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	10/30/2024

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47286 Based on observation, interview, and record review, the facility failed to ensure that three of seven sampled residents (Residents 1, 2, and 6) were free from physical abuse when the following occurred: 1. Resident 7 punched Resident 2 in the face after Resident 2 entered Resident 7 ' s room and stole a jar of instant coffee without permission on 10/10/24. 2. Resident 2 threw a cup of coffee and kicked Resident 1 on 10/11/2024. 3. Resident 2 kicked Resident 6 in the left leg after Resident 6 confronted Resident 2 for attempting to steal a jar of Resident 6 ' s coffee. These deficient practices resulted in Resident 2 being punched in the face, Resident 1 suffering a left thumb wound, and Resident 6 being kicked causing severe left leg pain. Findings: During a review of Resident 2 ' s Admission Record, the admission record indicated Resident 2 was admitted to the facility on [DATE]. Resident 2 ' s admitting diagnoses included a cognitive (ability to think and reason) communication deficit and schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 2 ' s History and Physical (H&P), dated 8/20/24, the H&P indicated Resident 2 could make his needs known but could not make medical decisions. During a review of Resident 2 ' s Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 8/26/24, the MDS indicated Resident 2 had moderately impaired cognition (problems with a person's ability to think, learn, remember, use judgement, and make decisions). The MDS indicated Resident 2 also displayed inattention and disorganized thinking (unclear or illogical flow of ideas, unpredictable switching from subject to subject). The MDS further indicated Resident 2 could ambulate (walk) independently and needed help from staff to assist with functional cognition (cognitive skills required to complete those meaningful daily activities, directly related to behavior). (continued on next page)

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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 2 ' s care plan titled, [Resident 2] has a behavior problem .increased agitation . attempting to take other residents snacks and drinks, dated 8/27/24, the care plan indicated staff were to intervene as necessary to protect the rights and safety of others. a. During a review of Resident 7 ' s Admission Record, the admission record indicated Resident 7 was admitted to the facility on [DATE] and readmitted on [DATE]. Resident 7 ' s admitting diagnoses included major depressive disorder, generalized muscle weakness, and lack of coordination. During a review of Resident 7 ' s MDS, dated [DATE], the MDS indicated Resident 7 did not have cognitive impairments or disorganized thinking. The MDS further indicated Resident 7 required a wheelchair and was independent with mobility. During an interview on 10/29/24 at 11:45 AM, with Resident 7, Resident 7 stated that on 10/10/24 she entered her room and saw Resident 2 holding her container of instant coffee that she kept in her bedside cabinet. Resident 7 stated Resident 2 ran into her bathroom with the container, and she confronted him. Resident 7 stated she told Resident 2 the coffee belonged to her, and Resident 2 replied, Yeah, I took it. So what?. Resident 7 stated this upset her and she hit Resident 2 in the face. b. During a review of Resident 2 ' s Change of Condition (COC), dated 10/11/24 at 8:06 AM, the COC indicated Resident 2 continued to display aggressive behavior, and staff witnessed Resident 2 throw hot coffee at another resident (Resident 1). The COC indicated Resident 2 was placed on one-to-one (1:1, close monitoring) supervision for his behavior until he was transferred to the hospital for a psychiatric evaluation. During a review of Resident 1 ' s Admission Record, the admission record indicated Resident 1 was admitted to the facility on [DATE] with admitting diagnoses that included acquired absence of the right and left leg below the knee, and muscle wasting and atrophy (thinning of muscle mass). During a review of Resident 1 ' s H&P, dated 5/21/24, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1 ' s MDS, dated [DATE], the MDS indicated Resident 1 did not have any cognitive impairment or disorganized thinking. The MDS further indicated Resident 1 required a wheelchair and was dependent on staff to transfer between surfaces. During an interview on 10/29/24 at 11:20 AM, with Resident 1, Resident 1 stated that on 10/11/24, while out in the smoking patio, Resident 2 took a cup of coffee from another resident. Resident 1 stated Resident 2 had a known history of stealing from other residents, and that staff were aware, but did not doing anything about it. Resident 1 stated that he went to confront Resident 2 for stealing the other resident ' s coffee, and Resident 2 threw the stolen cup at Resident 1 and began to kick him. Resident 1 stated he sustained an injury to his right thumb. During a concurrent observation and interview on 10/30/24 at 12:35 PM, with the Director Of Nursing (DON), the facility ' s camera footage from 10/11/24 was reviewed. The DON stated the camera footage from 10/11/24, at 9:55 AM, displayed Resident 2 throwing a cup of coffee at Resident 1, Resident 2 kicking Resident 1, and staff immediately breaking up the altercation. