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 08/29/2024

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41816 F-580 Notification of Changes Based on interview and record review the facility failed to immediately notify the physician of a significant change of condition in Resident 1's breathing status with life threatening clinical complications warranting a transfer to the hospital. This failure resulted in a delay of care for Resident 1. Findings: During a review of Resident 1's hospital records titled, Emergency Department Provider Notes, dated [DATE] at 3:00 a.m., the note indicated around 6:30 p.m. [[DATE]] Resident 1 had a choking episode involving a hard-boiled egg at dinner. At around 1 a.m. [[DATE]] staff noted Resident 1 was in respiratory distress, with oxygen saturations (oxygen levels in the blood) in the 70's (normal range is ,d+[DATE]). EMS (Emergency Medical System) transferred Resident 1 to the emergency department. The provider note indicated Resident 1 was a DNR/DNI (do not resuscitate/do not intubate, no artificial breathing or chest compressions) with selective treatment. Resident 1 was given morphine (an opiate, a strong drug used to treat serious pain. Sometimes given to ease the feeling of shortness of breath) for air hunger and pain. Resident 1 died of a cardiac arrest on [DATE] at 2:16 a.m. in the hospital. During a review of the facility's policy and procedure (P&P) titled, Change of Condition and Notifications, dated [DATE], the P&P indicated, The licensed nurse will report in a timely manner through the appropriate channels this information to promote prompt and accurate reporting of a change of condition. The P&P indicated . In emergent situations 911 and ,d+[DATE] (Office of Public Safety on facility grounds) are activated with notification to the Supervising Registered Nurse (SRN) and the PCP (Primary Care Physician) or the DOC (Doctor On-Call). The policy indicated an emergent situation would include a significant change in VS (vital signs) with associated symptoms, SOB (shortness of breath) or other respiratory symptoms. The P&P indicated, The licensed nurse will gather appropriate data related to the resident's condition and/or information on situation/ event prior to contacting the provider . (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 08/29/2024

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's Interdisciplinary Progress Notes (IDN), dated [DATE] in error, the IDN reflected the nursing notes from [DATE] at 24:30 [12:30 a.m.], by Licensed Vocational Nurse (LVN) 1, the note indicated the patient had unstable vital signs after an episode of vomiting. The note indicated, Supv (sic) (supervisor) & family already aware. There was no indication in the IDN a physician was notified of the change of condition. During a review of Resident 1's Interdisciplinary Progress Notes dated [DATE] at 1:45 a.m. by LVN 1, the note indicated, Resident [1] was transported to (Emergency Department) at 1:34 a.m. via 911 to r/o (rule out) or confirm aspiration pneumonia (type of lung infection that is due to a relatively large amount of material from the stomach or mouth entering the lungs). The IDN indicated another set of vital signs were unstable and Resident 1 was on 15 liters of oxygen delivered with a non-rebreather mask (a type of mask that delivers high concentrations of oxygen in emergency situations). The note indicated, a telephone call was made to the DOC, but was unsuccessful. The IDN did not indicate the time when the call was made or by who. During an interview on [DATE] at 11:45 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated she did not attempt to notify the DOC, or any other physician during the respiratory emergency with Resident 1. LVN 1 stated LVN 2 was not successful in reaching the DOC. LVN 1 stated the DOC phoned the unit near the end of the shift, several hours after the patient had been transferred to the hospital. This communication with the DOC was not documented in Resident 1's medical record. During an interview on [DATE] at 9:46 a.m. with LVN 2, LVN 2 stated, I was going to call the doctor. We needed an SBAR (an acronym for Situation, Background, Assessment, Recommendation; a technique that can be used to facilitate prompt and appropriate communication) report for that. I had to see what he [Resident 1] looked like to provide more information to the doctor when I called. I tried to call the MD but she did not answer, I called her twice, one call right after the first .I did not chart, I was just assisting the covering nurse. During an interview on [DATE] at 9:50 a.m. with DOC 1 who was on duty on [DATE] at 12:30 a.m. when Resident 1 had his change of condition. DOC 1 stated, I wanted to be notified if there was any change in Resident 1's condition. DOC 1 checked the call history on her phone and stated she received two calls from the facility that night, one at 1:02 a.m. and the other at 1:09 a.m. [34 minutes following the documented onset of distress by LVN 1]. Doc 1 stated, I inadvertently turned my ringer off instead of down, so it would not bother my husband. Both calls were missed. DOC 1 stated a heart rate of 119 and O2 saturation at 80% on 3 liters was unstable. DOC 1 stated if Resident 1's vital signs were unstable at 12:30 a.m., I would have expected them to call as soon as they could . I returned the call at 4:42 a.m. as soon as I realized I missed the call. He was already sent out to the hospital at that point. During an interview on [DATE] at 10:40 a.m. with Administrative Staff 1 (AS 1), AS 1 stated she called the fire department to get the record of the EMS report from the call on [DATE] for Resident 1. AS 1 stated she was told the 911 call came into the fire department on [DATE] at 1:14 a.m. The fire department arrived at 1:20 a.m. and EMS (emergency medical services -the ambulance) arrived at 1:22 a.m. During an interview on [DATE] at 11:05 a.m. with Resident 1's Primary Care Physician (PCP) 1, PCP 1 stated .a heart rate of 119 and oxygen saturation of 80% on 3 liters is unstable. 30 minutes is too long to wait to call 911 with those vital signs .

