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	10/01/2024

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44294 Based on interview and record review, for one of three sampled residents (Resident 1), the facility staff failed to: 1. Report immediately (right away) to the Administrator (Admin) or designated representative, the allegation of abuse, mistreatment on 5/28/2024, night shift (11p.m. to 7 am.), as indicated in the facility ' s Operational Manual- Abuse & Neglect, titled Abuse-Reporting and Investigations. 2. Report to the California Department of Public Health (CDPH) District Office (DO), allegation of abuse, within two (2) hours, as indicated in the All Facilities Letter ([AFL] a letter from the Center for Health Care Quality (CHCQ), Licensing and Certification (L&C) Program to health facilities that are licensed or certified by L&C with information that include changes in requirements in healthcare, enforcement, new technologies, scope of practice, or general information that affects the health facility) 21-26, which indicated facilities must file a written or electronic report, incidents that involved abuse or result in serious bodily injury, to the DO within two hours. This deficient practice resulted in a delay in investigation by CDPH and had the potential to place Resident 1 at risk for further abuse. Findings: During a review of Resident 1 ' s Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE]. Resident 1 ' s diagnoses included Stage 4 pressure ulcer (full thickness skin loss with extensive destruction; tissue necrosis; or damage to muscle, bones) on the sacral (tail bone) region and urinary tract infection ([UTI] an infection in any part of the urinary system). During a review of Resident 1 ' s Minimum Data Set ([MDS] a federally mandated resident assessment tool) dated 6/6/2024, the MDS indicated Resident 1 could understand and be understood by others. The MDS indicated Resident 1 was dependent and required a two or more person ' s assist with activities of daily living (ADLs) such as eating, oral hygiene, toileting hygiene, shower, dressing, personal hygiene, and bed mobility. The MDS indicated Resident 1 had a Stage 4 pressure ulcer. During a review of Resident 1 ' s History and Physical (H&P) dated 8/11/20204 Resident did not have the capacity to understand and make decisions. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s clinical records for May 2024, the records did not indicate progress notes, a record of a change of condition documentation regarding Resident 1 ' s bruise on the left cheek near left eye or an incident of Resident 2 being punched by a staff on the night shift of 5/28/2024. During a phone interview on 9/30/2024 at 1:20 p.m. with the caretaker (CT) and Family Member (FM 1), the CT stated she visited Resident 1 on 5/29/2024 (time not indicated) and observed a bruise on Resident 1 ' s left cheek near the left eye. The CT stated Resident 1 told her (CT), a Certified Nurse Assistant (CNA2) punched Resident 1, the night shift on 5/28/2024 (time not specified), leaving a bruise (an area of discolored skin on the body, caused by a blow or impact rupturing underlying blood vessels) on Resident 1 ' s left cheek near the left eye. The CT stated, on 5/29/2024, she called the Social Services Assistant (SSA) to Resident 1 ' s room and reported to SSA that Resident 1 was punched by a CNA on the left side of the face. CT stated she wanted to call the police, but SSA told CT it was not necessary. CT stated SSA told her she was going to take care of it (reporting). FM 1 stated she went to the facility on [DATE] and found out Resident 1 was punched on the face by CNA 2. FM 1 spoke to the Director of Nursing (DON), and the DON told FM 1 that she was not aware of the incident. During an interview on 9/30/2024 at 2:51 p.m. with SSA, the SSA confirmed CT reported to her on 5/29/2024 (time not indicated) that Resident 1 was punched on the face by CNA 2 on the night shift of 5/28/2024. The SSA stated she did not report the incident to the Admin (the Abuse coordinator), Ombudsman, CDPH, and local law enforcement. The SSA stated she was supposed to report the abuse allegation within two hours to ensure proper investigation was conducted and to prevent further abuse. The SSA stated she did not remember if there was a bruise on Resident 1 ' s cheek. The SSA stated she called CT and informed her that Resident 1 stated CNA 2 was rough handling him but did not punch Resident 1. During an interview on 9/30/2024 at 3:15 p.m. with Director of Staff Development (DSD), the DSD stated SSA did not report to him (DSD) that CNA 2 punched Resident 1 on the face on 5/28/2024 night shift. During a phone interview on 10/2/2024 at 9:40 a.m., with the SSA, the SSA stated she reported the incident to the DSD on 5/29/2024 and DSD informed SSA that CNA2 was let go (terminated). SSA stated she then informed CT and FM1. During an interview with the Admin on 10/1/2024 at 2:30 pm., the Admin stated the SSA did not report the 5/28/2024 (night shift) abuse allegation to her. