

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555207	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2025
NAME OF PROVIDER OR SUPPLIER Piners Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 observations, interviews and record reviews, the facility failed to ensure:1. licensed nurses (LNs) and the Certified Nursing Aides (CNAs) were provided annual skills competency assessments (a process of evaluating an individual's knowledge, skills, abilities, and behaviors against the requirements for a specific job or role to identify proficiency levels and potential skill gaps).2.staff were aware of Trauma Informed Care (TIC, an approach to delivering care that involves understanding, recognizing and responding to the effects of all types of traumas).These failures have the potential to decrease the quality of care, for all residents of the facility, provided by staff who may not possess the skills and training necessary.Findings:1.During an interview on 8/27/2025 at 10:42 a.m., The Director of Staff Development (DSD) verified he was responsible for completing the annual skills competency assessment for both the LNs and the CNAs. The DSD stated there were no annual skills competency assessments being done for either the CNAs and the LNs for years now. The DSD stated the last annual skills competency for the LNs and the CNAs was done as far back as 2022. The DSD stated doing the annual skill competency assessment for the LNs and the CNAs was a huge issue as the facility had no skills laboratory and had no space nor resources to use when teaching the LNs or the CNAs. The DSD stated he had been the DSD at the facility for 2 years and had never done any annual skills competency assessments for the LNs and the CNAs. The DSD stated it was important to have annual competency for LNs and CNAs to be able to ensure they can care for the patients safely.During an interview on 8/27/2025 at 11:03 a.m., the Director of Nursing (DON) stated she was not aware the annual skills competency assessments were not being done by the DSD for the LNs and CNAs as far back as 2022. The DON stated the skills competency assessments for LNs and CNAs should be done annually to ensure the facility staff had the skill set to care for the residents safely. The DON stated not having the LNs and CNAs skills competency assessment done annually put the residents at risk for injury, trauma and accidents.During an interview on 08/27/2025 at 11:18 a.m., the Assistant Director of Nursing (ADON) stated the last time she had a LN annual skills competency assessment was about 2022. The ADON stated it was important to ensure the LNs and CNAs have annual skills competency assessments to ensure they have the necessary skills to care for the residents safely.During an interview on 8/27/2025 at 12:31 a.m., Unlicensed Staff C verified she had not received the CNAs annual skill competency assessment for years and added, she believed the last CNA annual skills competency assessment she had done was in 2022.A review of the facility's policy and procedure (P&P) titled [facility name] Nursing Home (PNH) Staffing, Sufficient and Competent Nursing, updated 8/18/25, the P&P indicated, ,competency is a measurable pattern of knowledge, skills, abilities behaviors and other characteristics that an individual needs to perform work roles or occupational functions successfully.all nursing staff must meet the specific competency requirements of their respective licensure and certification requirements as defined by state law.LNs and CNAs are trained and must demonstrate competency in identifying, documenting and reporting resident changes of condition.competency requirements and trainings for nursing staff are established and monitored by nursing leadership with input from medical director.2. During an interview on 08/27/2025 at 11:27 a.m., the DSD stated the facility admits residents with behavioral (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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	issues. The DSD was not aware of what TIC was and stated he had not given an in-service to staff about TIC at all. The DSD stated it was important for the staff to know about TIC to ensure they knew how to interact and provide care for residents that have psychological trauma. During a concurrent interview and record review on 08/27/2025 at 12:15 p.m., with the DON, the Facility Assessment tool (a comprehensive, facility-wide evaluation required by the Centers for Medicare & Medicaid Services that determines the necessary resources-including staff, training, and equipment-to competently care for the facility's unique resident population), dated 8/2025, was reviewed. The DON verified that the facility assessment tool indicated the facility admits residents with Post Traumatic Stress Disorder (PTSD, an anxiety problem after seeing or having a traumatic event), and that one of the competencies the facility oversees was caring for residents with mental, psychosocial disorder and PTSD. The DON stated she was not aware of what TIC was and had not received an in-service about it. The DON stated learning about TIC was important so that staff were aware of how to interact and care for residents with trauma, PTSD and behavioral issues. The DON stated it was also important to learn about TIC to ensure staff were aware of how to prevent triggering residents with PTSD and behavioral issues. During an interview on 08/27/2025 at 12:31 PM, Unlicensed Staff C stated she did not receive in-service on TIC and she was not aware of what TIC was. During an interview on 08/27/2025 at 12:49 PM, the Assistant Director of Nursing (ADON) stated she did not receive in-service nor really knew what TIC was about. A review of the Facility Assessment Tool dated 8/25, it indicated a list of some of the competencies we oversee, but not limited to: Caring for residents with mental and psychosocial disorders, as well as residents with history of trauma and/or PTSD, and implementing nonpharmacological interventions [treatments and preventative methods that do not involve medication to treat or manage health problems, reduce pain, or improve quality of life].		