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 08/29/2024

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 0713 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or arrange emergency care by a doctor 24 hours a day. 41816 Based on interview and record review the facility failed to ensure the Doctor on Call (DOC 1) responded promptly to the notification of Resident 1's change of condition by nursing staff. This failure resulted in nursing staff not having the guidance of a physician to manage Resident 1's change of condition and transport to the emergency department. Findings: During an interview on 8/21/24 at 9:46 a.m. with LVN 2, LVN 2 stated, I tried to call the doctor, but she did not answer. I called two times, one after the other. I then notified the supervisor who advised me to call 911. LVN 2 could not recall the times. During an interview on 8/26/24 at 9:50 a.m. with the Doctor on Call 1 (DOC 1), DOC 1 stated on 8/2/24-8/3/24 NOC shift, I wanted to be notified if there was any change in condition. DOC 1 stated she received two calls from the facility that night, one at 1:02 a.m. and the other at 1:09 a.m. DOC 1 stated, I inadvertently turned my ringer off instead of down, so it would not bother my husband. Both calls were missed .I returned the call at 4:42 a.m., as soon as I realized I missed the call. Resident 1 was already sent out to the hospital at that point. During a review of the facility's policy and procedure (P&P) titled, Doctor on Call, dated 2/4/21, the P&P indicated the on-call hours are from 4:30 p.m. until 8:00 a.m. the following day. The P&P indicated the duties of the on-call doctor include providing in-person or phone consultation to the Long-Term Care SRN (Supervising Registered Nurse)/Nursing staff, and to make and receive calls to the local emergency department as appropriate when sending and receiving residents. The P&P indicated the doctor on call was expected to respond to phone calls within 10-15 minutes.

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 08/29/2024
NAME OF PROVIDER OR SUPPLIER Veterans Home of California - Yountville - Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41816 Based on interview and record review the facility failed to document complete and accurate records of assessments and interventions provided to Resident 1 during his change in medical condition. This failure resulted in Resident 1's medical records being incomplete and inaccurate. Findings: During a review of Resident 1's hospital records titled, Emergency Department Provider Notes, dated [DATE] at 3:00 a.m., the note indicated around 6:30 p.m. [[DATE]] Resident 1 had a choking episode involving a hard-boiled egg at dinner. At around 1 a.m. [[DATE]] staff noted Resident 1 was in respiratory distress, with oxygen saturations (oxygen levels in the blood) in the 70's (normal range is ,d+[DATE]). EMS (Emergency Medical System) transferred Resident 1 to the emergency department. The provider note indicated Resident 1 was a DNR/DNI (do not resuscitate/do not intubate, no artificial breathing or chest compressions) with selective treatment. Resident 1 was given morphine (an opiate, a strong drug used to treat serious pain. Sometimes given to ease the feeling of shortness of breath) for air hunger and pain. Resident 1 died of a cardiac arrest on [DATE] at 2:16 a.m. in the hospital. During an interview on [DATE] at 11:45 a.m. with Licensed Vocational Nurse (LVN 1), LVN 1 stated, I was told Resident 1 had a vomiting episode on the pm shift [prior shift], the MD (Medical Doctor) was notified, and the patient was to be monitored. LVN 1 indicated this meant to notify the physician if there was any change of condition. LVN 1 indicated during the initial rounds of her shift, Resident 1 was OK. LVN1 stated the CNA (certified nursing assistant) took the vital signs on identified patients and made their rounds as well. She stated she could not remember what the initial vital signs were, but either the CNA or the previous shift applied the oxygen. She stated she did not apply the oxygen. There was no documentation within the chart of the oxygen being started and what the oxygen levels were in the blood (O2 sats) when the oxygen was started. During an interview on [DATE] at 9:09 a.m. with LVN 3, LVN 3 stated he remembered he took a set of vital signs that night at the beginning of the shift, he was working as the CNA on the unit. LVN 3 stated he did not document the vital signs but gave them to LVN 1 on a piece of paper for her to review. LVN 3 stated he did not apply the oxygen to Resident 1, Resident 1 already had it on. LVN 1 stated, Possibly it was the PM shift that put the oxygen on him. During a review of Resident 1's Interdisciplinary Progress Note (IDN), dated [DATE] in error, the IDN reflected the nursing notes from [DATE] at 24:30, (12:30 a.m.) by LVN 1, the initial note indicated 2300 (11:00 p.m.) was written, then crossed off, then 2400 (12:00 a.m.) was written, then crossed off. Then finally written as [DATE] 24:30 (12:30 a.m.). The note indicated, Moderate amount of food substances, vomit. Unstable V/S (vital signs) 98XXX[DATE]-,d+[DATE]-,d+[DATE] 80% 3L -DX Stage IV Colon Cancer. MD, Supv (supervisor) & family already aware. There was no documentation the Doctor on Call (DOC) had been notified, and it was unclear at what time the Supervising Registered Nurse (SRN) was notified. (continued on next page)

