STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056153	A. BUILDING _____ B. WING _____	03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NAPA POST ACUTE	**705 TRANCAS ST. NAPA, CA 94558**

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during a Recertification Survey conducted from March 3, 2025 to March 7, 2025. The facility was found to be not in compliance with 42 CFR 483.5-483.75 - Subpart B - Requirements for Long Term Care Facilities. Representing the California Department of Public Health: Surveyor: 37683, Health Facility Surveyor Surveyor: 45645, Health Facility Surveyor Surveyor: 46194, Health Facility Surveyor, and Surveyor: 51680, Health Facility Surveyor. The facility census was 116.	F 000		
F 577 SS=F	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with	F 577	**How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** No residents were affected by the deficient practice. Within 5 minutes the survey binder was located and put in the correct position. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents have the potential to be affected by the deficient practice. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:**	POC & EOC approved 4/14/25 BIC 3/28/25 Anna-Marie De Jesus

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Abigail Castro Abigail Castro	Director of Nursing	3/31/2025

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.

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F 577	Continued From page 1 respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and facility policy review, the facility failed to ensure the most recent survey results were readily accessible for all residents to review. This deficient practice had the potential to affect all residents who resided in the facility. Findings included: A facility policy titled, "Examination of Survey Results," revised 04/2017, indicated, "2. A copy of the most recent survey report and any plans of correction are kept in a binder in the residents' dayroom." During observations on 03/05/2025 beginning at 8:15 AM of readily accessible areas to residents, the state survey results could not be found in the facility. During an interview on 03/05/2025 at 8:24 AM, the Activities Director revealed she did not know where the survey results were posted. She stated she did not know the survey results were required to be available without asking. During an interview on 03/05/2025 at 9:40 AM, the Social Services Director (SSD) stated the	F 577	Once we were notified that the survey binder was missing, it was located within two minutes and returned to the front desk of the facility. The survey binder had only been away from the front for less than 24 hours. It was temporarily taken to the copier for updates following a deficiency received through RSS on February 28th. During the rush of the survey, the facility inadvertently forgot to place it back at the front. To prevent recurrence of this issue, we have placed a laminated sign that reads “DO NOT REMOVE SURVEY BINDER FROM TABLE FOR ANY REASON.” In instances where the survey binder needs updating, staff will ensure it is promptly returned to the front desk. In addition, the facility educated all staff in-service on 3/28/25 educating where the survey binder is located and the importance of residents and resident’s family having access to these results. **How the facility plans to monitor its performance to make sure that solutions are sustained:** For the next three months, the Activities Director will conduct a weekly audit to ensure that the survey binder is consistently located on the front table by the entrance of the building. Additionally, these audit findings will be discussed during monthly Quality Assurance and Performance Improvement (QAPI) meetings to ensure ongoing accountability and improvements are made as necessary.	

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F 577	Continued From page 2 survey binder was on the table near the building's entrance. She said she last saw the survey binder when the state surveyors were at the facility, which was about three weeks prior. During an interview on 03/05/2025 at 9:50 AM, the Administrator stated he did not know where the survey binder was, but it was supposed to be on the table across from the conference room. During an interview on 03/05/2025 at 10:26 AM, the Director of Nursing (DON) stated she took the survey results binder on Monday (03/03/2025) to add the most recent survey and she had forgotten to return it. She confirmed that the survey results binder had not been in its usual location for that week, and she further confirmed that the survey results binder was supposed to be available without having to ask. During an interview on 03/07/2025 at 10:56 AM, the Administrator stated the survey results binder should be available for all residents. During an interview on 03/07/2025 at 11:31 AM, the DON stated the survey results binder was supposed to be posted in the lobby for residents to access.	F 577	**Include dates when corrective actions will be completed:** All corrective actions will be completed by March 28, 2025.	
F 585 SS=F	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been	F 585	**How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** No residents were affected by the deficient practice. We have promptly implemented corrective actions for all residents in the facility to enhance the grievance process.	

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F 585	Continued From page 3 furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;	F 585	This includes: Increased Access to Grievance Forms: Grievance forms are now readily available in public areas, allowing both residents and family members to easily access and submit their concerns anonymously. Placement of Grievance Forms: The forms are strategically posted at the reception desk, in front of the activities room, and at the East Social Service office for maximum visibility. Secure Grievance Submission: A locked grievance box has been installed at both the East and West Nurses stations, ensuring confidentiality. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents have the potential to be affected by this deficient practice. **How the facility plans to monitor its performance to make sure that solutions are sustained:** To ensure that the identified deficiencies do not recur, the facility will implement the following systemic changes: Enhanced Accessibility to Grievance Forms: Grievance forms are now readily	

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F 585	Continued From page 4 (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement	F 585	available in public areas, ensuring both residents and family members can easily access them. Strategic Placement: Grievance forms have been posted in visible locations, including the reception desk, the activities room, and the East Social Service office, to facilitate convenient access. Secure Submission Process: Locked grievance boxes have been installed at both the East and West Nurses stations, ensuring that grievances can be submitted confidentially. Education of Staff: The Social Services and Activities Departments have been reeducated on 3/7/25 and 3/19/25 on residents' rights to file grievances anonymously, reinforcing the importance of this practice in supporting resident empowerment. Communication: The locations of the grievance forms and locked boxes were clearly communicated during the resident council meeting, ensuring that all residents are aware of how to voice their concerns. These measures aim to create a transparent and effective grievance process that empowers residents and their families, ultimately contributing to ongoing quality improvement within the facility.	

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F 585	Continued From page 5 Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and facility policy review, the facility failed to protect the rights of residents and their representatives to have the ability to file grievances anonymously. This deficient practice had the potential to affect all residents who resided in the facility. Findings included: A facility policy titled, "Grievances / Complaints, Filing," dated 2001, indicated, "5. Grievances and/or complaints may be submitted orally or in writing, and may be filed anonymously." An undated facility "Grievance Process," indicated, "Grievance forms are available for the individual and/or their family members to complete independently and/or with employee assistance. Forms can be obtained by contacting the executive director, director of nursing services, social services director and other department heads, or they can be obtained from the nurses' station." A sign posted in the facility indicated that the Grievance Officer was Social Worker (SW) #16. During an observation on 03/05/2025 at 8:15 AM, there were no grievance forms available for	F 585	**What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** The grievance form clipboards and locked grievance boxes are monitored Monday-Friday by the social service director throughout the week to ensure that forms remain available and that any grievances submitted are promptly received and processed. Furthermore, the facility will implement a monthly review of the grievance logs as part of its Quality Assurance and Performance Improvement (QAPI) program. This proactive approach will help to ensure that the grievance management systems are functioning effectively and efficiently. **Include dates when corrective actions will be completed:** 3/24/2025	

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F 585	Continued From page 6	F 585		

public use. There was no way to take a grievance form anonymously to fill out and submit.

