STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555207	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Piners Nursing Home	1800 Pueblo Ave 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. Based on interview and record review, the facility failed to treat one of three sampled residents (Resident 1) with kindness, respect, and dignity, when the Director of Nursing (DON) was witnessed bullying Resident 1. This failure resulted in Resident 1 crying.During an interview on 3/24/26 at 2:19 p.m., Confidential Witness (CW) stated that back in January 2026 something happened during activities that caused Resident 1 to get mad at someone. CW stated that while CW was at the nurses station that afternoon, Resident 1 was in the lobby when DON came at the nurses station very emotional and aggressive and said Resident 1 was out of control and we need to do something about her, we need to send her out. CW stated DON was very physically and verbally aggressive about the way she approached the nurses at the desk, all within earshot of Resident 1, who was only a few feet away. CW stated that when Resident 1 heard DON talking about her in this way, she began sobbing. CW stated it felt immediately like DON was bullying Resident 1. CW stated Resident 1 was sent later that day to the emergency department (ED).Review of Resident 1's progress note, dated 1/9/26 at 3:34 p.m. indicated, During Bingo today [Resident 1] got upset at [staff named] because she saw that [another resident] had not covered one of the numbers that had previously been called. When I approached [Resident 1] I asked her if she had an issue with [another resident] and she againstated that if someone doesn't know how to play they shouldn't be playing. I let her know that we help everyone that needs it, even her and as I was removing her from the table she threatened to slap [another resident] in the face so, I took [Resident 1] down the hall towards her room and as I did so she threw 2 bingo chips, that she had in her hand, against the wall. She then started yelling which caused our Administrator and DON to come around the corner to see what was going on. I explained the situation to them and then let them handle it from there.Review of Resident 1's progress note, dated 1/9/26 at 5:20 p.m. indicated, Resident noted with redness to face and starting shaking. [Shortness of breath] noted. No change in [level of consciousness] noted. Resident was under emotional distress and crying. Notified [doctor] and ordered resident to go to ED for further evaluation. [Responsible party] notified. Ambulance arrived to facility @ [5:15] pm and resident was taken via gurney to [local acute care hospital] ED for further evaluation.Review of facility policy Resident Rights, last reviewed 3/31/26 indicated, Employees shall treat all residents with kindness, respect, and dignity.

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to inform the family member of one of three sampled residents (Resident 1) of changes to Resident 1's treatment plan for her behaviors and her pain. This failure resulted in Resident 1's family member (FM) finding out after the changes to the treatment plan had already been implemented, feeling that Resident 1 was being over-medicated with sedating drugs, and having to request further changes to Resident 1's medication regimen.During an interview on 3/11/26 at 1:28 p.m., Family Member (FM) stated he got a call in February 2026 that Resident 1 was in respiratory distress due to an increase in her fentanyl patch (a powerful synthetic opioid, 50 to 100 times more potent than morphine, that is absorbed through the skin for consistent pain relief) dose. FM stated that if facility staff had asked him he would not have agreed to the 50 mcg/hr (micrograms per hour, the rate the drug is released from the patch) fentanyl patch because Resident 1 was already on multiple drugs that depress her central nervous system (consists of the brain and spinal cord, acting as the primary control center for processing information, coordinating body movements (including breathing), and managing thoughts, sensations, and emotions). FM stated Resident 1's Seroquel (an anti-psychotic medication) was doubled while she was in the hospital but she had delirium from the fentanyl overdose and from being transferred from floor to floor, she wasn't at her baseline. FM stated that while Resident 1 was in the hospital she was hallucinating that she was [AGE] years old and looking for her dad and trying to get out of bed because she was trying to escape from a fire. FM stated that the increased dose of Seroquel that was ordered in the hospital was continued after Resident 1's return to the facility without discussing it with him. FM stated that two weeks ago when he visited Resident 1, she was slumped