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	05/15/2026

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

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure each resident receives an accurate assessment. Based on interview and record review, the facility failed to submit accurate Minimum Data Set (MDS- a federally mandated assessment tool used to guide resident care) data for eight of 13 sampled residents (Residents 1, 2, 3, 7, 15, 16, 17, and 21) when the MDS did not reflect the following: 1. Resident 1 had a diagnosis of psychotic disorder (mental health condition that causes a person to lose touch with reality). 2. Resident 2 received hospice care (end-of-life care). 3. Resident 3 had diagnoses of Traumatic Brain Injury (TBI- damage to the brain caused by an outside physical force), dementia (decline in brain function that affects a person's memory and thinking skills) and hemiplegia (paralysis of one vertical half of the body). 4. Resident 7 received anticonvulsant (medication used to calm the brain) daily. 5. Resident 15 received daily treatment for viral hepatitis (inflammation of the liver caused by an infection). 6. Resident 16 had Preadmission Screening and Resident Review (PASRR- used to ensure individuals are placed in an appropriate setting and receive needed mental health services) level II evaluation completed and used peg tube (tube surgically inserted into the stomach for nutrition, hydration, and medications). 7. Resident 17 received anticonvulsant daily and had diagnosis of hip fracture. 8. Resident 21's preferred language was Vietnamese, required an interpreter and was diagnosed with dementia, Alzheimer's Disease (progressive brain disorder that destroys memory, thinking skills and ability to carry out basic tasks) and depression.These failures resulted in the transmission of inaccurate data to the Centers for Medicare and Medicaid Services (CMS) and had the potential to result in inaccurate resident care and planning.Findings:During a concurrent interview and record review on 5/13/26 from 2 PM to 3:06 PM with MDS Coordinator (MDSC) and the Director of Nursing (DON), Residents 1, 2, 3, 7, 15,16, 17, and 21's most recent MDS assessments and treatment plans were reviewed. -Resident 1's Treatment Plan, dated 3/17/26, indicated Resident 1 had diagnosis of psychotic disorder. Resident 1's Quarterly MDS, dated 4/6/26 indicated Resident 1 did not have a diagnosis of psychotic disorder in Section I (Active Diagnoses). -Resident 2's Treatment Plan, dated 2/5/26, indicated Resident 2 was receiving hospice care. Resident 2's Quarterly MDS, dated 4/24/26, indicated Resident 2 was not receiving hospice care in Section O (Special Treatments, Procedures, and Programs). -Resident 3's Treatment Plan, dated 3/3/26, indicated Resident 3 had diagnoses of TBI and hemiplegia. Resident 2's Comprehensive MDS, dated 5/7/26, indicated Resident 2's primary reason for admission was non-traumatic brain injury (brain damage caused by an internal event not caused by an outside physical force) and did not show diagnosis of hemiplegia in Section I. -Resident 7's Treatment Plan, dated 4/16/26, indicated Resident 7 received valproic acid (anticonvulsant medication) twice daily. Resident 7's Quarterly MDS, dated 3/12/26, indicated Resident 7 was not receiving an anticonvulsant in Section N (Medications). -Resident 15's Treatment Plan, dated 4/14/26, indicated Resident 15 was administered entecavir (medication to treat viral hepatitis) daily. Resident 15's Quarterly MDS, dated 2/26/26, indicated Resident 15 did not have an active infection for viral hepatitis in Section I. -Resident 16's Treatment Plan, dated 4/21/26, indicated Resident 16 received medications via peg-tube. Resident 16's PASRR Determination Letter, dated 11/20/25, indicated Resident 16 was considered by the state level II PASRR process to have serious mental illness. Resident 16's Comprehensive MDS, dated 4/1/26, indicated Resident 16 was not considered by the state level II PASRR process to have serious mental (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	illness in Section A (Identification Information) and did not have a peg-tube in Section K (Swallowing/Nutrition). -Resident 17's Treatment Plan, dated 2/24/26, indicated Resident 17 received valproic acid twice daily, and diagnosed with an old left hip fracture that caused inability to ambulate, decreased range of motion and current contractures. Resident 17's Quarterly MDS, dated 5/7/26, indicated Resident 17 did not receive an anticonvulsant in Section N nor had a hip fracture in Section I. -Resident 21's Treatment Plan, dated 5/5/26, indicated Resident 21's primary language was Vietnamese, he needed an interpreter and diagnosed with Alzheimer's Disease, dementia and depression. Resident 21's Quarterly MDS, dated 5/11/26, indicated in Section A his primary language was English an he did not require an interpreter, and in Section I he was not diagnosed with Alzheimer's Disease, dementia or depression.MDSC confirmed Residents 1, 2, 3, 7, 15, 16, 17, and 21 had inaccurate data submitted on their MDS assessments. MDSC stated the treatment plans were accurate, she made mistakes, and she was unaware what PASRR was, so she selected no for PASRR Level II. MDSC further stated she was not comfortable within her position as the MDSC and did not believe she had enough training to complete the assessments accurately. The DON stated she was unaware of all the inaccurate resident assessments and the MDS should have accurately reflected the resident's status.During a review of CMS Long-Term Care Facility [LTCF] Resident Assessment Instrument [RAI] 3.0 User's Manual, dated October 2024, CMS LTCF RAI 3.0 User's Manual indicated, If the resident does not appear to be fluent in English or continues to have difficulty understanding . Code 1, Yes: if the resident indicates the need or want for an interpreter to communicate with a doctor or health care staff. Ensure that preferred language is indicated . All individuals who are admitted to a Medicaid certified nursing facility, regardless of the individual's payment source, must have a Level I PASRR completed to screen for possible mental illness(MI) . Code 1, yes: if PASRR Level II screening determined that the resident has a serious mental illness . Code disease that have a documented diagnosis in the last 60 days and have a direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments . Only feeding tubes that are used to deliver nutritive, substance and/or hydration during the assessment period are coded in K0520B: Nutritional Approaches . N0415K1. Anticonvulsant: Check if an anticonvulsant medication was taken by the resident at any time during the 7-day observation period .

