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	05/16/2024

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49936 Based on observation, interview, and record review, the facility failed to ensure safe medication storage room practices per the facility's policy and procedure when: 1. The medication cart was left unlocked multiple times in the medication room where unlicensed staff had access. 2. Expired medical supplies were not removed from stock. These failures had the potential for drug diversion (illegal distribution or abuse of prescription drugs) by unauthorized staff with access to medications and for expired and unsafe medical supplies to be used for residents. Findings: 1. During an observation [DATE] at 11:13 a.m. in the Medication Room, medication cart #2 was left unlocked. During an interview on [DATE] at 11:15 a.m. with Psychiatric Technician (PT), PT stated she left the medication cart unlocked in the medication room. During an interview on [DATE] at 2:14 p.m. with PT, PT stated unlicensed staff had the key to access the medication room to get supplies. PT stated narcotics and controlled drugs in the medication cart were stored in a metal drawer with a secondary lock. During an observation on [DATE] at 2:32 p.m. in the Medication Room, medication cart #2 was unlocked and the screen clearly instructed, Press Sign Out to lock. Press CS to unlock the narc (narcotic) drawers. During an interview on [DATE] at 3:41 p.m. with the Supervising Registered Nurse (SRN), the SRN stated the medication cart should be locked and should be checked by staff if it was locked properly. SRN further stated all staff members, including unlicensed staff, had a key to the medication room, but only licensed staff had the keys to the medication carts and cabinets where medications were stored. (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 4:05 p.m. with the SRN, the SRN stated medication cart #2 was replaced with a new medication cart in case it was left unlocked due to a malfunction. During an observation on [DATE] at 10:25 a.m. in the medication room, Licensed Vocational Nurse (LVN) 1 left the newly replaced medication cart #2 unlocked and did not check if the cart was locked before leaving the medication room. During an interview on [DATE] at 10:27 a.m. with LVN 1, LVN 1 stated he should not have left the medication room with the medication cart unlocked. During an interview on [DATE] at 11:05 a.m. with the SRN, the SRN stated the staff should have checked if a medication cart was properly locked before they left it in the medication room. During a review of the facility's policy and procedure (P&P) titled, Medication/Treatment Room/Emergency Equipment Checklists, Inventory, Inspections, dated [DATE], the P&P indicated, Check the safety and security of the following: .Securely locked medication cart drawers. During a review of the facility's policy and procedure (P&P) titled, Procurement, Storage, and Disposition of Pharmaceuticals: Unit Medication Storage, dated [DATE], the P&P indicated, Controlled drugs shall be kept behind two locks, except when in use. During a review of the facility's policy and procedure (P&P) titled, Medication Administration General Information, dated [DATE], the P&P indicated, Licensed staff shall . Lock and check all medication carts and cabinets except when preparing or administering medications. 2. During a concurrent observation and interview on [DATE] at 2:24 p.m. with Psychiatric Technician (PT) in the Medication Room, there were 12 expired medical supplies labeled, Epump ENPlus Spike Set (medical device used for people on continuous tube feedings, food in liquid form being fed to a person through a flexible tube). Five of the supplies had an expiration date of [DATE], and seven had an expiration date of [DATE]. PT stated the expired medical supplies should have been returned to Central Supply. During an interview on [DATE] at 3:38 p.m. with the Supervising Registered Nurse (SRN), the SRN stated expired medical supplies should be removed, returned to Central Supply Department, and replaced. During a review of the facility's Administrative Directive titled, Central Supply, dated [DATE], the document indicated, It is the responsibility of the unit/department to monitor the expiration dates of medical supplies and equipment. Staff shall return all expired supplies/equipment to Central Supply according to hospital policy.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36804 Based on observation, interview, and record review the facility failed to follow facility policies and procedures relating to safe storage and labeling of food, domestic hot water supply, cleaning of can openers and storing staff food in patient freezer. 1. Water temperature in the main kitchen 74 - 76 degrees Fahrenheit. 