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	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interviews, and record review, the facility failed to ensure that food safety and sanitation guidelines were followed when multiple expired food items were found in the dry storage and refrigerator of the main and satellite kitchen. These failures posed the risk for food-borne illnesses (a sickness caused by consuming food, or drinks contaminated with harmful substances) in a medically fragile population of 162.Findings: During a concurrent observation and interview on 3/23/26 at 2:01 PM in the Main Kitchen- G07 Refrigerator with the Food Manager (FM) 1, one large tray labeled Orzo Pasta had an expiration date of 3/11/26. FM 1 stated the orzo pasta needed to be thrown away because it was only good for 7 days.During a concurrent observation and interview on 3/23/26 at 2:28 PM in the Main Kitchen- Dry Storage Room with FM 1, the following food items were found expired:One container of chorizo seasoning had an expiration date of 12/31/25Eight packages of ranch dressing/dip had expiration dates of 2/14/26.Three bottles of browning seasoning sauce had expiration dates of 8/29/25.Four bags of vanilla artificial flavor instant pudding had expiration dates of 3/17/23.Nine bags of marshmallows had expiration dates of 2/27/26.Two bags of vanilla puddings had expiration dates of 11/3/21.FM 1 confirmed all the items were expired and stated all expired foods needed to be discarded.During a concurrent observation and interview on 3/23/26 at 2:59 PM in the Satellite Kitchen- Refrigerator with FM 2, the following food items were found expired: - One box of Sweet n Sour sauce had an expiration date of 3/14/26. - Two boxes of Plant-Based baked tofu had expiration dates of 2/26/26.FM 2 confirmed the items were expired and stated they should have been thrown away.During a review of the U.S [United States] Food and Drug Administration (FDA) Food Code dated 2022, the U.S FDA Food Code indicated, . foods that exceed the use-by date . must be disposed of .

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the recommendations identified in the Level II PASRR (Preadmission Screening and Resident Review- used to ensure individuals are placed in an appropriate setting and receive needed mental health services) evaluation were implemented into the comprehensive care plan and resident care for one of 33 sampled residents (Resident 15). This failure resulted in Resident 15 not receiving the necessary specialized services and support identified through the PASRR process, placing Resident 15 at risk for unmet mental health needs, decline in Activities of Daily Living's (ADL- essential, basic self-care tasks done every day such as bathing, dressing, eating and moving around.) and diminished quality of care.Findings:During a review of Resident 15's admission Summary, undated, the admission Summary indicated Resident 15 was admitted to the facility on [DATE] for diagnosis to include bipolar disorder (mental health condition characterized by extreme, alternating shifts in mood, energy and activity levels). The admission Summary further indicated Resident 15 had generalized weakness. Patient will require assistance with meals, medications, clothing, dressing self. During a concurrent observation and interview on 3/24/26 at 8:57 AM in Resident 15's room with Resident 15, Resident 15 was sitting on the edge of his bed with his breakfast tray on the bedside table in front of him. Resident 15 was unable to reach his coffee and attempted to lean forward with mouth open to try and reach the straw with his lips, was unsuccessful and requested assistance. Resident 15 attempted to open a napkin, to wipe his nose, and fell backwards laying horizontal across his bed. Resident 15 stated he was not receiving any therapy and I should be, but I don't.During a concurrent interview and record review on 3/26/26 at 9:58 AM with Supervising Registered Nurse (SRN) 2, Resident 15's PASRR Level II Notice of Individual Determination, dated 10/25/25 was reviewed, the document indicated, Are Specialized Add-on Services Needed: Yes. This Individualized Determination Report is based on a review of the applicant's medical and social history, which reveals a significant medical condition with mental stressors that require nursing care. Recommended Specialized Add-on Services. Occupational Therapy [OT] Consultation- services to improve independence in activities of daily living. SRN 2 reviewed Resident 15's entire medical record and stated an OT consultation was not completed after the PASRR Level II recommendation was received.During an interview on 3/26/26 at 10:21 AM with the Chief of Rehabilitation Services (CRS), the CRS stated she cancelled Resident 15's OT consultation without evaluation and was not aware of the PASRR Level II recommendation.During an interview on 3/26/26 at 2:20 PM with the Medical Director (MD), MD confirmed with Resident 15's PASRR Level II Notice of Individual Determination, dated 10/25/25, that an OT consultation was recommended and stated Resident 15 should have received the OT consultation in accordance with PASRR Level II recommendation.The facility was unable to provide a policy and procedure for PASRR.