over in her chair and slurring her words. FM stated he texted Resident 1's doctor and requested that Resident 1's morning and afternoon Seroquel doses be decreased, and that was when he learned that Resident 1 also had an additional order for a Seroquel dose to be given as needed (PRN). When queried, FM stated he did not know why the facility staff were not talking to him about the dose changes. FM stated Resident 1 had very limited ability to understand these treatment changes or make healthcare decisions and there was no one else but FM in Resident 1's life to make healthcare decisions for her. FM stated, It hurts my heart to find my mom like that.During a medical record review on 3/12/26 at 12:15 p.m., Resident 1's face sheet indicated an admission date of 2/5/21, age [AGE], and medical diagnoses including dementia (a decline in cognitive function severe enough to interfere with daily life) with other behavioral disturbance, epilepsy (a seizure disorder), chronic pain, traumatic brain injury, wedge compression fracture of T11 - T12 vertebra (occurs when the front part of the mid-back bones collapse, forming a wedge shape), bipolar disorder (a chronic mental health condition characterized by extreme, often debilitating, mood swings that include intense highs (mania) and severe lows (depression)), anxiety disorder, and cerebral infarction (a blockage of blood flow to the brain), among others. Further review of Resident 1's face sheet indicated Resident 1 was her own responsible party. Review of Resident 1's physician's orders indicated a fentanyl patch 25 mcg/hr was ordered on 11/26/25, and discontinued on 1/26/26. Further review of Resident 1's physician's orders indicated an order dated 1/30/26 for fentanyl patch 50 mcg/hr and an order dated 9/25/25 for Seroquel 25 mg three times a day for agitation. Review of Resident 1's January 2026 medication administration record (MAR) indicated the fentanyl patch 50 mcg/hr was administered on 1/30/26.Review of Resident 1's February MAR indicated an order dated 2/3/26, and discontinued 2/22/26, for Seroquel 50 mg three times daily, and Seroquel 25 mg 1 tablet every 6 hours PRN for agitation with 1 tablet administered on 2/11/26, 2/14/26, and 2/22/26.Review of Resident 1's nurse progress notes indicated a note dated 1/30/26 at 12:41 p.m., Discontinued existing order of Fentanyl patch 25 mcg start new order fentanyl transdermal patch 72 hour 50 mcg/hr . Start Date:2/2/26. Further review of Resident 1's progress note indicated no documentation of FM being notified of this change.During an interview on 3/24/26 (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at 1:40 p.m., Licensed Nurse A stated FM was not informed of the decision to increase Resident 1's fentanyl patch to 50 mcg/hr at the end of January 2026.During an interview and concurrent record review on 3/26/26 at 3:29 p.m., Licensed Nurse B reviewed Resident 1's medical record and verified there was no informed consent signed for the Seroquel 50 mg three times a day or the Seroquel PRN order. Licensed Nurse B verified if the dose was increased and a PRN dose added while at the hospital, a new consent should have been obtained. Licensed Nurse B stated she did not know where the physician documented in the residents' records the residents' capacity to make decisions.During a phone interview on 3/30/26 at 11:36 a.m., Medical Director verified that when he was interviewed by the Department in October 2025 about Resident 1, he told the surveyor that Resident 1 did not have the capacity to make healthcare decisions. Medical Director stated that had not changed, Resident 1 still did not have capacity to make decisions and no county conservator had been arranged. Medical Director verified residents' family had the right to participate in the resident's plan of care.During a phone interview on 3/30/26 at 3:44 p.m., Medical Director stated he expected the facility nursing staff to have informed FM of the fentanyl patch dose increase.Review of facility policy Resident Rights, last reviewed 3/31/26, indicated, 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: . c. Choose a physician and treatment and participate in decisions and care planning . 2. Residents are entitled to exercise their rights and privileges to the fullest extent possible.Review of facility policy Psychotropic Medication Use, last revised 2/2025, indicated, Informed Consent or Refusal: 1. Prior to initiating the use of, increasing the dose of, or switching to a different psychotropic medication, the staff and physician will review the following with the resident/representative prior to obtaining documented consent or refusal: a. non-pharmacological alternatives; b. the indications and rationale for the recommendation; c. the potential risks and benefits (including possible side effects, adverse consequences, and black box warnings) and; d. the resident's/representative's right to accept or decline the treatment.Review of facility policy Care Plans, Comprehensive Person-Centered, last revised 8/2024, 1. