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	05/05/2026

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 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** Based on interview and record review, the facility failed to ensure an altercation between two of four sample residents (Resident 3 and Resident 4) was reported to the California Department of Public Health (CDPH) when Resident 4 hit and threw coffee at Resident 3's face.This deficient practice of not reporting the altercation to the CDPH within two hours delayed the investigation and placed Resident 3 at risk for further injuries. Findings:During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was admitted to the facility on [DATE]. Resident 3 diagnoses included schizophrenia (a mental illness that is characterized by disturbances in thought), anxiety (a mental health condition characterized by excessive, persistent, and uncontrollable worry that interferes with daily functioning), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest).During a review of Resident 3's History and Physical (H&P), dated 2/13/2026, the H&P indicated Resident 3 had the capacity to understand and make decisions.During a review of Resident 3's Minimum Data Sheet ([MDS]- a resident assessment tool), dated 2/19/2026, the MDS indicated Resident 3's cognition (ability to learn, reason, remember, understand, and make decisions) was intact. The MDS indicated Resident 3 required partial/moderate assistance (helper does less than half the effort for lifts or holds trunk or limbs and provides less than half the effort) by staff for toileting hygiene, showering, and dressing.During a review of Resident 3's Progress Notes, dated 4/26/2026, the Progress Notes indicated on 4/26/2026, Resident 3 reported Resident 4 had thrown a cup of coffee at her and hit her in the face. The Progress Notes indicated Resident 3 had slight redness to her chin and near her cheeks. The Progress Notes indicated Resident 3 reported pain 10 out of 10 (10 being severe pain) on a pain scale.During a review of Resident 3's Change of Condition (COC), dated 4/26/2026, the COC indicated on 4/26/2026, Resident 3 was in an altercation with Resident 4. The COC indicated Resident 3 had redness to the chin and cheek.During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was admitted to the facility on [DATE] and readmitted [DATE]. Resident 4's diagnoses included dementia (a progressive state of decline in mental abilities), anxiety (a mental health condition characterized by excessive, persistent, and uncontrollable worry that interferes with daily functioning), and metabolic encephalopathy (a brain dysfunction caused by systemic illness).During a review of Resident 4's MDS dated [DATE], the MDS indicated Resident 4's cognition was severely impaired. The MDS indicated Resident 4 required supervision (helper provides verbal cues as resident completes activity) from staff for toileting hygiene, showering, and dressing.During a telephone interview on 5/5/2026 at 2 p.m., with Registered Nurse (RN) 1, RN 1 stated she filled out an abuse reporting form and faxed it to the Ombudsman within two hours. RN 1 stated she did not get a confirmation after she faxed the form over to CDPH. RN 1 stated it had been ten days since the altercation and since CDPH did not receive notice of the incident, there was a delay for CDPH to investigate.During a concurrent interview and record review on 5/5/2026 at 3:30 p.m., with the Administrator (ADM), a letter faxed to CDPH, dated 5/4/2026 was reviewed. The letter indicated on 4/26/2026 an abuse reporting form was completed and faxed to the local Ombudsman and the local law enforcement was called. The letter indicated (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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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	there was an accidental oversight during the facility's reporting process, and the abuse reporting form was not sent to CDPH. The ADM stated CDPH was not notified and should have been notified within two hours of the altercation.During a review of the facility's policy and procedure (P&P) titled, Abuse Reporting & Investigations, dated 3/2018, the P&P indicated the facility will report all allegations of abuse as required by law and regulations to the appropriate agencies. The P&P indicated the Administrator, or designed representative will notify CDPH by telephone and in writing 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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure Certified Nursing Assistant (CNA) 1 was within three to five feet ([ft.] - unit of length) for one sample resident (Resident 2) who was