

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

Printed: 10/09/2026
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 07/31/2026
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 - Minimal harm or potential for 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 two of four sampled residents remained separated after a resident-to-resident altercation on 7/12/2026. This failure resulted in Resident 2 entering Resident 1's room on 7/16/2026 and placed Resident 1 at risk for abuse and injuries. Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted [DATE]. Resident 1 diagnoses included schizophrenia (a mental illness that is characterized by disturbances in thought), anxiety disorder (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 1's Minimum Data Sheet ([MDS]- a resident assessment tool), dated 4/17/2026, the MDS indicated Resident 1 was usually able to understand and be understood by others. The MDS indicated Resident 1 required partial/moderate assistance (Helper does less than half the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort) from staff for upper body dressing, bed mobility, transfers and walking 10-50 feet. During a review of Resident 2's admission Record indicated Resident 2 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 2's diagnoses included schizoaffective disorder (a mental illness that can affect thoughts, mood and behavior) anxiety disorder and restlessness with agitation (a state of mental tension paired with physical unease or excessive, unintentional movements). During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2 was able to understand and be understood by others. The MDS indicated Resident 2 required supervision or touching assistance (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) from staff for upper body dressing, bed mobility, transfers and walking 10-50 feet. During a review of Resident 2's History and Physical (H&P), dated 6/12/2026, the H&P indicated, Resident 2 had fluctuating capacity to understand and make decisions. During a review of Resident 3's admission Record indicated Resident was admitted to the facility on [DATE] with diagnoses including schizophrenia, anxiety, and diabetes mellitus ([DM] -a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 3's MDS dated [DATE], the MDS indicated Resident 3 was able to understand and be understood by others. The MDS indicated Resident 3 required supervision or touching assistance from staff for upper body dressing, bed mobility and walking 10-50 feet. During an interview on 7/30/2026 at 8:45 a.m., with Resident 1's roommate, Resident 3, Resident 3 stated, (on 7/16/2026) Resident 2 came into the room (Resident 1 and 3's room). Resident 2 pulled Resident 1 off the bed and Resident 2 fell to the floor. Resident 3 stated Resident 1 and Resident 2 were fighting over a trash can and Resident 2 hit Resident 1 with the trash can. During a review of Resident 4's (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 - Minimal harm or potential for actual harm Residents Affected - Few	admission Record, indicated Resident 4 was admitted to the facility on [DATE] with diagnoses including schizophrenia, anxiety, and restlessness with agitation. During a review of Resident 4's MDS, dated [DATE], the MDS indicated Resident 4's cognition was able to understand and be understood by others. The MDS indicated Resident 4 required supervision or touching assistance from staff for upper body dressing, bed mobility and walking 10-50 feet. During an interview on 7/30/2026 at 11:51 a.m., with Resident 4, Resident 4 stated, (on 7/16/2026) before breakfast time, Resident 2 went into Resident 1's room and both residents (Residents 1 and 2) started to fight over the trash can and had a physical altercation with each other. During a concurrent observation of the facility's video surveillance and interview on 7/30/2026 at 3:15 p.m., with the Director of Nursing (DON), Resident 2 was observed wandering into Resident 1's room and staff escorted Resident 1 out of the room. On 7/16/2026 at 4:41 a.m., Resident 2 re-entered Resident 1's room (2nd time) and was removed from the room by the Certified Nursing Assistant (CNA) 1 at 4:51 a.m. (10 minutes later). The DON stated Resident 4 was standing near Resident 1's room and faced the direction of Resident 1's room when Resident 2 was in Resident 1's room. During a telephone interview on 7/30/2026 at 4:14 p.m., with Certified Nursing Assistant (CNA) 2, CNA 2 stated Residents 1 and 2 were previously roommates. (On 7/12/2026 she (CNA 2) heard Resident 1 and Resident 2 arguing with each other. Resident 1 threw a lotion bottle towards Resident 2 and Resident 2 sustained a cut on her face. CNA 2 stated she reported the incident to the Registered Nurse (RN) Supervisor (unspecified) and Resident 2 was transferred to another room on 7/12/2026. CNA 2 stated after the incident, she (CNA 2) had to redirect Resident 2 because the