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	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Napa Community Health Center	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 0658 Level of Harm - Actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the nursing staff failed to provide care that met professional standards of nursing for two residents (Resident 3 and Resident 8) of 16 sampled residents when:1. Nurses did not assess, prevent, and identify the development of a pressure injury (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) on Resident 3's left cheek; and,2. Nurses did not notify the physician when Resident 8 experienced significant and progressive weight loss.These failures resulted in Resident 3 obtaining a facility-acquired Stage 2 pressure injury (a partial-thickness loss of skin, presenting as a shallow open sore or wound) and Resident 8 unhappy and concerned about her weight loss. Cross Reference F684, F692.Findings:1. A review of Resident 3's admission record indicated she was admitted to the facility in February 2021 with the diagnosis of long-term use of anticoagulants (medication used to prevent blood clots from forming or getting larger), protein-calorie malnutrition (an inadequate intake of protein or calories), rosacea (a chronic inflammatory skin condition which causes redness and swollen bumps), congestive heart failure (a condition where the heart pumps ineffectively), cerebral infarction (stroke), atherosclerotic heart disease of the coronary artery (coronary artery disease, a narrowing of arteries which reduces blood flow and oxygen flow to the heart), chronic embolism and thrombosis of deep veins in the left leg (an old blood clot located in the deep veins of the lower leg), chronic kidney disease (damage to the kidneys which affects their ability to filter waste and excess fluid from the blood), and chronic obstructive pulmonary disease (a progressive lung condition that restricts airflow and causes breathing difficulties).A Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 3/10/26, indicated she had mild memory impairment.A review of Resident 3's integrity skin assessment documented by a Licensed Nurse (LN) and dated 6/1/26 at 10:46 a.m. indicated Resident 3 had redness to her bilateral breast folds and was receiving ongoing treatment but did not have any new skin issues.A review of Resident 3's care plan regarding skin conditions, last revised on 1/26/26 and reviewed on 3/16/26, indicated she was at risk for impaired skin integrity due to her history of having pressure ulcers and diagnosis of rosacea. Resident 3's goal was for her skin to remain intact daily through 3/16/26. To assist Resident 3 to meet her goal, nursing staff were expected to conduct a Braden scale assessment (an evidence-based assessment tool used by healthcare professionals to predict a resident's risk of developing a pressure injury) every quarter and as needed, monitor her skin by conducting skin observations, keep her skin clean and dry, reduce friction and shear, and certified nursing assistants (CNA) were to immediately notify licensed nurses of any skin breakdown.In an observation of Resident 3 in Resident 3's room on 6/2/26 at 7:51 a.m., Resident 3 was sitting up in bed with a nasal cannula (a flexible plastic tube used to deliver oxygen from a machine directly into the nostrils) in place which lay just below her nostrils and across both of her cheeks to wrap behind both ears. A scabbed wound was seen on her left cheek just under where the nasal cannula tubing lay. There was no padding, dressings, or gauze seen on Resident 3's cheeks or ears to prevent pressure injury from the nasal cannula.A review of Resident 3's electronic medical chart 6/3/26 roughly between 8 a.m. and 9 a.m. indicated the following:A review of Resident 3's progress notes between 5/24/26 and 6/1/26 showed no documented evidence (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 0658 Level of Harm - Actual harm Residents Affected - Few	of Resident 3 having any pressure injuries.A review of Resident 3's medical chart between 5/24/26 and 6/1/26 showed no documented evidence of a change of condition notification to the physician regarding Resident 3 having a skin concern on her face.In an interview and concurrent record review with the Assistant Director of Nursing (ADON) on 6/3/26 at 10 a.m., the ADON stated if a CNA identified a new skin issue, the CNA was expected to notify the licensed nurse. The licensed nurse is then expected to conduct an assessment, document the assessment, notify the physician and request treatment orders. The ADON further stated it was important for licensed nurses to conduct assessments and document them accurately as part of the monitoring process to determine the progression of the skin issue. If the skin issue worsens, the treatment plan would need to be re-evaluated and changed. Communication between the nurses is important when monitoring the concern. The ADON reviewed Resident 3's medical chart between 5/24/26 and 6/1/26:There were no skin issues identified by CNAs and verified by an LN on Resident 3's shower sheets dated 5/24/26 or 5/27/26;There were no new skin issues identified by LNs on Resident 3's skin assessment dated [DATE]; and,There were no new skin issues documented in the skin log at the nurse's station for Resident 3.The ADON confirmed Resident 3 had no documented skin issues on her shower sheets, the skin log, or her most recent skin assessment.In a concurrent observation and interview with the ADON on 6/3/26 at 10:14 a.m., the ADON assessed Resident 3's left cheek and determined it was a Stage 2 pressure injury. The DON stated the pressure injury was likely from the oxygen tubing which she often used. The DON further stated the skin on the cheek was really susceptible to breakdown and infection; if the tubing continuously provided pressure and moved, it could cause friction which can result in the injury getting larger or reopening. The DON added, This [the pressure injury] is not new. This has been here for a few days. No one charted this.In an interview with CNA 3 on 6/4/26 at 4:37 p.m., CNA 3 stated she had not noticed a skin issue on Resident 3's cheek.In an interview with Licensed Nurse 2 (LN 2) on 6/4/26 at 4:39 p.m., LN 2 stated she was unaware Resident 3 had a skin concern on her cheek.In an interview with the Assistant Administrator (AADM) on 6/5/26 at 9:33 a.m., the AADM stated the facility did not have a policy and procedure for skin tears or skin assessments. The AADM stated the closest document she had was a document titled Braden Scale- For Predicting Pressure Sore Risk.A review of an article titled Pressure Ulcers in the Long-Term Care Setting dated 2008 and published by the American Medical Directors Association indicated, Examine the patient's skin thoroughly to identify existing pressure ulcers.Inspect the patient's skin at least once weekly during routine care (e.g., during a bath). Direct caregivers should be aware of the signs and symptoms.of pressure ulcers as well as predisposing factors.A history of pressure ulcers is a primary risk factor for the development of new pressure ulcers. Patients with a history of pressure ulcers are more than five times as likely to develop another pressure ulcer.The patient's history of pressure ulcers can be obtained from.the plan of care.Conditions related to these risk factors should be evaluated.Risk factors that increase a patient's susceptibility to developing pressure ulcers.include.Comorbid conditions (e.g.end-stage renal disease.drugs that may affect ulcer healing [anticoagulants]. Impaired diffuse or localized blood flow [atherosclerotic heart disease of the coronary artery and chronic embolism and thrombosis of deep veins in the left leg].Increase friction.Undernutrition, malnutrition [protein-calorie malnutrition].regardless of an individual's score on a pressure ulcer assessment instrument, when a patient has any of the risk factors for a pressure ulcer.a pressure ulcer prevention plan should be implemented.Other risk factors that should be assessed include.congestive heart failure.complications (e.g., cellulitis.pain.presence of depression.A review of an article titled Preventing Pressure Injuries updated March 2022 and published by The Joint Commission (an independent, non-profit organization that accredits and certifies healthcare organizations in the United States) indicated, The presence of pressure injuries.may contribute to premature mortality in some patients.The majority of the following strategies are based on the NPIAP's [National Pressure Injury Advisory Panel] ?Pressure Injury Prevention Points'. The earlier a risk is identified, the more quickly it can be addressed.Refine the assessment by identifying other risk (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	factors [such as the use of a nasal cannula].Protecting and monitoring the condition of the patient's skin is important for preventing pressure sores and identifying Stage 1 sores early so they can be treated before they worsen. Inspect the skin.at least daily for signs of pressure ulcers. Assess pressure points.and the skin beneath medical devices.Educate and train all members of the interdisciplinary team. Make sure they are aware of the plan of care and that all care is documented in the patient's record. Ensure leadership support, oversight, and allocation of adequate resources.2. A review of Resident 8's admission record indicated Resident 8 was admitted to the facility on [DATE] with Acute on Chronic Systolic and Diastolic Heart Failure (a long-term condition in which the heart is too weak to pump efficiently and too stiff to fill with blood) and chronic kidney disease. A review of Resident 8's care plan, dated 9/3/25, indicated Resident 8 was at risk for nutritional complications related to her nutritional deficiency. The care plan included a goal for Resident 8 to have no significant weight changes (10% weight loss over a six-month period). To meet this goal, the nursing staff were directed to administer ondansetron (a fast-acting medication used to prevent nausea and vomiting) before meals, weigh Resident 8 monthly, monitor meal intake in percentages, notify licensed staff when intake was below 50% and document food substitutes, and provide a calorie and protein dense nutritional supplement. A review of Resident 8's documented meal percentage intake, dated 5/6/26 to 6/4/26, indicated Resident 8 was served 87 meals. Of these meals, 21 meals reflected 50% or less consumed. Some meals were marked as refused or were not recorded because Resident 8 was unavailable.A review of Resident 8's monthly weights indicated the following:12/1/25: 123 lbs.;1/5/26: 120 lbs.;2/1/26: 116.4 lbs.;3/1/26: 112.4 lbs.;4/1/26: 109.2 lbs.; 5/2/26: 107.2 lbs.; and,6/1/26: 104.6 lbs.A review of the physician progress notes dated 12/30/25 through 3/11/26 revealed no documentation from Physician 1 (MD 1) addressing new concerns, orders or an assessment of Resident 8's ongoing weight loss. The physician entries only documented weight data without comment. No additional physician documentation was found until 6/3/26, when a new physician (MD 2) began providing care. However, the note documented by MD 2 did not address Resident 8's current weight or the amount of weight loss that had occurred.A review of Resident 8's nutritional risk assessment dated [DATE] indicated Resident 8 had no significant weight loss during the previous six months. The Registered Dietitian (RD) calculated Resident 8's estimated caloric needs to be 1,325-1,590 calories per day, which required the resident to consume at least 75% of each meal daily to meet these needs. During the assessment, the RD documented Resident 8 had consumed only 58% of meals. A goal was established to increase the resident's intake, acknowledging Resident 8's current consumption was insufficient to meet her caloric requirements. The RD also documented that Resident 8's family preferred she be served food she enjoyed and not be placed on a restrictive diet.A review of Resident 8's quarterly nutritional assessments indicated the following:1/6/26: Resident 8 consumed an average of 48% of meals over a 14ˆday period. Resident 8 had a 3ˆlb weight loss from December 2025, which was not considered significant at that time.5/29/26: Resident 8 consumed an average of 58% of meals over a 14ˆday period. Resident 8 had a 4ˆlb weight loss, representing a 10.67% weight loss over the previous six months.A review of the facility's weight meeting and progress note dated 4/16/26 indicated the RD documented Resident 8's weight had decreased to 109.2 lbs., representing a 9% weight loss over the previous 90 days. The RD also noted Resident 8 consumed an average of 69% of meals and reported improvement in nausea and stomach pain. The notes further documented that Resident 8 requested the discontinuation