Department of Veterans Affairs State Veterans Home Survey Report

This survey report and the information contained herein, resulted from the State Veterans Home (SVH) Survey as a Summary Statement of Deficiencies. (Each Deficiency Must be Preceded by Full Regulatory or applicable Life Safety Code Identifying Information.) Title 38 Code of Federal Regulations Part 51 is applied for SVHs applicable by level of care.

General Information:

Facility Name: Veterans Home of California - Yountville

Location: 100 California Drive Yountville, CA 94599

Onsite / Virtual: Onsite

Dates of Survey: 9/26/22-9/29/22

NH / DOM / ADHC: NH

Survey Class: Annual

Total Available Beds: 336

Census on First Day of Survey: 220

VA Regulation Deficiency	Findings
	Initial Comments: A VA Annual Survey was conducted from 9/26/22, through 9/29/22, at the Veterans Home of California - Yountville. The survey revealed the facility was not in compliance with Title 38 CFR Part 51 Federal Requirements for State Veterans Homes.
§ 51.100 (a) Dignity. The facility management must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Level of Harm – No Actual Harm, with potential for more than minimal harm Residents Affected - Few	Based on observation, interview, record review, and review of facility policy, it was determined that for one (1) of 32 sampled residents (Resident #6) the facility failed to ensure the resident was provided assistance with donning personal clothing, based on the resident's preferences. Resident #6 was observed lying in bed wearing a hospital gown. The resident indicated wearing a hospital gown was not their preference, but staff did not offer to assist the resident with selecting and wearing their own personal clothing. The findings include: Review of a facility policy titled, "ADL [Activities of Daily Living] Standards," revised 5/9/22, revealed, "P. CLOTHING Residents will be assisted with dressing as needed.". The policy stated: "Residents [sic] clothing would be: 1. Street clothes while out of bed (unless resident is ill). 2. Season appropriate and will provide adequate coverage & warmth. 3. Comfortable and properly labeled. 4. Specific to resident's level of independence and activity. 5. Reflective of resident's individual preference."

	Resident #6 was admitted to the facility in 2021. The resident's diagnosis included Post Traumatic Stress Disorder (PTSD), Depression, Obesity, and Cerebrovascular Accident (CVA) with resulting Hemiplegia. Review of an annual Minimal Data Set (MDS) assessment, dated [DATE], revealed Resident #6 had a Brief Interview for Mental Status (BIMS) score of 13, indicating independence in cognition for decision making. The resident required the extensive assistance of one (1) staff person with dressing, and hygiene. Resident #6 required the total assistance of one (1) person with toileting and bathing. The resident triggered for further review of ADL status using the Care Area Assessment (CAA) process. A review of the CAA summary revealed the resident had a history of CVA with left sided weakness affecting his/her ability to self-perform ADL care. A review of Resident #6's Care Plan, dated [DATE], revealed the problem deficit of an ADL function alteration related to being non-ambulatory requiring total assistance with transfers. The deficit was related to diagnoses including CVA with left sided Weakness, Chronic Neuropathic Pain, Coumadin Use, Edema, Hypothyroidism, Obesity, PTSD, Mood Disorder, Depression, and Incontinence of Bowel and Bladder. The goal was for Resident #6 to have good hygiene and be clean and free from odor. Interventions included that the resident would be encouraged to make choices in their daily routines. The interventions included a notation from an interview conducted with the resident regarding daily preferences on [DATE]. The intervention stated it was very important for the resident to choose what clothes to wear, to take care of their personal belongings or things, and to choose between a bath or shower. Observation and interview, on 9/26/22, at 11:02 a.m., revealed Resident #6 was lying in bed on their back wearing a hospital gown. The resident complained their adult brief needed to be changed but staff would not assist them. Resident #6 stated staff did not respond when they called for them. Observation, on 9/27/22, at 9:20 a.m., revealed Resident #6 was lying in bed wearing a hospital gown. When questioned regarding wearing a hospital gown, Resident #6 stated the staff never offered to dress them in their own clothing. Observation of Resident #6 on the same day at 3:15 p.m., revealed the resident remained in bed wearing a hospital gown. Observation, on 9/28/22, at 9:50 a.m., revealed Resident #6 was lying on their back in bed. The resident was wearing a hospital gown. When questioned, the resident stated they did have their own clothing, however staff always put a hospital gown on them when in bed. The resident further stated they guessed the staff put a hospital gown on them to make it easier for the staff to change

	their brief. Resident #6 stated they would like to wear their own clothes sometimes. Resident #6's call light was pushed and the assigned Licensed Nurse A entered the resident's room. Resident #6 asked what the time was. The resident pointed to a clock on the wall stating it had not worked for a long time and they were never able to determine what time of day it was. Observation of the clock revealed the time displayed was 2:40, but the actual time was 10:00 a.m. Resident #6 stated staff would not fix the clock on the wall and they "lay here with no idea what the real time is." Resident #6 stated that they wished they could put their own clothes on and get out of the bed. An interview was conducted, on 9/26/22, at 11:10 a.m., with Licensed Nurse B, who was assigned to care for Resident #6. Licensed Nurse B stated it was Resident #6's preference to wear a hospital gown while in bed. Licensed Nurse B stated the resident wearing a hospital gown also made it easier for staff to change the resident's brief. An interview was conducted, on 9/27/22, at 9:30 a.m., with Licensed Nurse A who was assigned to care for Resident #6. Licensed Nurse A stated Resident #6 was "bed bound." Licensed Nurse A stated Resident #6 preferred to wear a hospital gown and added the resident was incontinent, so it was more comfortable for them to wear a hospital gown. Licensed Nurse A stated the resident did have their own "civilian clothes," but staff did not put them on the resident. An interview was conducted, on 9/28/22, at 10:15 a.m., with Certified Nurse Aide A who was assigned to provide care for Resident #6. Certified Nurse Aide A stated Resident #6 wore a hospital gown in bed because it was more comfortable and easier for staff to change the resident's adult brief. An interview was conducted, on 9/28/22, at 12:30 p.m., with Consultant Staff A who provided services for Resident #6. Consultant Staff A stated the resident had been depressed ever since being admitted to the facility. Consultant Staff A stated that they were aware Resident #6 was usually in bed wearing a hospital gown. Consultant Staff A stated Resident #6 had told them the staff wouldn't dress them in their own clothing. Consultant Staff A stated they had discussed with the direct care staff and the resident's Interdisciplinary Team (IDT) the importance of assisting Resident #6 with wearing their own personal clothing. However, according to Consultant Staff A, Resident #6 continued to remain in a hospital gown while lying in bed. Consultant Staff A stated they were not sure why assistance with dressing was not being provided.