resident (Resident 2) wanted to go to Resident 1. During an interview on 7/31/2026 at 9:06 a.m. with Registered Nurse (RN)1, RN 1 stated Resident 1 and Resident 2 were previously roommates and did not get along. On 7/12/2026, staff (unspecified) reported to him that there was an altercation between Resident 1 and Resident 2, and Resident 2 was transferred to another room. RN 1 stated staff should have kept Residents 1 and 2 separated and ensured that Resident 1 did not go into Resident 2's room on 7/16/2026 unattended because it placed Resident 1 in danger. During an interview on 7/31/2026 at 1:42 p.m., with DON, the DON stated Resident 1's and 2's rooms were near one another (despite the relocation of Resident 2 on 7/12/2026) and Resident 2 was not closely monitored for wandering. Resident 2 entered Resident 1's room (on 7/16/2026) and placed the Resident (Resident 1) at risk of physical abuse by Resident 2. During an interview on 7/31/2026 at 3:49 p.m., with Administrator (ADM), the ADM stated she was not aware of the altercation between Resident 1 and Resident on 7/12/2026. The ADM stated when Resident 2's room was changed; she was placed too close to Resident 1's room which had the potential for the residents to have another altercation with each other. During a 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 identifies, corrects and intervenes in situations in which abuse, neglect and mistreatment is more likely to occur. The ADM, or designated representative, will provide a safe environment for the resident. If the suspected perpetrator is another resident, separate the resident so they do not interact with each other. The P&P indicated if the suspected perpetrator was another resident, separate the resident so they do not interact with each other.		

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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 or designated representative will report all allegations of abuse to the California Department of Public Health (CDPH) Licensing and Certification within two hours, for one of four sampled residents (Resident 2), when Resident 1 allegedly threw a lotion bottle at Resident 2 on 7/12/2026. This deficient practice delayed the investigation by the CDPH and placed Resident 2 at risk for further abuse and injuries. Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted [DATE]. Resident 1 diagnoses included schizophrenia (a mental illness that is characterized by disturbances in thought), anxiety disorder (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 1's Minimum Data Sheet ([MDS]- a resident assessment tool), dated 4/17.2026, the MDS indicated Resident 1 was usually able to understand and be understood by others. The MDS indicated Resident 1 required partial/moderate assistance (Helper does less than half the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort) from staff for upper body dressing, bed mobility, transfers and walking 10-50 feet. During a review of Resident 1's Progress Notes, dated 7/12/2026, the Progress Notes indicated Resident 1 was showing behavior of being aggressive and agitated. During a review of Resident 2's admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including schizoaffective disorder (a mental illness that can affect thoughts, mood and behavior) anxiety disorder and restlessness with agitation (a state of mental tension paired with physical unease or excessive, unintentional movements). During a review of Resident 2's History and Physical (H&P), dated 6/12/2026, the H&P indicated, Resident 2 had fluctuating capacity to understand and make decisions. During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2 was able to understand and be understood by others. The MDS indicated Resident 2 required Supervision or touching assistance (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) from staff for upper body dressing, bed mobility, transfers and walking 10-50 feet. During a telephone interview on 7/30/2026 at 4:14 p.m., with Certified Nursing Assistant (CNA) 2, CNA 2 stated Residents 1 and 2 were previously roommates. (On 7/12/2026 she (CNA 2) heard Resident 1 and Resident 2 arguing with each other. Resident 1 threw a lotion bottle towards Resident 2 and Resident 2 sustained a cut on her face. CNA 2 stated she reported the incident to the Registered Nurse (RN) Supervisor (unspecified). During an interview on 7/31/2026 at 9:06 a.m., with RN 1, RN 1 stated on 7/12/2026, staff (unspecified) reported to him that there was an altercation between Resident 1 and Resident 2 and Resident. The altercation was considered abuse and should have been reported to the Administrator (ADM) and CDPH within two hours. RN 1 stated not reporting the altercation delayed the investigation and had the potential for further abuse and injury to the residents. During an interview on 7/31/2026 at 3:49 p.m., with the ADM, the ADM stated she did not report the altercation that occurred