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	07/17/2024

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 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. 36067 Based on interview and record review, the facility failed to provide adequate supervision and follow their policy and procedure Missing resident and Elopement - Code Purple (SNF / ICF), for one of two sampled residents (Resident 1) when Resident 1 signed out of the unit and did not specify where he was going and gone for two days. The assigned nurse was aware that Resident 1 was out of the unit all night and didn't alert anyone. Unit staff initiated the policy for missing resident and elopement on the following day. These failures placed Resident 1's safety at risk for accidents, injuries, and resulted in Resident 1 going without scheduled and as needed medications for two days while he was at a motel in a nearby city. Findings: During a review of Resident 1's Face Sheet (FS-a document which contains patient medical history and contact details), undated, the FS indicated, Resident 1 had diagnoses of Schizoaffective Disorder (mental health condition that is marked by a mix of schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms, such as depression), muscle weakness, Dysphagia (difficulty swallowing) and Post-Traumatic Stress Disorder (a disorder that develops in some people who have experienced a shocking, scary, or dangerous event). During a review of Resident 1's Investigation Report dated 7/1/24, the Investigation Report indicated, On 07/1/24 at 1150, the Supervising Registered Nurse II reached Resident 1 through his cellphone. Resident 1 declined to disclose his location and reported he was with a 'girlfriend' whom he met in . [nearby city.] During an interview on 7/15/24 at 1:50 p.m. with Supervising Registered Nurse (SRN 2), SRN 2 stated on 6/30/24, at around 1:16 a.m., per nursing notes, Resident 1 went to the nursing station and asked if he could take his schedule morning medications. SRN 2 stated the night shift nurse informed Resident 1 she would not be able to give him his morning medications. SRN 2 stated the night shift nurse did not document and did not endorse to the incoming staff that Resident 1 had left the unit at 1:32 a.m. and had not returned all night. SRN 1 stated she was the morning nursing supervisor, and she was not aware Resident 1 had been missing, she was only informed about it on 7/2/24. SRN 2 stated the night shift nurse should have informed the night shift supervisor that Resident 1 had left the unit and should have begun searching for Resident 1's location. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555095	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/17/2024
NAME OF PROVIDER OR SUPPLIER Veterans Home of California - Yountville - Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 100 California Drive Yountville, CA 94599	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/17/24 at 7:20 a.m., with SRN 3, SRN 3 stated the night shift staff Certified Nurse Assistant (CNAs) and nurses made hourly rounds to check on residents whereabouts. SRN 3 stated when a resident signs out, nurses expect the resident to return within 2 hours. SRN 3 stated per nursing notes on 6/30/24 at 1:16 a.m. while Resident 1 had requested his morning medications, the night shift nurse should have questioned, why the resident was asking for his medications that early in the morning. SRN 3 stated per documentation unit staff had initiated the policy for missing residents the next day 7/1/24 at 1:30 a.m. SRN 3 stated CNAs were responsible for making hourly rounds and documenting the whereabouts of the residents. During an interview on 7/17/24 at 9:20 p.m., with SRN 3, SRN 3 stated the 6/30/24 safety round sheet form indicated that from 12:30 a.m. to 6:45 a.m. resident was out of the unit. SRN 3 stated if the resident was still not in the unit after 2 hours, the CNA must report the resident missing to the charge nurse and start searching for the resident. SRN 3 stated because this wasn't done the resident was placed at risk for accidents and hypothermia since it was cold during the night. SRN 3 stated nurses and CNAs were responsible for making rounds during the shift and to ensure all residents were accounted for. During an interview on 7/17/24 at 9:55 a.m., with the Director of Nursing (DON), the DON stated the residents were monitored by staff during safety rounds. The DON stated per the facility policy if a resident did not indicate the estimated return time when signing out, the staff must start searching for the resident and call the family. The DON stated if they were not able to locate the resident after the search, the facility must implement the missing resident / elopement policy. During an interview on 7/17/24 at 3:45 p.m., with SRN 5, SRN 5 stated she was a night shift SRN on 6/30/24. SRN 5 stated it was not reported to her that Resident 1 had signed out and left the unit and had not returned all night. SRN 5 stated at around 1:15 a.m., the nurse called and informed her that Resident 1 was asking for his 8 a.m. medications. SRN 5 stated she told the nurse it was too early and the medications could not be given. SRN 5 stated per night nurse Resident 1 got agitated, therefore SRN 5 contacted the Office of Public Safety Officer (OPS) to go check on Resident 1. SRN 5 stated 30 minutes later around 2 a.m., she called the nurse to check on Resident 1. SRN 5 stated the nurse informed her that OPS came, the resident had calm down and was back in his room. SRN 5 stated when she returned to work, after her day off, she was informed about the incident. SRN 5 stated on 6/30/24 at 2 a.m. when she called to nurse, Resident 1 was in the unit according to the nurse. SRN 5 stated nurses know they must call her and report resident concerns. SRN 5 stated before the end of the shift she asked the unit staff if there was anything she needed to know, but nothing was reported to her. SRN 5 stated she checked the MAR (medication administration records) on 6/30/24; the medication nurse had documented at 8:39 a.m. that Resident 1 was off the [NAME] (unit) during medication administration. SRN 5 stated the medication nurse should have informed the SRN and they should have started searching for the resident. (continued on next page)

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Veterans Home of California - Yountville - Snf	100 California Drive Yountville, CA 94599