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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. Based on observation, interview, and record review, the facility failed to ensure food safety and sanitation guidelines were followed when:Six cups of sherbet were undated in the freezer of the satellite kitchen.Six cups of ice cream were undated in the freezer of the satellite kitchen.One cup of cooked rice was expired in the refrigerator of the satellite kitchen.Two cups of tofu were expired in the refrigerator of the satellite kitchen.Six cups of egg salad were unlabeled and undated in the refrigerator in the satellite kitchen.One refrigerator had a holding temperature of 48 degrees Fahrenheit, above the maximum temperature, in the satellite kitchen.One package of oven roasted turkey breast was unlabeled and undated in the cooler of the main kitchen.A scoop was stored in a food bin labeled Thickener in the main kitchen.These failures posed the risk of food borne illness in a medically fragile resident population of 22 facility residents who received food prepared in the kitchen. During a concurrent observation and interview on 5/11/26 at 1:35 PM with Food Service Technician (FST), in the satellite kitchen, six cups of sherbet and six cups of ice cream stored in the refrigerator/freezer were observed to be unlabeled and undated. FST stated the food items should have been labeled and dated and confirmed that food items stored in the refrigerator or freezer were required to be labeled and dated according to facility practice. During a concurrent observation and interview on 5/11/26 at 1:45PM, with FST, in the satellite kitchen, one cup of cooked plain rice dated 5/3/26 and six cups of egg salad without labels or dates were observed stored in the three-door refrigerator. Additionally, two cups of tofu dated 5/5/26 were observed stored in the refrigerator. FST stated according to facility guidelines, refrigerated foods such as cooked plain rice and cups of tofu food must be discarded after five days if kept in the refrigerator. FST further stated the cooked plain rice and tofu had expired and confirmed that the egg salad should have been labeled and dated in accordance with facility policy. During a concurrent observation and interview on 5/11/26 at 1:50 PM, in the satellite kitchen, FST checked the temperature of the two-door refrigerator and stated it was 48 degrees Fahrenheit rechecked and remained at 48 degrees . Approximately 10 minutes later, the refrigerator temperature was 48 Fahrenheit. FST stated the refrigerator temperatures should be maintained at 41 degrees Fahrenheit or below and confirmed that residents' breakfast in hotel pans for 5/12/26 were stored in the two-door refrigerator.During an interview on 5/11/26 at 2:10 PM, with the Director of Dietetics (DOD), the DOD stated that refrigerator temperatures should be maintained at 41 degrees Fahrenheit or below. The DOD further stated that a refrigerator temperature of 48 degrees Fahrenheit was not safe for storing food, including the breakfast food scheduled for 5/12/26. The DOD also stated that all food items in the refrigerator or freezer should be labeled and dated. Additionally, the DOD stated that cooked rice and tofu should not be stored in the refrigerator for more than five days in accordance with facility policy.During a concurrent observation and interview on 5/11/26 at 2:25 PM, with Supervising [NAME] (SC), in the main kitchen, one package of oven roasted turkey breast was observed stored without a label or date in the walk-in cooler. SC confirmed the package of oven roasted turkey breast was unlabeled and undated. SC further stated it was not acceptable to store food items in the cooler without a label and date according to facility practice.During an interview on 5/11/26 at 2:30 PM, with the Assistant Director of Dietetics (ADOD), ADOD stated it was not acceptable to store a package of oven roasted turkey breast in the walk-in cooler without proper labeling and dating in accordance with facility policy.During a concurrent observation and interview on 5/12/26 at 10:30 AM, with the SC , in the main kitchen, a scoop was observed inside a food bin labeled Thickener in the food preparation area. SC confirmed that it was not good practice to leave a scoop inside the food thickener.During an interview on 5/12/26 at 10:33 AM, with ADOD, ADOD stated that leaving a scoop in the food thickener could result in food contamination.During a review of the facility's document titled Shelf-Life Refrigerated /Frozen/ Canned Items, dated 2/27/26, the document indicated that all refrigerated food items must be (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	covered, labeled, and dated; all frozen items must remain in their original containers with the date received marked. The document further indicated ice cream, sherbet, and special request items from the main kitchen must be dated upon receipt and maintained for five days from the date on the pan.During a review of the facility's policy and procedure (P&P) titled Food Temperature, dated August 2025, P&P indicated that food temperatures must always be maintained at appropriate levels. Specifically, refrigerated items must be kept at 41 F or below.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on interview and record review, the facility failed to develop and maintain a comprehensive, data-driven facility assessment that accurately identified the resources necessary to care for its resident population. These failures had the potential to result in insufficient staffing, unmet resident care needs, delayed interventions, and inability to safely provide services consistent with resident acuity and diagnoses.Findings:During a concurrent interview and record review on 5/14/26 at 10:47 AM with Assistant Executive Director (AED) and Standards Compliance Director (SCD), the Facility Assessment, dated 2026, was reviewed. The Facility Assessment did not include the following: 1. A data-driven staffing plan based on resident acuity and care needs. 2. Documentation of participation by leadership, direct care staff, and resident/family representatives. 3. Assessment of staffing contingency plans during emergencies or staffing shortages. 4. Ongoing evaluation of competencies and resources necessary to provide behavioral health services to the facility's specialized resident populations.The AED and SCD confirmed with the Facility Assessment that multiple key components were missing, and the AED stated the Facility Assessment needed to be updated.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on interview and record review, the facility failed to ensure its Quality Assurance and Performance Improvement (QAPI) program was comprehensive and data-driven when the facility failed to identify, monitor, and correct facility-wide non-compliance in two areas:1. Ongoing inaccuracies in Minimum Data Set (MDS- standardized, federally mandated assessment tool used to evaluate the health, functional abilities and care needs of every patient in a skilled nursing facility) submissions were identified.2. Continued detection of legionella pneumophila (harmful bacteria causing Legionnaires' disease- type of serious infection in the lungs) in the kitchen cooling tower was not resolved.This deficient practice resulted in a lack of system-wide tracking, data analysis, and quality oversight for issues of non-compliance that affected 22 of 22 residents.Findings:1. During a concurrent observation and interview on 5/13/26 at 1:59 PM with Director of Nursing (DON) and MDS Coordinator (MDSC), the list of all skilled nursing facility (SNF) residents was observed on Internet Quality Improvement and Evaluation System (iQies- a database used by healthcare providers to submit patient assessment records). 