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	07/02/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to accommodate Resident 1's right to access services outside the facility when transportation for Resident 1's off^campus medical appointment was not properly coordinated. This failure resulted in Resident 1 missing his physical^therapy appointment and experiencing emotional distress related to feeling neglected and having unmet care needs.Findings:During a review of Resident 1's Face Sheet (demographics), dated 7/6/26, the Face Sheet indicated Resident 1 was admitted on [DATE] with diagnoses including quadriplegia (paralysis of all four limbs), acromegaly and pituitary gigantism (disorder that causes body parts to become abnormally enlarged), and spinal stenosis (narrowing of the spine that can lead to is narrowed).During an interview on 7/2/26 at 10:38 a.m. with Resident 1, Resident 1 stated he had a standing appointment twice a week at an off-campus specialty clinic that provided physical therapy for people with spinal injuries like his. Resident 1 stated he had a pickup time scheduled at 10 a.m. with the facility's transportation service for his 11 a.m. appointment. Resident 1 stated Certified Nursing Assistant (CNA) 1 escorted him to the pickup location at around 9:45 a.m. When they got there, Automotive Equipment Operator (Driver) 1 told them he was the only driver and could not take Resident 1 to his off-campus appointment at the specialty clinic because he was only assigned to take the residents going for appointments within the local campus, referring to the other residents that were also waiting at the pick-up point. Resident 1 stated Driver 1 did not offer any alternative transportation options so CNA 1 escorted Resident 1 back to his room. Resident 1 stated how incredibly upset he was that no one notified him about no driver being available, so he filed an official complaint. Resident 1 stated, later that day, the Director of Nursing (DON) told him there was another driver, Driver 2, that was available to take him if he had just waited downstairs. Resident 1 stated that he went back upstairs because Driver 1 already told him there were no other drivers. In addition, Driver 2 never called to notify him that they were downstairs and available to take him. Resident 1 stated this was not the first time he missed an appointment because his transport was not arranged properly, and he felt neglected, like the facility did not want to take care of him.During a concurrent interview and record review on 7/2/26 at 4:23 p.m. with Driver 2, the facility provided document titled, Transportation Medical Appointments, dated 6/29/26, was reviewed. The document indicated Resident 1 had an off-campus appointment with a pick-up time scheduled at 10 a.m. and a hand-written notation indicating it was canceled. Driver 2 stated she wrote down canceled because Driver 1 told her Resident 1 went downstairs and went back up to his room. Driver 2 stated she did not call the unit and let them know she was available to take Resident 1 to his appointment and did not confirm with anyone that Resident 1's appointment was canceled. Driver 2 stated, We are not personal drivers, and we can't cater to just one resident.During an interview on 7/3/26 at 8:59 a.m. with Registered Nurse (RN) 1, RN 1 stated Resident 1 and CNA 1 told her there was no driver available to take Resident 1 to his appointment on 6/29/26, but she did not call to check whether there was a driver available or assist in coordinating transportation to his appointment.During an interview on 7/3/26 at 1 p.m. with Driver 1, Driver 1 stated he told Resident 1 and CNA 1 that he was the only (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	driver on 6/29/26 and did not tell them another driver was coming because he did not know when the other driver was coming. Driver 1 stated that if there were only two drivers working and a resident has an off-campus appointment, usually one driver handled all the local transport while the other handled the off-campus appointment.During an interview on 7/6/26 at 9 a.m. with CNA 1, CNA 1 stated she was escorting Resident 1 to the pick-up location on 6/29/26 for his off-campus appointment. CNA 1 stated Driver 1 told them there was no driver available to take Resident 1 to his appointment, so CNA 1 escorted Resident 1 back to the unit. CNA 1 stated she was unaware Driver 2 was available as Driver 2 did not notify staff of her arrival to transport Resident 1. CNA 1 stated she and Resident 1 never told anyone to cancel the appointment and that other drivers would call the unit as a courtesy if Resident 1 was not downstairs at the scheduled pick-up time.During an interview on 7/6/26 at 10:49 a.m. with the General Services Manager (GM), the GM stated Driver 2 was supposed to take Resident 1 to his appointment, but if a resident isn't in the lobby or waiting in the front, the drivers don't call up to the unit to ask if the resident's still going. They assume the resident's not coming.During a review of Resident 1's Care Plan, dated 6/16/26, the Care Plan indicated a care plan in place for Resident 1's risk for emotional distress related to having no transportation to physical therapy appointments. The Care Plan indicated an intervention for nursing to coordinate with transportation staff regarding Resident 1's off-campus appointments.During a review of Resident 1's Clinical Notes - Social Worker, dated 6/29/26, the notes indicated, [Resident 1] appeared unhappy and resigned after hearing the news after he was informed that there was no driver available for him. The notes further indicated Resident 1 reported that missing his standing medical appointment made him feel like his care was being neglected by the facility and that the event made him feel like other residents' care was more important than [his] care.' During a review of the facility's policy and procedure (P&P) titled, Transportation Service, dated 4/16/2026, the P&P indicated, It is the policy of the [facility name] to provide safe and timely transportation to the Residents . The P&P further indicated, Driver will coordinate with Nursing staff if a passenger is not at the designated loading area on time for departure.