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	05/22/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 35030 Based on observation, interview and record review, the facility failed to maintain sanitary conditions for a universe of 23 residents, when a Food Service Technician (FST 2) did not perform hand hygiene between tasks. This failure had the potential to cause food- borne illnesses in a vulnerable population. Findings: During an observation on 5/21/25 at 11:20 a.m in A-4 satellite kitchen the following was observed. FST 2 was observed pouring ice with gloved hands into a tray, FST 2 then walked to the dishwasher area and placed an ice scooper through the dishwasher with the same gloved hands. The FST 2 picked up the ice scooper from the dishwasher and returned to the ice tray with the same gloved hands and proceeded to scoop ice into a tray. During an interview on 5/21/25 at 11:51 a.m with the Food Service Supervisor (FSS), the FSS stated, handwashing should be done after every task to prevent cross contamination. During an interview on 5/21/25 at 11:54 a.m with the FST 2, the FST 2 stated she should have washed her hands after placing the ice scooper through the dishwasher to prevent cross contamination. During a review of the facility's policy and procedure (P&P) titled, Hand Washing and Glove Use, dated, August 2014, the P&P indicated, . Standards B. Thorough hand washing is done: 3. Between handling dirty and clean dishes and utensils.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51225 This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure safe infection control practices were followed when: 1. Enhanced barrier precautions (EBP - infection control strategy focused on preventing the spread of infection) were not implemented for one of 13 sampled residents (Resident 10), during personal hygiene care. 2. Sterile technique (a set of practices used to prevent contamination and reduce the risk of infection) was not used when irrigating the suprapubic catheter (SPC- a tube that drains urine from the bladder through the lower abdomen) for one of 13 sampled residents (Resident 4). This deficient practice placed Resident 4 at risk for catheter-associated urinary tract infection (UTI- infection of the bladder) and other complications. These failures had the potential to expose residents to cross contamination of infectious disease. Findings: 1. During a review of Resident 10's Minimum Data Set (MDS, standardized assessment tool), dated 2/28/25, the MDS indicated Resident 10's diagnoses included Benign Prostatic Hyperplasia (enlarged prostate) and Neurogenic Bladder (bladder problem caused by nerve damage that affects one's ability to urinate). During a concurrent observation and interview on 5/19/25 at 9:30 a.m. with Nursing Instructor (NI) 1 outside Resident 10's room, three Psychiatric Technician Apprentices providing personal hygiene care (cleaning private area of resident) without personal protective equipment. NI 1 stated, The red marker on the room entrance indicated that Resident 10 was on EBP. The students should have had on gowns and gloves while providing personal hygiene care. During a concurrent observation and interview on 5/19/25 at 9:45 a.m. with Registered Nurse (RN) 1 outside resident 10's room, RN 1 verified that Resident 10 had orders for EBP due to having a supra pubic catheter (a tube that drains urine from the bladder through the lower abdomen). RN 1 stated that gowns and gloves should be worn while providing personal care. RN 1 stated EBP is used to prevent cross contamination of infectious disease and protects vulnerable residents and staff from each other. During a review of Resident 10's Nursing Care Plan (NCP - a guide that identifies a patient's needs or problems and what the nurse will do to take care of the patient), dated 4/26/25, the NCP indicated, Normal Pressure Hydrocephalus (progressive neurological condition) with Neurogenic Bladder s/p Suprapubic Catheter. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure titled, Enhanced Barrier Precautions (EBP), dated 3/10/25, the P&P indicated, II. EBP . A. Gowns and gloves shall be used during specific high-contact care activities (personal hygiene care) . F. EBP are indicated for residents with any of the following: indwelling urinary catheters. 52357 2. A review of Resident 4's Face Sheet (demographics), dated 5/20/25, and Nursing Care Plan (a guide that identifies a patient's needs or problems and what the nurse will do to take care of the patient), dated 4/30/25, indicated Resident 4 was admitted on [DATE] with diagnoses that include neurogenic bladder (bladder problem caused by nerve damage that affects one's ability to urinate) status post (after) SPC placement with repeated UTI. During a concurrent observation and record review on 5/20/25 at 3:42 p.m., in Resident 4's room, Registered Nurse (RN) 2, donned clean gloves and gown and reviewed the physician's order which directed staff to irrigate Resident 4's suprapubic catheter every shift with 150 ml (milliliters- unit of measurement) of 0.9% sodium chloride (solution used to flush tubing) and 50 ml of 0.25% acetic acid solution (mild acid solution used to kill bacteria and fungus) . RN 2 poured a total of 150 ml of 0.9% sodium chloride into 3 medication cups (not sterile (completely free of germs that can cause infection)), which were set up on top of the treatment cart (not a sterile field- an area free of bacteria that includes sterile tools and surfaces and is set up during medical procedures to prevent infection) in the hallway outside the resident's room. RN 2 then poured 50 ml of 0.25% acetic acid solution into a fourth medication cup (not sterile). RN 2 then placed the cups of solution on a rolling bedside table (not a sterile field) inside the resident's room and moved it to the side of the resident's bed. Instead of sterile gloves (gloves which have been sterilized to eliminate any bacteria to protect residents from infection during procedures), RN 2 donned the same gloves that touched non-sterile surfaces to disconnect the drainage bag (bag that collects urine) and tubing from the suprapubic catheter and opened the plastic wrap packaging of the piston syringe (now not sterile). RN 2 used the piston syringe (not sterile) to draw up and inject 150 ml of 0.9% sodium chloride solution into the suprapubic catheter tubing without first disinfecting the port with an alcohol pad. RN 2 used the same piston syringe to draw up and inject 50 ml of 0.25% acetic acid solution into the suprapubic catheter tubing. RN 2 then reconnected the urinary drainage bag to the suprapubic catheter. During a concurrent interview and record review on 5/21/25 at 1:57 p.m. with Infection Control Nurse (ICN), ICN reviewed the facility's policy and procedure (P&P) titled, GYNGU-812: Urinary Catheters, dated 5/8/25, and stated that the irrigation of a suprapubic catheter should be performed as a sterile procedure. During a review of the facility's policy and procedure (P&P) titled, GYNGU-812: Urinary Catheters, dated 5/8/25, the P&P indicated, .staff shall follow the most current Centers for Disease Control (CDC) Guidelines when caring for a patient with an indwelling catheter (a tube that stays in the body to drain urine from the bladder) to decrease the possibility of contracting a catheter-associated urinary tract infection. Under Procedures for Indwelling Urinary Catheter Irrigation, the P&P required that licensed nursing staff disinfect the collection port with an alcohol pad and use aseptic (sterile) technique when performing irrigation of an indwelling urinary catheter.