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Care Plan was updated on one (1) of 33 sampled residents, when Resident 160 complained of swallowing difficulty. This failure had the potential to result in life-threatening outcomes including fatal aspiration pneumonia, choking, severe dehydration, and malnutrition.Findings: During a review of Resident 160's Face Sheet indicated he was originally admitted to the facility on [DATE] and was re-admitted on [DATE] with diagnosis including atrial fibrillation (a common heart rhythm disorder where the heart's upper chambers beat irregularly), chronic obstructive pulmonary disease (a progressive, incurable lung disease), and respiratory failure. During a review of Resident 160's Minimum Data Set (MDS) [standard assessment used in long-term care] Section C1000 - Cognitive Skills for Daily Decision Making, indicated a score of 0 meaning Resident 160 was independent with decisions regarding tasks of daily life. Also, in MDS Section K - Swallowing/Nutritional Status indicated Resident 160 complaints of difficulty or pain with swallowing. During a review of Resident 160's Care Plan indicated a problem for nutrition alteration related to dysphagia, chewing difficulty that was initiated on 7/17/25. Goal for the said problem included no signs and symptoms of aspiration. Resident 160 complained of swallowing difficulty on 2/11/26 and it was not documented on the care plan. During a concurrent observation and interview on 3/24/26 at 10:11 AM with Resident 160, Resident 160 was observed sitting on his wheelchair next to his bed with supplemental oxygen via nasal cannula (flexible tube used to deliver oxygen). Resident 160 stated he feelt like he had mucus build up and sore throat and sometimes had difficulty swallowing pills and food. Resident 160 also stated PM head nurse was aware about the swallowing issue and he brought it up numerous times. During a concurrent interview and record review on 3/24/26 at 9:39 AM with Desk Clerk (DC), Resident 160's Physician Orders from January to March 2026 were reviewed. DC stated there was no physician order found for swallow evaluation. During a concurrent interview and record review on 3/25/26 at 9:50 AM with Registered Dietitian (RD), Dietary Follow-Up Report dated 2/25/26 was reviewed. The report indicated Resident 160 reported difficulty swallowing water. Resident stated it gets stuck in his throat and he has to burp it up. Wrote recommendation for swallow eval in MD book. Nursing and SLP were notified. RD stated she recall notifying the nurse and speech pathologist on 2/11/26 about Resident 160's swallowing difficulty. During an interview on 3/25/26 at 9 AM with Licensed Vocational Nurse (LVN) 1, LVN 1 stated during emergency or urgent situations, physician needed to be notified right away and assess the resident. LVN 1 also stated that swallowing difficulty was considered change of condition which required immediate attention. LVN 1 stated licensed staff were required to document assessments, vital signs, signs and symptoms in the nursing progress notes. LVN 1 stated Resident 160's care plan should have been updated if resident complained of swallowing difficulty. During an interview on 3/25/26 at 9:06 AM with Supervising Registered Nurse (SRN) 1, SRN 1 stated swallowing difficulty was considered a change of condition which required resident assessment, physician notification, updated care plan and documentation on nursing progress notes because swallowing difficulty can affect resident's respiratory system and required urgent attention. During a concurrent interview and record review on 3/25/26 at 9:09 AM with Registered Nurse Case Manager (RNCM) 1, Resident 160's Care Plan and Nursing Progress Notes were reviewed. Resident 160's care plan was not updated when he reported swallowing difficulty on 2/11/26 and there were no nursing progress notes found indicating Resident 160's complaints of swallowing difficulty on 2/11/26. RNCM 1 stated the care plan should have been updated and there should have been a nursing progress note on 2/11/26 when Resident 160 reported swallowing difficulty. During a review of the facility's policy and procedure (P&P) titled, Change of Condition and Notification, dated 9/12/24, the P&P indicated, Urgent Situations a. Any sudden and/or marked adverse change in signs, symptoms . exhibited by a patient . D. Documentation (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. The Licensed Nurse will: a. Record all attempts to notify and communicate with the DOC or PCP regarding resident change of condition or status whether verbally communicated or placed in the 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 incident and assessment in the interdisciplinary Progress Notes . e. Update care plan to reflect current status. During a review of the facility's P&P titled, Care Plans - SNF/ICF (All Homes), dated 1/15/26, the P&P indicated, the baseline care plan must reflect changes to approaches or interventions, when there is/are significant changes) in condition or need(s).

