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	06/06/2025

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect the resident's right to be free from neglect (failure of the facility, its employees or service providers to provide services to a resident that were necessary to avoid pain, mental anguish or emotional distress) and ensure Resident 3, who required assistance from staff with activities of daily living (ADLs - essential and routine activities include eating, dressing, getting into or out of a bed or chair, taking a bath or shower, and using the toilet) received needed care and services. The facility failed to: -Provide Resident 3, who required moderate assistance (the helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) and was dependent on a helper, with transfer from chair-to-bed, per Resident 3's comprehensive assessment dated [DATE]. Resident 3 called for a Certified Nursing Assistant (CNA) to put him in bed from his wheelchair on 5/25/2025. CNA 2 told him to get out of the chair and do it himself, then left the room. -Implement the At Risk for Falls Care Plan related to gait (the way a person walks) and balance problems dated 5/23/2025, to anticipate and meet the resident's needs once Resident 3 called for assistance for transfer. -Implement the facility's policy and procedure titled, Abuse - Prevention, Screening, & Training Program, revised July 2018, regarding neglect and deprivation of goods and services by CNA 2 for Resident 3 to attain or maintain physical, mental, and psychosocial well-being and avoid physical harm, pain, mental anguish, or emotional distress. This deficient practice resulted in Resident 3 being subjected to neglect by CNA 2 while under the care of the facility. Resident 3 fell out of his wheelchair attempting on his own to return to bed. Resident 3 was angry, had pain to his face and was transferred to General Acute Care Hospital (GACH) on 5/27/2025 where he was diagnosed with generalized anxiety disorder. Findings: A review of the admission Record indicated Resident 3 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including hemiplegia and hemiparesis affecting left side (weakness and loss of muscle function resulting in the inability to move), and presence of a pacemaker (a small, electronic device implanted under the skin that helps regulate a person's heartbeat when it is too slow or irregular). (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 0600 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 3's Minimum Data Set (MDS -a resident assessment tool), dated 3/27/2025, indicated the resident had no cognitive impairment (problems with a person's ability to think, remember, use judgement, and make decisions), had the ability to express ideas and wants, and had the ability to understand others and be understood. The MDS indicated the resident required use of a manual wheelchair and required moderate assistance from a helper for transfer to and from a bed to a wheelchair, to come to a standing position from sitting in a wheelchair, or on the side of the bed, or the ability to get in and out of a tub/shower. A review of Resident 3's Progress Notes dated 5/23/2025, indicated the resident used a manual wheelchair, required assistance to wheel the chair 50 feet or more and was dependent on a helper to transfer him from chair-to-bed. A review of Resident 3's At Risk for Falls Care Plan related to gait (the way a person walks) and balance problems dated 5/23/2025, indicated the goal was to have Resident 3 free from falls. The care plan interventions indicated to anticipate and meet the resident's needs, ensure the call light was working, within reach, and encourage the resident to use it for assistance as needed. The care plan did not indicate any interventions to provide assistance to Resident 3 during transfers. During a review of Resident 3's Fall Risk Evaluation dated 5/23/2025, the fall risk evaluation indicated Resident 3 had no falls in the past three months and was alert and oriented to person, place and time. The fall risk evaluation indicated under ambulation that Resident 3 was chairbound, required the use of assistive devices (cane, wheelchair, walker), and was not able to perform gait / balance (standing on both feet without holding on to anything). The Fall Risk Evaluation indicated Resident 3 scored a 15, as a score of 10 or higher indicated a high risk of fall. During a review of Resident 3's Change of Condition (COC) dated 5/27/2025 at 2:36 PM, the COC indicated Resident 3 reported to the Social Services Assistant (SSA) that on 5/25/2025 evening shift he was hit on the left side of his face with a call light by the CNA (CNA 2). The COC indicated Resident 3 sustained no visible facial injuries and reported discomfort rated at a 5 out of 10 (using the pain scale 0-10, 10 being the worst possible pain). The COC did not indicate CNA 2 refused to assist Resident 3 with the transfer to bed. A review of Resident 3's COC dated 5/27/2025 at 4:47 PM, indicated Resident 3 reported that he was in his room and fell to the floor from his wheelchair on 5/25/2025. Resident 3 