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. During a review of Resident 6 ' s Admission Record, the admission record indicated Resident 6 was admitted to the facility on [DATE] with admitting diagnoses including major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), generalized muscle weakness, and history of broken left leg. During a review of Resident 6 ' s H&P, dated 5/28/24, the H&P indicated Resident 6 could make her needs known. During a review of Resident 6 ' s MDS, dated [DATE], the MDS indicated Resident 6 did not have cognitive impairments or disorganized thinking. The MDS further indicated Resident 6 required substantial to maximal assistance from staff with mobility while in bed and between surfaces. During a review of Resident 6 ' s COC, dated 10/26/24, the COC indicated Resident 6 was involved in an altercation with Resident 2 and three other residents. The COC indicated Resident 6 complained of severe pain to her left leg. During a review of Resident 2 ' s COC, dated 10/26/24, the COC indicated Resident 2 was approached and assaulted by four other residents while in the smoking patio. During a concurrent observation and interview on 10/29/24 at 11:36 AM, with Resident 6, Resident 6 stated that on an unspecified date, Resident 2 went into her room to steal her jar of instant coffee. Resident 6 stated that she confronted Resident 2, and Resident 2 emptied the coffee onto her bed. Resident 2 was teary-eyed while recounting the story. Resident 6 stated she told unidentified staff, and the staff told her she should lock up her belongings. While crying, Resident 6 stated, Why should I have to lock up my stuff?. Resident 6 stated she did not feel that her belongings were safe in the facility, and stated it happened multiple times. Resident 6 stated that during the altercation on 10/26/24, Resident 2 kicked her in her left leg causing severe pain. Resident 6 stated she did not feel safe in the facility with Resident 2 walking around. During an interview on 10/29/24 at 10:02 AM, with AS 2, AS 2 stated he was in the smoking patio on 10/26/24 when the resident-to-resident altercation between Resident 1, 2, 6, and 7 occurred. AS 2 stated he was unaware that Resident 1 and Resident 2 had a previous resident-to-resident altercation on 10/11/24, and stated he was not aware they needed to be kept separate from one another to prevent an additional altercation. AS 2 stated that after the resident-to-resident altercation on 10/26/24, Resident 2 was rushing to leave from the patio, and that the other residents involved stated Resident 2 tried to kick them. During an interview on 10/29/24 at 10:58 AM, with AS 3, AS 3 stated on 10/26/24, Resident 1 was attacked, but AS 3 could not recall the names of the residents involved at the time of the interview. AS 3 stated Resident 2 entered the patio by himself and went to lay down on a bench. AS 3 stated he did not know Resident 1 and Resident 2 had a previous altercation on 10/11/24. AS 3 stated that Resident 2 was approached by Resident 1 and other residents, and they began to hit Resident 2 on the arm and body. AS 3 stated that after the residents were separated, the residents told AS 2 the residents confronted Resident 2 because Resident 2 was stealing from them. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/29/24 at 11:20 AM, with Resident 1, Resident 1 stated the altercation on 10/26/24 was a planned confrontation because he and other residents were tired of Resident 2 stealing from them. Resident 1 stated they felt the facility was not doing enough to prevent Resident 2 from continuing to steal from them. Resident 1 stated he hit Resident 2 on the arm and stated Resident 2 kicked Resident 6 in the leg. Resident 1 stated Resident 2 did not have any direct supervision prior to the altercation on 10/26/24, and stated no staff stopped him from approaching Resident 2 before the altercation started. During an interview on 10/29/24 at 11:45 AM, with Resident 7, Resident 7 stated she confronted Resident 2 on 10/26/24 after their previous altercation on 10/10/24. Resident 7 stated she hit Resident 2 again on 10/26/24 because she was frustrated knowing Resident 2 was still in the facility, and that staff were not acting on his behavior of stealing from other residents. During an interview on 10/30/24 at 12:38 AM, with the DON, the DON stated staff were aware of Resident 2 ' s behavior of stealing from other residents, but his care plan had not been revised to address the stealing. The DON stated it was reasonable for the other residents to feel frustrated if they felt that their belongings were not safe, and stated their frustration could escalate to a physical altercation. During a review of the facility ' s P&P titled, Abuse Prevention and Management, dated 6/2024, the P&P indicated abuse included physical abuse (willful, deliberate infliction of injury), as well as misappropriation of resident property (wrongful, temporary, or permanent use of a resident ' s belongings without the resident ' s consent). The P&P indicated the facility was supposed to identify, correct, and intervene in situations where abuse and/or misappropriation of resident property was more likely to occur. The P&P indicated that in the event abuse or misappropriation of property occurred, the Administrator or their designee was supposed to provide a safe environment for the resident as indicated by the situation. The P&P further indicated that in the event the perpetrator was another resident, staff were supposed to separate the residents so that they did not interact with each other.