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	05/05/2025

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 0627 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50379 Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1), was safely discharged to a lower level of care by failing to: 1. Follow its policy and procedure (P&P) titled, Discharge and Transfer of Residents, which indicated the facility may discharge a resident if the services provided by the facility were no longer required, when Resident 1, who required the services provided by the facility was discharged to a Board and Care facility ([B&C] a small residential home that provides lower-level of care and supervision to seniors who need assistance with daily living tasks but do not require 24-hour nursing care). 2. Ensure Resident 1 was safely discharged to B&C 1. B&C 1 was not a licensed B&C and could not provide ambulation (walking) assistance, epilepsy (recurrent seizures) management and response, or assistance with medication administration and storage. 3. Ensure Resident 1 ' s discharge planning was conducted by the Interdisciplinary Team ([IDT] group of healthcare professionals, including resident/ resident representative, working together to provide residents with needed care) prior to discharging the resident to a Board and Care facility on 3/24/2025. 4. Ensure the Board and Care facility was provided with a hand-off report (a structured communication tool used to transfer patient care information from one healthcare provider to another) regarding Resident 1 ' s medical conditions to ensure the facility could meet the resident ' s needs prior to his discharge. 5. Ensure Resident 1 continued receiving prescribed medications at the B&C including Seroquel (medicine for schizophrenia [a mental illness that is characterized by disturbances in thought]), Depakote (medicine for seizures [sudden, uncontrolled electrical disturbances in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness]), klonopin (antianxiety medicine), and Zonisamide (medicine for epilepsy). 6. Follow-up with the Board and Care to ensure Resident 1 was safe and comfortably settled, post discharge. (continued on next page)

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

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F 0627 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	These deficient practices resulted in Resident 1 falling at B &C 1, sustaining a laceration (a deep cut or tear) on the scalp and was admitted to a general acute care hospital (GACH 1) for evaluation and treatment from 3/30/2025 to 4/10/2025 (a total of 11 days). Resident 1 was discharged back to B&C 1 on 4/10/2025 and on 4/12/2025, Owner 1 transferred Resident 1 to B&C 2, and on 4/13/2025, Resident 1 eloped (to leave without supervision), was found confused and wandering on the street by the law enforcement (Police) and transported to GACH 2 on 4/13/2025. Resident 1 was admitted to GACH 2 from 4/14/2025 to 4/27/2025 and discharged to another facility (facility 2). These failures also had the potential to result in Resident 1 ' s exposure to worsening medical and psychiatric conditions (mental illness), adverse reaction from medication overdose, and elevated risk for serious injuries, elopement (a situation in which a resident leaves the premises or a safe area without the facility ' s knowledge and supervision), seizures and death. On 5/1/2025 at 4:15 p.m., an Immediate Jeopardy ([IJ] a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause serious injury, harm, impairment, or death to a resident) was called in the presence of the Director of Nursing (DON) and Administrator (Admin) due to the facility ' s failure to safely discharge Resident 1. On 5/3/2025 at 5:22 p.m., the facility submitted an acceptable IJ removal plan ([IJRP] interventions to immediately correct the deficient practices). After verification of IJRP implementation through observation, interview, and record review, the IJ was removed onsite on 5/3/2025 at 6:55 p.m. in the presence of the Admin and DON. The IJRP included the following immediate actions: 1). On 5/1/2025, the Social Services consultant initiated an educational in-service to licensed nurses and IDT regarding facility Discharge and Transfer policy and procedures. In-service included Surrogate Decision Maker-Informed Consent, Discharge and Transfer of Residents, Personal Representatives of Residents, Resident Rights, Treating Residents Without Decision-Making Capacity, Conducting IDT prior to discharge, and the importance of initiating discharge planning prior to discharge or transfer of a resident. In-service education is ongoing by the facility ' s Director of Nursing (DON)/Director of Staff Development (DSD)/Designee including the new processes implementation related to identified concerns to all active license nurses and IDT members. The facility has 30 licensed nurses and 24 have been provided with in-service and education. Facility does not have a licensed staff on vacation, leave nor FMLA (Family and Medical Leave Act). On 5/1/2025, the Social Services consultant worked 1:1 (one on one) with the Social Services Director (SSD). The SSD completed the Discharge Planning Review form, sections 1 (Discharge Goals/ General Information) A (Discharge Goals/ General Information) & B (Caregiver Responsibilities), 2 (Self Care Evaluation and Equipment) Q (equipment and supplies), Contacts and Sign and Date of the Discharge Summary, for training purposes. On 5/2/2025, the facility DON and Medical Records initiated an audit to residents who have been discharged to a lower level of care in the past 30 days to ensure proper discharge planning was conducted prior to discharge with resident/responsible party, an IDT meeting was conducted prior to discharge, an endorsement of the resident ' s medical history and medication reconciliation was provided to receiving facility. No similar issues were identified. (continued on next page)