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. 6. If the participation of the resident and his/her resident representative in developing the resident's care plan is determined to not be practicable, an explanation is documented in the resident's medical record.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to protect one of three sampled residents (Resident 1) from chemical restraint when Resident 1 had a physician order for an antipsychotic drug (mood altering drugs- used to treat symptoms like hallucinations, delusions, and paranoia) to be given as needed (PRN) for longer than 14 days without a re-evaluation for continued need. This failure resulted in Resident 1 having the potential to receive a dose of the antipsychotic when the drug continued to remain an active order for seven weeks.During an observation on 3/12/26 at 11:50 a.m., a musician in the common room adjacent to the lobby sang into a microphone and played an electric guitar. Resident 1 was in the lobby in her wheelchair with her eyes closed and her chin resting on her chest.During an observation on 3/12/26 at 12:22 p.m., Resident 1 was in the lobby in her wheelchair with her eyes closed and her tongue hanging out of her mouth, her chin resting on her chest.During a medical record review on 3/12/25 at 12:15 p.m., Resident 1's electronic medical record indicated an admission date of 2/5/21, age [AGE], and medical diagnoses including dementia (a decline in cognitive function severe enough to interfere with daily life), epilepsy (a seizure disorder), chronic pain, bipolar disorder (a chronic mental health condition characterized by extreme, often debilitating, mood swings), anxiety disorder, and cerebral infarction (a stroke), among others. A review of Resident 1's electronic medical record and physician orders, titled Medication Administration Record (or MAR, a legal document nurses documented drug given to resident based on doctor's order), dated 2/2026 and 3/2026, the record indicated the following order: SEROquel Oral Tablet 25 MG (Quetiapine; Mind altering drug; MG is milligram, a unit of measure); Give 1 tablet by mouth three times a day for agitation related to ANXIETY DISORDER,-Order Date-2/3/26. Review of the February 2026 MAR indicated Resident 1 had been administered one tablet of Seroquel 25 mg PRN for agitation on 2/11/26, 2/14/26, and 2/22/26. During an interview and concurrent record review of Resident 1's medical record on 3/26/26 at 3:29 p.m.at the nurses' station, when queried, Licensed Nurse B stated the physician re-evaluated orders for PRN antipsychotic medications during the quarterly gradual dose reduction process and then monthly when he signed the orders recapitulation. Licensed Nurse B found Resident 1's most recent orders recapitulation, which included the Seroquel PRN order, and pointed to Medical Director's signature at the bottom. Licensed Nurse B stated she did not know of anywhere in the record that Medical Director might have documented a re-evaluation of Resident 1's continued need for the Seroquel PRN order or his rationale for continuing the order. Licensed Nurse B acknowledged the PRN Seroquel has been in place from 2/3/26 to 3/26/26 without the doctor or mental health doctors' assessments. During a phone interview on 3/30/26 at 11:36 a.m., when queried, Medical Director stated he could not recall if he documented a re-evaluation of Resident 1's continued need for Seroquel PRN, but I'm sure I did. Medical Director stated, They have it at the nurses' station somewhere, they can find it. When informed of facility policy verbiage regarding PRN antipsychotics, Medical Director stated, So I have to document every 14 days if I want the PRN order to continue?During a phone interview on 4/1/26 9:12 a.m., Pharmacist C stated she did Resident 1's medication regimen review a couple of weeks ago and she noted the Seroquel PRN order. Pharmacist C stated she included in her report that she was recommending to discontinue the Seroquel PRN order.Review of facility policy Psychotropic Medication Use, last revised 2/2025, indicated, PRN Medication: 1. Psychotropic medications are not prescribed or administered on a PRN basis unless the medication is necessary to treat a diagnosed specific condition that is documented in the clinical record. 3. PRN orders for psychotropic medications are limited to 14 days. b. For psychotropic medications that ARE antipsychotics: PRN orders cannot be renewed unless the attending physician or prescriber evaluates the resident and documents the appropriateness of the medication.

