STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055167	A. BUILDING _____ B. WING _____	**04/01/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 -** 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 a physician when one of three sample residents (Resident 1), Resident 1 had a change of condition ((COC) sudden, clinical deviation from a resident's baseline) on 2/26/2020 at 11:03 p.m. when Resident 1 first experienced lethargy (sluggish), decrease respiratory rate of 10 breaths per minute ((bpm) Normal Reference Range (NRR) 16-20 bpm) and an unreadable oxygen saturation (measure of how much oxygen the blood is carrying (NRR 94-100 percent (%) in room air)); follow physician's orders [REDACTED]. These deficient practices resulted in a delay of provision of care and a transfer to the GACH on 2/27/2020 at 1:47 a.m. (2 hours and 45 minutes after initial COC) for shortness of breath (SOB) and altered mental Status (AMS). Findings: A review of Resident 1's Face Sheet (Admission Record) indicated Resident 1 was admitted to the facility on [DATE] and last readmitted on [DATE]. Resident 1's [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set (MDS), a standardized care screening and assessment tool, dated 1/3/2020 indicated Resident 1 was usually able to make himself understood and understand others. The MDS indicated Resident 1 was totally dependent on a one-person physical assist for bed mobility, eating and personal hygiene. A review of Resident 1's physician's orders [REDACTED]. A review of Resident 1's COC form, dated 2/27/2020 and timed at 12:05 a.m. indicated on 2/26/2020 at 11:03 p.m. Resident 1's respiration rate was 10 bpm and had an unreadable oxygen saturation (amount of oxygen in the blood) level. The COC indicated Resident 1 was noted lethargic, placed in an upright position and two (2) liters of oxygen was administered via nasal canula (lightweight tube place on the nose to deliver oxygen). At 12:15 a.m. on 2/27/2020, Resident 1 was found unresponsive, pale and lethargic, physician was notified, and orders received to transfer Resident to the GACH via 911. A review of Resident 1's physician telephone order, dated 2/27/2020 and timed at 12:15 a.m. indicated to transfer indicated to transfer Resident 1 to a GACH via 911 for decrease respiration rate, desaturation (low oxygen) and altered level of consciousness ((ALOC) abnormal measurement of a resident's awakening and responsiveness to stimuli). A review of Resident 1's Prehospital Care Report Summary, dated 2/27/2020 indicated the paramedics were dispatched at 1:14 a.m. on 2/27/2020 for Resident 1's decreased oxygenation. The report indicated Licensed Vocational Nurse 3 (LVN 3) contacted 911 at 1:14 a.m. for Resident 1's decreased oxygen levels of 90% on room air and Resident 1 was transferred to the GACH for further evaluation. A review of Resident 1's GACH history and physical (H/P), dated 2/27/2020 and timed at 9:13 a.m., indicated Resident 1 was admitted to the GACH for worsening AMS and low oxygenation. The H/P indicated upon arrival Resident 1 was found to have four [MEDICATION NAME]es on various parts of his body that were promptly removed. The H/P indicated Resident 1 had acute [MEDICAL CONDITION] (brain disease, damage, or malfunction) and dehydration (excessive loss of body water). A review of the revised 10/15/19 DailyMed report, indicated serious, life-threatening, or fatal respiratory depression occurs with the use of opioids (narcotics), even when used as recommended. Respiratory depression, if not immediately recognized and treated, may lead to respiratory arrest and death. Management of respiratory depression may include close observation, supportive measures, and use of opioid antagonists, depending on the resident's status. The report indicated Life-threatening respiratory depression is more likely to occur in elderly, cachectic (marked weight loss and muscle loss), or debilitated patients because they may have altered pharmacokinetics (branch of pharmacology concerned with the movement of drugs within the body) compared to younger, healthier