of the nutritional supplement, believing it contributed to her nausea and abdominal discomfort.During an interview in Resident 8's room on 6/2/26 at 8:54 a.m., Resident 8 stated the food was often too spicy and did not taste good to her. Resident 8 further stated the food gave her a stomachache.During an interview on 6/4/26 at 9:05 a.m., the CNA 2 stated Resident 8 would often pick at her meals and rarely finished them. CNA 2 stated she did not report unfinished meals to the licensed nurse because it is documented in the electronic medical record (EMR).During a phone interview on 6/4/26 at 9:10 a.m., the RD stated she worked as a consulting RD for the facility through an outside agency. The RD (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	reported she had visited the facility twice per month to assess residents and provide recommendations. The RD stated her supervisor informed her she could no longer provide services to the facility due to nonˆpayment for her work over the past three to four months. The RD stated her last day at the facility was either 4/25/26 or 4/26/26.During an interview on 6/4/26 at 9:54 a.m., the Dietary Assistant/Manager (DM) acknowledged Resident 8 did not like spicy food and stated the kitchen had prepared a bland diet for her, but she still did not like it. The DM then described the process used by the facility to monitor residents at nutritional risk and explained the EMR system flagged residents when a significant weight loss was calculated. This flag was intended to trigger an RD assessment and recommendation, followed by a physician assessment and order. The DM further stated he had not yet received his certification in dietary management and still needed to complete the required examination to become fully certified. Therefore, the DM stated he did not possess the necessary credentials to assess Resident 8 or to make recommendations related to her significant weight loss.During an interview on 6/4/26 at 10:01 a.m., LN 1 stated Resident 8 has had stomach issues, mainly nausea for the past few months. LN 1 stated ondansetron and over the counter antacid (relieves acid indigestion and upset stomach) were ordered upon admission and administered when necessary. LN 1 stated she had noticed Resident 8 had appeared thinner recently. During an interview on 6/4/26 at 10:05 a.m., the ADON stated the DON, or the RD was responsible for notifying the physician when a resident experienced weight loss. The ADON explained weight changes were typically identified during the monthly weightˆvariance meeting, where each resident was reviewed, recommendations were developed, and the physician was expected to be notified along with the RD's clinical recommendations. The ADON confirmed Resident 8 had experienced significant and progressive weight loss since January 2026. She also acknowledged MD 1 had not issued any orders or documented any mention of the resident's weight in the physician progress notes, other than the actual weight recorded. The ADON further stated the DON left the facility in midˆMay, MD 1 also departed during the same timeframe, and the RD had not provided services throughout the month of May. The ADON reported she was new to her role since the DON left and did not plan to remain in the position permanently. The ADON stated collectively, these circumstances resulted in no qualified clinical oversight, no physician notification, and no timely intervention for Resident 8's ongoing significant weight loss.During an interview on 6/5/26 at 7:48 a.m., the AADM stated due to the pending sale of the facility, staff that held critical positions within the facility had decided to leave. The AADM admitted the facility was behind on payments to the agency providing the facility with a consultant RD, though she would attempt to call and see if arrangements could be arranged. The AADM stated she had been relying on the DM for the RD duties, though he was not yet certified and would be unable to perform nutritional assessments.During an interview on 6/5/26 at 11:35 a.m., MD 2 stated he had just started working with the facility a few weeks prior. The MD 2 stated he did not receive any type of resident hand-off report from MD 1 before starting. MD 2 reported he had just assessed Resident 8 a few days ago and understood she had a poor appetite. MD 2 stated he was unaware of Resident 8's significant weight loss and would speak with the RD. When MD 2 was informed there was no RD to consult, MD 2 stated he would look into the weight loss and determine the best route to prevent further weight loss.During an interview on 6/5/26 at 12:54 p.m., the DM stated he normally reported to the RD but now he was required to report to the MDS Supervisor since the RD was no longer at the facility. The DM stated he completed the quarterly nutrition assessment for Resident 8 on 5/29/26. Though the normal process would have been for the RD to review the quarterly nutrition assessment, assess the resident and make recommendations with significant weight loss, the DM stated he was now relying on someone to contact someone so appropriate action could be taken. The DM acknowledged the important role an RD held in that the RD was able to take immediate action to intervene.During an interview on 6/5/26 at 1:24 p.m., Resident 8 stated about her weight loss Lord no, I'm not happy! I'm too bony! Resident 8 stated she was concerned about her weight loss and added What can I do about it? She stated her clothes were too baggy, but she did not (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	feel up to go shopping for new clothes. A review of the facility's clinical protocol titled, Nutrition (Impaired)/Unplanned Weight Loss, revised September 2012, indicated, The staff will report to the physician significant weight.losses.The physician will review for medical causes of weight.loss before ordering interventions. Conditions such as heart failure and renal failure [kidney failure] .the physician, with the help of the multidisciplinary team, will identify conditions and medications that may be causing anorexia, weight loss or increasing the risk of weight loss.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one resident (Resident 8) of four sampled residents received necessary care and services to prevent continued weight loss when:Resident 8's weight loss went unaddressed;Nursing staff did not notify the physician of Resident 8's weight loss; and,There was no Registered Dietician to provide oversight.These failures decreased the facility's potential to maintain Resident 8's nutritional status (the state of health determined by balance of nutrient intake, absorption, and the body's physiological needs) which placed Resident 8 at risk for worsening malnutrition, further weight loss, and a decline in overall health. Cross Reference F658, F835Findings:A review of Resident 8's admission record indicated Resident 8 was admitted to the facility on [DATE] with Acute on Chronic Systolic and Diastolic Heart Failure (a long term condition in which the heart is too weak to pump efficiently and too stiff to fill with blood) and Chronic Kidney Failure (a condition in which the kidneys gradually lose the ability to filter waste and excess fluid from the blood). A review of Resident 8's care plan, dated 9/3/25, indicated Resident 8 was at risk for nutritional complications related to her nutritional deficiency. The care plan included a goal for Resident 8 to have no significant weight changes (10% weight loss over a six-month period). To meet this goal, the nursing staff were directed to administer ondansetron (a fast-acting medication used to prevent nausea and vomiting) before meals, weigh Resident 8 monthly, monitor meal intake in percentages, notify licensed staff when intake was below 50% and document food substitutes, and provide a calorie and protein dense nutritional supplement. A review of Resident 8's documented meal percentage intake, dated 5/6/26 to 6/4/26, indicated Resident 8 was served 87 meals. Of these meals, 21 meals reflected 50% or less consumed. Some meals were marked as refused or were not recorded because Resident 8 was unavailable.A review of Resident 8's monthly weights indicated the following:9/2/25 (Upon admission): 118.2 lbs.;10/1/25: 117.2 lbs.;11/2/25: 121.4 lbs.;12/1/25: 123 lbs.;1/5/26: 120 lbs.;2/1/26: 116.4 lbs.;3/1/26: 112.4 lbs.;4/1/26: 109.2 lbs.; 5/2/26: 107.2 lbs.; and,6/1/26: 104.6 lbs.A review of the physician progress notes dated 12/30/25 through 3/11/26 revealed no documentation from Physician 1 (MD 1) addressing new concerns, orders or an assessment of Resident 8's ongoing weight loss. The physician entries only documented weight data without comment. No additional physician documentation was found until 6/3/26, when a new physician (MD 2) began providing care. However, the note documented by MD 2 did not address Resident 8's current weight or the amount of weight loss that had occurred.A review of Resident 8's nutritional risk assessment dated [DATE] indicated Resident 8 had no significant weight loss during the previous six months. The Registered Dietitian (RD) calculated Resident 8's estimated caloric needs to be 1,325-1,590 calories per day, which required the resident to consume at least 75% of each meal daily to meet these needs. During the assessment, the RD documented Resident 8 had consumed only 58% of meals. A goal was established to increase the resident's intake, acknowledging Resident 8's current consumption was insufficient to meet her caloric requirements. The RD also documented that Resident 8's family preferred she be served food she enjoyed and not be placed on a restrictive diet.A review of Resident 8's quarterly nutritional assessments indicated the following:1/6/26: Resident 8 consumed an average of 48% of meals over a 14ˆday period. Resident 8 had a 3ˆlb weight loss from December 2025, which was not considered significant at that time.5/29/26: Resident 8 consumed an average of 58% of meals over a 14ˆday period. Resident 8 had a 4ˆlb weight loss, representing a 10.67% weight loss over the previous six months.A review of the facility's weight meeting and progress note dated 4/16/26 indicated the RD documented Resident 8's weight had decreased to 109.2 lbs., representing a 9% weight loss over the previous 90 days. The RD also noted Resident 8 consumed an average of 69% of meals and reported improvement in nausea and stomach pain. The notes further documented that Resident 8 requested the discontinuation of the nutritional supplement, believing it contributed to her nausea and abdominal discomfort.During an interview in (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Resident 8's room on 6/2/26 at 8:54 a.m., Resident 8 stated the food was often too spicy and did not taste good to her. Resident 8 further stated the food gave her a stomachache.During an interview on 6/4/26 at 9:05 a.m., the Certified Nursing Assistant 2 (CNA 2) stated Resident 8 would often pick at her meals and rarely finished them. CNA 2 stated she did not report unfinished meals to the licensed nurse because it is documented in the electronic medical record (EMR).During a phone interview on 6/4/26 at 9:10 a.m., the RD stated she worked as a consulting RD for the facility through an outside agency. The RD reported she had visited the facility twice per month to assess residents and provide recommendations. The RD stated her supervisor informed her she could no longer provide services to the facility due to nonˆpayment for her work over the past three to four months. The RD stated her last day at the facility was either 4/25/26 or 4/26/26.During an interview on 6/4/26 at 9:54 a.m., the Dietary Assistant/Manager (DM) acknowledged Resident 8 did not like spicy food and stated the kitchen had prepared a bland diet for her, but she still did not like it. The DM then described the process used by the facility to monitor residents at nutritional risk and explained the EMR system flagged residents when a significant weight loss was calculated. This flag was intended to trigger an RD assessment and recommendation, followed by a physician assessment and order. The DM further stated he had not yet received his certification in dietary management and still needed to complete the required examination to become fully certified. Therefore, the DM stated he did not possess the necessary credentials to assess Resident 8 or to make recommendations related to her significant weight loss.During an interview on 6/4/26 at 10:01 a.m., Licensed Nurse 1 (LN 1) stated Resident 8 has had stomach issues, mainly nausea for the past few months. LN 1 stated ondansetron and over the counter antacid (relieves acid indigestion and upset stomach) were ordered upon admission and administered when necessary. LN 1 stated she had noticed Resident 8 had appeared thinner recently. During an interview on 6/4/26 at 