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F 0757 Level of Harm - Actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on interview and record review, the facility failed to follow FDA (U.S. Food and Drug Administration) Black Box Warnings (or BBW, the most stringent safety warning required by the FDA for prescription drugs) and manufacturer specification for dosing a fentanyl transdermal patch (a powerful synthetic opioid, 50 to 100 times more potent than morphine, that is absorbed through the skin for consistent pain relief) for one of three sampled patients, Resident 1 when:1. Resident 1's fentanyl patch initiation on 11/26/25 did not follow FDA Black Box Warnings and manufacturer specification on starting dose based on history of opioid use, old age, and Chronic Obstructive Pulmonary Disease (or COPD, a long-term lung inflammation and obstruction, making it hard to breathe without medication or supplemental oxygen).2. Resident 1's fentanyl dose increase, which doubled the dosage, on 1/30/26 also did not follow FDA and manufacturer dose escalation guidelines, soon after administration of Norco and anxiety medication called lorazepam (or Ativan, anti-anxiety drug) in span of 1.5 hours apart may have contributed to respiratory depression (unable to breath) and hospitalization.These failures resulted in Resident 1 becoming hypoxic (low oxygen levels in the blood) and being sent to the emergency department (ED) where she was diagnosed with an accidental opiate overdose (a potentially fatal medical emergency occurring when too many opioids (such as heroin, fentanyl, or prescription pain meds) suppress breathing). A review of the fentanyl patch drug information using DailyMed (U.S. government database providing up-to-date, FDA-approved manufacturer drug labeling information), last accessed on 4/6/26 via https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=2a2238e9-4b5d-c56d-8663-dd354ff9ae0c, the record under FDA Black Box Warning (BBW) indicated Fentanyl transdermal system should ONLY be used in patients who are already receiving opioid therapy, who have demonstrated opioid tolerance [a state where the body and brain adapt to regular opioid use, reducing the drug's effectiveness and requiring higher or more frequent doses to achieve the same pain relief], and who require a total daily dose at least equivalent to fentanyl trans dermal system 25 mcg/hr [microgram per hour, a rate at which the drug is released to the body]. Patients who are considered opioid-tolerant are those who have been taking, for a week or longer, at least 60 mg [milligrams] of morphine daily, . or an equianalgesic [the amount of one pain medication required to produce the same pain relief as another] dose of another opioid. (the Conversion factor from hydrocodone (an opioid) to morphine was 1:1 or 1.5:1 depending on the total dose 40mg hydrocodone per day). The FDA's fentanyl package inserts under Geriatric [the branch of medicine focusing on the treatment of elderly people] Use indicated Respiratory depression is the chief hazard in elderly or debilitated [in a very weakened state] patients, usually following large initial doses in non-tolerant patients or when opioids are given in conjunction with other agents that depress respiration. Fentanyl transdermal system should be used with caution in elderly . patients as they may have altered pharmacokinetics [how the body processes a drug, from the moment is taken until it is completely gone] due to poor fat stores, muscle wasting, or altered clearance [occurs when the body's ability to eliminate medication is compromised by disease (kidney/liver dysfunction), drug interactions, or physiological factors (age/genetics)]. The document under CONTRAINDICATIONS (significant harm to the patient or a warning signal that the potential risks of an intervention outweigh any expected benefits) indicated, Because serious or life-threatening hypoventilation [breathing is too slow or shallow to meet the body's needs] could occur, fentanyl transdermal system is contraindicated: in patients who are not opioid-tolerant . in the management of intermittent pain (e.g., use on an as needed basis [prn]), in situations of significant respiratory depression . and in patients who have acute [sudden] or severe bronchial asthma [airway constriction, swelling, and mucus production]. The document under Chronic Pulmonary Disease [long-term, often irreversible conditions that obstruct airflow and hinder breathing] indicated, Because potent opioids can cause serious or life-threatening hypoventilation, fentanyl transdermal system should be administered with caution to patients with pre-existing medical conditions (continued on next page)