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility ' s Operational Manual- Abuse & Neglect titled Abuse-Reporting and Investigations, dated 1/3/2024, the manual indicated all allegations of abuse, neglect, mistreatment or reasonable suspicion of a crime should be reported to the Administrator or designated representative immediately. The manual indicated, when the Administrator or designated representative received report of an incident or suspected incident of resident abuse, mistreatment, neglect, the Administrator, or designated representative, will initiate an investigation immediately. The manual indicated the facility does not inhibit (obstruct) facility staff/ covered individuals from their mandated reporting obligations and will not be disciplined or retaliated against good-faith reporting. The manual indicated if the suspected perpetrator was an employee, remove the employee immediately from the care of the resident and immediately suspend the employee pending the outcome of the investigation on accordance with the facility policies. The manual indicated, the Administrator or designated representative will send a written SOC341(Report of Suspected Dependent Adult/Elder Abuse) to the CDPH Licensing and Certification within 24 hours for all other cases of abuse and provide CDPH results of the investigations within five (5) working days of the reported allegation. During a review of AFL 21-26 dated 7/26/2021, the AFL indicated a reminder to facilities regarding the mandated reporting requirements of abuse, neglect, exploitation, and/or mistreatment of residents, particularly elders or dependent adults. The AFL indicated, Pursuant to Title 42 CFR section 483.12(c)(1) for incidents that involved abuse or result in serious bodily injury, facilities must file a written or electronic report to the District Office (DO) within two hours

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44294 Based on interview and record review, the facility failed to ensure the allegation of abuse on 5/28/2024, night shift (11p.m. to 7 a.m.), for one of three sampled residents (Resident 1), was investigated. This deficient practice placed Resident 1 at risk for further abuse. Findings: During a review of Resident 1 ' s Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE]. Resident 1 ' s diagnoses included Stage 4 pressure ulcer (full thickness skin loss with extensive destruction; tissue necrosis; or damage to muscle, bones) on the sacral (tail bone) region and urinary tract infection ([UTI] an infection in any part of the urinary system). During a review of Resident 1 ' s Minimum Data Set ([MDS] a federally mandated resident assessment tool) dated 6/6/2024, the MDS indicated Resident 1 could understand and be understood by others. The MDS indicated Resident 1 was dependent and required a two or more person ' s assist with activities of daily living (ADLs) such as eating, oral hygiene, toileting hygiene, shower, dressing, personal hygiene, and bed mobility. The MDS indicated Resident 1 had a Stage 4 pressure ulcer. During a review of Resident 1 ' s History and Physical (H&P) dated 8/11/20204 Resident did not have the capacity to understand and make decisions. During a review of Resident 1 ' s clinical records for May 2024, the records did not indicate progress notes or any documentation regarding an investigation conducted regarding Resident 1 ' s bruise on the left cheek near left eye or an incident of Resident 2 being punched by a staff on the night shift of 5/28/2024. During a phone interview on 9/30/2024 at 1:20 p.m. with the caretaker (CT) and Family Member (FM 1), the CT stated she visited Resident 1 on 5/29/2024 (time not indicated) and observed a bruise on Resident 1 ' s left cheek near the left eye. The CT stated Resident 1 told her (CT), a Certified Nurse Assistant (CNA2) punched Resident 1, the night shift on 5/28/2024 (time not specified), leaving a bruise (an area of discolored skin on the body, caused by a blow or impact rupturing underlying blood vessels) on Resident 1 ' s left cheek near the left eye. The CT stated, on 5/29/2024, she called the Social Service Assistant (SSA) to Resident 1 ' s room and reported to SSA that Resident 1 was punched on the left side of the face by a CNA. CT stated she wanted to call the police, but SSA told CT it was not necessary. CT stated SSA told her she was going to take care of it (reporting). FM 1 stated she went to the facility on [DATE] and found out Resident 1 was punched on the face by CNA 2. FM 1 spoke to the Director of Nursing (DON), and the DON told FM 1 that she was not aware of the incident. (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/30/2024 at 2:51 p.m. with SSA, the SSA confirmed CT reported to her on 5/29/2024 (time not indicated) that Resident 1 was punched on the face by CNA 2 on the night shift of 5/28/2024. The SSA stated she was supposed to report the abuse allegation within two hours to ensure proper investigation was conducted and to prevent further abuse. During a phone interview on 10/2/2024 at 9:40 a.m., with the SSA, the SSA stated she reported the incident to the DSD on 5/29/2024 and DSD informed SSA that CNA2 was let go (terminated). SSA stated she then informed CT and FM1. During an interview