§ 51.110 (e) (2) Comprehensive care plans. A comprehensive care plan must be— (i) Developed within 7 calendar days after completion of the comprehensive assessment; (ii) Prepared by an interdisciplinary team, that includes the primary physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and (iii) Periodically reviewed and revised by a team of qualified persons after each assessment. Level of Harm – No Actual Harm, with potential for more than minimal harm Residents Affected – Few	Based on observations, interviews, and record review, the facility failed to ensure a comprehensive care plan was revised to include measurable interventions for response to residents experiencing hypoglycemic episodes for one (1) of one (1) (Resident #29) residents reviewed. The findings include: Review of Resident #29's medical record revealed an initial admission date of 2018, and a readmission date of 2022. Resident #29's medical diagnoses included Type 2 Diabetes. Resident #29 required limited assistance with most activities of daily living (ADLs). Resident #29's blood glucose was monitored by a continuous glucose monitoring system (CGM). On 9/28/22, at 8:48 a.m., Resident #29 was observed walking from their room into the hallway and yelling loudly, "I need my blood sugar checked! I feel like I am going to black out!" Resident #29 then returned to their bed. Approximately eight (8) minutes later, at 9:02 a.m., Licensed Nurse C responded to Resident #29's room and checked the blood glucose using the CGM meter. The result read "Low." Licensed Nurse C explained that they would recheck the blood glucose using the facility's glucometer. On 9/28/22, at 9:05 a.m., Licensed Nurse C checked Resident #29's blood glucose with a result of "65." Resident #29 was lying in bed with eyes closed and stated, "I don't feel good." Licensed Nurse C did not respond to Resident #29's complaint and left the room. While Licensed Nurse C was out of the room, a brief interview was conducted with Resident #29. Resident #29 stated they had "big problems controlling my blood sugar here." Resident #29 added, "I go through this all the time. I tell them my sugar is low and I have to wait and wait for somebody to check it and fix it." On 9/28/22, at 9:10 a.m., Licensed Nurse C returned to Resident #29's room with approximately four (4) ounces of orange juice in a plastic cup. Licensed Nurse C stated, "Here you go I have some orange juice." Resident #29 asked, "Can I please have a straw so I can drink it. I can't drink it like this." Licensed Nurse C replied, "Drink that orange juice and I will recheck your blood sugar in an hour." Licensed Nurse C did not respond to Resident #29's request for a straw. The surveyor intervened at this point and reminded Licensed Nurse C that Resident #29 requested a straw as they were not able to drink the orange juice directly from the cup due to their positioning in the bed. Licensed Nurse C responded by providing Resident #29 with a straw and then quickly left the room. The surveyor remained at Resident #29's bedside and observed Resident #29 drink approximately 75% of the orange juice. At approximately 9:15 a.m., Resident #29 stated, "I still don't feel good."

	On 9/28/22, at 9:26 a.m., an interview was conducted with Licensed Nurse C. Licensed Nurse C stated, "I gave [Resident #29] the orange juice and I will recheck the blood sugar in about an hour." Licensed Nurse C was asked to review Resident #29's Physician Orders on the Medication Administration Record. Licensed Nurse C reviewed the Medication Administration Record and stated, "Oh, yea. I'm supposed to recheck in 30 minutes." On 9/28/22, at 9:30 a.m., Licensed Nurse C entered Resident #29's room and checked the blood glucose using the CGM. The result was "43." Licensed Nurse C stated, "Oh, it's lower. I will get you some more orange juice." Resident #29 responded by saying, "Will you just get me some of that stuff in the tube." Resident #29 was referencing glucose gel. Licensed Nurse C stated, "I will see what I can find." After searching through the medication cart, Licensed Nurse C was unable to locate glucose gel and asked Administrative Nurse A to find some. Administrative Nurse A returned to the unit with glucose gel at approximately 9:33 a.m., and handed it to Licensed Nurse C. Licensed Nurse C opened the packaging and removed the twist top on the tube. Licensed Nurse C then stated, "Oh the tip is defective. Look it won't come off. I'll see if we can get another one." Due to the emergent nature of Resident #29's blood glucose continuing to decline, the surveyor intervened at this point and asked Licensed Nurse C whether they had scissors and whether the tip of the tube could be cut open. Licensed Nurse C obtained scissors from the medication cart, cut the tube open, and handed the tube to Resident #29. Resident #29 consumed the contents of the glucose gel tube and Licensed Nurse C left the room. On 9/28/22, at 9:58 a.m., Licensed Nurse C rechecked Resident #29's blood glucose and the result was "111." Resident #29 reported feeling much better. Review of Resident #29's comprehensive Care Plan revealed a focus area for weight loss with a goal for Resident #29 to experience no signs or symptoms of hypoglycemia. Interventions read, "Monitor blood glucose as ordered. Monitor for [signs and symptoms] of hypoglycemia." The Care Plan did not instruct staff on interventions to correct hypo/hyperglycemic episodes. During an interview with Administrative Nurse B, on 9/29/22, at approximately 12:50 p.m., Resident #29’s hypoglycemia event on [DATE], was discussed. Administrative Nurse B reviewed Resident #29’s Care Plan and acknowledged that measurable actions to address hypoglycemia were not included in the Care Plan.
§ 51.110 (e) (3) Comprehensive care plans.	Based on observations, interviews, policy review, and record review, the facility failed to ensure each resident had a Physician’s Order for dialysis services and failed to provide evidence of communication between the facility and the dialysis center with