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F 0757 Level of Harm - Actual harm Residents Affected - Few	predisposing them to hypoventilation. In such patients, normal analgesic doses of opioids may further decrease respiratory drive [the body's natural instinct to breathe in and out at a rate and depth that meets the body's needs] to the point of respiratory failure [the respiratory system cannot adequately supply oxygen to the blood or remove carbon dioxide]. 1. During a record review, Resident 1's face sheet, not dated, indicated an admission date of 2/5/21, age late 70s, and medical diagnoses including dementia (a decline in cognitive function severe enough to interfere with daily life), chronic pain, wedge compression fracture of T11 - T12 vertebra (occurs when the front part of the mid-back bones collapse, forming a wedge shape), bipolar disorder (a chronic mental health condition characterized by extreme mood swings that interfere with daily life), anxiety disorder, and COPD, among others. During a review of Resident 1's electronic medical record, titled Medication Administration Record or MAR, dated 11/2025, the record indicated Resident 1 was taking hydrocodone-acetaminophen (same as Norco; two pain medications in one: an opioid and a mild pain reliever/fever reducer) four times per day for pain as follows: HYDROcodone-Acetaminophen Oral Tablet 5-325 MG (MG is milligram, a unit of dosage); Give 1 tablet by mouth every 6 hours for Pain Hold for sedation (drowsiness)-Order Date- 10/21/25 HYDROcodone-Acetaminophen Oral Tablet 5-325 MG ; Give 1 tablet by mouth at bedtime for pain Total of 2 tablet of 5/325 mg tablet only at 1800 [6 p.m.]-Order Date- 10/21/25The MAR record for the month of November 2026 indicated Resident 1 either refused or was too sedated to take scheduled Norco on seven occasions which was a total of five Norco tablets per day (equivalent of 25 mg of hydrocodone per day).During a review of Resident 1's electronic medical record, titled Medication Administration Record or MAR, dated 10/2025, the record indicated Resident 1 was taking Norco six times per day for 14 days from 10/1/25 to 10/14/25 during which the drug was not given or held 14 times. The MAR record further indicated when the Norco frequency of use changed to every six hours from 10/15/25 to 10/31/25, the drug was not given or held a total of seven times.Review of Resident 1's electronic medical record, titled Medication Administration Record, dated 11/2025, the record indicated Resident 1 was started on a fentanyl patch on 11/26/25 and Norco was changed to as needed basis (or PRN) as follows: Duragesic-25 Transdermal Patch 72 Hour 25 MCG/HR (or fentanyl, a very potent pain drug that delivered drug through the skin; MCG/HR is microgram per hour, a rate at which drug released to body on hourly basis); Apply 1 patch transdermally (put on skin) one time a day every 3 day(s) for pain management related to OTHER CHRONIC PAIN . -Order Date- 11/26/25 HYDROcodone-Acetaminophen Oral Tablet 5-325 MG (or Norco); Give 1 tablet by mouth every 6 hours as needed for pain -Order Date-11/28/25Review of Resident 1's medical record did not show any justification for switching from Norco to fentanyl patch and/or a risk assessment (a systematic process of identifying hazards, evaluating potential harm, and implementing control measures to manage risks) for an elderly resident with baseline COPD diagnosis and not meeting the FDA Black Box Warning and manufacturer dosing specification. Resident 1's hydrocodone use (Norco opioid) was 25 mg per day prior to fentanyl 25 mcg/hr patch start. The daily hydrocodone use was equivalent to 25-37.5 mg Morphine Equivalent (ME) per day (When a 1:1 to 1.5:1 ratio was used for conversion from hydrocodone to morphine).During a phone interview with facility's Consultant Pharmacist (Pharmacist C) and concurrent record review on 4/1/26 at 9:12 a.m., Pharmacist C verified she reviewed the medication regimen for Resident 1 last month. Pharmacist C verified Resident 1 was started on a fentanyl patch 25 mcg/hr on 11/26/25. Pharmacist C stated that according to the morphine equivalent (ME) calculator (a tool that converts various opioid pain medications into a standardized, equivalent daily dose of oral morphine. It identifies at-risk patients, aids in switching medications, and is essential for safety monitoring when assessing high-dose opioid therapy), based on Resident 1's daily use of hydrocodone, Resident 1 was taking 20 to 25 mg of morphine equivalent per day when the fentanyl patch was started on 11/27/25. Pharmacist C reviewed the Duragesic (brand name for fentanyl) patch dosing guidelines and verified the guidelines indicated that when starting the patch at 25 mcg/hr, the patient should have been taking at least 60 mg morphine equivalent per day for minimum of 7 days in a row. Pharmacist C (continued on next page)

