

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056153	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/01/2026
NAME OF PROVIDER OR SUPPLIER Napa Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 705 Trancas St. Napa, CA 94558	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to maintain the dignity of two of six sampled residents (Residents 2 and 3) when they were not assisted with toileting timely. This failure caused both Resident 2 and Resident 3 to be left in bedding soaked in urine for over an hour and caused Resident 2 to feel dirty and gross. During an observation and concurrent interview on 5/20/26 at 11 a.m., Resident 2 was sitting in bed with her husband seated at her bedside. Resident 2 stated she had long waits for call light response. Resident 2 stated every evening she would sit for hours in a wet bed. Resident 2's husband verified he had witnessed this. Resident 2 stated she could not say how long she had to sit in a wet bed, but it was long enough that the urine on the sheets dried and she smelled like urine. Resident 2 stated it made her feel dirty and gross. During an observation and concurrent interview on 5/20/26 at 11:47 a.m., Resident 3 was in a wheelchair at Resident 4's bedside. Resident 3 stated she and Resident 4 were roommates. Resident 3 stated she had long waits for a response to her call light, sometimes over 30 minutes. Resident 4 verified it took over 30 minutes for staff to respond when Resident 3 pressed her call light. Resident 3 stated she was continent but had had accidents in her bed every other day since admission due to long waits for assistance to the bathroom. Resident 3 stated the staff told her not to get up without them. Resident 3 stated she could get to the bathroom in time if they would just let her go by herself. Resident 3 verified she was sitting in a wet bed the whole time she was waiting. Resident 3 stated yesterday (5/19/26) in the morning she was just soaked [with urine] and her aide was interrupted multiple times while cleaning her up, the therapist came to work with her, and had to leave because she had not finished cleaning her up. During an interview on 5/21/26 at 1:28 p.m., Unlicensed Staff (US) B stated it was her goal to answer the call light as soon as possible. US B stated it was important to answer lights quickly because the residents need something, they need help, there were a lot of reasons. US B stated Resident 2 and Resident 3 were on her assignment. US B stated Resident 2 was sometimes continent and sometimes not, and Resident 3 was continent. US B stated that today (5/21/26) Resident 3 had to wait over an hour for help to the bathroom. US B stated Resident 3 needed help but she (US B) was tied up with another resident who had therapy waiting for them. US B stated since she was not able to help right away, she asked another staff to help Resident 3. US B stated that when she came back, no one had helped Resident 3, so it was at least an hour or more she was waiting for help. US B stated Resident 3 needed help to the bathroom, to get cleaned up, and to get dressed because she wanted to go to the dining room for lunch. When queried, US B stated that if a resident who was continent had an accident in bed, they often felt bad and apologized, but she tells them it's ok, not to worry, no need to be sorry. During an interview on 5/21/26 at 3:30 p.m., Director of Staff Development (DSD) stated it was her expectation that residents get assistance within two minutes when they pressed their call lights. DSD stated 30 minutes was too long for residents to wait for help. DSD stated if a resident was sitting in wet bedding from having an accident in bed, they should be changed immediately, have their bedding changed, and be helped to the shower. DSD stated that if a resident who was continent had an accident in bed, it would probably be embarrassing for (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 056153
		If continuation sheet Page 1 of 4

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	them. Review of Resident 2's face sheet indicated an admission date of 5/9/26 and multiple diagnoses including cerebral infarction (stroke, a blockage of the blood flow to the brain), abnormality of gait and mobility, and need for assistance with personal care, among others. Review of Resident 2's MDS (minimum data set, an assessment tool) indicated Resident 2 was completely dependent on staff assistance for toileting. Review of Resident 3's face sheet indicated an admission date of 5/13/26 and multiple diagnoses including falls, overactive bladder, and abnormalities of gait and mobility, among others. Review of Resident 3's document titled Bowel and Bladder Observation/assessment dated [DATE], indicated Resident is continent of bowel and bladder with occasional bladder incontinence. [Wheelchair] bound with moderate 1 person transfers. Review of facility policy