STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055167	A. Building B. Wing	10/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vernon Healthcare Center	1037 W. Vernon Avenue Los Angeles, CA 90037

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50379 Based on interview and record review, the facility failed to ensure a written notice of discharge and the right to appeal, was provided to one of 3 residents ' (Resident 2) representative, prior to the resident ' s discharge to an assisted living facility (housing that provides nursing care, meals, and laundry services) on 10/2/2024. This failure resulted in Resident 2 ' s representative not knowing about Resident 2 ' s discharge. Findings: During a review of Resident 2 ' s Admission Record dated 10/7/2024, the Admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including schizoaffective disorder (mental illness that affects a resident ' s thoughts, mood, and behavior), autistic disorder (a disorder that affects a resident ' s ability to communicate and interact), and anxiety disorder (a condition that causes strong feelings of fear and worry). The Admission Record indicated Resident 2 had a designated responsible party (person to make medical decisions for the resident). During a review of Resident 2 ' s History and Physical (H&P) dated 1/30/2024, the H&P indicated Resident 2 could make needs known but could not make medical decisions. During a review of Resident 2 ' s Physician Orders dated 10/2/2024, the Physician Orders indicated Resident 2 could be discharged to an assisted living facility. During an interview on 10/4/2024 at 1:49 p.m. with Resident 2 ' s representative, Resident 2 ' s representative stated he was not notified of Resident 2 ' s discharge in writing or on the phone. Resident 2 ' s representative stated he was not informed of his right to appeal and did not have the opportunity to appeal prior to discharge. During a concurrent interview and record review on 10/4/2024 at 3:05 p.m. with Social Service Assistant (SSA 1), Resident 2 ' s Admission Record, Progress Notes dated 10/2024, and Physician Orders dated 10/2024 were reviewed. The SSA 1 stated Resident 2 had a physician order to be discharged on [DATE] to an Assisted Living facility. The SSA 1 stated she (SSA 1) was not notified regarding Resident 2 ' s discharge plan or discharge on 10/2/2024, therefore, Resident 2 ' s responsible party to make decisions was not notified prior to discharge. The SSA 1 stated she was notified two hours after Resident 2 was discharged . (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 10/7/2024 at 12:16 p.m. with Licensed Vocational Nurse (LVN 2), Resident 2 ' s progress notes dated 10/2024 and Notice of Proposed Transfer and discharge date d 10/2/2024 were reviewed. LVN 2 stated the Notice of Proposed Transfer and Discharge (notice) did not indicate date and signature the resident or resident representative was notified regarding the discharge. The notice indicated a facility ' s representative signature and a note dated 10/2/2024 indicating a message was left. LVN 2 stated Resident 2 ' s progress notes did not indicate Resident 2 ' s representative called back and acknowledged the message. LVN 2 stated she did not call again or provide written notice of the discharge. LVN 2 stated Resident 2 ' s representative was not notified in writing and Resident 2's representative did not acknowledge Resident 2 ' s discharge order, discharge rights, and discharge location. LVN 2 stated a resident could go to a facility unable to care to for their needs, which could result in mental or physical decline if a resident is discharged without their resident representative ' s involvement. During a concurrent interview and record review on 10/7/2024 at 9:27 a.m. with Director of Nursing (DON), Resident 2 ' s progress notes dated 9/2024 and 10/2024 and the undated P&P titled Discharge and Transfer of Residents were reviewed. The DON confirmed Resident 2 ' s progress notes did not indicate Resident 2 ' s representative was notified of the discharge plan or discharge. The DON stated the P&P indicated the Social Service or Nursing Departments should have provided Resident 2 ' s representative with the written Notice of Proposed Transfer and Discharge document prior to discharge. The DON stated the facility did not provide written notification to Resident 2's representative. The DON stated the P&P indicated nursing staff should have obtained and documented Resident 2 representative ' s acknowledgement of the resident ' s discharge and receipt of the Notice of Proposed Transfer or Discharge and Discharge Summary prior to Resident 2 ' s discharge. During a concurrent interview and record review on 10/7/2024 at 12:16 p.m. with the Administrator, Resident 2 ' s progress notes dated 10/2024, and physician orders dated 10/2024 were reviewed. The Administrator stated Resident 2 expressed interest to be discharged on [DATE]. The Administrator stated she called Resident 2 ' s doctor and requested an order for discharge. The Administrator stated she did not notify Resident 2 ' s representative of Resident 2's discharge plan or order. During a review of the facility ' s undated P&P titled, Discharge and Transfer of Residents, the P&P indicated nursing staff must provide the resident and their representative a written notice of discharge 30 days prior to discharge or as soon as practicable. The P&P indicated the informed written or telephone acknowledgement of a resident's discharge by the resident's authorized representative must be documented in the resident ' s clinical record prior to discharge. The P&P indicated, when a resident is discharged , nursing staff must document in the resident's medical record, the informed written or telephone acknowledgement of the resident's discharge by the resident's authorized representative, except in an emergency situation.