between Resident 1 and Resident 2 on 7/12/2026 to CDPH because she was not aware of the incident. Staff should have notified her or the Director of Nursing (DON). The ADM stated all forms of abuse should be reported (to CDPH) within two hours. Reporting abuse promptly is important to prevent future (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	incidents and to ensure residents' safety. During a review of the facility's P&P titled, Abuse Prevention and Management, dated 6/12/2024, the P&P indicated allegations of abuse are to be reported to the Administrator or designated representative immediately. The Administrator or designated representative will send a written report to the CDPH Licensing and Certification within two hours. During a review of the facility's RN Staff Nurse Job Description undated, the Job Description indicated the RN clinical duties and responsibilities included reporting allegations of abuse per State and Federal Regulations and facility policy.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the care plan was revised for two out of four sampled residents (Resident 1 and 2) after Residents 1 and 2 had an altercation on 7/12/2026. This deficient practice had the potential for Resident 1 and 2 to be involved in another altercation. Findings a. During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] and readmitted [DATE]. Resident 1's 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 1's care plan titled, Resident had the potential to be physically and verbally aggressive, dated 4/14/2026, the care plan interventions included to analyze times of day, places, circumstances, triggers, and what de-escalated behavior and document. During a review of Resident 1's Minimum Data Sheet (MDS, a resident assessment tool), dated 4/17/2026, the MDS indicated Resident 1's cognition (ability to think and process) was moderately impaired. The MDS indicated Resident 1 required substantial/maximal assistance (helper does more than half of the effort) from staff for toileting hygiene, showering, and dressing. b. During a review of Resident 2's admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including schizophrenia, anxiety, and restlessness with agitation (a state of mental tension paired with physical unease or excessive, unintentional movements). During a review of Resident 2's History and Physical (H&P), dated 6/12/2026, the H&P indicated Resident 2 had fluctuating capacity to understand and make decisions. During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2's cognition was severely impaired. The MDS indicated Resident 2 required partial/moderate assistance (helper does less than half the effort) from staff for toileting hygiene, showering, and dressing. During a review of Resident 2's care plan titled, Resident 2's Behavior Management manifested by aggressive behavior, dated 7/9/2026, the care plan interventions included to monitor /record behaviors such as pacing, wandering, and aggression towards staff/others. During a telephone interview on 7/31/2026 at 10:02 a.m. with Registered Nurse (RN) 1, RN 1 stated Resident 1 and Resident 2 had an altercation on 7/12/2026. RN 1 stated the care plan should have been revised to reflect the current issues of their behavior. RN 1 stated the revised care plan should align with the current issues the residents were demonstrating. During a concurrent interview and record review on 7/31/2026 at 1:30 p.m. with the Director of Nursing (DON), Resident 1's care plan titled, Resident had the potential to be physically and verbally aggressive, dated 4/14/2026 was reviewed. The DON stated the care plan should have been revised on 7/12/2026 due to Resident 1's aggressive behavior after Resident 1 and Resident 2 had an altercation. During a concurrent interview and record review on 7/31/2026 at 1:42 p.m., with the DON, Resident 2's care plan titled, Resident 2's Behavior Management manifested by aggressive behavior, dated 7/9/2026, was reviewed. The DON stated after the altercation, Resident 2's care plan needed to be revised to closely monitor the restlessness, touching, and wandering to prevent escalation of Resident 2's behavior. During a review of the facility's policy and procedure (P&P) titled, Person-Centered Care Planning, dated 4/2025, the P&P indicated the facility must develop and implement a comprehensive person-centered care plan for each resident. The P&P indicated a comprehensive care plan must be reviewed and revised by the interdisciplinary team after each (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessment, including both the comprehensive and quarterly review assessment. During a review of the facility's P&P titled, RN Staff Nurse Job Description, unknown date, the P&P indicated licensed professional nurse directly under supervision of the DON that provides care and services to residents in a long-term care setting. The P&P indicated to initiate and revise care plans.		