| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056153 | A. Building<br>B. Wing | 02/17/2026 |

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

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| F 0880<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**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<br>(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 |
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| F 0880<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | 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 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:<br><br>A.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | have dedicated equipment that stays in the room.<br><br>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. Unlicensed Staff D further stated that Resident 31 used to have her own vitals equipment in her room but it had broken.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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 (continued on next page) |

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| F 0880<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | 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 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.<br><br>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.<br><br>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.<br><br>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.<br><br>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 (continued on next page) |

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| F 0880<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | 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.<br><br>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.<br><br>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.<br><br>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].<br><br>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.<br><br>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<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | 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.<br><br>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 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.<br><br>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.<br><br>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).<br><br>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.<br><br>Review of a facility document titled Surveillance Info Log date 2025 and 2026, it indicated a total of<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | 11 resident cases of Cdiff were identified between 2/6/25 to 2/6/26.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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).<br><br>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<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Corporate Director stated that the water system had not been tested since Legionella was first identified on February 27, 2025.<br><br>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 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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | 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.<br><br>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 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).<br><br>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 |

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| F 0697<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide safe, appropriate pain management for a resident who requires such services.<br><br>Based on observation, interview, and record review, the facility failed to ensure one of two residents (Resident 19) sampled for pain management received professional treatment when Licensed Nurse S did not assess, evaluate, treat, or reassess Resident 19's migraine pain.This failure resulted in persistent migraine pain for Resident 19 and affected her overall well-being. A review of Resident 19's admission record indicated she was admitted in 08/2024 with diagnoses of Chronic pain (persistent pain lasting longer than 3-6 months), a burn wound to her left thigh, and Migraine with Aura (severe headaches with visual disturbance such as zig-zag lines, flashing lights or blind spots).A review of Resident 19's Minimum Data Set (MDS-a resident assessment tool) dated 11/17/25 indicated no cognitive impairment.A review of Resident 19's Care Plan last revised 12/15/25 indicated interventions to assess pain at least every shift and as indicated and administer medications as ordered to attain a tolerable pain level per resident report.A review of Resident 19's Physician Order Summary dated 2/11/26 indicated Resident 19 had an injectable medication Sumatriptan Succinate ordered every 12 hours as needed for migraine pain.During an interview on 2/10/26 at 9:20 a.m. with Resident 19 in her room, Resident 19 presented with legs hugged towards her chest, avoided eye contact, fatigued, and grimaced at times during interview. Resident 19 stated pain was her largest obstacle and even with her scheduled pain medications her overall pain level was usually between 7-9 on a scale of 0-10 severity, 0 being lowest level and 10 being the highest level.During a concurrent observation and interview on 2/11/26 at 8:00 a.m. with Licensed Nurse S and Resident 19, medication administration is observed. Resident 19 presented with tired eyelids, and slow speech, she reported migraine pain to Licensed Nurse S. Licensed Nurse S did not further assess her pain level or quality. Resident 19 informed Licensed Nurse S that she had an injectable medication for her migraine pain. Licensed Nurse S went to the med cart and could not find the medication, he checked to see if it had been ordered, and it had been ordered on 2/10/26 at 10:10 a.m. No further action was taken by Licensed Nurse S.A review of Resident 19's eMAR ( an electronic document that records medications, assessments and treatments administered by nurses) on 2/11/26 at 9:38 a.m. indicated no pain level was documented and the migraine medication had not been given.During an interview on 2/11/26 at 10:35 a.m. with Licensed Nurse S, Licensed Nurse S stated he had not assessed Resident 19's pain because she always wanted any pain medication available to her and he concurs he should have obtained a pain level and the migraine medication should be delivered soon.During a concurrent observation and interview on 2/11/26 at 2:00 p.m. with Resident 19 during wound care procedure to left thigh wound, Resident 19 gasped and grimaced during wound care despite the team pre-medicating her, and stated she was feeling extra sensitive due to ongoing migraine pain reported at a level of 7-8.During an interview on 2/11/26 at 3:19 p.m. with Licensed Nurse S while he was sitting at nurses' station east, Licensed Nurse S stated, the migraine medication had been delivered yesterday on 2/10/26 and he had since located it. Licensed Nurse S further stated he had not reassessed Resident 19's migraine pain since 8:00 a.m. this morning nor had he offered her the migraine medication now that it was located.A review of a facility invoice of medication delivery indicated the migraine medication had been delivered on 2/10/26 at 3:52 p.m. A review of Resident 19's eMAR ( an electronic document that records medications, assessments and treatments administered by nurses) at 4:42 p.m. indicated Licensed Nurse S documented Resident 19's pain level at the end of his shift at a 7, and the migraine medication was never administered that day During an interview on 2/12/26 at 12:45 p.m. with the Director of Nursing (DON), DON stated pain should be assessed by nurses throughout the shift and pain source, level and quality should have been obtained, especially if the resident was reporting migraine pain, all medications ordered should be available, and if not an alternative should have been requested. DON further stated not treating a resident's pain did not meet her expectation as pain was a vital sign and should be effectively managed.A review of a facility policy titled, Pain Assessment and Management, revised 03/2015 indicated, the facility pain<br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | management program is based on a facility-wide commitment to resident comfort and pain management interventions shall reflect the sources, type and severity of pain and .shall address the underlying causes of the residents pain.pain should be reassessed to determine if the residents pain is being adequately controlled.A review of a facility policy titled, Administering Pain medications, revised 04/2025, indicated, provide the resident privacy, explain the purpose of the pain assessment to the resident, conduct a pain assessment as indicated, administer pain medications as ordered, re-evaluate the residents pain level 30-60 minutes after medication is administered. |

