STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055167	A. Building B. Wing	12/18/2024

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47286 Based on observation, interview, and record review, the facility failed to ensure the facility's abuse prevention policy and procedure (P&P) was implemented for one of four sampled residents (Resident 9) when Certified Nursing Assistant (CNA) 1 failed to immediately report a verbal resident-to-resident altercation on 12/8/2024, between Resident 9 and Resident 10, to the supervising licensed nurse. This deficient practice resulted in Resident 9 being left in Room A with Resident 10, where Resident 10 then repeatedly struck Resident 9 in the face, and Resident 9 sustained pain to her head and face, and verbalized fear of further abuse. Findings: During a review of Resident 9's Admission Record, the admission record indicated Resident 9 was admitted to the facility on [DATE]. Resident 9's admitting diagnoses included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (one-sided muscle weakness), generalized muscle weakness, and polyosteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage). During a review of Resident 9's Minimum Data Set (MDS, a resident assessment tool), dated 11/12/2024, the MDS indicated Resident 9 had severe cognitive impairment (problems with a person's ability to think, learn, remember, use judgement, and make decisions). The MDS indicated Resident 9 could not move on her own and was dependent on staff for mobility while in and out of bed. During a review of Resident 10's Admission Record, the admission record indicated Resident 10 was originally admitted to the facility on [DATE] and was most recently readmitted on [DATE]. Resident 10's admitting diagnoses included anxiety disorder (a condition that causes excessive worry, fear, dread, and uneasiness), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), cognitive communication deficit, schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior). During a review of Resident 10's MDS, dated [DATE], the MDS indicated Resident 10 had moderate cognitive impairment. The MDS indicated Resident 10 could independently get in and out of bed and could walk around her room and the facility without requiring assistance from staff. (continued on next page)

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

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 9's Change of Condition (COC) Assessment, dated 12/8/2024, the COC assessment indicated an unspecified staff member reported to Registered Nurse (RN) 1 that Resident 9 was observed being repeatedly struck in the face by Resident 10. The COC assessment indicated RN 1 separated and assessed Resident 9 and Resident 10. During a review of Resident 9's assessment titled Neurological Flow Sheet , dated 12/8/2024 to 12/11/2024, the assessment indicated Resident 9 had a pain score of 3 (scale 1-10, with 10 being the worst pain) for 45 minutes after the altercation with Resident 10. During an interview on 12/16/2024 at 3:07 PM, with RN 1, RN 1 stated a CNA reported a physical altercation between Resident 9 and Resident 10. RN 1 stated she could not recall which CNA reported the altercation. RN 1 stated she immediately went to Room A after receiving report of the altercation. RN 1 stated upon arrival to Room A, Resident 9 was repeatedly stating she wanted Resident 10 to be kept away from her. RN 1 stated Resident 10 was still in Room A. RN 1 stated she did not recall any staff in Room A when she arrived. RN 1 stated that if a CNA observed or became aware of an incident of verbal or physical resident abuse, it was to be reported to her immediately. RN 1 stated prompt reporting by the CNA would allow necessary interventions to be carried out right away to ensure the safety of the residents. During an interview on 12/16/2024 at 3:33 PM, with Resident 9, Resident 9 stated Resident 10 approached her bedside and verbally threatened to hurt her and yelled at her when she refused to give Resident 10 her television remote. Resident 9 stated Resident 10 then hit her in the head multiple times after Resident 9 continued to refuse to give Resident 10 her television remote. Resident 9 stated Resident 10's hands were closed into fists, and stated it hurt when Resident 10 was hitting her. Resident 9 stated she