residents. https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=4c3a6171-19e4-40c2-83f3-fb54d4736e4b#S5.4 On 3/10/2020 at 4 p.m., during a telephone interview, Resident 1's Responsible Party (RP) stated not being informed by the facility's staff of the first COC on 2/26/2020. The RP stated she was notified on 2/27/2020 at 6 a.m., of Resident 1's transferred to the GACH. The RP stated she notified the facility's ADM and DON on 2/27/2020 of the neglect Resident 1 suffered when the facility's licensed nurses left four (4) [MEDICATION NAME]es on various parts of the resident's body. On 3/11/2020 at 10:12 p.m., during a telephone interview, the GACH's Social Services Worker (GSW) stated Resident 1 was admitted to the GACH on 2/27/2020 for respiratory distress. The GSW stated Resident 1 appeared malnourish, dirty, unkept, and with four [MEDICATION NAME]es found on his body. On 3/12/2020 at 9:13 a.m., during an interview, the DON stated she was made aware of the [MEDICATION NAME]es found on Resident 1 by the GACH. The DON stated an investigation was conducted and Licensed Vocational Nurse 1 and 2 (LVN 1 and 2) did not document several dates Resident 1's [MEDICATION NAME]es removed. The DON stated LVN 3 was suspended because she failed to assess Resident 1 prior to being transferred to the GACH and to identify the patches. On 3/12/2020 at 3:10 p.m., during an interview with the DON and ADM, the ADM stated LVN 3 was suspended and later terminated for failing to follow the physician's orders [REDACTED]. A review of LVN 3's Notice to Employee as to Change in Relationship, dated 3/6/2020 indicated LVN 3 was terminated for not following the facility's policy and procedures to assess Resident 1 prior to the hospital transfer. On 3/19/2020 at 4:17 p.m., during a telephone interview, LVN 3 stated on 2/26/2020 at 11 p.m. during rounds, Resident 1 was noted restless, had difficulty breathing and chest pain. LVN 3 stated she administered 2 liters of oxygen via nasal canula to Resident 1 but stated she was not able to read Resident 1's oxygen saturation level. LVN 3 stated she checked on Resident 1 an hour later (12:05 am on 2/27/2020) and Resident 1 was lethargic and short of breath (SOB). LVN 3 stated she called Resident 1's physician and received an order to transfer the resident via 911. LVN 3 stated she waited an hour and then call 911 at 1:14 a.m., on 2/27/2020 because she was getting Resident 1's paperwork ready prior to the paramedics arrival so that the paramedics would not complain. Paramedics complained when the resident's paperwork was not ready, as they did every time they came in. When ask, LVN 3 stated an order for [REDACTED]. On 3/27/2020 at 1:17 p.m., during an interview, CNA 1 stated Resident 1 had a Foley catheter since his admission on 12/2019. CNA 1 sated she notify the treatment nurse of Resident 1's catheter tubing did not appear it was placed right because the opening of Resident 1's pee hole, was becoming bigger with white pus on it and as if it was cutting open the penis. CNA 1 stated she mention it on different occasions to the treatment nurse and 3/2020 being the last time they removed it because it appeared swollen, cutting open the tip of the penis and greenish from the tubbing. CNA 1 stated the treatment nurse stated to keep Resident 1 with no catheter so allow time to heal. CNA 1 stated Resident 1 did not had injuries to his penis when he was readmitted on ,[DATE]. A review of the facility's policy and procedures titled, Change of Condition Notification, revised on 4/1/15, indicated that the facility will promptly inform the resident's Attending Physician and notify the legal representative of a significant change in resident's physical, mental or psychosocial status. The policy indicated the licensed nurse would assess the resident and notify the physician immediately of an emergency such as unexpected shortness of breath or intense pain. The policy indicated the staff would document findings each shift for 72 hours.
F 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.**

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

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.