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F 0627 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Process: For those residents who lack capacity or with fluctuating capacity, the Office of Public Representative (OPR) will be contacted by the facility ' s SSD/Designee to act as an advocate in the discharge plan IDT prior to the discharge to ensure location is safe and appropriate given the residents ' conditions. If the OPR does not wish to participate, the facility IDT in conjunction with the physician will hold an IDT meeting to review and document appropriateness. Process: For those residents who lack capacity or with fluctuating capacity and have resident representatives, an IDT meeting will be held with the responsible party to review and discuss the discharge location for safety and appropriateness. 2. On 5/1/2025, the Social Services consultant initiated an educational in-service to licensed nurses and IDT regarding facility Discharge and Transfer policy and procedures. In-service included Surrogate Decision Maker-Informed Consent, Discharge and Transfer of Residents, Personal Representatives of Residents, Resident Rights, Treating Residents Without Decision-Making Capacity, Conducting IDT prior to discharge, and the importance of initiating discharge planning prior to discharge or transfer of a resident. In-service education is ongoing by the facility ' s DON/DSD/Designee including the new processes implementation related to identified concerns to all active licensed nurses and IDT members. Discharge planning will begin on the residents ' admission to the facility. The Attending Physician and the IDT will review the residents ' progress and determine a possible discharge date and document in resident ' s health record. On 5/2/2025, the facility Admin notified Resident 1 ' s attending physician, by phone of the concerns related to the resident ' s transfer to the Board and Care, the fall sustained and readmission to the hospital. On 5/2/2025, the facility Admin notified facility Medical Director by phone of the Immediate Jeopardy that was issued, deficient practice and plan to correct. On 5/3/2025, the facility Admin initiated a QAPI (Quality Assurance and Performance Improvement) regarding the Transfer and Discharge of residents. 3. Disposition of Resident ' s Drugs Upon Discharge: The facility staff will assist the physician and the resident to obtain medications after discharge from the facility. When discharged , remaining medications that have been administered to the resident while in the facility may be provided to the resident at the time of discharge if the medications were specifically ordered to be sent home with the resident. The Licensed Nurse will assure that the medication orders are reviewed with the resident and/ responsible party and explanation of all discharge medication orders occur at the time of discharge and documented on the resident ' s health record. (continued on next page)