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47286 Based on interview and record review, the facility failed to implement and revise the care plan interventions, initiated on 8/27/24, for one of eight sampled residents (Resident 2) to address his continued behavior of stealing residents food (Resident 1, Resident 6, and Resident 7). This deficient practice resulted in Resident 2 ' s continued thefts causing psychosocial distress for Resident 1, Resident 6, and Resident 7, and three resident-to-resident altercations that occurred on 10/10/24, 10/11/24, and 10/26/24. Findings: a. During a review of Resident 2 ' s Admission Record, the record indicated Resident 2 was admitted to the facility on [DATE]. Resident 2 ' s admitting diagnoses included a cognitive (ability to think and reason) communication deficit and schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 2 ' s History and Physical (H&P), dated 8/20/24, the H&P indicated Resident 2 could make his needs known, but could not make medical decisions. During a review of Resident 2 ' s Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 8/26/24, the MDS indicated Resident 2 had moderately impaired cognition (problems with a person's ability to think, learn, remember, use judgement, and make decisions). The MDS indicated Resident 2 also displayed inattention and disorganized thinking (unclear or illogical flow of ideas, unpredictable switching from subject to subject). The MDS further indicated Resident 2 could ambulate (walk) independently and needed help from staff to assist with functional cognition (cognitive skills required to complete those meaningful daily activities, directly related to behavior). During a review of Resident 2 ' s care plan titled, [Resident 2] has a behavior problem .increased agitation . attempting to take other residents snack and drinks, dated 8/27/24, the care plan indicated goals of care included Resident 2 having no further episodes of the behavior. Care plan interventions included monitoring behavior episodes and documenting the behaviors and their potential causes. Care plan interventions further included staff interventions as necessary to protect the rights and safety of others. There were no documented revisions to the care plan interventions. During an interview on 10/28/24 at 11:04 AM, with Activity Staff (AS) 1, AS 1 stated Resident 2 had a known history of attempting to steal things from other facility residents and staff. AS 1 stated Resident 2 recently stole drinks from the nurse ' s station, stole other residents ' coffee and water from their rooms, and stole another facility resident ' s instant noodles. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 10/28/24 at 11:35 AM, with Registered Nurse (RN) 1, Resident 2 ' s care plan titled, [Resident 2] has a behavior problem .increased agitation .attempting to take other residents snack and drinks, dated 8/27/24, was reviewed. RN 1 stated the care plan interventions indicated Resident 2 ' s behavior was supposed to be monitored and documented. RN 1 stated staff did not document when the behavior occurred. RN 1 stated staff were not keeping record of the frequency of the behavior or interventions taken to address Resident 2 ' s behavior. During an interview on 10/28/2024 at 12:14 PM, with Certified Nursing Assistant (CNA) 1, CNA 1 stated that on 10/11/24, Resident 2 attempted to steal a cannister of hot coffee from a coffee cart. CNA 1 stated that when she attempted to intervene, Resident 2 punched her in the face. During an interview on 10/29/24 at 10:02 AM, with AS 2, AS 2 stated he started working at the facility a week prior and heard from various facility residents and staff that Resident 2 had a habit of stealing from staff and residents. AS 2 further stated facility residents told him they were tired of Resident 2 stealing their belongings. During an interview on 10/29/24 at 10:58 AM, with AS 3, AS 3 stated that on 10/26/24 a physical altercation occurred where multiple facility residents approached Resident 2 and attacked him. AS 3 stated that after the altercation, multiple facility residents stated the altercation happened because they were tired of Resident 2 stealing their belongings and nothing being done about it. AS 3 further stated that housekeeping staff found items that belonged to other facility residents in Resident 2 ' s room while cleaning. During a concurrent interview and record review, on 10/29/24 at 12:40 PM, with the Director of Nursing (DON), Resident 2 ' s care plan titled, [Resident 2] has a behavior problem .increased agitation .attempting to take other residents ' snack and drinks, dated 8/27/24 was reviewed. The DON stated the facility staff were aware of Resident 2 ' s continued behavior of agitation and stealing other residents ' things, and stated the care plan did not have any revisions to address the continued behavior. The DON stated there should have been a care plan meeting to discuss and address Resident 2 ' s continued behavior and revise the care plan. The DON stated the facility was the residents ' home, and they should not have to lock up their food or beverages out of fear of them getting stolen. The DON stated staff were responsible for preventing Resident 2 from stealing. During a concurrent interview and record review on 10/30/24 at 12:38 PM, with the DON, Resident 2 ' s care plan titled, [Resident 2] has a behavior problem .increased agitation .attempting to take other