STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555095	A. Building B. Wing	03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Veterans Home of California - Yountville - Snf	100 California Drive Yountville, CA 94599

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. 41816 Based on interview and record review the facility failed to ensure one of three residents (Resident 1) had an updated Care Plan. This failure had the potential to place Resident 1 at risk for preventable falls and potential injury. Findings: During a review of the facility Occupational Therapy (OT) Evaluation Note, dated 2/12/24, the Occupational Therapist 1 (OT 1) documented for a visit occurring on 2/5/24. The assessment indicated, Patient (Pt) will benefit from Stand By Assist (SBA)-(CGA) Contact Guard Assist for out of bed mobility and activity/transfers/functional ambulation for safety .Pt will benefit from line-of-sight supervision from nursing. Pt with impaired safety, ADL's, functional mobility, fall risk, impaired cognition. During an interview on 3/15/24 at 11:45 AM with OT 1, OT 1 stated that a home evaluation was ordered for weakness. OT 1 stated her assessment found the resident would benefit from stand by assistance (SBA) to contact guard assistance (CGA) while ambulating for safety. OT 1 stated her recommendations included line-of-sight supervision from nursing staff. OT 1 stated, I do not write orders but make recommendations for the health care team. It's up to the rest of the medical team to decide what to do with my recommendations. During a concurrent interview and record review on 3/19/24 at 9:36 AM with Supervising Registered Nurse (SRN 1) and Resident 1's Care Plan with a run date of 1/13/24 was reviewed. The Care Plan indicated the interventions for Problem #4 Activities of Daily Living function, alteration in, was last updated on 7/29/23 except the section for a Neurology department consult on 12/12/23. SRN 1 stated she did not see the 2/5/24 OT consultation recommendations for Resident 1 to be SBA to CGA assistance or to be in line-of-site added to the Care Plan. I do not see it reflected under problem #4. It's not in writing, It is not in the Care Plan.

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

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 41816 Based on interview and record review the facility failed to ensure one of three sampled residents (Resident 1) was 1.) Provided a timely occupational therapy (OT) evaluation. 2.) Followed occupation therapy recommendations for care. This failure led to several potentially preventable falls for Resident 1 and had the potential for additional falls and injury. Findings: 1.) During a review of OT Communication Note dated 1/30/24, the note indicated an OT evaluation order was placed on 1/8/24 for diagnosis of weakness. It indicated on 1/30/24 OT 1 attempted to evaluate Patient 1. The note indicated, Nurse reports patient feels his Parkinson's (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination) is progressing. Patient in computer room per RN will f/u (follow up) when patient is available. During a review of the facility's policy and procedure (P&P) titled, Physical and Occupational Therapy Services, dated 7/31/23, the P&P indicated, Physical/Occupational Therapy Evaluation referrals for acute conditions or events will be evaluated within 5 business days .Acute conditions/events may include but are not limited to: .new and recent multiple falls (2 or more falls within 30 days with or without injury. During an interview on 3/22/24 at 1:31 PM with Speech Pathologist (SP 1), Chief of Restorative Care Services, SP 1 stated the policy indicated Resident 1 should have been seen within 5 days of the referral. SP 1 stated the referral was from the MD (Medical Doctor) for weakness, an Home Assessment (assessment of the home environment for adaptive equipment and assistance requirements with Activities of Daily Living (ADLS)). SP 1 stated OT attempted several times, on 1/26/24, 1/30/24 and 2/2/24. SP 1 stated, (Resident 1) was evaluated on 2/5/24. 2.) During a record review of Occupational Therapy (OT) Evaluation Note on 2/12/24, Occupational Therapist 1 (OT 1) documented for a visit occurring on 2/5/24. The assessment indicated, Patient (Pt) will benefit from Stand By Assist (SBA)-(CGA) Contact Guard Assist for out of bed mobility and activity/transfers/functional ambulation for safety .Pt will benefit from line-of-sight supervision from nursing. Pt with impaired safety, ADL's, functional mobility, fall risk, impaired cognition. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/15/24 at 11:45 AM with OT 1, OT 1 stated that a home evaluation was ordered for weakness. OT 1 stated the assessment found the resident would benefit from stand by assistance (SBA) to contact guard assistance (CGA) while ambulating for safety. OT 1 stated the recommendations included line-of-sight supervision from nursing staff. OT 1 stated, I do not write orders but make recommendations for the health care team. It's up to the rest of the medical team to decide what to do with my recommendations. During a concurrent interview and record review on 3/19/24 at 9:36 AM with Supervising Registered Nurse (SRN 1) and Resident 1's Care Plan with a run date of 1/13/24 was reviewed. The Care Plan indicated the interventions for Problem #4 Activities of Daily Living function, alteration in, was last updated on 7/29/23 except the section for a Neurology department consult on 12/12/23. SRN 1 stated she did not see the 2/5/24 OT consultation recommendations for Resident 1 to be SBA to CGA assistance or to be in line-of-site added to the Care Plan. I do not see it reflected under problem #4. It's not in writing, .It is not in the Care Plan. During a review of the facility's policy and procedure (P&P) titled, Accident Prevention, Fall, dated 6/21/23, the P&P indicated the Post Fall Interdisciplinary Team meeting (IDT) is scheduled by the licensed nurse within one week of the fall. The IDT is responsible to address each Resident's risk for accidents and safety needs .after each fall . The IDT records their recommendations on the ' IDT Conference Record' and the Resident Care Plan. During a review of the facility's policy and procedure (P&P) titled, Interdisciplinary Team Conference, dated 8/16/23, the P&P indicated the IDT members include appropriate clinical staff in disciplines as determined by the Resident's needs. IDT responsibilities are to review the active residents care plan problems . and re-evaluate and revise . as the resident's status changes. During a review of Resident 1's Interdisciplinary Residential Fall Investigation and Intervention, dated 2/20/24, regarding a fall on 2/18/24, the IDT notes indicated the Care Plan was updated. There were no interventions included to the care plan from Resident 1's Home Safety Assessment completed by OT 1 on 2/5/24. During a review of the Resident 1's Interdisciplinary Residential Fall Investigation and Intervention, dated 2/27/24, regarding the fall on 2/24/24, the IDT notes indicated the Care Plan was updated. There were no interventions included to the care plan from Resident 1's safety assessment completed by OT on 2/5/24. During a review of the Resident 1's Interdisciplinary Residential Fall Investigation and Intervention, dated 2/27/24, regarding the fall on 2/25/24 the IDT notes indicated the Care Plan was updated. There were no interventions included to the care plan from Resident 1's safety assessment completed by OT on 2/5/24. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/22/24 at 1:31 PM with Speech Pathologist (SP 1), Chief of Restorative Care Services,SP 1 stated after an evaluation the therapist would discuss the recommendations with the RN on duty who would then update the care plan. The assessment is printed and put in the chart. Nurses have access to the assessment. SP 1 stated that following a fall, the PT/OT staff would be included in the IDT meeting to represent their discipline from restorative services and review their recommendations and interventions. SP 1 stated, They always do take rehab's (rehabilitation's) recommendations. We go around the room and each discipline will summarize progress or changes SP 1 stated, Rehab has not been updating the problem areas. It was not our process to change the care plan in the problem section, we have an interventions section where we document .I do not see OT is in that section. During an interview on 4/2/24 at 1:37 PM with OT 2, OT 2 stated, We don't review the care plan from start to finish in the IDT meeting. Just things regarding the fall. We would not have looked at the ADL's, but we would look at problem #2 Injury. OT 2 stated the interventions for ADL's were not reflective of his care needs. OT 2 stated they were not accurate.