16 out of 22 residents were indicated as not having the mandatory PASRR (Pre-admission Screening and Resident Review- evaluation that ensures people with disabilities or mental health conditions receive appropriate care) level II evaluations. MDSC stated that she was not familiar with PASRR and could not provide an explanation for the inaccuracies in patient assessments she submitted. When questioned regarding oversight, DON confirmed that she oversees MDSC and was not aware that inaccurate patient assessments were submitted for 16 of 22 residents.During a review of the facility's Quality Council meeting minutes for the last 3 quarters (October 2025 through April 2026), the review indicated that a Performance Improvement Project (PIP) was not initiated to address inaccurate patient assessment submissions for SNF residents. No evidence of MDS audit findings, tracking error rates, or data tracking trends were reported or reviewed by the committee.During an interview on 5/15/26 at 9:35 AM with DON, DON confirmed that she was responsible for identifying issues affecting SNF residents that required improvement and developing PIPs for QAPI. DON confirmed that her focus for PIPs in the last year was determined by 2025 recertification survey findings which identified deficiencies in staff annual health exams and staff performance reviews. When asked if inaccurate resident assessment submissions in MDS were addressed in Quality Council (QC) meetings or PIPs, DON stated that because she was unaware that inaccurate resident assessments were being transmitted, it had not been identified or tracked in QAPI.During a review of the facility's policy and procedures (P&P) titled, [Facility Name] Skilled Nursing QAPI Plan, reviewed 5/1/25, the P&P indicated, The purpose of the. Quality Assurance Performance Improvement (QAPI) plan is to establish a systemic process that monitors and evaluates various aspects of patient care to ensure that established standards of quality are met and/or maintained. Focus areas will include all systems that affect the quality of care and services provided, and all areas that affect the quality of life for patients living in the skilled nursing unit at [Facility Name] .The Program 4 Director and Nurse Administrator will prioritize topics for PIPs based on the current needs of the patients.Priority will be given to areas or issues identified as high-risk to patients and staff, high-prevalence, or high-volume, and areas that are problem-prone.During a review of the facility's policy and procedures (P&P), titled [Facility Name]: Hospital-wide Standing Committees (AD 016 Attachment A), revised 3/28/25, the P&P indicated, under 6. Quality Council (QC), The QC shall provide oversight for both Risk Management and Performance Improvement processes to reduce or eliminate the risk of harm to patients, employees, and visitors. The performance improvement functions include strategic planning and quality improvement process.2. During a review of the facility's Legionella Test Results, dated 3/5/26, the Legionella Test Results indicated legionella pneumophila was still detected in the Kitchen Cooling Tower and the recommendation listed, Kitchen Cooling Tower persists in testing positive for the Legionella. Waste Management Program (WMP) procedure dictates further remediation.During a (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	review of the facility's Quality Council meeting minutes for the last 3 quarters (October 2025 through April 2026), the review indicated that a Performance Improvement Project (PIP) was not initiated to address the ongoing detection of legionella pneumophila (harmful bacteria causing Legionnaires' disease- type of serious infection in the lungs) in the kitchen cooling tower. No evidence of data tracking or remediation evaluations performed by Infection Prevention was identified.During an interview on 5/15/26 at 9:35 AM with DON, DON stated that she was responsible for identifying issues affecting SNF residents that require improvement and developing PIPs for QAPI. When asked if the ongoing detection of legionella pneumophila in the kitchen cooling tower has been addressed in QAPI, DON stated that the Infection Preventionist (IP) 1 participates in Quality Council meetings but the continued detection of legionella pneumophila was not identified or being tracked in QAPI.During a review of the facility's policy and procedures (P&P), titled [Facility Name] Skilled Nursing QAPI Plan, reviewed 5/1/25, the P&P indicated, The purpose of the. Quality Assurance Performance Improvement (QAPI) plan is to establish a systemic process that monitors and evaluates various aspects of patient care to ensure that established standards of quality are met and/or maintained. Focus areas will include all systems that affect the quality of care and services provided, and all areas that affect the quality of life for patients living in the skilled nursing unit at [Facility Name] .The Program 4 Director and Nurse Administrator will prioritize topics for PIPs based on the current needs of the patients.Priority will be given to areas or issues identified as high-risk to patients and staff, high-prevalence, or high-volume, and areas that are problem-prone.During a review of the facility's policy and procedures (P&P), titled [Facility Name]: Hospital-wide Standing Committees (AD 016 Attachment A), revised 3/28/25, the P&P indicated, under 6. Quality Council (QC), The QC shall provide oversight for both Risk Management and Performance Improvement processes to reduce or eliminate the risk of harm to patients, employees, and visitors. The performance improvement functions include strategic planning and quality improvement process.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to implement infection prevention and control practices that protect residents from the spread of infectious diseases when:Remediation was not completed and documented after legionella pneumophila (harmful bacteria causing Legionnaires' disease- type of serious infection in the lungs) was detected in the kitchen cooling tower.12 of 12 residents (Residents 1, 2, 3, 5, 8, 10, 11, 12, 15, 16, 21, and 22) were on Enhanced Barrier Precaution (EBP-infection control intervention used to protect patients from the spread of multi-drug resistant organisms (MDROs- bacteria that are resistant to most antibiotics)) and did not have Personal Protective Equipment (PPE-specialized clothing or equipment used to reduce exposure to hazards or infections) available immediately outside the residents' rooms in accordance with The Center for Disease Control and Prevention (CDC) guidelines.Licensed Vocational Nurse (LVN) 1 did not wear PPE while administering medication to Resident 1 via gastrostomy tube (G-tube- a soft flexible tube surgically placed through the skin into the stomach for the delivery of nutrition, fluids, and medication).These failures had the potential to spread infection in