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	06/30/2026

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 follow its Policy and Procedure (P&P) titled, Abuse Prevention and Management which indicated the Administrator (ADM) or designated representative will report all injuries of unknown origin to the California Department of Public Health (CDPH) Licensing and Certification within two hours, for one of three sampled residents (Resident 1), when Resident 1 sustained nasal (nose) fractures (broken bone), frontal scalp hematoma (collection of blood that forms in the tissue caused by a broken blood vessel that could be due to trauma or injury) and a laceration (cut or tear in the skin) to the Resident's left eyebrow on 6/9/2026. This failure had the potential to delay the investigation by the CDPH and placed Resident 1 at risk for continued abuse, neglect and injuries. Findings: During a 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 chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing), dysphagia (difficulty in swallowing), difficulty in walking, muscle weakness, schizophrenia (a mental illness that is characterized by disturbances in thought), dementia (a progressive state of decline in mental abilities), and depression (a mental health condition that makes a person feel very sad, hopeless, or uninterested in things they normally enjoy). During a review of Resident 1's Minimum Data Sheet (MDS, a resident assessment tool) dated 8/27/2025, the MDS indicated Resident 1 had moderate cognitive impairment. The MDS indicated Resident 1 was dependent on staff (Helper does all the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) for Activities of Daily Living such as bed mobility (the ability to roll from lying on back to left and right side, and return to lying on back on the bed), sit to lying (the ability to move from sitting on side of bed to lying flat on the bed), lying to sitting on side of the bed (the ability to move from lying on the back to sitting on the side of the bed and with no back support), chair to bed transfers and personal hygiene. During a review of Resident 1's Change in Condition (COC) Evaluation dated 6/9/2026, the COC indicated Resident 1 was seen with large amount of blood on person, and surrounding area. Resident 1 had a laceration to the left eye area that was actively bleeding. Pressure was applied to site of injury, and the Resident was taken to the General Acute Care Hospital (GACH). During a review of Resident 1's Computed Tomography (CT) of the head and maxillofacial (face scan) dated 6/10/2026, the CT indicated Resident 1 had an acute (new) comminuted fracture (occurs when a bone shatters or breaks into three or more fragments) at the distal tip of the right and left nasal bone with soft tissue swelling, as well as a left frontal scalp hematoma with soft tissue laceration. During a review of Resident 1's GACH Reexamination/Revaluation Note dated 6/10/2026, the Note indicated Resident 1 underwent a repair of a two cm laceration of the left eyebrow and had 5 sutures (used to stitch and close wounds or lacerations) placed. During an interview on 6/22/2026 at 3:12 p.m., with Licensed Vocational Nurse (LVN) 2, LVN 2 stated (on 6/9/2026) when he arrived for his shift at approximately 11:00 p.m., he saw Resident 1 sitting on his bed with blood on his face, bed, clothes and on the floor. LVN 2 stated he did (continued on next page)

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not witness how Resident 1 sustained the injury and Resident 1 could not tell him (LVN 2) how he (Resident 1) sustained the injury. LVN 2 stated there were no staff present in Resident 1's room and Resident 1's roommates were asleep when he saw the Resident. During an interview on 6/22/2026 at 4:45 p.m., with Registered Nurse (RN) 2, RN 2 stated, on 6/9/2026 at approximately 11:00 p.m., LVN 2 notified her about Resident 1's injury. RN 2 stated she (RN 2) saw Resident 1 sitting on his bed, with blood on his forehead. RN 2 stated she asked Resident 1 what happened, and the Resident could not respond. During interviews on 6/23/2026 at 10:30 a.m. and 12:17 p.m., with the Director of Nursing (DON), The DON stated on 6/9/2026, LVN 2 found Resident 1 on his bed with blood on his face and the floor. Resident 1 sustained fractures of the left and right nasal bones, a left frontal scalp hematoma with soft tissue laceration to left side of face. The DON stated all injuries of unknown origin should be reported to the CDPH within 2 hours. She