2. Meat in the main kitchen freezer, unlabeled and undated. 3. Flour tortillas in the main kitchen cooler dated [DATE]. 4. Can opener with black substance on cutting wheel in the main kitchen. 5. Staff food stored in the skilled nursing satellite kitchen. These failures had the potential to affect the skilled nursing population by food borne illness in a highly susceptible population by subjecting patients to infection control and quality issues. Findings: 1. During an observation on [DATE] at 9:12 a.m. at the handwashing sink located by the main kitchen entrance, it was noted that the water was cold and did not warm up with time. During an interview on [DATE] at 9:12 a.m. with Supervising [NAME] I (SC I), SC I stated that the hot water has always been an issue. During an observation on [DATE] at 9:55 a.m. at the prep sink, SC I took the temperature of the water with a digital thermometer and obtained a temperature of 74 degrees Fahrenheit. A temperature of the handwashing sink located by the main kitchen entrance was taken by SC I with a digital thermometer and obtained a temperature of 76 degrees Fahrenheit. During review of the work order dated [DATE], the work order indicated, The hot water in the Nutritional Services building is not working correctly. In the morning there is hot water, by noon there is no hot water in the building. Making it very hard to properly clean the equipment. During review of the facility's policy and procedure (P&P) titled, Domestic Hot Water Supply, dated [DATE], the P&P indicated, Facilities Management shall maintain all water heaters, pressure control valves, and temperature control valves. Water temperatures shall not exceed 120 degrees Fahrenheit or fall below 105 degrees Fahrenheit . 2. During an observation on [DATE] at 9:15 a.m. in the main kitchen freezer #2, cooked meat in a grocery type bag was unlabeled and undated. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 9:15 a.m. with Supervising [NAME] 1 (SC 1), SC 1 stated the meat should be labeled and dated. SC 1 further stated the meat should not have been stored in a grocery bag. SC 1 stated he did not know who placed the grocery type bag with meat in the freezer. During review of the facility's policy and procedure (P&P) titled, Food Storage, dated/revised February 2018, the P&P indicated, All food items and storage containers are clearly labeled with date and contents. Outdated or unlabeled items are discarded. 3. During an observation on [DATE] at 9:20 a.m. in the main kitchen cooler #4 flour tortillas dated [DATE] was unlabeled. During an interview on [DATE] at 9:20 a.m. with Supervising [NAME] 1 (SC 1), SC 1 stated the tortillas might have been expired and were likely returned from the unit and should have been discarded. During review of the facility's policy and procedure (P&P) titled, Food Storage, dated/revised February 2018, the P&P indicated, All food items and storage containers are clearly labeled with date and contents. Outdated or unlabeled items are discarded. 4. During an observation on [DATE] at 9:48 a.m. in the main kitchen, the main line electric can opener was observed to have a black substance on the can opener cutting wheel. During an interview on [DATE] at 9:48 a.m. with Supervising [NAME] 1 (SC 1), SC 1 stated the black substance on the can opener cutting wheel was unacceptable. The SC 1 stated the can openers should be cleaned at the end of each shift. (The policy indicated can openers should be cleaned after each use in the main kitchen). During review of the facility's policy and procedure (P&P) titled, Can Openers, dated/revised [DATE], the P&P indicated, Can openers are cleaned in the dining rooms following each meal period and in the Main Kitchen after each use. 5. During an observation on [DATE] at 10:55 a.m. in the Skilled Nursing Facility satellite kitchen, a food item belonging to staff was observed in the patient freezer. During an interview on [DATE] at 10:55 a.m. with Food Service Technician II (FST II), FST II stated the food belonged to her. FST II stated she knew the food should not be stored in the patient's freezer. FST II stated staff had a mini fridge/freezer, however the freezer did not get cold enough. During an interview on [DATE] at 3:07 p.m. with the Quality Improvement Director (QID), QID stated that staff food should not be stored with patient food. QID stated the food should be stored separately. QID stated there was no facility policy.