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	06/10/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the physician of a resident's refusal to take their scheduled medications for one of four sampled residents (Resident 2).This deficient practice had the potential for Resident 2 to decline and resulted in delayed necessary care and medical interventions due to the physician not being notified in a timely manner.Findings:During a review of Resident 2's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated, Resident 2 was admitted to the facility on [DATE]. Resident 2's diagnoses include bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), atrial fibrillation (irregular and often very rapid heart rhythm), and hypertension ([HTN] - high blood pressure).During a review of Resident 2's Minimum Data Set ([MDS] - a resident assessment tool), dated 5/30/2026, the MDS indicated, Resident 2's cognitive (ability to think and reason) skills for daily decision making was moderately impaired (decisions are poor, cues and supervision required). The MDS indicated, Resident 2 required moderate assistance (helper does less than half the effort) from staff with toileting hygiene, lower body dressing, and personal hygiene.During a review of Resident 2's History and Physical (H&P), dated 5/27/2026, the H&P indicated, Resident 2 did not have the capacity to consent.During a review of Review of Resident 2's physician order, dated 5/23/2026, the physician order indicated, Resident 2 was to receive the following medications:Depakote (an anticonvulsant drug used to treat seizure disorder and other psychiatric conditions) 250 milligrams ([mg] - metric unit of measurement, used for medication dosage and/or amount) by mouth two times a day (9:00 a.m. and 5:00 p.m.) for seizure disorder (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness).Eliquis (a drug that can prevent and treat blood clots) by mouth 5mg twice a day for cerebrovascular accident ([CVA] - stroke, loss of blood flow to a part of the brain) prophylaxis (prevention).Losartan Potassium (drug used to treat HTN) by mouth 25mg once a day (9:00 a.m.) for HTN.Risperdal (drug used for treatment of bipolar disorder) by mouth 1mg two times a day for bipolar disorder manifested by striking out.During a review of review of Resident 2's Medication Administration Record ([MAR] - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), from 5/24/2026 to 5/27/2026, the MAR indicated, Resident 2 refused (coded as 2) to take Depakote, Eliquis, Losartan, and Risperdal.During a concurrent interview and record review on 6/10/2026 at 8:20 a.m., with Licensed Vocational Nurse 4 (LVN 4), Resident 2's Progress Notes, from 5/24/2026 to 5/27/2026, was reviewed. The Progress Notes did not indicate Resident 2's physician was notified of the resident's refusal of Depakote, Eliquis, Losartan, and Risperdal on 5/24/2026, 5/25/2026, 5/26/2026, and 5/27/2026. LVN 4 stated the standard of practice was to notify the physician when a resident refused medications after three consecutive episodes. LVN 4 stated when Resident 2 refused medication, the physician should be notified because it was considered as a resident's change of condition.During an interview on 6/10/2026 at 11:00 a.m., with the Director of Nursing (DON), the DON stated notifying the physician when a resident refused medication was (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	essential for resident safety and for the physician to offer an alternative treatment plan.During a review of the facility's policy and procedure (P&P) titled, Refusal of Treatment, dated 1/1/2012, the P&P indicated, The attending physician will be notified of refusal of treatment in a time frame determined by the resident's condition and potential serious consequences of the refusal.During a review of the facility's P&P titled, Medication Administration, dated 6/26/2025, the P&P indicated, For resident refusing medication, the licensed nurse will notify the prescribing provider and document in the medical record including the reason for refusal.

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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 develop a person-centered care plan for right ear pain for one of one sampled resident (Resident 1).This deficient practice had the potential to result in a lack meeting necessary care and addressing medical needs for Resident 1.Findings:During a review of Resident 1's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated, Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1's diagnoses included schizophrenia (a mental illness that is characterized by disturbances in thought), chronic obstructive pulmonary disease ([COPD] - a chronic lung disease causing difficulty in breathing), and Diabetes Mellitus ([DM] - a disorder characterized by difficulty in blood sugar control and poor wound healing).During a review of Resident 1's History and Physical (H&P), dated 2/14/2026, the H&P indicated, Resident 1 had fluctuating capacity to understand and make decisions.During a review of Resident 1's Minimum Data Set ([MDS] - a resident assessment tool), dated 4/10/2026, the MDS indicated, Resident 1's cognitive (ability to think and reason) skills for daily decision making was moderately impaired (decisions are poor, cues and supervision required). The MDS indicated, Resident 1 required substantial assistance (helper does more than half the effort) from staff with toileting hygiene, upper and lower body dressing.During a review of Resident 1's Change in Condition Evaluation (an electronic assessment tool used in long-term and post-acute care to safely manage resident health changes in-house and prevent avoidable hospital transfers) dated 5/24/2026, the Change in Condition indicated on 5/24/2026, Resident 1 had right ear pain.During a concurrent interview