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| F 0865<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Have a plan that describes the process for conducting QAPI and QAA activities.<br><br>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. |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**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:<br><br>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.).<br><br>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.<br><br>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.<br><br>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.<br><br>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<br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>During a record review of a facility Policy and Procedure titled Grievances/Complaints, Filing, 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.<br><br>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<br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | for help, but staff did not come. Resident 15's call light could not be visualized near him or his bed.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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. 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.<br><br>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<br>(continued on next page) |

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| Napa Post Acute | 705 Trancas St.<br>Napa, CA 94558 |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Resident 16's well-being.<br><br>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!<br><br>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.<br><br>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).<br><br>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.<br><br>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).<br><br>A review of Resident 41's MDS, dated [DATE], indicated he had no memory impairment.<br><br>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).<br><br>A review of Resident 42's MDS dated [DATE], indicated he had no memory impairment.<br><br>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).<br><br>A review of Resident 69's MDS dated [DATE], indicated he had no memory impairment.<br><br>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.<br><br>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.<br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 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.<br><br>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.<br><br>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.<br><br>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.<br><br>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. |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>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 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.<br>(continued on next page) |

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

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect one of five residents sampled for medication review from chemical restraint when Resident 4 had lorazepam (an anti-anxiety medication) ordered as needed without a frequency, duration, or monitoring for target symptoms. This failure had the potential to result in Resident 4 receiving an anti-anxiety medication unnecessarily, which can cause sedation, dizziness, weakness, and unsteadiness. During a record review on 2/11/26 at 8:08 a.m., review of Resident 4's face sheet revealed an admission date of 2/9/24, age over [AGE] years old, and medical diagnoses that included cerebral infarct (a blockage in a blood vessel to the brain), major depressive disorder in full remission, and dementia without behavioral disturbance. Review of Resident 4's physician orders revealed an active order dated 1/28/26 for lorazepam 1 mg (milligram) PRN (pro re [NAME], Latin for as needed) for anxiety manifested by inability to relax. The order did not include a frequency or a stop date. Further review of Resident 4's physician orders revealed no order to monitor for anxiety or inability to relax. During an interview on 2/12/26 at 8:37 a.m., Licensed Nurse (LN) FF verified Resident 4 was on her regular assignment. LN FF stated Resident 4 had lorazepam added recently because she was constipated and agitated. LN FF stated they were able to resolve her constipation and Resident 4 calmed down. LN FF verified the order for lorazepam did not have a time frame or frequency indicated. LN FF stated the order should include a frequency. LN FF stated psychotropic medications (drugs that affect a person's mental state) that were ordered PRN needed to be renewed once a month. LN FF stated she reviewed her residents' orders and if a PRN psychotropic medication was getting close to 30 days, she would let her Director of Nursing know or reach out to the physician herself to ask about getting it renewed. LN FF stated psychotropic medications should have behavior monitoring for the target behavior. LN FF stated the behavior monitoring was important to see if the resident was having any outbursts, and to document