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F 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed implement its policy to report one of three-sampled residents (Resident 1) medication error and change of condition ((COC) sudden, clinical deviation from a resident's baseline), to the Department of Public Health (DPH) within two (2) hours from the time the incident occurred. This deficient practice resulted in the inability for the facility to implement their policy and for other findings to go uninvestigated. Findings: A review of Resident 1's Face Sheet (Admission Record) indicated Resident 1 was admitted to the facility on [DATE] and last readmitted on [DATE]. Resident 1's [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set (MDS), a standardized care screening and assessment tool, dated 1/3/2020 indicated Resident 1 was able to usually make himself understood and understand others. The MDS indicated Resident 1 was total dependent of a one-person physical assist for bed mobility, eating and personal hygiene. A review of the physician's orders [REDACTED]. A review of Resident 1's physicians telephone order, dated 1/28/2020 and timed at 5:10 p.m., indicated to apply a [MEDICATION NAME] 12 mcg/hour every 72 hours for chronic pain for Resident 1. A review of Resident 1's document titled, Topical Patches Sheet indicated to immediately witnessed and sign by to licensed nurses when patch was removed and disposed. The Sheet indicated on 2/1/2020, 2/4/2020, 2/13/2020, and 2/19/2020 no second signature of a licensed nurse witnessed the removal and disposal of the [MEDICATION NAME]. A review of Resident 1's Medication Administration Record [REDACTED]. The MAR indicated [REDACTED]. A review of Resident 1's COC, dated 2/27/2020 and timed at 12:05 a.m. indicated on 2/26/2020 at 11:03 p.m., Resident 1 respiration rate were 10 bpm and staff were unable to read oxygen saturation. The COC indicated Resident 1 was noted lethargic (sluggish) placed on an upright position and oxygen 2 liters administered via nasal canula. At 12:15 p.m., Resident 1 was found not responding, pale and lethargic. Orders received from Resident 1's physician to transfer to the GACH via 911. A review of Resident 1's GACH H/P, dated 2/27/2020 and timed at 9:13 a.m., indicated Resident 1 was admitted to the GACH for worsening altered mental status and low oxygenation. The H/P indicated upon arrival Resident 1 was found to have four [MEDICATION NAME]es on him and were promptly removed. On 3/12/2020 at 9:13 a.m., during an interview, the DON stated she was made aware of the [MEDICATION NAME]es found on Resident 1 by the GACH. The DON stated an investigation was conducted and it was found Licensed Vocational Nurse 1 and 2 (LVN 1 and 2) did not document several date Resident 1's [MEDICATION NAME] was removed. The DON stated LVN 3 was suspended because she failed to assess Resident 1's COC and transfer him to the GACH. On 3/12/2020 at 10:22 a.m., during an interview and review of the facility's policy with the ADM and the DON, the ADM stated the policy did not indicate proper disposal of the [MEDICATION NAME] upon removal. The ADM stated LVNs 1 and 2 were suspending upon identification of the medication error by not signing the [MEDICATION NAME] disposal day. The ADM stated she did not make any reports to the DPH because she did not consider the event to be reportable. The ADM stated she did not report because it was a medication error. A review of the facility's undated policy and procedure titled, Reporting Abuse to State Agencies and Other Entities/Individuals. Indicated that suspicion of neglect should be reported to the State Licensing, local Ombudsman, Adult Protective Services, and law enforcement. Verbal/written notice to the agencies should be made within two hours of the occurrence and if such allegation found to be true, the employee involved should be terminated from employment.