During an interview on 03/05/2025 at 2:08 PM, SW #16 confirmed she was the grievance official and had been for the past two months. She stated it was facility practice for a resident to either tell staff or her if they wished to file a grievance. She stated that the residents could also call the Ombudsman. SW #16 stated the grievance forms were stored in the front and back social services offices, and they could not be obtained without asking social services staff. SW #16 stated that there was a grievance binder located behind the nurses' station with grievance forms, but residents would have to ask nursing staff for access to those forms. She stated the grievance forms were not kept in public areas for anonymous use. She stated that the grievance official could not address a grievance without knowing who made the grievance. She stated that she could keep grievances confidential, but she needed to know who made the grievance to investigate it.

During an observation on 03/05/2025 at 2:20 PM, a grievance binder with grievance forms on the East Hall nurses' station was on a rack with resident charts behind the nursing station. SW #16 confirmed the observation and confirmed that any resident who wished to fill out one of the grievance forms at the nurses' station would have to ask staff for assistance to obtain the grievance form.

During an observation on 03/05/2025 at 2:26 PM, a grievance binder with grievance forms on the West Hall nurses' station was behind the nursing

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F 585	Continued From page 7 station in a cabinet with the door shut. During an interview on 03/07/2025 at 10:56 AM, the Administrator stated that there should be an option for residents and their families to file grievances anonymously. During an interview on 03/07/2025 at 11:31 AM, the Director of Nursing (DON) stated that residents should be able to file grievances anonymously.	F 585		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to ensure Minimum Data Set (MDS) assessments accurately reflected the status of 3 (Residents #107, #106, and #61) of 29 sampled residents reviewed for MDS accuracy. Specifically, the MDS assessments inaccurately reflected Resident #107 was discharged to a hospital; Resident #106 was discharged to home/community, and Resident #61 did not use a wander/elopement alarm. Findings included: A facility policy titled, "Certifying Accuracy of the Resident Assessment," revised 11/2019, indicated, "Any person completing a portion of the Minimum Data Set/MDS (Resident Assessment Instrument) must sign and certify the	F 641	**How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The MDS coding for Resident #107 has been corrected to accurately reflect that the resident discharged home from the facility on 3/07/25. The MDS updated coding for Resident #106 3/07/25 to correctly indicate the resident discharged to a hospital . The MDS coding for Resident #61 has been revised 3/07/25 to ensure accurate documentation of the WanderGuard assessments. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents may potentially be impacted by this deficient practice.	

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F 641	Continued From page 8 accuracy of that portion of the assessment." The policy also indicated, "3. The information captured on the assessment reflects the status of the resident during the observation ("look-back") period for that assessment." 1. An "Admission Record" indicated the facility originally admitted Resident #107 on 05/29/2024, readmitted the resident on 11/18/2024, and discharged the resident on 12/06/2024. According to the Admission Record, the resident had a medical history that included a diagnosis of traumatic subdural hemorrhage. A discharge return not anticipated MDS, with an Assessment Reference Date (ARD) of 12/06/2024, indicated Resident #107 was discharged to a short-term general hospital. Resident #107's "Post-Discharge Plan of Care," effective 12/03/2024, indicated a discharge status of home/community. The Post-Discharge Plan of Care indicated the reason for discharge was Resident #107 no longer required skilled services and was discharged home with a referral for home health services. During an interview on 03/07/2025 at 10:00 AM, MDS Nurse #1 revealed Resident #107 was discharged home with home health and the discharge MDS was coded incorrectly. During an interview on 03/07/2025 at 11:17 AM, the Director of Nursing (DON) stated the MDSs needed to be comprehensive and accurate. The DON stated Resident #107 was discharged home, and the discharge MDS was inaccurate.	F 641	MDS Regional completed the review on 3/7- 3/10/25 of all residents who had discharged assessment completed the last 90 days for accuracy to ensure that assessments reflect the correct discharged status, and no residents' assessments were identified with the same deficient practice. RAI specialist completed the review on 3/26/25 of MDS assessments of all the resident currently that has Wanderguard order; to verify coding accuracy of Wanderguard on section P and no other resident's assessment were identified with incorrect coding. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** On March 19, 2025, an informative in-service training session was conducted specifically for the two MDS nurses at the facility. The primary objective of this in-service was to provide comprehensive reeducation on the critical importance of accurately coding Minimum Data Set (MDS) assessments. This training emphasized how precise MDS coding can significantly affect the quality of patient care and overall healthcare outcomes for residents. Lead MDS Nurse will cross check all MDS completed to ensure accuracy of coding before letting the MDS regional	

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F 641	Continued From page 9 During an interview on 03/07/2025 at 11:55 AM, the Administrator stated the expectation was for MDSs to be accurate. The Administrator stated Resident #107 was discharged home, and the discharge MDS was inaccurate. 2. An "Admission Record" revealed the facility admitted Resident #106 on 11/23/2024. According to the Admission Record, the resident had a medical history that included diagnoses of acute on chronic diastolic congestive heart failure, presence of a cardiac pacemaker, and dependence on supplement oxygen. A physician's telephone order, dated 12/16/2024, indicated Resident #106 was to be sent to a hospital. Resident #106's "Progress Notes," dated 12/16/2024, revealed Resident #106 was having a hard time breathing, the medical doctor was informed and agreed to send the resident to the hospital. The Progress Notes revealed the resident left the facility at approximately 6:18 PM. A discharge return anticipated MDS, with an Assessment Reference Date (ARD) of 12/16/2024, revealed Resident #106's discharge status as to home/community. The MDS indicated Licensed Vocational Nurse (LVN) Manager #2 signed the discharge MDS on 12/26/2024 indicating the completion and accuracy of the discharge status section. On 03/04/2025 at 2:42 PM, MDS Nurse #1 stated Resident #106 was discharged to the hospital and the MDS was inaccurate. MDS Nurse #1 stated the MDS should be accurate including the resident's discharge location.	F 641	know for 2nd review and signing of the MDS for completion and accuracy. The Regional Resident Assessment Instrument (RAI) Specialist, and MDS Coordinator developed a quarterly training program for the facility MDS Coordinators that complete MDS's for coding accuracy. RAI Specialist will complete a monthly MDS audit for accuracy to ensure compliance and resident condition accurately captured on each MDS assessments, result will be sent to the facility MDS, Admin and DON. Any inaccuracies/coding error will be discussed with the MDS and follow up training will be schedule as needed. Ongoing training sessions will be organized for MDS nurses and relevant staff to reinforce best practices in coding, ensuring they stay updated on any changes in regulations or procedures. This commitment to continuous education will help maintain high standards of coding practice. **How the facility plans to monitor its performance to make sure that solutions are sustained:** QAPI will review monthly audits performed by Reginal RAI specialist for accuracy/completion and thoroughness.	