what intervention was used. LN FF stated the nurses count the outbursts and then let the physician know so they can re-evaluate if the dosage needed adjusting.During an interview at 2/12/26 at 1 p.m., Director of Nursing (DON) stated she and the nursing supervisor reviewed all new orders daily. DON stated they printed out all new orders from the previous day and reviewed them. DON stated Resident 4's lorazepam order with no frequency should have been caught during their review. DON stated that PRN psychotropic medications should be limited to 14 days and a specific stop date should be entered with the order. DON stated the charge nurse would review their orders for medications that were about to reach the stop date and reach out to the doctor to discuss if the order needed to continue. DON stated PRN psychotropic medications should have an order for behavior monitoring on the medication administration record. Review of website DailyMed.nlm.nih.gov, accessed 2/18/26, revealed the package insert for lorazepam indicated, In a sample of about 3,500 patients treated for anxiety, the most frequent adverse reaction to lorazepam was sedation (15.9%), followed by dizziness (6.9%), weakness (4.2%), and unsteadiness (3.4%). The incidence of sedation and unsteadiness increased with age. Review of facility policy policy and procedure Psychotropic Medication Use, last revised 2/2025, indicated, Medications in the following categories are considered psychotropic medications and are subject to prescribing, monitoring, and review requirements specific to psychotropic medications: . Anti-anxiety medications . Psychotropic medication management is an interdisciplinary process that involves the resident, family, and/or the representative and includes: a. determining adequate indications for use; b. establishing appropriate dose . and duration; c. adequate monitoring for efficacy and adverse consequences . PRN orders for psychotropic medications are limited to 14 days. |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>Based on observation, interview, and record review, the facility failed to ensure one of three residents sampled for nutrition (Resident 19) Care Plan was evaluated and revised to include new means by which to monitor her weight after Resident 19 had refused to have her weight measured using the Hoyer Lift (a mechanical device used to lift and/or transfer a person) for 7 months.This failure caused the facility to be unable to properly assess a vulnerable resident, Resident 19, for significant weight loss, under nutrition, and worsening health status.A review of Resident 19's admission record indicated she was admitted in 08/2024 with diagnoses of Chronic pain (persistent pain lasting longer than 3-6 months) and a large burn wound to her left thigh.A review of Resident 19's Minimum Data Set (MDS-a resident assessment tool) indicated she had no cognitive impairment.A review of Resident 19's weight measurements indicated her last weight was obtained on 7/1/25 and was 135.6 lbs.A review of Resident 19's Care Plan indicated Resident 19 was at risk for weight fluctuations and mal-nutrition, interventions were ordered to monitor her weight per protocol and notify the physician of any significant weight loss or weight gain. It further indicated no revisions to the Care Plan beyond 08/29/25.During an interview on 2/10/26 at 9:20 a.m. with Resident 19 in her room, Resident 19 stated she refused to have her weight measured using the Hoyer Lift once or twice as the sling caused pain and bleeding to her left thigh wound and staff had not asked to measure her weight in a long time.During an interview on 2/12/26 at 10:15 a.m. with Licensed Nurse FF, Licensed Nurse FF stated, Resident 19 refused weights consistently and the team had not discussed other options for obtaining her weight. Licensed Nurse FF concurred that 7 months is a long time and a lot could change during that time.A review of most recent Interdisciplinary Team meeting notes dated 8/19/25 indicated no current weight and weight refusal with no new interventions documented.During an interview on 2/12/26 at 12:45 p.m. with the Director of Nursing (DON), DON stated if weight measurements are ordered they should be done monthly, if a resident refused we should have used alternative options as the resident could have significant weight loss and we wouldn't know.A review of a facility policy titled, Weighing and Measuring the Resident, indicated, weight is monitored on admission and monthly during a residents stay. to provide a baseline and ongoing record of the residents body weight as an indicator of the nutritional status and medical condition of the resident. and. the appropriate scale should be used.Platform scale for non-ambulatory residents or a tape measure for non-ambulatory or bedfast residents. and. to Notify the Nurse Supervisor if resident refuses.A review of a facility policy titled, Care Plans, Comprehensive and Person Centered, revised 03/2022, indicated Assessments of Residents are ongoing and care plans are revised as information about the residents and the residents conditions change. |

