident 7's laboratory report dated 1/27/26 indicated the stool specimen was collected on 1/23/26 and resulted on 1/27/26 showing Resident 7 was positive for C-diff. MD orders also included: Diffcile Oral Tablet 200 mg, give 1 tablet by mouth two times a day for c-diff for 14 days, start date 1/27/26 and Contact Precautions (isolation) related to a positive c-diff result every shift, start date 1/28/26. Nurse progress notes dated 1/27/26 indicated the roommate was relocated. During a review of Resident 60's medical records on 2/3/26, it was noted that the CNA task sheet indicated Resident 60 had 12 loose, runny stools on 1/15/26, 1/18/26, 1/20/26, to 1/21/26. Nurse Progress notes dated 1/18 /26 indicated Notes: Stool specimen collected and picked up. Results pending. All needs attended by staff accordingly. Will continue to monitor. Change of Condition notes dated two days later on 1/20/26 at 11:30 a.m. indicated a Change of Condition Resident lab results came in today. Clarifying that res. is positive for C.Diff. Res. BM (Stool) is loose, soft, foul smelling and had a discharge like consistency. An Infection Notes dated 1/21/26 at 11:08 a.m., two days after sending in a stool specimen for suspicion of Cdiff, indicated On 1/20/26 Resident stool specimen results came back with +C Diff. Contact precautions were initiated. A document titled Care Plan, revised 1/21/26 indicated Resident requires[+}Contact Precaution due to +Clostridium Difficile (+C.Diff). During a record review on 2/3/26, of the facility Infection Prevention Policy and Procedure Manual, revised 9/2023 on 2/3/25, approved by the Patient Care Committee on 1/15/25, it indicated [name of affiliated facility] Infection Control Plan. No Policy and Procedure or protocol for Clostridium Difficile was observed, and no national standards for infection control were cited as a resource. POLICY: It is the policy of the facility to implement infection control measures to prevent the spread of communicable diseases and conditions. In LTC (Long Term Care) , it is appropriate to individualize decisions regarding resident placement (share or private), balancing infection risks with the need for more than one occupant in the room, the presence of risk factors that increase the likelihood of transmission . Room Placement: will depend on the epidemiology of the specific microorganisms, the ability of the resident to assist in confining and containing the microorganisms and the temporal relationship of the known infected or colonized residents to newly identified cases. Dedicated use of non-critical care equipment (i.e. sphygmomanometer (blood pressure cuff and equipment), stethoscope, and thermometer) will be provided to MDRO (Multi drug resistant organism) and other pathogenic microorganism. Review of a facility document titled Surveillance Info Log date 2025 and 2026, it indicated a total of 11 resident cases of Cdiff were identified between 2/6/25 to 2/6/26. A document titled CDC (Centers for Disease Control) C.Diff Facts for Clinicians, dated 3/5/24, indicated Clinical features, Watery diarrhea, fever, Loss of appetite, Nausea, Abdominal pain or tenderness. Treatment and recovery. If a patient has had three or more stools in 24 hours: Isolate patients with possible C. diff immediately, even if you only suspect CDI. (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	02/17/2026

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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a record review on 2/3/26, the facility Infection Prevention Policy and Procedure Manual, was observed to include Appendix PP F880 documentation that indicated The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. 483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: .When and to whom possible incidents of communicable disease or infections should be reported; Standard and transmission-based precautions to be followed to prevent spread of infections; When and how isolation should be used for a resident; including but not limited to: The type and duration of the isolation, depending upon the infectious agent or organism involved. The hand hygiene procedures to be followed by staff involved in direct resident contact. A record review of a document titled M3 Vital Signs Monitor Version 2.5 USER MANUAL, not dated, indicated WARNING The monitor and reusable accessories shall be disinfect to avoid patient cross infection. Disinfecting the Blood Pressure Cuff: .1. Take out the air bladder (The balloon inside a material blood pressure cuff that inflates during a blood pressure reading) before disinfection. 2. Wipe the cuff and the air bladder with a soft cloth dampened with the disinfectant solution. 3. Leave the cuff and air bladder to air dry for at least 30 minutes. B. During an interview on 2/11/25 at 8:45 a.m., the Infection Preventionist could not to fully describe the facility's Legionella prevention program or monitoring activities related to the facility's Water Management Program (WMP, a documented plan to systematically prevent and control germs in water systems). She stated the facility had the water tested in February 2025. She was unable to state what the results were or what was being done to ensure residents risk of exposure to Legionella was reviewed and monitored. The Infection Preventionist confirmed that Legionella monitoring and prevention were not discussed in the Infection Control Committee (ICC) meetings, since the only ICC meeting that she was aware since she became the Infection Preventionist, took place the first week of February 2026. She stated the Medical Director and Infection Prevention Consults did not attend. She stated that Legionella should have been discussed in the ICC meetings after the germs were identified in the water system. During an interview and document review on 2/11/25 at 8:45 a.m. the Administrator stated the facility water system had been tested in February 2025 and had been positive for Legionella. He stated he was not Administrator at that time and was unsure of what was done about the positive test results. He stated he thought the facility had replaced the water heaters and the water lines as a result of the test results. A review of a document provided by the Administrator indicated a document titled LEGIONELLA TEST RESULTS SUMMARY LOG, dated 2/27/25, indicated results of Legionella Bacterium testing on 10 samples taken in the facility on 2/18/25. The document indicated total number of Legionella samples 10, % Positive 90% (9 out of 10 sampled tested positive for Legionella). During an interview with Regional Corporate Director and prior administrator of the facility on 2/11/26 at 11:52 a.m., in the conference room, the Regional Corporate Director confirmed that the water test results indicated the facility's water system contained Legionella in February 2025. The Regional Corporate Director stated that the water system had not been tested since Legionella was first identified on February 27, 2025. During an interview and document review on 2/11/2026 11:52 a.m., Regional Corporate Director and prior administrator of the facility, stated the water testing company had informed him Legionella was common in Napa and it was recommended to perform a hot water flush of all lines would manage the positive test results. He stated the facility conducted a RUN FLUSH for sinks and showers for 30 (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	02/17/2026