verbalized that he was assisted by a CNA 2 back into his bed (after the fall). During a review of Resident 3's Progress Notes / Skin assessment dated [DATE], the skin assessment indicated Resident 3's left side of face was assessed to be clear and intact, no open areas noted, or abrasions noted. The skin assessment indicated Resident 3 reported pain on left side of face rated at a 5. A review of the Physician's Order dated 5/27/2025 indicated to transfer Resident 3 to the GACH for medical clearance with 7-day bed hold. A review of the GACH face sheet indicated Resident 3's chief complaint and reason for admit was an elevated troponin level (blood test indicates damage to the heart muscle, often associated with heart attack, other related conditions include heart failure and intense exercise), atrial fibrillation (heart condition where heart beats irregularly, rapidly and out of sync), and acute chest pain. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A review of the GACH Physician's Order dated 5/27/2025 indicated Resident 3 was admitted to the telemetry unit (specialized area for continuous cardiac monitoring) for two nights for acute chest pain and generalized weakness. A review of Resident 3's GACH Physician Psychiatry Progress Note dated 5/30/2025 at 10:25 pm, indicated Resident 3 was anxious (a mental health condition characterized by excessive and persistent worry that is difficult to control), restless, and irritable. Resident 3 was assigned a new diagnosis of Generalized Anxiety Disorder. A review of Resident 3's GACH Physical exam dated 5/31/2025, indicated Resident 3 had difficulty ambulating due to musculoskeletal weakness. During an interview on 6/5/2025 at 10 am, Resident 3 stated he called for a CNA to put him in bed from his wheelchair. Resident 3 could not recall date or time. CNA 2 told him to get out of the chair and do it himself, then CNA 2 left the room. Resident 3 stated when he tried to get in bed, he fell. Resident 3 stated he then pressed the call light again. CNA 2 came in and snatched the call light and the cord, hit Resident 3 in the face. Resident 3 stated he felt angry and was in pain. During an interview on 6/5/2025 at 10:15 am, the Social Services Assistant (SSA) stated that on 5/27/2025 at 2:45 pm, Resident 3 came to her office and reported the incident with CNA 2. During an interview on 6/6/2025 at 1:55 pm, the Administrator (ADM) stated CNA 2 was terminated on 5/27/2025 for not satisfactorily passing his 90-day probation period. When a copy of CNA2's termination letter was requested, none was provided. A review of the Faxed Document from the facility to the Department dated 6/9/2025 indicated upon receiving a report of an allegation of abuse that occurred on 5/25/2025 during the 3 pm - 11 pm shift, the alleged perpetrator (CNA 2) was placed on administrative leave. A review on the facility's job description titled, Nursing Assistant Job Description, undated, indicated the CNA general duties and responsibilities included performing all duties as assigned and in accordance with facility's established policies and procedures, nursing care procedures and safety rules and regulations. A review of the facility P&P titled, Abuse - Prevention, Screening, & Training Program, revised July 2018, indicated the facility would prevent and did not condone any form of abuse or neglect. The P&P indicated the ADM as the abuse prevention coordinator was responsible for the coordination and implementation of the facility's abuse prevention, program policies and that the facility established a safe environment that reasonably supports residents. The P&P indicated the facility promoted an environment free from abuse, neglect, exploitation, and mistreatment of the residents. The P&P indicated, Neglect and deprivation of goods and services by staff were defined as failure to provide goods and services necessary to attain or maintain physical, mental, and psychosocial well-being and avoid physical harm, pain, mental anguish, or emotional distress. The P&P indicated the facility assured that residents were free from neglect by having the structures and processes to provide needed care and services. The P&P did not indicate any information regarding an employee 90-day probationary period. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A review of the facility policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, revised November 2018, indicated the facility would ensure that a comprehensive person-centered care plan was developed for each resident. The P&P indicated the facility would provide care that reflected best practice standards for meeting psychosocial, behavioral and safety needs of residents in order obtain or maintain the highest physical, mental, and psychosocial well-being. The care plan indicated additional changes or updates to the residents' comprehensive care plan would be made on the assessed needs of the resident. The comprehensive care plan would be periodically reviewed and revised after each MDS assessment as required.