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F 641	Continued From page 10 On 03/05/2025 at 3:00 PM, LVN Manager #2 stated they completed the discharge MDS for Resident #106, and the resident discharged to the hospital. LVN Manager #2 stated it was an error. On 03/05/2025 at 9:01 AM, the Director of Nursing (DON) stated her expectation was that the MDS was as accurate as possible. On 03/07/2025 at 8:40 AM, the Administrator stated the expectation was for the MDS to be accurate and reflective of the resident's condition while at the facility and at discharge. 3. An "Admission Record" indicated the facility admitted Resident #61 on 11/09/2021. According to the Admission Record, the resident had a medical history that included diagnoses of hemiplegia and hemiparesis (partial paralysis) following cerebral infarction (stroke) affecting the right dominant side, difficulty in walking, schizophrenia, psychotic disorder with delusions, anxiety disorder, unspecified epilepsy, and type 2 diabetes mellitus without complications. Resident #61's quarterly MDSs, with Assessment Reference Dates (ARDs) of 07/30/2024, 10/28/2024, and 01/27/2025, did not indicate the resident used a wander/elopement alarm. Resident #61's "Care Plan Report" included a focus area initiated on 03/04/2023, that indicated the resident was at risk for elopement/exit seeking. Interventions directed staff to keep the resident's picture in the elopement book (initiated 03/04/2023) and check for placement and function of the WanderGuard device (departure	F 641	**Include dates when corrective actions will be completed:** March 19, 2025	

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F 641	Continued From page 11	F 641		

alert system) attached to the lower part of the resident's wheelchair (initiated 04/30/2024 and revised 01/20/2025).

Resident #61's "Order Details," dated 04/30/2024, revealed an order for a WanderGuard device to be attached to the back of the resident's wheelchair with instructions for staff to check for placement and function every shift. The Order Details revealed the order expiration date was 02/03/2025.

Resident #61's "Order Details," dated 01/03/2025, revealed an order for a WanderGuard device to be attached on the lower part of the resident's wheelchair with instructions for staff to check placement and function every shift. The Order Details revealed the order expiration date was 02/03/2025.

Resident #61's "Order Details," dated 01/20/2025, revealed an order for a WanderGuard device to be attached to the lower part of the resident's wheelchair with instructions for staff to check for function every night shift. The Order Details revealed the order expiration date was 06/09/2025.

Resident #61's "Order Summary Report," with active orders as of 03/04/2025, revealed an order dated 01/20/2025 for a WanderGuard device to be attached to the lower part of the wheelchair with instructions for staff to check for function every night shift.

On 03/04/2025 at 2:37 PM, MDS Nurse #1 stated Resident #61 had an order for a WanderGuard device, and it was not coded on three quarterly

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F 641	Continued From page 12 assessments. On 03/05/2025 at 9:01 AM, the Director of Nursing (DON) stated Resident #61 had alarms (WanderGuard device), and it was not coded on two or three assessments. The DON stated her expectation was that the MDS was as accurate as possible. On 03/07/2025 at 8:40 AM, the Administrator stated the expectation was for the MDS to be accurate and reflective of the resident's condition while at the facility.	F 641		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State	F 645	**How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The Pre-Admission Screening and Resident Review (PASRR) for Resident #64 was promptly reviewed and updated. Upon further examination, it was determined that a correction was necessary, and a revised PASRR was resubmitted on March 5, 2025. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents within the facility have the potential to be affected by the deficient practice. Medical Records did a facility wide audit of current residents' PASRR for accuracy on 3/21/25 and no additional deficient practice was noted.	

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F 645	Continued From page 13 intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).	F 645	**What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** A thorough audit of residents' PASSR was conducted by medical records to identify individuals who may have experienced any adverse effects on 3/21/2025, no additional issues were found. on 3/19/2025 an in-service was given by the Director of Nursing to all those involved in the PASRR screening process, this included the medical records team, nursing management team, and admissions team. The purpose of this in-service was reeducated those involved on the process and importance of PASRR screening about patient care and facility protocol. To ensure compliance with regulations, the facility will implement a system-wide change to improve the review process for all Pre-Admission Screening and Resident Review (PASRR) assessments. Going forward, the clinical team, including nurses, MDS, and other relevant healthcare professionals, will conduct a thorough review of the PASRR assessment upon each resident's admission to the facility. This review will verify that each resident's needs, including any mental health or specialized care requirements, are accurately identified and addressed in their individualized care plan.	