10:05 a.m., the Assistant Director of Nursing/Clinical Coordinator (ADON) stated the Director of Nursing (DON), or the RD was responsible for notifying the physician when a resident experienced weight loss. The ADON explained weight changes were typically identified during the monthly weightˆvariance meeting, where each resident was reviewed, recommendations were developed, and the physician was expected to be notified along with the RD's clinical recommendations. The ADON confirmed Resident 8 had experienced significant and progressive weight loss since January 2026. She also acknowledged MD 1 had not issued any orders or documented any mention of the resident's weight in the physician progress notes, other than the actual weight recorded. The ADON further stated the DON left the facility in midˆMay, MD 1 also departed during the same timeframe, and the RD had not provided services throughout the month of May. The ADON reported she was new to her role since the DON left and did not plan to remain in the position permanently. The ADON stated collectively, these circumstances resulted in no qualified clinical oversight, no physician notification, and no timely intervention for Resident 8's ongoing significant weight loss.During an interview on 6/5/26 at 7:48 a.m., the Assistant Administrator (AADM) stated due to the pending sale of the facility, staff that held critical positions within the facility had decided to leave. The AADM admitted the facility was behind on payments to the agency providing the facility with a consultant RD, though she would attempt to call and see if arrangements could be arranged. The AADM stated she had been relying on the DM for the RD duties, though he was not yet certified and would be unable to perform nutritional assessments.During an interview on 6/5/26 at 11:35 a.m., MD 2 stated he had just started working with the facility a few weeks prior. The MD 2 stated he did not receive any type of resident hand-off report from MD 1 before starting. MD 2 reported he had just assessed Resident 8 a few days ago and understood she had a poor appetite. MD 2 stated he was unaware of Resident 8's significant weight loss and would speak with the RD. When MD 2 was informed there was no RD to consult, MD 2 stated he would look into the weight loss and determine the best route to prevent further weight loss.During an interview on 6/5/26 at 12:54 p.m., the DM stated he normally reported to the RD but now he was required to report to the Minimum Data Set (MDS) Supervisor since the RD was no longer at the facility. The DM stated he completed the (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	quarterly nutrition assessment for Resident 8 on 5/29/26. Though the normal process would have been for the RD to review the quarterly nutrition assessment, assess the resident and make recommendations with significant weight loss, the DM stated he was now relying on someone to contact someone so appropriate action could be taken. The DM acknowledged the important role an RD held in that the RD was able to take immediate action to intervene.During an interview on 6/5/26 at 1:24 p.m., Resident 8 stated about her weight loss Lord no, I'm not happy! I'm too bony! Resident 8 stated she was concerned about her weight loss and added What can I do about it? She stated her clothes were too baggy, but she did not feel up to go shopping for new clothes. A review of the facility's clinical protocol titled, Nutrition (Impaired)/Unplanned Weight Loss, revised September 2012, indicated, The staff will report to the physician significant weight.losses.The physician will review for medical causes of weight.loss before ordering interventions. Conditions such as heart failure and renal failure [kidney failure] .the physician, with the help of the multidisciplinary team, will identify conditions and medications that may be causing anorexia, weight loss or increasing the risk of weight loss.

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Napa Community Health Center	1800 Pueblo Ave Napa, CA 94558

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observations, interviews, and document review, the facility failed to ensure resident rights were exercised when:1. A census of 24 residents and/or their Responsible Parties (RP) were not informed about their right to vote on June 2, 2026 for a primary election for state government elected officials; and,2. One resident (Resident 22) of three sampled residents did not have their final wishes followed when staff allowed family members to sign their Physician Order for Life Sustaining Treatment (POLST) forms when they did not have the legal authority to do so.These failures resulted in 24 residents not being informed of their right to vote by the facility, and Resident 22 being consented as Do Not Resuscitate (DNR) by people who were not authorized to make that decision. Cross Reference F942 Findings: 1. During the Resident Council meeting on 6/3/26 at 11 a.m., attended by Residents 1, 3, 6, 11, 12, 14, 16, 21, 26, and 27, the interim Activities Director (IAD), the Ombudsman, and this surveyor. All residents in attendance stated they had not voted yesterday. During an interview with the Social Services Designee (SSD) on 6/3/26 at 2:37 p.m., the SSD stated none of the residents came to ask for transportation to be able to vote. The SSD stated she was not following the election and stated she was unaware of the California Primary election on 6/2/26. During an interview with the IAD on 6/3/26 at 3:45 p.m., the IAD stated she did not know who was responsible for informing the residents that there was an upcoming election. The IAD acknowledged residents had not received information about the election yesterday from the Activities Department. The IAD stated residents were not asked if they wanted to vote yesterday. The IAD stated no vote-by-mail ballots were received by the facility for any of their residents. She stated she did not know if families of residents brought their vote-by-mail ballots and if other residents were able to vote. During an interview with the Assistant Administrator (AADM) on 6/3/26 4:13 p.m., the AADM stated past elections were posted on the activity calendar. The AADM acknowledged yesterday's California election was not on the activity calendar. The AADM stated she was not aware if the activity staff asked residents if they wanted to participate in yesterday's elections. A picture of the Activities Department calendar of activities dated June 2026 was taken on 6/4/26 at 7:33 a.m. and did not indicate the June 2, 2026, California primary election as an offered activity for residents to participate in on 6/2/26. During an interview on 6/3/26 at 3:55 p.m., Resident 8 stated the facility did not inform her about the election yesterday. During an interview on 6/3/26 at 3:56 p.m., Resident 7 stated she liked to vote and has done so in the past. Resident 7 stated she did not know that there was an election yesterday, that the facility did not talk to her about voting, and was not able to vote. During an interview on 6/3/26 at 3:58 p.m., Resident 27 stated she liked to vote and has done so in the past. Resident 27 stated knew about the election yesterday, the facility did not talk to her about (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	voting and was not able to vote. During an interview on 6/3/26 at 3:59 p.m., Resident 13 stated she liked to vote and has done so in the past. Resident 13 stated she did not know about the election yesterday, the facility did not talk to her about voting and was not able to vote. During an interview on 6/3/26 at 4:01 p.m., Resident 21 stated she liked to vote and has done so in the past. Resident 21 stated she knew about the election yesterday, the facility did not talk to her about voting and was not able to vote. During an interview on 6/3/26 at 4:01 p.m., Resident 24 stated she liked to vote and has done so in the past. Resident 24 stated she did not know about the election yesterday, the facility did not talk to her about voting and was not able to vote. During an interview on 6/3/26 at 4:13 p.m., Resident 20 stated he liked to vote and has done so in the past. Resident 20 stated he was aware of the election yesterday; the facility did not talk to him about voting and was not able to vote. During an interview on 6/3/26 at 4:15 p.m., Resident 19 stated she liked to vote and has done so in the past. Resident 19 stated she did not know about the election yesterday, the facility did not talk to her about voting and was not able to vote. During an interview on 6/3/26 at 4:16 p.m., Resident 11 stated she liked to vote and has done so in the past. Resident 11 stated she did not know about the election yesterday, did not like to vote in the past, and that facility did not talk to her about voting. During an interview on 6/3/26 4:27 p.m., with Resident 5, she stated she knew about the election yesterday, the facility did not talk to her about voting and was not able to vote. In an observation on 6/4/26 at 7:52 a.m., there were no posted copies of resident rights throughout the facility as indicated on the facility's policy and procedure (P&P) on Resident Rights. During a concurrent observation and interview on 6/4/26 at 7:55 a.m., the AADM stated copies of the residents' rights may be at the back dining room. The back dining room was inspected with Certified Nursing Assistant 1 (CNA 1) who confirmed she did not see any copies of the residents' rights posted at the back dining room. During an interview on 6/4/26 at 7:58 a.m., the AADM stated she had not read the P&P requirements and stated copies of residents' rights were not posted throughout the facility but are located in a binder. A review of the facility's P&P titled, Resident Rights, dated 3/31/26, indicated, Federal and State laws guarantee certain basic rights to all residents of this facility. Residents are entitled to exercise their rights and privileges to the fullest extent possible. Our facility will make every effort to assist each resident in exercising his/her rights to assure that the resident is always treated with respect, kindness, and dignity. Copies of resident rights are posted throughout the facility, and a copy is provided to each employee upon hire.Orientation and in-service training programs are conducted quarterly to assist our employees in understanding our resident's rights. Inquiries concerning resident's rights should be referred to the Social Services Director. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. A review of Resident 22's admission record indicated she was admitted in September 2019 with diagnoses of Alzheimer's disease (a disease characterized by a progressive decline in mental abilities) and dementia (a progressive state of decline in mental abilities). A review of a Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 5/6/26, indicated she had complete memory impairment. A review of Resident 22's POLST prepared on 3/24/19 indicated Resident 22's Financial RP (someone who is legally allowed to make financial decisions for someone who is no longer able to for themselves) signed the document, but the Financial RP's signature was not dated nor was the Financial RP's relationship to Resident 22 filled out. The POLST also indicated Resident 22's Financial RP had consent to sign the POLST from an Advanced Directive that had been signed and dated on 9/13/17. A review of Resident 22's document titled Uniform Statutory Form Power of Attorney, dated 9/13/17 indicated, This document does not authorize anyone to make medical and other healthcare decisions for you. During an interview with the SSD on 6/5/26 at 8:58 a.m., the SSD stated, This [POLST] is not correct. The signer did not have consent based on the POA. I must not have read it. A review of the facility's P&P titled, Informed Consent Policy and Procedure, revised 6/5/26, indicated, Purpose.Protect resident rights and autonomy.Ensure informed decision-making regarding medical care and treatment.The practitioner shall determine whether the resident possess decision-making capacity. If the resident lacks capacity.Consent shall be obtained from the legally authorized representative. Documentation supporting incapacity and surrogate authority shall be maintained in the medical record.Quality Assurance.The Director of Nursing or designee shall.Audit consent documentation quarterly.