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F 0627 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility will ensure that the resident receives adequate follow-up including the ability to have a physician ' s prescription available to procure drug supply immediately after discharged from the facility and conduct a proper endorsement of resident ' s ordered medications and discharge instructions to the receiving facility and documented on the resident ' s health record. 4. On 5/2/2025, the facility ' s SSD and Admin located Resident 1. Resident 1 resided in Skilled Nursing Facility (SNF) 2 and was doing well. The facility ' s SSD/ Designee will conduct a post discharge follow up call within 72 hours to ensure that the resident has transitioned adequately to the new facility/location moving forward. 5. On 5/1/2025, the Social Services consultant initiated an educational in-service to licensed nurses and IDT regarding facility Discharge and Transfer P&P. In-service included Surrogate Decision Maker-Informed Consent, Discharge and Transfer of Residents, Personal Representatives of Residents, Resident Rights, Treating Residents Without Decision-Making Capacity, Conducting IDT prior to discharge, and the importance of initiating discharge planning prior to discharge or transfer of a resident. In-service education is ongoing by the facility ' s DON/ DSD/Designee including the new processes implementation related to identified concerns to all active licensed nurses and IDT members. Newly hired licensed nurses/IDT will be educated by the facility ' s DON/DSD on facility ' s P&P pertaining to Discharge and Transfer of residents during their orientation and as needed. 6. On 5/1/2025, the Social Services consultant initiated an educational in-service to licensed nurses and IDT regarding facility Discharge and Transfer policy and procedures. In-service included Surrogate Decision Maker-Informed Consent, Discharge and Transfer of Residents, Personal Representatives of Residents, Resident Rights, Treating Residents Without Decision-Making Capacity, Conducting IDT prior to discharge, and the importance of initiating discharge planning prior to discharge or transfer of a resident. In-service education is ongoing by the facility ' s DON/ DSD/Designee including the new processes implementation related to identified concerns to all active licensed nurses and IDT members. For those residents who lack capacity or with fluctuating capacity, the OPR will be contacted by the facility ' s SSD/Designee to act as an advocate in the discharge plan IDT prior to the discharge to ensure location is safe and appropriate given the residents ' conditions. If the OPR does not wish to participate, the facility IDT in conjunction with the physician will hold an IDT meeting to review and document appropriateness. For those residents who lack capacity or with fluctuating capacity and have resident representatives, an IDT meeting will be held with the responsible party to review and discuss the discharge location for safety and appropriateness. Findings: During a review of Resident 1 ' s Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE]. The Admission Record indicated Resident 1 had a history of epilepsy, encephalopathy (group of conditions that cause brain dysfunction), anxiety disorder (excessive and persistent worry, fear, and unease), and schizophrenia. (continued on next page)

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F 0627 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of Resident 1 ' s History and Physical (H&P), dated 10/3/2024, the H&P indicated Resident 1 had fluctuating capacity to make medical decisions. During a review of Resident 1 ' s Fall Risk Assessment, dated 1/9/2025, the Fall Risk Assessment indicated Resident 1 was at risk for falls due to intermittent confusion, incontinence (no control of bowel and bladder elimination), pre-disposing diseases (risk factors), use of assistive devices (mobility aids), instability while making turns, and medications. During a review of Resident 1 ' s Minimum Data Set (MDS - a resident assessment tool), dated 1/9/2025, the MDS indicated Resident 1 was unable to express ideas and wants, and unable to understand others. The MDS indicated Resident 1 required set-up or clean-up assistance with eating and oral hygiene, required partial/ moderate assistance (helper does more than half the effort) with toileting hygiene and with shower/ bathing self. The MDS indicated Resident 2 required supervision or touching assistance (helper provides verbal cues and/or touching/ steadying and/or contact guard assistance as resident completes activity, throughout or intermittently) with personal hygiene. The MDS indicated Resident 1 required supervision or touching assistance with sit to stand, chair/bed-to-chair transfer, toilet transfer, tub/shower transfer and walking 50 feet with two turns. The MDS indicated Resident 1 required setup or clean-up assistance walking 10 feet and 150 feet. During a review of Resident 1 ' s physician orders, dated 3/2025, the physician orders indicated: 1. Seroquel oral tablet 200 mg (milligrams- metric unit of measurement, used for medication dosage and/or amount) by mouth at bedtime for schizophrenia m/b (manifested by) disorganized speech (talking off topic). 2. Depakote oral tablet 750 mg by mouth two times a day for seizures 3. Klonopin oral tablet 1 mg by mouth two times a day, for anxiety m/b inability to relax 4. Zonisamide 100 mg capsule, 1 capsule by mouth, one time a day for epilepsy During a review of Resident 1 ' s care plan, titled Resident wishes to move to lower level of care such as Board and Care facility, dated 3/21/2025, the care plan indicated to coordinate Resident 1 ' s discharge goals with rehabilitative therapies, follow up with resident to assure understanding of plan and make arrangements with required community resources to support independence post-discharge with home health ([HH] medical services provided in a patient's home), Registered Nurse (RN) and physical therapy (PT) services and durable medical equipment (DME - medical devices). During a review of Resident 1 ' s physician orders, dated 3/24/2025, the physician orders indicated Resident 1 may discharge to Board and Care (B&C 1) with HH services for RN/PT treatment and evaluation and a standard wheelchair on 3/24/2025. During a review of Resident 1 ' s physician report for the Residential Care Facilities for the Elderly (RCFE) Report, dated 3/24/2025, the report indicated Resident 1 was confused and disoriented at times and required medication management due to mild cognitive impairment. The report indicated Resident 1 was unable to store or administer his own medications. (continued on next page)