The services provided or arranged by the facility must— (i) Meet professional standards of quality; and (ii) Be provided by qualified persons in accordance with each resident's written plan of care. Level of Harm – No Actual Harm, with potential for more than minimal harm Residents Affected – Few	each visit for one (1) of three (3) residents reviewed who received dialysis services outside the facility (Resident #3). The facility also failed to ensure services to monitor and treat hypoglycemia were adequate by failing to 1) Promptly assess a resident following a verbal complaint of low blood sugar, and 2) Follow Physician Orders for a resident experiencing a hypoglycemic episode, and 3) Notify the physician regarding repeated hypoglycemic episodes (Resident #29). The findings include: 1. Review of facility policy titled, "Dialysis," approved 8/31/16, revealed the "Purpose" was identified to be: "to ensure residents receiving dialysis are assessed and care plans are developed in accordance with the residents' individualized needs." Section I for "Resident Assessment A," noted: "The licensed nurse will evaluate the resident pre and post dialysis and document the assessment in the resident's medical record." Section VI for "Inter-facility Communication," noted: "A. The licensed nurse will complete the Inter-facility Communication form according to policy and ensure necessary post dialysis information is obtained from the Dialysis Center. B. The licensed nurse will review the information received from the dialysis center and provide any necessary follow up indicated." [sic] Review of the facility policy titled, "Physician Orders and Progress Notes," approved 9/3/14, noted the definition of "Physician Order" as: "A prescription to prepare or dispense a specific treatment for the care of a resident i.e. (for example) mediations, restraints, diet, therapy, type of care." The definition for "Physician orders for immediate care," was: "Those written orders facility staff need to provide the essential care to the resident, consistent with the resident's mental and physical status upon admission." A section for "PCP (Primary Care Provider) Responsibilities," noted: "A. The primary care physician is responsible for the orders for admission of a resident to the facility to include diagnoses, preferred intensity of care (PIC), diet, care, diagnostic tests, and treatment of the resident by others." [sic] Review of the medical record for Resident #3 revealed they were admitted to the facility in 2022. Diagnoses included, but were not limited to: End Stage Renal Disease (ESRD), Hypothyroid, Hypertension, Depression, Heart Failure and Diabetes Mellitus Type Two (2). Review of the medical record information for Resident #3 revealed they attended dialysis outside the facility weekly on Monday, Wednesday, and Friday.

	Review of the current Physician Orders for Resident #3 revealed there was no order to send Resident #3 to the dialysis center three (3) times a week as the facility was doing. Review of the medical record for Resident #3 and the facility dialysis communication notebook from [DATE] through [DATE], revealed there were two (2) days in [DATE], two (2) days in [DATE], three (3) days in [DATE], and four (4) days in [DATE] that Resident #3 went to dialysis and did not have communication sheets completed. On 9/27/22, at 11:05 a.m., during an interview with Licensed Nurse D, they stated the facility did not always get the communication papers back from the dialysis center. They stated that they would call the dialysis center if they did not receive a report but did not document the report in the medical record or on the communication sheet. They stated they would just pass it on in the report to the oncoming shift if there were any irregularities. A follow up interview with Licensed Nurse D, on 9/27/22, at 11:40 a.m., revealed they were not able to locate a Physician Order for dialysis in the medical record for Resident #3. On 9/27/22, at 12:01 p.m., during an interview with Licensed Nurse E, they stated there was no Physician Order to send Resident #3 to dialysis three (3) times a week as the facility was doing. Licensed Nurse E stated the facility had never had a Physician Order to send Resident #3 to dialysis. Licensed Nurse E stated Resident #3 had been going to dialysis before they were admitted to the facility and the service continued after Resident #3 had been admitted to the Nursing Home from the Domiciliary. Licensed Nurse E stated they were unable to locate any additional dialysis communication forms for Resident #3 for the missing visits. 2. According to the Mayo Clinic, Hypoglycemia is a condition in which blood glucose levels are lower than the standard range. Hypoglycemia requires immediate treatment. Treatment involves quickly getting blood sugar back to within the standard range, either with a high-sugar food or drink or with medication. Long-term treatment requires identifying and treating the cause of hypoglycemia. According to *Lippincott Manual of Nursing Practice* (11th Edition), prevention of injury secondary to Hypoglycemia requires close monitoring of blood glucose levels to detect Hypoglycemia. Hypoglycemia should be treated promptly using the 15-gram/15-minute rule established by the American Diabetes Association. 15 grams of rapidly absorbing carbohydrates should be administered followed by a repeating blood glucose. If the result is less than 70 milligrams (mg) per deciliter (dL), the treatment should be repeated. Additionally, if Hypoglycemia occurs frequently, the

	concern should be discussed with the healthcare provider as dose adjustments of insulin and/or oral medications may be necessary. Review of Resident #29's medical record revealed an initial admission date in 2018, and a readmission date in 2022. Resident #29's medical diagnoses included Type 2 Diabetes. Resident #29 required limited assistance with most activities of daily living (ADLs). Resident #29's blood glucose was monitored by a continuous glucose monitoring system (CGM). On 9/28/22, at 8:48 a.m., Resident #29 was observed walking from their room into the hallway and yelling loudly, "I need my blood sugar checked! I feel like I am going to black out!" Resident #29 then returned to their bed. Approximately eight (8) minutes later, at 9:02 a.m., Licensed Nurse C responded to Resident #29's room and checked the blood glucose using the CGM meter. The result read "Low." Licensed Nurse C explained that they would recheck the blood glucose using the facility's glucometer. On 9/28/22, at 9:05 a.m., Licensed Nurse C checked Resident #29's blood glucose with a result of "65." Resident #29 was lying in bed with eyes closed and stated, "I don't feel good." Licensed Nurse C did not respond to Resident #29's complaint and left the room. While Licensed Nurse C was out of the room, a brief interview was conducted with Resident #29. Resident #29 stated they had "big problems controlling my blood sugar here." Resident #29 added, "I go through this all the time. I tell them my sugar is low and I have to wait and wait for somebody to check it and fix it." On 9/28/22, at 9:10 a.m., Licensed Nurse C returned to Resident #29's room with approximately four (4) ounces of orange juice in a plastic cup. Licensed Nurse C stated, "Here you go I have some orange juice." Resident #29 asked, "Can I please have a straw so I can drink it. I can't drink it like this." Licensed Nurse C replied, "Drink that orange juice and I will recheck your blood sugar in an hour." Licensed Nurse C did not respond to Resident #29's request for a straw. The surveyor intervened at this point and reminded Licensed Nurse C that Resident #29 requested a straw, as they were not able to drink the orange juice directly from the cup due to their positioning in the bed. Licensed Nurse C responded by providing Resident #29 with a straw and then quickly left the room. The surveyor remained at Resident #29's bedside and observed Resident #29 drink approximately 75% of the orange juice. At approximately 9:15 a.m., Resident #29 stated, "I still don't feel good." On 9/28/22, at 9:26 a.m., an interview was conducted with Licensed Nurse C. Licensed Nurse C stated, "I gave [Resident #29] the orange juice and I will recheck the blood sugar in about an hour." Licensed Nurse C was asked to review Resident #29's Physician Orders on the Medication Administration Record.

