STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555795	A. Building B. Wing	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Veterans Home of California - Chula Vista	700 East Naples Court Chula Vista, CA 91911

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 - 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** 35626 Based on observation, interview and record review, the facility failed to provide adequate/ necessary supervision to prevent elopement (when a resident leaves the premises or safe area without the facility's knowledge and supervision) with injury for one of three sampled residents (Resident 1), when the facility staff failed to assess level of supervision required for safety for Resident 1, who was cognitively impaired, for elopement risk when he attempted to leave the facility and fell at the facility's back gate on 6/5/2023. In addition, the facility staff did not follow the facility expectation as directed to visualize the resident every two hours. Resident 1 eloped and fell approximately one mile from the facility, and was missing for approximately 9 hours, on 1/24/2024. These failures resulted in a two-centimeter forehead laceration that required five sutures for Resident 1 and had the potential to result in serious impairment and death. Findings: During a review of the Minimum Data Set (MDS- assessment tool that measures health status in nursing home residents), dated 12/10/2023, the MDS indicated Resident 1 had a BIMS (Brief Interview for Mental Status- a tool to measure and track a resident's cognitive decline or improvement) score of 9 out of 15 (a score of 8 to 12 suggests moderate cognitive decline). During a review of the Physician Order (PO), dated 9/29/2023, indicated Resident 1 may go out of the facility on pass with a responsible party. During a review of the History and Physical (H&P), dated 5/22/2023, the H&P indicated Resident 1 was readmitted to the facility on [DATE]. Resident 1's diagnoses included dementia (the loss of cognitive function-thinking, remembering, and reasoning, which interferes with a person's daily life) and paranoid schizophrenia (serious mental illness that causes disorganized thinking). During an interview with the Facility Administrator (FM) on 1/26/2024 at 10 AM, the FM stated the facility's staff did not know Resident 1's whereabouts on 1/24/2024 after 9:12 AM until he was returned to the facility via ambulance from the hospital at 6:40 PM. (Resident 1 was missing for approximately 9 hours). (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 - Actual harm Residents Affected - Few	During a concurrent observation and interview on 1/26/2024 at 10:19 AM, in the facility's Activity Room, Resident 1 was observed with a bandage on his forehead, dark purple discoloration on the skin under both eyes, and an abrasion/scab along the entire length of his nose. Resident 1 was ambulatory with a walker. He had on a red color-coded identification (ID) badge. Resident 1 was alert and oriented. Resident 1 stated he walked without his walker to the nearby shopping center (approximately a one mile walk from the facility), tripped, and fell on his face in the parking lot, on 1/24/2024. He stated he was taken by ambulance to the hospital for his injuries. Resident 1 stated that he did not notify staff that he was leaving the campus, and he did not sign out when he left. Resident 1 further stated he attempted to go to the same shopping center a few months ago (on 6/5/2023) but he could not control his walker going downhill and fell by the facility's back gate (South Gate). During a review of Resident 1's Nursing Note, dated 6/5/2023, indicated the facility's Security Guard called at 8:50 AM to report that Resident 1 fell on the pavement at the facility's South Gate (back gate). Resident 1 sustained a forehead abrasion, and skin tears on his left elbow and right fourth finger. Resident 1 stated, I tripped from my walker, and I lost my balance. During a review of the Interdisciplinary Team (IDT) Meeting Note for Resident 1's fall on 6/5/2023, the IDT Meeting Note indicated Resident 1 was alert and oriented x2, with intermittent confusion and forgetfulness. Resident 1 was found by nursing staff on the pavement outside of the South Gate (back gate). Per the resident, he wanted to go to the store to buy reading glasses, but had difficulty maneuvering his walker going downhill, lost his balance on the pavement and fell . During a concurrent interview and review with the Standards Compliance Coordinator (SCC) on 2/14/2024 at 5:32 PM, the facility's Security Video Surveillance Record, dated 1/24/2024, indicated Resident 1's physical locations as follows: a. At 9:07 AM - walking through the facility's lobby past the Pharmacy. b. At 9:10 