STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555891	A. Building B. Wing	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Veterans Home of California - Redding	3400 Knighton Road Redding, CA 96002

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. (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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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to reassess fall risk factors and update the care plan interventions for 1 of 3 sampled residents (Resident 2), who was identified as being at high risk for falls. This failure resulted in Resident 2's unwitnessed fall, transfer to the acute care hospital for evaluation and treatment, and subsequent admission due to several broken ribs and a broken right collarbone on 8/3/25 (refer to Intake 2581256).Findings: During a concurrent observation and interview on 8/20/25 at 11:35 AM with Resident 2 in his room, Resident 2 was observed with multiple purplish black discolorations on the right side of his trunk, right side of his head/face, and some small, scattered purplish black discoloration on his right arm. Resident 2 was alert and oriented to person, place, and time. However, Resident 2 got short of breath easily and was drowsy during the interview. Resident 2 stated he did not recall what happened on 8/3/25 when he fell and sustained his injuries. During an interview on 8/19/25 at 11:45 AM with Certified Nurse Assistant 1 (CNA 1), CNA 1 stated Resident 2 was independent with his activities of daily living but was considered a high fall risk. CNA 1 stated Resident 2 was on frequent rounding checks for a little bit until it was discontinued. CNA 1 stated frequent rounding was checking on the residents every 15 to 30 minutes sometimes hourly depending on the resident's need and noting what was seen, addressing the 4Ps (pain, potty [bathroom needs], positioning, and possessions [or proximity of personal items]), and ensuring alarms were in place and working. During a review of Resident 2's face sheet, the face sheet indicated Resident 2 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (a progressive respiratory disease, causing shortness of breath), heart failure, and progressive joint disease resulting in joint pain. Resident 2 had a history of falls. During a review of Resident 2's Case Manager's Note, dated 7/3/25, the note indicated his Brief Interview for Mental Status (BIMS) score was 13/15 (intact cognition). The note also indicated Resident 2 fell on 5/30/25, prior to his admission to the facility and he used a four-wheel walker to ambulate. During a review of Resident 2's Interdisciplinary Progress Note - Nursing, dated 8/3/25 at 10:30 PM, the note indicated Resident 2 had an unwitnessed fall while toileting and was found on the floor with his four-wheel walker behind him on 8/3/25 at 8:30 PM. During a review of Resident 2's Interdisciplinary Progress Note - Nursing, dated 8/4/25 at 4:10 AM, the note indicated Resident 2 was admitted to the acute care hospital with several broken ribs and broken right collarbone on 8/3/25. During a review of Resident 2's Interdisciplinary Resident Fall Investigation and Intervention, the notes indicated Resident 2 had unwitnessed falls on the following dates: a. 7/25/25 at 3:28 PM - due to inability to gauge sleepiness and exhaustion and retire to bedb. 7/26/25 at 1:20 AM - due to impaired balance and overestimated ability. During a review of Resident 2's Fall Risk Assessment Forms (total score of 10 or above represents HIGH RISK), indicated Resident 2 scores were as follows:a. 6/24/25 (on admission), scored 16. b. 7/25/25 (post-fall), scored 15. c. 7/26/25 (post-fall), scored 18. During a review of Resident 2's Interdisciplinary Progress Note - Nursing, dated 8/4/25 at 8 AM, the note indicated a late entry for 7/28/25 when Resident 2's daughter requested the alarms (SMART alarms [devices that use sensors to detect when a patient or resident gets out of bed or a chair, alerting a caregiver wirelessly to help prevent a fall]) to be removed because the alarms were Keeping him awake and exhausted. The note also indicated that both the resident and his daughter appeared relieved after the alarms were removed. During a concurrent interview and record review on 8/20/25 at 2:08 PM with the Director of Nursing (DON), Resident 2's Fall Prevention Care Plan initiated on 6/24/25 was reviewed. The care plan was updated after each fall with the following interventions: a. Frequent rounding was initiated on 7/25/25 for one week (end date 8/1/25). b. Initiate SMART alarms on 7/26/25 and were discontinued on 7/28/25. c. Frequent rounding for two weeks was initiated on 8/3/25 (date of most current fall- after Resident 2 fell).The DON stated Resident 2's frequent rounding that was initiated on 7/25/25 concluded on 8/1/25. The DON also stated the nurses should have reassessed Resident 2 risk factors and updated the care plan to continue frequent rounding indefinitely since Resident 2 and his family refused the use of alarms on 7/28/25. The DON was unable to provide documented evidence to show there were fall prevention interventions implemented after the frequent rounding intervention was discontinued on 8/1/25, two days prior to Resident 2's unwitnessed fall with significant injuries on 8/3/25. In addition, the DON was unable to provide a policy and procedure (P&P) for the frequent rounding checks intervention. During a review of the P&P titled, Fall Risk Assessment and Prevention Program, dated 3/20/23, the P&P indicated, A Registered Nurse (RN), will complete the fall risk

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the pain medication was administered as prescribed for Resident 1. This failure had the potential to result in uncontrolled pain management and adverse outcomes for Resident 1 (refer to Intake 2573274).Findings: During a review of Resident 1's face sheet, the face sheet indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included heart failure, metastatic (the spread of cancer cells from the place where they first formed to another part of the body) prostate cancer, and muscle weakness. During a review of the facility's policy and procedure titled, Medication Administration, General Guidelines (SNF), dated 4/21/25, the P&P indicated, Medications are administered only by nursing . 1. As Ordered: Medications are administered in accordance with and with orders of the prescriber. During a concurrent interview and record review on 8/20/25 at 10:23 AM with the LVN 1, the physician order for Oxycodone (narcotic pain medication usually prescribed for severe pain) 5 milligrams (mg) immediate release was reviewed. The physician order indicated, Take one tablet by mouth every 4 hours, as needed for lower back pain. LVN 1 stated she did not administer the Oxycodone as prescribed and she should have called the physician to obtain a medication order for Resident 1's generalized pain. During a concurrent interview and record review on 8/20/25 at 10:32 AM with the Director of Nursing (DON), Resident 1's Medication Record, dated July 2025, was reviewed. The Medication Record indicated the pain medication Oxycodone 5 mg immediate release was administered on 10 occasions by multiple nurses for the incorrect indication as follows: 1. 7/16/25 at 3:35 PM - Increased generalized pain2. 7/18/25 at 3 PM - Body pain 3. 7/25/25 at 7 PM - Generalized pain 4. 7/26/25 at 7 AM - Generalized/facial/neck 5. 7/26/25 at 12 PM - Neck pain6. 7/26/25 at 9 PM - Neck pain 7. 7/27/25 at 4:40 AM - Face and Neck pain 8. 7/28/25 at 7 AM - Face Pain9. 7/29/25 at 1 PM - Face and Neck pain 10. 7/31/25 at 8 AM - Neck pain The DON stated the nurses should have obtained a physician order for Resident 1's general pain. During an interview on 8/20/25 at 1:40 PM with Medical Doctor 1 (MD 1), MD 1 stated the nurses can administer Resident 1's pain medication Oxycodone 5 mg immediate release as needed for other pain indications even though the indication on his physician order stated for lower back pain. During an interview on 8/20/25 at 1:46 PM with Pharmacist 1 (Pharm 1), Pharm 1 stated it was okay for nurses to administer Resident 1's pain medication Oxycodone 5 mg immediate release as needed for other pain reasons other than the indication stated on the physician's order.