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| F 0841<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**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.<br><br>add F880 language<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br>(continued on next page) |

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| F 0841<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>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.<br><br>A review of Resident 10's Minimum Data Set (MDS-a resident assessment tool) dated 12/22/25 indicated severe cognitive impairment.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>A review of Resident 10's diagnoses list indicated the diagnosis of schizoaffective disorder was added on 10/16/23 by Physician R.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>During an interview on 2/12/26 at 12; 45 p.m. with the Director of Nursing (DON), DON stated a<br>(continued on next page) |

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| F 0841<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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 (continued on next page) |

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| | 056153 | A. Building<br>B. Wing | 02/17/2026 |

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

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| F 0841<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | verified 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.<br><br>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.<br><br>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.<br><br>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.<br><br>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. |

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| F 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are fully informed and understand their health status, care and treatments.<br><br>Based on interview, and record review, the facility failed to ensure advanced knowledge and approval of ongoing treatment with psychotropic medications ( any medication that affects brain activity associated with mental processes and behavior) for two of five sampled residents ( Resident 10 and Resident 12) for unnecessary medications when resident representatives did not recall contact from the facility and the informed consent ( a document that confirms residents or resident representatives were informed on the risks, benefits, and alternatives of a medical intervention) forms were not signed nor was verbal consent documented.This failure prevented the resident's representative's from participating in their right to determine treatment interventions for Resident 10 and Resident 12.A review of Resident 10's admission record indicated she was admitted to the facility in 12/2022 with diagnoses of Dementia (a progressive state of decline in mental abilities) and Major Depressive Disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest).A review of Resident 10's Minimum Data Set (MDS-a resident assessment tool) indicated she had a BIMS (Brief Interview for Mental Status-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 01 indicating significant cognitive decline.A review of Resident 10's informed consent form dated 12/19/25 for psychotropic medication Paroxetine for depression was not signed by the resident's representative and verbal consent was not indicated.A review of Resident 10's informed consent form dated 12/19/25 for psychotropic medication Trazodone for depression and inability to sleep was not signed by the resident's representative and verbal consent was not indicated.A review of Resident 12's admission record indicated she was admitted to the facility in 03/2025 with diagnoses of Dementia and Schizophrenia (a mental illness that is characterized by disturbances in thought).A review of Resident 12's MDS indicated she had a BIMS score of 4 indicating significant cognitive decline.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 not heard from the medical doctor at the facility ever, and the nurses had not reached out to her in a very long time. Resident 10's representative further stated she had not signed any forms about medication and felt she was not kept in the loop and expected the facility would have communicated 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 staff she did not want Resident 12 to take 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 was that Physician R reached out to the resident representatives for education and the nurses would then obtain confirmation of their consent by documenting verbal consent or obtaining the representatives' signature. DON further stated if there is no education done, no verbal consent or signature we should not be giving the medication.During an interview on 2/13/26 at 9:45 a.m. with Physician R, Physician R stated resident representatives should have heard from Physician R or the nurses and that without documented verbal consent or representative signature it would be difficult to confirm informed consent occurred.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. |