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49936 Based on observation, interview, and record review, the facility failed to maintain complete and accurate documented medical records for the pain management of one of 13 sampled residents (Resident 3). This failure had the potential for inaccurate and incomplete representation of Resident 3's pain management. Findings: 1. During a record review of Resident 3's clinical record, updated 5/13/24, the clinical record indicated Resident 3 was admitted on [DATE]. Resident 3's diagnoses included cervical myelopathy (compression in spine that may result in pain, numbness, and weakness), polyneuropathy (multiple nerve damage that may result in pain, lack of coordination, and increased sensitivity to touch), degenerative joint disease (pain and stiffness in joints that worsens over time), history of patellectomy (surgical removal of knee cap), and left knee contracture (pain and loss of movement in the left knee joint). During an interview on 5/13/24 at 10:29 a.m. with Resident 3, Resident 3 stated he felt pain all over, and the medications he received for pain did not work too well. During a concurrent interview and record review on 5/14/24 at 10:54 a.m. with the Supervising Registered Nurse (SRN), Resident 3's RN Pain Assessment IDN (pain assessment tool), last dated 4/4/24 was reviewed. The assessment indicated Resident 3 was receiving routine narcotics and was able to verbalize the severity of the pain. The SRN stated the pain assessment tool was supposed to be completed weekly. The facility was unable to provide evidence of the pain assessment tool or any other documented pain assessment being completed after 4/4/24 to reflect weekly assessments. During a concurrent interview and record review on 5/14/24 on 11:04 a.m. with Psychiatric Technician (PT) 1, Resident 3's [undated] Pain Management Flowsheet (tool used for pain management) was reviewed. The flowsheet indicated sections for assessing the resident's pain, listing the medications and interventions used, and evaluation of interventions with regards to the resident's pain. The flowsheet indicated it was filed with the Medication Records. The flowsheet was noted to be blank, indicating no pain assessment was completed and documented. PT 1 stated the Pain Management Flowsheet was found in the Medication and Treatment Record. PT 1 confirmed Resident 3's Pain Management Flowsheet was blank because they did not chart on it if pain medications administered were scheduled. During a record review of Resident 3's Physician's Orders, dated 4/16/24, the orders indicated Resident 3 was prescribed routinely scheduled pain medications including Acetaminophen, Gabapentin, and Tramadol (narcotic pain medication). During a record review of Resident 3's Nursing Care Plan - Focus Number 6.37, dated 2/1/24, the care plan indicated, Licensed nursing staff will administer prescribed medications and will monitor their effectivity. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of the Resident 3's Medication and Treatment Record (MAR), dated April-May 2024, the MAR indicated the resident was being administered acetaminophen, gabapentin, and tramadol routinely. The MAR indicated no assessment of their effectivity was being documented. The MAR indicated the dose for gabapentin was lowered on 4/11/24 due to low renal (kidney-related) function. The facility was unable to provide any pain assessment completed after dosage change to reflect medication effectiveness on Resident 3's pain. During a record review of Resident 3's Nursing Care Plan - Focus Number 6.25, dated 2/1/24, the care plan indicated the goal was that the patient will demonstrate or state that pain is relieved or controlled. The care plan further indicated, Licensed designee will assess and monitor for the presence of pain q (every) shift and will notify MD if unable to tolerate pain. During a record review of the facility's policy and procedure (P&P) titled, Pain Management, dated 3/12/24, the P&P indicated, The RN (registered nurse) shall assess each patient for pain on admission, annually; for change in physical condition; and for other circumstances that include, but are not limited to: .B. Unresolved pain or the goal for pain is not met .F. Weekly when taking scheduled narcotics or using a pain control device. The P&P also indicated that for Previously identified pain that is being treated Licensed nursing staff shall follow the plan of care and provide documentation within one (1) hour on the Pain Management Flow Sheet to include description of pain, pain rating, provided interventions, and response to interventions. The P&P further indicated that for Scheduled narcotic regimen or pain control device .The RN shall complete the RN Pain Assessment IDN each week. The P&P indicated, If the patient's acceptable level of pain is not met, the pain remains unresolved, the pain has increased, or the patient is experiencing breakthrough pain, licensed nursing staff shall refer the patient to the RN for further assessment. The RN shall complete the RN Pain Assessment IDN, shall notify the Physician, carry out received orders as applicable, and shall revise the NCP, as indicated.