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interviews and record review, the facility failed to ensure:1.the facility has a Registered Nurse (RN) providing services at least eight consecutive hours a day, seven days a week.2.the facility staffing policy and procedure reflects the current requirement.These failures could lead to delayed provision of advanced care, for all residents of the facility, such as resident assessments, evaluating plans of care and may put residents at risk for inadequate medical care.Findings:A review of the Payroll Based Journal (PBJ, a quarterly, auditable submission of direct care staffing data that nursing homes must provide to the Centers for Medicare & Medicaid Services [CMS- a federal agency that administers major health coverage programs]) indicated the facility did not have an RN coverage for 8 consecutive hours seven days a week in the first quarter on dates: 1/4/25, 1/18/25, 1/25/25, 2/15/25, 2/22/25, 2/23/25, 3/8/25 and 3/22/25.A review of the facility policy and procedure (P&P) titled [Facility name] Nursing Home (PNH) Staffing, Sufficient and Competent Nursing, the P&P indicated, . a licensed nurse may be an RN or an LVN.a licensed nurse provides services at least eight consecutive hours every 24, seven days a week .During a concurrent interview and record review on 08/28/2025 at 11:23a.m., with the DON, the facility policy and procedure (P&P) titled [facility name] Nursing Home (PNH) Staffing, Sufficient and Competent Nursing, updated 8/18/25, was reviewed. The Director of Nursing (DON) stated their staffing policy did not reflect the current regulation where it specified an RN was needed to be on duty eight consecutive hours a day seven days a week. The DON verified there were no RN present at the facility on these dates: 1/4/25, 1/18/25, 1/25/25, 2/15/25, 2/22/25, 2/23/25, 3/8/25 and 3/22/25. The DON stated it was important to have an RN coverage for eight consecutive hours seven days a week because Licensed Vocational Nurse (LVN) could not assess residents and could not administer intravenous (IV, given directly into the blood stream) medications. The DON stated RNs have more autonomy and could manage more unstable or high-risk patients. A review of the Quality and Safety Oversight (QSO, a formal document, from the Quality, Safety & Oversight Group, that communicates specific regulatory requirements, guidelines, or important information to Medicare and Medicaid-certified providers and suppliers.) 25-14-NH, dated 3/10/25, indicated, using the information on PBJ when investigating staffing and added the need for RN coverage for eight consecutive hours seven days a week.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observations, interviews and record review the facility failed to ensure the method of destruction for unused and/or unwanted medications and controlled substances (medication with a high potential for abuse and addiction) rendered the substances unusable, prevented diversion and/or accidental exposure for all residents. These failures resulted in the potential risk for abuse or misuse of medications. Findings: During a concurrent observation and interview on 8/27/25 at 9:34 a.m. with the Assistant Director of Nursing (ADON), in the medication storage room, a large cardboard box was observed full of residents' medications in blister packs (medication packaging with seal compartments or blisters each blister offers one dose of medication) received from the pharmacy. The ADON confirmed the resident medications in the box were either unwanted or unused medications and needed to be disposed. The ADON indicated the facility's method of disposal was to extract each pill from the blister packs into a plastic container that contained a solution which rendered the medication unusable. The ADON stated the disposition for controlled substances was maintained by the Director of Nursing (DON) and the facility's Pharmacy Consultant (PC). During a concurrent observation and interview on 8/27/2025 at 11:22 a.m. with the DON, the DON confirmed the cardboard box in the medication storage room was resident medications that were either unused or unwanted. The DON stated the process for the disposition of resident medications included removing each pill from the blister pack into a dry plastic bin and picked up for destruction by a medical waste company. The DON confirmed controlled substances are kept in her office and the PC visits the facility once a month and assists with the destruction of controlled substances. During a concurrent observation and interview on 8/27/25 at 11:40 a.m. with the Director of Staff Development (DSD) the DSD stated the medication destruction container is kept in a locked storage area of the facility and a medical waste company will pick up the medications for disposal. The DSD confirmed the plastic bin for medication destruction did not have a lid securely attached, had whole pills at the bottom of the bin and did not have a substance to render the medications unusable. The DSD acknowledged anyone would be able to reach their hand in the bin and access the medications. The DSD acknowledged the DON and PC completed the destruction of controlled substances. During a follow-up interview on 8/27/25 at 1:04 p.m. with the ADON, the ADON confirmed the DSD kept the plastic bin for medication destruction and was unaware the bin did not include a substance that rendered the medications unusable. The method for the disposition of controlled substances included reconciliation of the medication blister packs or designated pharmaceutical container and the signatures of two licensed nurses. The controlled substances were then given to the DON in a locked box. When the controlled medications were ready for destruction the controlled medications in pill form were crushed and placed in a dry plastic red biohazard bag. The ADON acknowledged that crushing of controlled substances did not render them unusable or irretrievable, which posed a risk for abuse, misuse or accidental exposure. During a follow-up interview on 8/27/25 at 3:03 p.m. with the DON, the DON confirmed the current process for the destruction of controlled substances was to crush the pills and place them all together in a dry plastic biohazard bag. The DON confirmed a solution should be added to the controlled substances to render the medications irretrievable and unusable to decrease the risk of unwanted exposure or abuse of the medications. During a telephone interview on 8/28/25 at 10:22 a.m. with the facility's Pharmacist (RPH) the RPH discussed the process for medication destruction including the destruction of controlled substances. The RPH stated the destruction process for the facility should include the use of a solution to render the medications and controlled substances unusable. The RPH confirmed the facility's current method for the disposition and destruction of medications and controlled substances was not appropriate. During a telephone interview on 8/28/25 at 12:04 p.m. with the Pharmacy Consultant (PC) the PC stated the facility's process for the destruction of medications and controlled substances needed to include a solution or substance that would render the items for (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	disposal irretrievable. The PC confirmed the crushed controlled substances still posed a risk for abuse, misuse or retrieval.A review of the facility's policy and procedure (P&P) titled Discarding and Destroying Medications, revised April 2012 stipulated, . 3. Non-controlled and Schedule V controlled drugs [drug that have the lowest potential for abuse and dependence] must be destroyed in the presence of two (2) licensed nurses. 