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F 645	Continued From page 14 (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to ensure a resident's admission Pre-Admission Screening and Resident Review (PASRR) accurately captured an admission diagnosis of a serious mental illness (SMI) for 1 (Resident #64) of 2 residents reviewed for PASRR. Specifically, Resident #64's admission PASRR did not capture their admission diagnosis of unspecified psychosis. Findings included: A facility policy titled, "Pre-Admission Screening and Resident Review," revised 12/2016, revealed, "a. The facility will participate in or complete the Level I screen for all potential admissions regardless of payer source to determine if the individual meets the criterion for mental disorder (SMI/SMD), intellectual disability (ID) or related condition." An "Admission Record" revealed the facility admitted Resident #64 on 11/01/2024. According to the Admission Record, the resident had a medical history that included a diagnosis of unspecified psychosis (onset date 11/01/2024). Resident #64's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/06/2025, revealed the resident had a	F 645	**How the facility plans to monitor its performance to make sure that solutions are sustained:** Upon admission, the admissions team will verify that a Pre-Admission Screening and Resident Review (PASRR) has been received, preferably via file exchange or, if necessary, as a paper copy. In cases where follow-up is required for file exchange completion, the clinical team will notify the hospital for review or new PASRR. As part of the verification process, the clinical team immediately reviews the PASRR and checks for accuracy. A secondary screening will be performed before the PASRR is officially uploaded to the patient's chart by the medical records team. Additionally, the medical records department will review the PASRR for accuracy to ensure compliance with regulatory requirements. Furthermore, the unit manager will reassess any PASRRs requiring follow-up, with all follow-up actions being systematically tracked through the Interdisciplinary Plan of Care (IPOC) by medical records. To maintain accountability and ensure accuracy, the medical records department will conduct regular audits of PASRR. Additionally, when the facility does the resident review for new admits, if an inaccuracy is noted we will create a new PASRR/resident review assessment to ensure the residents' PASSR is accurate according to the residents' needs.	

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F 645	Continued From page 15 Brief Interview for Mental Status (BIMS) score of 6, which indicated the resident had severe cognitive impairment. Resident #64's "Preadmission Screening and Resident Review (PASRR) Level I Screening," dated 10/15/2024, indicated the resident did not have a SMI. During an interview on 03/05/2025 at 2:50 PM, Registered Nurse (RN) #13 stated the PASRR process started on admission. RN #13 stated for an admission diagnosis that was not captured on the PASRR, the facility would have sent the PASRR back to the hospital so it could be completed correctly. During an interview on 03/06/2025 at 10:12 AM, the Director of Nursing (DON) stated that if a resident had a diagnosis of an SMI that was not captured by their PASRR, the facility should do another resident review. During an interview on 03/07/2025 at 11:31 AM, the DON stated that Resident #64's PASRR was resubmitted on 03/05/2025 because the surveyor brought it to their attention during the survey process. Resident #64's "Preadmission Screening and Resident Review (PASRR) Level I Screening," dated 03/05/2025, indicated the resident had an SMI of unspecified psychosis.	F 645	This process will be monitored by and reported to our Quality Assurance and Performance Improvement (QAPI) monthly meeting. This will stay on our QAPI for 90 days/and or 3 QAPI meetings. **Include dates when corrective actions will be completed:** March 21st, 2025	
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a	F 688	**How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident #28 was evaluated by the	

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F 688	Continued From page 16 resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to ensure residents with limited range of motion (ROM) received care and services to prevent any further decrease in ROM for 1 (Resident #28) of 2 residents reviewed for rehabilitation and restorative services. Specifically, Resident #28 had an order for staff to ask rehabilitation services to perform passive ROM, but there was no documentation that this order had been completed. Findings included: A facility policy titled, "Restorative Nursing Services," indicated, "1. Restorative nursing care consists of nursing interventions that may or may not be accompanied by formalized rehabilitative services (e.g. [exempli gratia, for example],	F 688	therapy staff on 3/6/2025 and RNA program 3x a week or as tolerated for BUE/BLE PROM was started on 3/7/2025. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** A comprehensive review of all residents' records performed by the Director of Nursing was started on 3/11/2025 to identify individuals with similar orders for restorative care that have not been followed. No other resident identified with the same findings/ deficient practice. A weekly audit of MDS assessments and therapy orders will be implemented for all residents to ensure that any unaddressed restorative needs are promptly identified, and actions are taken. Affected residents will receive the necessary restorative interventions as determined by their care plans. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** On 3/21/2025, The Director of Nursing Services in serviced the Licensed nursing staff to enhanced communication protocols between nursing and therapy	

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F 688	Continued From page 17 physical, occupational or speech therapies). 2. Residents may be started on a restorative nursing program upon admission, during the course of stay or when discharged from rehabilitative care." An "Admission Record" revealed the facility admitted Resident #28 on 03/04/2017. According to the Admission Record, the resident had a medical history that included diagnoses of morbid obesity, unspecified joint contracture, rheumatoid arthritis, and difficulty in walking. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/03/2025, revealed Resident #28 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. According to the MDS, the resident had impairment in their functional limitation in range of motion on both lower extremities. Resident #28's "[Facility Name] Order Recap [Recapitulation] Report" revealed an order dated 10/28/2024, that indicated, "Ask rehab [rehabilitation] to do passive ROM." Further review revealed the order was written by the Medical Director. Resident #28's "Rehab - Joint Mobility Screen," dated 01/29/2025, revealed the resident had severe impairment in their left and right shoulder, elbow, wrist, hand, hip, knee, and ankle. During an interview on 03/03/2025 at 11:00 AM, Resident #28 stated they would like therapy to help them pivot and stand. Resident #28 stated that the doctor had agreed and ordered therapy,	F 688	departments to ensure that all restorative therapy orders are communicated to therapy department. Medical Record will do a daily audit for orders established to review therapy orders and restorative care compliance. This will allow the nursing manager to verify if communication was sent to therapy department. Any gaps in this communication will be flagged immediately and nursing will follow up with therapy to ensure orders are seen and acted upon. **How the facility plans to monitor its performance to make sure that solutions are sustained:** The Director of Nursing with the IDT will implement monthly reviews/monthly recaps of restorative care compliance, which will include tracking the timely execution of therapy orders and resident feedback on the effectiveness of interventions. Outcomes related to restorative nursing services will be discussed in monthly Quality Assurance and Performance Improvement (QAPI) meetings to ensure ongoing accountability and improvement. A designated staff member will be assigned to oversee the restorative nursing program and oversee continuous monitoring for adherence to policies and procedures.	

