

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555161	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2026
NAME OF PROVIDER OR SUPPLIER Napa Valley Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure two of four sampled residents (Resident 1 and Resident 2) were protected from abuse when Resident 1 and Resident 2 threw fluids at one another, exchanged verbal profanities, and Resident 2 hit Resident 1 on the shoulder. This failure resulted in an altercation between Resident 1 and Resident 2 and placed both residents at risk for physical and psychological harm. A review of Resident 1's admission record indicated she was admitted to the facility in April 2025 with medical diagnosis which included cirrhosis of the liver (permanent scarring of healthy liver [an organ that filters toxins, produces bile for digestion and regulates blood sugar] tissue) and cerebellar ataxia (damage to a part of the brain that regulates balance, posture and muscle coordination). A review of Resident 1's Minimum Data Set (MDS-a federally mandated resident assessment tool) dated 6/25/26, indicated her Brief Interview of Mental Status (BIMS-a cognition [the processes of thinking and reasoning] assessment) score was 11 which indicated her cognition was moderately impaired (a score of 1-7 indicates cognition is severely impaired, 8-12 indicates cognition is moderately impaired, and 13-15 indicates cognition is intact). A review of Resident 1's progress notes, type, 72-hour Charting, dated 6/06/26 at 11:46 a.m., indicated, S [Situation]: Resident exhibited physical aggression toward other resident. A review of Resident 1's progress notes, type, 72-hour Charting, dated 6/06/26 at 11:48 a.m., indicated, When [Resident 2] threw paint products at her, [Resident 1] then threw water at her. During altercation, per witness [Resident 2] hit her [Resident 1] shoulder twice with her first [fist] closed. A review of Resident 1's progress notes, type, IDT (interdisciplinary team, typically includes the nursing leadership, social services, and medical records) NOTE, dated 6/06/26 at 2:51 p.m., indicated, .[Resident 1] then recounts that [Resident 2] threw paint and water at her.[Resident 1] then retaliated by throwing her own drink at [Resident 2] and had admitted to calling [Resident 2] '[profanity]'. [Resident 2] then became enraged and screamed at [Resident 1], also calling her '[profanity]'.as [Resident 1] was attempting to leave the area, [Resident 2] then swung at [Resident 1] twice hitting her left shoulder.[Resident 2] has admitted to her actions. A review of Resident 2's admission record indicated she was admitted to the facility in August 2020 with medical diagnosis which included paranoid schizophrenia (a chronic mental disorder characterized by intense irrational delusions [false beliefs] and auditory hallucinations [hearing voices]), and dementia (a progressive state of decline in mental abilities). A review of Resident 2's MDS dated [DATE], indicated her BIMS score was 13 which indicated her cognition was intact. A review of Resident 2's progress notes, type, Change of Condition [COC], dated 6/06/26 at 12:19 p.m., indicated, Resident had an altercation with another resident.[Resident 2] did say she punched the other resident on her shoulder and threw water and ginger ale at her.The other resident [Resident 1] also threw water at her. During an interview on 7/02/26 at 10:47 a.m., Resident 1 stated, I was assaulted in the dining room. Resident 1 stated she was seated at a table in the dining room and was approached by Resident 2 and Resident 2 told her, This is my table. Resident 1 stated they had a verbal exchange about the table and then Resident 2 called her a [profanity]. Resident 1 further stated that in return she called Resident 2 a [profanity]. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 1 stated Resident 2 proceeded to throw a drink at her. Resident 1 further stated that Resident 2 picked up a bucket full of paint bottles and threw it at her hitting her right shoulder and the top of her right foot. Resident 1 stated that Certified Nurse Assistant 2 (CNA 2) was present and witnessed the entire incident. Resident 1 stated, For three days I stayed in my room. I was nervous. I didn't want to be assaulted again. Resident 1 further stated, The whole situation bothers me mentally. Mentally, it really set me back. I'm nervous and scared to move around the facility. During an interview on 7/02/26 at 11:30 a.m., Resident 2 stated, I was upset and I got in a fight with someone. I feel ashamed. Resident 2 was unable to recall further details of the incident. During an interview on 7/02/26 at 1:30 p.m., CNA 1 stated that staff were expected to respond immediately when a resident-to-resident altercation was witnessed so that physical contact could be avoided. CNA 1 confirmed that profane name calling between residents was considered verbal abuse. CNA 1 further confirmed if residents attempted to hit one another or make physical contact it was considered physical abuse. CNA 1 stated it was everyone's [all facility staff] responsibility to ensure residents were safe from abuse. During an observation and interview on 7/02/26 at 1:43 p.m. with CNA 2, when asked if he witnessed a resident-to-resident altercation between Resident 1 and Resident 2 approximately one month ago in the dining room, he stated, Yes. When asked to explain what he witnessed, CNA 2 stated both Resident 1 and Resident 2 were in the dining room and he was seated directly next to the table that Resident 1 was seated at. CNA 2 stated Resident 1 was approached by Resident 2 in her wheelchair and overheard Resident 1 say, This is bullshit, you always do this to me! CNA 2 stated Resident 2 threw her crackers and ginger ale at Resident 1. CNA 2 further stated he heard Resident 1 yell at Resident 2, You [profanity] [profanity]! CNA 2 stated Resident 1 then threw a cup of fluids at Resident 2. CNA 2 stated he saw Resident 2 stand up from her wheelchair and swung at Resident 1. CNA 2 mimicked the action made by Resident 2. CNA 2 was observed standing from a seated position with a closed fist and made an upward and downward swinging motion with his arm. CNA 2 further stated that he saw Resident 2 hit Resident 1 in the left shoulder twice. CNA 2 stated he heard a slapping sound and that is how he knew that Resident 2 made physical contact with Resident 1. CNA 2's recollection of the incident was reiterated to him, and CNA 2 confirmed that he heard the slap of Resident 2 arm or fist against Resident 1's left shoulder. CNA 2 stated that Resident 2 then proceeded to throw the bucket with paint bottles that was on the table onto the floor. When asked if Resident 2's physical contact was intentional, CNA 2 stated, Yes, because she actually stood up from her wheelchair and hit her [Resident 1]. She [Resident 2] made a fist and swung at her [Resident 1]. When asked if the verbal exchange that occurred between Resident 1 and Resident 2 was verbal abuse, CNA 2 stated, Yes. [Resident 1] did call her [Resident 2] a [profanity] [profanity]. During an interview on 7/02/26 at 2:09 p.m., Licensed Nurse 1 (LN 1) stated she was at the nurse's station when she witnessed Resident 1 coming from the dining room and she appeared very distressed. LN 1 stated that Resident 1 informed her that Resident 2 threw water at her. LN 1 stated later that shift, Resident 1 complained of bilateral (both right and left) foot pain. LN 1 stated that Resident 1 told her she thinks the pain to her foot may have been from getting hit with the cup that was thrown. LN 1 stated that Resident 1 stayed in her room for the remainder of the shift. LN 1 stated the following day Resident 1 complained of left shoulder pain and medication was given. LN 1 confirmed that profane name calling between residents was considered abuse. LN 1 further confirmed physical contact between residents was considered abuse, and stated, Yes, actual physical contact is abuse. During an interview on 7/02/26 at 2:50 p.m., the Director of Nursing (DON) confirmed that physical contact and the verbal exchange of profanity between a resident to another was considered physical and verbal abuse. A review of the facility's policy and procedure titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised 2021, indicated, Residents have the right to be free from abuse. This includes but is not limited freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse. Protect residents from abuse by anyone including other residents.		