

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555432	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2025
NAME OF PROVIDER OR SUPPLIER Solheim Senior Community		STREET ADDRESS, CITY, STATE, ZIP CODE 2236 Merton Ave. Los Angeles, CA 90041	

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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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, facility failed to develop and implement a comprehensive person-centered care plan (a document that outlines the facility's plan to provide personalized care to a resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs) for one of two sampled residents (Resident 1) to address resident's poor mobility and balance per facility policy. This deficient practice resulted in Resident 1 sustaining a fall in the shower room on 11/2/2025 at around 10 AM while sitting in a shower chair. Resident 1 sustained laceration (a deep cut or tear in the skin) to forehead and was sent to the General Acute Care Hospital (GACH) on 11/2/2025 at 10:40 AM, where Resident 1 was diagnosed with acute nondisplaced fracture (a break in the bone that has not moved out of position, is recent) of first cervical vertebra (C1, the topmost bone that connects the skull to the spine) right posterior (back) arch, midline forehead hematoma (a collection of blood outside of a blood vessel caused by a broken blood vessel) with laceration, and blunt head trauma (an injury to the head caused by a forceful impact). Cross Reference F689 Findings: During a review of Resident 1's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities), cerebral infarction (the death of brain tissue due to a lack of blood flow) and dementia (a progressive state of decline in mental abilities). During a review of Resident 1's Care Plan (CP), dated 2/5/2025, the Care Plan indicated Resident 1 is dependent on staff for meeting emotional, intellectual, physical and social needs related to cognitive deficits (impairments in mental processes like memory, attention, reasoning, and language), immobility (the state of not moving) and physical limitations. The CP interventions included that Resident 1 needs assistance with ADL as required during the activity. During a review of Resident 1's Mobility (the ability to move or be moved freely and easily) Assessment, dated 10/22/2025, the Mobility Assessment indicated Resident 1's mobility and balance was assessed having poor ability to sit up unassisted, poor ability to maintain sitting balance, poor ability to stand, and poor ability to maintain standing balance. During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 10/23/2025, the MDS indicated Resident 1's cognitive (ability to think and reason) skills for daily decision making was severely impaired (never/rarely made decisions). Resident 1 was dependent (helper does all the effort) with eating, oral hygiene, toileting hygiene, shower/bath, upper and lower body dressing, and putting on/taking off footwear and personal hygiene. The MDS indicated Resident 1 was dependent on tub/shower transfer (the ability to get in and out of a tub/shower). During a concurrent observation and interview on 11/14/2025 at 12:25 PM with the Director of Nursing (DON), Resident 1 was sitting in a reclining wheelchair, in a reclining position. The DON stated Resident 1 started using the reclining wheelchair when Resident 1 was readmitted back to the facility on [DATE]. During a concurrent interview and record review on 11/14/2025 at 3:25 PM with the Director of Rehabilitation (DOR), Resident 1's Mobility assessment dated [DATE] was reviewed. The DOR stated Resident 1 has a poor posture (the position in which you hold your body, both when moving and when still like sitting) and poor trunk control wherein Resident 1 has the tendency of leaning to sides and leaning forward which could result in a fall. The DOR stated Resident 1 should be in a reclined position while being seated to a chair like shower chair and wheelchair to prevent sliding and leaning forward that can result in a fall. The DOR stated when a reclining shower chair is tilted, it could prevent residents from leaning forward. The DOR stated that per Mobility Assessment, Resident 1 was assessed to have poor ability to roll from side to side, poor ability to sit up unassisted, poor ability to maintain sitting balance, poor ability to stand, poor ability to maintain standing balance. The DOR stated Resident 1 required total assistance (a situation where a person is unable to complete an activity without full physical help) while seated in a wheelchair or shower chair. During an interview on 11/14/2025 at 4 PM with MDS nurse (MDSN), MDSN stated Resident 1 has the tendency of leaning on the side because of poor trunk control. MDSN stated Resident 1 does not have the control to push back to normal position to prevent from falling. MDSN stated having Resident 1 in reclining position while being seated in a wheelchair or shower chair could have benefited Resident 1. MDSN stated reclining shower chairs can be used for safety for residents who have poor balance and poor trunk control because the reclining position makes it harder for residents to lean forward. MDSN verified that Resident 1 did not and should have a care plan for leaning on the side and for poor mobility and balance. MDSN stated care plan interventions such as recommendation from rehabilitation and reclining wheelchair could have</p>		