with the Admin on 10/1/2024 at 2:30 pm., the Admin stated the SSA did not report the 5/28/2024 (night shift) abuse allegation to her. During a review of the facility ' s Operational Manual- Abuse & Neglect titled Abuse-Reporting and Investigations, dated 1/3/2024, the manual indicated all allegations of abuse, neglect, mistreatment, or reasonable suspicion of a crime should be reported to the Administrator or designated representative immediately (right away). The manual indicated, when the Administrator or designated representative received report of an incident or suspected incident of resident abuse, mistreatment, neglect, the Administrator, or designated representative, will initiate an investigation immediately (right away). The manual indicated the facility does not inhibit (obstruct) facility staff/ covered individuals from their mandated reporting obligations and will not be disciplined or retaliated against good-faith reporting. The manual indicated if the suspected perpetrator was an employee, remove the employee immediately from the care of the resident and immediately suspend the employee pending the outcome of the investigation on accordance with the facility policies. The manual indicated, the Administrator or designated representative will send a written SOC341 to the CDPH Licensing and Certification within 24 hours for all other cases of abuse and provide CDPH results of the investigations within five (5) working days of the reported allegation.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44294 Based on observation, interview and record review, the facility failed to ensure 1 of three sampled residents (Resident 1), indwelling catheter (tube that drain urine from the bladder to a drain bag), was secured with anchoring device (a device to keep catheter tubing in place to prevent pulling, dislodgement). This failure had the potential for the catheter to get accidentally pulled out, causing pain, injury, and possible ([UTI] an infection in any part of the urinary system). Findings: During a review of Resident 1 ' s Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE]. Resident 1 ' s diagnoses included pressure ulcer (tissue loss with visible bone, tendon, or muscle) Stage four (4) on the sacral (tail bone) region and UTI . During a review of Resident 1 ' s Minimum Data Set ([MDS], a standardized assessment and care screening tool) dated 6/6/2024, the MDS indicated Resident 1 could understand and be understood by others. The MDS indicated Resident 1 was dependent and required a two or more person ' s assist with activities of daily living (ADLs) such as eating, oral hygiene, toileting hygiene, shower, dressing, personal hygiene, and bed mobility. The MDS indicated Resident 1 had an indwelling catheter and was always incontinent of bowel. The MDS indicated Resident 1 had a Stage 4 pressure ulcer (full thickness skin loss with extensive destruction; tissue necrosis; or damage to muscle, bones). During a review of Resident 1 ' s History and Physical (H&P) dated 8/11/20204 Resident did not have the capacity to understand and make decisions. During an interview and concurrent observation on 9/26/2024 at 9:15 a.m., with Licensed Vocational Nurse (LVN 1) and Certified Nursing Assistant (CNA 1), Resident 1 was on bed. Resident 1 had an indwelling catheter. CNA 1 stated she Resident 1 ' s catheter was not anchored with a device to prevent from being pulled. LVN 1 stated the foley catheter should have been secured with the anchoring device to prevent pulling, dislodgement and injury to Resident 1 ' s urethra. LVN 1 stated accidental pulling of the catheter could lead to serious injury and hospitalization . During a concurrent observation and interview on 9/26/2024 at 12:16 p.m., with CNA 1, CNA 1 verified Resident 1 ' s catheter did not have an anchor device. During a review of the facility ' s undated policy and procedure (P&P) titled Catheter - Care of, the P/P indicated residents with foley catheters will be cared for utilizing the most current CDC guidelines to prevent UTI. The P&P indicated, to prevent catheter associated urinary tract infections, the catheter will be anchored to not touch the floor.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44294 Based on observation, interview and record review, the facility failed to ensure one of three sampled residents (Resident 1), was turned, and repositioned every two hours. This failure placed Resident 1 at risk for delay in wound healing, worsening of wound condition and risk for further skin breakdown. Findings: During a review of Resident 1 ' s Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE]. Resident 1 ' s diagnoses included Stage 4 pressure ulcer (full thickness skin loss with extensive destruction; tissue necrosis; or damage to muscle, bones) on the sacral (tail bone) region and urinary tract infection ([UTI] an infection in any part of the urinary system). During a review of Resident 1 ' s Minimum Data Set ([MDS] a federally mandated resident assessment tool) dated 6/6/2024, the MDS indicated Resident could understand and be understood by others. The MDS indicated Resident 1 was dependent and