	Licensed Nurse C reviewed the Medication Administration Record and stated, "Oh, yea. I'm supposed to recheck in 30 minutes." On 9/28/22, at 9:30 a.m., Licensed Nurse C entered Resident #29's room and checked the blood glucose using the CGM. The result was "43." Licensed Nurse C stated, "Oh, it's lower. I will get you some more orange juice." Resident #29 responded by saying, "Will you just get me some of that stuff in the tube." Resident #29 was referencing glucose gel. Licensed Nurse C stated, "I will see what I can find." After searching through the medication cart, Licensed Nurse C was unable to locate glucose gel and asked Administrative Nurse A to find some. Administrative Nurse A returned to the unit with glucose gel at approximately 9:33 a.m., and handed it to Licensed Nurse C. Licensed Nurse C opened the packaging and removed the twist top on the tube. Licensed Nurse C then stated, "Oh the tip is defective. Look it won't come off. I'll see if we can get another one." Due to the emergent nature of Resident #29's blood glucose continuing to decline, the surveyor intervened at this point and asked Licensed Nurse C whether they had scissors and whether the tip of the tube could be cut open. Licensed Nurse C obtained scissors from the medication cart, cut the tube open, and handed the tube to Resident #29. Resident #29 consumed the contents of the glucose gel tube and Licensed Nurse C left the room. On 9/28/22, at 9:58 a.m., Licensed Nurse C rechecked Resident #29's blood glucose and the result was "111." Resident #29 reported feeling much better. On 9/29/22, at 10:15 a.m., a follow up interview was conducted with Licensed Nurse C. Licensed Nurse C confirmed that Resident #29 had experienced several hypoglycemic episodes and added that Administrative Nurse C had been notified of Resident #29's hypoglycemic episodes on [DATE], and that there had been some order changes. A second review of Resident #29's Physician Orders was conducted which revealed orders to discontinue Levemir insulin 40 units twice daily and start Levemir insulin 20 units once daily. An endocrinology referral was also noted.
§ 51.120 Quality of care. Each resident must receive and the facility management must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well being, in accordance with the comprehensive assessment and plan of care.	Based on observations, interviews, and record reviews, the facility failed to provide necessary care and services related to hypoglycemia by failing to: 1) Promptly assess a resident following a verbal complaint of low blood sugar; 2) Follow Physician Orders for a resident experiencing a hypoglycemic episode; and 3) Notifying the physician regarding repeated hypoglycemic episodes. The findings include: Review of Resident #29's medical record revealed an initial admission date of 2018, and a readmission date of 2022. Resident #29's medical diagnoses included Type 2 Diabetes. Resident #29

Level of Harm – No Actual Harm, with potential for more than minimal harm Residents Affected – Few	required limited assistance with most activities of daily living (ADLs). Resident #29's blood glucose was monitored by a continuous glucose monitoring system (CGM). On 9/28/22, at 8:48 a.m., Resident #29 was observed walking from their room into the hallway and yelling loudly, "I need my blood sugar checked! I feel like I am going to black out!" Resident #29 then returned to their bed. Approximately eight (8) minutes later, at 9:02 a.m., Licensed Nurse C responded to Resident #29's room and checked the blood glucose using the CGM meter. The result read "Low." Licensed Nurse C explained that they would recheck the blood glucose using the facility's glucometer. On 9/28/22, at 9:05 a.m., Licensed Nurse C checked Resident #29's blood glucose with a result of "65." Resident #29 was lying in bed with eyes closed and stated, "I don't feel good." Licensed Nurse C did not respond to Resident #29's complaint and left the room. While Licensed Nurse C was out of the room, a brief interview was conducted with Resident #29. Resident #29 stated they had "big problems controlling my blood sugar here." Resident #29 added, "I go through this all the time. I tell them my sugar is low and I have to wait and wait for somebody to check it and fix it." On 9/28/22, at 9:10 a.m., Licensed Nurse C returned to Resident #29's room with approximately four (4) ounces of orange juice in a plastic cup. Licensed Nurse C stated, "Here you go I have some orange juice." Resident #29 asked, "Can I please have a straw so I can drink it. I can't drink it like this." Licensed Nurse C replied, "Drink that orange juice and I will recheck your blood sugar in an hour." Licensed Nurse C did not respond to Resident #29's request for a straw. The surveyor intervened at this point and reminded Licensed Nurse C that Resident #29 requested a straw, as they were not able to drink the orange juice directly from the cup due to their positioning in the bed. Licensed Nurse C responded by providing Resident #29 with a straw and then quickly left the room. The surveyor remained at Resident #29's bedside and observed Resident #29 drink approximately 75% of the orange juice. At approximately 9:15 a.m., Resident #29 stated, "I still don't feel good." On 9/28/22, at 9:26 a.m., an interview was conducted with Licensed Nurse C. Licensed Nurse C stated, "I gave [Resident #29] the orange juice and I will recheck the blood sugar in about an hour." Licensed Nurse C was asked to review Resident #29's Physician Orders on the Medication Administration Record. Licensed Nurse C reviewed the Medication Administration Record and stated, "Oh, yea. I'm supposed to recheck in 30 minutes." On 9/28/22, at 9:30 a.m., Licensed Nurse C entered Resident #29's room and checked the blood glucose using the CGM. The result was "43." Licensed Nurse C stated, "Oh, it's lower. I will get