a medically fragile population of 22 residents.Findings:1.During a concurrent interview and record review on 5/14/26 at 11:55 AM with the Chief of Plant Operations (CPO), the following documents were reviewed: -The Legionella Test Results, dated 11/5/25, indicated legionella pneumophila was detected in the Kitchen Cooling Tower and the recommendation listed, Kitchen Cooling Tower continues to test positive and has periodic overflow issues. Per your WMP [waste management program], please take offline and physically clean. -The Legionella Test Results, dated 3/5/26, indicated legionella pneumophila was still detected in the Kitchen Cooling Tower and the recommendation listed, Kitchen Cooling Tower persists in testing positive for the Legionella. WMP procedure dictates further remediation. The CPO stated the remediation required after testing positive for legionella would have been emptying the whole cooling tower, dropping chemicals into the cooling tower, and then completing a retest for the presence of legionella to see if the remediation was effective. The CPO further stated there was no documentation of remediation after the Legionella Test Result for 11/5/25, and there should have been a documented remediation and retest. During an interview on 5/14/26 at 4:10 PM with the Standards Compliance Director (SCD), the SCD confirmed there was no remediation completed for legionella on the Kitchen Cooling Tower after it was detected on 11/5/26. During a review of the facility's policy and procedure (P&P) titled, Legionella, dated 6/4/25, the P&P indicated, .Preventing legionella infections involves maintaining the water system. 2. During an observation on 5/11/26 at 2:00 PM on Unit A4, personal protective equipment (PPE) was stored inside a locked supply room and not readily available outside the rooms for Residents 1, 2, 3, 5, 8, 10, 11, 12, 15, 16, 21, and 22. During an interview on 5/14/26 at 8:59 AM with the Infection Preventionist (IP) 2, the following guidelines were referenced: California Department of Public Health (CDPH)'s All Facilities Letter (AFL) 24-15, dated 6/13/24, indicated, California SNFs [Skilled Nursing Facilities] should refer to the CDC website on (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) . for guidance and tools for implementing EBP. CDC's Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), dated 4/2/24, indicated, When implementing. Enhanced Barrier Precautions, it is critical to ensure staff have. access to appropriate supplies. To accomplish this. Make PPE, including gowns and gloves, available immediately outside of the resident room. IP 2 confirmed that personal protective equipment was not available immediately outside the rooms of residents who were on EBP (Residents 1, 2, 3, 5, 8, 10, 11, 12, 15, 16, 21, and 22) in accordance with CDC guidelines for EBP. IP 2 confirmed that residents who require EBP are considered vulnerable and at increased risk for infection and possible serious infection-related complications. 3. During a record review of Resident 1's most recent Minimum Data Set (MDS- a detailed health, functional, and psychological assessment performed on every patient), accepted on 4/6/26, the record indicated, under Section K. Swallowing/Nutritional Status, Resident 1 has a feeding tube. During a concurrent observation and interview on 5/14/26 at 7:55 AM in Resident 1's room, LVN 1 was observed administering multiple medications to Resident 1 via G-tube while not wearing a gown and gloves. An EBP sign was posted above Resident 1's bed, indicating that gown and gloves must be worn for high-contact care activities for this patient. When asked why Resident 1 required EBP, LVN 1 stated that because Resident 1 had a G-tube, she was at risk for infection. LVN 1 confirmed that he should have worn personal protective equipment when administering Resident 1's medications via G-tube. During an interview on 5/14/26 at 10:02 AM with Infection Preventionist (IP) 1, IP 1 stated that the purpose of EBP was to avoid introducing infection to residents who are vulnerable due to having indwelling devices or wounds and to provide diligent care. IP 1 stated that neglecting to wear PPE as indicated for EBP could result in exposing residents to infection and infection-related complications. During a record review of the facility's policy and procedure (P&P) titled Enhanced Barrier Precautions, effective 4/30/26, the P&P indicated, EBP is employed when performing the following high-contact resident care activities: .Device care or use: central line, urinary catheter, feeding tube.Gowns and gloves are the minimum level of PPE required for these high-contact resident care activities.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview and record review, the facility failed to maintain the environment in a safe, comfortable, and functional condition for residents when: 1. One pothole and a large area of uneven surface was observed in the courtyard. 2. Multiple walls in the day hall with deep gouges exposing the drywall were observed. These failures had the potential to affect the safety and well-being of residents, staff, and visitors.During a concurrent observation and interview on 5/13/26 at 10:45 AM, with the Supervising Registered Nurse (SRN 1), of the courtyard, a pothole and a large area of uneven surface were identified. SRN 1 confirmed the presence of a pothole measuring approximately 1 foot by 2 feet, as well as a large area of uneven surface in the courtyard. SRN 1 further stated the unit census was 20 residents, including 10 residents who use wheelchairs and can self-propel, and one resident who used a walker for mobility and confirmed all residents in the unit have access to the courtyard. During an interview on 5/13/26 at 2:55 PM, with Plant Operations Supervisor (POS), POS stated environmental checks were conducted twice a year. POS further stated he was not aware of the pothole or the large area of uneven surface in the courtyard and confirmed that no work order had been submitted for repair. 2. During an observation on 5/13/26 at 2:50 PM, of the day hall, multiple walls were noted to have deep gouges exposing the drywall. During an interview conducted on 5/13/26 at 3:05 PM, with the POS, POS confirmed the presence of multiple damaged wall areas in the day hall, with gouges exposing drywall measuring approximately 20 feet in total length. POS stated they were not aware of the damage. POS also confirmed that no work order had been submitted for repair. During a review of the facility's policy and procedure (P&P) titled Maintenance Services, dated 7/28/25, P&P indicated the facility's policy is to provide patients, staff, and visitors with a safe and healthy environment by ensuring that infrastructure functions safely, properly, and consistently, and is routinely maintained. The policy further indicated that its purpose is to establish an orderly process for requesting and completing maintenance and repairs. During a review of the facility's P&P titled, Rights of LPS Patients [[NAME]-Petris-Short Act, which is a California law that governs the involuntary civil commitment of individuals with serious mental health disorders], dated 5/26/25, P&P indicated that patients have the right to decent living conditions, including the right to receive services in facilities that are physically safe, sanitary, and conducive to treatment.