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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	minutes where the water temp was set at 170-degree Fahrenheit per the water treatment company's recommendations. He stated that was completed on 3/6/25. Regional Corporate Director stated that was supposed to manage the Legionella and a 15-minute run flush every week was performed according to the contractor's suggestion to keep the system safe. He stated a water treatment system was installed later to remove the legionella risk and work completed 8/30/25. He stated the only other testing for Legionella occurred in January or February 2026. He stated the contractor recommended to not test for Legionella again until this year. During an interview with the Administrator on 2/12/26 at 10:35 a.m. he stated that testing for Legionella bacteria in February of 2025 was part of their yearly testing. He stated he was uncertain if there was monitoring for pneumonia after becoming aware of the Legionella contamination. He stated he did not know if the water testing program was discussed in the Quality meeting and he would have to check. During an interview and concurrent record review on 2/12/26 at 12:52 a.m. the Administrator and Facility Nurse Consultant presented a water management plan binder that had been in the facilities office. They stated it indicated that the most recent Legionella test took place on February 9th, 2026, the preliminary test results were not available because the actual Sample hadn't even made it into the lab yet. During an interview and record review on 2/12/26 at 2:01 p.m., the Administrator reviewed a document titled QAPI (Quality Assurance and Performance Improvement) Minutes 2025. It indicated on 3/10/25 that a discussion about the legionella testing results lead to development of a Performance Improvement Plan (PIP) on 3/10/25 with goals to implement a monitoring of the weekly hot water flushing of the water system, review the monitoring and flushing results at QAPI meetings, and implementation of a water management program to monitor results of project and safety of residents. Further review of the minutes did not reflect any further QAPI follow up, discussion or recommendations for repeat testing or completion of a water management plan based on national standards through the end of 2025. The review of the facility's document titled LEGIONELLA TEST RESULTS SUMMARY LOG, dated 2/27/2025, indicated that the facility's water was tested on [DATE]. The test results indicated that the facility's water system contained Legionella. During a record review on 2/11/25 in the conference room the document titled Legionella Test Results Summary Log, dated 2/27/25, it indicated Breakdown of Findings The excessively high levels of legionella along with low to zero chlorine residuals in the hot water system demonstrate that the temperature and stagnancy conditions are favorable for bacterial growth. Occupant Susceptibility VERY HIGH The presence of legionella SGI at such high concentrations represents an immediate risk to patient health. COMMENTS, SUMMARY OF FINDINGS AND RECOMMENDATIONS: Very high levels of legionella SGI and non-pseudomophila legionella were detected at multiple hot water points of use. We strongly recommend the immediate implementation of a water management program to best address specific equipment risks throughout the facility. A water management program is mandated by CMS for any Medic-aid/Medic-care facility. Given the extremely high levels of Legionella SCI, we recommend addressing these results immediately. Legionella SGI is the specific legionella strain most associated with legionella-related deaths. A review of the facility's Infection Control Committee (ICC, a mix of health and care professionals responsible for developing, implementing, and monitoring policies to prevent healthcare-associated infections) minutes, dated February 2025 to February 2026, was conducted. The ICC minutes indicated (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	02/17/2026

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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	that there was no discussion or documentation of Legionella monitoring, water system oversight, or risk management (a process to identify potential hazards, reduce risks, and take steps to keep residents safe). C. During a concurrent observation on the northwest resident shower room and interview with the Infection Preventionist on 2/11/26 at 9:50 a.m., the room appeared dim and on the left of the doorway was a space where a toilet might have been and a large diameter pipe close to the floor was observed to be stuffed with wet paper towel. She stated it was an infection risk to have wet paper towels[TRUNC