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	08/01/2025

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to obtain and document informed consent for the use of psychotropic medications (drugs that affect mental processes and behaviors) for one of two sampled residents (Resident 1).This deficient practice placed Resident 1 at risk for sustaining adverse effects from the medications and removed Resident 1's right to refuse psychotropic medications at a dose or route (e.g. by mouth, by injection, etc.) he did not want.Findings:During a review of Resident 1's admission Record, dated 7/31/2025, the admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including cognitive communication deficit (difficulties in communication), anxiety (intense, excessive, and persistent worry and fear about everyday situations), and dementia (a progressive state of decline in mental abilities). During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 4/28/2025, the MDS indicated Resident 1 had severely impaired cognition (a condition where an individual experiences significant difficulty with mental processes like learning, remembering, concentrating, and making decisions, affecting their daily life). The MDS indicated Resident 1 was dependent on staff for all activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 1's discontinued physician order, dated 2/18/2025 to 3/4/2025, the physician order indicated Resident 1 received one (1) milligram (mg, a unit of dose measurement) of lorazepam (an anti-anxiety medication) every 12 hours as needed (PRN) for 14 days. During a review of Resident 1's discontinued physician order, dated 3/9/2025 to 3/13/2025, the physician order indicated Resident 1 received one (1) mg of lorazepam every eight (8) hours PRN for 14 days. The order indicated an increased frequency of administration compared to the previously ordered dose. During a review of Resident 1's discontinued physician order, dated 3/24/2025 to 4/7/2025, the physician order indicated Resident 1 received one (1) mg of lorazepam every eight (8) hours by mouth PRN for 14 days. During a review of Resident 1's discontinued physician order, dated 3/30/2025 to 4/8/2025, the physician order indicated Resident 1 received one (1) mg of lorazepam every six (6) hours PRN via injection for 14 days. The order indicated an increased frequency of administration, and a different administration route, compared to the previously ordered dose. During a review of Resident 1's discontinued physician order, dated 6/15/2025 to 6/16/2025, the physician order indicated Resident 1 received a one-time administration of two (2) mg of lorazepam via injection. During a review of Resident 1's discontinued physician order, dated 7/13/2025 to 7/21/2025, the physician order indicated Resident 1 received one (1) mg of lorazepam every eight (8) hours PRN for 14 days. The order indicated was a new psychotropic order as the previous order was discontinued on 6/16/2025 and no other lorazepam order was in place. During an interview on 7/31/2025 at 2:01 PM, with the Medical Records Director (MRD), the MRD stated there were no informed consents in the medical record for Resident 1's discontinued lorazepam orders dated 6/15/2025 to 6/16/2025 and 7/13/2025 to 7/21/2025. The MRD stated that if informed consents were obtained, they would be in Resident 1's electronic medical record (EMR). During an interview on 8/1/2025 at 11:26 AM, with the MRD, the MRD stated the last informed consents for lorazepam were obtained in 10/2024. The MRD stated the only informed consent obtained in 2025 was for Resident 1's current order dated 7/21/2025 for one (1) mg of lorazepam every 6 hours PRN for 30 days starting 7/22/2025. During an interview on 8/1/2025 at 1:28 PM, with the Director of Nursing (DON), the DON stated informed consents were to be stored in the EMR. The DON stated the purpose of obtaining informed consent was to ensure the resident/responsible party was informed of the indication for the use of a psychotropic medication, and aware of the possible adverse effects associated with it. The DON stated adverse effects of lorazepam included drowsiness, suppressed appetite, and respiratory depression (a condition where breathing slows down or becomes shallow, resulting in inadequate oxygen intake and carbon dioxide buildup in the body). The DON stated a new informed consent was to be obtained when there was a change in the frequency or route the psychotropic medication was administered. During a review of the facility's policy and procedure (P&P) titled Behavior/Psychoactive Medication Management, revised 4/2025, the P&P indicated the facility must obtain a resident's written informed consent for treatment using psychotropic medications, including anti-anxiety medications and the consent needed to be renewed every six months. During a review of the facility's P&P titled Informed Consent, revised 6/2024, the P&P indicated informed consents were to be placed in the resident's medical record.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure an as needed (PRN) psychoactive medication (drugs that affect brain chemistry and alter a person's mental state, mood, or behavior) order for one of two sampled residents (Resident 1) did not exceed 14 days. This deficient practice placed Resident 1 at risk of sustaining adverse effects related to the prolonged use of psychoactive medication without documented indication. Findings:During a review of Resident 1's admission Record, dated 7/31/2025, the admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including cognitive communication deficit (difficulties in communication), anxiety (intense, excessive, and persistent worry and fear about everyday situations), and dementia (a progressive state of decline in mental abilities). During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 4/28/2025, the MDS indicated Resident 1 had severely impaired cognition (a condition where an individual experiences significant difficulty with mental processes like learning, remembering, concentrating, and making decisions, affecting their daily life). The MDS indicated Resident 1 was dependent on staff for all activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 1's discontinued physician order, dated 7/13/2025, the physician order indicated Resident 1 received one (1) milligram (mg) of lorazepam (a medication used to treat anxiety disorders) every eight (8) hours