F 0690 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility's nursing staff failed to follow physician orders [REDACTED]., trauma and injury for one of three sampled residents (Resident 1). Resident 1 had an indwelling urinary catheter for wound maintenance and there was no documented evidence the nursing staff were changing the catheter tube. This deficient practice of not assessing and changing the catheter as prescribed by the physician resulted in Resident 1 sustaining a urethral (duct by which urine is conveyed out of the body from the bladder) trauma (physical injury) from the urinary catheter. Findings: A review of Resident 1's Face Sheet (Admission Record) indicated Resident 1 was admitted to the facility on [DATE] and last readmitted on [DATE]. Resident 1's [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set (MDS), a standardized care screening and assessment tool, dated 1/3/2020 indicated Resident 1 was usually able to make himself understood and understand others. The MDS indicated Resident 1 was totally dependent on a one-person physical assist for bed mobility, eating and personal hygiene. The MDS indicated Resident 1 had an indwelling urinary catheter in place. A review of Resident 1's physician's orders [REDACTED]. A second physician order [REDACTED]. A review of Resident 1's readmission assessment dated [DATE] indicated Resident 1 was readmitted with a Foley catheter. A review of Resident 1's care plans did not indicate a care plan for Resident 1's indwelling urinary catheter was created. A review of Resident 1's initial admission assessment dated [DATE] indicated no lacerations to Resident 1's penis was assessed or documented. A review of Resident 1's physician telephone order, dated 2/27/2020 indicated to transfer Resident 1 to the general acute care hospital (GACH) via 911 (emergency service number) for decrease respiration rate, desaturation (low oxygen) and altered level of consciousness ((ALOC) abnormal measurement of a resident's awakening and responsiveness to stimuli). A review of Resident 1's GACH Skin Integrity Record, dated 2/27/2020 indicated there was a penis urethra wound present on admission. The photos taken by the GACH's staff, dated 2/27/2020 noted Resident 1's catheter with spots of blood on the tubing and with redness on the urethral during the admission assessment. A review of another photo taken upon admission to the GACH on 2/27/2020 indicated Resident 1's urinary catheter was coated with a slimy dark grayish substance towards the tip of the catheter upon removal. On 3/10/2020 at 4 p.m., during a telephone interview, Resident 1's Responsible Party (RP) stated not being informed by the facility's staff of the first Change of Condition ((COC) sudden, clinical deviation from a resident's baseline) form on 2/26/2020. The RP stated she was notified on 2/27/2020 at 6 a.m., of Resident 1's transfer to the GACH. The RP stated she notified the facility's Administrator (ADM) and Director of Nursing (DON) on 2/27/2020 of the neglect Resident 1 suffered when the facility's licensed nurses left four (4) [MEDICATION NAME]es on the resident. The RP stated Resident 1 was admitted with no injuries to his penis and Certified Nurse Assistant 1 (CNA 1) had mention to the staff of Resident 1's penis splitting in half. On 3/12/2020 at 10 a.m., during an interview and review of Resident 1's Treatment Assessment Record (TAR), Licensed Vocational Nurse 4 (LVN 4) stated Resident 1 had a urinary catheter that she last assessed on 2/24/2020 and she stated Resident 1 had a laceration to his penial area upon admission on 12/14/19 (sic). LVN 4 stated there was no care plans for Resident 1's urinary catheter care found or nursing progress notes regarding any care she or other staff provided to the resident's penial area. A review of Resident 1's 2/2020 TAR indicated LVN 4's initials for urinary catheter treatment and assessment on 2/26/2020 through 2/29/2020. LVN 4 stated Resident 1 was transferred to the GACH on 2/26/2020 and she (LVN 4) documented four (4) days mistakenly because she was in a hurry. LVN 4 stated and confirmed there was no assessment or nurses notes upon admission on 4/26/19 regarding Resident 1 being admitted with a laceration to his penis. LVN 4 stated she had no documentation of Resident 1's wound treatments to Resident 1's penial area or the date she (LVN 4) changed Resident 1's catheter tubing. On 3/27/2020 at 1:17 p.m., during an interview, CNA 1 stated Resident 1 had a Foley catheter since his admission on 12/2019. CNA 1 sated she notify the treatment nurse of Resident 1's catheter tubbing did not appear it was placed right because the opening of Resident 1's pee hole, was becoming bigger with white puss on it and as if it was cutting open the penis. CNA 1 stated she mention it on different occasions to the treatment nurse and 3/2020 being the last time they removed it because it appeared swollen, cutting open the tip of the penis and greenish drainage from the tubing. CNA 1 stated the treatment nurse stated to keep Resident 1 without a catheter to allow time to heal. CNA 1 stated Resident 1 did not had injuries to his penis when he was readmitted in 12/2019. A review of the facility's policy and procedure titled, Comprehensive Person-Center Care Planning, dated 11/2017 indicated it was the facility's responsibility to provide person-center care that reflects best practice standards for meeting health, safety, and environmental needs for the residents. The policy indicated a case line care plan should reflect the resident's stated goals and objectives, and include interventions that addressed his/her concerns.