8. The medication disposition record must contain, as a minimum, the following information: . g. Method of destruction.A review of the State Operations Manual (SOM) section titled Pharmacy Services issued April 2025 indicated, .Procedures addressing the disposition of medications include: Timely identification and removal (from current medication supply) of medications for disposition. Identification of storage method for medications awaiting final disposition. Control and accountability of medications awaiting final disposition consistent with standards of practice. Method of disposition (including controlled medications) should prevent diversion and/or accidental exposure and is consistent with applicable state and federal requirements, local ordinances, and standards of practice. Disposal methods for controlled medications must involve a secure and safe method to prevent diversion and/or accidental exposure		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews the facility failed to ensure, for all facility residents: Three mobile carts with medical and treatment supplies were secured from unauthorized access; and, One multi-dose vial of tuberculin (a combination of proteins that are used in the diagnosis of tuberculosis) was removed from use after the expiration date. These deficient practices had the potential for unauthorized access to medical supplies, topical prescriptions, and residents and staff to receive expired biologicals with reduced potency from being used past the discard date. Findings: 1. During a concurrent observation and interview on 8/25/25 at 10:29 a.m. at the nursing station with Licensed Nurse (LN) A and LN B the mobile cart labeled Lab was observed unattended and unlocked. LN A acknowledged the cart was unlocked and unattended, contained sharp objects (such as needles), and the cart should be locked when unattended. During a concurrent observation and interview on 8/25/25 at 2:39 p.m. with LN A and LN B, the mobile cart labeled TX (treatment) Cart, [NAME] Side was observed unattended and unlocked. LN 2 acknowledged the cart was unlocked and unattended, contained items such as: scissors, general use creams and lotions and prescribed topical medicinal treatments for specific residents. LN A and LN B confirmed the cart should be locked when unattended for safety reasons. During a concurrent observation and interview on 8/26/25 at 10:13 a.m. with the Assistant Director of Nursing (ADON) in the hallway between rooms [ROOM NUMBERS], a mobile cart labeled TX Cart, East Side was observed unattended and unlocked. The ADON stated the cart should be locked for safety and to prevent unauthorized access to the items inside the cart. 2. During observation on 8/27/2025 at 9:14 a.m. in the medication storage room, one vial of multi-dose tuberculin was observed open and without an open date. The tuberculin box had a handwritten date of 7/10/25 on the outside and the vial had a printed label wrapped around it with a date of 7/7/25. During a concurrent observation and interview on 8/27/2025 at 11:10 a.m. with LN C, in the medication storage room, LN C acknowledged the tuberculin vial was open, without an open date labeled and available for use. LN C stated, Those [multi-use tuberculin vials] expire 30 days after it's opened, this one is expired, and it needs to be discarded. During a concurrent observation and interview on 8/27/25 at 11:17 a.m. with the ADON, the ADON confirmed the vial of tuberculin was opened without an open date. The ADON acknowledged tuberculin expires after 30 days and should be discarded once it has expired. During a concurrent observation and interview on 8/27/2025 at 11:22 a.m. with the Director of Nursing (DON) the DON acknowledged medication and treatment carts should be locked for safety and to prevent theft and multi-dose vials needed to have an open date labeled on the vial. The DON acknowledged tuberculin expired after 30 days after opening and the vial found needed to be discarded. The DON stated, The efficacy of the medication decreases past the expiration date and administering expired medications was not good practice. During a phone call on 8/28/25 at 12:04 p.m. with the facility's Pharmacy Consultant (PC) the PC confirmed medication and treatment carts should be locked when not in use and multi-dose vials needed an open date. The PC confirmed multi-dose vials had an expiration date of either 28 or 30 days after opening, depending on the manufacturer's guidelines. The PC confirmed expired medications and biologicals should be removed from use and discarded. A review of the facility's policy and procedure (P&P) titled, Medication Labeling and Storage, revised February 2023, stipulated, The facility stores all medications and biologicals in locked compartments. Medications and biologicals are locked when not in use. carts used to transport such items are not left unattended if open. Multi-dose vials that have been opened or accessed (e.g. needle punctured) are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial.		

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. Based on interview and record review, the facility's governing body failed to implement it's policy for annual skills competency assessment for licensed Nurses (LNs) and Certified Nursing Assistants (CNAs) when leadership staff did not address the lack of annual assessments during QAPI meetings (QAPI, a systematic, comprehensive, and data-driven approach to maintaining and improving safety and quality in nursing homes in practical and creative problem solving). These failures resulted in lack of oversight and responsibility for the skill competency of staff providing care to all residents of the facility. Cross reference F726. Findings: A review of the QAPI agendas, for 3/2025 and 6/2025, did not indicate that LNs and CNAs lacked their annual skill competency assessments were addressed. During an interview with the Assistant Administrator (AA) on 08/28/2025 at 11:23 AM, the AA stated she was not aware of the annual skill competency assessment for LNs and CNAs was not being done and added, the lack of skill assessments was not included as a topic in QAPI. The AA stated the lack of annual skill competencies was a concern because it put all the residents at risk. The AA stated QAPI was important because it identified issues to prevent problems from recurring, which leads to better resident outcomes and resident safety. The QAPI policy and procedure was requested but was not provided.		

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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. Based on observation, interview and records review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents when:1. preventive maintenance and cleaning was not performed for Resident 8's, Resident 23's, and Resident 30's wheelchairs.2. broken, cracked and missing tiles in the kitchen floor was not repaired. These failures had the potential to contribute to the spreading of germs throughout the facility affecting all residents.Findings:1. During an interview on 8/25/2025 at 12:23 PM, Resident 8 stated her wheelchair had not been cleaned as far as she can remember but she would like it to be cleaned.During an interview on 8/28/2025 at 8:28 AM, Resident 23 stated he uses a wheelchair that stays in his room but is not aware of it being maintenance or cleaned by facility staff.During an interview on 8/28/2025 at 8:32 AM, Unlicensed Staff C stated the Maintenance Supervisor used to wash the residents' wheelchairs, especially Resident 30's wheelchair because she spits food and her wheelchair gets dirty. Unlicensed Staff C stated no one is cleaning the wheelchairs anymore. During an interview on 8/28/2025 at 11:44 AM, Maintenance Staff I stated he was not sure if there was a schedule for maintenance and cleaning of the wheelchairs. Maintenance Staff I stated he has not cleaned residents' wheelchairs since he was hired in February 2025.During an interview on 8/28/2025 at 12:04 PM, the Maintenance Supervisor stated maintenance and cleaning of wheelchairs is on an as needed basis. He further stated there are no logs or documentation indicating maintenance and cleaning of wheelchairs has been performed. A review of the facility's policy and procedure on wheelchair maintenance updated 8/27/25, indicated, To maintain a wheelchair, regularly clean, inspect, and lubricate it. Pay close attention to the tires, brakes, and moving parts, and ensure all bolts and nuts are tightened. For manual wheelchairs, monthly cleaning, lubrication, and inspection of tires and brakes are recommended. For power wheelchairs, pay extra attention to the battery and joystick. A breakdown of the cleaning schedule indicated: Daily - wipe down the frame and wheels with damp cloth to remove dirt and grime. Monthly - use a mild detergent and water to thoroughly clean the entire wheelchair, including the frame, upholstery, and wheels.2. During an observation on 8/25/2025 at 10:32 AM, in the kitchen, there were several broken, cracked and missing tiles on the floor. Photographs were taken to document the findings.During an interview on 8/27/2025 at 9:40 AM, the Certified Dietary Manager (CDM) acknowledged the presence of cracks, broken and missing tiles on the floor. She stated she had discussed the tile concerns with the facility owner previously and the facility needed to have the floors repaired.During an interview on 8/28/2025 at 12:04 PM, the Maintenance Supervisor was requested to provide a copy of the policy and procedure on maintenance cleaning of residents' equipment and the kitchen floor.During an interview on 8/28/2025 at 1:29 PM, a follow-up request to the Assistant Administrator for the policy and procedure on maintenance of kitchen floor was done but the policy was never provided.		