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F 0757 Level of Harm - Actual harm Residents Affected - Few	verified Resident 1 was taking less than the minimum morphine equivalent per day when the patch was started according to the FDA Black Box Warning and manufacturer specification on use. 2. During a record review, Resident 1's face sheet indicated an admission date of 2/5/21, age late 70s, and medical diagnoses including dementia (a decline in cognitive function severe enough to interfere with daily life), chronic pain, wedge compression fracture of T11 - T12 vertebra (occurs when the front part of the mid-back bones collapse, forming a wedge shape), bipolar disorder (a chronic mental health condition characterized by extreme, often debilitating, mood swings), anxiety disorder, and cerebral infarction (a blockage of blood flow to the brain), among others. Review of Resident 1's November 2025 medication administration record (MAR) indicated a fentanyl patch 25 mcg/hr was ordered on 11/26/25 and administered on 11/27/25. Further review of Resident 1's November 2025 MAR indicated Resident 1 was administered hydrocodone-acetaminophen 5-325 mg 1 tablet every 6 hours, with an additional tablet at 6 p.m., for a total of five tablets a day, every day in November until 11/28/25. Review of Resident 1's January 2026 MAR indicated lorazepam (or Ativan, a benzodiazepine anxiety medication) 0.5 mg (milligrams) tablet was administered on 1/29/26 at 5:20 p.m., and one Norco tablet was administered on 1/29/26 at 4 p.m. The record further indicated the next day Resident 1's fentanyl patch dose was increased to 50 mcg/hr starting on 1/30/26 at 9 p.m. Further review of Resident 1's January MAR indicated Resident 1 had an order dated 11/28/25 for hydrocodone-acetaminophen 5-325 mg 1 tablet every 6 hours as needed for pain. Further review of Resident 1's January MAR indicated Resident 1 was administered hydrocodone-acetaminophen 5-325 mg one to three tablets per day, with nine days when no pain medication (Norco) tablets were administered. Review of Resident 1's pain score in January 2026 revealed scores varied between 0 and 9 (on a scale of 0 to 10 where 0 is no pain and 10 is worst pain imaginable).Review of Resident 1's MAR for January of 2026, the MAR indicated Resident 1's nurse removed the Fentanyl patch 25 mcg/hr from her skin on 1/26/26 at 9 a.m. The MAR record further indicated new fentanyl patch ordered was not available to replace the old patch on 1/26/26, 1/27/26,1/28/26, and 1/29/26.Review of Resident 1's nurse progress note dated 1/29/26 at 5:15 p.m. indicated Resident 1 was restless and unable to be consoled by the sitter. Further review of Resident 1's nurse progress note dated 1/29/26 at 5:15 p.m. indicated that the nurse obtained an order from the doctor for lorazepam 0.5 mg for anxiety.Review of Resident 1's nurse progress note dated 2/1/26 at 11 a.m. indicated, . Resident started screaming out 'Help Me'. [Licensed Nurse] went to assist resident with needs. Resident stated, 'I can't breathe, I can't talk, I can't swallow'. Further review of Resident 1's nurse progress note dated 2/1/26 at 11 a.m., indicated the nurse gave Resident 1 supplemental oxygen (oxygen delivered to the nostrils through plastic tubing), but Resident 1's oxygen level in her blood dropped to 77% (normal oxygen level is greater than 90%), her temperature was 100.1 degrees, and the nurse notified Medical Director who gave an order to send Resident 1 to the emergency department (ED).During an interview on 3/30/26 at 3:44 p.m., Medical Director stated that he followed the fentanyl patch dosing guidelines for Resident 1. Medical Director stated that if the guidelines were not followed Resident 1 could have uncontrolled pain if the dose was not enough, or somnolence (sleepiness) if the dose was too high. Medical Director stated that he ordered the dose increase for the fentanyl patch because Resident 1's pain was not controlled. When queried, Medical Director stated Resident 1's difficulty breathing on 2/1/26 could have been caused by any number of things, but he did not know what caused it.During a phone interview and concurrent record review on 4/1/26 at 9:12 a.m., Pharmacist C verified she reviewed the medication regimen for Resident 1 two weeks ago and she was able to review Resident 1's records on her computer. Pharmacist C verified Resident 1 was started on a fentanyl patch 25 mcg/hr on 11/27/25. Pharmacist C stated that according to the morphine equivalent calculator, based on Resident 1's daily use of