F 0757 **Level of harm -** Actual harm **Residents Affected -** Some	**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 ensure one of three (3) sampled resident (Resident 1) received medication as prescribed by the physician and with adequate monitoring of medication side effects, assessment, and proper disposal of medication as per the facility's policy and procedures (P/P) titled, Controlled Medication Disposal, dated 2/23/15 (Cross referenced to F580). Resident 1 had an order for [REDACTED].) for chronic pain. The licensed nurses fail to

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F 0757 **Level of harm -** Actual harm **Residents Affected -** Some	(continued... from page 2) document the application and removal date and time after 72 hrs. prior to the placement of the next patch on 2/1/2020, 2/4/2020, 2/13/2020, 2/19/2020. There was also no documented site of the [MEDICATION NAME] placement on 2/22/2020 and 2/25/2020 as per the facility's policy and procedure. These deficient practices resulted in Resident 1 requiring an emergency transfer to the general acute care hospital (GACH) for respiratory distress with a decreased rate of 10 breaths per minute ((bpm) normal Reference Range (NRR) 16-20 bpm) and low oxygen levels (NRR 94-100 percent (%) on room air). Resident 1 was found to have four (4) intact [MEDICATION NAME]es on various parts of his body and one last dated 11/2019 upon initial admission to the GACH's Emergency Department (ED). On 3/12/2020 at 3:12 p.m., the Administrator (ADM) and the Director of Nursing (DON), were notified 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 for the facility's inability to provide the necessary care and services to monitor and assess a resident use of a narcotic. The facility's ADM and DON were notified of the immediacy and seriousness of the residents' health and safety being threatened. On 3/15/2020 at 1:11 p.m., the ADM submitted an acceptable Plan of Action (POA) for the correction of the IJ which included: 1. On 2/27/2020 an audit was conducted to identify other residents receiving [MEDICATION NAME]. No other residents were identified with an opioid (narcotic) patch. An investigation initiated on 3/2/2020 of the licensed nurses that administered the patch. Two licensed nurses were suspended on 3/2/2020 due to improper documentation and assessment of the [MEDICATION NAME] placement. 2. Developed a process for opioid patches disposal on 3/2/2020. The process included confirmation/documentation of opioid patch placement every shift and removal by two licensed nurses to be completed and sign. The patch will be folded in half (adhesive side to adhesive side), placed in the foil wrapper and return to the box. Upon utilizing of the five (5) patches in the box, the licensed nurse will be responsible for returning the box with the five used patches to the DON with the controlled substance log to be properly disposed together with the pharmacist. 3. Licensed Nurses were educated on the facility's policy for [MEDICATION NAME]es ([MEDICATION NAME] is a medicated adhesive patch that is placed on the skin to deliver a specific dose of medication through the skin and into the bloodstream) and the updated process by the Director of Staff Development (DSD) on 3/5/2020 through 3/12/2020. Nurses scheduled for upcoming shifts will be in-serviced prior to the start of their shift. 4. Licensed Nurses were in-serviced on 3/12/2020 regarding F757 Drug Regimen Free from Unnecessary Drugs. The remaining nurses will be in-serviced prior to their next scheduled shift. 5. The Pharmacist Consultant in-serviced all licensed nurses on 3/14/2020 regarding [MEDICATION NAME] Drug Delivery System (patch) application and medication handling. 6. Residents with [MEDICATION NAME]es will be checked daily for 14 days, then three times a week for 90 days by the DON or designee to ensure only one patch is intact and the removal of the patch is properly documented by two nurses. Any negative findings will be reported directly to the Administrator. 