STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555917	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Veterans Home of California - West Los Angeles	11500 Nimitz Avenue Los Angeles, CA 90049

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39474 Based on observation, interview and record review, the facility failed to develop and implement a resident centered comprehensive care plan with interventions for resident preferences including to be left alone in the shower room and aiding with showering, to meet the needs of one of three sampled residents, Resident 1. This failure resulted in Resident 1's unsupervised fall, fractured breastbone, breastbone bruise, fractures of thoracic spine (the mid-back section of the spine), scalp bruise and 2-day hospital stay. Findings: Resident 1 was a [AGE] year-old female admitted to the skilled nursing facility on 3/18/25, with a history of legal blindness and severe osteoarthritis (degeneration of joint cartilage and the underlying bone, causes pain and stiffness, especially in the hip, knee, and thumb joints. During an observation and interview on 4/22/25 at 2:40 p.m. Resident 1 was observed in bed laying face up, and stated she recalled the fall event on 4/15/25. Resident 1 stated she was legally blind but could see peripherally (the ability to see things to the side). Resident 1 stated she was alone in the shower, with the nursing assistant was outside the bathroom door when she lost balance, yelled out and fell . Resident 1 stated she suffered a bump on her head, hurt her neck and went out to the hospital emergency department after her fall. During an interview on 4/23/25 at 12:00 p.m. with Registered Nurse 3 (RN3), RN3 stated, on 4/15/25 at approximately 10:10 a.m. she responded to Resident 1's bathroom and found Resident 1 with a Certified Nurse's Aide (CNA1) sitting on the floor in the bathroom after a fall. RN3 further stated she assessed Resident 1 and notified Resident 1's doctor and family of the fall. RN3 stated Resident 1 initially denied pain but minutes later, started complaining of pain to her shoulder. RN3 stated the doctor ordered Resident 1 to go to the hospital emergency department for further evaluation. RN3 stated Resident 1 was legally blind and the fall could have been avoided if CNA1 had stayed in the shower and assisted Resident 1 with showering. (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	During an interview on 4/23/25 at 3:02 p.m. with CNA1, she stated on 4/15/25 she assisted Resident 1 with shower preparation. CNA1 stated she waited outside the bathroom while Resident 1 showered. CNA1 further stated approximately 3 minutes later, she heard a yell and a boom from inside the bathroom. CNA1 stated she found Resident 1 laying on the bathroom floor halfway out of the shower. CNA1 stated this fall could have been avoided if someone was with Resident 1 to help during her shower. Review of Resident 1's admission History and Physical dated 3/18/25 indicated Resident 1 was a [AGE] year-old female with a history of blindness and severe osteoarthritis (OA), independent for her activities of daily living (ADL), however, her function level decreased to the point where she required more assistance with her ADLs. Review of Resident 1's care plan dated 3/18/25, indicated Resident 1 had a high risk for fall with injury, a history of falls, unsteady gait, poor vision and was prescribed opioid (medication used to reduce moderate to severe pain), hypnotic (medication tending to produce sleep), and diuretic (drugs that increase urine output, leading to the removal of excess water and salt from the body) medication. Review of Resident 1's fall risk assessment dated [DATE] indicated, Vision status: legally blind. Gait and balance: required use of assistive devices. Resident 1 was assessed as at high risk for fall. Review of Resident 1's resident assessment instrument/ minimum data set (RAI / MDS, a health status screening and assessment tool used for all residents of long-term care nursing facilities) Section GG: functional abilities-admission (self-care) dated 3/25/25 indicated, admission performance: E. Shower and bathe self: Resident 1 required supervision or touching assistance, helper provide verbal cues, steadying, contact guard assistance (caregiver places one or two hands on the patient's body to help with balance but provides no other assistance to perform the functional mobility task) as resident completed activity . Review of Resident 1's care plan dated 3/26/25 10:02 a.m. indicated, problem: at risk for falls related to, limited mobility due to severe macular degeneration with poor vision, unsteady gait, chronic pain, numbness of fingers/foot (right), occasional bladder incontinent, taking hypnotics/diuretic/opioid/ medications, diagnosis of osteoporosis/ Cervical compression fracture (one or more of the vertebrae in the spine collapses or breaks). Goals: resident will demonstrate the ability to ambulate/transfer without fall related injuries. Resident 1's care plan did not contain interventions addressing resident preferences including to be left alone in the shower room, assistance with showering, or refusal of supervision while in the shower room. Review of Resident 1's nurse note dated 4/15/25 at 1:06 p.m. indicated, unwitnessed fall without injury. At about 10:10 a.m., was notified that Resident 1 had a fall in the bathroom, on getting there 3 staff were assisting her already and she was noted sitting in the shower. Resident was still alert and verbally responsive, was able to narrate what happened, she said that she had just finished her shower and was trying to wear her robe when she lost her balance and fell on the bathroom floor, hit her back on the floor. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 1's History and Physical dated 4/18/25 indicated, hospitalization : 4/15/25-4/17/25 Readmission Diagnosis: status post fall with acute (sudden) manubrial (breastbone) fracture with parasternal hematoma (breastbone bruise), multiple thoracic (mid back) fractures, scalp contusion (bruising). Patient endorses prior history of thoracic spine compression fractures. Also has prior history of left arm injury with resultant weakness . Review of facility policy and procedure titled, Accident / Fall Prevention dated, 5/30/24 indicated, The Home will routinely assess each Skilled Nursing Facility (SNF) Resident for risk of accidents and implement preventive measures to decrease modifiable risks, as able. If an incident occurs, pertinent data will be collected, appropriate care will be provided, and the preventive measures will be re-evaluated in attempt to provide the safest environment possible. A. Evaluation Frequency: Residents are minimally evaluated for risk of accidents or falls: 1. Upon admission, 2. Quarterly, 3. Annually, 4. As needed (PRN); after each fall, incident, or change of condition. Evaluation methods and prevention planning may include: 1. Physician Assessment, 2. The Fall Risk Assessment 3. RAI/MDS - Assessment Tool . Review of facility policy and procedure titled, Care Plans dated, 2/13/25 indicated, I. Resident Assessments & Care Plans A. The Resident Assessment Instrument. Minimum Data Set (RAI/MDS) is completed as the basis for care plan decision-making at the skilled nursing facility (SNF) levels of care. B. All components of the care plan must be individualized for the Resident. Baseline Care Plan A. The facility must develop and implement a baseline care plan for each Resident within 48 hours upon admission that includes the instructions needed to provide effective and person-centered care of the Resident. B. The baseline care plan must reflect the Resident's stated goals and objectives and include interventions that address his/her current needs .Comprehensive Care Plan: A. The facility must develop and implement a comprehensive person-centered care plan for each Resident, consist with the Resident rights and includes measurable objectives and timeframes to meet a Resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment .O. The comprehensive care plan will be reviewed and revised by the Interdisciplinary Team (IDT) within 7 days after each RAI/MDS assessment, including both the comprehensive and quarterly review RAI/MDS assessment.