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: 9/11/23 – 9/14/23

NH / DOM / ADHC: NH

Survey Class: Annual

Total Available Beds: 336

Census on First Day of Survey: 211

VA Regulation Deficiency	Findings
	Initial Comments: A VA Annual Survey was conducted from 9/11/23, through 9/14/23, 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.
§ 51.43(b) Drugs and medicines for certain veterans VA will also furnish drugs and medicines to a State home for a veteran receiving nursing home, domiciliary, or adult day health care in a State home pursuant to 38 U.S.C. 1712(d), as implemented by § 17.96 of this chapter, subject to the limitation in § 51.41(c)(2). **Level of Harm** – No Actual Harm, with potential for minimal harm **Residents Affected** – Few	The facility was unable to demonstrate that medications are only furnished subject to the limitations § 51.41(c)(2). Based on interviews facility leadership and subsequent record reviews, it was identified that the facility did not ensure that medication costs for one (1) of eight (8) sampled residents for which the facility receives the prevailing rate are covered in full by the facility. Review of records for [DATE] revealed that the resident's insurance was billed for which the facility is responsible for all medication costs.
§ 51.70 (e) (1) – (3) Privacy and confidentiality. The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. (1) Residents have a right to personal privacy in their accommodations,	Based on observation, interview, record review, and policy review, the facility failed to afford privacy during care to one (1) of 23 sampled residents and one (1) resident of random opportunity (Resident #15 and Resident #27). The findings include:

medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups. This does not require the facility management to give a private room to each resident. (2) Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility; (3) The resident's right to refuse release of personal and clinical records does not apply when— (i) The resident is transferred to another health care institution; or (ii) Record release is required by law. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	1. The facility policy titled, "Wound Care, Routine," last reviewed on 3/28/23, stated: "Policy Details and Implementation I. GENERAL WOUND CARE…F. Provide privacy (pull the cubicle curtain around the bed for privacy)." Record review revealed Resident #15 was readmitted to the facility on [DATE], and diagnoses included [DIAGNOSIS] and a Stage 4 Pressure Ulcer to the Sacrum. Review of Resident #15's Quarterly Minimum Data Set (MDS) Assessment, dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of nine (9), which indicated moderately impaired cognition. According to the MDS, Resident #15 was dependent on one (1) or more persons for all activities of daily living, including bed mobility. Further record review found the following Physician Order: "Daily Cleanse with NS [Normal Saline], Apply Santyl, Calcium Alginate to Wound Miconazole 2%, Calmoseptine to cover peri wound, then cover with abdominal pad" [sic]. Review of Resident #15's Care Plan found the following problem: "Self care deficit R/T [related to]: [DIAGNOSIS], muscle spasticity." Interventions to address this problem included: "Ensure privacy by keeping bedside curtain pulled from door to bed." Observation of wound care to Resident #15 began at 9:47 a.m., on 9/12/23. Licensed Nurse A knocked on Resident #15's closed door and obtained permission to enter. When Licensed Nurse A opened the door, observation from the doorway found Resident #15's lying in bed wearing no clothing or bed linens, with only a towel covering their genitals. After Licensed Nurse A gained Resident #15's permission for the surveyor to observe wound care, the surveyor entered the room. Observation at that time found the right side of the bed was against the wall, and the back of the headboard faced the door. There was a ceiling-mounted privacy curtain track encircling the resident's bed, and the privacy curtain was gathered at the far end of the track against the wall at the foot of the bed. When Licensed Nurse A exited the room to gather their supplies from the treatment cart parked in the hallway, the door to the room remained open. Licensed Nurse A re-entered the room at 9:49 a.m., on 9/12/23, and carried the treatment supplies in a plastic basket. The surveyor and Licensed Nurse B also

	entered the room at that time, and Licensed Nurse B closed the door. At approximately 9:50 a.m., on 9/12/23, Consultant Staff A opened the door, entered the room, and closed the door. Over the course of the treatment, the door to Resident #15's room was opened two (2) more times, as Licensed Nurse B exited and re-entered the room to bring additional supplies into the room. The privacy curtain was not drawn around the resident's bed before, during, or after the treatment observation. During an interview, at 12:55 p.m., on 9/12/23, Administrative Nurse A acknowledged that Resident #15's Care Plan required the cubicle curtain to be pulled for privacy. 2. Review of the facility policy titled, "Resident Bill of Rights, California Code of Regulations Title 22," dated February, 2005 revealed on page 3: "(11) To be treated with consideration, respect and full recognition of dignity and individuality, including privacy in treatment and in care of personal needs." Furthermore, review of the Code of Federal Regulations, Title 42, Public Health, Section 483.10 Resident rights, page 23 noted: "(e) Privacy and confidentiality. The resident has the right to personal privacy and confidentiality of [their] personal and clinical records. (1) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident." Record review revealed Resident #27 was admitted to the facility on [DATE], and active diagnoses included disorder of Conjunctivitis, inflammation or infection of the outer membrane of the eyeball and the inner eyelid, Prostatic Hypertrophy, and Gastroesophageal Reflux Disease. Review of Resident #27's Annual MDS, dated [DATE], documented a BIMS score of 15, which indicated the resident was cognitively intact. Resident #27's Physician Orders included the following: Refresh Tear drops 0.5% ophthalmic apply one (1) drop in each eye Three (3) Times A Day (TID) at 9:00 a.m., 1:00 p.m., and 6:00 p.m., and Pataday solution 0.7% apply one (1) drop bilateral eyes every morning (QD) at 9:00 a.m. Observation in the hallway directly outside the [LOCATION], at 8:35 a.m., on 9/13/23, revealed Licensed Nurse C administered eye drops to both of Resident #27's eyes, without providing