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on interviews and record reviews, the facility failed to ensure the Notice of Medicare Non Coverage (NOMNC, a standardized form provided by Medicare to Medicare beneficiaries when their covered service(s) are ending) and the Advance Beneficiary Notice (ABN, a written notice from a Medicare provider that informs a patient that Medicare may not pay for a service or item, allowing the patient to decide whether to receive the service and pay out-of-pocket) were issued within 48 hours of anticipated Medicare non- coverage for one out of three sampled residents (Resident 1).This failure has the potential to impede the resident's right to appeal for continued Medicare coverage and the potential for the resident to incur unanticipated financial burden.Findings:A review of Resident 1's NOMNC and ABN indicated the Medicare last covered day (LCD, last day to receive inpatient or skilled care for which Medicare will pay) of 8/20/25 and signed by Resident 1 on 8/19/25During a concurrent interview and record review with the Social Services Director (SSD) on 8/27/2025 at 9:42 AM, Resident 1's NOMNC and ABN were reviewed. The SSD verified Resident 1s Medicare LCD was on 8/20/25 and the NOMNC and ABN were issued on 8/19/25. The SSD stated it was important to issue these notices timely to ensure residents have time to appeal and was aware of whether they had any financial responsibility to the facility. During a concurrent interview and record review on 8/27/2025 at 9:49 AM, with the Administrator Assistant (AA), Resident 1's NOMNC and ABN were reviewed. The AA verified Resident 1s NOMNC and ABN were issued and signed on 8/19/25. The AA stated the NOMNC and the ABN should be issued within 48 hours of the LCD. The AA stated that NOMNC and ABN for Resident 1 was issued late and did not meet this requirement. The facility policy for NOMNC and ABN was requested but was not provided. A review of the Form Instructions for the Notice of Medicare Non Coverage (NOMNC) CMS 10095 indicated, Medicare health provider must give in advance completed copy of the NOMNC to enrollees receiving skilled nursing.no later than two days before the termination of services. A review of the Form Instructions Advance Beneficiary Notice of Non Coverage (ABN) OMB Approval Number: 0938-0566 indicated, . the ABN must be delivered far enough in advance that the beneficiary or the representative has time to consider the option and make an informed choice.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review, the facility failed to ensure residents transferred or discharged from the facility were provided with the required transfer and bed hold notices for one resident (Resident 37) and that a copy of the notice was provided to the Ombudsman for two residents (Resident 39 and Resident 37) out of two sampled residents, when: 1. The Ombudsman (an advocate for residents in nursing homes addressing issues related to care, safety, and residents' rights) was not provided a copy of the notice of transfer and discharge for Resident 39 when discharged from the facility; and, 2. The required transfer and bed hold notice was not provided to Resident 37 or a copy provided to the Ombudsman when transferred to the hospital. These failures placed the residents at risk for an unsafe discharge or transfer and denied the residents or resident's responsible party, the ability to access advocacy and appeal options before the discharge or transfer. Findings: 1. A review of Resident 39 face sheet (front page of the chart that contains a summary of basic information about the resident) indicated an admission date June 2025. A review of Resident 39's Notice of Transfer and Discharge form indicated she was discharged to home on 6/22/25. During an interview on 8/26/2025 at 10:19 AM, the Social Services Assistant (SSA) stated the facility policy was to ensure the Ombudsman was notified whenever a resident was discharged from the facility. The SSA stated the facility normally faxes a copy of the notice of transfer and discharge to the Ombudsman. The SSA stated if she could not find the fax confirmation sheet, it meant the notice was not sent to the Ombudsman. The SSA stated it was important that the Ombudsman was notified of a resident's discharge or transfers to ensure safety and continuity of care. During an interview on 8/26/2025 at 11:14 AM, the Administrator Assistant (AA) stated the facility's policy was to ensure the Ombudsman was notified whenever a resident was discharged from the facility. The AA stated it was important the ombudsman was notified of a resident's discharge from the facility to ensure the residents were protected from inappropriate discharge and to provide them with an advocate to inform them of their rights and options. During an interview on 8/27/2025 at 11:15 AM, the SSA verified she could not find the fax confirmation or documentation that would indicate the Ombudsman was notified when Resident 39 was discharged from the facility. A review of the All Facilities Letter (AFL) 25-17, dated 5/28/25, indicated, . pursuant to Title 42 CFR section 483.15(c)(3)", before a SNF transfers or discharges a resident, the SNF must. Send a copy of the notice of transfer or discharge to the representative of the Office of the State Long-Term Care (LTC) Ombudsman . 2. A review of Resident 37's admission Record indicated Resident 37 was admitted to the facility in July 2025 with diagnoses which included intracerebral hemorrhage (bleeding in the brain) with left-sided weakness and transferred to the emergency room on 7/29/25. During a review of Resident 37's Progress Notes, dated 7/29/25 at 10:13 a.m., the note indicated Resident 37 had a change of condition which included increased confusion and difficulty swallowing. The licensed nurse (LN) documented notification of Resident 37's change of condition to the Medical (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Director (MD), who ordered to send Resident 37 to the Hospital's Emergency Department (ED) for further evaluation. The note also indicated Resident 37's Responsible Party (RP) was aware. During a record review of Resident 37's medical records, there was no documented evidence the facility provided Resident 37 or their RP with a Notice of Transfer and Discharge form which would have included notification of resident's right to hold bed (a period of time where the facility reserves the resident's bed while they are away for short-term hospitalization) or that the Ombudsman was notified when Resident 37 was transferred to the ED on 7/29/25. During a concurrent interview and record review on 8/27/25 at 4:06 p.m. with the SSA, the SSA confirmed the Notice of Transfer and Discharge and the Notification of Resident's Right to Hold Bed had not been provided to Resident 37, Resident 37's RP or the Ombudsman. The SSA acknowledged the form was required for residents who were transferred or discharged from the facility. During a review of the facility's policy and procedure (P&P) titled, Transfer or Discharge Notices, revised March 2025, the P&P stipulated, .Notice of Transfer or Discharge (Emergency) 2. Notice of Transfer is provided to the resident and representative as soon as practicable before the transfer and to the long-term care (LTC) ombudsman when practicable. 3. Notice of Facility Bed-Hold. are provided to the resident and representative within 24 hours of emergency transfer.		