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	rechecked at 4:15 a.m., with a result of "116." The note did not indicate the physician was notified. The facility's policy for blood glucose monitoring titled, "Blood Glucose, Monitoring," was reviewed. The policy was dated 9/2015, as the date last reviewed. Section 1B of the policy read: "Nurse will promptly notify the physician when a blood glucose result is <= 50mg [milligram]/dL [deciliter] or >=400 mg/dL (unless other parameters are specified) and/or when signs &/or symptoms of hypo/hyperglycemia are noted. Consider emergency measures (i.e., sublingual instant glucose, glucagon, etc.) as indicated." On 9/29/22, at 10:15 a.m., a follow up interview was conducted with Licensed Nurse C. Licensed Nurse C confirmed that Resident #29 had experienced several hypoglycemic episodes and added that Administrative Nurse C had been notified of Resident #29's hypoglycemic episodes on [DATE], and that there had been some order changes. A second review of Resident #29's Physician Orders was conducted which revealed orders to discontinue Levemir insulin 40 units twice daily and start Levemir insulin 20 units once daily. An endocrinology referral was also noted.
§ 51.120 (b) (2) Activities of daily living. A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (b)(1) of this section; Level of Harm – No Actual Harm, with potential for more than minimal harm Residents Affected – Few	Based on observation, interview, record review, and review of facility policy, it was determined that for two (2) of 32 sampled residents (Residents #6 and #9) the facility failed to ensure each resident was provided the assistance needed with transfers and mobility. Residents #6 and #9 were observed to remain in bed without being offered assistance with getting out of bed. The findings include: Review of a facility policy titled, “ADL [Activities of Daily Living], Standards,” revised 5/9/22, revealed: “each resident will be kept active, out of bed for reasonable periods of time, except when contraindicated by physician’s orders. Meals, individual and group activities will be accomplished while out of bed whenever possible. ADLs are recorded in the medical record.” 1. Resident #6 was admitted to the facility in 2021. The resident’s diagnosis included Post Traumatic Stress Disorder (PTSD), Depression, Obesity, and Cerebrovascular Accident (CVA) with resulting Hemiplegia. Review of an annual Minimal Data Set (MDS) assessment, dated [DATE], revealed Resident #6 had a Brief Interview for Mental Status (BIMS) score of 13, indicating independence in cognition for decision making. The resident required the extensive assistance of one (1) staff person with bed mobility and transfers from bed did not occur during the review period. The resident triggered for further review of ADL status using the Care Area Assessment (CAA) process. A review of the CAA summary revealed the

	resident had a history of CVA with left sided weakness affecting their ability to self-perform ADL mobility and transfers. Review of a quarterly MDS assessment, dated [DATE], revealed Resident #6 had a BIMS score of 12, indicating moderate cognition for decision making. The resident required total assistance of one (1) staff person with bed mobility and transferred from the bed on one (1) to two (2) occasions during the review period. A review of Resident #6's Care Plan, dated [DATE], revealed the problem deficit of an ADL function alteration related to being non-ambulatory requiring total assistance with transfers. The deficit was related to diagnoses including CVA with left sided Weakness, Chronic Neuropathic Pain, Coumadin Use, Edema, Hypothyroidism, Obesity, PTSD, Mood Disorder, Depression, and Incontinence of Bowel and Bladder. The goal was for Resident #6 to have good hygiene and be clean and free from odor. Interventions included the resident would be encouraged to make choices in their daily routines. There were no goals or interventions established regarding staff assisting Resident #6 to transfer out of the bed. Observation, on 9/26/22, at 11:02 a.m., revealed Resident #6 was lying in bed on their back wearing a hospital gown. The resident complained their adult brief needed to be changed but staff would not assist them. Resident #6 stated staff did not respond when they called for them. Observation, on 9/27/22, at 9:20 a.m. revealed Resident #6 was lying in bed wearing a hospital gown. Observation of Resident #6 on the same day at 3:15 p.m., revealed the resident remained in bed wearing a hospital gown. Observation, on 9/28/22, at 9:50 a.m., revealed Resident #6 was lying on their back in bed. The resident was wearing a hospital gown. Resident #6 stated they were "sick and tired of being in this bed. They won't get me up." Resident #6 stated they would like to wear their own clothes sometimes. Resident #6's call light was pushed, and the assigned Licensed Nurse A entered the resident's room. Licensed Nurse A began talking about the comfort level of the air mattress Resident #6 was lying on and, during the conversation, the resident asked to get up and out of the bed. Licensed Nurse A did not acknowledge the resident and continued to talk about the mattress comfort. Resident #6 was noted to ask for assistance to get out of bed a second time without acknowledgement by Licensed Nurse A. The surveyor intervened and asked Licensed Nurse A to please listen to Resident #6's request. Resident #6 repeated for the third time their desire for assistance to get out of bed. Licensed Nurse A responded they would get the staff to assist the resident to get out of bed. Resident