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of two sampled residents (Resident 1), who had a diagnosis of schizophrenia (a serious mental disorder in which people interpret reality abnormally, may result in delusions and behavior that impairs daily functioning, may have grandiose delusions [strong beliefs of things that are untrue]), and history of aggressive behavior, was provided with the necessary behavioral health care in accordance with the comprehensive assessment and care plan. The facility failed to: -Ensure an accurate Minimum Data Set (MDS, a comprehensive quarterly resident assessment) to include Resident 1's history of aggressive physical and verbal behavior. -Develop effective and individualized care plan interventions for Resident 1's behaviors including supervision, frequency and re-evaluation. As a result, on 5/27/2025, Resident 1 entered Resident 2's room and was told to leave the room. Resident 1 and Resident 2 began a physical altercation and per the facility's Change in Condition (COC) form, Resident 1 had an outburst of anger and hit Resident 2 in the chest. Resident 2 had no injury and Resident 1 was administered Ativan, Haldol and Benadryl intramuscularly (a method of administering medications directly into the muscle) for aggressive behavior. Findings: A review of the admission Record (face sheet) indicated Resident 1 was originally admitted to the facility on [DATE] with diagnoses including schizophrenia, depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety disorder (a group of mental health conditions that cause feelings of fear, dread, and other symptoms that are excessive or out of proportion to the situation). During a review of Resident 1's COC dated 4/7/2025, the COC indicated Resident 1 displayed aggressive behavior, verbally and physically, towards staff. The COC indicated Resident 1 was screaming, yelling aggressively, scratched and grabbed a staff member as the staff member stored away food trays. The COC indicated Resident 1 was unable to be redirected and close visual monitoring was started. During a review of Resident 1's COC dated 4/29/2025, the COC indicated Resident 1 provoked another resident to fight him and asked the resident if he was scared. A review of the Physician's Order Summary Report, dated 4/29/2025, indicated to monitor Resident 1's target behaviors for use of Haldol (an antipsychotic medication used to treat nervous emotional mental health conditions) for schizophrenia manifested by (m/b) yelling and pacing, and to monitor for behaviors for use of Lorazepam (Ativan) due to anxiety m/b agitation, as evidenced by yelling and provoking others. The Physician's Order Summary Report indicated to number the behavior occurrences each shift. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the care plan for exhibiting a behavior problem related to schizophrenia, dated 4/29/2025, indicated Resident 1 was being aggressively verbal towards another resident. The care plan interventions indicated to administer medications as prescribed, if resident posed a potential threat to injure self or others notify provider, if safe allow resident personal space, monitor for cognitive, emotional or environmental factors that may contribute to violent behaviors, monitor for signs and symptoms of agitation, and provide verbal feedback to resident regarding behavior. Further review of this care plan indicated the facility canceled the care plan on 5/13/2025. A review of the Resident 1's medical record indicated there was no Behavior or Schizophrenia care plan in place from 5/13 - 5/26/2025. During a review of Resident 1's History and Physical (H&P), dated 5/13/2025, the H&P indicated Resident 1 could not make medical decisions due to impaired judgement. During a review of Resident 1's MDS, dated [DATE], the MDS indicated Resident 1 had the ability to express ideas and wants, and the ability to understand others. The MDS indicated the resident had trouble falling or staying asleep or sleeping too much for about 7-11 days over the last two weeks. The MDS indicated Resident 1 did not exhibit any physical or verbal behaviors directed towards others, which contradicted the April 2025 COC. During a review of Resident 1's COC dated 5/26/2025, the COC indicated Resident 1 was restless, taking trash from the trashcan and throwing it on the floor. The COC indicated Resident 1 was informed that his behavior was inappropriate and unacceptable. The COC indicated Resident 1 laughed hysterically and continued with the disruption. Nurse Practitioner (NP) 1 was notified of Resident 1's behavior. A review of Resident 1's Behavior Management related to New Disruptive behavior care plan dated 5/26/2025 indicated interventions to ensure safety of resident and others and to initiate visual supervision during acute episode. This care plan did not indicate Resident 1's diagnosis of Schizophrenia. A review of Resident 2's admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses including paranoid schizophrenia (a subtype of schizophrenia with prominent delusions and hallucinations often involving false beliefs of being watched or targeted), depression (persistent sadness and loss of interest