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	02/06/2025

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41816 Based on observation, interview and record review, the facility failed to provide a safe environment by ensuring the safety of their residents for one of three sampled residents when Resident 1 was found dead outside the facility basement exit door. Findings: During a review of Resident 1's Interdisciplinary Note, dated [DATE] at 8:00 p.m., the note indicated Resident 1 was identified as missing at 6:00 p.m. on [DATE] when Resident 1 failed to return to the unit. A search for Resident 1 was initiated in the ward and throughout the building where the Skilled Nursing Facility (SNF) unit was located. A high-risk reportable incident was initiated. During a review of Resident 1's Patient Care Plan, dated [DATE], the plan indicated Resident 1 had the potential for Injury or Accident with his risk factors listed in Problem # 2 as a history of falls, chronic pain, neuropathy (a nerve condition that can lead to pain, numbness, weakness or tingling), weakness/unsteady gait, history of hypotensive (low blood pressure), history of ETOH [alcohol] consumption, poor safety awareness, forgets limitations, use of assistive device (4ww [four wheel walker], electric scooter) and Cognitive Impairment (Problems with a person's ability to think, learn, remember, use judgement, and make decisions). Problem # 8 indicated an additional risk for injury to Resident 1 when leaving the ward unaccompanied. The care plan problem indicated Resident 1 could experience a serious accident and/or injury (i.e. falls, dehydration, heat stroke, hypothermia (low body temperature), assault, traffic danger, etc.) that may lead to death. Or the resident could potentially get lost and unable to return to the ward on time for their care such as medications and or other treatments. During a review of the facility document titled, Office of Public Safety - Patrol Division Officers Daily Log, dated [DATE], it indicated at 11:27 p.m., CHP found the missing person, Resident 1, in the west wing at the exterior the portion of the building. [State] Fire declared Resident 1 deceased at 11:27 p.m. (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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 10:45 a.m. with California Highway Patrol officer (CHP 1), CHP 1 stated he was called on [DATE] by the graveyard CHP officer who needed assistance with initiating a Silver Alert (a public announcement that a senior citizen is missing). At 8:30 p.m. the process was started for initiating the Silver Alert. CHP 1 stated, There was aircraft available to assist in the search. It was them who located someone outside of the building, they requested the CHP office go to check the location. During a concurrent observation and interview on [DATE] at 3:35 p.m., with Certified Nursing Assistant 1 (CNA 1) in the basement of the building where the facility's SNF was located, CNA 1 walked through the basement explaining the areas he searched for Resident 1 on [DATE] at approximately 7:00 p.m. He stated he did not open the exit door near the smoking area to check outside when he was searching. He stated that door was not being used. CNA 1 stated he knew the door was unlocked and accessible. CNA 1 stated, I skipped that area, I'm not sure why. It is not an access for residents. We did not talk anything about that door during our search. CNA 1 stated he should have looked there too. The area directly outside the door was observed. The area was coned off for safety and there was a cyclone fence barrier enclosing a construction zone atop a stairway several feet from the door. There was no direct access to the public sidewalk from the doorway except over a grassy incline. During an interview on [DATE] at 4:10 p.m. with Registered Nurse 1 (RN 1), the RN in charge of Resident 1's ward on [DATE], RN stated he did not consider the resident would exit the door where he was found dead. RN 1 stated, I believe it was open and residents did have access to that area. I felt OPS (Office of Public Safety) would be doing the search outside . I was not asked to search the perimeter of the building. During an interview on [DATE] at 6:18 p.m. with the Office of Public Safety officer (OPS 2) on duty on [DATE] from 6:00p.m. to 6:00 a.m., OPS 1 stated, I did not ask if they completed a perimeter search of the building . My assumption was we were two different entities working on this. I feel like us lacking a detailed SOP [standard operating procedure] is a crutch for everybody . We are using a nursing missing person policy. I have asked for policies a hundred times. I have been told to just wait. There should be a policy for every department for missing persons. I was told we work alongside with nurses to help find the person . I had not received any additional training other than the nursing policy for a missing person situation . Those doors he exited out of are to be secured usually between ,d+[DATE] p.m. by us [OPS]. With the priorities of what needed to be done, I was more focused on the missing person than locking the doors. During an interview on [DATE] at 4:15 p.m. with Supervising Registered Nurse (SRN 1), SRN 1 stated, I called the morning shift and asked them when they last saw him. I was told at 12:30 p.m. he [Resident 1] was going to his podiatry appointment then to [city]. I was the point person. The contact person for the whole incident . I did not ask if the perimeter was searched. It was not in my thought. I assumed OPS did that. I did not ask OPS if they did a perimeter search. We can't go outside long enough. We cannot leave the residents. We searched every floor in the building. I did not think about that area [outside the side door where Resident 1 was located]. I passed through that area three times that night. It was not in my thought to look there or to open the door. The door was unlocked. I think it should have been looked at. At that time, we were so focused on the search in [city] . No one goes in there, it is a construction area. It should have been searched. I should have pushed the door open. My concern was the building, not the perimeter. (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 [DATE] at 10:15 a.m. with OPS Chief (OPS 1), OPS 1 stated the OPS was primarily involved in the exterior and grounds search. They use the nursing policy on missing persons as their guide. During an interview on [DATE] at 4:03 p.m. with RN 2, RN 2 stated she saw the door where Resident 1 was located, but she did not check it. It was pitch black outside . I feared for my safety. During an interview on [DATE] at 5:00 p.m. with SRN 2, SRN 2 stated, I do not think the perimeter of the building was checked. There are stairs out that door, but no access in or out besides the door. If we were going to check the whole building, we should have checked the perimeter. SRN 2 stated the CNA said he drinks, he may have been confused. I'm thinking they might not have checked outside that door as it was nighttime already. During an interview on [DATE] at 8:46 a.m. with Chief Health and Safety Officer (HSO 1), HSO 1 stated the Emergency Only exit sign, caution tape and cones were placed after the incident. HSO 1 stated, That is something we should have considered prior to the event . It is not an area of high traffic. The signage now is to minimize even more traffic through there. HSO 1 stated the exit discharge does not meet the requirements of exit regulations as it was an old building and to meet the code it would cost too much money. HSO 1 stated she did not consider the exit area to be a risk. During a concurrent observation and interview on [DATE] at 10:30 a.m. with Administrative Staff 2 (AS 2) in the basement of the building through the hallway adjacent to the smoking area and outside the door where Resident 1 was located. AS 2 stated the door is always left unlocked for emergency exits due to the Health and Safety Code. AS 2 stated, The area was not observed by the staff that night after the CHP found Resident 1 as it was considered a crime scene. During a review of the facility policy and procedure titled, Missing Resident/Elopement - Code Purple, dated [DATE], the policy indicated Phase 1, the initial search and notification process shall be completed within the first 2 hours of a known or suspected missing Resident. The policy indicated, Licensed Nurse gathers available staff to implement a search of the environment as follow The staff searches the Residents room, the unit, the last known location, the immediate outside perimeter of the building, neighboring units, and finally the Supervising registered nurse or designee and Office of Public Safety (OPS) coordinate an expanded facility wide search.