	#6 stated that they wished they could get out of bed, put their own clothes on, and go to the PX (post exchange). An interview was conducted, on 9/26/22, at 11:10 a.m., with Licensed Nurse B, who was assigned to care for Resident #6. Licensed Nurse B stated Resident #6 had a tilt 'n space wheelchair which was kept in a storage room. Licensed Nurse B stated the resident would refuse to get out of the bed. When asked, Licensed Nurse B reviewed the resident's medical record for documentation regarding Resident #6 refusing to get out of bed, however, was unable to find the documentation. An interview was conducted, on 9/27/22, at 9:30 a.m., with Licensed Nurse A who was assigned to care for Resident #6. Licensed Nurse A stated Resident #6 was "bed bound." Licensed Nurse A stated staff did encourage the resident to get out of bed, however, the resident would refuse. Licensed Nurse A was asked to provide documentation from the resident's medical record regarding refusal to get out of bed, however, did not provide the documentation. An interview was conducted, on 9/28/22, at 10:15 a.m., with Certified Nurse Aide A who was assigned to provide care for Resident #6. Certified Nurse Aide A stated Resident #6 was not usually asked if they wanted to get out of bed because the resident would let staff know if they wanted to get up. Certified Nurse Aide A stated it was not reported to the nurse when Resident #6 didn't get out of bed, because the nurses already knew the resident didn't get up. An interview was conducted, on 9/28/22, at 12:30 p.m., with the Consultant Staff A who provided services for Resident #6. Consultant Staff A stated the resident had been depressed ever since being admitted to the facility. Consultant Staff A stated that they were aware Resident #6 was usually in bed wearing a hospital gown. Consultant Staff A stated Resident #6 had told them the staff wouldn't dress them in their own clothing or assist them with getting out of the bed. Consultant Staff A stated they had discussed with the direct care staff and the resident's Interdisciplinary Team (IDT) the importance of assisting Resident #6 with wearing their own personal clothing and being provided assistance with getting out of bed. However, according to Consultant Staff A, Resident #6 continued to remain in a hospital gown while lying in bed. Consultant Staff A stated they were not sure why assistance with dressing and getting out of bed was not being provided. An interview was conducted with Administrative Nurse B, on 9/27/22, at 3:10 p.m. Administrative Nurse B stated that Resident #6 refused assistance with getting out of bed. A request was made for documentation from Resident #6's medical record to support

	the reported refusals and the facility's attempts to intervene. Administrative Nurse B did not provide documentation regarding Resident #6 refusing staff assistance with getting out of bed. After Resident #6's noted concerns with receiving assistance from staff with getting out of bed were reported to the facility, the resident was observed on the evening of 9/28/22, and morning of 9/29/22, to be dressed in their personal clothing, sitting up in a tilt 'n space wheelchair, and positioned in the resident lounge area. 2. Resident #9 was admitted to the facility in 2005, and readmitted in 2021, after an acute care stay. Current diagnoses included Recurrent Falls with Right Clavicle Fracture and Multiple Right Rib Fractures, Hypertension, Mild Cognitive Impairment, and Depression. Review of a quarterly MDS assessment, dated [DATE], revealed Resident #9 had a Brief Interview for Mental Status (BIMS) score of 13, indicating independence in cognitive skills for decision making. Resident #9 was assessed to be independent in bed mobility and walking, requiring oversight when transferring. The resident had sustained two (2) falls, one (1) without injury, and one (1) with minor injury. A Care Plan to address the resident's risk for falls was developed with interventions to address the deficit and prevent falls. Review of an "Investigative Report" revealed, on [DATE], at 4:35 p.m., Resident #9 was observed by nursing staff ambulating with a cane down the hallway, toward the nursing station. The resident attempted to sit down in a chair, lost their balance, and fell on their right side, landing on the floor. Observation, on 9/26/22, at 12:40 p.m., revealed Resident #9 was lying in bed on their back. The resident was eating lunch independently with Certified Nurse Aide B in the room. Resident #9 stated their position was not comfortable and Certified Nurse Aide B repositioned the resident in the bed. Observation, on 9/27/22, at 5:00 p.m., revealed Resident #9 was lying in bed on their back. The head of the bed was up, and Resident #9 was noted to be receiving a breathing treatment. Observation, on 9/28/22, at 10:50 a.m., revealed Resident #9 was lying in bed on their back. The resident complained they were tired of lying in the bed. Resident #9 stated their muscles were getting weak from laying in the bed all the time. The resident asked, "how can I get better if I lay in bed all the time?" Certified Nurse Aide C was observed to be seated in the room to supervise the resident. Certified Nurse Aide C stated the resident had complained all morning about wanting to get out of the bed. Certified Nurse Aide C stated, however, because of injuries sustained during a fall, the resident was not allowed to get out of the bed.

	Observation, on 9/28/22, at 2:48 a.m., revealed Resident #9 remained in bed, on their back. The resident stated they were so tired of lying in the bed. Resident #9 stated they would like to get out of the bed but “they won’t let me.” Observation, on 9/29/22, at 9:50 a.m., revealed Resident #9 was lying in bed. Licensed Nurse F provided the resident with a bed bath to the upper body. Licensed Nurse F stated this was their first day providing care for Resident #9. Licensed Nurse F stated, “They told me [they] used to walk and want [them] to walk again.” Licensed Nurse F stated they did not know how long it had been since the resident had walked. Licensed Nurse F stated they were waiting for someone to bring the resident a wheelchair and they were going to take the resident outside, with a plan to let Resident #9 walk. An interview was conducted, on 9/29/22, at 10:30 a.m., with Consultant Staff B. Consultant Staff B stated Consultant Staff C and Consultant Staff D had received Physician Orders the previous day to evaluate Resident #9 and treat, as indicated. Consultant Staff B stated they had done an evaluation the previous evening and determined standing activity should be held due to the resident’s blood pressure dropping when they stood up for the evaluation. Consultant Staff B stated the resident’s blood pressure had dropped too low to initiate walking activity at that time, indicating the first step would be getting Resident #9 up in a chair. When questioned regarding observation and interview with Licensed Nurse F, which indicated the resident was being taken outside in a wheelchair, to walk, Consultant Staff B stated nursing should not take Resident #9 outside to walk until cleared through therapy and Consultant Staff E. Consultant Staff B stated prior to experiencing a fall with injury, Resident #9 had used a powered scooter to go long distances. Consultant Staff B stated they noticed when evaluating the resident, the previous day, Resident #9 did not have a chair in their room to sit in when out of bed. Consultant Staff B stated Consultant Staff D evaluation would determine the most comfortable and safe chair for the resident, and one (1) would be obtained based on the evaluation. An interview was conducted, on 9/29/22, at 11:00 a.m., with Resident #9’s Consultant Staff E. The physician stated Resident #9 had sustained a fall with injury on [DATE]. The physician stated an order had not been given after the fall for Resident #9 to be bedfast. Consultant Staff E stated the resident should not be walking until skilled therapy had completed evaluations and treatment, as indicated. Consultant Staff E stated they did not think Resident #9 would even be able to walk at this time, but staff should get the resident up to a chair, as tolerated. Consultant Staff E further stated they were not aware Resident #9 had been bedfast since sustaining the fall.