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure the baseline care plan (BCP, a document created within 48 hours of a resident's admission to a nursing home, outlining the initial care needed to ensure residents' safety and well-being, focusing on basic needs and resident-specific information) was:1. completed timely for one out of two sampled residents (Resident 9), and2. the BCP summary was provided to the resident and or the responsible party (RP, a person who is designated in making decisions about health care and financial matters) for two out of two sampled residents (Residents 9 and 34).These failures have the potential to compromise patient safety, hinder effective staff communication, and lead to adverse events during the initial days of admission. Findings:1. A review of Resident 9's face sheet indicated Resident 9 was admitted to the facility on [DATE].A review of Resident 9's BCP/BCP summary indicated the rehabilitation and nursing departments did not complete Resident 9's BCP until 6/24/25. Resident 9's BCP summary did not indicate it was provided to Resident 9 or their RP.A review of Resident 34's face sheet indicated Resident 34 was admitted to the facility on [DATE]. A review of Resident 34's BCP/BCP summary indicated the BCP summary was not provided to Resident 34 or their RP.During a concurrent interview and record review on 08/26/2025 at 5:07 p.m., with the Assistant Director of Nursing (ADON), Residents 9's and Resident 34's BCP/BCP summary were reviewed. The ADON acknowledged she was not aware exactly what the time frame was of when a BCP should be completed. The ADON verified the BCP summary was not given to either Resident 9 or Resident 34. The ADON verified Rehabilitation and Nursing department completed Resident 9's BCP on 6/24/25. The ADON stated it was important to ensure BCPs are completed timely and the BCP summary was provided to the resident or their RP.During an interview on 08/26/2025 at 5:23 PM, the Director of Nursing (DON) stated the facility policy was to complete the BCP within 48 hours of admission and to provide the BCP summary to the resident or RP. The DON stated if a BCP was completed 48 hours after a resident was admitted and a BCP summary was not provided to the resident or RP, it meant the facility policy was not followed. The DON stated it was important to ensure BCPs were completed within 48 hours of admission and BCP summary was provided to the resident and RP to ensure staff was providing safe and quality care to the residents.A review of the facility policy and procedure (P&P) titled Care Plans-Baseline, undated, the P&P indicated.is developed within 48 hours of the resident's admission.resident and or representative are provided a written summary of the baseline care plan.provision of the summary to the resident and or resident representative is documented in the medical record.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record reviews, the facility failed to identify and provide the needed care and service in accordance with the professional standards of practice to preserve the skin integrity and prevent the development of wounds for one out of four sampled residents (Resident 9), when Resident 9 acquired a wound while residing in the facility .This failure resulted in Resident 9 experiencing discomfort related to the acquired wound. Findings:A review of Resident 9's face sheet (front page of the chart that contains a summary of basic information about the resident) indicated an admission date in June 2025 with a diagnosis of Adult Failure to Thrive (AFTT, a condition characterized by significant unintentional weight loss, muscle loss and decreased activity levels in older adults), and edema (swelling due to fluid retention).A review of Resident 9's Brief Interview for Mental Status (BIMS, an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident), dated 6/20/25, indicated Resident 9 had intact cognition (a person has healthy mental functions, including sufficient judgment, memory, planning, and problem-solving abilities to manage daily life). A review of Resident 9's Minimum Data Set assessment (MDS, a federally mandated resident assessment tool), dated 6/20/25, indicated Resident 9 required moderate assistance (a helper provides less than half the effort required to complete an activity) with putting on and taking off shoes. The MDS also indicated Resident 9 did not have any open lesions (wounds) on the feet nor were there any applications of dressings or topical medications.A review of Resident 9's Nursing Baseline Assessment Integumentary System [the protective, outermost layer of the body, consisting of the skin, hair, nails, and glands], dated 6/16/25, indicated Resident 9's skin was clean dry and intact (CDI) with no redness or open areas noted.A review of Resident 9's skin integrity assessments, dated 6/24/25, 7/1/25, 7/8/25, 7/10/25, 7/22/25, 7/25/25, 7/26/25, 8/5/25, and 8/12/25, indicated Resident 9 had no skin issues. A review of Resident 9's Integrity skin assessment, dated 8/19/25, indicated a new skin issue: left heel open wound measuring three centimeters (cm, a measure of length) by three cm.A review of Resident 9's care plan (a detailed, written document that outlines a resident's individual needs, goals, and how their care will be managed) titled, Risk for Skin Integrity Risk Factors, initiated 6/29/25, did not show any interventions specific to address the risk of Resident 9 acquiring/reopening a wound on her left heel.A review of Resident 9's CP titled Risk for Skin Integrity Risk Factors, dated 8/19/25, indicated Resident 9 had a wound on her left heel measuring three cm of length by three cm with clear drainage (a fluid that leaks from a wound).A review of Resident 9's Surgical and Wound Care initial note, dated 8/25/25, indicated Resident 9 had a full thickness (wound that extends through all layers of the skin-fat, muscle, or even to bone beneath the skin) traumatic wound (a physical injury to the skin and underlying tissues caused by an external force, such as a cut) with slough (a layer of non-viable or dead tissue in the wound bed) on posterior (further back in position) left heel. The initial note also indicated the physician believed the traumatic injury was from Resident 9's shoes. During a concurrent observation and interview on 08/25/2025 at 2:51 PM, Resident 9 was wearing shoes that had a low heel counter (a semi-rigid or firm insert in the back of a shoe, usually made of plastic or cardboard) that touched her left heel which was covered with a wound dressing (sterile pad or covering applied directly to a wound to protect it, promote healing, control bleeding, and absorb fluids). Resident 9 stated the shoes she was wearing had been the ones she had been wearing since she was admitted to the facility. Resident 9 stated the shoes created friction on her left heel which hurt. Resident 9 verified she previously had a wound on her left heel that had healed, she did not have the wound when she was admitted to the facility, and now has a wound on her left heel. Resident 9 stated she continued to wear the shoes since no one at the facility told her not to. During an interview on 08/26/25 at 2:30 PM, Licensed Nurse (LN) B stated Resident 9 did not have an open wound on her left heel when she was admitted at the facility and it was acquired while she resided at the facility. