

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055167	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/08/2026
NAME OF PROVIDER OR SUPPLIER Vernon Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of four sampled residents (Resident 1) was free from physical abuse by failing to protect Resident 1 from a physically aggressive resident (Resident 2), when Resident 2 physically abused Resident 1. This deficient practice resulted in Resident 1 being physically abused by Resident 2. Resident 1 sustained right eye injury after being struck in the face, requiring emergency transfer to a General Acute Care Hospital (GACH). Resident 1 underwent emergency surgical repair (an operative procedure to treat traumatic damage to the eye and surrounding structures, preserve vision, restore the eye's anatomy and function, relieve pressure, and promote healing) of the right eye and remained hospitalized from [DATE] through 7/1/2026. Findings: During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility of 5/23/2026. Resident 2's diagnoses included bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), and psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality). During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool), dated 5/30/2026, the MDS indicated Resident 2's cognitive skills for daily decision making was intact (ability to think and reason). The MDS indicated Resident 2 required moderate (helper does less than half the effort) assistance from staff for activities of daily living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 2's care plan titled Physically Aggressive, initiated 5/24/2026, and revised 6/19/2026, the care plan indicated staff were to provide close visual monitoring and one-to-one (1:1) sitter supervision (an assigned staff member who always remains within arm's length or visual range of the resident). During a review of Resident 2's physician order, dated 6/19/2026, the physician order indicated 1:1 sitter for continuous visual monitoring due to assaultive (physically aggressive) behaviors. During a review of Resident 2's physician order, dated 6/22/2026, the physician order indicated Resident 2 was to remain on 1:1 supervision due to an altercation (a physical or angry confrontation) and aggressive behaviors. During a review of Resident 2's Situation, Background, Assessment, Recommendation (SBAR- a communication tool used by healthcare workers when there is a change of condition among the residents), dated 6/28/2026 at 1:45 p.m., the SBAR indicated Resident 2 struck Resident 1. Resident 2's hands were assessed and noted with minor blood splatter and scratches on the right arm. 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]. Resident 1's diagnoses included schizophrenia (a mental illness that is characterized by disturbances in thought), bipolar disorder and diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar (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 0600 Level of Harm - Actual harm Residents Affected - Few	control and poor wound healing). During a review of Resident 1's MDS, dated [DATE], the MDS indicated Resident 1's cognitive skills for daily decision making were severely impaired. The MDS indicated Resident 1 was dependent (helper does all the effort) on staff for ADLs. During a review of Resident 1's SBAR, dated 6/28/2026 at 1:38 p.m., the SBAR indicated on 6/28/2026, an unidentified Certified Nursing Assistant (CNA) observed Resident 1 lying in bed bleeding from the face and right eye. Resident 1's right eye was bulging (eyeball protrusion). Resident 1 was transferred to the general acute care hospital (GACH) for evaluation and treatment. During a review of Resident 1's GACH emergency room (ER) report, dated 6/28/2026, the report indicated Resident 1 had a right eye injury which included a prolapsed right eye (abnormal forward displacement of the eye) with diffused 360-degree hemorrhagic chemosis (severe swelling of the membrane covering the white part of the eye, with bleeding around the entire eye), shallow anterior chamber (a reduced space between the cornea the clear front surface of the eye and the iris the colored part, which indicate significant eye injury), inferior hyphema (blood collecting at the bottom of the eye), and a hard globe (an abnormal eyeball indicating significant injury). The report indicated Resident 1 required evaluation and treatment by an ophthalmologic (a medical doctor specializing in eye disease and eye injury), including erythromycin ophthalmic medication (an antibiotic eye medication used to treat or prevent infection). During a review of Resident 1's Computed Tomography scan ([CT] process of taking pictures of body parts to diagnose and treat disease or injury), dated 6/28/2026, the CT scan indicated Resident 1 had right exophthalmos (abnormal forward protrusion of the right eye), vitreous hemorrhage (bleeding inside the eye), and irregularity of the globe (abnormal shape of the eyeball) concerning for globe rupture (a break in the eyeball, representing a serious open-eye injury). During a review of Resident 1's GACH progress note, dated 6/28/2026, the progress note indicated on 6/28/2026, Resident 1 had right eye surgery which included the following procedures: a. Right globe exploration (surgical examination of the right eyeball) b. Right canthotomy (a surgical incision of the right eyeball) c. Right superior and inferior cantholysis (surgical release of the tissues of the upper and lower right eyelids) d. Right canthoplasty (surgical repair and reconstruction of the right eyelids) e. Right tarsorrhaphy (a surgical procedure in which right eye lids are temporarily or permanently joined together to partially close the eye and protect the eyeball while healing). During a review of Resident 1's GACH discharge summary, the discharge summary indicated Resident 1 was admitted to GACH on 6/28/2026 for ocular trauma (a serious injury to the right eye). Resident 1 was discharged back to the facility on 7/1/2026 (three days later). During a concurrent observation and interview on 7/8/2026 at 11:45 a.m., with Resident 1, at Resident 1's bedside, Resident 1 was observed lying in bed. Resident 1 had purplish and bluish skin discoloration surrounding the right eye. Resident 1's right eye was closed, red, and