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on interview and record review, the facility's Administration failed to ensure the Dietary Manager (DM) had the required qualifications to manage the facility's kitchen in a skilled nursing facility in California.This failure decreased the facility's potential to ensure safe food handling and the prevention of food-borne illness in a highly susceptible population of 24 residents. Cross Reference F835Findings:In an interview on 6/4/26 at 9:45 a.m., DM stated he had been employed at the facility for six years and had been in the position of DM for approximately three months when the previous DM resigned. The DM stated he had a ServeSafe(R) Manager certificate (a nationally accredited certificate in food safety that is required by law in many states) but did not have a Certified Dietary Manager (CDM) certification. The DM stated he qualified for the Certified Dietary Manager examination, was in the process of registering, but he currently did not have a date to take the exam. The DM further stated he was not a nutritionist, stating, I have not done the 900 hours. In an interview on 6/5/26 at 9:33 a.m., the Assistant Administrator (AADM) stated, The CDM left because she didn't want to work for the new owner. I can't hire a new one because the new owner wants to make that decision. I have [the DM] stepping into the Dietary Manager position. He is qualified; he just hasn't taken the test. He cannot make assessments, though - that is the problem. In an interview with the previous Registered Dietitian (RD) on 6/4/26 at 9:10 a.m., the RD stated she was employed by a third-party company and contracted to work at the facility. The RD stated the previous CDM left the faciity on 4/17/26 and the RD's last day at the facility was 4/25/26. The RD stated she was instructed not to return to the facility until they paid their bill in full.A review of the facility's job description titled, Director of Food & Nutrition Services, dated 3/16/23, stipulated, Being a certified food protection manager who has shown proficiency of required information through passing a test that is part of an accredited program.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility's dietary staff failed to store food in a sanitary manner for a census of 24 when:Multiple boxes in the dry pantry were either misdated or not dated;Multiple food items in the food pantry were stored improperly, not dated, or expired;Multiple food items in the walk-in refrigerator were stored improperly, not dated, or expired;Multiple spices on the spice shelf were undated or expired;Food being prepared to be cooked was expired;The floor and blender were found dirty; and,The Dietary Manger (DM) did not adhere to the hair containment policy.These failures decreased the facility's potential to prevent the transmission of foodborne illnesses throughout the facility.Findings:1. In an initial observation of the dry pantry on 6/2/26 at 5:41 a.m., this surveyor observed no dates to indicate when the item was received and two cans of cranberry sauce which were labeled 11/15.In a concurrent observation and interview with the DM on 6/2/26 at 10:26 a.m., the DM stated, I inspect the food, unpackage them, and make sure there are no items expired. The DM confirmed not all boxes had delivery stickers with received dates on them, so he was unable to state when they were received and did not know when they needed to be discarded. The DM also acknowledged he did not know what year the two cans of cranberry sauce were received because it was not written on the cans.A review of the facility's document titled Dry Goods Storage Guide dated 2023, stipulated unopened canned foods had a shelf life of 12 months. 2. In an initial observation of the food pantry on 6/2/26 at 5:41 a.m., this surveyor observed:- several clear plastic bags of sliced bread and bread rolls without received and use-by dates on them; and,- a white cardboard box with a stain from liquid having spilled on its lid had plenty of red potatoes with sprouts growing out of them.In a concurrent observation and interview with the facility [NAME] on 6/2/26 at 7:09 a.m., the [NAME] stated the bread in the pantry should have been dated and added I know they came in Thursday. The [NAME] also stated the cook who works at night was supposed to write the dates on the bread and fresh produce when they were received. The [NAME] confirmed the cardboard box the potatoes were stored in should not have had a stain on top of it and acknowledged the potatoes were not good. The [NAME] added he was going to throw them away.In a concurrent observation and interview with the DM on 6/2/26 at 10:26 a.m., the DM stated, I was told the bread guy was going to label and rotate the bread for us.We should have been doing it too. The DM stated he was unaware that fresh produce had to be labeled and said he would start doing that right away.A review of the facility's policy and procedure (P&P) titled Food Storage revised 12/1/21 indicated, All open food items will have an open date and use-by-date per manufacturer's guidelines.A review of the facility's guide titled Refrigerated/Freezer Storage Guide, dated 2023 stipulated fresh fruits or vegetables received by the facility were good for 14 days.A review of the facility's guide titled Dry Goods Storage Guide dated 2023 indicated bread on the shelf (opened and unopened) was good for 5 days.3. In an initial observation of the walk-in refrigerator on 6/2/26 at 5:41 a.m., this surveyor observed:- one stainless-steel sheet pan with red gelatin and cut up strawberries inside of it sat on a shelf without a cover to protect it from bacteria, mold, or debris and labeled Regular.Prepared 6/1/26.Use By 6/2/26;- one stainless-steel sheet pan with red gelatin sat adjacent to the other sheet pan with gelatin and strawberry on the shelf without a cover to protect it from bacteria, mold, or debris and labeled SF [sugar Free] [Brand Name gelatin].Prepared 6/1/26.Use By 6/2/26;- several cardboard boxes and plastic bags that contained fresh vegetables (potatoes, carrots, white mushrooms, peas, tomatoes, strawberries, blueberries, and green leafy vegetables) did not have received dates on them;- A transparent, plastic container with cut garlic inside of it was labeled Garlic.Prepared 5/24/26.Use By 5/31/26 was on a shelf;- A transparent, plastic container with cut pineapple inside of it was labeled Pineapple.Prepared 5/31/26.Use By 6/10/26 was on a shelf;- A transparent, plastic container with cut cantaloupe inside of it was labeled Cantaloupe.Prepared 5/31/26.Use By 6/15/26 was on a shelf;- A transparent, plastic container with cut honeydew inside (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	of it was labeled Honeydew.Prepared 5/31/26.Use By 6/10/26 was on a shelf; and,- A transparent, plastic container with a pinkish mixture inside of it was labeled Tuna Salad.Prepared 5/25/26.Use By 5/30/26 was on a shelf.In an interview with the DM on 6/2/26 at 10:26 a.m., the DM stated cut fruit should be good for 5 days. The DM also stated there is a higher risk for food borne illness each day an item goes beyond its expiration date. The DM acknowledged the gelatin had been sitting uncovered since 6/1/26 and should have been covered.A review of the facility's guide titled, Refrigerated/Freezer Storage Guide, dated 2023 stipulated fresh fruits or vegetables received by the facility were good for 14 days; when fresh vegetables or fruit are cut or prepared, they were good for 7 days; when house prepared foods (i.e. tuna salad) were made, they were good for 3 days in the refrigerator.4. In an initial observation of the spice shelf on 6/2/26 at 5:41 a.m., this surveyor observed the following:- a clear plastic container of whole tarragon leaves dated 3/10/25 [and] 9/10/25;- a clear plastic container of Italian seasoning without opened and discard dates;- a clear plastic container of ground cumin seeds without opened and discard dates;- a clear plastic container of rubbed sage without opened and discard dates;- a clear plastic container of ground cinnamon without opened and discard dates;- a clear plastic container of granulated garlic without opened and discard dates;- a clear plastic container of granulated onion without opened and discard dates;- a clear plastic container of ground black pepper without opened and discard dates; and,- a clear plastic container of whole basil leaves without opened and discard dates.In an interview with the DM on 6/2/26 at 10:26 a.m., the DM acknowledged the bottles of spices were not properly dated and should have been. The DM also acknowledged the bottle of tarragon was expired and should have been discarded.A review of the facility's guide titled Dry Goods Storage Guide dated 2023 indicated opened spices on the shelf were good for 12 months.5. In a concurrent observation and interview at the preparation (prep) table on 6/2/26 at 5:56 a.m. with the facility Cook, the [NAME] stated she planned to cook cut carrots that were inside a transparent plastic container labeled Carrots.Prepared Date 5/27/26.Use By 6/1/26 located on top of the prep table for that day's lunch. The [NAME] stated, They look good. The carrots looked dehydrated even though there was condensation on the inside of the plastic container to indicate they had been stored inside a refrigerator.In an interview with the DM on 6/2/26 at 12:28 p.m., the DM stated, Consuming expired foods is something that can lead to further complications. The residents here are of a weakened status so spoiled food can aggravate a resident and impede healing.6. In an initial observation of the kitchen on 6/2/26 at 5:41 a.m., this surveyor observed the main kitchen floor appeared dirty.In a concurrent observation and interview with DM on 6/3/26 at 12:37 p.m., the blender was found to have a gooey substance on top of it. The DM stated, That's this morning's apple sauce. It never got cleaned. In an interview with the Assistant Administrator (AADM) on 6/3/26 at 1:36 p.m., the AADM stated, The floor is clean, they mop it every day, it just looks bad because it's old.In an observation in the facility kitchen on 6/4/26 at 4:44 p.m., the kitchen floor looked brighter and cleaner after it had been power washed. A review of the facility's policy titled, Kitchen Equipment Cleaning Schedule Guide, dated 2023 stipulated, the blender was to be cleaned after each use by the person who used it. This policy did not list the frequency the kitchen floor was to be cleaned nor who was responsible for cleaning it.A review of the Food & Drug Administration [FDA] Food Code 2022 indicated Food Contact Surfaces, Nonfood Contact Surfaces, and Utensils.Equipment, food contact surfaces, and utensils shall be clean to sight and touch.Nonfood contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris.A review of the FDA Food Code 2022 indicated, Cleaning, Frequency and Restrictions.PHYSICAL FACILITIES shall be cleaned as often as necessary to keep them clean.7. In an observation with the DM on 6/2/26 at 9:03 a.m., the DM wore a baseball cap, turned around, with exposed hair and no beard cover.In an observation on 6/3/26 at 4:25 p.m. the DM wore a baseball cap, turned around, with exposed hair and no beard cover. In an observation on 6/5/26 at 12:51 p.m. the DM wore a baseball cap, turned around, with exposed hair and no beard cover. In an interview on 6/5/26 at 12:54 p.m., the DM confirmed he wore a baseball hat in the kitchen and food prep areas. The (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	DM stated he was told it was acceptable to wear a baseball hat. The DM also acknowledged hair was exposed on the sides of his head where the hat did not cover. The DM also verified he had not worn a beard cover to cover his beard and stated he should wear one.A review of the FDA Food Code indicated, Food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to ensure trash was stored in a sanitary manner for a census of 24 residents when trash dumpsters were observed left open.This failure decreased the facility's potential to prevent a nuisance or breeding ground for insects and rodents.Findings:In an observation on 6/2/26 at 5:41 a.m., Trash Dumpster 1 (TD 1) was observed open with no one in attendance, and TD 2 had a four-inch gap between the lids; furthermore, the lid was cracked and broken. In a concurrent observation and interview the Dietary Manager (DM) on 6/2/26 at 10:34 a.m., the DM stated, Someone forgot to close this, as he closed TD 1. The DM stated trash dumpsters were expected to be closed when not in active use. The DM also stated the lids should be intact. During multiple observations on 6/2/26 at 5:41 a.m., 10:34 a.m., and at 11:40 am; on 6/3/26 at 4:26 p.m.; on 6/4/26 at 12:17 p.m. and 4:45 p.m.; and on 6/5/26 at 7:22 a.m., 12:51 a.m., and 1:37 p.m., TD 1 was observed open and unattended.A review of the facility's policy titled, General Waste (Garbage) Disposal, dated 6/4/26 indicated, Waste shall be managed in a way that prevents transmission of communicable disease, minimizes odors, and eliminates conditions that may attract insects, rodents, or other vermin .outdoor waste containers shall .Have tight fitting covers .Be leakproof .Be maintained in good repair .Be rodent resistant .Outdoor dumpsters or movable bins shall .remain closed except during loading. Be maintained in sanitary condition .