§ 51.180 (c) Drug regimen review. (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. (2) The pharmacist must report any irregularities to the primary physician and the director of nursing, and these reports must be acted upon. Level of Harm – No Actual Harm, with potential for more than minimal harm Residents Affected – Few	Based on record review and interview, the facility failed to ensure each resident's medication regimen was reviewed monthly by a licensed pharmacist and any irregularities identified by the pharmacist were acted upon in a timely manner for one (1) of 30 residents reviewed for monthly drug regiment reviews (Resident #3). The findings include: Review of the facility policy titled, "Drug Regimen Review by Pharmacy Service," which was approved on 3/15/21, found that the policy noted: "DRR (Drug Regimen Review) Requirements… 2. The Pharmacist shall review the drug regimen of each resident: A. Monthly for SNF (Skilled Nursing Facility)… 4. The Pharmacist is responsible for reporting DRR findings in writing to the: A. Primary Care Provider and Medical Director, B. Director of Nursing (DON) for SNF and C. Supervising Registered Nurse (SRN) of the Ambulatory Residential Care Clinic (ACC) for the DOM (Domiciliary). 5. Immediate Action Required-when finding requires immediate action, the pharmacist will: A. Immediately notify the SRN and the Primary Care Physician (PCP) in writing and via phone, B. Document finding and communication to providers int eh progress notes. C. Document finding in monthly or biannual DRR report sent to medical providers." [sic] Review of the medical record for Resident #3 revealed that they were admitted to the facility in 2022. Diagnoses included, but were not limited to: End Stage Renal Disease (ESRD), Hypothyroid, Hypertension, Depression, Heart Failure and Diabetes Mellitus Type Two (2). Review of the Drug Regimen Review (DRR) for Resident #3 revealed pharmacy recommendations, dated [DATE], and [DATE]. A list of records reviewed by Consultant Staff F for which there were no recommendations was provided for review. The pharmacy reviews were dated [DATE], [DATE], [DATE], [DATE], and [DATE]. Resident #3 was not listed on these reports as having a pharmacy drug regimen review completed on the dates of the monthly reports. On 9/27/22, at 9:50 a.m., during an interview with Administrative Nurse D, they stated Resident #3 had been admitted in 2022. They provided a list of monthly pharmacy reports for records Consultant Staff F reviewed and had no recommendations from [DATE] through [DATE]. Administrative Nurse D confirmed Resident #3 was not named on the list of records reviewed by Consultant Staff

	F for the months of [DATE]; [DATE]; [DATE]; [DATE]; and [DATE]. Administrative Nurse D also provided the recommendations from pharmacy dated [DATE], and [DATE], for Resident #3. Administrative Nurse D stated some months for Resident #3 were missing. Administrative Nurse D confirmed that they were not able to find documentation that Consultant Staff F had reviewed the medical record of Resident #3 for the months of [DATE]; [DATE]; [DATE]; [DATE]; and [DATE]. On 9/27/22, at 1:40 p.m., Administrative Nurse B stated they were still looking for information from the pharmacy for Resident #3. On 9/29/22, at 9:55 a.m., Administrative Nurse B presented three (3) documents for review for Resident #3. These documents were as follows: 1. A pharmacy recommendation, dated [DATE], with medication interaction alerts. This was signed by Consultant Staff E on [DATE]. 2. A pharmacy recommendation, dated [DATE], regarding as needed pain medication. This was signed by Consultant Staff E on [DATE]. 3. A pharmacy recommendation, dated [DATE], regarding unused medications and repeat recommendation from [DATE]. This was signed by Consultant Staff E on [DATE], with a note to see response for [DATE], for repeat recommendations. On 9/29/22, at 10:10 a.m., during an interview with Consultant Staff F, they stated the monthly reviews were completed for Resident #3. They stated that the reports were provided to Administrative Nurse B, who gave them to Consultant Staff E. Consultant Staff F had no explanation why Resident #3 was not identified on the list of records reviewed that had been provided to Administrative Nurse B. Consultant Staff F stated the three (3) reports presented this morning had been removed by Consultant Staff E and put to the side and not addressed in a timely manner. Consultant Staff F had no explanation why Consultant Staff E would remove three (3) reports for Resident #3 and not all five (5) reports. They also had no explanation why only those three (3) recommendations for only Resident #3 had been removed from the packet of recommendations supplied to Administrative Nurse B each month. Consultant Staff F confirmed the recommendations had not been followed up on in a timely manner. On 9/29/22, at 10:10 a.m., Administrative Nurse B, who was present during the interview with Consultant Staff F, confirmed the recommendations presented for review this a.m., had not been followed up on in a timely manner. They stated no one followed up on recommendations from the pharmacy after they were provided

	to Consultant Staff E for review. Administrative Nurse B stated the reports were given to Consultant Staff E and it was their responsibility to review them. Administrative Nurse B stated that nobody checked to ensure that Consultant Staff E had reviewed or followed up on the monthly pharmacy recommendations. Administrative Nurse B had no explanation why Resident #3 was not on the list of monthly pharmacy reviews.
§ 51.190 (a) Infection control program. The facility management must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection control program. The facility management must establish an infection control program under which it— (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. Level of Harm – No Actual Harm, with potential for more than minimal harm. Residents Affected – Some	Based on observations, interviews, record review, and policy review, the facility failed to maintain an infection control program designed to provide a sanitary environment and to help prevent the development and transmission of disease and infection as evidenced by: 1. Observations of staff delivering multiple food trays without sanitizing hands/changing gloves between tray delivery. 2. Failure to change gloves and sanitize hands during Resident #23's dressing change. 3. Observations of failure to wash hands following repositioning of a resident and then assisting with meal set up. Review of facility policy titled, "Hand Hygiene Procedure (All Homes)," was dated 12/24/18. The policy noted: "Procedure II. When and how should you wash your hands or perform hand hygiene? Times/Activities: Before your shift begins and after your shift ends; After touching an animal, animal food or treats, animal cages or animal waste; After touching garbage; If your hands are visibly dirty or greasy. "Food Contact: Before during and after food preparation; Before and during food service; Before eating food "People Contact: Before and after caring for someone who is sick; Before and after treating a cut or wound; After contact with a person sick with Clostridium difficile; Before and after removing gloves when caring for a Resident; After contact with a person experiencing vomiting or diarrhea; After coming into contact with blood or body fluids or pen skin (rash, cut, etc. (etcetera)); After blowing your nose, coughing or sneezing; After using the bathroom, changing diapers, or cleaning up a child who has used the bathroom." [sic] The findings include: 1. On 9/26/22, at 11:50 a.m., during observation of the noon meal service, Certified Nurse Aide D was observed passing meal trays to residents on [LOCATION]. Certified Nurse Aide D was observed putting on gloves, obtaining a tray from the meal cart, serving the tray to a resident, removing gloves, and putting on clean gloves, but did not wash or sanitize their hands when changing gloves. This was observed for six (6) unsampled residents. Also observed was Certified Nurse Aide E passing meal trays to residents on [LOCATION]. Certified Nurse Aide E did not wear gloves. They