PRN for 14 days for agitation. The order was discontinued on 7/21/2025. During a review of Resident 1's active physician order, dated 7/21/2025, the physician order indicated Resident 1 was to receive one (1) mg of lorazepam every 6 hours PRN for 30 days starting on 7/22/2025. During a review of Resident 1's Electronic Medication Administration Record (EMAR), dated 7/1/2025 to 7/31/2025, the EMAR indicated Resident 1 displayed a behavior of agitation on four (4) of the 24 shifts between 7/13/2025 and 7/21/2025 (the duration of Resident 1's previous lorazepam order), with no behaviors indicated on any shifts from 7/18/2025 to 7/21/2025 (the date the lorazepam was reordered), or on 7/22/2025 (the date the lorazepam was readministered). During a review of Resident 1's progress notes dated 7/21/2025 to 7/22/2025, there were no progress notes indicating the prescribing provider communicated or documented a rationale for the 30-day administration of lorazepam, instead of the facility's policy of 14 days. During an interview on 7/31/2025 at 2:53 PM, with Licensed Vocational Nurse (LVN) 1, LVN 1 stated the facility's policy for PRN psychoactive medications, including lorazepam, was that the order for administration could not exceed 14 days. LVN 1 stated she was not sure why this was the facility's policy. LVN 1 stated Resident 1's physician order for lorazepam, dated 7/22/2025, was originally ordered by the psychiatric provider for a 14-day duration. LVN 1 stated she requested for the duration to be extended to 30 days. LVN 1 stated the psychiatric provider did not make the request or suggestion. During an interview on 8/1/2025 at 11:11 AM, with the Director of Nursing (DON), the DON stated the purpose of not exceeding a 14-day administration was to prevent the residents' dependence on the medications. The DON stated there were also risks associated with prolonged use of psychoactive medications such as sedation and falls. The DON stated there needed to be documentation from the physician/prescriber indicating the need for administration beyond 14 days, and stated there was no documentation from the provider to indicate a 30-day administration. The DON stated it was not within the LVN's scope of practice to make the determination to exceed the facility's policy of 14-day administration. During an interview on 8/1/2025 at 1:45 PM, with the DON, the DON stated there should be an increase in the indicated behavior (agitation) to justify the 30-day administration of lorazepam. The DON stated it did not make sense for LVN 1 to request a 30-day administration since there was no documented indication/presence of the behavior. During a review of the facility's policy and procedure (P&P) titled Behavior/Psychoactive Medication Management, revised 4/2025, the P&P indicated any psychoactive medication ordered on an as necessary basis not be ordered to exceed 14 days. The P&P indicated that if the physician felt the medication needed to be continued beyond a 14-day limit, they must document the reason(s) for the continued usage.

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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** Based on interview and record review, the facility failed to ensure an Interdisciplinary Team (IDT, a group of healthcare professionals from various disciplines who collaborate to provide comprehensive care) meeting, a fall risk evaluation, and a post-fall evaluation were conducted for one of two sampled residents (Resident 1) following a fall. This deficient practice placed Resident 1 at risk for sustaining repeat falls and potential injuries. Findings:During a review of Resident 1's admission Record, dated 7/31/2025, the admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including cognitive communication deficit (difficulties in communication), anxiety (intense, excessive, and persistent worry and fear about everyday situations), and dementia (a progressive state of decline in mental abilities). During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 4/28/2025, the MDS indicated Resident 1 had severely impaired cognition (a condition where an individual experiences significant difficulty with mental processes like learning, remembering, concentrating, and making decisions, affecting their daily life). The MDS indicated Resident 1 was dependent on staff for all activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 1's Change of Condition (COC) assessment, dated 7/27/2025, the assessment indicated Resident 1 had an unwitnessed fall and was found on the side of his bed. The assessment indicated Resident 1 sustained a skin tear (traumatic wound caused by friction when the upper layer of the skin becomes torn from the underlying layers) to his right arm. During an interview on 7/31/2025 at 1:07 PM, with Registered Nurse (RN) 2, RN 2 stated after a resident falls, staff were to conduct a fall risk evaluation for the resident. RN 2 stated any licensed nursing staff could complete the evaluation, and the evaluation had to be completed immediately and documented in the electronic medical record (EMR). RN 2 stated Resident 1 had a fall on 7/27/2025 but a fall risk evaluation was not done following the fall. RN 2 stated the purpose of the fall risk evaluation was to identify risk factors for further falls and to identify necessary revisions to the plan of care. During an interview on 8/1/2025 at 11:05 AM, with the Director of Nursing (DON), the DON stated Resident 1 had a fall on 7/27/2025. The DON stated an IDT meeting and post-fall evaluation were not conducted following Resident 1's fall on 7/27/2025. The DON stated after a fall, the purpose of the post-fall evaluation and the IDT meeting was to identify risk factors for future falls and identify necessary revisions to the plan of care. The DON stated without a fall risk evaluation, post-fall evaluation, and IDT meeting to address the fall, Resident 1 was at risk for repeated falls and potential injury from the fall. During a review of the facility's policy and procedure (P&P) titled Fall Prevention and Management Program, revised 3/2021, the P&P indicated that following a fall, staff were to conduct a new fall risk evaluation. The P&P indicated staff were to complete a post-fall evaluation and update, initiate or revise the resident's care plan. The P&P indicated the IDT was to review the circumstances following a fall and summarize their findings in an IDT note.