STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056433	A. Building B. Wing	07/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vermont Healthcare Center	22035 S. Vermont Avenue Torrance, CA 90502

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement care plan interventions for one of one resident (Resident 1) by failing to ensure visual checks were done and documented to prevent falls.This deficient practice resulted in Resident 1 having an unwitnessed fall that resulted in a bilateral (both sides) inferior pubic ramus (bony structure that forms part of the pelvis [bones between the lower stomach and upper thighs that connect the spine to the leg]) and right superior ramus (branch of the pelvic bone that make up part of the pelvis) fracture that required hospitalization at the General Acute Care Hospital (GACH). Findings:During a review of Resident 1's admission Record (Face Sheet), the admission Record indicated Resident 1 was initially admitted on [DATE] and was readmitted on [DATE] with diagnoses including fracture of right ischium (paired bone forming the lower and back part of the hip bone), fracture of right pubis, (lower and front part of each side of the hip bone), wedge compression fracture (fracture that forms on the front of the vertebra [small bones forming the backbone]) that looks like a wedge shape due to the broken bone collapsing) of the second lumbar vertebra (second bone down the lower back), and repeated falls.During a review of Resident 1's minimum data set (MDS: a resident assessment tool) dated 7/1/2025, the MDS indicated Resident 1 was cognitively (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) mildly impaired. The MDS indicated Resident 1 required maximal assistance (provides more than half the effort) for toilet transfer, chair/bed-to-chair transfer, roll left and right, toileting hygiene, bathing, lower body (waist below) dressing, required moderate assistance (provides less than half the effort) for oral care, upper body (waist above) dressing, and required setup for eating. The MDS indicated Resident 1 utilized a walker and had impairment on one side of the upper (arms/shoulder) extremity and impairment on both sides on the lower (hips, legs) extremity. During a review of Resident 1's Care Plan (CP), untitled, dated 6/27/2025, the CP indicated Resident 1 was a high fall risk with a fracture upon admission and repeated falls at home. The CP intervention indicated to continue visual checks and document every shift. During a review of Resident 1's Change of Condition (COC: worsening of or a new condition developing) dated 7/1/2025 at 1:00a.m., the COC indicated Resident 1 had an unwitnessed fall. During an interview on 7/16/25 at 3:52p.m. with Registered Nurse Supervisor 1 (RNS 1), RNS 1 stated care plans are important to indicate exactly what staff should do to prevent falls. During a concurrent interview and record review on 7/17/2025 at 2:09p.m. with RNS 1, RNS 1 stated if the care plan indicated to continue visual checks every shift, then it should be documented every shift. RNS 1 stated the intervention needs to correlate with the physician order to ensure they know what they are monitoring and what the nurses are expected to chart. During a concurrent interview and record review on 7/17/2025 at 2:39p.m. with the Director of Nursing (DON), the DON stated frequent visual checks are indicated in the care plan and there is no documentation that the frequent checks were done. The DON stated the frequent visual checks should be documented as a part of the nursing measure. The DON stated care plans are a guide on how to take care of the residents, and to indicate how residents are monitored for safety and supervision.During a review of the facility's policy and procedure (P&P) titled, Comprehensive Plan of Care undated, the P&P indicated it is the policy of this facility to provide each resident with a comprehensive plan of care developed that includes goals, measurable objectives and timetables to meet their medical, nursing, mental, psychosocial needs identified during comprehensive assessment. The P&P indicated the CP develop goals and approaches for each problem and/or conditions that are realistic, specific, measurable, and include interventions/approaches that related to each stated long or short-term goal.During a review of the facility's P&P titled, Charting and Documentation undated, the P&P indicated all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care.