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| F 0691<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services.<br><br>Based on observation, interview, and record review, the facility failed to ensure one out of one resident's sampled for ostomy care( a surgical opening in the abdomen that redirects waste outside the body into a wearable pouch system) ( Resident 110), received care according to professional standards of practice when Licensed Nurse S disregarded Resident 110's verbal and non-verbal signs of pain with old appliance removal, did not follow the correct procedure for appliance change to minimize skin exposure to feces and urine, and did not notify the supervisor of any abnormal findings. This failure caused Resident 110 to have pain, discomfort, and had the potential to contribute to further skin breakdown around his stoma(a surgically created opening in the abdomen that diverts stool flow). A review of Resident 110's admission record indicated he was admitted in 09/2024 with left sided hemiparesis (a neurological condition characterized by weakness on one side of the body affecting the arm, leg, and trunk) after a stroke, chronic pain, and had an ostomy.A review of Residents 110's Minimum Data Set (MDS-a resident assessment tool) dated 1/29/26 indicated he had a BIMS (Brief Interview for Mental Status-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 13 indicating minimal cognitive impairment.A review of Resident 110's Order Summary Report, indicated his ostomy appliance was to be changed every 3 days and as needed and specified that the wafer (the adhesive baseplate designed to protect the skin around the stoma and secure the pouch) should be cut to fit the ostomy size. It further indicated Resident 110 had medication for both mild and moderate pain levels.A review of Resident 110's Care Plan indicated he was at risk for skin breakdown related to his ostomy site and the skin integrity surrounding the stoma should be observed and any abnormal findings or complications should be reported to the physician.During an interview on 2/2/26 at 11:20 a.m. with Resident 110 in his room at bedside, Resident 110 reported he didn't feel the nurses that were caring for his ostomy knew what they were doing. Resident 110 stated they did not use skin prep (liquid-based wipes that form a protective barrier film on intact skin) and the appliance leaked feces and urine all over his skin daily, and staff did not clean him timely.During a concurrent observation and interview on 2/11/26 at 10:00 a.m. for Resident 110's ostomy appliance change procedure with Licensed Nurse S, Licensed Nurse S began to remove old, adhered appliance. Resident 110 grimaced and stated, Ow, that pulls and stings, Licensed Nurse S replied, it'll be over quick, you're a tough guy. Licensed Nurse S continued with removal without any interventions to lessen pain. Licensed Nurse S stated, the skin around the stoma looks red and irritated. Licensed Nurse S did not measure stoma size using measurement guide or trace the opening size on the ostomy wafer. Licensed Nurse S cut the opening much larger than actual stoma size leaving approximately 1/3 inch of exposed skin around the stoma. Licensed Nurse S did not assess Resident 110's tolerance of the procedure and did not notify the physician of pain with removal or skin breakdown. Licensed Nurse S left the room and Resident 110 stated ,it really stung when the old appliance was removed and skin was cleansed, and he did not feel Licensed Nurse S cared about that.During an interview on 2/11/26 at 10:35 a.m. with Licensed Nurse S, Licensed Nurse S stated he did realize that Resident 110 was having pain with the old appliance removal but felt Resident 110 didn't need medication and getting it over quickly was the best way to address it, he was not sure what else could have been done. Licensed Nurse S concurred the skin around the stoma was red and looked irritated and stated he was not sure what else could be done for skin breakdown but supposed he could have reached out to the treatment nurses. Licensed Nurse S concurred he used his finger to measure the stoma size instead of using the measurement guide and may have cut the opening too big which could expose the skin to feces and urine.During an interview on 2/12/26 at 12:45 p.m. with the Director of Nursing (DON), DON stated she expected that any pain during a procedure should be assessed and addressed, she would never expect a resident's pain to be ignored. DON further stated the ostomy wafer opening should be measured to fit the stoma, (continued on next page) |

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| F 0691<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | if not this could cause skin breakdown, our treatment nurses should have been consulted.A review of a facility document titled, Colostomy Care; Changing Pouch, Licensed Nurse Competency Evaluation, indicated in step 4, to assess resident for pain and medicate as indicated, in step 13, to gently remove faceplate from skin by pushing skin from the appliance rather than pulling the appliance from skin, in step 16, assess the condition of the surrounding skin, in step 18, measure stoma using measurement guide, in step 19, trace the same size opening on the back of the new faceplate and cut the opening to be 1/8 inch larger than stoma size, in step 27, notify physician of any abnormal findings.A review of a facility policy titled, Colostomy /Ileostomy Care, revised 10/2010, indicated, The following information should be recorded in the resident's medical record.any breaks in the resident's skin.how the resident tolerated the procedure. It further indicated, Notify the supervisor of any abnormal findings (i.e. breaks in the skin, excoriation, signs of infection, etc). |