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents received the necessary care and services to maintain or improve Activities of Daily Living (ADLs- essential, basic self-care tasks done every day such as bathing, dressing, eating and moving around) for five (5) of 33 sampled residents (Residents 15, 105, 97, 40, and 69) when:1. Resident 15 did not receive Occupational Therapy (OT) services in accordance with the physician order. This failure resulted in functional decline in ADLs.2. Residents 105, 97, 40, and 69 did not receive daily partial baths in accordance with the facility's policy and procedure (P&P). This failure placed residents at risk for poor hygiene, including body odors that can lead to social withdrawal, depression and significant emotional distress. 1. During a review of Resident 15's Face Sheet (demographics), undated, the Face Sheet indicated Resident 15 was admitted to the facility on [DATE] with diagnosis to include bipolar disorder (mental health condition characterized by extreme, alternating shifts in mood, energy and activity levels). During a concurrent observation and interview on 3/24/26 at 8:57 AM in Resident 15's room with Resident 15, Resident 15 was sitting on the edge of his bed with his breakfast tray on the bedside table in front of him. Resident 15 was unable to reach his coffee and attempted to lean forward with mouth open to try and reach the straw with his lips, he was unsuccessful and requested assistance. Resident 15 attempted to open a napkin, to wipe his nose, and fell backwards, laying horizontal across his bed. Resident 15 stated he was not receiving any therapy and I should be, but I don't. During a concurrent interview and record review on 3/26/26 at 9:58 AM with Supervising Registered Nurse (SRN) 1, Resident 15's medical record was reviewed. A physician order for Occupational Therapy (OT) was ordered on 10/21/25 but there was no OT evaluation completed. SRN 1 stated she does not know why the OT evaluation was not completed and she was aware of Resident 15 requiring moderate assistance for ADLs. During a concurrent interview and record review on 3/26/26 at 10:21 AM with the Chief of Rehabilitation Services (CRS), the following documents of Resident 15 were reviewed: - Physician Orders (PO), dated 10/21/25, indicated an evaluation and screening of OT was to be completed. - ADL Flow Sheet, dated October 2025, indicated Resident 15 was independent (resident completes the activity by himself with no assistant from staff) for toileting hygiene, putting on/taking off footwear, and majority of the time for lower body dressing. The ADL Flow Sheet further indicated he required moderate assistance (staff does less than half of the task) for personal hygiene. - ADL Flow Sheet, dated March 2026, indicated Resident 15 was dependent (staff does all the effort, resident does none of the effort to complete the activity) for toileting and personal hygiene, and required moderate assistance for putting on/taking off footwear. The ADL Flow Sheet further indicated he required moderate assistance for lower body dressing. The CRS stated Resident 15 had a decline in his ADL's and required an immediate evaluation of OT. During an interview on 3/26/26 at 10:40 AM with Licensed Vocational Nurse (LVN) 2, LVN 2 stated (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 15 was more independent when he was first admitted to the facility, but now he needed a lot more help with all ADLs. LVN 2 stated Resident 15 needed more help with administering medications, drinking, feeding, hygiene, lying to sitting, and getting dressed. During an interview on 3/26/26 at 10:42 AM with Certified Nursing Assistant (CNA) 3, CNA 3 stated Resident 15 needed maximum assistance with ADLs to include: putting on shoes, straightening/sitting up in bed, getting dressed, brushing his teeth, and feeding. CNA 3 further stated he has declined more noticeably in the past month. During an interview on 3/26/26 at 2:25 PM with the Medical Director (MD), the MD stated he was not aware prior to the survey of Resident 15 declining with ADL's and not receiving OT. The MD stated after he was made aware by the CRS, he reviewed Resident 15's medical record and confirmed Resident 15 had a decline in ADL's and required an OT evaluation/ therapy. During an interview on 3/26/26 at 3:03 PM with the Administrator, the Administrator confirmed with Resident 15's medical record he had a decline in ADL's and stated there was a possibility that the ADL decline would have been prevented if Resident 15 received the occupational therapy and followed the recommendations. During an interview on 3/26/26 at 3:27 PM with Occupational Therapist, Occupational Therapist stated he had not seen Resident 15 for OT. Occupational Therapist further stated OT was provided to help with ADLs to include bathing, toileting, eating and dressing. During a review of Resident 15's History and Physical (H&P), undated, the H&P indicated Resident 15 was transferred from a lower level of care unit due to needing increased assistance