residents ' snack and drinks, dated 8/27/24 was reviewed. The DON stated the care plan indicated staff were supposed to document Resident 2 ' s behavior of agitation and stealing and identify potential causes. The DON stated the purpose was to be able to track the behavior, report to the doctor, and revise care plan and stated staff were not implementing the care plan. The DON further stated it was reasonable for the facility residents to feel frustrated if they felt that their belongings were not safe, and stated their frustration could escalate to a physical altercation. The DON stated that if staff had revised and implemented the care plan to address Resident 2 ' s behaviors, the physical altercations that occurred on 10/10/24, 10/11/24, and 10/26/24 could have been avoided. b. During a review of Resident 1 ' s Admission Record, the record indicated Resident 1 was admitted to the facility on [DATE] with admitting diagnoses that included acquired absence of the right and left leg below the knee, and muscle wasting and atrophy (thinning of muscle mass). (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s H&P, dated 5/21/24, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1 ' s MDS, dated [DATE], the MDS indicated Resident 1 did not have any cognitive impairment or disorganized thinking. The MDS further indicated Resident 1 required a wheelchair and was dependent on staff to transfer between surfaces. During an interview on 10/29/24 at 11:20 AM, with Resident 1, Resident 1 stated that on multiple occasions Resident 2 came into his room and took food and beverages that belonged to him and his roommate. Resident 1 stated he and his roommate required wheelchairs, and they could not chase after Resident 1. Resident 1 stated staff were aware of Resident 2 ' s stealing and did not do anything about it. Resident 1 stated this made him very frustrated and angry. Resident 1 stated that staff ' s lack of action led him to confront Resident 1 on 10/11/24 when Resident 1 stole a coffee from another resident while on the patio. Resident 1 stated that when he approached Resident 2 on 10/11/24, Resident 2 threw the cup of coffee at him and kicked him, leading to a wound on Resident 1 ' s right hand. c. During a review of Resident 6 ' s Admission Record, the record indicated Resident 6 was admitted to the facility on [DATE] with admitting diagnoses including major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), generalized muscle weakness, and history of a broken left leg. During a review of Resident 6 ' s H&P, dated 5/28/24, the H&P indicated Resident 6 could make her needs known. During a review of Resident 6 ' s MDS, dated [DATE], indicated Resident 6 did not have cognitive impairments or disorganized thinking. The MDS further indicated Resident 6 required substantial to maximal assistance from staff with mobility while in bed and between surfaces. During an interview on 10/29/24 at 11:36 AM, with Resident 6, Resident 6 stated she had a jar of instant coffee in her room and Resident 2 went into her room to steal it. Resident 6 stated that when she confronted him, Resident 2 emptied the coffee onto her bed. Resident 2 was teary-eyed while recounting the story. Resident 6 stated she told facility staff and was told to lock up her belongings. While crying, Resident 6 stated, Why should I have to lock up my stuff?. Resident 6 stated she did not feel that her belongings were safe in the facility, and stated it happened multiple times. Resident 6 stated she did not feel safe in the facility with Resident 2 walking around. d. During a review of Resident 7 ' s Admission Record, the record indicated Resident 7 was admitted on [DATE]. And readmitted on [DATE]. Resident 7 ' s admitting diagnoses included major depressive disorder, generalized muscle weakness, and lack of coordination. During a review of Resident 7 ' s MDS, dated [DATE], indicated Resident 7 did not have cognitive impairments or disorganized thinking. The MDS further indicated Resident 7 required a wheelchair and was independent with mobility. (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/29/24 at 11:45 AM, with Resident 7, Resident 7 stated that on 10/10/24 she entered her room and saw Resident 2 holding her container of instant coffee that was stored in her bedside cabinet. Resident 7 stated Resident 2 ran into her bathroom, and she confronted him. Resident 7 stated she told Resident 2 the coffee belonged to her and Resident 2 replied, Yeah, I took it. So what?. Resident 7 stated this upset her and she hit Resident 2 in the face. Resident 7 stated she confronted Resident 2 again on 10/26/24 and hit him because she was frustrated to know Resident 2 was still in the facility and that staff were not acting on his behavior. During a review of the facility policy and procedure (P&P) titled Comprehensive Person-Centered Care Planning, dated 11/2018, the P&P indicated changes or updates to the resident ' s comprehensive care plan would be made based on the assessed needs of the resident, and indicated the comprehensive care plan was supposed to be reviewed and revised as appropriate or necessary. During a review of the facility P&P titled Personal Property, dated 7/2017, the P&P indicated it was the facility policy that staff take reasonable steps to protect residents ' personal property, and the facility was supposed to make every effort to maintain the security of the residents ' property while helping to create a home-like environment.