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	12/09/2025

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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to document a change of condition (COC) assessment for one of six sampled Residents (Resident 6) when Resident 6 refused psychotropic medications. This deficient practice had the potential to result in Resident 6 not receiving proper monitoring and treatment for behavior changes and placed Resident 6 at risk for hospitalization. Findings:During a review of Resident 6's admission Record, the admission Record indicated Resident 6 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 6's diagnoses included schizoaffective disorder, bipolar disorder, epilepsy (a chronic neurological condition marked by recurrent, unprovoked seizures, which are sudden bursts of abnormal electrical activity in the brain).During a review of Resident 6's History and Physical (H&P) dated 12/4/2025, the H&P indicated Resident 6 had the capacity to make needs known but could not make medical decisions.During a review of Residents 6's Minimum Data Set (MDS - a resident assessment tool) dated 11/25/2025, the MDS indicated Resident 6 had severe cognition impairment. The MDS indicated Resident 6 required supervision or touching assistance from staff with activities of daily living (ADLs) such as dressing, toilet use, personal hygiene, transfer and mobility.During a concurrent observation and interview on 12/9/2025 at 9:45 a.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 was passing medication to Resident 6. Resident 6 refused to take all the medications. LVN 2 stated Resident 6 would often refuse medications. LVN 2 stated on 12/8/2025 and 12/9/2025 when Resident 6 refused medications, LVN 2 documented Resident 6 refused but did not document a COC.During an interview on 12/9/2025 at 11:05 a.m. with Resident 6, Resident 6 stated she did not take medications, and she did not need medication. During an interview on 12/9/2025 at 3:00 p.m. with LVN 2, LVN 2 stated refusing medications was a change in condition and must be documented. LVN 2 stated that if Resident 6 was not taking her medications, she could be at risk of mood changes and that could exacerbate her behavior and may cause transfer to the hospital. LVN 2 stated it was important to monitor her behavior on a continuous basis.During a concurrent interview and record review on 12/19/2025 at 4:50 a.m., with Director of Nursing (DON), Resident 6's COC was reviewed. The DON stated Resident 6 did not have a COC regarding refusal of medications. The DON stated the purpose of the COC was to ensure the nurses were aware of Resident 6's current condition and to monitor Resident's behavior. The DON stated by not having a COC, Resident 6 was at risk of not getting the care and monitoring that she required.During a review of the facility's policies and procedure (P&P) titled, Change of Condition dated 8/25/2022, the P&P indicated the licensed nurse would assess the change of condition and determined what nursing interventions are appropriate. The P&P indicated the licensed nurse would notify the residents' Physician and legal representative or an appropriate family member when there was any untoward response or reaction by patient to medications or treatment.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure a person-centered care plan was developed for one of six residents (Resident 6) who had been refusing to take medications. This failure had the potential for poor communication and result in the resident not receiving the necessary care and services to maintain its highest practicable physical, mental and psychosocial well-being. Findings:During a concurrent observation and interview on 12/9/2025 at 9:41 a.m., with Resident 6, Resident 6 was observed laying on bed covered with blankets. Resident 6 stated, I do not take medications but the nurses want me to take it. Resident 6 stated, I am okay, I do not need medication.During a review of Resident 6's admission Record, the admission Record indicated Resident 6 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 6's diagnoses included schizoaffective disorder (mental illness that is characterized by disturbances in thought), bipolar disorder (mood swings that range from the lows of depression to elevated periods of emotional highs), epilepsy (a chronic neurological condition marked by recurrent, unprovoked seizures, which are sudden bursts of abnormal electrical activity in the brain).During a review of Resident 6's H&P dated 12/4/2025, the H&P indicated Resident 6 had the capacity to make needs known but cannot make medical decisions.During a review of Residents 6's Minimum Data Set (MDS - a resident assessment tool), dated 11/25/2025, the MDS indicated Resident 6 had severe cognitive impairment. The MDS indicated Resident 6 required supervision or touching assistance with ADLs.During a review of Resident 6's Physicians Orders dated 12/2/2025, Resident 6's physician's orders indicated Aripiprazole tablet 10 milligrams (mg- a unit of measurement), 1 tablet by mouth at bedtime for schizoaffective disorder, Haloperidol oral tablet 10 mg tablet twice a day (BID) for schizoaffective disorder, Levetiracetam oral solution 100 mg, 5 milliliters (ml- a unit of measurement) by mouth BID for seizures, Divalproex Sodium oral solution 250mg/ 5 ml, 10ml by mouth BID for Bipolar.During a review of Resident 6's Care Plan on 12/9/2025. There is no care plan created for Resident 6's refusal of medications.During an interview on 12/9/2025 at 9:30 a.