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	05A357	A. Building B. Wing	05/15/2026

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Dept of State Hospitals - Napa D/P Snf	2100 Napa-Vallejo Highway Napa, CA 94558

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a transmittal of a quarterly Minimum Data Set (MDS- a federally mandated assessment tool used to guide resident care) was submitted no more than 14 days after the assessment reference date (ARD-the date the resident assessment was completed) for one of 13 sampled residents (Resident 15). This failure resulted in Resident 15's Quarterly MDS being submitted untimely.Findings:During a review of Resident 15's Treatment Plan, dated 4/14/26, the Treatment Plan indicated Resident 15 was admitted to the facility on [DATE], with diagnoses to include dysphagia (difficulty swallowing) and need for total care (staff assisting with all daily activities of living).During a concurrent interview and record review on 5/13/26 at 2:26 PM with MDS Coordinator (MDSC) and the Director of Nursing (DON), Resident 15's Quarterly MDS, dated 2/26/26 was reviewed. Resident 15's Quarterly MDS indicated the ARD was 1/30/26 and the assessment was not submitted until 2/26/26. The MDSC stated the assessment should have been submitted within 14 days after the ARD. The DON stated she was unaware of any resident assessments being submitted late, but they should have been submitted timely.During a review of CMS Long-Term Care Facility [LTCF] Resident Assessment Instrument [RAI] 3.0 User's Manual, dated October 2024, CMS LTCF RAI 3.0 User's Manual indicated, Quarterly. Transmission Date No Later Than: MDS Completion Date + 14 calendar days.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure completion and submission of federally mandated Preadmission Screening and Resident Review (PASRR- used to ensure individuals are placed in an appropriate setting and receive needed mental health services) were completed for seven of 13 sampled residents (Resident 1, 3, 4, 5, 8, 11, and 21). These failures resulted in seven residents not receiving federally mandated evaluations and determinations, which could result in residents with serious mental illness' not receiving a standardized plan of care consistent with their assessed needs.Findings:During a review of Resident 1's Treatment Plan, dated 3/17/26, the Treatment Plan indicated Resident 1 was admitted to the facility on [DATE] with diagnoses to include major neurocognitive disorder (severe, ongoing decline in memory and thinking that makes it impossible for a person to live independently), personality change, psychotic disorder (mental health condition that causes a person to lose touch with reality) and hallucinations (seeing something that is not real).During a review of Resident 3's Treatment Plan, dated 3/3/26, the Treatment Plan indicated Resident 3 was admitted to the facility on [DATE] with diagnoses to include schizophrenia (chronic brain disorder that disrupts a person's ability to think, feel or interpret reality) and major neurocognitive disorder.During a review of Resident 4's Treatment Plan, dated 2/17/26, the Treatment Plan indicated Resident 4 was admitted to the facility on [DATE] with diagnoses to include psychotic disorder, hallucinations, neurocognitive disorder, and pedophilic disorder (sexual attraction to children).During a review of Resident 5's Treatment Plan, dated 3/3/26, the Treatment Plan indicated Resident 5 was admitted to the facility on [DATE] with the diagnosis of schizoaffective disorder (having a hard time telling what is real), bipolar type (extreme uncontrollable shifts in person's mood, energy, and activity levels).During a review of Resident 8's Treatment Plan, dated 4/7/26, the Treatment Plan indicated Resident 8 was admitted to the facility on [DATE] with diagnoses to include schizophrenia and paraphilic disorder (extreme unusual sexual interests).During a review of Resident 11's Treatment Plan, dated 3/24/26, the Treatment Plan indicated Resident 11 was admitted to the facility on [DATE] with diagnosis of schizoaffective disorder, bipolar type.During a review of Resident 21's Treatment Plan, dated 5/5/26, the Treatment Plan indicated Resident 21 was admitted to the facility on [DATE] with diagnoses to include depressive disorder (extreme sadness, emptiness, and loss of interest) and neurocognitive disorder.During a concurrent interview and record review on 5/12/26 at 11:13 AM with the Social Worker (SW), California Department of Health Care Services (DHCS) Application portal for PASRR was reviewed. DCHS Application portal indicated five residents had PASRR screenings I and II but Residents 1, 3, 4, 5, 8, 11, and 21 did not have PASRR Level I Screenings submitted. The SW stated she did not know why she did not submit a PASRR Level I Screening for Resident 1, 3, 4, 5, 8, 11, 20 and 21.During a review of the PASRR General Overview, undated, the PASRR General Overview indicated, Which health care facilities are subject to PASRR? . All Medicaid certified SNFs [skilled nursing facilities] are subject to the PASRR process. This includes California's: SNF certified by Medicaid. institution for Mental Disease that are designated as Skilled Nursing Facilities. Is PASRR required for anyone being admitted to a NF [nursing facility]? Yes, a Level 1 screening, a level 2 evaluation (if needed), and a determination must be completed.