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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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50379 Based on interview and record review, the facility failed to follow its policy and procedure (P&P) when it did not involve the Interdisciplinary Team (IDT) in discharge planning for two of three (Resident 1 and Resident 2) residents. This failure had the potential to result in resident goals, needs, and preferences to be unmet after discharge. a) During a review of Resident 1 ' s Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including cerebral infarction (illness affecting blood flow to the brain), psychoactive substance (substance that affects how the brain thinks) abuse-induced psychotic disorder (overuse resulting in mental illness), and insomnia (disorder that affects sleep). During a review of Resident 1 ' s History and Physical (H&P) dated 11/21/2023, the H&P indicated Resident 1 had a history of strokes (disrupted blood flow to the brain) and schizophrenia (mental disorder affecting thought and behavior). The H&P indicated Resident 1 did not have the ability to make medical decisions. During a review of Resident 1 ' s Physician Orders dated 9/30/2024, the Physician Orders indicated Resident 1 may discharge to a senior home (housing that provides nursing care, meals, and laundry services). During a concurrent interview and record review on 10/4/2024 at 3:33 p.m. with Social Service Assistant (SSA) 1, Resident 1 ' s Admission Record, Progress Notes dated 10/2024, and Physician Orders dated 10/2024 were reviewed. SSA 1 stated Resident 1 had a Physician Order to be discharged on [DATE]. SSA 1 stated there was no progress note indicating an IDT meeting was no conducted to plan Resident 1's discharge. SSA 1 stated SSA 1 ' s Progress Note on 10/2/2024 indicated the Social Service Department was not notified of the discharge plan or order until the day after Resident 1 was discharged . SSA 1 stated SSA 1 did not conduct an IDT meeting prior to discharge because SSA 1 was not notified prior to Resident 1 ' s discharge. During a concurrent interview and record review on 10/7/2024 at 9:15 a.m. with Director of Nursing (DON), Resident 1 ' s Progress Notes dated 9/2024 and 10/2024 were reviewed. The DON stated there were no Progress Notes indicating an IDT meeting was performed for Resident 1 ' s discharge planning and an IDT meeting was not performed. The DON stated resident discharges require IDT meetings for resident safety to ensure residents receive adequate care after discharge. b) During a review of Resident 2 ' s Admission Record dated 10/7/2024, the Admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including schizoaffective disorder (mental illness that affects a resident ' s thoughts, mood, and behavior), autistic disorder (a disorder that affects a resident ' s ability to communicate and interact), and anxiety disorder (a condition that causes strong feelings of fear and worry). The Admission Record indicated Resident 2 had a designated responsible party (person to make medical decisions for the resident). (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 2 ' s History and Physical (H&P) dated 1/30/2024, the H&P indicated Resident 2 could make needs known but could not make medical decisions. During a review of Resident 2 ' s Physician Orders dated 10/2/2024, the Physician Orders indicated Resident 2 may discharge to an assisted living facility (housing that provides nursing care, meals, and laundry services). During an interview on 10/4/2024 at 1:49 p.m. with Resident 2 ' s representative, Resident 2 ' s representative stated he was not invited to an IDT meeting related to Resident 2 ' s discharge. During a concurrent interview and record review on 10/4/2024 at 3:05 p.m. with SSA 1, Resident 2 ' s Admission Record, Progress Notes dated 10/2024, and Physician Orders dated 10/2024 were reviewed. SSA 1 stated Resident 2 ' s Admission Record indicated Resident 2 had a responsible party to make medical decisions for Resident 2. SSA 1 stated Resident 2 had a Physician Order to be discharged on [DATE]. SSA 1 stated SSA 1 ' s Progress Note on 10/2/2024 indicated the Social Service Department was not notified of the discharge plan and order until after Resident 2 was discharged . SSA 1 stated SSA 1 did not notify Resident 2 ' s responsible party prior to discharge because SSA 1 was not aware of Resident 2 ' s discharge plan or discharge order. SSA 1 stated an IDT meeting should occur for every resident discharge and include the resident and their responsible party. SSA 1 stated an IDT meeting is necessary for every discharge for resident safety and to ensure residents receive sufficient care and equipment after discharge. During a concurrent interview and record review on 10/7/2024 at 9:27 a.m. with Director of Nursing (DON), Resident 2 ' s Progress Notes dated 9/2024 and 10/2024 was reviewed. The DON stated the Progress Notes indicated there was not an IDT meeting about discharge planning for Resident 2. The DON stated resident discharges require IDT meetings for resident safety to ensure residents receive adequate care after discharge. During a review of the facility ' s undated P&P titled Social Services Program, the P&P indicated social services would communicate with the residnet and the resident's family members and invite then to participate in care planning meetings. During a review of the facility ' s undated P&P titled Discharge and Transfer of Residents, the P&P indicated each member of the IDT would participate in and document the development of the discharge summary/ post discharge plan of care.