STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555161	A. BUILDING _____ B. WING _____	**05/15/2020**

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 1) was safe from harm or possible physical abuse by other residents, when Resident 1's behavior of lying on the floor left him vulnerable to potential injury. This failure resulted in Resident 2 kicking Resident 1 in the head while Resident 1 laid in the hallway, with the potential for head aches or a serious skull injury. Findings: On 9/17/2019 the facility notified the Department about an altercation between two residents, Resident 1 and Resident 2. During a tour and observation of the facility on 9/23/19 at 2:15 p.m., the tour revealed Resident 1 and Resident 2 had rooms on the same hallway but Resident 1 had a room on the left side of the hall, and Resident 2 had a room on the right side of the hall and 3 doors down. During an interview on 9/23/19, at 11:45 a.m., Administrator stated Resident 1 had a known behavior in which he would lay down on the hallway floor. The staff helped him back to bed as necessary. Review of Resident 1's nursing Progress Note, dated 9/16/19, at 6:25 a.m., documented an incident that occurred to Resident 1 on the morning of 9/14/19: Certified Nursing Assistant B (CNA B) reported seeing Resident 2 come out of his room and kick Resident 1 in the head while Resident 1 was lying on the hallway floor. During an interview with CNA B on 9/23/19, at 12:10 p.m., CNA B stated, she had been passing ice to residents and heard Resident 1 moaning in the hallway. CNA B stated she heard Resident 2 yell at Resident 1 to be quiet. CNA B stated she saw Resident 2 return to his room and found Resident 1 lying on the floor in the hallway, just outside his own bedroom. CNA B stated Resident 1 told her Resident 2 had kicked him in the head. CNA B clarified that she did not see the actual kicking but she was the CNA who reported the issue to the nurse. During an interview on 9/23/19, at 2:20 p.m., CNA C stated Resident 1 had a history of [REDACTED]. When asked about Resident 2, CNA C stated Resident 2 could be grouchy in the morning especially if his sleep was disrupted. During an interview on 9/23/19, at 2:30 p.m., Licensed Staff A stated, Resident 1 used a wheelchair to get around, but often walked in the hallway and laid down on the floor, .moaning as if he was in pain. She stated the CNAs helped him back to bed when he was ready. When asked about Resident 2, Licensed Staff A stated, Resident 2 had a history of [REDACTED]. Licensed Staff A stated that they stepped out of Resident 2's way when he was yelling at them. Review of Resident 1's individualized nursing care plan, Nursing Care Plan History, initiated 2/27/19, indicated Resident 1 had .episodes of sitting and laying on the floor in the hallways. A discontinuation date of 3/8/19 indicated the care plan was no longer relevant. Review of current nursing care plans did not address Resident 1's behavior of lying on the floor of the hallway, or of interventions to prevent harm to Resident 1 or other residents who could trip over Resident 1. Review of Resident 2's individualized nursing care plan, initiated 12/23/17, indicated Resident 2 had an issue with his mood related to depression. Interventions were to have a psychologist consult and to encourage him to participate in activities. The nursing care plan did not indicate aggressive behaviors to the other residents. Review of the facility's policy, Care Plans - Comprehensive, 10/2010, indicated each resident's comprehensive care plan was designed to identify problem areas and individual risk factors. The policy indicated the facility assessed, created, and revised care plans as needed to prevent decline. Review of the facility's policy, titled Abuse Prevention Program Policy, dated 12/2016 indicated that as part of the resident abuse prevention the administrator would Protect our residents from abuse by anyone including: Facility Staff, other residents, consultants, volunteers, staff form other agencies, family members, legal representatives, friends , visitors or any other individual.

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

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.