sustained a headache after the incident occurred. Resident 9 stated the staff were aware Resident 10 was verbally threatened her and hit her, and stated it took a while for staff to remove Resident 10 from Room A. Resident 9 stated Resident 10 was no longer her roommate, but she was still scared Resident 10 would come back to hit her again. During an interview on 12/16/2024 at 2:22 PM, with CNA 1, CNA 1 stated that on 12/8/2024, in the late afternoon, she overheard a verbal altercation from outside Room A, between Resident 9 and Resident 10. CNA 1 stated she entered Room A and Resident 10 told her nothing happened. CNA 1 stated she then left Room A and overheard a second verbal altercation a few minutes later between Resident 9 and Resident 10 from the hallway. CNA 1 stated she entered Room A a second time and observed Resident 10 standing at Resident 9's bedside. CNA 1 stated she observed Resident 10 repeatedly hitting Resident 9 in the face. CNA 1 stated she told Resident 10 to stop hitting Resident 9 and told Resident 10 she was not allowed to hit Resident 9. CNA 1 stated she then left Room A and returned to patient care for another resident. CNA 1 stated she did not immediately report the altercations to her supervising licensed nurse. CNA 1 stated she overheard a third verbal altercation between Resident 9 and Resident 10 a few minutes later. CNA 1 stated she entered Room A a third time and observed Resident 10 at Resident 9's bedside. CNA 1 stated Resident 10 looked threatening and was planning to strike Resident 9 again. CNA 1 stated after the third altercation, she reported the observed abuse to Registered Nurse (RN) 1. CNA 1 stated abuse of any type was to be reported to the Charge Nurse or Registered Nurse immediately for the safety of the residents. CNA 1 stated she did not report immediately because Room A was not assigned to her care on the schedule. (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/18/2024 at 9:16 AM, with the Director of Staff Development (DSD), the DSD stated she was responsible for educating and training staff related to abuse prevention, identification, and reporting. The DSD stated all staff were responsible for the safety of all facility residents, regardless of the staff assignments. The DSD stated that if a CNA was aware of or directly witnessed an incident of abuse, the incident was to be reported to the LVN Charge Nurse or RN immediately. The DSD stated the task of reporting should not be delegated to another staff member. The DSD stated delayed reporting created a delay in the implementation of staff interventions to prevent further abuse from occurring. The DSD stated delayed reporting created additional opportunities for the aggressor to continue to hurt or harm the victim. During an interview on 12/18/2024 at 2:09 PM, with the Director of Nursing (DON), the DON stated that all facility staff were mandated reporters and were to report any incidents of abuse immediately. The DON stated it did not matter if the abuse involved residents that were not assigned to the staff member who witnessed the abuse. The DON stated the staff who observed the abuse was the staff member required to report it. The DON stated resident safety was a priority, and stated prompt reporting was important for prevention of further abuse. The DON stated residents involved in a resident-to-resident altercation were not to be left alone together following an incident of abuse. The DON stated that if left alone, another altercation could occur, with potential physical and psychosocial harm to the residents. During a review of the facility's job description titled Certified Nurse Assistant (CNA), undated, the job description indicated CNAs reported to the Charge Nurse. The job description indicated CNAs were to report any resident abuse to the Charge Nurse immediately. During a review of the facility's policy and procedure (P&P) titled Abuse Prevention and Management , dated 6/12/2024, the P&P indicated abuse included verbal and physical abuse. The P&P indicated staff were to identify, correct, and intervene in situations where abuse was likely to occur. During a review of the facility P&P titled Abuse Reporting and Interventions , dated 1/2024, the P&P indicated staff were to ensure that all incidents of resident abuse were reported promptly.