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on interview and record review, the facility failed to ensure the electronic submission of the Payroll Based Journal (PBJ, a system by which skilled nursing facilities submit staffing information to the Centers for Medicare and Medicaid) data as required quarterly for a census of 24 residents when the Certification and Survey Provider Enhanced Reporting system (CASPER, an assortment of real-time reports that allows SNFs the opportunity to pinpoint areas where changes in care and operations are necessary to improve performance) report indicated there was no information for the first quarter (Q1-1/26 through 3/26). This failure prevented regulatory agencies, residents, and residents' families from being able to verify that facilities had enough staff to provide necessary care to residents. Findings: During an interview on 6/4/26 at 1:30 p.m., the Social Services Designee (SSD) stated she was responsible for submitting the PBJ data. The SSD stated when she attempted to submit the first quarter data, she ran into internet related issues which prevented her from transmitting the data. The SSD stated when the connection was finally established, It was too late to submit the data. During an interview on 6/5/26 at 8:04 a.m., the Assistant Administrator (AADM) stated PBJ staffing information had to be reported quarterly. The AADM stated they tried to submit the data as required but encountered technical difficulties. The AADM stated she understood the necessity and importance of submitting the data. The AADM stated there is no facility policy regarding PBJ.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observations, interviews, and record reviews, the laundry staff failed to prevent the development and transmission of communicable diseases and infections for a census of 24 residents when clean linens were not transported by methods that protected from dust, soil, moisture, and infectious organisms during transport within the facility.This failure decreased the facility's potential to prevent the transmission of infectious pathogens (tiny organisms that can make you sick if they get inside your body) residents in the facility.Findings:During a concurrent observation and interview on 6/5/26 at 9:04 a.m., with Housekeeping Staff 1 (HS 1), HS 1stated the person who usually did the laundry was on leave. HS 1 showed this surveyor a gray container labeled cube truck and stated the container was used to transport clean linen to the clean linen storage inside the facility. An observation of the container found it had a gaping hole on one side of it as it sat outside of the laundry room over pavement which had soil and small rocks within a foot of the container. The HS 1 acknowledged this container had clean linen inside it and had a white blanket on top of it to protect the clean linen from getting dirty. The HS 1 showed the surveyor a second clean linen container which also had a hole on one side but did not have clean linens inside it during the time of the observation. Pictures were taken during this observation.During a concurrent observation and interview with the ADON (Assistant Director of Nursing) on 6/5/26 at 9:33 a.m., the ADON observed the container with clean linens inside which had a hole on the side of it as it sat outside of the laundry room, exposed to the elements and possible pathogens on the ground. The ADON verified the hole on the side of the container exposed the residents' clean linens to pathogens that could contaminate the linens and could possibly affect the residents.A review of the facility's policy and procedure (P&P) titled, Infection Control and Laundry Services. dated 6/1/26, indicated, Purpose.To establish procedures for the safe handling, collection, transport, processing, storage, and distribution, of linen and clothing while maintaining infection prevention standards throughout the facility. Transport clean linens in covered carts. Protect clean linen from dust, moisture, and contamination.

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Napa Community Health Center	1800 Pueblo Ave Napa, CA 94558

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observation, and document review, the facility failed to maintain an effective pest control program when a cockroach was seen inside the facility's beauty shop. This failure decreased the facility's potential to prevent contamination of food supplies and respiratory distress among residents when cockroach droppings are inhaled.Findings: During a concurrent observation and interview with Licensed Nurse 1 (LN 1) inside the facility's beauty shop on 6/2/26 at 9:35 a.m., a live cockroach lying on its back was seen on the floor. LN 1 stated, I think it is a cockroach .Residents can get an infection if cockroaches are in the facility. During an interview with the Maintenance Worker (MW) on 6/2/26 at 9:50 a.m., the MW stated there were complaints of cockroaches in room [ROOM NUMBER] three weeks ago and room [ROOM NUMBER], one week ago. The MW stated traps were set and checked weekly. The MW stated the last time he checked the two traps he placed in room [ROOM NUMBER], there was a cockroach found in each trap. A review of the facility's policy and procedure (P&P) titled, Pest Control, dated May 2008, indicated, Our facility shall maintain an effective pest control program .This facility maintains an on-going pest control program to ensure that the building is kept free from insects and rodents.

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F 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that staff members are educated on resident rights and facility responsibilities to properly care for its residents. Based on interviews, observations, and document review, the facility failed to ensure staff members were educated on residents' rights for a census of 24 residents , when the Social Services Designee (SSD), the Interim Activities Director (IAD), and the Assistant Administrator (AADM) unaware they were responsible for providing residents the ability and option to vote during an election. This failure denied eligible and willing residents who wanted to exercise their right to vote as citizens of the United States. Cross reference F550, F942Findings:During the Resident Council meeting on 6/3/26 at 11 a.m., attended by Residents 1, 3, 6, 11, 12, 14, 16, 21, 26, and 27, the interim Activities Director (IAD), the Ombudsman, and this surveyor. All residents in attendance stated they had not voted yesterday. During an interview with the Social Services Designee (SSD) on 6/3/26 at 2:37 p.m., the SSD stated none of the residents came to ask for transportation to be able to vote. The SSD stated she was not following the election and stated she was unaware of the California Primary election on 6/2/26.During an interview with the IAD on 6/3/26 at 3:45 p.m., the IAD stated she did not know who was responsible for informing the residents that there was an upcoming election. The IAD acknowledged residents had not received information about the election yesterday from the Activities Department. The IAD stated residents were not asked if they wanted to vote yesterday. The IAD stated no vote-by-mail ballots were received by the facility for any of their residents.During an interview with the Assistant Administrator (AADM) on 6/3/26 4:13 p.m., the AADM stated past elections were posted on the activity calendar. The AADM acknowledged yesterday's California election was not on the activity calendar. The AADM stated she was not aware if the activity staff asked residents if they wanted to participate in yesterday's elections.A picture of the Activities Department calendar of activities dated June 2026 was taken on 6/4/26 at 7:33 a.m. and did not indicate the June 2, 2026, California primary election as an offered activity for residents to participate in on 6/2/26. In an observation on 6/4/26 at 7:52 a.m., there were no posted copies of resident rights throughout the facility as indicated on the facility's policy and procedure (P&P) on Resident Rights.During a concurrent observation and interview on 6/4/26 at 7:55 a.m., the AADM stated copies of the residents' rights may be at the back dining room. The back dining room was inspected with Certified Nursing Assistant 1 (CNA 1) who confirmed she did not see any copies of the residents' rights posted at the back dining room. During an interview on 6/4/26 at 7:58 a.m., the AADM stated she had not read the P&P requirements and stated copies of residents' rights were not posted throughout the facility but are located in a binder.A review of the facility's P&P titled, Resident Rights, dated 3/31/26, indicated, Federal and State laws guarantee certain basic rights to all residents of this facility. Residents are entitled to exercise their rights and privileges to the fullest extent possible. Our facility will make every effort to assist each resident in exercising his/her rights to assure that the resident is always treated with respect, kindness, and dignity. Copies of resident rights are posted throughout the facility, and a copy is provided to each employee upon hire.Orientation and in-service training programs are conducted quarterly to assist our employees in understanding our resident's rights. Inquiries concerning resident's rights should be referred to the Social Services Director.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. Based on interview and record review, the facility failed to obtain informed consent for one resident (Resident 3) of three sampled residents when Resident 3's Responsible Party (RP) did not have legal authorization to provide consent.This failure decreased the facility's potential to provide Resident 3 the ability to make her own medical decisions.Findings:A review of Resident 3's admission record indicated she was admitted in February, 2021 with the diagnosis of unspecified dementia (a progressive state of decline in mental abilities), unspecified severity, without behavioral disturbances, psychotic disturbance, mood disturbance and anxiety. A Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 3/10/26, indicated she had mild memory impairment.A review of Resident 3's informed consent for psychotropic medications, Trazadone, dated 3/19/25 by the physician, indicated it was signed by Resident 3's son on 3/24/25. A review of Resident 3's informed consent for psychotropic medications, Lexapro, dated 6/20/25 and Buspirone, dated 10/7/25, indicated they were signed by Resident 3. A review of Resident 3's order summary report, May, 2026, indicated an order for and daily administration of Trazadone, Buspirone and Lexapro.A review of Resident 3's Advanced Directive indicated it was signed on 3/19/2026. An interview on 6/05/2026 at 8:58 am with the Social Services Designee (SSD), the SSD stated, No, technically, the son does not have consent to make medical decisions for [Resident 3]. This consent is not correct. [Resident 3] was the Responsible Party. It should have been signed by [Resident 3] A review of the facility's policy and procedure titled, Informed Consent . dated 6/5/26 indicated, Purpose .Protect resident rights and autonomy .Establish a consistent process for obtaining, documenting, and maintaining informed consent .Psychotherapeutic and Antipsychotic Medications .Prior to initiation or increase of a psychotherapeutic or antipsychotic medication .Written informed consent shall be obtained from the resident or representative. The consent form shall describe .The Director of Nursing or designee shall .Audit consent documentation quarterly .Provide education to staff regarding informed consent requirements annually .

