

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/17/2025
NAME OF PROVIDER OR SUPPLIER Vermont Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 22035 S. Vermont Avenue Torrance, CA 90502	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation interview and record review, the facility failed to ensure one of five sampled residents, Resident 1 was provided with a dignity bag (a bag covering Foley catheter [soft, thin, and [NAME] tube that helps a person go to the bathroom when they can't do it on their own]) for the Foley catheter while seated in wheelchair in the hallway. This failure has the potential to compromise the resident's dignity. During a review of Resident 1's admission Record, the admission Record indicated the resident was admitted on [DATE] to the facility with the diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side (total paralysis of the arm, leg, and trunk the left side of the body following a stroke), difficulty in walking, anemia (a condition where the body does not have enough healthy red blood cells). During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 11/24/2025, the MDS indicated the resident had the ability to make self-understood and had the ability to understand others. The MDS further indicated Resident 1 was independent with bed mobility (moving to and from lying positions, turning side to side, and positioning body while in bed), transfer (moving to or from bed, chair, wheelchair, standing position with walker), dressing, and toilet use and required supervision with personal hygiene. The MDS further indicated Resident 1 had Foley catheter or urinary incontinence (when a person leaks pee by accident because they cannot control their bladder). During a review of Resident's 1's physician order on 12/17/2025, the attending physician's order indicated to reinsert the Foley catheter into the resident. During an observation and interview on 12/16/2025 at 2:26 p.m., in Resident 1's room, the resident was sitting in the wheelchair, about to wheel himself into the hallway by the front door. Resident 1 had a Foley catheter without a dignity bag. Resident 1 stated they do not have a dignity bag cover for his Foley catheter bag and do not use one. During an interview on 12/16/2025 at 3:22 p.m. with Certified Nursing Assistant (CNA) 2, CNA 2 stated she was not aware the resident had a Foley catheter and therefore did not need to cover up catheter bag. During an interview and on 12/16/2025 at 3:47 p.m. with Licensed Vocational Nurse (LVN) 1, LVN stated she did not notice the Resident 1's Foley catheter bag during her shift this morning. During an interview and record review on 12/17/2025 at 10:30 a.m. with the Director of Nursing (DON), DON stated Resident 1 should have a Foley catheter in use to maintain privacy and dignity at all times. The DON stated that the Certified Nurse Assistant (CNA) must maintain dignity during Foley catheter care by keeping the Foley catheter always covered. During a review of the facility's policy and procedure (P&P) titled, Resident Rights, undated, the P&P indicated the Resident are to be treated with respect and dignity. During a review of the facility's P&P titled, Catheter Care, undated, the P&P indicated, ensure that the Foley catheter is covered with a dignity bag.</p>

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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/17/2025
NAME OF PROVIDER OR SUPPLIER Vermont Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 22035 S. Vermont Avenue Torrance, CA 90502	

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)
<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/17/2025
NAME OF PROVIDER OR SUPPLIER Vermont Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 22035 S. Vermont Avenue Torrance, CA 90502	
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)		
<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure the Interdisciplinary Team (IDT-a team composed of members from different departments working collaboratively to set goals and make decisions that ensure residents receive optimal care) initiated a care conference for one of two sampled residents (Resident 2) following an alleged resident-to-resident altercation (an incident involving two residents fighting or mistreating each other). This failure had the potential to delay addressing Resident 2's care needs, resulting in a delay in necessary interventions. Findings: During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including unspecified dementia (a progressive state of decline in mental abilities) generalized anxiety disorder(mental health condition marked by persistent, excessive and uncontrollable worry about everyday things), unspecified psychosis,(a severe mental condition in which thought, and emotions are so affected that contact is lost with reality) and hemiplegia (paralysis of one side of the body) and hemiparesis (weakness of one side of the body) following cerebral infarction (damage to the brain from interruption of its blood supply) affecting the left non-dominant side. During a review of Resident 2's Minimum Data Set (MDS- a resident assessment tool) dated 11/17/2025, the MDS indicated Resident 2 had severely impaired cognitive skills (ability to think, learn, remember and decide)and required supervision or touching assistance (helper provides verbal cues and touching/steadying or contact guard assistance as the resident completes the activity) with toilet transfer and transfer to and from a bed to a chair. During a review of Resident 2's Change in Condition (COC- a sudden, clinically important deviation from a patient's baseline in physical, cognitive, behavioral, or functional status which without immediate intervention, may result in complications or death) dated 12/7/2025 timed at 9:15 p. m., the COC indicated Resident 2 allegedly pushed Resident 1's left shoulder three times. The COC indicated Resident 2 was unable to answer when asked about the incident. During a review of Resident 2's Care Plan titled, Resident with Aggressive Behavior related to Pushing Roommate, created on 12/14/2025, the Care Plan goals indicated Resident 2's aggressive behavior will be effectively managed by reducing the risk of injury to themselves and others. The Care Plan's interventions included implementing appropriate safety protocols to ensure the physical safety of the patient. During a concurrent interview and record review on 12/16/2025 at 4:46 p.m. and subsequent interview on 12/17/2025 at 9:13 a.m. with the Social Worker (SW), Resident 2's Interdisciplinary Team Note and Progress Notes, were reviewed. SW stated there was no IDT Meeting conducted after the alleged resident to resident altercation on 12/7/2025 for Resident 2. SW stated IDT Meeting was a collaborative plan of care of a resident to ensure the care was appropriately provided to the resident. During an interview on 12/16/2025 at 4:34 p.m. with Assistant Administrator (AA), AA stated the facility conducts an IDT meeting when there was a change in condition, on initial review of a resident's plan of care, quarterly and annually. AA stated resident to resident altercation was a change in condition and IDT meeting should have been performed for Resident 2. During a concurrent interview and record review on 12/17/2025 at 10:11 a.m. with the Director of Nursing (DON), Resident 2's IDT Meeting Notes were reviewed. The DON stated there were no documented IDT Meeting Notes in relation to the alleged resident to resident altercation for Resident 2. The DON stated there should be an IDT Meeting for Resident 2 addressing the alleged resident to resident altercation with his roommate and his physical aggression. She stated it should have been done during 72 hours of the incident to discuss the incident and implement a safety plan. The DON stated IDT Meeting was a collaboration of care to ensure the facility can take care of the residents and able to meet Resident 2's needs. The DON stated conducting IDT Meeting was a best practice to address change in condition. During a review of facility's policy and procedure (P&P) titled, Comprehensive Person-Centered Care Plans, undated, the P&P indicated the IDT with the resident and his/her family or legal representative will develop and implement a comprehensive, person-centered care plan for each resident. The P&P indicated the IDT will review the care plan when there has been a significant change in resident's condition. The endpoint process of interdisciplinary (collaborative meeting of various health care professionals to create a person- centered and comprehensive plan of care) included identifying problem areas and their causes and developing targeted and meaningful interventions.</p>		