with ADLs. The admission Summary further indicated Resident 15 had diagnosis of, generalized weakness. Patient will require assistance with meals, medications, clothing, dressing self. During a review of Resident 15's Interdisciplinary Team Conference (IDTC), dated 10/29/25, the IDTC indicated Resident 15 had a problem with ADL function and the team recommendation was Resident 15 needed an OT evaluation/therapy for muscle and strengthening. The IDTC further indicated Resident 15 was independent for toileting and hygiene and required set up assistance with showering and partial assistance for lower body dressing. During a review of Resident 15's Interdisciplinary Team Conference (IDTC), dated 1/20/26, the IDTC indicated Resident 15 had a problem with ADL function and required partial assistance with toileting, hygiene and substantial assistance for lower body dressing. During a review of the Facility Assessment, dated 3/2/26, the Facility Assessment indicated, .The list below provides general categories of services and care the facility offers residents based on needs identified through the assessment process. Activities of daily living: Bathing, showers, oral/denture care, dressing, eating, supporting resident independence in doing as many of these activities by themselves as possible. Occupational therapy (OT). During a review of the facility's policy and procedure (P&P) titled, ADL, dated 9/8/25, the P&P indicated, .each resident will be encouraged and/or assisted to achieve and maintain their highest level of self-care and independence. During a review of the facility's P&P titled, Physical & Occupational Therapy Services, dated 2/24/26, (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the P&P indicated, .Occupational therapy services will be provided to residents of the skilled nursing facility. according to primary care provider (PCP) orders. Occupational therapy service: those services ordered by a physician for a resident or upon a physician's referral and provided to a resident. Occupational Therapists will respond timely to PCP's order. Requests for therapy evaluations will be completed as soon as possible. Occupational Therapy Services. ADL Training. 2. During a review of Resident 105's Face Sheet, the Face Sheet indicated Resident 105 was originally admitted on [DATE] and was re-admitted on [DATE] with diagnosis that included heart disease, nicotine dependence, gait abnormalities, and muscle weakness. ^ During a review of Resident 105's Minimum Data Set (MDS) [standard assessment used in long-term care] Section C – Cognitive Patterns, dated 2/26/26, the MDS indicated Resident 105's Brief Interview for Mental Status (BIMS) [15-point cognitive screening tool used in long-term care to assess memory and orientation] total score of 12. In the MDS Section GG0130 – Self-Care functional abilities (assessment period was day the assessment was performed plus two (2) previous calendar days), the MDS indicated Resident 105's shower/bathe self was Coded 09 (indicating the activity was not applicable - not attempted and the resident did not perform this activity). During a review of the facility's Smokers List, dated 3/20/26, the list indicated Resident 105 and Resident 97 were smokers and both go off ward daily on their own time.^ During a concurrent observation and interview on 3/23/26 at 3:08 PM with Resident 105, Resident 105 was observed lying in bed with strong nicotine smell in the room. Resident 105 said Monday was his scheduled shower day, but the assigned staff ignored him this morning. Resident 105 stated his last shower was about 5 weeks ago before moving to this unit from another ward. Resident 105 stated he did not want to complain but really wanted to shower because he smoked every day. ^ During an interview on 3/23/26 at 4:23 PM with Registered Nurse Quality Assurance (RNQA) 1, RNQA 1 stated Resident 105 moved from another ward to his current location on 1/16/26. RNQA stated Resident 105 was independent with shower.^ During a concurrent interview and record review on 3/25/26 at 10:24 AM with Certified Nurse Assistant (CNA) 1, Resident 105's Activities of Daily Living Flowsheets (ADL Flowsheet) were reviewed. The flowsheet for Resident 105's shower/bathe self, dated from 1/16/26 to 1/31/26, indicated 14 out of the 16 days for the month of January were documented as Code 09 (indicating the activity was not applicable - not attempted and the resident did not perform this activity). The flowsheet for Resident 105's shower/bathe self, dated from 2/1/26 to 2/28/26, indicated 18 out of the 28 days for the month of February were documented as Code 09. And on the flowsheet for Resident 105's shower/bathe self, dated from 3/1/26 to 3/22/26, indicated 19 out of the 22 days for the month of March were documented as Code 09. CNA 1 stated we were supposed to shower or bath each resident or offer it to the resident daily. ^ During a concurrent interview and record review on 3/25/26 at 10:38 AM with CNA 1, Resident 97's (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ADL