	were observed to deliver a lunch tray to a resident, place the tray on the overbed table, pull up the back of their shirt, insert their hands in the top of their pants, remove their hands and pull their shirt down, and continued to assist the resident with set up of the meal tray. Certified Nurse Aide E was observed passing meal trays to six (6) residents without washing their hands or using hand sanitizer between residents. On 9/26/22, at 12:00 p.m., Certified Nurse Aide D stated they were registry staff and not an employee of the facility. They stated that they had not received training on when hand washing was needed during meal service. On 9/26/22, at 12:02 p.m., Certified Nurse Aide E stated they were registry staff and not an employee of the facility. They stated that they had not received training on when hand washing was needed during meal service. On 9/28/22, at 1:30 p.m., during an interview Licensed Nurse G, stated staff received hand washing training upon hire and must complete yearly education in the electronic learning system. They stated surveillance was completed by all supervisors, with education opportunities as they arose. Licensed Nurse G stated that “Glow Germ” is sometimes used as training to show staff how areas could be missed when washing their hands. On 9/28/22, at 2:52 p.m., Licensed Nurse H stated that training for registry staff was an abbreviated version of what full time staff received. They provided a “Competency Validation Checklist” to be completed by the registry employee’s mentor. This checklist included “Perform hand hygiene-washing hand with water & soap for 20 seconds or using hand sanitizer cleansing all parts of hands, fingers and nail beds.” Licensed Nurse H stated registry staff did not work at the facility long enough to get the full orientation. They stated that registry staff were provided with hand washing instructions and validated that they were able to complete hand washing correctly, but they were not provided with information that the facility expected them to complete hand hygiene between each resident during meal service. Licensed Nurse C provided an outline of orientation for “Contract/Registry CNA Orientation Schedule.” This schedule is listed for one (1) day and did not include instructions or expectations for hand hygiene. Licensed Nurse H stated all Certified Nurse Aides received hand hygiene education when they went to school, so it was understood they knew when to perform hand hygiene. Licensed Nurse H provided for review, “Orientation Registry Handbook 2022.” The “Table of Contents” included “Yountville Veterans Home-General Instructions; Employee Rules and Guidelines; Facility Rules, Issues and Emergencies; and Resident Issues.” These categories did not include instructions, expectations, or policies regarding hand hygiene. Licensed Nurse H confirmed registry staff did not

	receive the facility policy or expectation for hand hygiene during meal service. 2. Review of the policy and procedure titled, “Hand Hygiene Procedure,” dated 12/24/18, documented: “Hand Hygiene: When and How…After coming into contact with blood or body fluids or open skin (rash, cut).” Review of the Physician Order for Resident #23, dated [DATE], stated: “Bilateral lower extremity venous stasis ulcers, apply Unna boot every other day and PRN [as needed] when dressings soaked through with drainage.” Orders dated [DATE]: “Clarification orders: Bilateral LE venous stasis ulcer Change M-W treatment, Cleanse with wound cleanser, pat dry, apply Unna boot, cover with kerlix then Coban/ace wrap every other day and PRN when dressing soaked through with drainage.” Observation of a dressing change on Resident #23, on 9/28/22, at 9:12 a.m., with Licensed Nurse I, revealed the nurse was wearing two (2) sets of gloves on each hand. The nurse changed the outer layer of gloves after taking the dressings off and cleaning the areas on both of the residents’ legs. The inner layer of gloves remained on. Licensed Nurse I also changed the outer layer of gloves before putting a clean dressing on the resident’s left leg, however, the original inner gloves remained on. Licensed Nurse I took off both layers of gloves, sanitized their hands, and put clean gloves on to finish putting the dressing on the right leg. On 9/28/22, at 10:05 a.m., in an interview with Licensed Nurse I, they stated they double gloved due to logistics. It was too difficult to get to the sink to change gloves and wash hands due to the electric wheelchair being in the way. In an interview with Administrative Nurse B, on 9/28/22, at 5:40 p.m., they acknowledged the nurse should have changed both layers of gloves and sanitized their hands during Resident #24’s dressing change. Record review of a “Mandatory In-Service” sign in sheet, dated 9/28/22, documented as part of the training, “Strictly no “double” gloving with multiple use.” 3. Observation of the lunch meal service, on 9/26/22, at 12:42 p.m., revealed Resident #9 was positioned in bed with the head of bed up approximately 40 degrees. The resident indicated being positioned in an uncomfortable manner for eating. Certified Nurse Aide B, who was in the room, pulled the resident up in bed by grabbing onto the resident’s shoulders and touched the button on the bed to raise the head of the bed. Certified Nurse Aide B proceeded to reposition a napkin under Resident #9’s chin, reposition the resident’s meal tray, and touched the resident’s food

	items by moving the milk, soup, and silverware on the tray to different positions. Certified Nurse Aide B did not wash their hands between touching the numerous items to reposition the resident and the food/utensils on the resident's meal tray.