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47286 Based on interview and record review, the facility failed to ensure Certified Nursing Assistant (CNA) 1 had the appropriate compentencies and skills required when reporting resident abuse immediately after witnessing a resident-to-resident altercation between two of four sampled residents (Resident 9 and Resident 10). This failure placed Resident 9 at risk for continued abuse by Resident 10, and any resulting physical and/or psychosocial harm. Findings: During a review of Resident 9's Admission Record, the admission record indicated Resident 9 was admitted to the facility on [DATE]. Resident 9's admitting diagnoses included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (one-sided muscle weakness), generalized muscle weakness, and polyosteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage). During a review of Resident 9's Minimum Data Set (MDS, a resident assessment tool), dated 11/12/2024, the MDS indicated Resident 9 had severe cognitive impairment (problems with a person's ability to think, learn, remember, use judgement, and make decisions). The MDS indicated Resident 9 was dependent on staff for mobility while in and out of bed. During a review of Resident 10's Admission Record, the admission record indicated Resident 10 was originally admitted to the facility on [DATE] and was most recently readmitted on [DATE]. Resident 10's admitting diagnoses included anxiety disorder (a condition that causes excessive worry, fear, dread, and uneasiness), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), cognitive communication deficit, schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior). During a review of Resident 10's MDS, dated [DATE], the MDS indicated Resident 10 had moderate cognitive impairment. The MDS indicated Resident 10 could independently get in and out of bed and could walk around her room and the facility without requiring assistance from staff. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/16/2024 at 2:22 PM, with CNA 1, CNA 1 stated that on 12/8/2024, in the late afternoon, she overheard a verbal altercation from outside Room A, between Resident 9 and Resident 10. CNA 1 stated she entered Room A and Resident 10 told her nothing happened. CNA 1 stated she then left Room A and overheard a second verbal altercation a few minutes later between Resident 9 and Resident 10 from the hallway. CNA 1 stated she entered Room A a second time and observed Resident 10 standing at Resident 9's bedside. CNA 1 stated she observed Resident 10 repeatedly hitting Resident 9 in the face. CNA 1 stated she told Resident 10 to stop hitting Resident 9 and told Resident 10 she was not allowed to hit Resident 9. CNA 1 stated she then left Room A and returned to patient care for another resident. CNA 1 stated she did not report this altercation. CNA 1 stated she overheard a third verbal altercation between Resident 9 and Resident 10 a few minutes later. CNA 1 stated she entered Room A a third time and observed Resident 10 at Resident 9's bedside. CNA 1 stated Resident 10 looked threatening and was planning to strike Resident 9 again. CNA 1 stated she reported the observed abuse to Registered Nurse (RN) 1 after the third altercation. CNA 1 stated abuse of any type was to be reported to the Charge Nurse or Registered Nurse immediately for the safety of the residents. CNA 1 stated she did not report immediately because Room A was not assigned to her care on the schedule. During an interview on 12/16/2024 at 3:07 PM, with Registered Nurse (RN) 1, RN 1 stated that if a CNA were to observe or become aware of an incident of resident abuse, it was supposed to be reported to her immediately. RN 1 stated prompt reporting by the CNA would allow necessary interventions to be carried out right away to ensure the safety of the residents. During an interview on 12/18/2024 at 9:16 AM, with the Director of Staff Development (DSD), the DSD stated she was responsible for educating and training staff related to abuse prevention, identification, and reporting. The DSD stated all staff were responsible for the safety of all facility residents, regardless of the staff assignments. The DSD stated that if a CNA witnessed abuse, the incident was to be reported to the Charge Nurse or RN immediately. The DSD stated the task of reporting should not be delegated to another staff member. The DSD stated that delayed reporting created a delay in the implementation of staff interventions to prevent further abuse from occurring. The DSD stated delayed reporting created additional opportunities for the aggressor to continue to hurt or harm the victim. During a review of CNA 1's employee file, the records indicated CNA 1 completed abuse training with a post-test evaluation on 8/12/2024. During a review of CNA 1's employee file record titled [State] Abuse Post-Test, dated 8/12/2024, the record indicated CNA 1 correctly identifed that all incidents of abuse were to be reported immediately. During a review of the facility job description for a Certified Nurse Assistant (CNA), undated, the job description indicated CNAs reported to the Charge Nurse. The job description indicated CNAs were to report any resident abuse to the Charge Nurse immediately. During a review of the facility policy and procedure (P&P) titled Abuse Reporting and Interventions , dated 1/2024, the P&P indicated staff were to ensure that all incidents of resident abuse were reported promptly. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility P&P titled Resident-to-Resident Altercations , dated 11/2015, the P&P indicated that to protect the health and safety of facility residents, staff were to observe residents for aggressive or inappropriate behavior toward other residents, and if observed, report the behaviors promptly to the Charge Nurse, Director of Nursing Services, and Administrator. During a review of the facility P&P titled Resident Safety , dated 4/2021, the P&P indicated it was the facility policy to provide a safe and hazard free environment. The P&P indicated any facility staff who identified an unsafe situation was to immediately notify their supervisor or Charge Nurse.