required a two or more person ' s assist with activities of daily living (ADLs) such as eating, oral hygiene, toileting hygiene, shower, dressing, personal hygiene, and bed mobility. The MDS indicated Resident 1 had a Stage 4 pressure ulcer. During a review of Resident 1 ' s History and Physical (H&P) dated 8/11/20204 Resident did not have the capacity to understand and make decisions. During a review of Resident 1 ' s Braden Scale for Prediction Pressure Ulcer Risk dated 9/2/2022, the Pressure Sore Risk Assessment indicated Resident 1 was at risk of developing pressure ulcers. During a review of Resident 1 ' s care plan titled, Resident has stage 3 pressure ulcer (deep and painful wounds in the skin) on right buttock related to history of ulcers, dated 9/26/2024, the intervention indicated to educate the caregivers causes of skin breakdown, including transfer/positioning requirements and frequent repositioning. During a concurrent observation on 9/26/2024 at 9:15 a.m., with Licensed Vocational Nurse (LVN 1) and Certified Nursing Assistant (CNA 1), Resident 1 was in his room, lying flat on his back, on his bed. During a concurrent observation on 9/26/2024 at 11:06 a.m., with CNA 1, Resident 1 was in his room, lying flat on his back, on his bed. During a concurrent observation and interview on 9/26/2024 at 2:17 p.m., with LVN 1 and CNA 1, Resident 1 was in his room, lying flat on his back, on his bed. During a concurrent observation and interview on 9/26/2024 at 2:36 p.m., with CNA 1, Resident 1 was in his room, on the same flat-lying position on his back, on bed. CNA 1 stated Resident 1 had not been turned and repositioned today yet because her other residents had took most of her time. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/26/2024 at 3:00 p.m., CNA 1 stated she was supposed to turn Resident 1 every two hours because Resident 1 was bed bound and could not turn himself. CNA 1 stated Resident 1 was at risk of developing more pressure ulcers if not turned. CNA 1 stated Resident 1 was supposed to be turned every two hours. During a concurrent interview and record review on 10/1/2024 at 1:02 p.m., with the Director of Nursing (DON), Resident 1 ' s documented task titled, Roll left and Right (the ability to roll from lying on back, to left and right side, and return to lying on back on the bed) was reviewed. The document was not checked off on 9/26/2024 at 5:21 a.m., checked at 12:09 p.m. and at 10:38 p.m The DON stated staff was supposed to document every two hours after residents are turned. The DON stated if it was not documented it was not done. The DON stated she was not sure if the staff could only document on electronic record only once a shift. During a review of the facility ' s undated lesson plan titled Turning and Repositioning, the lesson plan indicated how to document or chart turning and repositioning every 2 hours/ as needed, as one of the interventions in managing skin integrity.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44294 Based on observation, interview and record review, the facility failed to ensure the indwelling foley catheter (catheter tube draining urine from bladder into a bag outside the body) bag for one of 3 sampled residents (Resident 1) was not on the floor. This failure placed Resident 1 at risk for cross contamination and urinary tract infection (UTI- urine infection). Findings: During a review of Resident 1 ' s Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE]. Resident 1 ' s diagnoses included Stage 4 pressure ulcer (full thickness skin loss with extensive destruction; tissue necrosis; or damage to muscle, bones) on the sacral (tail bone) region and UTI. During a review of Resident 1 ' s Minimum Data Set ([MDS] a federally mandated resident assessment tool) dated 6/6/2024, the MDS indicated Resident 1 could understand and be understood by others. The MDS indicated Resident 1 was dependent and required a two or more person ' s assist with activities of daily living (ADLs) such as eating, oral hygiene, toileting hygiene, shower, dressing, personal hygiene, and bed mobility. The MDS indicated Resident 1 had a Stage 4 pressure ulcer. During a review of Resident 1 ' s History and Physical (H&P) dated 8/11/20204 Resident did not have the capacity to understand and make decisions. During a concurrent observation and interview on 9/26/2024 at 9:15 a.m., with Licensed Vocational Nurse (LVN 1) and Certified Nursing Assistant (CNA 1), Resident 1 was on bed and with the indwelling foley catheter bag flat laying on the floor. LVN 1 stated the foley bag should be off the floor because of the risk of infection. LVN 1 stated bacteria could travel through the urethra (tube that allows urine to pass out of the body and empty from the bladder) into the bladder (hollow, muscular organ that stores urine and is part of the urinary system). During a review of the facility ' undated policy and procedure (P&P) titled, Catheter - Care of, the P&P indicated the facility should ensure the catheter tubing, bag, or spigot (device that controls the flow of a liquid, such as water, from a container or pipe) should be anchored to not touch the floor.