did not immediately notify CDPH because she assumed Resident 1's injuries were due to the Resident falling. The DON also stated no one saw Resident 1 fall, staff did not find Resident 1 on the floor, and Resident 1 could not verbalize the cause of the injuries. During an interview on 6/30/2026 with the ADM, the ADM stated she was notified of Resident 1's injuries on 6/10/2026. The incident was not reported within two hours to the CDPH because the injuries were due to a fall. The ADM stated staff did not witness Resident 1 falling. During a record review of the facility's policy and procedure (P&P) titled, Abuse Prevention and Management, dated 6/12/2024, the P&P indicated the facility commits to identifying, correcting, and intervening in situations involving abuse, neglect or injuries of unknown source. The P&P indicated 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; and the injury is suspicious because of the extent of the injury, the location of the injury, or the incidents of injury over time. The P&P indicated the Administrator, or designated representative will send a written report to the CDPH Licensing and Certification 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 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 interview and record review, the facility failed to thoroughly investigate an injury of unknown origin for one of three sampled residents (Resident 1) when Resident 1 sustained nasal (nose) fractures (broken bone), frontal scalp hematoma (collection of blood that forms in the tissue caused by a broken blood vessel that could be due to trauma or injury) and a laceration (cut or tear in the skin) to the Resident's left eyebrow on 6/9/2026. This failure had the potential to result in unidentified abuse and neglect towards Resident 1 and could negatively affect the Resident's well-being. Findings: During a 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 chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing), dysphagia (difficulty in swallowing), difficulty in walking, muscle weakness, schizophrenia (a mental illness that is characterized by disturbances in thought), dementia (a progressive state of decline in mental abilities), and depression (a mental health condition that makes a person feel very sad, hopeless, or uninterested in things they normally enjoy). During a review of Resident 1's Minimum Data Sheet (MDS, a resident assessment tool) dated 8/27/2025, the MDS indicated Resident 1 had moderate cognitive impairment. The MDS indicated Resident 1 was dependent on staff (Helper does all the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) for activities of daily living such as bed mobility (the ability to roll from lying on back to left and right side, and return to lying on back on the bed), sit to lying (the ability to move from sitting on side of bed to lying flat on the bed), lying to sitting on side of the bed (the ability to move from lying on the back to sitting on the side of the bed and with no back support), chair to bed transfers and personal hygiene. During a review of Resident 1's Change in Condition (COC) Evaluation dated 6/9/2026, the COC indicated Resident 1 was seen with large amount of blood on person, and surrounding area. Resident 1 had a laceration to the left eye area that was actively bleeding. Pressure was applied to site of injury, and the Resident was taken to the General Acute Care Hospital (GACH). During a review of Resident 1's Computed Tomography (CT) of the head and maxillofacial (face scan) dated 6/10/2026, the CT indicated Resident 1 had an acute (new) comminuted fracture (occurs when a bone shatters or breaks into three or more fragments) at the distal tip of the right and left nasal bone with soft tissue swelling, as well as a left frontal scalp hematoma with soft tissue laceration. During a review of Resident 1's GACH Reexamination/Revaluation Note dated 6/10/2026, the Note indicated Resident 1 underwent a repair of the two cm laceration of the left eyebrow and had 5 sutures (used to stitch and close wounds or lacerations) placed. During an interview on 6/22/2026 at 3:12 p.m., with Licensed Vocational Nurse (LVN) 2, LVN 2 stated (on 6/9/2026) when he arrived for his shift at approximately 11:00 p.m., he saw Resident 1 sitting on his bed with blood on his face, bed, clothes and on the floor. LVN 2 stated he did not witness how Resident 1 sustained the injury and Resident 1 could not tell him (LVN 2) how he (Resident 1) sustained the injury. LVN 2 stated there were no staff present in Resident 1's room and Resident 1's roommates were asleep when he saw the Resident. LVN 2 stated no one at the facility had interviewed him as part of an investigation of the incident regarding Resident 1's injuries. During an interview on 6/22/2026 at 4:13 p.m., with Certified Nurse Assistant (CNA) 1, CNA 1 stated on 6/9/2026 at 10:30 p.m.