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Advance Directives (AD - a legal document indicating resident preference on end-of-life treatment decisions) and Physician Orders for Life-Sustaining Treatment (POLST - a form that contains written medical orders for healthcare professionals regarding specific medical treatments that can or cannot be done at the end-of-life) were formulated for five of 16 residents (Resident 3, Resident 22, Resident 5, Resident 7, and Resident 6).This failure increased the risk for the residents to receive unwanted, aggressive and invasive life-sustaining treatment during a sudden medical crisis and exclude the resident and resident's family from crucial decision making. Cross Reference F835 Findings: A review of Resident 3's admission record indicated she was admitted in February 2021 with the diagnosis of unspecified dementia (a progressive state of decline in mental abilities), unspecified severity, without behavioral disturbances, psychotic disturbance, mood disturbance and anxiety. A Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 3/10/26, indicated she had mild memory impairment. A review of Resident 3's POLST indicated there was no documentation of a discussion with the resident regarding AD. A review of Resident 22's admission record indicated she was admitted in September 2019 with diagnoses of Alzheimer's disease (a progressive brain disorder that slowly destroys memory and thinking skills) and dementia. An MDS assessment, indicated she had complete memory impairment. A review of Resident 22's POLST indicated Resident 22's Financial RP signed the document, without dating or identifying her relationship to the resident. The POLST indicated Resident 22's Financial RP had consent from an Advanced Directive dated 9/13/17, identifying her as Power of Attorney (POA). A review of the POA dated 9/13/19 indicated, This document does not authorize anyone to make medical and other healthcare decisions for you. An interview and concurrent record review on 6/5/2026 at 8:58 am with the Social Services Designee (SSD), the SSD stated, When a resident is admitted , I ask them if the resident is the Responsible Party (RP) or if they have a designee. If they do [have an RP], I ask for a copy [of the legal documents designating the RP] and put it in the file. If they don't, I ask them to do the form I have here. It's in the admissions packet. The SSD reviewed Resident 3's POLST and stated, It doesn't look like we had the Advanced Directive conversation with [Resident 3]. The SSD reviewed Resident 22's POLST and stated, Based on this POA, Resident 22's Financial RP did not have the power to make medical decisions for [Resident 22]. This DNR is not valid. We are not in compliance at the moment. A review of Resident 5's admission record indicated she was admitted to the facility on [DATE] with a diagnosis of Polymyositis (a rare, chronic condition that causes swelling, heat, and pain to the skeletal muscles). (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 5's physician order for 1/20/25 indicated Resident 5 had a Full Code Status (a medical order for the medical team to attempt all medically appropriate measures to save life if the heart stops beating). No evidence of an AD or POLST was found in Resident 5's chart. A review of Resident 7's admission record indicated she was admitted to the facility on [DATE] with a diagnosis of Acute on Chronic Systolic Heart Failure (a pre-existing condition in which the weak heart is unable to pump blood with sudden worsening symptoms). A review of Resident 7's POLST indicated there was no documentation of a discussion with the Resident 7 regarding AD. During a concurrent interview and record review, on 6/4/26, at 11 a.m., the Medical Record Supervisor (MRS) confirmed there was no evidence of a POLST or AD in Resident 5's chart and no evidence of an AD in Resident 7's chart. A review of Resident 6's admission record indicated she was admitted to the facility on [DATE] with a diagnosis of chronic obstructive lung disease and diabetes. A review of Resident 6's physician order summary for 6/26 indicated Resident 6 had a Full Code Status (a medical order for the medical team to attempt all medically appropriate measures to save life if the heart stops beating). During an interview with the Assistant Director of Nursing (ADON) on 6/5/26 at 11:21 AM, the ADON stated if they do not have an AD, the facility will not know who the decision maker for the resident is, they could not provide the proper care for the resident, and the patient might die in their care. During a concurrent interview with Medical Records Supervisor (MRS) and review of Resident 6's chart on 6/5/26 at 11:30 AM, the MRS confirmed there is no POLST or AD in the chart and stated she already called Resident 6's daughter to request the documents. During a follow-up interview on 6/5/26 at 12:21 PM, the MRS stated she is unable to provide the AD and POLST of Resident 6. A review of the facility's policy titled, Provision of Written Information on Advanced Directives, revised 6/4/26, the policy stated, To ensure that all residents/responsible parties have been provided with written information regarding Advanced Directives, all newly admitted residents/responsible parties will be provided with this information upon admission. The Administrative Assistant will ensure that the form, entitled, 'Advanced Directives Policy and Information' is signed by the resident/responsible party at the time of admission.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility did not maintain hot water temperatures within safe regulatory limits when water temperatures in multiple resident-use restrooms were measured above 120 degrees Fahrenheit (F, a unit measurement of heat) for 16 residents out of a facility census of 24. This failure decreased the facility's potential to provide a hazard-free environment and prevent thermal injury. Cross Reference F835Findings:During a concurrent interview and observation in Resident 8's room on 6/3/26 at 8:15 a.m., Resident 8 stated she was bothered by not having any cold water in her restroom. Upon entering Resident 8's restroom and turning on the cold-water tap, the surveyor observed the water was lukewarm. When the hot water tap was turned on, the water became too hot to safely hold hands under, even briefly. A calibrated thermometer was obtained, and the hot water temperature measured 128.5 degrees F.During observations on 6/3/26 between 8:15 a.m. and 8:45 a.m., hot water temperatures were measured in the facility's remaining 12 resident-use restrooms:room [ROOM NUMBER]: Surveyor Thermometer (ST) Temperature (Temp.) 124.9 F;room [ROOM NUMBER]/105 (shared restroom): ST Temp 128.5 F;room [ROOM NUMBER]/106 (shared restroom): ST Temp 122.4 F;room [ROOM NUMBER]/109 (shared restroom): ST Temp 124 F;room [ROOM NUMBER]/110 (shared restroom): ST Temp 120.1 F;room [ROOM NUMBER]/112 (shared restroom): ST Temp 129.3 F;room [ROOM NUMBER]/116 (shared restroom): ST Temp 129.3 F;room [ROOM NUMBER]/119 (shared restroom): ST temp 122.6 F;room [ROOM NUMBER]/120 (shared restroom): ST Temp 124 F;room [ROOM NUMBER]/123 (shared restroom): ST Temp 123.8 F;room [ROOM NUMBER]/124 (shared restroom): ST Temp 127.6 F; and,room [ROOM NUMBER]/126 (shared restroom): ST Temp 117 F. During a concurrent interview and observation on 5/3/26 at 10:07 a.m., the Maintenance Worker (MW) confirmed that lukewarm warm water ran from cold water tap in Resident 8's restroom. The MW measured the hot water in Resident 8's restroom and obtained a reading at 123.1 degrees F. The MW stated the hot water temperature should be between 115-120 degrees F and acknowledged temperatures above 120 degrees F had the potential to scald the residents. The surveyor accompanied the MW to the boiler room and verified the hot water tank thermostat was set at 120 degrees F. The MW stated he was unsure why the water temperature was running above 120 degrees F and stated, I'm not a plumber. The MW stated he would adjust the thermostat to lower the temperature on the hot water tank after speaking with his supervisor.During a concurrent interview, observation, and record review on 6/3/26 at 12:45 p.m., the surveyor and the MW measured the water temperatures in two resident-use restrooms.room [ROOM NUMBER]/119 ST Temp 130.3, Facility Maintenance Thermometer (FMT) Temp 136 F, and Facility Kitchen Thermometer (FKT) Temp 137.3 F; and,room [ROOM NUMBER]/120 ST Temp 125.2 F, FMT Temp 123.6 F, FKT Temp 128.1 F.The MW stated he checked water temperatures Monday through Friday and recorded them in a maintenance binder. A review of the facility's Room Water Temperature log, dated 5/1/26 through 6/2/26, excluding weekends and one holiday, indicated consistent documented temperatures of 115 degrees F with only one-to-two-degree variances for a period of five days. The same resident restroom in room [ROOM NUMBER] was used to measure temperatures on all days except for three. The MW stated he had not calibrated his thermometer since starting his position as an MW one and a half years ago. He further stated he did not know how or how often calibration was required.On 6/3/26 at 4:15 p.m., the AADM acknowledged the facility understood the necessity to keep residents from harm from temperatures above 120 degrees F. The AADM stated the facility's plan to remove the immediacy of the IJ included turning off the hot water to resident restrooms that continued to measure above 120 degrees F and using alternative methods for residents to wash their hands and faces. The AADM further stated the facility would purchase and install a new mixer valve for the hot water tank on 6/4/26.On 6/4/26, at 9:30 a.m., the AADM stated the mixer valve had been (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	replaced on the hot water tank. During an interview and observations on 6/4/26 at 1:58 p.m., the MW and surveyor measured temperatures in six resident restrooms:room [ROOM NUMBER]/119 ST Temp 116.8 F, FMT Temp 115.3 F, FKT Temp 116.4 F;room [ROOM NUMBER]/120 ST Temp 121.2 F, FMT Temp 121.7 F, FKT Temp 122.2 F;room [ROOM NUMBER]/126 ST Temp 120.7 F, FMT Temp 121.2 F, FKT Temp 120.7 F;room [ROOM NUMBER]/112 ST Temp 121.5 F, FMT Temp 121.3 F, FKT Temp 121.6 F;room [ROOM NUMBER]/106 ST Temp 121.5 F, FMT Temp 120.8 F, FKT Temp 120.9 F; and,room [ROOM NUMBER] ST Temp 121.5 F, FMT Temp 121.5 F, FKT Temp 121.6 F.The MW stated he would adjust the valve one-quarter turn to reduce temperatures within a safe range. On 6/4/26 at 3:04 p.m., the MW and surveyor measured temperatures in six resident restrooms:room [ROOM NUMBER]/119 ST Temp 106.6 F, FMT Temp 106.3 F, FKT Temp 107.2 F;room [ROOM NUMBER]/120 ST Temp 96.8 F, FMT Temp 97.5 F, FKT Temp 97.7 F;room [ROOM NUMBER]/126 ST Temp 101.4F, FMT Temp 104.2 F, FKT Temp 102.2 F;room [ROOM NUMBER]/112 ST Temp 98.6 F, FMT Temp 102.6 F, FKT Temp 99.5 F;room [ROOM NUMBER]/106 ST Temp 104.4 F, FMT Temp 107.3 F, FKT Temp 107.3 F; and,room [ROOM NUMBER]/105 ST Temp 106.9 F, FMT Temp 103 F, FKT Temp 106.7 F.A review of facility's policy titled, Water Temperatures, Safety of, dated 2001, indicated, Tap water in the facility shall be kept within a temperature range to prevent scalding of residents.Water heaters that service resident rooms, bathrooms, common areas, and tub, shower areas shall be set to temperatures of no more than 120 degrees F.Maintenance staff is responsible for checking thermostats and temperature controls in the facility and recording these checks in a maintenance log.