and record review on 6/10/2026 at 8:15 a.m., with Licensed Vocational Nurse 4 (LVN 4), Resident 1's care plans, were reviewed. the care plans did not indicate a specific comprehensive care plan was developed to address Resident 1's complaint of right ear pain. LVN 4 stated care plans had a problem, goal, and interventions. LVN 4 stated the facility staff would not be able to solve Resident 1's complaint of right ear pain because there was no care plan developed and interventions implemented. LVN 4 stated care plans should be individualized and should pertain to the care of each resident. LVN 4 stated the purpose of the care plan was for continuity of care.During an interview on 6/10/2026 at 10:45 a.m., with the Director of Nursing, the DON stated a care plan was very important to address resident's areas of concern and to show facility's plan of action.During a review of the facility's policy and procedure (P&P) titled, Comprehensive Person-Centered Care Planning, dated 8/24/2023, the P&P indicated, The comprehensive care plan will be reviewed and revised if there is an onset of new problems and a change of condition.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to monitor two of four sampled residents (Residents 1 and 3) behaviors while prescribed psychotropic medications (any drug that affects brain activities associated with mental processes and behavior).This deficient practice had the potential to result in the administration of unnecessary psychotropic medication that could cause harm to Residents 1 and 3. Findings:a. During a review of Resident 1's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated, Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1's diagnoses included schizophrenia (a mental illness that is characterized by disturbances in thought), chronic obstructive pulmonary disease ([COPD] - a chronic lung disease causing difficulty in breathing), and Diabetes Mellitus ([DM] - a disorder characterized by difficulty in blood sugar control and poor wound healing).During a review of Resident 1's History and Physical (H&P), dated 2/14/2026, the H&P indicated, Resident 1 had fluctuating capacity to understand and make decisions.During a review of Resident 1's Minimum Data Set ([MDS] - a resident assessment tool), dated 4/10/2026, the MDS indicated, Resident 1's cognitive (ability to think and reason) skills for daily decision making was moderately impaired (decisions are poor, cues and supervision required). The MDS indicated, Resident 1 required substantial assistance (helper does more than half the effort) from staff with toileting hygiene, upper and lower body dressing.During a review of Resident 1's physician order, dated 2/13/2026, the physician order indicated, Divalproex Sodium Delayed Release (an anticonvulsant drug used to treat seizure disorder and other psychiatric conditions) 500 milligrams ([mg] - metric unit of measurement, used for medication dosage and/or amount) one tablet by mouth three times a day (9:00 a.m., 1:00 p.m., and 5:00 p.m.) for schizophrenia manifested by striking out and Seroquel (psychotropic medication used for treatment of schizophrenia) 200mg one tablet by mouth two times a day (9:00 a.m., and 5:00 p.m.) for schizophrenia manifested by verbal aggression and outburst of anger.During a concurrent interview and record review on 6/10/2026 at 8:05 a.m., with Licensed Vocational Nurse 4 (LVN 4), Resident 1's Medication Administration Record ([MAR] - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), from 2/14/2026 to 6/3/2026, was reviewed. The MAR did not indicate documented evidence of Resident 1's behavior monitoring for striking out, aggression, and angry outburst. LVN 4 stated when residents were receiving psychotropic medications, the licensed nurses should monitor for the behavior manifested by putting a hashmark and documenting the number of episodes on the MAR. LVN 4 stated behavior monitoring was important in order to keep track of the target behavior and to determine if the psychotropic medications would be decreased or increased based on the number of the frequency of the behavior.b. During a review of Resident 3's Face Sheet, the Face Sheet indicated, Resident 1 was admitted to the facility on [DATE]. Resident 3's diagnoses included attention deficit hyperactivity disorder ([ADHD] - a neurodevelopmental difference that affects a person's ability to regulate focus, impulses, and energy levels), major depressive disorder ([MDD] - a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety disorder (a mental health condition characterized by intense, excessive, and persistent worry or fear about everyday situations).During a review of Resident 3's H&P, dated 5/30/2026, the H&P indicated, Resident 3 had fluctuating capacity to understand and make decisions.During a review of Resident 3's physician order, dated 5/29/2026, the physician order indicated Bupropion Hydrochloride Extended Release (drug used to treat MDD) one tablet by mouth two times a day (9:00 a.m. and 5:00 p.m.) for depression manifested by self-isolation.During a concurrent interview and record review on 6/10/2026 at 10:55 a.m. with the Director of Nursing (DON), Resident 3's MAR from 5/30/2026 to 6/9/2026, was reviewed. The MAR did not indicate behavior monitoring of Resident 3's self-isolation. The DON stated it was important to tally and document Resident 3's behavior in order to evaluate the (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	continued use and dose adjustment of psychotropic medications.During a review of the facility's policy and procedure (P&P) titled, Behavior and Psychoactive Medication Management, dated 1/30/2026, the P&P indicated, Any order for psychoactive medications must include a specific behavior manifestation. The P&P did not disclose the frequency and importance of monitoring resident's behavior.