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| F 0813<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Have a policy regarding use and storage of foods brought to residents by family and other visitors.<br><br>Based on observations, interview, and record review the facility failed to properly maintain the residents' food refrigerator for a census of 116 when food items were not properly labeled.This failure had the potential to result in residents consuming contaminated food, increasing the risk of foodborne illness and adverse health outcomes.During a concurrent observation and interview on 2/2/26 at 9:40 a.m., with the Dietary Services Manager (DSM), the freezer unit of the resident refrigerator contained one opened 16 oz container of Dean's French Onion Dip and two (8-pack) unopened packages of El Monterey Beef and Bean Chimichangas the DSM stated, he did not see any identifying labels on the french onion dip container or either of the chimichanga packages. During an interview on 2/12/26 at 10:27 a.m., with the Director of Nursing (DON), the DON stated she expected items placed in the resident refrigerator were labeled properly with dates and who the item belonged to, otherwise resident food could be shared with another resident if not properly labeled. The DON also stated she would expect foods to be removed and thrown out right away if it is unlabeled to prevent the risk of contamination and possible stomach upset for the residents.During a review of the facility's policy and procedure (P&P) titled, Foods Brought by Family/Visitors, revised 2/14, the P&P stipulated, items left for the residents to consume later will be labeled and stored in a distinguishable manner with the resident's name, the item, and the use by date. |

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| F 0909<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not securely attach the bed rails to the bedframe for one of seven residents who use bed rails, (Resident 105.) Resident 105's bed rails were loose and wobbly, easily swinging away from the bed. Resident 105 stated she did not feel safe using the bed rails for repositioning or getting in and out of bed and stated she almost fell to the floor.During an interview and concurrent observations on 02/09/2026 at 4:26 p.m., in Resident 105's room, Resident 105 reported that broken bed rails nearly caused a fall while repositioning. She stated, the rail just fell down and demonstrated how the left rail could move side to side, creating a 2 to 3-inch gap between the mattress and rail . The surveyor confirmed the rail could swing towards the middle of the room, forming a large gap which posed a fall risk. The right bed rail was also loose and could be pushed away from the bed towards the wall.During an interview and concurrent observations on 02/10/2026 7:45 a.m., in Resident 105's room, Licensed Nurse (LN HH) came into the room and evaluated Resident 105's bed rails. LN HH tested the bed rail and found that it was loose and could be pulled out away from the bed and the resident. LN HH stated the bed rail was not safe for resident use and needed to be reported to maintenance as soon as possible and added the broken bed rails to the facilities Maintenance log.During an interview and concurrent observations on 02/10/2026 at 8:20 a.m., Maintenance staff was seen examining the bed rails for Resident 105. Maintenance staff identified that the rails were not properly attached to the bed frame. Maintenance staff stated any problem with bed rails should be reported and repaired as soon as possible for resident safety.During a review of Resident 105's Medical Records, Resident 105's Face Sheet (some key health information of the resident) dated 2/11/26, indicated that Resident 105 was admitted to the facility on [DATE]. Resident 105's records included a document titled The Bed Rail and Entrapment Risk Observation dated 12/22/25 and indicated bed rails that were on the bed were recommended for Resident 105 to use when the resident was in bed to enhance mobility, including moving within the bed and transferring in and out of it. The section titled entrapment risk evaluation confirmed that no gaps were observed between the mattress and the bed rails.During a review of Resident 105's Nursing Care Plan, dated 12/23/25, the use of bed rails was documented. The stated goals included: (Resident) Will be compliant with using device. (Resident) will not have any complications or injuries related to the device. The Interventions included: Assess use of bedrail for appropriateness of use as indicated, Complete Bed Rail observation evaluation as indicated and ensure the device is clean and in good repair.During a review of the facilities procedure titled Bed Safety and Bed Rails, dated 8/2022, this indicated bed frames, mattresses and bed rails are checked for compatibility and size prior to use. Maintenance is to routinely inspect all beds to identify risks and problems, and any worn or malfunctioning bed system components are repaired or replaced. |