Flowsheets were reviewed. The flowsheet for Resident 97's shower/bathe self, dated 1/1/26 to 1/31/26, indicated 28 out of the 31 days for the month of January were documented as Code 09. The flowsheet for Resident 97's shower/bathe self, dated 2/16/26 to 2/28/26, indicated 11 out of the 13 days for the month of February were documented as Code 09. And on the flowsheet for Resident 97's shower/bathe self, dated from 3/1/26 to 3/24/26, indicated 15 out of the 24 days for the month of March were documented as Code 09. CNA 1 stated a Code 09 meant the activity was not attempted or resident did not do the activity. CNA 1 also stated shower, or bath should have been offered daily to Resident 97. ^ During a concurrent interview and record review on 3/25/26 at 10:52 AM with CNA 1, Resident 40's ADL flowsheets were reviewed. The flowsheet for Resident 40's shower/bathe self, dated 1/1/26 to 1/31/26, indicated 29 out of the 31 days for the month of January were documented as Code 09. The flowsheet for Resident 40's shower/bathe self, dated 2/1/26 to 2/28/26, indicated 25 out of 28 days for the month of February were documented as Code 09. And on the flowsheet for Resident 97's shower/bathe self, dated from 3/1/26 to 3/24/26, indicated 20 out of the 24 days for the month of March were documented as Code 09. CNA 1 stated we should have attempted or offered a daily bath to Resident 40. ^ During a concurrent interview and record review on 3/25/26 at 11:05 AM with CNA 1, Resident 69's ADL flowsheets were reviewed. The flowsheet for Resident 69's shower/bathe self, dated 1/1/26 to 1/31/26, indicated 1 out of the 31 days for the month of January was documented as Code 09. The flowsheet for Resident 69's shower/bathe self, dated 2/1/26 to 2/28/26, indicated 16 out of the 28 days for the month of February were documented as Code 09. And on the flowsheet for Resident 69's shower/bathe self, dated from 3/1/26 to 3/24/26, indicated 20 out of the 24 days for the month of March were documented as Code 09. CNA 1 stated daily baths should have been attempted or offered to Resident 69. During an interview on 3/26/26 at 7:51 AM with Assistant Director of Nursing (ADON) 1, ADON 1 stated residents hygiene shower or partial baths should have been offered or attempted to provide daily.^ During a review of the facility's P&P titled, ADL, STANDARDS, dated 9/8/25, the P&P indicated, Staff will ensure residents are free of offensive odors by providing daily partial baths .^

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one (1) of 33 sampled residents (Resident 97), Resident 97's food tray matched the meal ticket. This failure had the potential to result in malnutrition and weight loss.Findings: During a review of Resident 97's Face Sheet, the Face Sheet indicated Resident 97 was originally admitted on [DATE] and was re-admitted on [DATE] with diagnoses including traumatic subdural hematoma (a life-threatening collection of blood between the brain's surface and its outer covering) without loss of consciousness, atrial fibrillation (a common heart rhythm disorder where the heart's upper chambers beat irregularly), chronic obstructive pulmonary disease (a progressive, incurable lung disease), and abnormalities of the gait. During a concurrent observation and interview on 3/23/26 at 5:14 PM with Resident 97, Resident 97 was observed sitting at the edge of his bed with his dinner tray on top of the bedside table. Verbal consent was obtained and granted to compare the food on his tray with the meal ticket. There was no grilled ham and cheese sandwich found on the tray. A tomato soup was found on the tray instead which was not on the meal ticket. During a review of Resident 97's Meal Ticket for 3/23/26 Supper, the meal ticket indicated regular diet with the following food items: salt pepper sugar, pudding variety, ice cream, gel strawberry with peaches, salad Caesar, juice v-8, mighty shake chocolate, and grill ham and cheese sandwich. During a concurrent observation, interview and record review on 3/23/26 at 5:42 PM with Registered Nurse Quality Assurance (RNQA) 1, Resident 97's meal ticket was reviewed. The grill ham and cheese sandwich was missing, and tomato soup was served on the food tray. RNQA 1 stated the meal ticket should have matched what was on the Resident 97's food tray. During an interview on 3/26/26 at 9:11 AM with Assistant Director of Nursing (ADON) 1, ADON 1 stated licensed nurses checked both the diet order and also the food tray for accuracy during mealtimes prior to serving the food trays to the residents. During a review of the facility's policy and procedure (P&P) titled, Diet, Meals and Snacks, dated 2/4/26, the P&P indicated, Licensed nurse personnel ensure patients are served the diets as ordered by the attending licensed healthcare practitioner acting within the scope of his/her professional licensure. During a review of the facility's P&P titled, Meal Observations, dated 1/2/26, the P&P indicated, B. Meal Observations . 1. Tray Accuracy - Did the resident receive what is on the meal ticket .?