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure staff maintained resident's dignity and provided care in a manner that was respectful for one of 13 sampled residents (Resident 15) when Psychiatric Technician Assistant (PTA) 1 stood over Resident 15 while feeding him dinner. This failure had the potential to result in Resident 15 feeling intimidated or uncomfortable during meal assistance.Findings:During a review of Resident 15's Treatment Plan, dated 4/14/26, the Treatment Plan indicated Resident 15 was admitted to the facility on [DATE], with diagnoses to include dysphagia (difficulty swallowing) and need for total care (staff assisting with all daily activities of living).During an observation on 5/11/26 at 5:42 PM in Resident 15's room, Resident 15 was sitting upright in bed and PTA 1 was at bedside, standing over him and feeding him dinner.During an interview on 5/11/26 at 5:57 PM with PTA 1, PTA 1 stated she normally stood over residents while feeding them.During an interview on 5/13/26 at 3:07 PM with the Director of Nursing (DON), the DON stated it was not normal for staff to be standing while feeding a resident and the staff member should have been at eye level. The DON further stated feeding a resident at eye level was done for dignity and respect.During a review of Resident 15's Nursing Care Plan (NCP): Dysphagia, dated 3/26/26, the NCP indicated, .Nursing staff will assist patient in feeding in all his meals.During a review of the facility's policy and procedure (P&P) titled, Dysphagia/Choking Screen, dated 6/26/25, the P&P indicated, .Total Assistance- Patient requires total during feeding or total assistance to feed self. Do not rush the patient. Position at eye level when assisting with feeding the patient.During a review of the facility's P&P titled, Rights of LPS [[NAME]-Petris-Short- legal power to make decisions on the behalf of another individual that is mentally ill] Patients, dated 5/26/25, the P&P indicated, .Non-deniable rights. A right to dignity.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that the call light for one of 13 sampled residents (Resident 6) was placed within reach, preventing Resident 6 from independently requesting assistance from staff. This failure resulted in putting Resident 6 at risk for unmet needs and delayed care.Findings:During a review of Resident 6's Treatment Plan, dated 2/24/26, the Treatment Plan indicated Resident 6 was admitted on [DATE] with diagnosis of spastic quadriparesis (muscle weakness and stiffness resulting in jerky and difficult movement of both arms and legs) and required total assistance provided by staff with regards to transferring (moving in and out of bed) and activities of daily living (ADLs- basic, routine personal care tasks such as hygiene, toileting, dressing and eating).During a concurrent observation and interview on 5/12/26 at 9:24 AM with Registered Nurse (RN) 1 in Resident 6's room, Resident 6 was observed lying in bed with his E-Z call light (a specialized call light designed for patients with very limited strength or range of motion) on the bedside table and out of reach. RN 1 confirmed the call light was on the bedside table out of Resident 6's reach and stated that nursing staff does hourly rounding to make sure residents' needs are met.During an interview on 5/13/26 at 3:08 PM with Director of Nursing (DON), DON confirmed that even with hourly rounding, it was possible for Resident 6 to experience an urgent need for assistance from staff, such as a medical emergency, in between hourly rounding checks and that if Resident 6 was unable to reach his call light, he was at risk for delayed and unmet urgent care needs.During a review of the facility's P&P titled, Rights of LPS [[NAME]-Petris-Short- legal power to make decisions on the behalf of another individual that is mentally ill] Patients, dated 5/26/25, the P&P indicated, It is the policy of [Facility Name] to protect and promote the legal rights of patients and not deny a patient any of such rights without legal justification and need. Furthermore, the P&P indicated under Section B. Non-Deniable Rights include a right to prompt medical care and treatment.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of 13 sampled residents (Resident 15) was free from unnecessary physical restraints when Psychiatric Technician Assistant (PTA) 1 placed all four side rails in the raised position on Resident 15's bed prior to exiting the room. This failure had the potential to restrict Resident 15's freedom of movement and place the resident at risk for injury related to entrapment.Findings:During a review of Resident 15's Treatment Plan, dated 4/14/26, the Treatment Plan indicated Resident 15 was admitted to the facility on [DATE] with diagnoses to include dementia (decline in brain function that affects a person's memory and thinking skills), spastic quadriplegia (most severe form of extreme muscle stiffness and limited movement of all four limbs) and need for total care (staff assisting with all daily activities of living).During a concurrent observation and interview on 5/11/26 at 5:57 PM in Resident 15's room, Resident 15 was sitting upright in bed with two upper side rails up on his bed. PTA 1 finished feeding Resident 15 his dinner, lowered Resident 15's head of bed, and then pulled up the two bottom side rails on his bed, totaling all four side rails up. PTA 1 stated she put all the side rails up on Resident 15's bed, so he doesn't fall out of bed.During an interview on 5/13/26 at 3:08 PM with the Director of Nursing (DON), the DON stated Resident 15 did not have a physician's order for restraints, and no residents were allowed to have all side rails up on their bed due to it being considered a restraint. The DON further stated residents should never be restrained in their bed.During a review of the facility's policy and procedure (P&P) titled, Medical Restraint, dated 1/27/25, the P&P indicated, Medical Restraint shall be used only when the use of less restrictive assistive devices has not been successful. Restraints shall never be used for patient discipline or staff convenience. All restraint use requires a physician's order. Acceptable forms of Medical Restraint include but not limited to: Side Rails.