STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A357	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dept of State Hospitals - Napa D/P Snf	2100 Napa-Vallejo Highway Napa, CA 94558

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure adequate supervision and monitoring of residents when Psychiatric Technician Assistants (PTA 2 and PTA 3) were observed with their eyes closed while assigned to provide enhanced one-to-one (1:1) supervision for two of two sampled residents (Resident 1 and Resident 2). This failure compromised the safety and security of the residents, as continuous observation was required to prevent potential harm. The deficient practice placed residents at risk for unmet care needs, potential injury, and lack of timely intervention.During an observation on 4/1/26 at 1:40 PM, in Resident 1's room, staff member PTA 2 was observed with her eyes closed while assigned to provide 1:1 supervision for Resident 1.During an interview on 4/1/26 at 2:05 PM with PTA 2, PTA 2 stated she was assigned to 1:1 observation for Resident 1. PTA 2 further stated while performing the observation, her eyes may have been closed at times. PTA 2 stated she had worked a double shift, from night to day shift, and stated she felt tired during her assignment.During an interview on 4/1/26 at 4:10 PM with PTA 1, PTA 1 stated on 3/19/26, she observed staff PTA 3 sleeping while assigned as a 1:1 for Resident 2. PTA 1 stated she waved to the assigned staff member, but the staff member did not acknowledge her. During an interview on 4/2/26 at11:55 AM with PTA 3, PTA 3 stated on either 3/19/26 or 3/20/26, he worked a double shift covering both night and day shifts and was also conducting orientation to a new PTA 1. During that time, while performing 1:1 observation for Resident 2, he had his eyes closed but stated he was not asleep. The PTA 1 orientee called his name, and he opened his eyes. This occurred at approximately 11:30 AM.A review of Resident 1's clinical record titled, Physician's Orders, dated 3/19/26, indicated that Resident 1 was placed on 1:1 observation for self-injurious behavior (SIB).A review of Resident 2's clinical record titled, Physician's Orders, dated 2/27/26, indicated that Resident 2 was placed on 1:1 observation for safety of self and others.A review of the facility's policy and procedure titled, Enhanced Observation of Patients, dated 11/24/25, indicated its purpose was to promote the safety of both patients and staff by implementing time-limited enhanced observation when less restrictive interventions had proven ineffective or could not be safely or reasonably applied.

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