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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 interview and record review, the medical and nursing staff failed to ensure one resident (Resident 5) out of four sampled residents received a gradual dose reduction (GDR) and behavioral interventions when Resident 5 was given a psychotropic (medication that alter brain chemistry to affect mood, thoughts, behavior and perception) drug.This failure decreased the facility's potential to ensure Resident 5 was not given unnecessary psychotropic medication without evaluating its effectiveness or necessity. Cross Reference F835Findings:A review of Resident 5's admission record indicated she was admitted to the facility on [DATE] with diagnoses of Polymyositiis (a rare, chronic condition that causes swelling, heat, and pain to the skeletal muscles) and major depressive disorder (a mood disorder characterized by feelings of sadness, emptiness and a loss of interest in activities).A review of Resident 5's care plan, revised on 11/20/25, indicated Resident 5 was receiving a psychotropic medication. The plan established a goal for Resident 5 to experience no complications from the medication. To achieve this goal, the nursing staff were directed to document Resident 5's moods, behaviors, and medication side effects every shift.A review of Resident 5's physician orders, dated 7/25/25, indicated Resident 5 was ordered Citalopram Hydrobromide [a psychotropic drug taken for depression] oral tablet 10 milligrams [mg-a unit of measure] give one tablet by mouth one time a day. A review of Resident 5's medication administration record (MAR) dated May 2026 indicated a GDR was completed on 5/14/26.A review of Resident 5's GDR form, dated 5/14/26, indicated, As per State and Federal Regulations, residents on psychotropic drugs need to be evaluated every six (6) months. Suggestions include taper down the dose or if there is a continued need, then document the rationale to continue therapy. Resident 5's name was written on the form along with the name and dose of the drug, Citalopram 10 mg po [by mouth] daily for depression. However, there was no physician's response documented, and the physician's signature did not indicate the date and time it was signed.During a phone interview on 6/5/26 at 9:35 a.m., the pharmacy consultant (PharmD) stated GDRs must occur at least every six months. The PharmD stated monthly pharmacy reviews are sent to nursing staff and the Administrator, but the PharmD expressed concern the nursing staff appeared to be going by [NAME] [completing a task through habit rather than understanding the purpose of the task]. The PharmD further explained the nursing staff send the forms to the physician without behavior monitoring or attempts at dose reduction. The PharmD stated he has not seen any evidence of psychotropics doses being lowered at the facility. During a concurrent interview and record review on 6/5/26 at 10:05 a.m., the Assistant Director of Nursing (ADON) stated GDRs were performed three times a year: monthly, quarterly and annually in addition to an as needed basis. The ADON stated the GDR form was filled out and faxed to the physician for completion and return. The ADON confirmed Resident 5's returned GDR form lacked the physician's indication to continue or taper the citalopram and was not dated. The ADON also confirmed there was no evidence of behavior monitoring. She identified that behavior monitoring for citalopram should include increased confusion, increased weakness, crying, agitation, and suicidal thoughts. The ADON was unaware of the occurrence of any monthly meeting in which GDRs were reviewed.A review of facility's policy titled Psychotropic Medication Use, revised July 2022, indicated, Residents on psychotropic medications receive gradual dose reductions (coupled with non-pharmacological interventions) .in an effort to discontinue these medications.

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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 licensed nurses failed to develop a baseline care plan within 48 hours of admission and provide written copies of the baseline care plan summaries to two residents (Resident 14 and Resident 16) of three sampled residents.These failures decreased the facility's potential to effectively communicate resident needs among facility staff to promote a continuity of care and prevent adverse events from occurring right after admission.Findings:A review of Resident 14's admission record indicated admission to the facility on 5/14/26. This document also indicated Resident 14 was her own Responsible Party (RP, able to make decisions for herself).A review of Resident 14's Minimum Data Set (MDS, an assessment tool) dated 5/20/26 indicated Resident 14 had a Brief Interview for Mental Status (BIMS) score of 15 which meant she had no cognitive (mental processes like memory, learning, concentration, or decision-making) impairment.).A review of Resident 14's baseline care plan provided to this surveyor by the Medical Records Director on 6/4/26, at 11:30 a.m., indicated it had not been signed by Resident 14 or any staff member.A review of Resident 16's admission record indicated admission to the facility on 5/22/26. This document also indicated Resident 15 was her own RP.A review of Resident 16's MDS dated [DATE] indicated a BIMS score of 14 which meant Resident 16 had no cognitive impairment.A review of Resident 16's baseline care plan provided to this surveyor by the Medical Records Director on 6/4/26, at 11:30 a.m., indicated it had not been signed by Resident 16 or any staff member.During an interview with Resident 14 on 6/4/26 at 4 p.m., Resident 14 stated she did not receive a copy of her baseline care plan summary, nor did she remember signing her baseline care plan summary. Resident 14 stated she did not know how the facility would provide care for her.During an interview with Resident 16 on 6/5/26 at 8:18 a.m., Resident 16 stated she was not provided a copy of her baseline care plan summary. Resident 16 stated she yelled at the staff all the time because she wanted to know what was going on.During an interview with the ADON (Assistant Director of Nursing) on 6/5/26 at 9:43 a.m., the ADON stated the baseline care plan should be developed within 48 hours of the resident's admission to the facility. The ADON stated if the baseline care plan was not signed by the staff who did the assessment, it would be incomplete. The ADON stated the facility should provide a copy of the baseline care plan to the residents. The ADON stated after the resident was provided with a summary of their baseline care plan, the resident should acknowledge that he/she received a copy of the summary by signing the baseline care plan summary.A review of the facility's policy and procedure (P&P) titled, Care Plans-Baseline, dated March 2022, indicated, A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission.The resident and /or representative are provided a written summary of the baseline care plan. that includes, but is not limited to the following.The stated goals and objective of the resident.A summary of the resident's medications and dietary instructions.Any services and treatments to be administered by the facility and personnel acting on behalf of the facility, and Any updated information based on the details of the comprehensive care plan as necessary.