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LN B stated the wound doctor indicated the left heel wound was from Resident 9's shoes that Resident 9 had been wearing since admission. LN B stated staff had noticed Resident 9's footwear heel counter was creating friction on her heels and confirmed Resident 9's left heel wound could have been avoided if Resident 9 switched footwear to one that would have no contact with her heels. During a concurrent interview and record review on 08/28/2025 at 09:23 AM with the Director of Nursing (DON), Resident 9's baseline skin assessment, dated 6/16/25, Resident 9's skin integrity assessments, with dates from 6/24/25 to 8/19/25, and Resident 9's skin At Risk Care Plan, dated 6/29/25, were reviewed. The DON verified the baseline skin assessment dated [DATE], and the skin integrity assessments from 6/24/25 through 8/12/25 all indicated Resident 9 had no skin issues. The DON verified the left heel open wound measuring three cm by three cm was noted on Resident 9's skin integrity assessment dated [DATE]. The DON Resident 9 had acquired the wound while in the facility from the shoes Resident 9 was wearing. The DON verified Resident 9's skin at risk CP also had no interventions to address the risk of Resident 9 reopening the wound on her left heel. The DON stated there was a high incidence of Resident 9 reopening the wound on her left heel because the new scar tissue was weaker and less elastic than the original, undamaged skin tissue. A review of the facility's policy and procedure (P&P) titled Prevention of Pressure Injuries, revised 4/2025, the P&P indicated, . the purpose of this procedure is to provide information regarding identification of pressure injury risk factors and interventions for specific risk factors.review residents care plan and identify the risk factors as well as the interventions designed to reduce or eliminate those considered modifiable.keep the skin clean and hydrated.do not rub or otherwise cause friction on skin that is at risk of injuries.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview and record review the facility failed to ensure adequate supervision was provided for one resident (Resident 2) out of 15 sampled residents during a lunch meal. This failure resulted in Resident 2's delayed evaluation and treatment of respiratory distress and an increased risk for aspiration (accidental inhalation of foreign material into the lungs, such as food or liquid). Findings: A review of Resident 2's admission Record indicated Resident 2 was admitted to the facility in February 2021 with diagnoses which included acute respiratory failure with hypoxia (a life-threatening condition where the lungs fail to adequately exchange oxygen and carbon dioxide, resulting in low blood oxygen levels) and dysphagia (difficulty swallowing). A review of Resident 2's Order Summary Report (OSR, physician orders) indicated the following orders: 1. Aspiration precautions: Upright positioning as close as possible to a 90-degree angle, flex the head to a neutral or slightly downward position, avoid rushed or forced feeding. Inspection of the oral cavity for residual food or liquid after swallowing, dated 8/5/22. 2. Monitor for aspiration precautions, dated 12/5/23. 3. Monitor for shortness of breath, for aspiration precautions, dated 12/15/25. 4. To be up on a chair or 90 degrees for all meals, for aspiration precautions, dated 2/25/25. A review of Resident 2's Care Plan Report indicated the following risks and interventions: 1. Meal trays set up, encouragement to feed self and supervision during meals, dated 2/15/21. 2. History of dysphagia, choking and aspiration: a. Keep head of bed elevated at all meals and sit up at all meals, dated 3/2/31. b. Monitor for aspirations, every meal, dated 10/25/23. c. Monitor/Observe aspiration precautions, dated 10/30/23. 3. History of choking: Sit up for meals, check during meal for signs of choking, to be up on a chair or 90 degrees for all meals, dated 7/14/21. During a dining observation on 8/25/25 at 12:32 p.m., in the social dining room, during lunch time, approximately six residents were seated at the dining table, unsupervised by staff. Resident 2 was observed in a wheelchair at the dining table in a hunched posture and was picking and poking the meal with a fork. During a concurrent observation and interview on 8/25/25 at 12:40 p.m. Resident 2 pushed away from the dining table drooling, coughing and hunched over. After a coughing episode Resident 2 was able to respond and stated, I can't breathe. During a concurrent observation and interview on 8/25/25 at 12:45 p.m. the surveyor alerted Licensed Nurse (LN B) who was seated at the nursing station of Resident 2's respiratory distress. LN B entered the dining area, acknowledged residents were not adequately supervised and a staff member should provide supervision during mealtimes. LN B approached Resident 2 and removed the resident from the dining area. During a concurrent observation and interview on 8/25/25 at 12:53 p.m. the Activity Director (AD) entered the dining room and sat down away from the dining table. The AD stated the activity staff provided supervision in the social dining area. The AD acknowledged the importance of adequate supervision during mealtimes, in case a resident had an emergency and needed assistance. During an interview on 8/28/25 at 9:17 a.m. with the Director of Staff Development (DSD) the DSD confirmed facility staff should provide adequate supervision for residents who eat in the social dining area. The DSD confirmed the lack of supervision in the dining room was a safety concern and stated he was unaware if the facility had a policy and procedure for the supervision of residents during mealtimes. During an interview on 8/28/25 at 12:56 p.m. with the Director of Nursing (DON) the DON confirmed residents in social dining should be supervised by facility staff to ensure resident safety during mealtimes. During an interview on 8/28/2025 at 1:37 p.m. the facility's policy and procedure (P&P) regarding resident safety and supervision during mealtimes was requested from the DON, Administrator Assistant (AA) and Medical Record Director (MRD). The facility was unable to provide the requested P&P. A review of the State Operations Manual (SOM) section titled, Accidents, issued April 2025 indicated, The intent of this requirement is to ensure the facility provides an environment that is free from accident hazards over which the facility has control and provides supervision . to each resident to prevent avoidable accidents . Implement interventions, including adequate (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	supervision and assistive devices, consistent with a resident's needs, goals, care plan and current professional standards of practice in order to eliminate the risk, if possible, and, if not, reduce the risk of an accident . Facilities are obligated to provide adequate supervision to prevent accidents. Adequacy of supervision is defined by type and frequency, based on the individual resident's assessed needs.		