	privacy for the administration of these drops in the resident's room. During an interview with Resident #27, on 9/13/23, at 9:15 a.m., with Administrative Nurse A present, when referred to the above observations, Resident #27 was asked if they would have preferred to have had their eye drops administered with privacy in their room; they stated "yes." Administrative Nurse A reported at the time of the above observation that it was their expectation that the resident should have been afforded privacy when they received their eye drops. Record review of Resident #27's Medication Administration Record (MAR), on 9/13/23, at 10:30 a.m., noted that it had been documented that Resident #27 stated they would "prefer eye drops to be given in [their] room per Resident request."
§ 51.140 (h) Sanitary conditions. The facility must: (1) Procure food from sources approved or considered satisfactory by Federal, State, or local authorities; (2) Store, prepare, distribute, and serve food under sanitary conditions; and (3) Dispose of garbage and refuse properly. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	Based on observations, interviews, and review of the facility policy, the facility staff failed to discard leftover foods after each meal service, allowing pests to be attracted to the [LOCATION]. This failure affected all residents in [LOCATION]. The census was 74. The findings include: Review of the facility policy titled, "Food & Nutrition Services-Sanitation (All Homes)," last reviewed 10/7/22, revealed: "Policy Details and Implementation I. [LOCATION] and serving area(s): A. Will be kept clean, free from litter and rubbish. B. Will be protected from rodents, roaches, flies, and other insects." Review of the facility policy titled, "Pest Control," last reviewed 7/27/23, revealed: "VHC - Policy Statement The Veterans Home of California maintains a pest control program to eradicate and contain pest such as roaches, ants, mosquitoes, flies, bees, wasps, mice and rats, etc. All possible measures are taken, within reason, to maintain a pest-free environment…Policy Details and Implementation II. Food & Nutrition Services follow facility policies on food storage and food area sanitation." On 9/12/23, at 10:05 a.m., and 2:20 p.m., three (3) rolling carts were observed unattended in the [LOCATION]. Further observation revealed the residents' leftover foods were not discarded and were left on trays on the cart. During two (2) observations, flies and gnats were observed hoovering over the trays of food. On 9/12/23, at 2:37 p.m., in the presence of Dietary Staff A and Dietary Staff B, Dietary Staff A revealed nursing staff should have discarded the leftover foods and placed the trays in an

	enclosed cart. Dietary Staff A stated this process was completed after each meal, so the dietary staff could remove the trays and take them to the [LOCATION] to be washed. On 9/12/23, at 2:49 p.m., Administrative Nurse B revealed the facility were using agency Certified Nurse Aides, and the agency Certified Nurse Aides may not have been aware that they were to discard leftovers from the trays after each meal. Administrative Nurse B stated they would conduct an immediate in-service with all nursing staff to ensure everyone was on the same page moving forward.
§ 51.180 (e) (1) Storage of drugs and biologicals. (1) In accordance with State and Federal laws, the facility management must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	Based on observation, interview, record review, and policy review, the facility failed to ensure medications were not left at bedside without a Physician Order to do so for one (1) of 23 sampled residents (Resident #17). The findings include: The facility policy titled, "Medication, Storage & Labels," last reviewed on 3/14/23, stated: "Policy Details and Implementation…B. Drug Storage…3. Medications will not be left at the resident's bedside without a Physician order…E. Bedside Medications – Medication (prescription or non-prescription) will not be left at the bedside unless there is a specific order for bedside medication and the container is labeled and stored appropriately." Record review revealed Resident #17 was readmitted to the facility on [DATE], and diagnoses included: Hypertension, Anemia, and Benign Prostatic Hypertrophy. Review of Resident #17's Quarterly Minimum Data Set (MDS) Assessment, dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. According to the MDS, Resident #17 was independent with performing all activities of daily living, including bed mobility, transfers, eating, and toilet use. Further record review found the following Physician Orders scheduled to be administered to Resident #17 each morning: • Vitamin B-12 1000 micrograms (mcg) by mouth once daily • Ferrous Sulfate 324 milligrams (mg) by mouth twice daily • Vitamin C 500mg by mouth once daily • Amlodipine 10mg by mouth once daily – hold if systolic blood pressure is less than 95 millimeters of Mercury (mm Hg) • Finasteride 5mg by mouth once daily

	Observation in the company of Administrative Nurse C and Administrative Nurse D, at 11:26 a.m., on 9/11/23, found Resident #17 sitting at their bedside rummaging through personal possessions stored on the floor of their room. Observation of the bedside stand located behind Resident #17 found a medicine cup. When asked if the medicine cup contained medications, Resident #17 picked up the cup and showed the contents to the surveyor. The medicine cup contained five (5) tablets. After exiting the room, the surveyor asked Administrative Nurse C and Administrative Nurse D if Resident #17's physician had written an order for the resident to self-administer medications. At 11:35 a.m., on 9/11/23, Administrative Nurse D confirmed there were no Physician Orders in Resident #17's medical record for the resident to keep medications at bedside or to self-administer medications.