hydrocodone, Resident 1 was taking 20 to 25 mg of morphine equivalent per day when the fentanyl patch was started. Pharmacist C verified Resident 1's fentanyl patch dose was increased to 50 mcg/hr on 1/30/26. Pharmacist C stated that according to the morphine equivalent calculator, based on Resident 1's daily use of (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555207	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Piners Nursing Home	1800 Pueblo Ave 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 0757 Level of Harm - Actual harm Residents Affected - Few	hydrocodone, Resident 1 was taking 5 to 15 mg of supplementary morphine equivalent per day when the dose was increased. Pharmacist C reviewed the Duragesic (brand name for fentanyl) patch dosing guidelines and verified the guidelines indicated that when starting the patch at 25 mcg/hr, the patient should be taking at least 60 mg morphine equivalent per day, and at least 45 mg of supplementary morphine equivalent per day for a dose increase of 12.5 mcg/hr. Pharmacist C verified Resident 1 was taking less than the minimum morphine equivalent per day both when the patch was started and when the patch dose was increased according to the FDA and manufacturer guidelines. Pharmacist C verified Resident 1 was administered lorazepam 0.5 mg on 1/29/26 at 5:20 p.m. the day before the fentanyl patch was started. Pharmacist C stated respiratory depression was the potential outcome to Resident 1, when administering lorazepam and Norco the day before doubling the fentanyl patch dose on 1/30/26.Review of Resident 1's ED records, dated 2/1/26, indicated a triage note at 12:50 p.m., [Shortness of breath] reported by staff, [patient (pt)] had increased dose of fentanyl and still was administered [hydrocodone/acetaminophen], pt had slow, shallow respirations and pinpoint pupils [small, constricted pupils, a symptom of opiate overdose], had a positive response to [naloxone, medication that reverses opioid overdose] administered by [emergency medical services (EMS)]. Fentanyl patch removed by EMS, pt also possible [fever].Review of Resident 1's ED History and Physical, dated 2/1/26 at 12:58 p.m. indicated, Review of systems: Somnolence presumed due to opioid overdose, Shortness of breath. Review of Resident 1's ED physician's note dated 2/1/26 at 2:32 p.m., indicated Resident 1's arterial blood gas (measures the levels of oxygen, carbon dioxide, and the acid-base balance (pH) in blood taken from an artery) results indicated some hypoxia (low oxygen level), chest x-ray showed no aspiration (when something other than air gets into the airways), and this appears to be an iatrogenic event (adverse effect of treatment) that requires her pain management strategy to be re-evaluated. Review of Resident 1's ED diagnoses indicated accidental or unintentional opiate overdose and hypoxia.Review of facility policy, titled Pain - Clinical Protocol, last revised 10/2025, the policy under Treatment/Management section indicated 2a. Pain medications should be selected based on pertinent treatment guidelines. Generally, and to the extent possible, an analgesic [pain medication] regimen should utilize the simplest regimen and lowest risk medications before using more problematic or higher risk approaches. 4. If the physician determines that opioid medication is an appropriate option for managing acute (or in some cases chronic) pain in the resident, the lowest possible effective dose is prescribed for the shortest time possible with ongoing staff monitoring for effectiveness and adverse effects. 5. Combining opioids and benzodiazepines is avoided. If prescribed concomitantly, the resident will be carefully monitored for respiratory depression .A review of the fentanyl patch drug information using DailyMed (U.S. government database providing up-to-date, FDA-approved manufacturer drug labeling information), last accessed on 4/6/26 via https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=2a2238e9-4b5d-c56d-8663-dd354ff9ae0c, the record under Dose Titration [the process of adjusting a medication's dosage over time to find the lowest effective amount that provides maximum benefit with minimal side effects] indicated Appropriate dosage increments should be based on the daily dose of supplementary opioids, using the ratio of 45 mg/24 hours of oral morphine to a 12.5 mcg/hr increase in fentanyl transdermal system dose. The document under Important Dosage and Administration Instructions indicated Respiratory depression can occur at any time during opioid therapy, especially when initiating and following dosage increases with fentanyl transdermal system. Consider this risk when selecting an initial dose and when making dose adjustments.