- 11:00 p.m., she was assigned as a 1:1 (one staff delegated to supervise a single Resident) hourly sitter for Resident 1. CNA 1 stated no one at the facility had interviewed her as part of an investigation of the incident regarding Resident 1's injuries. During interviews on 6/23/2026 at 10:30 a.m. and 12:17 p.m., with the Director of Nursing (DON), The DON stated on 6/9/2026, Resident 1 was found on his bed by LVN 2, with blood on his face and the floor. Resident 1 sustained fractures of the left and right nasal bones, a left frontal scalp hematoma with soft tissue laceration to left side of face. The DON stated no one saw Resident 1 fall (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and Resident 1 could not verbalize the cause of the injuries. The DON stated she did not interview other Residents, including Resident 1's roommates nor staff who worked 6/9/2026 during the evening (3:00 p.m.- 11:00 p.m.) shift regarding the incident. She did not further investigate the incident because she had no reason to question whether another Resident or staff caused Resident 1's injuries. During a review of the facility's Policy and Procedure (P&P) titled, Injuries of Unknown Origin-Investigation dated 11/18/2015, the P&P indicated all unexplained injuries are promptly and thoroughly investigated by the Director of Nursing and/or other staff person appointed by the Administrator to ensure that Resident safety is not compromised and action is taken whenever possible, to avoid future occurrences. 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; and the injury is suspicious because of the extent of the injury. During a record review of the facility's P&P titled, Abuse Prevention and Management dated 6/12/2024, the P&P indicated the facility commits to identifying, correcting, and intervening in situations involving abuse, neglect or injuries of unknown source. The P&P indicated the Administrator, or designated representative will initiate an investigation immediately and will provide for a safe environment for the resident. The P&P indicated the Administrator or designated representative conducting the investigation will interview individuals who may have information relevant to the allegation.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement Resident 1's Care Plan titled, (Resident 1) was at risk for unsafe behaviors and impaired safety awareness related to schizophrenia (a mental illness that is characterized by disturbances in thought), encephalopathy (disease or damage that affects the brain), cognitive (ability to think and reason) impairment, akathisia (movement disorder) and behavioral disturbances as evidenced by agitation, restlessness, confusion, poor judgment.and ongoing need for 1:1(one to one, when one staff member is assigned to directly monitor no more than one resident. The staff shall stay within very close proximity to ensure constant supervision and immediate intervention if needed for safety reasons) monitoring for safety, which indicated the facility will maintain 1: 1 monitoring every shift to promote Resident safety and prevent unsafe behaviors. This failure resulted in Resident 1 sustaining injuries of unknown origin (an injury that was not observed by any person, or the source of the injury could not be explained by the resident and the injury is suspicious because of the extent of the injury.) and was transferred to a General Acute Care Hospital for evaluation and treatment on 6/9/2026. Findings: During a 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 chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing), dysphagia (difficulty in swallowing), difficulty in walking, muscle weakness, schizophrenia (a mental illness that is characterized by disturbances in thought), dementia (a progressive state of decline in mental abilities), and depression (a mental health condition that makes a person feel very sad, hopeless, or uninterested in things they normally enjoy). During a review of Resident 1's Minimum Data Sheet (MDS, a resident assessment tool) dated 8/27/2025, the MDS indicated Resident 1 had moderate cognitive impairment. The MDS indicated Resident 1 was