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F 0627 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of Resident 1 ' s Paramedic Report Sheet, dated 3/30/2025, the report sheet indicated paramedics were dispatched to B&C 1 on 3/30/2025, at 3:40 p.m., after Resident 1 fell , hit his head, and sustained a 0.5-inch (unit of measurement) laceration on the top of his head. The report sheet indicated Resident 1 was confused, slow to respond to questions, and had unequal pupils (pupils of the two eyes are not the same size). The report sheet indicated Resident 1 arrived at GACH 1 on 3/30/2025 at 4:05 p.m. During a review of Resident 1 ' s GACH 1 Emergency Department (ED) provider notes, dated 3/30/2025, the ED note indicated Resident 1 was taken into the ED by paramedics. The ED note indicated Resident 1 had a right parietal (top or side of the head) laceration with surrounding hematoma (a collection of blood outside of a blood vessel caused by a broken blood vessel) and anisocoria (unequal pupil size that can indicate brain damage). The ED note indicated Resident 1 was admitted to the GACH for alteration of mental status and blunt head trauma evaluation and treatment, following a fall. During a review of Resident 1 ' s GACH 1 Discharge Planning Note, dated 4/10/2025, the discharge summary note indicated Resident 1 was discharged to B&C 1 on 4/10/2025. During a review of Resident 1 ' s GACH 1 Discharge Summary Note, dated 4/18/2025, the note indicated Resident 1 had a computerized tomography (CT- diagnostic test) scan of his head which indicated some lymphadenopathy (lymph node enlargement) and no acute (sudden onset) intracranial (within the skull) hemorrhage (excessive bleeding). The discharge summary indicated Resident 1 had a magnetic resonance imaging ([MRI] a noninvasive medical imaging test that produces detailed images of almost every internal structure in the human body, including the organs, bones, muscles and blood vessels) scan of the brain which indicated no acute changes. The summary note indicated Resident 1 was evaluated for neurologic and malignancy (cancer-related) illnesses during his admission at GACH 1. During a review of Resident 1 ' s GACH 2 Discharge Summary, dated 4/27/2025, the Discharge Summary report indicated Resident 1 was admitted to GACH 2 from 4/14/2025 to 4/27/2025. The Discharge Summary indicated Resident 1 eloped from B&C 2 on 4/13/2025, had two Code Gold (behavioral issues, where a patient's violent or self-destructive behavior poses a threat to their own safety or the safety of others) episodes in the ED, were evaluated, and admitted to GACH 2 for observation and placement. The report indicated B&C 2 was unable to care for Resident 1 ' s high level of needs and was not an appropriate facility for Resident 1. The summary indicated Resident 1 had no capacity to make informed decisions and required long-term skilled nursing facility placement. During an interview on 4/28/2025 at 8:35 a.m., with a Social Worker from GACH 2 (SW), GACH 2 SW stated Resident 1 was discharged from the facility on 3/24/2025 and transferred to B&C 1. GACH 2 SW stated Resident 1 was admitted to GACH 1 on 3/30/2025 from B&C 1 and discharged back to B&C 1 on 4/10/2025. GACH 2 SW stated B&C 1 transferred Resident 1 to B&C 2 on 4/12/2025 because the resident ' s needs could not be met at B&C 1. GACH 2 SW stated Resident 1 eloped from B&C 2 on 4/13/2025 and was found by the Police wandering in the street. GACH 2 SW stated the Police transported Resident 1 to GACH 2 on 4/14/2025 where he was admitted and was discharged on [DATE] to another facility, where his needs could be met. GACH 2 SW stated Resident 1 was not awake or alert when he arrived at GACH 2 on 4/14/2025 and required long-term care due to his behavioral and medical needs. (continued on next page)

