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	04/10/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36331 Based on interview and record review, the facility failed to implement their policy and procedure titled Fall management Program to conduct and initiate an Interdisciplinary Team (a group of professionals from various disciplines who collaborate to address a patient's needs) meeting post fall for one of four sampled residents (Resident 1) after sustaining three falls. These failures resulted in Resident 1 continuing to fall and had the potential to cause life threatening injuries. Findings: During a review of Resident 1's admission record dated 4/09/2025, the admissions record indicated Resident 1 was admitted to the facility on [DATE], with diagnosis of muscle weakness, other abnormalities of gait and mobility, and alcoholic cirrhosis of theliver without ascites (a stage of alcohol-related liver disease characterized by scarring and damage to the liver, but without the presence of fluid accumulation in the abdomen). During a review of Resident 1's Minimum Data Set (MDS -a federally mandated resident assessment tool) dated 3/13/2025, the MDS indicated Resident 1 had clear speech, the ability to express needs and wants, and understands. The MDS indicated Resident 1 required partial/moderate assistance (helper does less than half the effort) from staff with oral hygiene, upper body dressing and personal hygiene. During a review of Resident 1's initial Fall Risk Evaluation progress note dated 3/08/2025 at 12:01 a.m., the Fall Risk Evaluation indicated Resident 1 had no falls in the past three months. The Evaluation indicated Resident 1's level of consciousness/mental status showed Resident 1 had intermittent confusion, was chairbound and continent (the ability to control one's bladder and bowel functions, meaning the ability to voluntarily retain urine and feces). The Fall Risk Evaluation indicated Resident 1 had one to two predisposing diseases, a recent hospitalization history in the last 30 days, and had a balance problem with walking. The Fall Risk Evaluation progress note indicated Resident 1 currently takes three to four medications and had a change in medication classes or a change in dosage in the past fivedays. The Fall Risk Evaluation indicated if the total score is above 10 or greater, the resident should be considered at high risk for potential falls. The Prevention protocol should be initiated immediately and documented on the care plan. Resident 1 was at a high risk for falls with a score of 19.0. (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's care plan titled Moderate Risk For Falls, dated 3/08/2025, indicated Resident 1 was at risk for falls related to mild cognitive (the mental processes involved in thinking, learning, remembering, and understanding) impairment of uncertain or unknown etiology (the cause), and blindness of the right eye. The care plan goals indicated Resident 1 would be free of falls through review date of 6/05/2025. The care plan nursing interventions included to anticipate and meet Resident 1's needs, be sure to place call light within reach and encourage Resident 1 to use it for assistance as needed and follow the fall protocol. During a review of Resident 1's Change of Condition Evaluation , dated 3/14/2025 at 1:10 p.m., theEvaluation indicated Resident 1 had a fall. The Change of Condition Evaluation summarized that Resident 1 was found on the floor on her right side next to her bed. Resident 1 stated she was trying to go to the bathroom; however, she slipped and fell and complained of right shoulder pain. The physician was notified and ordered an X-ray (a type of electromagnetic radiation used in medical imaging to create detailed images of internal structures, such as bones, organs, and blood vessels) of the right shoulder. During a review of Resident 1's Radiology Results Report , dated 3/14/2025 at 7:44 p.m., the report indicated no evidence of acute fracture or dislocation. During a review of Resident 1's Fall Risk Evaluation , progress note dated 3/14/2025 at 1:09 p.m., the Evaluation indicated Resident 1 had a history of 1-2 falls in the past three months, had a mental status of alert (oriented X 3) or comatose, and ambulatory and continent. The Fall Risk Evaluation progress note indicated Resident 1 had a change in gait pattern when walking through a doorway and jerking or unstable when making turns. The Evaluaton further indicated Resident 1 currently takes 3-4 medications and has a high fall risk score of 14.0. During a review of Resident 1's untitledcare plan, dated 3/14/2025, the care plan indicated Resident 1 had an actual fall with minor injury related to the slip and fall incident. The care plan goal indicated Resident 1 will resume usual activities without further incident through the review date of 6/05/2025. The nursing care plan included interventions to continue interventions on the at-risk plan (floor mats, low height bed, etc.), conduct neuro-checks (evaluates brain and nervous system functioning), keep resident floor clean and dry, and carry out physician orders for x-ray to the right shoulder. During a review of Resident 1's Change of Condition Evaluation , dated 3/20/2025, at 12:50 p.m., theEvaluation indicated Resident 1 had a fall. Resident 1 was witnessed by her certified nursing assistant (CNA) standing by her bedroom closet. Resident 1 walked back to her bed and stumbled to the floor, landing on her buttocks. Resident 1 had one slipper on her foot made of rubberymaterial. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the Fall Risk Evaluation progress note dated 3/20/2025 at 3:16 p.m., the Evaluation indicated Resident 1 had no history of falls in the past threemonths, which is incorrect because Resident 1 had an actual fall on 3/14/2025. The Fall Risk Evaluation indicated Resident 1's level of consciousness alert (oriented X 3) or comatose and Resident 1 is ambulatory and continent, and no predisposing (risk factors that make a person more susceptible to developing a disease) disease. The Fall Risk Evaluation progress note indicated Resident 1 had a change in condition in the last 14 days related to anemia and behavior. The evaluation further indicated Resident 1 has a balance problem while walking and currently takes three to four medications. Resident 1 has had a change in medication (or medication classes) or change in dosage in the past five days. Resident 1's fall score is 10.0. On admission, Resident 1 had an initial fall risk score of 19.0, and after the first fall the fall risk score was 14.0, and now after the 2nd fall, the fall risk score was 10.0. During a review of Resident 1's untitledcare plan, dated 3/20/2025, the care plan indicated Resident 1 had an actual fall with no injury, related to poor balance and unsteady gait. Resident 1 was ambulating in her room and stumbled. The care plan goal indicated Resident 1 will resume usual activities without further incident through review date 6/05/2025. The care plan nursing interventions included to perform neuro checks as indicated, monitor/document/report as needed for 72 hours signs and symptoms of pain, bruises, change in mental status, new onset: confusion, sleepiness, inability to maintain posture, agitation. Monitor labs and notify the medical doctor of abnormal results and conduct a physical therapy consult for strength and mobility. During a review of Resident 1's Change of Condition Evaluation , dated 3/22/2025, at 7:55 p.m., the Evaluation indicated Resident 1 had a fall, staff witnessed Resident 1 fall out from her wheelchair landing on the floor with her buttocks. The physician was notified and ordered staff to monitor Resident 1. During a review of the Fall Risk Evaluation progress note, dated 3/22/2025 at 8:44 p.m., the progress noteindicated Resident 1 had one to two falls in the past three months. Resident 1 has had threefalls in nine days. The Fall Risk Evaluation indicated Resident 1's level of consciousness is alert (oriented X 3) or comatose and Resident 1 is ambulatory, continent, and had no predisposing disease. The Fall Risk Evaluation progress note indicated Resident 1 had a change in condition in the last 14 days. Resident 1 had a balance problem while walking and currently takes three to four medications. The Fall Risk Evaluation Progress note indicated Resident 1 has had a change in medication (or medication classes) or change in dosage in the past five days and has a fall risk score of 10.0. During a review of Resident 1's untitled care plan, dated 3/22/2025, indicated Resident 1 had an actual fall with no injury, the fall was related to poor balance, unsteady gait. The care plan further indicated Resident 1 tried to transfer from the wheelchair unsuccessfully. The care plan goal indicated Resident 1 would resume usual activities without further incident through the review date 06/05/2025. The care plan interventions included to continue interventions on the at-risk plan, for no apparent acute injury, determine and address causative (a specific effect or is responsible for a particular event or result) factors of the fall and take blood pressure lying/sitting/standing X 1 in the first 24 hours. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/10/2025 at 2:15 p.m. with the Director of Nursing (DON), the DON acknowledged Resident 1 had 3 falls and IDT meetings were not conducted after each fall. The DON stated failure to conduct an IDT meeting post falls and implement safety measures to prevent falls jeopardizedResident 1's safety. The DON stated the inaccurate fall scores were due to incorrect information documented in the computer and may jeopardize Resident 1's safety. During a review of the facility's policy and procedure titled Fall Management Program , dated March 13, 2021, the policy indicated the purpose of the policy is to provide residents a safe environment that minimizes complications associated with falls. The IDT will initiate, review and update the Resident's fall risk status and care plan at the following intervals: on admission, quarterly, annually, upon identification of a significant change of condition post falls and as needed. The IDT will investigate the fall including a review of the Resident's medical record, post huddle and review of the incident and Accident report. The IDT will review the circumstances surrounding the fall then summarize their conclusions on an IDT note. In an effort to prevent more falls, the IDT will review and revise the care plan as necessary.