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on observations, interviews and record reviews, the facility failed to ensure pain was managed for one out of four sampled residents (Resident 1) when:1.Resident 1 continued to receive a narcotic medication that was ordered on as needed basis (PRN), almost daily and as much as twice a day without reevaluation from the nursing staff and the physician,2. Using a number pain scale (a tool used by healthcare providers to measure the intensity of a resident's pain. The Resident rates their pain on a scale of 0 to 10, where 0 means no pain and 10 means the worst pain imaginable) Resident 1 complained of a pain level (PL) consistent with moderate pain (PL 4-6) to severe pain (PL 7-10) despite current pain regimen,3.there were no nonpharmacological interventions (NPI, a health or therapeutic approach that doesn't involve medications or drugs) included to help alleviate Resident 1's pain, andThese failures resulted in Resident 1 feeling depressed, helpless, and stated being in constant pain. It also put Resident 1 at risk for functional impairment, social impairment and decreased quality of life.Findings:A review of Resident 1's face sheet (front page of the chart that contains a summary of basic information about the resident) indicated an admission date of 6/2025 with a diagnosis of pain disorder with related psychological factors (a chronic pain condition where psychological factors like stress, anxiety, or depression are judged to be the major cause of the pain) and anxiety disorder (a mental health disorder characterized by feelings of worry or fear that are strong enough to interfere with one's daily activities). A review of Resident 1's Minimum Data Set assessment (MDS, a federally mandated resident assessment tool), dated 6/30/25, section J Pain indicated Resident 1 was almost constantly in pain, affecting sleep, therapy, and day to day activities. A review of Resident 1's Brief Interview for Mental Status (BIMS, an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident), dated 8/20/25, Resident 1 had a score of 13 out of 15 indicating intact cognition (a person has healthy mental functions, including sufficient judgment, memory, planning, and problem-solving abilities to manage daily life). A review of Resident 1's Pain Assessment, Resident Interview, dated 8/20/25, indicated Resident 1 reported pain frequently, pain interfering with therapy activities and described a PL of 8 out of 10. The assessment also indicated Resident 1 complained of pain in her lower right leg. A review of Resident 1's electronic medication administration record (EMAR, a digital system used to track and document the administration of medications, ensuring accuracy and timeliness in medication delivery), for August 2025, indicated orders for:1. an external lidocaine (medication that numbs in a certain area) pain patch topically daily, site not indicated,2. acetaminophen (pain relievers) 650 milligrams (mg, unit of measure) three times daily and every 6 hours as needed (PRN) for pain management and3. an opioid analgesic concentrated solution 20 mg/milliliters (ml, unit of volume, in liquid) 0.5 ml by mouth every 6 hours PRN for pain management.a. Resident 1 was receiving this medication almost daily and often as much as twice a day. Resident 1's EMAR, for August 2025, further indicated Resident 1 complained of a PL of 8on dates 8/6/25, 8/8/25, 8/13/25, 8/15/25, 8/16/25, 8/23/25, 8/24/25, 8/26/25 and a PL of 9 on 8/16/25.During a concurrent observation and interview on 08/25/2025 at 11:05 AM, Resident 1 was in bed, grimacing. Resident 1 was complaining of pain in her back, knees and legs. Resident 1 stated her pain was currently at PL 8. Resident 1 stated her current pain medications were not enough to control her pain. Resident 1 stated she felt helpless at times, especially when she was in pain. During an observation on 08/28/2025 at 08:13 AM, Resident 1 was lying in bed and stated she was in pain, with a PL 9. Resident 1 stated she had not received her pain medications yet. Resident 1 stated she had pain in her back and both of her knees and legs. Resident 1 stated she gets a patch on her back, which helps a little with her back pain. Resident 1 stated the pain in her knees and legs started right after she fell over a week ago and since has asked if she could also have a patch for both of her knees and legs. Resident 1 stated staff have not responded to her about that request yet. Resident 1 stated she was in constant pain she just wanted to make sure she could have medications that could help manage her pain better. Resident 1 (continued on next page)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated her current pain medications were not effective as she was still mostly in pain. During an interview on 08/28/2025 at 08:18 AM, Licensed Nurse (LN) A stated acetaminophen was typically only effective to treat mild pain (PL 1 to 3). LN A stated when a resident was on a narcotic as needed, but the resident continued to receive it almost daily, the staff should reassess the resident's pain, as this may warrant the physician to reevaluate the current pain regimen. LN A stated if pain management was ineffective, it could result in residents feeling depressed, frustrated and anxious. During a concurrent interview and concurrent record review, on 08/28/2025 at 09:23 AM, with the Director of Nursing (DON), Resident 1's EMAR, for August 2025, was reviewed. The DON verified Resident 1 was receiving the PRN opioid analgesic almost daily, as much as twice a day. The DON stated since Resident 1 was receiving the PRN opioid analgesic daily, the nurses should have reached out to the physician to reevaluate the current pain regimen. The DON stated Resident 1's pain was probably the reason why Resident 1 stayed in bed and not participate in therapy/activities. A review of the facility's policy and procedure (P&P) titled Pain-Clinical Protocol, revised 10/2022, the P&P indicated, . the physician will order appropriate NPI and medication interventions to address the individuals pain. staff will provide the elements of comforting environment and appropriate physical and complementary interventions; for example local heat or ice, repositioning, massage or opportunity to talk about chronic pain. if there are more than occasional analgesic request, the physician will consider changing to regular administration of at least one analgesic with another medication for PRN use, increasing the standing dose [a prescribed dose of medication that remains the same until changed] of an existing analgesic, switching to another analgesic and or adding nonpharmacologic measures.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, interviews and record reviews, the facility failed to ensure respiratory and urinary supplies were stored in a sanitary condition for one out of 15 sampled residents (Resident 17), when Resident 17's nebulizer mask (a medical device that transforms liquid medicine into a fine, inhalable mist to be delivered directly to the lungs) and urinary catheter (a hollow tube inserted into the bladder to drain or collect urine) drainage bags (a device connected to a urinary catheter to collect and hold urine) were not labeled with a date when last replaced nor stored in a sanitary manner. These failures had the potential for an increased risk of oxygen and urinary supplies to become contaminated with bacteria, mold, and dust, posing a serious risk of respiratory and/or urinary infections to the resident. Findings: A review of Resident 17's admission Record indicated Resident 17 was initially admitted to the facility in December 2022 with diagnoses which included bronchitis (inflammation of the tubes letting air in and out of the lungs) and chronic obstructive pulmonary disease (COPD, a group of lung diseases that block airflow and make it difficult to breathe). A review of Resident 17's Order Summary Report (OSR, physician orders) indicated the following orders: 1. Ipratropium-albuterol inhalation solution 0.5mg/3mL to inhale orally every two hours as needed for wheezing or shortness of breath, dated 12/14/23. 