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	05/06/2026

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 observation, interview, and record review, the facility failed to follow its Policy and Procedure (P&P) titled, Abuse- Reporting and Investigations which indicated the facility will report injuries of unknown source (bodily harm that cannot be explained) to the California Department of Public Health (CDPH) within two hours, for one of four sampled residents (Resident 1) when Resident 1 was found with a wound to her right forearm on 4/30/2026. This failure had the potential to result in a delay in the investigation by the CDPH and placed Resident 1 at risk for neglect and abuse. Findings:During a record review of Resident 1's admission Record, the admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE]. The admission Record indicated Resident 1's diagnoses included type 2 diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevation periods of emotional highs), schizophrenia (a mental illness that is characterized by disturbances in thought), hypertension (high blood pressure) and anemia (a condition where the body does not have enough healthy red blood cells).During a review of Resident 1's history and physical (H&P) dated 3/7/2026, the H&P indicated Resident 1 had cognitive (ability to think and reason) impairment.During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 3/3/2026, the MDS indicated the resident was dependent (helper does all of the effort) for dressing, personal hygiene, showering, and transfers in and out of bed. During a review of Resident 1's Progress Note dated 4/30/2026 at 12:30 a.m., the Note indicated Resident 1 was found with an injury of unknown origin, and complained of pain level 10 out of 10 (pain scale reference: 0=no pain, 1-4=mild pain, 5-7=moderate pain, 8-9=severe pain, 10=excruciating pain). The Note indicated emergency medical services were activated, and the resident was transferred via ambulance to the General Acute Care Hospital (GACH). During a concurrent observation and interview on 5/4/2026 at 10:56 a.m., with Resident 1 in Resident 1's room, the resident was observed with gauze wrapped around her forearm. Resident 1 stated she did not know what happened to her arm and was unable to recall whether anyone had injured her arm.During a concurrent observation and interview on 5/4/2026 at 11:00 a.m., with Licensed Vocational Nurse (LVN) 2 in Resident 1's room, LVN 2 unwrapped Resident 1's right forearm gauze and observed Resident with a quarter-sized open wound that had exposed pink and red tissue. Resident 1 was also observed with another wound that had exposed reddened skin and dried blood, approximately 2 inches x 1 inch wide in size. LVN 2 stated facility staff did not know how the resident acquired the wound.During an interview on 5/4/26 at 3:39 p.m. with the Administrator (Admin), the Admin stated she did not report Resident 1's injury (of unknown source) to the CDPH because she was not made aware until this day (5/4/2026). During interviews on 5/6/2026 at 9:21 a.m. and 5/6/2026 at 3:15 p.m., with the Director of Nursing (DON), the DON stated Registered Nurse (RN) 1 notified her on 4/30/2026 that Resident 1 was sent to the GACH for a wound on her right arm. The DON stated Resident 1's wound was considered an injury of unknown origin because it was not known how the resident sustained the injury which required treatment at the GACH. The DON stated (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	the incident should have been reported to the State Agency within two hours of the facility being made aware of it. She did not report the incident because she did not know how it occurred. The DON stated it was important to report injuries of unknown origin for residents' safety. During a phone interview on 5/6/2026 at 12:32 p.m., with RN 1, RN 1 stated (on 4/30/2026) an unidentified CNA informed him about Resident 1's injury to the right forearm. RN 1 stated Resident 1 could not state how she got the wound. RN 1 stated he reported the incident to the DON and the Physician. Resident 1 was sent to the GACH for evaluation and treatment. During a review of the facility's P&P titled, Abuse- Reporting and 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 facility promptly reports and thoroughly investigates allegations of abuse, mistreatment, neglect or injuries of unknown source. The P&P indicated Administrator, or designed representative will notify the CDPH by telephone and in writing within two (2) hours if initial report.