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	555207	A. Building B. Wing	06/05/2026

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Napa Community Health Center	1800 Pueblo Ave Napa, CA 94558

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the nursing staff failed to assess, prevent, and identify the occurrence of pressure injury for one resident (Resident 3) of three sampled residents, when Resident 3 obtained a facility-acquired pressure injury (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) on her left cheek.This failure had the potential for the facility acquired Stage 2 pressure injury (a partial-thickness loss of skin, presenting as a shallow open sore or wound) to worsen and placed Resident 3 at risk of complications including infection and pain. Cross Reference F658, F835Findings:A review of Resident 3's admission record indicated she was admitted to the facility in February 2021 with the diagnosis of long-term use of anticoagulants (medication used to prevent blood clots from forming or getting larger), protein-calorie malnutrition (an inadequate intake of protein or calories), rosacea (a chronic inflammatory skin condition which causes redness and swollen bumps), congestive heart failure (a condition where the heart pumps ineffectively), cerebral infarction (stroke), atherosclerotic heart disease of the coronary artery (coronary artery disease, a narrowing of arteries which reduces blood flow and oxygen flow to the heart), chronic embolism and thrombosis of deep veins in the left leg (an old blood clot located in the deep veins of the lower leg), chronic kidney disease (damage to the kidneys which affects their ability to filter waste and excess fluid from the blood), and chronic obstructive pulmonary disease (a progressive lung condition that restricts airflow and causes breathing difficulties).A Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 3/10/26, indicated she had mild memory impairment.A review of Resident 3's integrity skin assessment documented by a Licensed Nurse (LN) and dated 6/1/26 at 10:46 a.m. indicated Resident 3 had redness to her bilateral breast folds and was receiving ongoing treatment but did not have any new skin issues.A review of Resident 3's care plan regarding skin conditions, last revised on 1/26/26 and reviewed on 3/16/26, indicated she was at risk for impaired skin integrity due to her history of having pressure ulcers and diagnosis of rosacea. Resident 3's goal was for her skin to remain intact daily through 3/16/26. To assist Resident 3 to meet her goal, nursing staff were expected to conduct a Braden scale assessment (an evidence-based assessment tool used by healthcare professionals to predict a resident's risk of developing a pressure injury) every quarter and as needed, monitor her skin by conducting skin observations, keep her skin clean and dry, reduce friction and shear, and certified nursing assistants (CNA) were to immediately notify licensed nurses of any skin breakdown.In an observation of Resident 3 in Resident 3's room on 6/2/26 at 7:51 a.m., Resident 3 was sitting up in bed with a nasal cannula (a flexible plastic tube used to deliver oxygen from a machine directly into the nostrils) in place which lay just below her nostrils and across both of her cheeks to wrap behind both ears. A scabbed wound was seen on her left cheek just under where the nasal cannula tubing lay. There was no padding, dressings, or gauze seen on Resident 3's cheeks or ears to prevent pressure injury from the nasal cannula.A review of Resident 3's medical chart 6/3/26 roughly between 8 a.m. and 9 a.m. indicated the following:A review of Resident 3's progress notes between 5/24/26 and 6/1/26 showed no documented evidence of Resident 3 having any pressure injuries.A review of Resident 3's medical chart between 5/24/26 and 6/1/26 showed no documented evidence of a change of condition notification to the physician regarding Resident 3 having a skin concern on her face.In an interview and concurrent record review with the Assistant Director of Nursing (ADON) on 6/3/26 at 10 a.m., the ADON stated if a CNA identified a new skin issue, the CNA was expected to notify the licensed nurse. The licensed nurse is then expected to conduct an assessment, document the assessment, notify the physician and request treatment orders. The ADON further stated it was important for licensed nurses to conduct assessments and document them accurately as part of the monitoring process to determine the progression of the skin issue. If the skin issue worsens, the treatment plan would need to be re-evaluated and changed. Communication between the nurses is important when monitoring the (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	concern. The ADON reviewed Resident 3's medical chart between 5/24/26 and 6/1/26:There were no skin issues identified by CNAs and verified by an LN on Resident 3's shower sheets dated 5/24/26 or 5/27/26;There were no new skin issues identified by LNs on Resident 3's skin assessment dated [DATE]; and,There were no new skin issues documented in the skin log at the nurse's station for Resident 3.The ADON confirmed Resident 3 had no documented skin issues on her shower sheets, the skin log, or her most recent skin assessment.In a concurrent observation and interview with the ADON on 6/3/26 at 10:14 a.m., the ADON assessed Resident 3's left cheek and determined it was a Stage 2 pressure injury. The DON stated the pressure injury was likely from the oxygen tubing which she often used. The DON further stated the skin on the cheek was really susceptible to breakdown and infection; if the tubing continuously provided pressure and moved, it could cause friction which can result in the injury getting larger or reopening. The DON added, This [the pressure injury] is not new. This has been here for a few days. No one charted this.In an interview with CNA 3 on 6/4/26 at 4:37 p.m., CNA 3 stated she had not noticed a skin issue on Resident 3's cheek.In an interview with Licensed Nurse 2 (LN 2) on 6/4/26 at 4:39 p.m., LN 2 stated she was unaware Resident 3 had a skin concern on her cheek.In an interview with the Assistant Administrator (AADM) on 6/5/26 at 9:33 a.m., the AADM stated the facility did not have a policy and procedure for skin tears or skin assessments. The AADM stated the closest document she had was a document titled Braden Scale- For Predicting Pressure Sore Risk.A review of an article titled Pressure Ulcers in the Long-Term Care Setting dated 2008 and published by the American Medical Directors Association indicated, Examine the patient's skin thoroughly to identify existing pressure ulcers.Inspect the patient's skin at least once weekly during routine care (e.g., during a bath). Direct caregivers should be aware of the signs and symptoms.of pressure ulcers as well as predisposing factors.A history of pressure ulcers is a primary risk factor for the development of new pressure ulcers. Patients with a history of pressure ulcers are more than five times as likely to develop another pressure ulcer.The patient's history of pressure ulcers can be obtained from.the plan of care.Conditions related to these risk factors should be evaluated.Risk factors that increase a patient's susceptibility to developing pressure ulcers.include.Comorbid conditions (e.g.end-stage renal disease.drugs that may affect ulcer healing [anticoagulants]. Impaired diffuse or localized blood flow [atherosclerotic heart disease of the coronary artery and chronic embolism and thrombosis of deep veins in the left leg].Increase friction.Undernutrition, malnutrition [protein-calorie malnutrition].regardless of an individual's score on a pressure ulcer assessment instrument, when a patient has any of the risk factors for a pressure ulcer.a pressure ulcer prevention plan should be implemented.Other risk factors that should be assessed include.congestive heart failure.complications (e.g., cellulitis.pain.presence of depression.A review of an article titled Preventing Pressure Injuries updated March 2022 and published by The Joint Commission (an independent, non-profit organization that accredits and certifies healthcare organizations in the United States) indicated, The presence of pressure injuries.may contribute to premature mortality in some patients.The majority of the following strategies are based on the NPIAP's [National Pressure Injury Advisory Panel] ?Pressure Injury Prevention Points'. The earlier a risk is identified, the more quickly it can be addressed.Refine the assessment by identifying other risk factors [such as the use of a nasal cannula].Protecting and monitoring the condition of the patient's skin is important for preventing pressure sores and identifying Stage 1 sores early so they can be treated before they worsen. Inspect the skin.at least daily for signs of pressure ulcers. Assess pressure points.and the skin beneath medical devices.Educate and train all members of the interdisciplinary team. Make sure they are aware of the plan of care and that all care is documented in the patient's record. Ensure leadership support, oversight, and allocation of adequate resources.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the licensed nurses failed to ensure expired and discontinued prescription medication were properly stored and disposed of when:Discontinued medications were observed overflowing from a large, uncovered cardboard box in front of shelves of prescription medications and medical supplies; and,Easily accessible undestroyed medication pills were found in a pharmaceutical waste container.These failures reduced the licensed nurses' ability to safely administer medication and decreased the facility's potential to prevent prescription drug diversion (the illegal redirection of prescription or controlled medication from their intended medical use to unauthorized or illicit use). Cross Reference F835Findings:During a concurrent interview with the Assistant Director of Nursing (ADON) and observation of the medication room on [DATE] at 8:42 a.m., the following were noted:An uncovered, cardboard box measuring 15 inches high by 16 inches wide by 25 inches long was overflowing with bubble packs (a card with clear plastic compartments that hold doses of prescribed medication) of discontinued residents' prescription medication and placed in front of shelves of other prescription medications and medical supplies were stored; and,Six discontinued bubble packs of prescription medications were placed on a metal basket located on the opposite side of the room away from the uncovered box of discontinued medications and between a resident's tote bag which contained medication brought in by the resident and stacked white container baskets.A receptacle designed to safely segregate and dispose of pharmaceutical waste was overfilled which made the dry, whole, loose pills inside of it easily accessible to anyone who had access to the receptacle. Further observation of the inside of the receptacle showed no undesirable substance used to inactivate the whole, loose pills to make them unusable. The ADON stated discontinued prescribed medication were supposed to be stored in the box until they could be destroyed. The ADON stated she was unaware of how often the medications were supposed to be destroyed because the Director of Staff Development (DSD) used to help the Director of Nursing (DON) destroy the medication. The ADON stated the last time she was aware medications were destroyed was in [DATE] before the DON left. The ADON stated the current system of storing discontinued medication was dangerous because anyone with access to this room can take the medications and possibly give them to other patients.During an interview with the DSD on [DATE] at 10:37 a.m., the DSD confirmed she used to help the DON destroy prescription medications weekly before the DON left. The DSD showed this surveyor destruction documentation dated [DATE] which was the last day medication was destroyed prior to the DON leaving. The DSD stated after the DON left, medication destruction had not been done because she had not received guidance or direction to resume the task; however, the Administrator instructed her to resume the medication destruction last week The DSD stated she and the Infection Preventionist (IP) destroyed medication on [DATE]. The DSD added that all nurses had easy access to the discontinued medication in the medication room.A review of the facility's policy titled Discarding and Destroying Medications revised [DATE] indicated, For unused, non-hazardous controlled substances that are not disposed of by an authorized collector, the EPA [Environmental Protection Agency] recommends destruction and disposal of the substance with other solid waste following the steps below.Take the medication out of the original containers.Mix medication, either liquid or solid, with an undesirable substance. Undesirable substances include sand, coffee grounds, kitty litter, or other absorbent materials. Place the waste mixture in a sealable bag, empty can, or other container to prevent leakage.Staff shall contact the provider pharmacy if unsure of proper disposal methods for a medication.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observation, interview and record review, the licensed nurses failed to ensure expired medication was properly stored when expired multivitamins and pain medication were not removed from one of two medication carts.This failure reduced the facility's ability to ensure administered medications are safe and effective.Findings:During a concurrent observation of the East medication cart and interview on [DATE] at 11:16 a.m. with Licensed Nurse 3 (LN 3), LN 3 confirmed the cart contained:One bottle of calcium 600 milligram (mg) with Vitamin D, expired on 6/26;One bottle of Daily Vite(R) multivitamin, expired on 5/26; and,Four acetaminophen 650 mg suppositories, expired on [DATE].LN 3 confirmed the medications were expired and removed them from the medication cart.During an interview with the Assistant Director of Nursing (ADON) on [DATE] at 4:38 p.m., the ADON stated licensed nurses were expected to check the expiration dates of medication prior their administration. The ADON stated licensed nurses should remove the medication from the cart and place the medication where it belongs for disposal. The ADON further stated expired medication may cause harm to a resident, or the medication may be not effective since it is expired.A review of the policy titled Discarding and Destroying Medications revised [DATE] indicated, Medications that cannot be returned to the dispensing pharmacy .are disposed of in accordance with federal, state, and local regulations .non-controlled and Schedule V (non-hazardous) controlled substances are disposed of in accordance with state regulations and federal guidelines regarding disposition of non-hazardous medications.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. Based on observation, interview, and record review, the facility failed to store food in a safe and sanitary manner in the resident refrigerator for a census of 24 when food was found unlabeled and undated. This failure decreased the facility's potential to prevent foodborne illnesses in a vulnerable resident population.Findings:In an observation of the resident refrigerator with the Dietary Manger (DM) on 6/3/26 at 4:07 p.m., a bowl with a half-eaten burrito in it and bottles of drinks and supplements were found unlabeled with a resident name to identify whose food it was and undated to identify when it was placed in the refrigerator and when it was expected to be discarded. The DM stated the items were likely a resident's who treated the resident refrigerator as her own personal refrigerator. The DM stated it was not good to have the items in the resident refrigerator unlabeled and undated.A review of the facility's policy titled, Food Brought in by an Outside Source Policy, dated 4/11/23, indicated, All food or beverages brought in from the outside will be labeled with the resident's name, room number and dated by staff with the current date the items are brought into the facility. Food or beverage items may be stored in the resident designated pantries, refrigerators or freezers. All cooked or prepared food brought in for a resident and stored in the resident designated pantries, refrigerators or freezes will be dated when accepted for storage and discarded after 72 hours/3 days.