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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. (continued on next page)		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>**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 two (2) sampled residents (Resident 1) who was assessed as dependent with staff for Activities of Daily Living (ADL's- basic self-care tasks essential for independent living, including bathing, dressing, eating, using the toilet, and moving from place to place) and with poor ability in maintaining sitting balance was not left unattended by Certified Nurse Assistant 1 (CNA1) by turning her back from Resident 1 who was in a shower chair while in the shower room on 11/2/2025. This deficient practice resulted in Resident 1 sustaining a fall in the shower room on 11/2/2025 at around 10 AM resulting in a laceration (a deep cut or tear in the skin) to the forehead. On 11/2/2025 at 10:40 AM, Resident 1 was transferred to General Acute Care Hospital (GACH) where Resident 1 was diagnosed with acute nondisplaced fracture (a break in the bone that has not moved out of position, is recent) of first cervical vertebra (C1, the topmost bone that connects the skull to the spine) right posterior (back) arch, midline forehead hematoma (a collection of blood outside of a blood vessel caused by a broken blood vessel) with laceration, and blunt head trauma (an injury to the head caused by a forceful impact). Findings: During a review of Resident 1's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities), cerebral infarction (the death of brain tissue due to a lack of blood flow), and dementia (a progressive state of decline in mental abilities). During a review of Resident 1's undated Care Plan (CP), the Care Plan indicated Resident 1 is dependent on staff for meeting emotional, intellectual, physical and social needs related to cognitive deficits (impairments in mental processes like memory, attention, reasoning, and language), immobility (the state of not moving) and physical limitations. The CP interventions included that Resident 1 needs assistance with ADL as required during the activity. During a review of Resident 1's Mobility (the ability to move or be moved freely and easily) Assessment, dated 10/22/2025, the Mobility Assessment indicated Resident 1's mobility and balance was assessed having poor ability to sit up unassisted, poor ability to maintain sitting balance, poor ability to stand, and poor ability to maintain standing balance. During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 10/23/2025, the MDS indicated Resident 1's cognitive (ability to think and reason) skills for daily decision making was severely impaired (never/rarely made decisions). Resident 1 was dependent (helper does all the effort) with eating, oral hygiene, toileting hygiene, shower/bath, upper and lower body dressing, and putting on/taking off footwear and personal hygiene. The MDS indicated Resident 1 was dependent on tub/shower transfer (the ability to get in and out of a tub/shower). During a review of Resident 1's Progress Notes, dated 11/02/2025, timed 10:10 AM, by Registered Nurse 1 (RN 1), the Progress Notes indicated RN 1 was called to the shower room, and upon arrival, Resident 1 was found lying on the floor with an approximately two inches (unit of measurement) laceration to the top of scalp. Paramedics (a person trained to give emergency medical care to people who are injured or ill) arrived at 10:35 AM and transported Resident 1 to GACH at 10:40 AM. During a review of Resident 1's GACH Trauma Surgery History and Physical (H&P), dated 11/2/2025, the GACH Trauma Surgery (H&P) indicated Resident 1 was status post ground level floor, and on Xarelto (blood thinner medication). Positive head strike (refers to a documented impact to the head that is associated with specific concerning symptoms or physical findings of a potential brain injury, such as a concussion [traumatic brain injury caused by a bump, blow, or jolt to the head or body that makes the brain move inside the skull] or intracranial bleeding [bleeding inside the skull, which can occur when a blood vessel in or around the brain ruptures or leaks]). Per Emergency Medical Services (EMS, a system that provides emergency medical care), Resident 1 slipped and fell from shower chair. Resident 1 has forehead hematoma and laceration. It also indicated hematoma at midline forehead with 1.5-centimeter (cm, unit of measurement) laceration with very light bleeding. During a review of Resident 1's GACH Trauma Daily Progress Note, dated 11/3/2025, the GACH Trauma Daily Progress Note indicated Resident 1's injuries that included the following: Acute nondisplaced fracture of C1 right posterior arch - maintain aspen (a type of neck brace designed to provide support, stability, and motion restriction to the neck, mid-back, or lower back to facilitate healing after injury). Midline forehead hematoma with laceration - status post repair with absorbable suture (a stitch used to close a wound). During a review of Resident 1's Progress Notes, dated 11/4/2025, timed 10:52 PM, the Progress Notes indicated Resident 1 was admitted from GACH with admitting diagnosis of posterior C1 fracture without displacement and midline</p>		