placed on one-to-one (1:1, close supervision) monitoring.This deficient practice of CNA 2 not standing three to five feet of Resident 2 had the potential for the resident to have another altercation.Findings:During a review of Resident 2's admission Record (front page of the chart that contains a summary of basic information about the resident), the admission Record indicated Resident 2 was admitted to the facility on [DATE] and readmitted [DATE]. Resident 2 diagnoses included schizophrenia (a mental illness that is characterized by disturbances in thought), anxiety (a mental health condition characterized by excessive, persistent, and uncontrollable worry that interferes with daily functioning), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest).During a review of Resident 2's History and Physical (H&P), dated 3/6/2026, the H&P indicated, Resident 2 could make needs known but could not make medical decisions.During a review of Resident 2's Minimum Data Sheet ([MDS]- a resident assessment tool), dated 3/13/2026, the MDS indicated Resident 2's cognition (ability to learn, reason, remember, understand, and make decisions) was severely impaired. The MDS indicated Resident 2 had the potential for hallucinations (perceptual experiences in the absence of real external sensory stimuli). The MDS indicated Resident 2 required partial/moderate assistance (helper does less than half the effort for lifts or holds trunk or limbs and provides less than half the effort) by staff for toileting hygiene, showering, and dressing.During a review of Resident 2's Change of Condition (COC), dated 5/1/2026, the COC indicated on 5/1/2026, Resident 2 had become physically aggressive and had struck other residents and was placed on one-to-one supervision.During a review of Resident 2's care plan titled, Resident had Episode of Aggressive Combative Behavior towards other Residents related to Schizophrenia, dated 5/1/2026, the care plan indicated to have a one-to-one close visual monitoring.During a review of Resident 2's physician orders titled, Order Summary Report, dated 5/3/2026, the Order Summary Report indicated Resident 2 was to have a one-to-one sitter for visual monitoring related to resident-to-resident altercation for seven days.During a concurrent observation and interview on 5/4/2026 at 11:06 a.m., with Activities Assistant (AA) 1, on the outside patio, Resident 2 was observed sitting between two other residents. Resident 2 was within arm's reach of the other residents. AA 1 stated CNA 1 was too far from Resident 2 and should be no more than three to five feet away from Resident 2. AA 1 stated one to one supervision was to prevent Resident 2 from another altercation.During a concurrent observation and interview on 5/4/2026 at 11:13 a.m., with CNA 1, on the outside patio, Resident 2 was observed seated between two residents. Resident 2 was within arm's reach (the physical distance a person can extend their arm to touch or grab an object without moving their feet) of the residents. CNA 2 was sitting in a chair looking at his phone and was approximately 10 feet away from Resident 2. CNA 1 stated he was Resident 2's assigned one-to-one sitter. CNA 1 stated he was seated away from Resident 2 because he wanted to keep his distance from the cigarette smoke.During a concurrent observation and interview on 5/4/2026 at 4 p.m., with the Maintenance Supervisor, observed the Maintenance Supervisor measure the distance from chair (Resident 2) to chair (CNA 1). The distance measured 11 and 1/2 feet. The Maintenance Supervisor stated the distance was greater than five feet.During an interview on 5/5/2026 at 8:50 a.m., with the Administrator (ADM), the ADM stated CNA 1 was nearly 12 feet away from Resident 2. The ADM stated CNA 1 was too far away from Resident 2 and would not be able to stop him in time from hitting other residents that were sitting next to him.During a review of the facility's policy and procedure (P&P) titled, Resident Supervision, dated 10/2023, the P&P indicated to ensure that adequate supervision was provided to residents to prevent accidents.During a review of the facility's P&P (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	titled, Sitters, dated 1/2024, the P&P indicated the facility will orient the sitter regarding safety practices, duties, and responsibilities of the sitter.During a review of the facility's lesson plan titled, One to One Supervision, dated 2/18/2025, the lesson plan indicated One-to-One Supervision indicated all staff have the responsibility to help prevent resident to resident altercations. The One-One Supervision indicated staff doing one-to-one duty were to maintain a safe distance of three to five feet.