2. May use condom catheter (an external catheter that helps manage urinary incontinence) at bedtime, dated 12/31/24. 3. Change urinary catheter drainage bag every week and as needed, dated 9/14/24. During a concurrent observation and interview on 8/25/25 at 11:43 a.m. with Unlicensed Staff E, in Resident 17's room, Unlicensed Staff E acknowledged Resident 17's nebulizer mask was on the floor and the presence of a handwritten sign on the wall that indicated Resident 17's catheter bags are not to be thrown away because they are expensive. Unlicensed Staff E retrieved Resident 17's nebulizer mask and tubing from the floor and stated, This needs to be thrown away, they should be stored in a plastic bag for sanitary reasons. Unlicensed Staff E opened one of Resident 17's drawers and stated, the [urinary drainage] catheter bags are being reused, sometimes rinsed and placed in [Resident 17's] bottom drawer. During a concurrent observation and interview on 8/27/25 at 3:51 p.m. with the Assistant Director of Nursing (ADON) in Resident 17's room, the ADON acknowledged Resident 17's urinary drainage bags were being reused and stored in Resident 17's bottom drawer. The ADON stated the urinary drainage bags should be dated when last changed, changed weekly or as needed, have a plastic cap on the open end of the tubing to protect against bacteria entering the system, and placed in a tied plastic bag for storage. The ADON confirmed urinary drainage bags that were reused needed to be cleaned and left to air dry prior to storage. The ADON observed and removed two plastic bags from Resident 17's bottom drawer, one with a loosely tied knot and the other bag untied. The ADON confirmed both urinary drainage bags were undated, contained residual urine, and without plastic caps on the tubing. The ADON stated, This is definitely an infection control concern and can lead to the harboring of bacteria. During an interview on 8/28/25 at 8:57 a.m. with the Director of Staff Development (DSD), the DSD confirmed nebulizer masks and catheter bags should be kept in a sanitary manner and stored in plastic bags to decrease the risk of infections. The DSD indicated that if urinary drainage bags are reused, they need to be cleaned and left to air dry before storage. When shown how Resident 17's drainage bags had been stored after being used, the DSD stated, No, these shouldn't be stored like this. We can order more [urinary drainage bags] this needs to stop, it's gross. During an interview on 8/28/25 at 1:33 p.m. with the DON the DON confirmed nebulizer masks and urinary drainage bags should be cleaned and stored in a sanitary manner if reused, to decrease the risk of infections for residents, otherwise they should be thrown away. A review of the facility's policy and procedure (P&P) titled, Catheter Care, Urinary, revised August 2022 stipulated, Cleaning and Disinfecting Drainage Bags. 2. Use a small plastic squirt bottle to rinse the used bag with tap water and drain. 3. Cleanse the drainage bag with a dilute solution of 1-part regular household bleach mixed with 10 parts tap water. a. Instill the diluted bleach solution through the drainage tubing or top of the bag, and agitate (continued on next page)		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555207	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2025
NAME OF PROVIDER OR SUPPLIER Piners Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the solution in the bag for 30 seconds. b. Drain the bleach solution, and allow the bag to air dry with the clamp open. 4. After cleansing, air-dry the bag. After disinfection, cap the drainage bag tubing between uses, and disinfect the end of the tubing before reconnecting it to the catheter. During an interview on 8/28/2025 at 1:37 p.m. the facility's P&P for the storage of respiratory supplies, including the use of oxygen and nebulizers, was requested from the DON, Administrator Assistant (AA) and Medical Record Director (MRD). The facility was unable to provide the requested P&P. A review of the State Operation Manual section titled, Infection Control, issued April 2025 indicated, Process surveillance is the review of practices by staff directly related to resident care. The purpose is to identify whether staff implement and comply with the facility's IPCP [Infection Prevention and Control Program] policies and procedures. Implementation of infection control practices for resident care such as but not limited to urinary catheter care. respiratory care. Equipment or items in the resident environment likely to have been contaminated with infectious fluids or other potentially infectious matter must be handled in a manner so as to prevent transmission of infectious agents (e.g., wear gloves for handling soiled equipment and properly clean and disinfect or sterilize reusable equipment .).		

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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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interviews and record reviews, the facility failed to ensure one out of three sampled residents (Resident 9) was offered the Corona virus vaccine (COVID vaccine). This failure could put Resident 9 at risk for increased risk of severe illness, hospitalization, or death from COVID-19. Findings: A review of Resident 9's face sheets (FS, front page of the chart that contains a summary of basic information about the resident) indicated admitted to the facility in June 2025 with a diagnosis of Asthma (lung disease where you have trouble breathing) and Acute Respiratory Failure (ARF, a life-threatening condition where there's not enough oxygen or too much carbon dioxide in your body). A review of Resident 9's immunization record did not indicate whether she was offered or refused a COVID vaccine. During a concurrent interview and record review on 08/27/2025 at 3:17 p.m. with the Assistant Director of Nursing (ADON), Resident 9's immunization record was reviewed. The ADON verified the immunization record did not indicate a COVID vaccine had been offered to Resident 9 and/or refused by Resident 9. The ADON stated, if it's not documented, then it did not happen. The ADON stated it was important to document whether a resident was offered or refused the COVID vaccine. During a concurrent interview and record review on 08/27/2025 at 5:37 p.m. with the Director of Nursing (DON), Resident 9's immunization record was reviewed. The DON verified there was no documentation to indicate that a COVID vaccine had been offered to Resident 9 and/or Resident 9 refused it. The DON stated documenting the COVID vaccination status of a resident is important to ensure they were offered COVID vaccine if they had not received it yet. The DON stated she expected the COVID vaccine was offered to all residents for their and other residents' safety. A review of the facility's policy and procedure (P&P) titled Charting and Documentation, revised 7/2017, the P&P indicated, . following information is to be documented in residents' medical record: medications administered .documentation of procedure and treatment will include care specific details including whether the resident refused procedure/treatment. A review of the facility's policy and procedure (P&P) titled Vaccination of Residents, revised 10/2019, the P&P indicated, . prior to receiving vaccination the resident or legal representative will be provided information and education regarding the benefits and potential side effects of the vaccination. if vaccines are refused the refusal shall be documented in the resident's medical record.		