

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056238	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2024
NAME OF PROVIDER OR SUPPLIER Windsor Vallejo Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2200 Tuolumne Street Vallejo, CA 94589	

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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39792</p> <p>Based on observation, interview and record review, the facility failed to provide adequate supervision during resident smoking sessions to reduce the risk of elopement. This failure resulted in one of one sampled residents (Resident 10) from being able to elope from the facility, potentially causing great bodily injury.</p> <p>Findings:</p> <p>During a review of Resident 10 ' s, Admission Record, dated 12/19/23, indicated Resident 10 had been admitted to the facility on [DATE], with a history of chronic obstructive pulmonary disease (a group of diseases that block airflow and make it difficult to breathe), acute respiratory failure with hypoxia (a condition where you do not have enough oxygen in the tissues in your body), congestive heart failure (a long-term condition that happens when your heart cannot pump blood well enough to give your body a normal supply) and moderate dementia (a general term for the impaired ability to remember, think, or make decisions that interferes with doing everyday activities).</p> <p>A review of Resident 10 ' s Admission MDS (Minimum Data Set, a clinical assessment process provides a comprehensive assessment of the resident's functional capabilities and helps staff identify health problems), dated 1/8/24, indicated Resident 10 had a BIMS (Brief Interview of Mental Status) score of 7, which indicated Resident 10 was moderately to severely cognitively impaired.</p> <p>During a review of Resident 10 ' s, Progress Note, dated 1/11/24, Resident 10 was indicated to be found wandering and attempting to go outside. The Progress Note indicated Resident 10 was found have a cigarette wrapper on his lap, since his friend had brought him cigarettes. The Progress Note indicated Resident 10 would be considered for a Wander Guard, due to his (mental) deficits and need for further observation if he went outside.</p> <p>During a review of Resident 10 ' s, Progress Note, dated 1/23/24, indicated Resident 10 entered the [NAME] Room (activity/dining room where residents had to enter to then gain access to the outdoor patio area reserved for smoking) and then patio where Resident 10 was indicated to walk off or eloped from facility grounds. A Code Yellow was initiated, and Resident 10 was located on Tuolumne Street, close by a facility with a higher level of care. A review of, Progress Note, dated 1/23/24, after the elopement, Resident 10 was indicated to be on elopement precautions, and Resident 10 was unaware of the potential harm regarding his behavior. Resident 10 ' s room was subsequently changed to be closer the nursing station.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview on 2/6/24 at 10:26 a.m., with Resident 10, he was in his room, laying on top of his made bed with a patient care gown on. Resident 10 stated he did smoke and indicated he would go outside at each smoking session every day. Resident 10 stated he did not communicate very well, and indicated he did not remember leaving the facility or why he might want to leave the facility.</p> <p>During an interview on 2/6/24 at 10:37 a.m., with Activity Assistant B (AAB), AAB indicated the Activity Department provided supervision for resident smokers in the building. AAB indicated, by pointing to the outside patio adjacent to the [NAME] dining room, would the space allocated for residents to smoke. The outdoor patio area was noted to have a fenced enclosure with a gate and steps to access the back parking area behind the facility. AAB indicated the number of residents who smoked could vary from five to fifteen, it just depended. AAB indicated there was an alarm for the Wander Guard (system which a resident would wear a device which would alarm if they attempted to leave the facility through an exit fit with the alarm detection device) at the exit of the [NAME] dining room. AAB indicated staff would, disarm, or turn off the alarm so any resident wearing the device would not activate the alarm. AAB indicated, since he used to smoke, he would usually be the designated smoking supervisor as the other activity assistants did not like supervising the smoking sessions. AAB indicated when it was his day off, someone else would be assigned to supervise the smoking sessions.</p> <p>During an interview on 2/6/24 at 11:38 a.m., with Activity Assistant C (AAC), AAC indicated the Activity Department supervised the smokers, and there has been no set schedule within the department about who would supervise. AAC indicated she could not do it very well since the smoke created migraines. AAC indicated she was not aware of Resident 10 leaving the smoking area.</p> <p>During a concurrent observation and interview on 2/13/24 at 9:24 a.m., with Activity Assistant D (AAD), AAD was supervising the residents smoking on the back patio area. The smoking area had a fire extinguisher, smoking apron and receptacles to extinguish cigarettes. AAD indicated she was not aware of the incident when Resident 10 left the smoking area.</p> <p>During an interview on 2/13/24 at 11:35 a.m., with Activity Director A (ADA), ADA indicated the Activity Department supervised the residents while they were out on the patio smoking in the designated smoking area. ADA indicated there was no set schedule or assignment from the Activity Department as to who would supervise; the team just worked it out. ADA indicated that many times she would supervise the residents during the designated smoking time. ADA indicated she was not aware of Resident 10 eloping during the smoke break; her staff had no knowledge and did not indicate that had occurred during the smoking session.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 2/21/24 at 2:08 p.m., with Assistant Director of Nursing (ADON), Resident 10 ' s, Progress Note, dated 1/11/24, indicated Resident 10 was observed to be found wandering and attempting to go outside while noticing the elements for smoking on his lap. The Progress Note indicated Resident 10 should be evaluated for a Wander Guard and supervised if going outside. Resident 10 ' s, Progress Note, dated 1/23/24, indicated Resident 10 had walked through the patio area (adjacent to the [NAME] Room and through the smoking area), and walked off facility grounds and was found approximately two blocks away. The ADON indicated she was working the day Resident 10 left the facility, and the alarms did not go off as they should have when Resident 10 left the facility. The ADON indicated the alarms were tested after Resident 10 had been returned safely, and the alarms were functioning appropriately. The ADON indicated Resident 10 was found on the street approximately 30 minutes after the smoking session and agreed it could have taken 30 minutes for him to walk slowly and be at the spot on the street where he was found. The ADON indicated there was no connection between the time Resident 10 eloped from the facility and the smoking session.</p> <p>A policy on supervision during smoking was requested, and facility was unable to provide one.</p>