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F 688	Continued From page 18 but they had not heard further about it. Resident #28 stated they requested therapy several times including a week and a half ago. During an interview on 03/06/2025 at 10:58 AM, Physical Therapy Assistant (PTA) #17 stated that the last documented visit they had with Resident #28 was in 2023. PTA #17 stated an order for rehabilitative ROM would be a restorative nursing aide (RNA) intervention, so nursing staff would be the staff to ask. PTA #17 stated the last documentation of restorative care for Resident #28 was in 2022. During an interview on 03/06/2025 at 11:11 AM, Resident #28 stated that RNAs had not been coming in to provide ROM care, nor had any other nursing staff. During an interview on 03/06/2025 at 11:14 AM, the Director of Staff Development and Human Resources (DSDHR) confirmed that she ran the restorative program. She stated that Resident #28 was not receiving restorative therapy. The DSDHR stated she was not aware of any order for restorative care. She stated that when nursing staff saw the order, they should have asked the therapy department if they could do passive ROM. She stated then the therapy department could put in an order for restorative care, and she would see that order and begin restorative care. The DSDHR stated that she did not know how that order slipped through, but there was no record that the order was being carried out. During an interview on 03/07/2025 at 11:31 AM, the Director of Nursing (DON) stated that if the doctor ordered rehabilitation services or therapy,	F 688	**nclude dates when corrective actions will be completed:** March 21st, 2025	

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F 688	Continued From page 19 staff should communicate that to the therapy department and/or restorative staff. During an interview on 03/07/2025 at 1:19 PM, the Medical Director stated passive ROM would definitely benefit the resident to prevent further contractures. The Medical Director then stated that passive ROM might not do anything, but might help. During an interview on 03/07/2025 at 1:53 PM, Certified Nursing Aide (CNA) #18 stated she had worked at the facility since July 2024. She stated that she worked with Resident #28 every day she was at the facility. CNA #18 stated that while she had done some passive ROM with the resident during transfers and showers, it was not an everyday occurrence. She stated that she did not know there was an order regarding passive ROM.	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to ensure a resident was safe from eloping from the facility for 1 (Resident #61) of 2 residents reviewed for elopements. Specifically, Resident	F 689	**How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** On 3/05/2025 Facility moved WanderGuard on resident #61's metal part of the wheelchair to the back of the wheelchair away from metal/anything which could interfere with the function of the system. Wanderguard is secured and not easily movable. Wanderguard is also visible to the staff for the licensed nurses to do placement and function checking. On 3/03/2025, maintenance switched the lock on the supply closet and converted the lock to auto lock. This makes ensures	

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F 689	Continued From page 20 #61 eloped from the facility on 02/25/2025 and was found in a parking lot approximately one block away from the facility. At the time of the elopement Resident #61 was utilizing a WanderGuard device (departure alert system); however, the WanderGuard device was not applied in accordance with manufacturer's instructions. Additionally, the facility failed to ensure 1 of 1 supply closet observed containing medical supplies was locked and inaccessible to residents. Findings included: 1. A facility policy titled, "Wandering and Elopements," revised 03/2019, specified, "2. If a resident is missing, initiated the elopement/missing resident emergency procedure:" which included, "c. if the resident is not located, notify the administrator and the director of nursing services, the resident's legal representative, the attending physician, law enforcement officials, and (as necessary) volunteer agencies (i.e. [id est, that is] emergency management, rescue squads, etc. [et cetera; and so forth]." A "WanderGuard User instructions" manual, dated 2023, revealed a "WARNING" box that indicated, "Do not place the signaling device on or next to metal, such as wheelchair frames, jewelry, watches, etc. or allow it to come in contact with a door or associated hardware such as crash-bars, push-bars etc. Metal could interfere with the signal sent to the door modules." An "Admission Record" indicated the facility	F 689	that the door will have to be unlocked every time it is opened. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential do be affected by the deficient practice of the storage of the supply closet. All Resident exhibiting behaviors associated with elopement or wandering have the potential to be affected by the deficient practice. All resident exhibiting behaviors associated with elopement or wandering have been identified through a facility-wide assessment conducted on March 19, 2025. No other issues were found with placement of the WanderGuard. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** All resident exhibiting behaviors associated with elopement or wandering have been identified through a facility-wide assessment conducted on March 19, 2025. All relevant care plans have been reviewed and adjusted to incorporate necessary interventions aimed at reducing elopement risks for these residents and	

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F 689	Continued From page 21 admitted Resident #61 on 11/09/2021. According to the Admission Record, the resident had a medical history that included diagnoses of hemiplegia and hemiparesis (partial paralysis) following cerebral infarction (stroke) affecting the right dominant side, difficulty in walking, schizophrenia, psychotic disorder with delusions, anxiety disorder, unspecified epilepsy, and type 2 diabetes mellitus without complications. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/27/2025, revealed Resident #61 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severe cognitive impairment. The MDS revealed the resident wandered four to six days during the assessment's seven-day lookback period. The MDS revealed the resident used a wheelchair for mobility during the assessment's seven-day lookback period. The MDS revealed the resident was independent with all areas of activities of daily living except for showering/bathing where they required partial/moderate assistance from staff. Resident #61's "Care Plan Report" included a focus area initiated on 03/04/2023, that indicated the resident was at risk for elopement/exit seeking. Interventions directed staff to keep the resident's picture in the elopement book and check for placement and function of the WanderGuard device attached to the lower part of the resident's wheelchair. Resident #61's "Order Summary Report," with active orders as of 03/04/2025, revealed an order dated 01/20/2025 for a WanderGuard device to	F 689	ensuring WanderGuard is in proper placement. An in-service training and competency check related to the proper use and placement of WanderGuard devices has been conducted for all Licensed Nurses from March 4, 2025, to March 21, 2025. A facility-wide in-service for all nursing staff has been initiated from March 12, 2025, to March 28, 2025, to review elopement procedures and reinforce adherence to protocols. An in-service was done on 3/19/25 reeducating nurses on the importance of ensuring the supply closet stays locked when not in use. Additionally, a systemic change has been implemented requiring competency checks for all new hires as well as annual assessments for Licensed Nurses to ensure their understanding and ability to handle elopement concerns effectively. **How the facility plans to monitor its performance to make sure that solutions are sustained:** Competencies will be reviewed by the Director of Staff Developement annually and upon hire on elopement prevention protocols and the effectiveness of WanderGuard device functioning and storage of medication/ensuring locked doors.	