in activities), and muscle weakness. During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2 had the ability to express ideas and wants, and the ability to understand others. The MDS indicated the resident needed partial assistance from another person to complete activities. During a review of Progress Notes dated 5/27/2025 at 1:46 pm, the progress notes indicated Resident 1 was restless, removing linens off roommates' bed and throwing away card games off tables in the activities room. The progress note indicated Resident 1 was reluctant when redirected. A review of Resident 1's COC dated 5/27/2025 at 10 pm, indicated Resident 1 and Resident 2 had a physical altercation. The COC indicated Resident 1 had an outburst of anger and hit Resident 2 in the chest. Resident 1 was administered Ativan, Haldol and Benadryl intramuscular for aggressive behavior. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's Fax Document sent to the Department, dated 5/28/2025, indicated there was an altercation involving Resident 1 and Resident 2 on 5/27/2025 at around 10 pm. The fax document indicated after the residents were separated, Resident 1 was assigned a 1:1 sitter (a care giver who provides one on one constant observation and support, a safety measure for residents at risk of harming themselves or others) and Resident 2 had no injury. A review of the Progress Note dated 5/29/2025 indicated Resident 1 was transferred to the General Acute Care Hospital (GACH) for acute psychiatric care. During an interview on 6/5/2025 at 11:35 am, Certified Nursing Assistant (CNA) 1 stated that on 5/27/2025 during the morning shift (7 am - 3 pm), Resident 1 was behaving erratically (unpredictable), throwing blankets and plates on the floor. During an interview on 6/6/2025 at 12:45 pm, Licensed Vocational Nurse (LVN) 1 stated documentation for Resident 1's behavior should have been done more often because Resident 1 was constantly disruptive and verbally aggressive toward staff. During a concurrent interview and record review on 6/6/2025 at 1:30 pm with the Director of Nursing (DON), Resident 1's care plan dated 5/26/2025 titled Behavior Management related to New Disruptive behavior was reviewed. The care plan did not include any individualized person-centered interventions for Resident 1, such as how or how often staff were to monitor Resident 1. The DON stated the interventions were not appropriate or effective for Resident 1's behaviors and staff were required to evaluate care plan interventions for their effectiveness and update or revise the interventions based on resident's behavior and needs. The DON stated the potential outcome of not developing a person-centered care plan with effective interventions for a resident with aggressive behavior were safety issues and harm. During an interview on 6/6/2025 at 1:55 pm, the Administrator (ADM) stated Resident 1's behavior was mostly outbursts. The ADM stated, He writes on walls and takes down the facility's decorations. To ensure safety of residents and others, we ask people to give him space until he works through his episodes. The ADM stated she was the facility's Abuse Coordinator and did not know what could have been done to keep the residents safe. A review of the facility policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, revised November 2018, indicated the facility would ensure that a comprehensive person-centered care plan was developed for each resident. The P&P indicated the facility would provide care that reflected best practice standards for meeting psychosocial, behavioral and safety needs of residents in order to obtain or maintain the highest physical, mental, and psychosocial well-being. The care plan indicated additional changes or updates to the residents' comprehensive care plan would be made on the assessed needs of the resident. The comprehensive care plan would be periodically reviewed and revised after each MDS assessment as required. A review of the facility P&P titled, Resident To Resident Altercations, Revised November 2015, indicated facility staff observed residents for aggressive or inappropriate behavior toward other residents, family members, visitors, or facility staff. The P&P indicated the facility would act promptly and conscientiously to prevent and address altercations between residents. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility P&P titled, Behavior/Psychoactive Drug Management, revised November 2018, indicated the facility provided a therapeutic environment to meet the safety and behavioral needs of patients, and to obtain or maintain the highest physical, mental, and psychosocial well-being of the patients. A review of the facility P&P titled, Abuse - Prevention, Screening, & Training Program, revised July 2018, indicated the facility would prevent and did not condone any form of abuse or neglect. The P&P indicated the ADM as the abuse prevention coordinator was responsible for the coordination and implementation of the facility's abuse prevention, program policies and that the facility established a safe environment that reasonably supports residents.