STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555161	A. BUILDING _____ B. WING _____	C 05/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NAPA VALLEY CARE CENTER	**3275 VILLA LANE NAPA, CA 94558**

(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 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an Abbreviated Standard Survey for Complaint Number CA00960790. Inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility. ONE DEFICIENCY WAS ISSUED FOR COMPLAINT NUMBER CA00960790 at F609.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her	F 609	POC accepted with Spencer Hadley, admin 6/3/25 at 3:40pm. BIC date 5/15/25. CM, HFES 35362	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Revision #1 Adminstrator 5/20/25 ~~06/16/2025~~

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 609	Continued From page 1	F 609		

designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:

Based on interview and record review, the facility failed to report an injury of unknown origin when one of two sampled residents (Resident 1) was found to have extensive bruising and pain to his left leg, that ultimately was found to be a fractured femur (broken thighbone, the longest and strongest bone in the human body) in the emergency department (ED), and facility staff were unable to explain how Resident 1 got the bruise. This failure prevented outside agencies from investigating the injury of a vulnerable resident who was nonverbal and unable to advocate for himself or explain how he was injured.

Findings:

During a record review on 5/8/25 at 11:06 a.m., Resident 1's face sheet indicated an admission date of 11/10/21 and multiple medical diagnoses including Lewy Body dementia (a progressive brain disorder causing problems with thinking, movement, mood, and behavior). Review of Resident 1's nurse progress note dated 5/3/25 at 2:15 p.m. indicated, "This nurse was called to room [approximately] 11am by CNA's [certified nursing assistants] to show me the residents [left] leg. Upon arrival this nurse noticed deep purple discoloration mid thigh to below the knee. Area was very firm when palpated [examined by touch]. Leg was in a weird position and when this

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F 609	Continued From page 2	F 609		

nurse tried to do ROM [range of motion] to the [left] leg resident showed facial grimacing showing he was clearly uncomfortable. . . . EMS [emergency medical services] arrived @ 1140 and they left the facility 10 minutes later with resident transferred to gurney."

During a record review on 5/13/25 at 8:30 a.m., Resident 1's emergency department document titled "History of Present Illness," dated 5/3/25, indicated the emergency physician's exam found Resident 1 was nonverbal and unable to provide any history. Further review of Resident 1's History of Present Illness revealed Resident 1 had a deformity present in his left upper leg and significant bruising and swelling over the distal (away from the hip) left leg. Review of Resident 1's x-ray results dated 5/3/25 at 1:30 p.m., indicated, "Comminuted [occurs when a bone breaks into three or more pieces, often caused by high-impact trauma] and markedly displaced and angulated [significantly out of alignment] fracture" of the left femur. Review of Resident 1's ED Triage Note, dated 5/3/25 at 12:11 p.m., indicated Resident 1 was brought in by ambulance "for bruising on left upper leg. [Patient] non-verbal upon arrival . . . . No reported fall. Obvious deformity/hematoma [bruise] to left upper leg."

During an interview on 5/14/25 at 9:47 a.m., Director of Nursing (DON) stated she did not report Resident 1's injury right away (to the Department) because they had not done their investigation yet and they "did not know if it was known or unknown." DON stated their investigation was started on Monday, 5/5/25. DON stated she also spoke to Resident 1's

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F 609	Continued From page 3 doctor, Physician A, on 5/5/25, who determined the fracture was pathalogical (caused by disease). DON stated this was her first time coming across an injury of unknown origin and was not aware it needed to be reported within two hours if serious bodily injury, or 24 hours if not. DON verified it should have been reported if that is what the policy says. DON stated Administrator usually did the reporting (to the Department) but anybody could report. DON stated they would need to have the x-ray report to know if the resident had a serious bodily injury. Review of facility policy "Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating," last revised 4/2021, revealed, "All reports of resident abuse (including injuries of unknown origin) . . . are reported to local, state, and federal agencies . . . . If resident abuse . . . or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. . . . 'Immediately' is defined as: a. within 2 hours of an allegation involving abuse or result in serious bodily injury; or b. within 24 hours of an allegation that does not involve abuse or result in serious bodily harm."	F 609		

NAPA VALLEY
CARE CENTER

June 3, 2025

Plan of Correction CA00960790 Revision #1

Preparation and/or execution of this response and Plan of Correction (POC) do not constitute an admission or agreement by the provider of truth or accuracy of alleged facts or conclusions set forth in this Statement of Deficiencies. This POC is prepared and/or executed solely for provisions of Federal and State required regulations. This POC is not an admission of noncompliance with cited regulation(s).

F 609

How corrective action(s) will be accomplished:

All Residents may potentially be affected by this deficiency.

A facility wide audit was conducted by the Assistant Director of Nursing (ADON) on 5/15/25 to review with facility Primary Care Physician (PCP) all residents. Nine (9) residents were identified as high risk related to diseases and co-morbidities. Care plans and diagnosis were updated on 5/15/25. PCP reviewed and ordered supplements if not contraindicated.

In addition, a facility wide staff interview was conducted on 5/5/25 to determine if there are any residents who have visible injuries of unknown origin that need to be reported as an unusual occurrence. The results of the interviews did not determine any injury of unknown origin, which will require investigation.

How will facility identify other residents having the potential to be affected:

Director of Staff Development (DSD) proactively gave an in-service to staff on skin discolorations reporting, root cause analysis collaboration with team including nurse and peers on 5/6/25.

DSD and DON collaborated in providing in-service to staff on Unusual Occurrence Policy and Procedures including time frame and reporting to appropriate agencies on 5/14/25. Administrator/Designee is the ultimate person responsible for reporting injuries of unknown origin to the Department of Health and other agencies.

What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur:

Director of Staff Development (DSD) proactively gave an in-service to staff on skin discolorations reporting, root cause analysis collaboration with team including nurse and peers on 5/6/25. DSD and DON collaborated in providing in-service to staff on Unusual Occurrence Policy and Procedures including time frame and reporting to appropriate agencies on 5/14/25.

How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained.

The DON/designee will report to the IDT weekly for eight weeks any unusual occurrence and its timely reporting to required agencies. The DON/designee analyzes trends and patterns which will be submitted to QA&A monthly for three months. The DON/designee will report to Quality Assurance and Assessment (QA&A) committee to ensure the processes set in place are compliant monthly for three months to evaluate and re-evaluate the effectiveness of corrective measures set in place and determine ongoing compliance.

The Quality Assurance and Assessment (QA&A) committee will ensure the processes set in place are compliant monthly for three months to evaluate and re-evaluate the effectiveness of corrective measures set in place and determine ongoing compliance.

Date of Compliance:

5/15/25

Signed,

Spencer L. Hadley

Administrator

Janice Diez

Director of Nursing