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F 689	Continued From page 22 be attached to the lower part of the resident's wheelchair with instructions for staff to check for function every night shift. Resident #61's "06. Nursing- Elopement and Wandering Risk Observation/Assessment - V 1.0," dated 01/23/2025, indicated the resident had exhibited unsafe wandering or had made one or more attempts to elope prior to admission or in the past year. The assessment revealed the resident exhibited unsafe wandering or elopement attempts and was difficult to redirect. The assessment revealed that based on the assessment findings a "wander alarm" was indicated. Resident #61's "Progress Notes," dated 02/25/2025 at 8:20 AM, revealed the Social Service Director was notified that the resident was last seen at 6:00 AM that morning. The Progress Notes revealed staff searched the rooms, parking lot, and surrounding grounds. Per the Progress Notes, staff left the facility via their personal vehicles and began a two-mile radius search. The Progress Notes revealed that the resident was found and brough back to the facility. Resident #61's "Progress Notes," dated 02/25/2025 at 2:11 PM, indicated that around 6:40 AM, a certified nursing assistant (CNA) reported to a nurse that the resident was missing. The Progress Notes indicated the resident was last seen at 6:00 AM in front of their room door. The Progress Notes revealed staff tried to find the resident inside and outside the facility. The Progress Notes revealed the staff notified the Director of Nursing (DON), Administrator,	F 689	All training sessions and competency checks will be documented and return demonstration will be done to verify understanding of the device and elopement protocol. We will bring forth all education done for new hires and annual competencies to our monthly Quality Assurance and Performance Improvement (QAPI) meetings to ensure continuous monitoring and improvement. This will stay in place for at least 90 days/3 QAPI meetings. Elopement drill will be done on different shift twice a month for the next 3 months by the Director of Staff Developement and any findings will be reported to QAPI. Nursing management will do twice a month audit for the next three months of medication storage areas to ensure they are all locked according to our policy and procedure. **5. Include dates when corrective actions will be completed:** March 28, 2025	

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medical doctor, the resident's emergency contact, and the police. The Progress Notes indicated staff found Resident #61 one block away from the facility.

An "Incident Summary Report," dated 02/26/2025, revealed that on 02/25/2025 Resident #61 left the facility "around 6:45 AM through the front door." The report revealed the front door had a functioning WanderGuard alarm, but it did not alarm during the incident. The report revealed the resident was found a block away from the facility "roughly an hour later." Per the report, when the resident was found, there were no signs of injury or distress. The report revealed that when the resident returned to the facility staff checked the WanderGuard device at all exits and confirmed that it was working.

During a telephone interview on 03/04/2025 at 10:42 AM, with the aid of a translator, Family Member (FM) #12, Resident #61's FM, stated the facility called to notify them Resident #61 was missing (on 02/25/2025), and they were told the staff did not hear the alarm.

On 03/04/2025 at 1:07 PM, CNA #10 stated that (on 02/25/2025) he completed his rounds and did not see Resident #61. He stated that he asked Licensed Vocational Nurse (LVN) #8 if he had seen the resident. He stated he went outside and did not find the resident. He stated he asked staff on the other side of the facility (if they had seen the resident) and came back to ask LVN #8 again, and LVN #8 did not know. CNA #10 stated he went outside and checked the smoking area. CNA #10 stated that when the morning nurse, LVN #4, had taken over, he told LVN #4 that

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Resident #61 was missing. Per CNA #10, LVN #4 was the only staff member who took the time to help him look for the resident. He stated that Resident #61's WanderGuard device was on the right wheel of their wheelchair. CNA #10 stated that the resident had a history of wandering and exit-seeking, and there had been multiple occasions when he found the resident in the parking lot by the time he could respond to the WanderGuard alarm.

On 03/05/2025 at 8:21 AM, LVN #4 stated that (on 02/25/2025) CNA #10 noticed that Resident #61 was not in their room, so they looked for the resident inside the facility. She stated they could not find the resident, so they called the Infection Preventionist (IP) and a nurse manager and started looking outside the facility. LVN #4 stated she got in her car and drove around looking for the resident. Per LVN #4, the resident was found one block away, and when the resident returned to the facility, she completed a skin assessment and took their vital signs. She stated that Resident #61 wandered a lot and their WanderGuard device was placed on their wheelchair because the resident became agitated and would remove it if they put it on them. She stated that when the resident would get close to any of the doors, they could hear the alarm through the halls.

On 03/04/2025 at 11:50 AM, the IP stated that (on 02/25/2025) at 6:45 AM he received a call from the DON and was informed that they had a missing person, and they needed him to drive around the vicinity. He stated that he picked up RN #20 and they found Resident #61 in a parking lot near a housing complex. He stated the

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F 689	Continued From page 25 resident was in a wheelchair sitting with their legs crossed and they called for transportation. On 03/04/2025 at 11:28 AM, Registered Nurse (RN) #20 stated that she did not see Resident #61 that morning (02/25/2025) but was told by a nurse that they were missing. RN #20 stated the nurse asked for help in locating the resident. RN #20 stated that (before the resident eloped on 02/25/2025) the last time the resident had been seen was by the night nurse during morning medication. She stated that they checked the common room and surrounding area of the facility; when they could not find the resident, they notified social services, the Administrator, and the DON. She stated they walked around outside, but it was too cold, so they returned to the facility, got in a car, and drove around. She stated she was with the IP when they found Resident #61 near an apartment. RN #20 stated the resident was sitting in their wheelchair with their legs and armes crossed. She stated she assessed Resident #61 and noted that they did not appear to be in distress; however, there was a language barrier, and they used the assistance of a language line to communicate with the resident. She stated the resident was wearing a shirt, jacket, long pants, and shoes when they were found. RN #20 stated she called the facility driver to bring the van so that they could transport the resident back to the facility. She stated that upon returning, they checked the resident's vital signs, completed a head-to-toe assessment to rule out any injuries, and provided the resident with blankets. She stated that the medical doctor was notified. Per RN #20, Resident #61's WanderGuard device was located on their wheelchair on that day (02/25/2025).	F 689		