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete a Significant Change in Status Assessment (SCSA- federally mandated comprehensive assessment required when a resident has a major decline or improvement) for one of three sampled residents (Resident 18) after Resident 18 experienced a major decline in condition for multiple areas of Resident 18's health status. This failure had the potential to result in unidentified causes of decline, ineffective or delayed interventions, continued escalation of behaviors, worsening nutritional status, and failure to provide care and services necessary to maintain Resident 18's highest practicable level of functioning.Findings:During a review of Resident 18's Treatment Plan, dated 4/9/26, the Treatment Plan indicated Resident 18 was admitted to the facility on [DATE] with diagnoses of Chronic Obstructive Pulmonary Disease (COPD- progressive lung disease that damages airways, making it hard to breathe), Congested Heart Failure (CHF- chronic condition where the heart muscle is too weak to pump blood efficiently), and dysphagia (difficulty swallowing) with peg-tube (feeding tube surgically placed into the stomach).During a concurrent interview and record review on 5/13/26 at 2:17 PM with Minimum Data Set Coordinator (MDSC) and the Director of Nursing (DON), Resident 18's most current MDS [a federally mandated assessment tool used to guide resident care] Quarterly, dated 3/12/26, and Treatment Plan, dated 4/9/26 were reviewed. -Resident 18's Quarterly MDS indicated Resident 18 exhibited physical and verbal behavioral symptoms towards others 1 to 3 days, and other behavioral symptoms not directed towards others were not exhibited. The Quarterly MDS further indicated Resident 18 did not have weight loss within the past six months. - The Treatment Plan indicated Resident 18 had one behavioral incident in the month of January 2026, two behavioral incidents in the month of February 2026 and 12 behavioral incidents from 3/9/26 to 4/1/26. The Treatment Plan further indicated Resident 18 had a 7.3 lb. weight loss in one month on 4/1/26, and was hospitalized due to lethargy (excessively sluggish and drowsy), hypernatremia (high level of sodium in blood stream), dehydration, acute kidney injury (when the kidneys temporarily stop working) and acute metabolic encephalopathy (sudden, temporary state of brain dysfunction that requires medical intervention) which required a four day hospital stay and medical intervention.MDSC stated she was aware of Resident 18 having increased behavioral incidents, over 7 lb. weight loss, and a four-day hospital stay requiring medical intervention all within the same month. MDSC further stated she should have completed a SCSA in the month of April 2026. The DON stated the expectation was for the MDSC to complete a SCSA when Resident 18 was identified to have a significant decline and submit timely.During an interview on 5/14/26 at 2:45 PM with Supervising Registered Nurse (SRN) 2, SRN 2 stated Resident 18's decline was discussed by the treatment team for the increased behaviors, weight loss and hospitalization. SRN 2 further stated she was being monitored for increasing decline but then had passed away before the next monthly meeting.During a review of CMS Long-Term Care Facility [LTCF] Resident Assessment Instrument [RAI] 3.0 User's Manual, dated October 2024, CMS LTCF RAI 3.0 User's Manual indicated, A SCSA is a comprehensive assessment for a resident that must be completed when. a resident meets the significant change guidelines of either major improvement or decline. A significant change is a major decline or improvement in a resident's status that: will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions. An SCSA is appropriate if there are either two or more areas of decline. decline in two or more of the following: presence of a resident mood item not previously reported. increase in the number of areas where behavioral symptoms are coded as being present and/or the frequency of a symptom increase for items in Section E (behavior). emergence of unplanned weight loss problem. emergence of a condition/disease in which a resident is judged to be unstable.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure pressure-relieving equipment was properly implemented for two of 13 sampled residents (Resident 15 and Resident 21) when the pressure-reducing mattresses were not set to the resident's accurate weight in accordance with the manufacturers' instruction. These failures had the potential to decrease the effectiveness of the pressure redistribution and place Resident 15 and Resident 21 at a higher risk for skin breakdown and/or impaired healing.Findings:1. During a review of Resident 15's Treatment Plan, dated 4/14/26, the Treatment Plan indicated Resident 15 was admitted to the facility on [DATE] with diagnoses to include spastic quadriplegia (most severe form of extreme muscle stiffness and limited movement of all four limbs), need for total care (staff assisting with all daily activities of living), and high risk for pressure ulcers.During a concurrent observation and interview on 5/13/26 at 9:34 AM with Registered Nurse (RN) 2, in Resident 15's room, Resident 15 had a pressure-reducing mattress on and programmed to setting 5 which indicated, weight 210-244 lbs. RN 2 stated the setting of the pressure-reducing mattress was not correct because, he doesn't weigh that much and it needed to show his accurate weight to be effective. RN 2 further stated she was unaware of how to change the setting and she did not receive training on the pressure-reducing mattresses.During an interview on 5/13/26 at 3:11 PM with the Director of Nursing (DON), DON stated all staff received training multiple times on how to operate the pressure-reducing mattress and the expectation was for staff to match mattress setting to the resident's most accurate weight.During a review of facility's Unit A4 Height/Weight BMI [body mass index], undated, the Height/Weight BMI indicated Resident 15's most recent weight was 166.2 lbs. on 5/2/26.During a review of the Quick Reference Card [manufacturer name of pressure-reducing mattress], dated 2021, the Quick Reference Card indicated, Controller Instructions. Using the soft/firm keys set patient comfort pressure settings by selecting the number corresponding closest to the patient's weight.2. During a review of Resident 21's Treatment Plan, dated 5/5/26, the Treatment Plan indicated Resident 21 was admitted to the facility on [DATE] with diagnoses to include dementia (decline in brain function that affects a person's memory and thinking skills), high risk for pressure ulcers, and inability to stand or walk.During a concurrent observation and interview on 5/13/26 at 9:39 AM with Registered Nurse (RN) 2, in Resident 21's room, Resident 21 had a pressure-reducing mattress on and programmed to setting 2 which indicated, weight 