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F 0627 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 4/28/2025 at 9:21 a.m., with the owner of B&C 2 (Owner 2), Owner 2 stated Owner 1 called a Psychiatric Emergency Team (PET- a mobile team that provides mental health crisis intervention and assessment) on 4/12/2025 who referred Resident 1 to B&C 2 on 4/12/2025. Owner 2 stated within hours of arrival on 4/12/2025, Resident 1 eloped from B&C 2, walked into the street, and had a psychotic episode (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality). Owner 2 stated Resident 1 required a higher level of care than a B&C could provide due to his high level of medical and psychological needs. During a concurrent interview and record review on 4/28/2025 at 12:20 p.m., with the SSD, Resident 1 ' s Discharge Planning Review Form, dated 4/24/2025 was reviewed. The SSD stated the form was initiated prior to Resident 1 ' s discharge from the facility on 3/24/2025 but was incompletely filled. The SSD stated she did not tour (go onsite) the B&C 1 or verify the B&C 1 ' s license prior to discharging Resident 1. The SSD stated she had no documentation about the services B&C 1 provided. During an interview on 4/30/2025 at 10:28 a.m., with the DON, the DON stated he was not present at Resident 1 ' s IDT meeting on 3/21/2025 and was not notified of Resident 1 ' s discharge plan or discharge. The DON stated he must be present for every IDT meeting. The DON stated he discovered that Resident 1 was discharged on [DATE], the day after Resident 1 had left the faciity on [DATE]. During an interview on 4/30/2025 at 10:35 a.m., with Owner 1, Owner 1 stated B&C 1 was not a licensed B&C and could not provide ambulation (walking) assistance, epilepsy management and response, or assistance with medication administration and storage. Owner 1 stated the staff from the facility did not inform B&C 1 of Resident 1 ' s medical diagnoses, behavior, and care needs on 3/24/2025. Owner 1 stated Resident 1 was not appropriate for B&C 1 because Resident 1 required more services than B&C 1 could provide. Owner 1 stated B&C 1 did not receive any written or verbal report about Resident 1, prior to his arrival at B&C 1 on 3/24/2025. Owner 1 stated Resident 1 exhibited continuous screaming, sexually inappropriate behavior, and agitation and could not be redirected. Owner 1 stated she observed Resident 1 on the floor, with a head injury and blood dripping from the injured site (scalp) on 3/30/2025. Owner 1 stated she called 911 and Resident 1 was transferred to GACH 1 for evaluation and treatment. Owner 1 stated Resident 1 was at GACH 1 from 3/30/25 to 4/10/2025 and was discharged back to B&C 1. Owner 1 stated Resident 1 ' s high level of needs was not appropriate for B&C 1, but GACH 1 forced her to take Resident 1 back on 4/10/2025. Owner 1 stated she called an emergency PET intervention on 4/12/2025 for Resident 1 ' s uncontrollable behaviors. Owner 1 stated she and the PET transferred Resident 1 to B&C 2, which had more services needed by Resident 1. Owner 1 stated the facility ' s staff did not call B&C 1 to follow-up on Resident 1, after the resident was discharged from the facility. (continued on next page)