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F 689	Continued From page 26 On 03/04/2025 at 12:50 PM, LVN #8 stated (on 02/25/2025) Resident #61 was last seen close to 6:00 AM, when the resident was administered 6:00 AM medication. LVN #8 stated a CNA reported Resident #61 was missing. LVN #8 stated he could not recall the location of Resident #61's WanderGuard device. He acknowledged that he signed Resident #61's Medication Administration Record (MAR) (on 02/25/2025), indicating he had verified the function of the WanderGuard device; however, he admitted he did not know how to check its functionality. He stated that the facility provided education (on how to check the function of the WanderGuard device), but he did not attend and did not know how to check the function of the WanderGuard device. Resident #61's February 2025 "Medication Administration Record," revealed, LVN #8 signed verifying function of the WanderGuard device on 02/25/2025. On 03/04/2025 at 11:21 AM, the Administrator stated that (on 02/25/2025) the WanderGuard device had malfunctioned, and he believed that (before the resident eloped on 02/25/2025) the last place Resident #61 was seen was near the front entrance. The Administrator stated that when the resident returned to the facility the WanderGuard device worked so they did not have to replace it. On 03/04/2025 at 11:39 AM, the DON stated the facility was not able to identify which exit door Resident #61 used and was not sure of the exact time the resident was last seen by staff (on	F 689		

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F 689	Continued From page 27 02/25/2025). During an interview on 03/04/2025 at 10:07 AM, Social Worker (SW) #16 stated Resident #61 used a wheelchair for locomotion. She stated she arrived at work (on 02/25/2025) at around 6:30 AM and was notified that Resident #61 was not in their room. She stated that they began searching the rooms and the area outside for the resident. SW #16 stated Resident #61 was in a parking lot of another facility that was a block away, approximately 0.3 miles. She stated that when the resident returned to the facility, she checked on them; however, she did not complete any psychosocial assessments; she only ensured that the resident contacted their family. She stated that Resident #61 would frequently go out to the parking lot. She stated the resident's WanderGuard device would alert staff, who would then bring them back into the facility. SW #16 revealed that she previously had to retrieve the resident from the parking lot and brought them back to the facility. She stated she did not document Resident #61's elopements but should have. She stated she informed the nurse (when the resident eloped); however, she stated that she would not report all instances (of the resident eloping). SW #16 stated that she did not have a system that tracked the elopements and would not be able to provide dates for Resident #61's elopements. An observation on 03/04/2025 at 8:04 AM revealed Resident #61 was in bed with their wheelchair nearby. The residents WanderGuard device was attached to the right wheel of their wheelchair.	F 689		

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F 689	Continued From page 28 An observation on 03/05/2025 at 11:13 AM revealed Resident #61's WanderGuard device was located on the metal part of their wheelchair. On 03/05/2025 at 11:48 AM, the Maintenance Assistant stated the WanderGuard device was usually attached to a resident's arm or leg. He stated that it might be possible to attach the WanderGuard device to a resident's wheelchair, but that they should follow the manufacturer's guidelines. The Maintenance Assistant stated that failing to adhere to these guidelines could result in residents leaving the facility unnoticed by the staff. On 03/05/2025 at 11:49 AM, Medical Director (MD) stated that he was unsure why they decided to affix the WanderGuard device to Resident #61's wheelchair, but that it was probably because it was less intrusive. The MD stated that the manufacturer guidelines should have been followed with regards to minimizing possible harm to the resident. The MD stated he was unsure if affixing the WanderGuard device to metal violated the manufacturers guidelines. On 03/05/2025 at 11:57 AM, the Administrator stated that he was uncertain about where to place the WanderGuard device on a resident and how the facility staff made that determination. He stated that he was unsure as to why staff chose to attach the WanderGuard device to Resident #61's wheelchair. He stated that it was important to follow the manufacturer's guidelines to ensure that the device was used correctly and functioning properly; however, he was unsure if attaching the WanderGuard device to the resident's wheelchair violated those guidelines.	F 689		

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F 689	Continued From page 29 On 03/07/2025 at 10:15 AM, the DON stated that she was unaware that attaching the WanderGuard device to metal could interfere with its function. Per the DON, they did not check the manufacturer's recommendations for the WanderGuard device during the facility's investigation (of Resident #61's elopement on 02/25/2025). She stated that failing to follow the manufacturer's guidelines could result in the device not functioning properly and not alarming, which would prevent staff from knowing if a resident was near a door and potentially allowing the resident to exit the facility. She stated that there was a possibility that having the WanderGuard device attached to the metal of the wheelchair may have caused the alarm to malfunction. 2. A facility policy titled, "Storage of Medications," revised April 2019, indicated, "The facility stores all drugs and biologicals in a safe, secure, and orderly manner." During an observation on 03/03/2025 at 12:01 PM, a supply closet was observed unlocked. The supply closet contained iodine swabs in packages and hydrogen peroxide in containers. There were no unassisted residents who were wandering or going past the unlocked supply room during the observation. On 03/03/2025 at 12:06 PM, Registered Nurse (RN) #13 stated there were only supplies for treatments and basic wound supplies in the supply closet. She stated there were no medications in that supply closet. She stated the supply closet had never been locked. During a concurrent observation, RN #13 observed the	F 689		

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F 689	Continued From page 30 supplies in the closet and stated there was ultrasound gel, hydrogen peroxide, iodine swab sticks, triamcinolone acetonide ointment cream, and alcohol prep pads located in the supply closet. She stated there would be a concern with poisoning if someone ingested these supplies. She stated there was a way to lock the supply closet. Per RN #13, the supply closet had a lock, and the nurses and DON had the key. RN #13 stated that the facility had residents that wandered. On 03/07/2025 at 11:00 AM, the Director of Nursing (DON) stated it was her expectation that the supply closet should be locked so that only authorized staff could get into the closet. The DON stated confused residents might access the closet and mess with the supplies, potentially affecting them negatively. On 03/07/2025 at 11:56 AM, the Administrator stated his expectation would be if there were medical supplies in the supply closet the closet would be locked. He stated the staff would need to investigate the root cause as to why the supply closet was not locked.	F 689		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals	F 761	**How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** No residents were affected by the deficient practice. Nurse was immediately informed she left her med cart unlocked and locked it right away. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:**	