AM - walking on campus towards the South Gate (back gate leads to public roads). c. At 9:12 AM - walking toward the South Gate (back gate), and then he walked out of camera view. The SCC stated Resident 1 left the facility's campus unsupervised on 1/24/2024 at 9:12 AM. During a review of the acute care hospital's Emergency Department (ED) Record, dated 1/24/2024 at 10:40 AM, the ED Record indicated Resident 1 arrived via ambulance after he fell down in the parking lot, face forward and sustained a two-centimeter forehead laceration that required five sutures. During a concurrent interview and record review with the Certified Nurse Assistant (CNA 1), on 3/6/2024 at 2:55 PM, the AM Shift Resident Monitoring Sheet, dated 1/24/2024, included documentation of Resident 1's physical locations as follows: a. At 7 AM -documented as [in] Room. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	b. At 9 AM -documented as [in] Room. c. At 11 AM -documented as Around/out of POD [common area]. CNA 1 stated she did not look for Resident 1 on 1/24/2024 at 11 AM because she knew his routine. She stated that he usually went to the Canteen to buy ice cream, and then he would go back to the POD. CNA 1 stated that when she went to deliver Resident 1's lunch on 1/24/2024 at around 12:15 PM, he was not in his room, but his walker was there. CNA 1 stated she looked for him but could not find him, so she notified the nurse. During an interview with the Registered Nurse (RN 1) on 6/5/2024 at 3:20 PM, RN 1 stated she expected CNA 1 to visualize Resident 1 when she monitored and documented his whereabouts. RN 1 stated it was unacceptable to document Around/out of POD, without the actual visualization on 1/24/2024 at 11 AM. During an interview with the Director of Nursing (DON) on 6/5/2024 at 10 AM, the DON stated CNAs were directed to observe and document the residents' whereabouts every two hours, as a Best practice. The DON further stated it was unacceptable for CNA 1 to document Resident 1's location without direct visualization on 1/24/2024 at 11 AM. During a review of Resident 1's Safety/Fall Risk Care Plan (CP) initiated on admission included Red ID badge, initiated on 3/27/2020, without an end date. The CP was updated after Resident 1's attempted elopement and fall with injuries on 6/5/2023. The interventions included to monitor resident's whereabout frequently, remind resident for safety precautions, and to not go out of the campus without a responsible party. During an interview with the Director of Nursing (DON) on 2/23/2024 at 11:58 AM, the DON stated that after Resident 1's attempt to leave the facility's campus without staff knowledge on 6/5/2023, the IDT Team agreed that Resident 1 was still able to travel safely throughout the campus and should continue to have [NAME] ID badge privileges. She stated there was no documented assessment, rather a discussion among IDT members. During a review the medical record, there was no documented evidence to show an order or an assessment for [NAME] ID badge privileges for Resident 1 after 6/5/2023 when Resident 1 attempted to go to the store (off of the facility's premises) by himself to buy reading glasses. During a follow-up interview on 2/23/2024 at 1 PM, with the DON, the DON stated they did not develop policies and procedures to prevent elopements because they were an unlocked facility, and residents had the right to leave the facility. The DON also stated an Elopement Risk Assessment was not conducted for Resident 1, after incident 6/5/2023 when he attempted to go to the store by himself. During a review of Resident 1's medical record, the medical record failed to show documented evidence of an Elopement Risk assessment was completed when Resident 1 attempted to elope on 6/5/2023, to prevent the elopement and fall with injuries on 1/24/2024. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of the facility Policy and Procedure (P&P), Campus Access Identification of (Facility) Residents, dated 5/30/2023, the P&P included, the purpose of identification (ID) badge color codes was to communicate to staff the primary care provider recommended safety protocols for all residents. [NAME] was for residents deemed able to safely travel throughout the campus without assistance, and Red was for residents with Physician recommendations to limit unsupervised travel within Building A and the sidewalks around Building A (facility's campus). During a review of the facility Policy and Procedure (P&P), Elder Abuse, Prevention and Reporting, dated 6/6/2022, the P&P included Neglect- the failure of the facility to provide services to the Resident necessary to avoid physical harm, and to identify, correct and intervene in situations in which neglect is more likely to occur.