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	01/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vernon Healthcare Center	1037 W. Vernon Avenue Los Angeles, CA 90037

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** Based on observation, interview, and record review the facility failed to: 1.Ensure a Change of condition ([COC] -a significant deviation from a patient baseline condition that requires immediate assessment and intervention to prevent further decline) form was initiated for Resident 3 with a skin rash (an area of irritation, inflamed, or damaged skin). 2. Provide treatment for Resident 3's skin rash. 3. Give a complete assessment report to General Acute Care Hospital ([GACH] -a hospital 24-hour medical services) regarding Resident 3's skin rash prior to admission. This deficient practice of not reporting, treating, or monitoring Resident 3's skin rash resulted in a diagnosis with scabies (highly contagious skin infestation).During a review of Resident 3's admission Record ([Face Sheet] front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 3 was initially admitted to the facility on [DATE] and was readmitted on [DATE]. Resident 3's diagnoses schizophrenia (a mental illness that is characterized by disturbances in thought), cardiomegaly (enlarged heart), and chronic kidney disease (progressive, irreversible loss of renal function). During a review of Resident 3's history and physical (H&P), dated 1/11/2026, the H&P indicated Resident 3 had fluctuated capacity to understand and make decisions. During a review of Resident 3's Minimum Data Set ([MDS] a resident assessment tool), dated 10/30/2025, the MDS indicated Resident 3's cognition (ability to learn, reason, remember, understand, and make decisions) was cognitively intact. The MDS indicated Resident 3 was independent (resident completes the activity by themself with no assistance from a helper) for eating, showering, and dressing. During a review of Resident 3's Progress Notes, dated 1/10/2026, the progress notes indicated resident was readmitted to the facility with generalized itchy rashes on her whole body. During a review of Resident 3's Skin Check, dated 1/10/2026, the skin check indicated Resident 3 had a rash on the abdomen, cervical region, and bilateral front and back thighs. The skin check indicated to track, and it was a new issue. During a review of Resident 3's Multidisciplinary Care Conference (IDT), dated 1/13/2026, the IDT had no indication of Resident 3's rash nor medical treatments for the itchy generalized rash. During a review of Resident 3's Skin Check, dated 1/15/2026, the skin check indicated Resident 3 had a rash on the abdomen, cervical region, and bilateral front and back thighs. The skin check indicated to track and needed to be reviewed. During a review of Resident 3's discharge summary titled, SNF/NF to Hospital Transfer Form, dated 1/15/2026, the discharge summary indicated Resident 3 had no skin issues. During a review of Resident 3's GACH records, dated 1/15/2026, the GACH records indicated Resident 3 had generalized rash on the whole body. During a review of Resident 3's GACH records, dated 1/17/2026, the GACH records indicated Resident 3 was on isolation precaution due to scabies. During a concurrent interview and record review on 1/27/2026 at 2:30 p.m., with Treatment Nurse (TN) 1, Resident 3's Progress Notes, dated 1/10/2026 was reviewed. The progress notes indicated resident was readmitted to the facility on [DATE] with generalized itchy rashes on her (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

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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	whole body. TN 1 stated there was no treatment initiated for the generalized rash. TN 1 stated this was a COC and the physician should have been notified so medical treatment could get started. During an interview on 1/27/2026 at 2:40 p.m., with TN 1, TN1 stated Resident 3 was not monitored for the generalized rash from 1/11/2026 to 1/15/2026. TN 1 stated the staff would not know if the rash was improving or getting worse. During an interview on 1/27/2026 at 2:45 p.m., with TN 1, TN 1 stated when Resident 3 was transferred to the hospital the licensed staff was to give a completed report which included the skin condition of the resident. TN 1 stated the hospital should know so they could properly accommodate the resident such as place her in isolation to prevent potential spread of infection. During a concurrent interview and record review on 1/28/2026 at 11:00 a.m., with Infection Preventionist (IP) Nurse, Resident 3's Progress Notes, dated 1/10/2026 was reviewed. The progress notes indicated resident was readmitted to the facility with generalized itchy rashes on her whole body. The IP Nurse stated Resident 3 should have been treated prophylactically (providing care aimed at preventing diseases, infections, or health issues before they occur or worsen) due to the generalized itchy rash. The IP Nurse stated for Resident 3 there was no COC done, she was not monitored for symptoms of the rash, and no treatment for the itching. The IP Nurse stated not following up with the symptoms could have placed the residents at risk for transmission (which a parasite spreads from an infected host to another) which could have resulted in a scabies outbreak. During a concurrent interview and record review on 1/28/2026 at 1:07 p.m., with Registered Nurse (RN) 1, Resident 3's discharge summary titled, SNF/NF to Hospital Transfer Form, dated 1/15/2026 was reviewed. The discharge summary indicated Resident 3 had no skin issues. RN 1 stated prior to transferring a resident to the hospital; we were to give a complete report. RN 1 stated this would include a detailed report of Resident 3's skin rash. RN 1 stated not notifying the hospital was poor communication on our part. RN 1 stated the poor communication had placed residents, staff, and the patients at the hospital at risk for the spread of infection. During a review of the facility's policy and procedures (P&P) titled, Prevention and Management of Scabies, dated 7/2020, the P&P indicated upon admission, residents will have skin, hair, and nail beds examined for signs and symptoms that might suggest scabies. The P&P indicated undiagnosed and untreated rash will be placed in isolation. The P&P indicated to notify the DON of any suspicious skin rash and to be treated according to the physician orders. During a review of the facility's P&P titled, Change of Conditions, dated 8/2022, the P&P indicated a licensed nurse will notify the resident physician a significant change in the resident's physical, mental, or a deterioration in health. The P&P indicated a summary of the condition change, an assessment, and SBAR. The P&P indicated a licensed nurse will communicate any changes in required interventions to the care team members involved in the resident's care. The P&P indicated a licensed nurse will document every 72 hours when there was a change in the resident's condition.