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated Resident 3 has a routine of refusing medications. LVN 2 stated Resident 3 needed to be encouraged to take medications several times so he will take it. LVN 2 stated the policy of the facility is to develop a care plan for refusal of medications.During an interview on 12/9/2025 at 9:45 a.m., with LVN 2 stated Resident 6 refused medication often.During an interview on 12/9/2025 at 3:00 p. m. with LVN 2, LVN 2 stated when residents refused medications, the medications should be re-offered at least 3 times and educate the residents about the consequence of refusing medicines. LVN 2 stated a care plan should be created when residents refuse medications so the nurses will be aware and implement the interventions outlined in the plan of care. the During an interview and record review on 12/9/2025 at 4:50 p.m. , with Director of Nursing (DON), the DON stated care plan should have been developed for Resident 6 regarding the refusals to take medications. During a review of the facility's policies and procedure (P&P) titled, Comprehensive Person-Centered Care Planning, dated 8/24/2023, the P&P indicated updates to the resident's comprehensive care plan should be made based on the assessed needs of the resident. The P&P indicated the comprehensive care plan should be reviewed and revised to address changes in care.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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F 0755 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: 1). Ensure three (3) of six (6) sampled residents' (Residents 1, 4, and 6) medications were administered timely. This failure resulted in delayed interventions and had the potential to exacerbate (worsen) the residents' conditionand can cause resident transfer to the general acute care hospital. 2). Ensure the Controlled Drugs-Count Record (Narcotic [medications that are regulated by law due to their potential for misuse or harm] count sheet), for two (2) of 3 medication carts at the facility, were completely filled-up. This deficient practice had the potential for loss of accountability, drug diversion, or theft. Findings:a). During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1's diagnoses included schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior) major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) and hypertension (HTN-high blood pressure).During a review of Resident 1's History and Physical (H&P) dated 6/16/2025, the H&P indicated Resident 1 had fluctuating capacity to understand and make decisions.During a review of Residents 1's Minimum Data Set (MDS - a resident assessment tool) dated 11/2/2025, the MDS indicated Resident 1 had moderate cognition impairment. The MDS indicated Resident 1 required supervision or touching assistance with activities of daily living (ADLs) such as dressing, toilet use, personal hygiene, transfer and mobility.During a review of Resident 1's doctors' orders dated 12/19/2024, the doctors' orders indicated lithium carbonate (mood stabilize) oral 150 milligrams (mg - a unit of measurement) three times (TID) a day for bipolar disorder (a mental condition marked by alternating periods of elation and depression), Lisinopril 5 mg daily for hypertension (HTN), Risperdal oral 1 mg two times a day (BID) for schizoaffective disorder, Gabapentin oral 100 mg twice a day (BID) for neuropathy (nerve damage).During a review of Resident 1's Medications Administration Record (MAR) for the month of 12/2025, the MAR indicated the following schedules for medication administration: 1). Lisinopril at 9:00 a.m. daily2). Risperdal at 9:00 a.m., and 5:00 p.m.3). Gabapentin at 9:00 a.m., and 5:00 p.m.4). Lithium carbonate at 9:00 a.m., 1:00 p.m., and 6:00 p.m.During a review of Resident 1's MAR Audit Report of Lithium carbonate, Lisinopril, Risperdal and Gabapentin dated 12/6/2025 timed 9:00 p.m., the medications were administered on 12/6/2025 at 10:55 a.m. b). During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 4's diagnoses included schizophrenia disorder (a mental illness that is characterized by disturbances in thought) type 2 diabetes (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and HTN.During a review of Resident 4's H&P dated 9/24/2025, the H&P indicated Resident 4 had the capacity to make needs known but cannot make medical decisions.During a review of Residents 4's MDS dated [DATE], the MDS indicated Resident 4 had moderate cognitive impairment. The MDS indicated Resident 4 required partial to moderate assistance with ADLs.During a review of Resident 4's doctors' orders dated 9/23/2025, the doctors' orders indicated Lisinopril oral 5 mg daily for HTN, Empagliflozin oral 10 mg daily for diabetes (abnormal blood sugar levels), Metformin oral 1000 mg BID for diabetes, Risperdal oral 2 mg BID for auditory hallucinations (a condition of hearing voices).During a review of Resident 4's MAR for the month of 12/2025, the MAR indicated the following schedules for medication administration:1). Empagliflozin at 9:00 a.m.2). Lisinopril at 8:00 a.m.3). Metformin at 9:00 a.m., and 5:00 p.m.4). Risperdal at 8:00 a.m., and 5:00 p.m. During a review of Resident 4's MAR Audit Report for Risperdal and lisinopril dated 12/5/2025, 12/6/2025 and 12/7/2025 timed 8:00 a.m., the medications were administered on 12/5/2025 at 10:35 a.m., on 12/6/2025 at 11:01 a.m., and on 12/7/2025, was administered at 11:36 a.m. The MAR Audit Report indicated Empagliflozin and Metformin scheduled for 12/5/2025, 12/6/2025 and 12/7/2025 timed 9:00 a.m., were administered on 12/5/2025 at 10:36 a.m., on 12/6/2025 at 11:01 a.m., and 12/7/2025 at 11:36 a.m. c). During a review of Resident 6's admission Record, the admission Record indicated Resident 6 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 6's diagnoses included schizoaffective disorder, epilepsy (a chronic neurological condition marked by recurrent, unprovoked seizures, which are sudden bursts of abnormal electrical activity in the brain) and dementia (a progressive state of decline in mental abilities).During a review of Resident 6's H&P dated 12/4/2025, the H&P indicated Resident 6 had the capacity to make needs known but cannot make medical decisions.During a review of Residents 6's MDS dated [DATE], the MDS indicated Resident 6 had severe cognitive impairment. The MDS indicated Resident