swollen with two sutures (stitches). Resident 1 stated approximately one week earlier Resident 2 entered her room and tried to kill her. Resident 1 stated Resident 2 beat her up and punched her in the face and eyes. Resident 1 stated she was scarred for life and unable to open her right eye. Resident 1 stated, I'm really worried I'm going to lose my eyeball and sight. During an observation on 7/8/2026 at 1:00 p.m., in the presence of the Director of Nursing (DON), the facility's surveillance footage, dated 6/28/2026 and timed 1:33 p.m. to 1:36 p.m., was reviewed. The surveillance footage showed the following: a. At approximately 1:33 p.m., Resident 2 walked out of his room unsupervised and entered Resident 1's room. Resident 2 remained inside Resident 1's room for approximately two minutes. b. At approximately 1:35 p.m., Resident 2 exited Resident 1's room unsupervised and returned to his room. During an interview on 7/8/2026 at 1:15 p.m., with the DON, the DON stated Resident 2 was supposed to have a 1:1 sitter for continuous monitoring due to his aggressive and assaultive behaviors. The DON stated Resident 2 should not (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	have been unsupervised and should not have been able to leave his room and enter Resident 1's room without staff supervision. The DON stated this failure allowed Resident 2 to enter Resident 1's room and physically assault her, resulting in Resident 1 sustaining a severe right eye injury and emotional distress. The DON stated the incident could have been prevented had Resident 2's 1:1 supervision been implemented as ordered. During an interview on 7/8/2026 at 2:20 p.m., with Licensed Nurse (LVN) 1, LVN 1 stated on 6/28/2026, Resident 2 was assigned a sitter. LVN 1 at approximately 1:00 p.m., she observed Resident 2 walking alone in the hallway. LVN 1 stated when Resident 2 hit Resident 1, no staff member was present. LVN 1 stated she reviewed the 1:1 sitter assignment for 6/28/2026, which indicated Certified Nursing Assistant (CNA) 1 was the assigned sitter from 1:00 p.m. to 2:00 p.m. LVN 1 stated the incident could have been avoided if CNA 1 had implemented the 1:1 monitoring as required. LVN 1 stated failure to provide 1:1 monitoring resulted in Resident 2 being left unsupervised and able to physically assault Resident 1. LVN 1 stated Resident 1 sustained a severe right eye injury as a result of the assault. During a concurrent interview and record review on 7/8/2026 at 2:45 p.m., with the Director of Staff Development (DSD), the facility's nursing assignment and 1:1 sitter monitoring assignment dated 6/28/2026, was reviewed. The nursing assignment indicated that on 6/28/2026, hourly 1:1 sitter coverage was assigned for Resident 2. The DSD stated the nursing assignment indicated CNA 1 was assigned to provide 1:1 monitoring from 1:00 p.m., to 2:00 p.m. The DSD stated Resident 2 had 1:1 continuous monitoring due to aggressive behaviors. The DSD stated the 1:1 sitter assignment identified the specific staff member responsible for continuous monitoring during each assigned hourly period. The DSD stated the assigned 1:1 staff was expected to remain with Resident 2 and provide continuous observation. The DSD stated Resident 2 should not have been left without 1:1 supervision. The DSD stated that on 6/28/2026, during the time Resident 2 was assigned 1:1 sitter monitoring, Resident 2 was able to leave his room unsupervised. The DSD stated the facility failed to monitor Resident 2 and prevent him from entering Resident 1's room and physically attacking her. During an interview on 7/8/2026 at 3:30 p.m., with LVN 2, LVN 2 stated the incident involving Resident's 1 and 2 occurred on 6/28/2026 at approximately 1:30 p.m. LVN 2 stated an unidentified CNA asked her to assess Resident 1 because she had blood all over her face and bed sheets. LVN 2 stated she immediately entered Resident 1's room and observed Resident 1's face and hands covered in blood. Resident 1's right eyeball was coming out. LVN 2 stated at that time, Resident 1 repeatedly stated He. that man tried to kill me. LVN 2 stated Resident 1's visible injuries were severe, with extensive bleeding and significant trauma to the right eye. LVN 2 stated Resident 2 should not have been left without supervision. LVN 2 stated this resulted in Resident 1 sustaining a severe right eye injury, eyeball protrusion (sticks out), extensive bleeding, laceration (skin tear), transfer to the hospital, and surgical intervention. During an interview on 7/8/2026 at 4:30 p.m., with the Administrator (ADM), the ADM stated on 6/28/2026, Resident 2 required 1:1 supervision; however, the staff member assigned to monitor Resident 2 failed to carry out the assigned 1:1 monitoring. The ADM stated this resulted in Resident 2 being unsupervised and able to enter Resident 1's room and physically assault her causing severe injury to the resident's right eye. The ADM stated it was unfortunate that Resident 1 was physically abused by Resident 2. The ADM stated the assault caused Resident 1 serious bodily injury and adversely affected her physical and psychological well-being. The ADM stated the incident could have been prevented had the assigned 1:1 supervision been implemented. During a telephone interview on 7/8/2026 at 4:45 p.m., with CNA 1, CNA 1 stated on 6/28/2026, at the beginning of the shift, she reviewed her assignment but was not aware that she had been assigned to provide 1:1 monitoring for Resident 2 from 1:00 p.m. to 2:00 p.m. CNA 1 stated she did not implement the 1:1 monitoring which resulted in Resident 2 physically assaulting Resident 1. (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	CNA 1 stated that if she carefully reviewed and followed her assignment, she would have remained with Resident 2, monitored his behavior, redirected him as needed, and intervened before the assault occurred. During a review of the facility's policy and procedure (P&P) titled Resident Rights, revised 1/1/2012, the P&P indicated the facility will promote and protect all residents rights, including health and safety. During a review of the facility's P&P titled Reporting Abuse, revised 1/8/2014, the P&P indicated the facility will ensure that the resident has the right to be free from physical abuse.		