7. All the Medication Administration Records (MAR) will include black box warning as part of the order for the [MEDICATION NAME]es. 8. The Director of Medical Records (DMR) will audit the resident's MARs with [MEDICATION NAME]es weekly for 90 days to ensure the Mar includes checking for patch placement every shift. On 3/15/2020 at 1:11 p.m., while onsite the surveyor verified and confirmed the POA was implemented through observation, interviews and record reviews including in-services provided to the licensed nurses by the pharmacist consultant and the pharmacist regarding the appropriate use and disposal of [MEDICATION NAME]es, in-service by the DSD and DON regarding care planning and documentation of medication administration. The IJ was removed and the ADM and DON were notified. Findings: A review of Resident 1's Face Sheet (Admission Record) indicated Resident 1 was admitted to the facility on [DATE] and last readmitted on [DATE]. Resident 1's [DIAGNOSES REDACTED]. The face sheet did not indicate Resident 1 had a [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set (MDS), a standardized care screening and assessment tool, dated 1/3/2020 indicated Resident 1 was usually able to make himself understood and understand others. The MDS indicated Resident 1 was totally dependent of a one-person physical assist for bed mobility, eating and personal hygiene. A review of Resident 1's care plan titled, Black Box Warning, dated 12/14/19 indicated Resident 1 was at risk for side effects from medications. The goal was for Resident 1 to have minimal side effects from the medication. The staffs' approach included to have the medications reviewed upon admission by the pharmacist, monitor the resident for any side effects, vital signs, abnormalities and report to the physician. The care plan did not indicate what medications were on the list for Black Box Warning. A review of the physician's orders [REDACTED]. A review of Resident 1's physician's telephone order, dated 1/28/2020 and timed at 5:10 p.m., indicated to apply a [MEDICATION NAME] 12 mcg/hour, every 72 hours, for chronic pain. A review of Resident 1's document titled, Topical Patches Sheet indicated to immediately witness and sign by two licensed nurses when a patch was removed and disposed. The Sheet indicated on 2/1/2020, 2/4/2020, 2/13/2020, and 2/19/2020 there was no second signature by a licensed nurse to witness the removal and disposal of Resident 1's [MEDICATION NAME]. A Review of Resident 1's MAR for the month of 2/2020 indicated Resident 1 received nine (9) [MEDICATION NAME]es. The MAR sheet did not indicate the location the patch was placed or removed on Resident 1 on 2/22/2020 and 2/25/2020. A review of Resident 1's Change of Condition ((COC) sudden, clinical deviation from a resident's baseline) form, dated 2/27/2020 and timed at 12:05 a.m. indicated on 2/26/2020 at 11:03 p.m., Resident 1 respiration rate 10 bpm and the staff was unable to read oxygen saturation (amount of oxygen in the blood). The COC indicated Resident 1 was noted lethargic (sluggish) placed in an upright position and administered two (2) Liters pe minute (L/m) of oxygen via nasal cannula (lightweight tube place on the nose to deliver oxygen). The COC indicated at 12:15 p.m., on 2/27/2020, Resident 1 was found not responding, pale and lethargic. Orders received from Resident 1's physician to transfer to the GACH via 911 (emergency services). A review of Resident 1's physician telephone order, dated 2/27/2020 indicated to transfer Resident 1 to the GACH via 911 for decrease respiration rate, oxygen desaturation (low oxygen) an altered level of consciousness ((ALOC) abnormal measurement of a resident's awakening and responsiveness to stimuli). A review of Resident 1's Prehospital Care Report Summary, dated 2/27/2020 indicated paramedics were dispatched at 1:14 a.m. on 2/27/2020 for decrease in oxygenation. The report indicated the facility's staff contacted 911 for Resident 1's oxygen levels at room air being below 90%. The report indicated Resident 1 was transferred to the GACH for further evaluation of respiratory distress and ALOC. A review of Resident 1's GACH History and Physical (H/P), dated 2/27/2020 and timed at 9:13 a.m., indicated Resident 1 was admitted to the GACH for worsening of an altered mental status and low oxygenation. The H/P indicated upon arrival, Resident 1 was found to have four [MEDICATION NAME]es on various areas of his body (with no exact location) and were promptly removed. A review of Resident 1's GACH Order Consults, dated 2/28/2020 and timed at 10:54 a.m. indicated Resident 1 was found with four old [MEDICATION NAME]es upon admission