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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** Based on observation, interview, and record review, the facility failed to thoroughly investigate an injury of unknown origin (bodily harm that cannot be explained) for one of four sampled residents (Resident) 1, when Resident 1 was found with a wound to her right forearm on 4/30/2026.This failure had the potential to result in unidentified abuse and placed Resident 1 at risk for continued abuse and injury. Findings:During a record review of Resident 1's admission Record, the admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE]. The admission Record indicated Resident 1's diagnoses included type 2 diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevation periods of emotional highs), schizophrenia (a mental illness that is characterized by disturbances in thought), hypertension (high blood pressure) and anemia (a condition where the body does not have enough healthy red blood cells).During a review of Resident 1's history and physical (H&P) dated 3/7/2026, the H&P indicated Resident 1 had cognitive (ability to think and reason) impairment.During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 3/3/2026, the MDS indicated the resident was dependent (helper does all of the effort) for dressing, personal hygiene, showering, and transfers in and out of bed. During a review of Resident 1's Progress Note dated 4/30/2026 at 12:30 a.m., the Note indicated Resident 1 was found with injury of unknown origin, with complaints of pain level 10 out of 10 (pain scale reference: 0=no pain, 1-4=mild pain, 5-7=moderate pain, 8-9=severe pain, 10=excruciating pain). The Note indicated emergency medical services were activated, and the resident was transferred via ambulance to the General Acute Care Hospital (GACH).During a concurrent observation and interview on 5/4/2026 at 10:56 a.m., with Resident 1 in Resident 1's room, the resident was observed with gauze wrapped around her forearm. Resident 1 stated she did not know what happened to her arm and was unable to recall whether anyone had injured her arm.During a concurrent observation and interview on 5/4/2026 at 11:00 a.m., with Licensed Vocational Nurse (LVN) 2 in Resident 1's room, LVN 2 unwrapped Resident 1's right forearm gauze and observed Resident with a quarter-sized open wound that had exposed pink and red tissue. Resident 1 was also observed with another wound that had exposed reddened skin and dried blood, approximately 2 inches x 1 inch wide in size. LVN 2 stated facility staff did not know how the resident acquired the wound.During an interview on 5/4/26 at 3:39 p.m. with the Administrator (Admin), the Admin stated she did not investigate Resident 1's injury (of unknown source) because she was not made aware until this day (5/4/2026). During interviews on 5/6/2026 at 9:21 a.m. and 5/6/2026 at 3:15 p.m., with the Director of Nursing (DON), the DON stated Registered Nurse (RN) 1 notified her on 4/30/2026 that Resident 1 was sent to the GACH for a wound on her right arm of unknown origin. The DON stated Resident 1's wound was considered an injury of unknown origin because it was not known how the resident sustained the injury which required treatment at the GACH. The DON stated she interviewed nurses and CNAs about Resident 1's arm injury, however no one knew how the resident was injured. The DON was unable to provide the names of the staff interviewed nor proof of her investigation. The DON stated she did not investigate further because she did not think another resident caused the injury. The DON stated it was important to thoroughly investigate an injury of unknown origin to keep residents safe, to determine if the incident was preventable and whether anyone should be held accountable for it. During a review of the facility's Policy and Procedure titled, Injuries of Unknown Origin-Investigation dated 11/18/2015, the P&P indicated an injury of unknown source is defined as an injury that meets both of the following conditions: The source of the injury was not observed by any person, or the source of the injury could not be explained by the resident; andThe injury is suspicious because of the extent of the injury, the location of the injury or the number of injuries observed at one particular time. The P&P indicated (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	unexplained injuries are promptly and thoroughly investigated by the DON and/or other staff person appointed by the Administrator, to ensure the resident safety is not compromised and action is taken whenever possible, to avoid future occurrences. During a review of the facility's P&P titled, Abuse Reporting and Investigations dated 3/2018, the P&P indicated the facility promptly thoroughly investigates allegations of resident abuse, mistreatment, neglect or injuries of unknown source. The P&P indicated the Administrator will provide a written report of the results of the investigation and appropriate action taken to the CDPH, within five working days of the reported allegation. During a review of the facility's P&P titled, Abuse and Neglect dated 12/22/2021, the P&P indicated, when the Administrator (or designated representative) receives a report of an incident or suspected incident of Resident abuse, neglect or injuries of an unknown source, the Administrator (or designated representative) will immediately initiate an investigation. The Administrator (or designated representative) conducting the investigation will interview individuals who may have information relevant to the allegation or suspected crime. Individuals who may have information relevant to the allegation are the resident, witnesses to the incident, other residents, roommates, family, visitors etc.