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F 0627 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a concurrent interview and record review on 4/30/2025 at 1:00 p.m., with the facility RN 1, Resident 1 ' s RCFE report dated 3/24/2025, Progress Notes dated 3/24/2025, and Discharge Planning Review Form dated 4/24/2025, were reviewed. The facility RN 1 stated the RCFE report indicated Resident 1 required assistance in storing and administering medications. The facility RN 1 stated the Discharge Planning Review Form indicated Resident 1 ' s medication reconciliation (medication review and comparison), discharge education, and self-care evaluation were not performed and not completed. Facility RN 1 stated the SSD was responsible for completing and documenting the Discharge Planning Review Form. The facility RN 1 stated she was not informed of what B&C 1 ' s services were, did not provide hand-off report to B&C 1, and she would not have discharged Resident 1 if she knew B&C 1 was not equipped to provide the services Resident 1 required. Facility RN 1 stated Resident 1 needed medical services provided by the facility. The facility RN 1 stated Resident 1 was at risk of seizures, psychological instability, elopement, hospitalization , and death, if he did not receive the services to meet his needs. The facility RN 1 stated she was notified of Resident 1 ' s discharge plan on 3/24/2025 around 1:30 p.m. The facility RN 1 stated Resident 1 was transported to the B&C 1 on 3/24/2025 at 3:45 p.m., approximately 2 hours after the nursing department was notified. The facility RN 1 stated the Director of Marketing, and the SSD did not allow time for the nursing department to coordinate services and ensure the B&C 1 was appropriate to meet Resident 1 ' s needs. The facility RN 1 stated the SSD was responsible for coordinating Resident 1 ' s home health services. During a concurrent interview and record review on 4/30/2025 at 2:10 p.m., with the facility SSD, Resident 1 ' s progress notes dated 3/21/2025, H&P dated 10/3/2024, care plan titled Resident wishes to move to lower level of car such as Board and Care facility dated 3/21/2025, Discharge Planning Review Form dated 4/24/2025, and the facility ' s P&P titled Discharge and Transfer of Residents, dated 3/21/2025, were reviewed. The facility SSD stated the progress notes indicated Resident 1 notified her of his request for discharge on 3/21/2025. The facility SSD stated Resident 1 ' s H&P indicated Resident 1 had fluctuating capacity to make medical decisions and his capacity was not reassessed at the time of the request. The facility SSD stated the progress notes she wrote on 3/21/2025, indicating Resident 1 ' s Discharge Planning IDT, were incorrect. The facility SSD stated the notes were entered in error and no IDT was conducted for Resident 1 ' s discharge planning. The facility SSD stated the P&P indicated every resident must have an IDT to review progress and plan discharges. The facility SSD stated the P&P was not followed because an IDT meeting was not conducted to plan Resident 1 ' s discharge. The facility SSD stated IDT meetings must have representatives from nursing and activities departments present to plan safe discharges and ensure the residents get proper care after discharge. The facility SSD stated the DON, Activity Director (AD), and Director of Rehabilitation (DOR) were not notified of Resident 1 ' s discharge plans prior to the discharge. The facility SSD stated Resident 1 ' s care plan indicated therapy was supposed to coordinate discharge goals. The facility SSD stated therapy was not notified or involved in Resident 1 ' s discharge and the intervention was not performed. The facility SSD stated the Discharge Planning Review Form indicated Resident 1 initiated his discharge to a lower level of care. The facility SSD stated she was not trained or informed about her responsibility to complete the Discharge Planning Review Form, and she expected the nursing department to complete and document Medication Reconciliation, Self Care Evaluation, and Learning Needs sections. The facility SSD stated she did not follow up with the nursing department. The SSD stated she notified RN 1 (Nursing Department) about Resident 1 ' s discharge plan for 3/24/2025 at 1:30 p.m. The facility SSD stated she should have verified B&C 1 ' s license, toured the facility, or received written information about B&C 1 ' s services, but she did not. The facility SSD stated she did not follow up with B&C 1, HH, or Resident 1 after discharge. (continued on next page)