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F 761	Continued From page 31 §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, the facility failed to ensure medication carts were locked when unattended by staff for 1 of 6 medication carts observed. Findings included: A facility policy titled, "Storage of Medications," revised 04/2019, indicated, "The facility stores all drugs and biologicals in a safe, secure, and orderly manner." The policy revealed the section titled, "Policy Interpretation and Implementation," included, "9. Unlocked medication carts are not left unattended." During an observation on 03/07/2025 at 10:35 AM, an unattended and unlocked medication cart was observed outside Room 3. The staff were not around or within eyesight of the cart. There were no residents nearby.	F 761	All residents have the potential to be affected by the deficient practice, and therefore, a comprehensive review will be initiated to assess any potential risks associated with the handling of medications. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** On March 21, 2025, the Director of Nursing provided an in-service training for Licensed Nurses on the critical importance of ensuring that medication carts are locked when not in use. This training will reinforce the protocol that all medication carts must be secured properly when left unattended. **How the facility plans to monitor its performance to make sure that solutions are sustained:** Starting on March 21, 2025, Nursing Managers and Supervisors, including the Director of Nursing Services, Assistant Director of Nursing, Infection Preventionist, and Director of Staff Development, will begin conducting weekly audits at various times throughout the day to verify adherence to the policy requiring that medication carts are properly locked when not in use. The outcomes of these weekly audits will be discussed during monthly Quality Assurance and Performance Improvement	

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F 761	Continued From page 32 During an interview on 03/07/2025 at 10:39 AM, Registered Nurse (RN) #19 confirmed she was in a resident's room and out of eyesight from the medication cart. She stated she should have locked the medication cart. During an interview on 03/07/2025 at 11:31 AM, the Director of Nursing (DON) stated medication carts should not be left unlocked and unattended.	F 761	(QAPI) meetings to ensure ongoing accountability and improvements are made as necessary. **Include dates when corrective actions will be completed:** March 21, 2025.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-	F 842	**How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** On 03/05/25, Resident #84 had the order for Pred Forte (prednisolone acetate) immediately discontinued in the clinical record. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents have the potential to be affected by the deficient practice, as the failure to document and discontinue medication orders can occur for any resident with outside medical appointments. On 03/19/25, medical records conducted a comprehensive review of all appointment/consul notes for each resident to ensure they are consistent	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 33 (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and	F 842	with the most recent provider instructions. No further discrepancy noted. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** On 03/21/25, The nursing and medical records staff we’re in serviced on the facility's policies for reviewing, documenting, and transcribing medication orders, particularly those issued by outside providers. A new process has been implemented to ensure that all outside provider notes are promptly reviewed by nursing staff upon receipt. Nurses will be responsible for identifying and entering any new orders, including medication discontinuations, into the EMR. Medical records staff will ensure that all physician progress notes are not scanned into the EMR until they have been reviewed and acted upon by nursing staff. Before scanning and uploading to resident’s documents, Medical Records make sure it is noted and verified by nursing staff. **How the facility plans to monitor its performance to make sure that solutions are sustained:** Regular audits will be conducted by Medical Records to review compliance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056153	A. BUILDING _____ B. WING _____	03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NAPA POST ACUTE	705 TRANCAS ST. NAPA, CA 94558

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F 842	Continued From page 34 (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to ensure an order to discontinue a medication was transcribed into the clinical record for 1 (Resident #84) of 28 sampled residents for whom orders were reviewed. Findings included: A facility policy titled, "Discontinued Medications," revised in 04/2007, indicated, "1. A practitioner's order to discontinue a resident's medication must be documented in the resident's clinical record and on the medication administration record (MAR)." An "Admission Record" indicated the facility admitted Resident #84 on 09/15/2024. According to the Admission Record, the resident had a medical history that included a diagnosis of type two diabetes mellitus. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/23/2024, revealed Resident #84 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. A physician note, dated 01/27/2025, revealed Resident #84 had a follow-up appointment with an outside provider, Physician #22, on 01/27/2025 and voiced concerns of worsening vision and floaters (spots in vision), aggravated	F 842	with the new procedures. These audits will focus on ensuring that all provider orders, including medication discontinuations, are accurately documented in the clinical record and MAR. Outcomes related to restorative nursing services will be discussed in monthly Quality Assurance and Performance Improvement (QAPI) meetings to ensure ongoing accountability and improvement. **Include dates when corrective actions will be completed:** Completion date March 28th, 2025	

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F 842	Continued From page 35	F 842		

by reading. The note indicated Resident #84 had "Combined Senile Cataract," and Physician #22 documented, "Unclear why patient is still on prednisolone, will d/c [discontinue] at this time."

However, Resident #84's "Order Summary Report," including active, discontinued, and completed orders as of 03/04/2025, contained an active order dated 12/20/2024 for Pred Forte (prednisolone acetate) ophthalmic suspension 1 percent (%), with instructions to instill one drop in both eyes two times a day "for Anti inflammatory [sic]."

On 03/03/2025 at 10:26 AM, Resident #84 stated they had prescribed eye drops that should have been discontinued per their eye doctor, but the facility did not discontinue the order. The resident stated their eye doctor's office faxed the paperwork regarding the discontinued order to the facility after their appointment.

On 03/05/2025 at 2:42 PM, Licensed Vocational Nurse (LVN) #14 stated that when residents had appointments with outside providers, the physician's office faxed any updates to the facility. LVN #14 stated faxes printed out at the nurses' station, but she had not received a fax about Resident #84's 01/27/2025 appointment. LVN #14 then reviewed the physician note from 01/27/2025 that was scanned into the resident's clinical record and stated the note did not appear to have been reviewed by a nurse. LVN #14 confirmed the resident's order for Pred Forte should have been discontinued.

On 03/05/2025 at 5:21 PM, Physician #22 stated that in 01/2025 he made it clear in his note that

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F 842	Continued From page 36 the resident's Pred Forte should have been discontinued. On 03/06/2025 at 11:55 AM, the Medical Records Director stated that when a patient came back from an outside appointment, the nurse should enter a progress note that indicated if there were any new orders. She stated that when nursing staff reviewed physician progress notes, they should document on the physician progress note to indicate the note was reviewed. She stated that once a nurse reviewed the physician progress note, the medical records staff scanned the physician note into the resident's electronic medical record (EMR). After reviewing Resident #84's physician note from 01/27/2025, the Medical Records Director stated there was no documentation on the physician note to indicate it was reviewed by a nurse. She stated the note should not have been scanned into the resident's EMR without first ensuring the physician progress note was reviewed by nursing staff. On 03/07/2025 at 11:09 AM, the Director of Nursing (DON) stated that once a resident returned from an outside physician appointment, nursing staff should check for new orders, notify the attending physician of any new orders, and then enter any new orders into the resident's EMR. She stated medical records staff should not scan physician notes into the computer until a nurse followed up on any orders.	F 842		