Resident Rights, last revised 8/2009, indicated, Employees shall treat all residents with kindness, respect, and dignity. Review of facility policy Call System, Residents, last revised 9/2022, indicated, Calls for assistance are answered immediately. Urgent requests for assistance are addressed immediately. Review of facility policy, Activities of Daily Living (ADL), Supporting, last revised 3/2028, indicated, Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to implement the care plan of one of six sampled residents (Resident 1) when nurses did not document pain assessments for three shifts during Resident 1's first two days of admission. This failure caused Resident 1 to feel panicked when her pain became out of control. During a phone interview on 5/20/26 at 11:03 a.m., Family Member (FM) stated Resident 1 was in quite a bit of pain during Resident 1's first day at the facility. FM stated that Resident 1 had suffered multiple fractures (broken bones) just three days prior to her admission to the facility, two in her spine and one in her pelvis. FM stated Resident 1 was on round-the-clock pain medications when she was at the hospital, taking oxycodone (a narcotic pain medication) every six hours. FM stated when Resident 1 was transferred to the facility from the hospital she did not receive any pain medication her first day and this caused Resident 1 a lot of panic because her pain was getting out of hand. FM stated that family had to be there with Resident 1 every day to advocate for her because when she asked for pain medication she would have to wait hours for the nurses to bring it. Review of Resident 1's face sheet indicated she was admitted on [DATE] with multiple diagnoses including acute pain due to trauma, fall on/from stairs, fracture of thoracic vertebra (bone in the middle of the back), fracture of sacrum (bone at the bottom of the spine), fracture of left pubis (the front of the pelvis), and panic disorder, among others. Review of Resident 1's April 2026 medication administration record (MAR) indicated the first dose of pain medication given to Resident 1 was oxycodone 5 mg (milligrams) administered on 4/26/26 at 7:42 a.m. with a pain score of 8 (on a scale of zero to 10, where zero is no pain and 10 is worst pain imaginable). Further review of Resident 1's April 2026 MAR indicated Resident 1 was not given a second dose of pain medication until the next day, 4/27/26, when Resident 1 was given oxycodone 5 mg at 8:15 a.m. Review of Resident 1's nurse progress notes, dated 4/25/26, written by Licensed Nurse A, indicated Resident 1 arrived to the facility from the hospital on 4/25/26 at 6 p.m. with no complaints of pain stating, I am comfortable in this position. Review of Resident 1's care plan for pain, dated 4/25/26 indicated interventions included assessing her pain every shift and as indicated. Review of Resident 1's pain assessments indicated no pain assessments were documented between her arrival on 4/25/26 at 6 p.m. and 4/26/26 at 7:42 a.m. (over 13 hours, including all of Noc shift), and no pain assessments between 4/26/26 at 7:42 a.m. and 4/27/26 at 8:15 a.m. (over 24 hours, including all of PM shift and Noc shift). During an interview on 6/1/26 at 1:12 p.m., Licensed Nurse A stated she remembered Resident 1's admission to the facility. Licensed Nurse A stated she recalled that when she did Resident 1's skin assessment, Resident 1 did not want to roll onto her side so that Licensed Nurse A could look at her back because rolling on her side would cause too much pain. Licensed Nurse A verified that when she wrote in her progress note that Resident 1 said, I am comfortable in this position, Resident 1 was saying she did not want to move because it caused her pain to move. Licensed Nurse A stated she did not give Resident 1 pain medication because Resident 1 stated she was not having any pain in that moment. During a record review and concurrent interview on 6/1/26 at 1:57 p.m., Director of Nursing (DON) reviewed Resident 1's care plan and verified one of the interventions was to assess pain every shift. DON verified there was only one pain assessment documented between Resident 1's arrival at 6 p.m. on 4/25/26 and 8:15 a.m. on 4/27/26 and verified nurses' documentation of pain assessments had been missed. DON stated it was her expectation that if a pain assessment was conducted, the nurse should document the assessment. DON stated that if the care plan included assessing pain every shift, the admission nurse should have entered a nursing order so that the nurses would be prompted to document a pain assessment on the MAR. DON stated pain assessments were important because they want to address the resident's comfort and medicate them as appropriate. Review of facility policy and procedure, Care Plans, Comprehensive Person-Centered, last revised March 2022, (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.		