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F 0627 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a concurrent interview and record review on 5/1/2025 at 1:25 p.m., with the facility DOR, Resident 1 ' s Physical Therapy (PT) Discharge Summary dated 12/18/2024, Care Plan, titled Resident wishes to move to lower level of care such as Board and Care facility dated 3/21/2025, and Fall Risk Evaluation dated 1/9/2025 were reviewed. The facility DOR stated Resident 1 ' s Physical Therapy Discharge Summary indicated Resident 1 needed partial to moderate assistance for transfers and ambulation. The facility DOR stated Resident 1 required supervision during ambulation and transfer but had not been evaluated by a therapist since PT services ended on 12/2024. The facility DOR stated the care plan indicated discharge goals will be coordinated with rehabilitative therapies. The facility DOR stated rehabilitative therapy was not involved in Resident 1 ' s discharge planning and the care plan was not performed. The facility DOR stated the therapy department was not involved in Resident 1 ' s discharge planning but should have been notified to assess Resident 1 and plan services after Resident 1 ' s discharge to prevent falls. During a concurrent interview and record review on 5/1/2025 at 2:00 p.m., with the DON, Resident 1 ' s Fall Risk Evaluation dated 1/9/2025 was reviewed. The DON stated the evaluation indicated Resident 1 was at risk for falling due to wheelchair usage and instability while turning. During an interview on 5/1/2025 at 3:40 p.m., with the facility AD, the facility AD stated she was not present during Resident 1 ' s discharge planning IDT meeting on 3/21/2025. The facility AD stated she or a representative of the Activity Department must be present at all IDT meetings for resident safety. The facility AD stated she was not notified or aware of discharge planning IDT for Resident 1 prior to discharge on 3/24/2025. During a concurrent interview and record review on 5/5/2025 at 8:15 a.m., with GACH 2 SW, Resident 1 ' s GACH 2 Discharge Planning Notes dated 4/14/2025, were reviewed. GACH 2 SW stated the notes indicated, the Police found Resident 1 wandering alone in the street on 4/13/2025 and brought Resident 1 to GACH 2 and was admitted on [DATE] for altered mental status evaluation and treatment. GACH 2 SW stated Resident 1 was confused, only knew his name, and mumbled incoherent words. GACH 2 SW stated Resident 1 was transferred to a locked facility (secured) that could provide appropriate services for his needs. During an interview on 5/2/2025 at 12:40 p.m., with Home Health Registered Nurse (HH RN] home visiting nurse), the HH RN stated HH had never provided services or received a referral for Resident 1. HH RN stated she had never heard of Resident 1 and had not been in contact with the facility. During a concurrent interview and record review on 5/5/2025 at 8:50 a.m., with the facility Medical Doctor (MD), Resident 1 ' s H&P dated 10/3/2024 was reviewed. The facility MD stated Resident 1 ' s H&P indicated Resident 1 was able to make medical decisions sometimes. The facility MD stated, he and the IDT should have worked together to assess if Resident 1 could make medical decisions and plan a safe discharge. The facility MD stated he did not interview or assess Resident 1 to know if the resident had the capacity to make medical decisions when Resident 1 made the decision to discharge. The facility MD stated he trusted RN 1 and the IDT team and did not verify that the IDT team had assessed Resident 1 ' s ability to make medical decisions. The facility MD stated if there was no IDT meeting to assess Resident 1 ' s mental capacity and plan his discharge, Resident 1 ' s safety was placed at risk. The facility MD stated the facility was responsible for coordinating and ensuring safe discharge for Resident 1. (continued on next page)

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	05/05/2025

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

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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 0627 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of the facility ' s P&P titled, Discharge and Transfer of Residents, dated 3/21/2025, the P&P indicated the facility may discharge a resident if the services provided by the facility were no longer required. The P&P indicated the attending physician, and IDT will review the resident ' s progress and determine a possible discharge date . During a review of the facility ' s P&P titled, Decision Making Capacity, dated 1/1/2012, the P&P indicated the attending physician will interview the resident and review the resident ' s medical record to determine the resident ' s capacity to consent to medical care and to provide informed consent. The P&P indicated the physician would review the resident ' s decision-making capacity and document his/her determination monthly.