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	03/26/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement infection control and prevention practices for two of 33 sampled residents (Resident 16 and 171) when:1. Certified Nursing Assistant (CNA) 3 was observed in Resident 171's room without the required Personnel Protective Equipment (PPE-gear worn to minimize exposure to illnesses) for Enhanced Droplet Precaution (EDP-strict rules used to prevent spread of serious illnesses that travel through the air).2. Certified Nursing Assistant (CNA) 4 was observed transferring Resident 16 from the bed to the wheelchair without the required Personnel Protective Equipment (PPE-gear worn to minimize exposure to illnesses) for Enhanced Barrier Precaution (EBP- infection control intervention designed to reduce the transmission of infections in nursing homes).Findings:1. During a review of Resident 171's Face Sheet (demographics), the Face Sheet indicated Resident 171 was admitted to the facility on [DATE] with diagnosis that included acute bronchitis (inflammation in respiratory system) due to rhinovirus (highly contagious cold that infects nose and throat).During a concurrent observation and interview on 3/24/26 at 4:23 PM in Resident 171's room with CNA 4, EDP signage that indicated, To prevent the spread of infections, Staff entering this room must wear: N95 Mask, Face Shield, Gown, Gloves. was posted outside of the door with a PPE cart. CNA 3 was observed walking away from Resident 171's bed and cleaning the vital signs machine while wearing gown, gloves and surgical mask. CNA 3 confirmed he was not wearing an N95 and face shield and stated he was unaware of the required PPE for EDP rooms.During an interview on 3/25/26 at 2:36 PM with Infection Preventionist (IP) 1, IP 1 stated Resident 171 was on EDP for respiratory symptoms associated with a positive test result of rhinovirus, enterovirus (contagious virus) and Methicillin-resistant Staphylococcus Aureus (MRSA-bacteria that causes infections that are resistant to many antibiotics) of the nose. IP 1 further stated all staff were to wear gloves, gowns, face shield and an N95 when entering Resident 171's room.During a review of Resident 171's Physician Orders (PO), dated 3/20/26, the PO indicated Resident 171 had an order for Enhanced Droplet Precaution.During a review of the facility's policy and procedure (P&P) titled, Infection Control- Viral Respiratory Illnesses, dated 3/20/26, the P&P indicated, All staff must wear appropriate PPE as required. Signs will be posted outside of resident rooms indicating appropriate infection control, prevention and precautions, including required PPE.2. During a review of Resident 16's Face Sheet (demographics), undated, the Face Sheet indicated Resident 16 was admitted to the facility on [DATE], with diagnosis that included neuromuscular dysfunction of bladder (lost control of bladder due to nerve damage).During a concurrent observation and interview on 3/24/26 at 9:36 AM in Resident 16's Room with CNA 4, EBP signage that indicated, Anyone participating in any of these movements must also: [NAME] [put on] gown and gloves. transferring. was posted outside of the door with a PPE cart. CNA 4 was observed assisting another CNA with transferring Resident 16 from his bed to the wheelchair with a Hoyer lift (mechanical device used by caregivers to safely transfer residents with limited mobility). CNA 4 was not wearing a gown or gloves. CNA 4 confirmed she was not wearing a gown or gloves and stated she did not have to wear the required PPE listed on the sign because Resident 16 was not exposed (unclothed/naked).During an interview on 3/25/26 at 2:45 PM with Infection Preventionist (IP) 1, IP 1 stated Resident 16 was on EBP for an indwelling catheter (flexible tube placed into the bladder to drain urine). IP 1 further stated all staff assisting in high contact activities, including transferring, were required to wear PPE such as gown, gloves and mask.During a review of the facility's tracking log of Precautions, dated 3/26/26, the tracking log indicated Resident 16 was on EBP for indwelling catheter device.During a review of the facility's policy and procedure (P&P) titled, Enhanced Barrier Precautions, dated 12/30/25, the P&P indicated EBP was defined as Infection control interventions requiring gown and glove use during high-contact resident care activities. The P&P further indicated the facility should implement EBP for residents with indwelling medical devices and that High-Contact Activities included . transferring.