to the GACH on 2/27/2020. On 3/10/2020 at 4 p.m., during a telephone interview, Resident 1's Responsible Party (RP) stated not being informed by the facility's staff of the resident's first COC on 2/26/2020. The RP stated she was notified on 2/27/2020 at 6 a.m., of Resident 1's transferred to the GACH. The RP stated she notified the facility's ADM and DON on 2/27/2020 of the neglect Resident 1 suffered when the facility's licensed nurses left four (4) [MEDICATION NAME]es on various parts of the resident's body. On 3/11/2020 at 10:12 p.m., during a telephone interview, the GACH Social Services Worker (SW) stated Resident 1 was admitted to the GACH on 2/27/2020 for respiratory distress. The SW stated Resident 1 appeared malnourish, dirty, unkept, and had four [MEDICATION NAME]es found on him one of them dating back to 11/2019. On 3/12/2020 at 9:13 a.m., during an interview, the DON stated she was made aware of the [MEDICATION NAME]es found on Resident 1 by the GACH. The DON stated an investigation was conducted by her and the DON after verifying the information it was found that Licensed Vocational Nurse 1 and 2 (LVN 1 and 2) did not document several dates on 2/2020 of Resident 1's [MEDICATION NAME]es when they removed and were placed. The DON stated LVN 3 was suspended because she failed to assess Resident 1's COC and identify the four patches on various parts of Resident 1's body and transfer him to the GACH immediately after receiving the physician order [REDACTED]. The ADM stated LVNs 1 and 2 were suspended upon identification and verification of the medication error by not signing the [MEDICATION NAME] disposal day on the MAR and narcotic sheet. A review of LVNs 1 and 2 Notice to Employee as to Change in Relationship, dated 3/6/2020 indicated LVNs 1 and 2 were discharge from the facility effective 3/6/2020 for failure to follow facility's and pharmacy policy and procedures for medication error. On 3/15/2020 at 11 a.m., during an interview, the ADM stated the facility did not have the second part of the [MEDICATION NAME] Patch policy which included how to dispose of the [MEDICATION NAME] upon removal off the resident. The ADM stated the second part of the policy was obtained on 3/12/2020 from the pharmacy. On 3/18/2020 at 11:02 a.m., during a telephone interview, LVN 1 stated not remembering who co-signed the [MEDICATION NAME] sheet the days she (LVN 1) removed them. LVN 1 stated she disposed the patches in the trash upon removing them from Resident 1. LVN 1 stated she did not receive an in-service on the administration and disposal of [MEDICATION NAME]es. LVN 1 stated, she did not know why there was no signature of the second nurse upon the removal of the patches on the dates she administered medication. LVN 1 stated not remembering the dates she administered the [MEDICATION NAME] Patches to Resident 1. On 3/18/2020 at 12:50 p.m., during a telephone interview, LVN 2 stated she disposed Resident 1's patches by flushing them in the toilet. LVN 2 stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055167	A. BUILDING _____ B. WING _____	**04/01/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0757 **Level of harm -** Actual harm **Residents Affected -** Some	(continued... from page 3) she was aware the proper way to dispose of the [MEDICATION NAME] upon removal was to have a witness cosign the disposal. LVN 2 stated not having a second witness when disposing of the patches. LVN 2 stated she had not been in-serviced on the disposal of [MEDICATION NAME] but was aware because it was common sense to have a second person sign the disposal. A review of the facility's policy and procedures titled, Specific Medication Administration Procedures ([MEDICATION NAME] application), dated 2/23/15 indicated the facility staff would place the patch after identifying the location of the body to be placed and document on the MAR the site it was placed. A review of the facility's policy and procedures titled, Controlled Medication Disposal, dated 2/23/15 indicated the DON and the pharmacist consultant were responsible for the facility's compliance in handling of controlled medications. The policy indicated when a dose of controlled medication was removed from the container for administration and was refused or removed, it was destroyed in the presence of two licensed nurses and flushed in the toilet.