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 08/29/2024

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 0842

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

During a review of Resident 1's Interdisciplinary Progress Notes, dated [DATE] at 1:45 a.m. by LVN 1, the IDN indicated, Resident [1] was transported to (Emergency Department) at 1:34 a.m. via 911 to r/o (rule out) or confirm aspiration pneumonia (type of lung infection that is due to a relatively large amount of material from the stomach or mouth entering the lungs). The IDN indicated another set of vital signs were unstable and Resident 1 was on 15 liters of oxygen delivered with a non-rebreather mask (a type of mask that delivers high concentrations of oxygen in emergency situations). The note indicated, a telephone call was made to the DOC, but was unsuccessful. The IDN did not indicate time the DOC was called and who ordered and administered 15 liters of oxygen with a non-rebreather mask.

During an interview on [DATE] at 11:45 a.m. with LVN 1, LVN 1 stated she called SRN 1 right away to inform her of Resident 1's unstable condition. LVN 1 stated SRN 1 sent over the float LVN (LVN 2) to help with assessing and transferring Resident 1 as LVN 2 was familiar with the Resident 1. LVN 1 stated LVN 2 had placed the patient on 15 liters of oxygen with a non-rebreather mask and took another set of vital signs. No time was documented on when the vital signs were taken. LVN 2 stated she then notified the SRN who then instructed her to call 911. LVN 1 stated she could not recall the time of the events. LVN 1 stated she did not assign the role of a scribe to anyone.

During an interview with LVN 1 on [DATE] at 11:06 am, LVN 1 stated she could not remember if LVN 3 gave her the initial set of vital signs. She could not recall what they were. LVN 1 stated, I had all my papers with the critical vital signs, the bed hold, everything was gathered and placed under a rubber band on top of the chart, I must have put them there. LVN 1 stated she was unsure how the notes were going to be documented.

During an interview on [DATE] at 9:46 a.m. with LVN 2, LVN 2 stated she was called by SRN 1 early in the shift, around midnight. LVN 2 stated she was notified by the SRN to go to Resident 1's unit to help with transferring a resident [to the emergency room]. LVN 2 stated, When I got there Resident 1 was removing his oxygen, LVN 3 was assisting me while LVN 1 was talking to the daughter. I needed to gather additional information for the SBAR (Situation, Baseline, Assessment, Recommendations) report to better inform the doctor. I tried to call DOC 1, but she did not answer. I called two times, one right after the other. Then I notified the SRN who advised me to call 911 . I did not chart, I was just assisting the covering nurse.

During an interview on [DATE] at 8:04 a.m. with SRN 1, SRN 1 stated at around 12:30 a.m. she received a call from LVN 1 with concerns of Resident 1's elevated heart rate, shortness of breath and another episode of vomiting. SRN 1 stated she told LVN 1 she was sending help over, and to notify the DOC. SRN 1 then stated LVN 2 called back and stated the DOC was unreachable, LVN 2 had phoned DOC 1 twice. SRN 1 stated, I told her to call 911. Then I called the dispatch operator to inform them the ambulance was coming. SRN 1 could not recall the timeline of events. She stated it was around 12:50 a.m. when she went to the unit to assist.

During a review of a document titled, Office of Public Safety Communications Division Dispatchers Daily Log, dated [DATE] at ,d+[DATE] (11pm -7 am), the log indicated at 0111 (1:11 a.m) Received a call on the emergency line from the NOC (night shift) SRN reporting that staff on ward 1D had contacted 911 to respond to the unit, to transport Resident 1 to an outside medical facility .

(continued on next page)

Printed: 10/31/2024
Form Approved OMB
No. 0938-0391

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 08/29/2024

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 10:40 a.m. with Administrative Staff 1 (AS 1), AS 1 stated she called the fire department on [DATE] at 4:18 p.m. to get the record of the EMS report from the call on [DATE] for Resident 1. AS 1 stated she was told the 911 call came into fire department at 1:14 a.m. on [DATE]. The fire department arrived at 1:20 a.m. and EMS (Emergency Medical Services, the ambulance) arrived at 1:22 a.m. During a review of the policy and procedure (P&P) titled, Documentation, Transfers/Discharges (All Homes), dated [DATE], the P&P indicated, the documentation to include in an emergency/urgent transfer to a higher level of care was to include, Documentation of the event according to the protocols and policies set by the Home for resident changes of condition and emergencies. During a review of the policy and procedure (P&P) titled, Changes of Condition and Notifications, dated [DATE], the P&P indicated under the section for documentation, The Licensed Nurse will: a.) Record all attempts to notify and communicate with the DOC or PCP [Primary Care Physician] regarding resident change of condition or status whether verbally communicated or placed in a communication book requires a note by the nurse including the date, time, and method of communication in the Nurses Notes in the resident's health record. b.) Document date, time, condition and pertinent details of (the) sic incident and assessment in the Interdisciplinary Progress Notes.