dependent on staff (Helper does all the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) for activities of daily living such as bed mobility (the ability to roll from lying on back to left and right side, and return to lying on back on the bed), sit to lying (the ability to move from sitting on side of bed to lying flat on the bed), lying to sitting on side of the bed (the ability to move from lying on the back to sitting on the side of the bed and with no back support), chair to bed transfers and personal hygiene. During a review of Resident 1's Change in Condition (COC) Evaluation dated 6/9/2026, the COC indicated Resident 1 was seen with large amount of blood on person, and surrounding area. Resident 1 had a laceration to the left eye area that was actively bleeding. Pressure was applied to site of injury, and the Resident was taken to the GACH. During an interview on 6/22/2026 at 3:12 p.m., with Licensed Vocational Nurse (LVN) 2, LVN 2 stated (on 6/9/2026) when he arrived for his shift at approximately 11:00 p.m., he saw Resident 1 sitting on his bed with blood on his face, bed, clothes and on the floor. LVN 2 stated he did not witness how Resident 1 sustained the injury and Resident 1 could not tell him (LVN 2) how he (Resident 1) sustained the injury. LVN 2 stated there were no staff present in Resident 1's room and Resident 1's roommates were asleep when he saw the Resident. LVN 2 also stated Resident 1 had a 1:1 sitter on previous shifts and did not have a 1:1 sitter that evening shift (on 6/9/2026 3:00 p.m.-11:00 p.m.). During an interview on 6/22/2026 at 4:13 p.m., with the Certified Nurse Assistant (CNA) 1, CNA 1 stated she was assigned as Resident 1's 1:1 hourly sitter on 6/9/2026 from 10:30 p.m. to 11:00 p.m. CNA 1 stated she last saw Resident 1 at 10:45 p.m. She changed Resident 1's shorts, then she left the room and did not return to Resident 1 before reporting off duty at 11:00 p.m. During concurrent interviews and record review on 6/23/2026 at 10:30 a.m. and 6/30/2026 at 10:40 a.m., with the Director of Nursing (DON), Resident 1's Care Plan titled, (Resident 1) was at risk for unsafe behaviors and impaired safety awareness related to schizophrenia, cognitive impairment, akathisia (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and behavioral disturbances as evidenced by agitation, restlessness, confusion, poor judgment.and ongoing need for 1:1 monitoring for safety dated 5/6/2026 was reviewed. The DON stated Resident 1's Care Plan indicated to provide 1:1 monitoring for the Resident's behaviors such as restlessness, agitation and poor judgment. The DON stated a 1:1 sitter was assigned to Resident 1 on 6/9/2026 during the 7:00 a.m.- 3:00 p.m. shift and was changed by her (the DON) to a 1:1 hourly sitter assignment to spot check the Resident as needed during the 3:00 p.m.- 11:00 p.m. shift. A 1:1 sitter assigned to the resident was expected to stay with the resident the entire shift for the safety of the resident or staff. A 1:1 hourly sitter was expected to check Resident 1 every ten to fifteen minutes and was not required to remain in Resident 1's room continuously during the shift. The DON stated Resident 1's care plan, indicated to provide ongoing one-to-one monitoring for the Resident's safety, and the facility should have continued the 1:1 sitter (not hourly) on 6/9/2026 during the 3:00 p.m. to 11:00 p.m. shift. The DON also stated there was no documentation to indicate 1:1 monitoring was provided to Resident 1. During a record review of the facility's policy and procedure (P&P) titled, Resident Safety dated 4/15/2021, the P&P indicated the facility is committed to identify circumstances that pose a risk for the safety of and wellbeing of residents. The Interdisciplinary Care Team (a group of healthcare professionals who work together to manage the Resident's care) will establish a person-centered observation or monitoring systems for the Resident to address the identified risk factors. To observe the safety and wellbeing of the Residents, a Resident check will be made at least every two hours around the clock by nursing service personnel, and the person-centered care plan may require more frequent safety checks. During a record review of the facility's P&P titled, Person-Centered Care Planning dated 5/22/2025, the P&P indicated the facility must implement a comprehensive person-centered care plan for each resident consistent with the resident rights to meet a resident's medical, nursing, and mental and psychosocial needs.