STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555161	A. Building B. Wing	05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Napa Valley Care Center	3275 Villa Lane 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 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 interview and record review, the facility failed to ensure dignity was maintained for one of three sampled residents (Resident 1) when a staff member did not close the privacy curtain before providing incontinence care. This resulted in another resident observing Resident 1's exposed buttocks, after which the staff member laughed.This failure caused Resident 1 to experience embarrassment, humiliation, and diminished dignity, and created the potential for emotional distress, loss of trust in facility staff, and reluctance to request assistance with personal care. A review of Resident 1's admission Record (facility demographic), indicated he was admitted to the facility on [DATE] with a primary admitting diagnosis of Hemiplegia (weakness on one side of the body) and Hemiparesis (total or partial paralysis of one side of the body) following a Cerebral Infarction (brain stroke) affecting the dominant left side of his body.A record review of the report submitted by the facility's Director of Nursing (DON) to the California Department of Public Health (CDPH) on 5/14/26 indicated that Resident 1 informed the facility on the evening of 5/13/26 that, approximately one and a half to two weeks earlier during the night, an unlicensed staff member 1 (US 1) failed to close his privacy curtain before providing incontinence care. This allowed a female resident to see his exposed buttocks. The DON reported that Resident 1 stated US 1 laughed after the female resident saw him and that he found it, odd and weird, that she laughed at the incident.During an interview on 5/20/26 at 10:46 a.m., the Director of Nursing (DON) confirmed that US 1 was suspended during a facility investigation of the incident reported by Resident 1. Following the investigation, US 1 was no longer permitted to provide care on Resident 1's hall and was reassigned to another hall with no further contact with Resident 1. The DON stated the facility staff could benefit from additional training.During an interview on 5/20/26 at 10:58 a.m. in the hallway outside the DON's office, Resident 1 stated that a few weeks earlier, during nighttime incontinence care, US 1 began the task without closing the privacy curtain. He stated that a female resident (Resident 2) entered the room, briefly apologized, and left after seeing his exposed buttocks as he was lying on his side. Immediately afterward, he heard US 1 laughing. Resident 1 stated he felt embarrassed and humiliated, particularly because of US 1's laughter. He reported that he formally reported the incident to the Director of Nursing.During an interview on 5/20/26 at 11:16 a.m., with Unlicensed Staff member (US 2), US 2 stated her first step in providing care for incontinence to a resident in the facility, was to provide the resident with privacy, by either pulling the resident's privacy curtain or shutting the door. During an interview on 5/20/26 at 11:19 a.m. in her room, Resident 2 confirmed she witnessed an incident a few weeks earlier when she went to see Resident 1. She said she found his door open and his privacy curtain stored at the foot of the bed, so she could not tell if he was inside. Resident 2 stated she tapped on the wall outside the room, did not hear a response, and entered. According to Resident 2, she then saw Resident 1's exposed buttocks and US 1 standing beside him. Resident 2 said US 1 looked at her and laughed. Resident 2 stated she immediately apologized and left the room, adding that she felt embarrassed by the incident and then felt bad for Resident 1 as well.During an interview on 5/20/26 at 12:36 p.m., with LN 1 at the nurses' station, LN 1 was queried about what a potential psychosocial harm risk for (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a resident might be due to an incident involving the resident's exposure of their buttocks to another resident during incontinence care. LN 1 stated the incident would likely cause the resident embarrassment. During a telephone interview on 5/13/26 at 3:25 p.m., with US 1 and an interpreter, US 1 confirmed she recalled an incident that happened involving Resident 1 becoming upset after Resident 2 came to his room during the time she was providing care for incontinence to Resident 1. A review of the facility policy titled, Dignity, revised in February 2021, indicated, Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. 1. Residents are treated with dignity and respect at all times. 2. The facility culture supports dignity and respect for residents by honoring resident goals, choices, preferences, values and beliefs. This begins with the initial admission and continues throughout their resident's facility stay . 11. Staff promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures. 12. Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents.A review of the facility policy titled, Resident Rights, revised in February 2021, indicated, Employees shall treat all residents with kindness respect and dignity. 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. a dignified existence; b. be treated with respect, kindness and dignity. t. privacy and confidentiality.