105-139 lbs. RN 2 stated the setting of the pressure-reducing mattress was not correct because Resident 21 weighed less than 105 lbs. RN 2 stated the pressure-reducing mattress needed to be programed to the resident's accurate weight to be effective. RN 2 further stated she was unaware of how to change the setting, and she did not receive training on the pressure-reducing mattresses.During an interview on 5/13/26 at 3:11 PM with the Director of Nursing (DON), DON stated all staff received training multiple times on how to operate the pressure-reducing mattress and the expectation was for staff to match mattress setting to the resident's most accurate weight.During a review of facility's Unit A4 Height/Weight BMI [body mass index], undated, the Height/Weight BMI indicated Resident 21's most recent weight was 97.2 lbs. on 5/2/26.During a review of the Quick Reference Card [manufacturer name of pressure-reducing mattress], dated 2021, the Quick Reference Card indicated, Controller Instructions. Using the soft/firm keys set patient comfort pressure settings by selecting the number corresponding closest to the patient's weight.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on interview and record review, the facility failed to ensure the Minimum Data Set (MDS- a federally mandated assessment tool used to guide resident care) Coordinator Nurse possessed and demonstrated competency to accurately complete federally mandated resident assessments when eight of 13 sampled residents (Residents 1, 2, 3, 7, 15, 16, 17, and 21) had inaccurate coding, one of 13 sampled residents (Resident 15) had untimely transmittal of a quarterly resident assessment, and one of three sampled residents (Resident 18) did not have a significant change in status assessment (SCSA- federally mandated comprehensive assessment required when a resident has a major decline or improvement) after decline was identified. These failures had the potential to affect all resident care and planning, by not ensuring residents received appropriate care and services consistent with their assessed needs.Cross reference F640, F641 and F645.Findings:During an interview on 5/13/26 at 2:00 PM with MDSC, MDSC stated she started working as the MDSC with the facility in 2017. MDSC stated she had no prior training on MDS before fulfilling her position, and she had only received a two-day training course which she believed was not sufficient enough. MDSC further stated she was not fully comfortable or confident with completing the resident assessments.During an interview on 5/13/26 at 3:07 PM with the Director of Nursing (DON), the DON stated she oversaw MDSC. The DON further stated she did not check MDSC's resident assessments for accuracy because she believed she did not need to. The DON confirmed eight resident assessments were inaccurate, one resident had late transmittal and one resident should have received a SCSA and stated she should have provided better oversight to MDSC's resident assessments.During a concurrent interview and record review on 5/15/26 at 10:21 AM with Supervising Registered Nurse (SRN) 2, MDSC's MDS 3.0 Basic Training, dated 7/13/17 was reviewed. The document indicated MDSC completed 14 credited hours of education for MDS. SRN 2 stated MDSC has not received any other training for MDS and has not had an adverse employee evaluation.During a review of MDSC's Duty Statement, dated 1/17/18, the Duty Statement indicated, site specific duties- OBRA nurse [Omnibus Budget Reconciliation Act-specialized nurse who oversees compliance for MDS]- performs admission/annual/ quarterly/significant change assessments based on patient and/or family interviews, physical assessments, observation, and input from treatment team. inputs patient's data in accordance with RAI rules and regulations; transmit completed MDS scheduled assessments to CMS. Technical proficiency: knowledge of MDS. Required competencies: MDS 3.0.

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure food was served in a palatable and appetizing manner for one of 13 sampled residents (Resident 15) when Psychiatric Technician Assistant (PTA) 1 mixed multiple pureed food items together prior to feeding Resident 15. This failure had the potential to result in negatively affecting Resident 15's meal enjoyment and food intake.Findings:During a review of Resident 15's Treatment Plan, dated 4/14/26, the Treatment Plan indicated Resident 15 was admitted to the facility on [DATE], with diagnoses to include dementia (decline in brain function that affects a person's memory and thinking skills), dysphagia (difficulty swallowing) and need for total care (staff assisting with all daily activities of living).During an observation on 5/11/26 at 5:52 PM, in Resident 15's room, Resident 15 was sitting upright in bed, with a dinner meal tray on the bedside table in front of him. The dinner meal tray had one plate with an unknown green pureed food, three different Styrofoam cups showing each a different beige colored pureed food item, and one vanilla ice cream. PTA 1 mixed all three beige colored pureed food items together, fed them to Resident 15 and then took three spoonfuls of the mixed beige colored pureed food and added it to the vanilla ice cream.During an interview on 5/11/26 at 5:57 PM with PTA 1, PTA 1 confirmed she mixed Resident 15's pureed dinner all together and stated she normally does not mix pureed food together.During an interview on 5/13/26 at 3:07 PM with the Director of Nursing (DON), the DON stated staff should not mix all pureed foods together because it would not be appetizing. The DON further stated, I wouldn't want my food like that.During an interview on 5/15/26 at 8:30 AM with Registered Dietician (RD), RD stated mixing multiple pureed food items together would be a strange decision and does not sound appetizing.During a review of the facility's policy and procedure (P&P) titled, Dietetics Department Procedure Manual, dated August 2014, the P&P indicated, .Dietetics Department is to provide patients served with the finest clinical nutritional care available. by providing a pleasant dining experience during which quality food is presented in an attractive manner.