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/18/24 at 10:05 a.m., with Certified Nurse Assistant (CNA 1), CNA 1 stated Resident 1 was assigned to her on 6/30/24 the day he left the facility. CNA 1 stated on 6/30/24 around 12:30 a.m. in the morning, she noticed Resident 1 went outside for a smoke and returned to the unit. CNA 1 stated around 1 a.m. she had seen Resident 1 talking to the nurse and was asking to get his 8 a.m. morning medications. CNA 1 stated the nurse did not give the resident his medications. CNA 1 stated Resident 1 was nice and did not have any hostile behavior. CNA 1 stated around 1:30 a.m. she had seen the nurse having a conversation with OPS. CNA 1 stated she asked the nurse what the update for Resident 1 was, and the nurse told her that the OPS was going to be with Resident 1. CNA 1 stated she assumed that OPS was going to be with Resident 1 while he was out of the unit. CNA 1 stated most of the time when Resident 1 was agitated OPS would come to the unit and talk to him until he calmed down. CNA 1 stated in her mind Resident 1 was going to be ok, because he was going to be with OPS. CNA 1 stated she asked the nurse if Resident will be OK, and nurse told her, Resident 1 was going to be OK because he's going to be with OPS. CNA 1 stated she did not report anything anymore because she assumed OPS and the nurse were going to make a report. CNA 1 stated she did not start looking for the resident because she thought that the resident was with OPS. CNA 1 stated at around 5 a.m. she reported to the nurse that Resident 1 had not return, the nurse told her Resident 1 was going to be with OPS. CNA 1 stated she did not have any instructions from the nurse to look for Resident 1. CNA 1 stated in the morning during the shift change the nurse reported to a.m. shift that resident was with OPS all night. During an interview on 7/18/24 at 2:50 p.m., with Licensed Vocational Nurse (LVN 1), LVN 1 stated on 6/30/24 she was the night shift nurse and Resident 1 was assigned to her the day he left the facility. LVN 1 stated she was aware that Resident 1 was missing all night. LVN 1 stated she endorsed Resident 1 missing to the morning shift, but she did not remember/recall who the nurse was. LVN 1 stated she did not report that Resident 1 was missing all night to SRN. LVN 1 stated she was not aware that she had to report the Resident missing to the SRN. LVN 1 stated at 1:16 a.m. Resident 1 asked for his 8 a.m. medications. LVN 1 stated she did not question the reason why Resident 1 had asked for his scheduled 8 a.m. medications at 1:16 a.m. LVN 1 stated the OPS officer came to the unit, she explained Resident 1 had calmed down and Resident 1 was no longer aggressive. The OPS officer did not have to speak with Resident 1 and the OPS officer left. LVN 1 stated she told CNA 1 that she spoke with the OPS officer and told her that the resident was ok, and that the OPS officer did not have to speak with the resident. LVN 1 stated she did not tell CNA 1 that Resident 1 was with OPS. LVN 1 stated around 2 a.m. she received a follow up phone call from the SRN regarding Resident 1. LVN 1 stated she informed the SRN that Resident 1 was fine and the OPS officer came to the unit but did not speak with the resident because she had told the OPS that the resident was fine. LVN 1 stated she informed the SRN that Resident 1 went out for a smoke. LVN 1 state at 2 a.m. Resident 1 was not in his room. LVN 1 stated she did not know about the policy, and she did not alert anyone else. During a review of Resident 1's Interdisciplinary Progress Notes (IPN), dated 6/30/24 at 1:16 a.m., the IPN indicated, Resident came to nursing station and asked if he could take his morning meds at this time. I told the patient I'm not able to give you that A.M. meds. He then said, please I need them right now . I told him I would check it with supervisor, and he was Ok with that. Manager said to not give the A.M. meds and sent OPS officer to come . I told the patient again I'm not able to give you the A.M. meds and he said Ok thanks for trying. Officer came and I explained the situation and he left. (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Missing resident and Elopement - Code Purple (SNF / ICF), dated 1/24/23, the P&P indicated, Resident whereabouts are monitored according to established guidelines for licensed care: Skilled Nursing Facility (SNF) and Intermediate Care Facility (ICF) . 2. SNF / ICF: A Resident is considered missing in SNF / ICF when he / she fails to return to the unit at the expected time (based on the sign-out or other evidence) and / or cannot be readily located . SNF: Staff will conduct Resident rounds every hour. During rounds staff will have either observe the 4 P's [resident presence, position, pain, and Potty toileting needs] of each Resident and whereabouts; or will confirm Resident's authorized absence. Staff will use SNF Resident Sign-out Log to assist in monitoring Residents' whereabouts . Complete Phase 1 within first two (2) hours of known or suspect missing Resident. In Phase 1 of missing Resident situation, the OPS assume the Incident Command Lead at the time they are made aware of the incident. During Phase 1 staff will proceed as follows: 1. Notification: Licensed Nurse promptly notifies the SRN . During a review of the facility's document CNA Annual Skills Competency Checklist, dated 2/26/19, the document indicated . Demonstrates understanding of safety rounds, signing rounds log, checking for 4 P's - resident presence, position, pain, and toileting needs . During a review of the facility's document Licensed Vocational Nurse: Skills Competency, dated 3/7/19, the document indicated . K. Safety Rounds - signs Rounds Log. Checks for - Resident Presence, position, pain, and toileting needs . During a review of the facility's document Safety Round Sheet - 15 Minutes Rounds, dated 6/30/24, the document indicated Procedure: Observe residents hourly, checking for 4 P's (present, Positioning, Potty, Pain): please follow the legend at the bottom of the page to indicate the patient's location. Write your initials at the end of the table after your observation. If resident's whereabouts is Unknown (U), Immediately Initiate A Search, per policy: Missing Residents . The document indicated Resident 1 was out of the unit from 12:30 a.m. to 6:45 a.m. During a review of the facility's document Log Book, dated 6/30/24, the Log Book indicated, Resident 1 signed out of the unit at 1:32 a.m., the sign out did not specify where he was going and/or the estimated return time.