

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: 056433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2026
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)		
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure two Certified Nursing Assistants (CNA 1 and CNA 2) did not shave the beard of one of five sampled residents (Resident 1), without Resident 1's Responsible Party's (RP) consent. This deficient practice resulted in Resident 1, who had his beard for many years, beard being completely removed without approval from Resident 1's RP. This deficient practice had the potential for Resident 1 and/or Resident 1's RP to feel disrespect and undignified. Findings: During a review of Resident 1's admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE]. Resident 1 had diagnoses including dementia (a progressive state of decline in mental abilities) and Alzheimer's disease (a disease characterized by a progressive decline in mental abilities). During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 7/24/2026, the MDS indicated Resident 1's cognition was moderately impaired, and he was dependent (helper does all of the effort) on facility staff to complete his activities of daily living ([ADLs] activities such as bathing, dressing and toileting a person performs daily). During an interview on 7/30/2026 at 11:28 a.m., Resident 1's RP stated Resident 1's beard was shaved without her knowledge or consent. The RP stated Resident 1 had his beard for many years and she had not seen him without it. During an interview on 7/31/2026 at 11:05 a.m., the Director of Nursing (DON) stated the RP should have been notified prior to Resident 1's beard being shaved because Resident 1 did not have capacity to make decisions for himself. The DON stated CNA 1 and CNA 2 informed her that Resident 1 looked unkempt and dirty when he was admitted to the facility, and they felt he needed to be groomed. During a review of the facility's Policy and Procedure (P/P) titled, Resident's Preferences dated 1/2026, the P/P indicated staff will ask the resident and when appropriate, the resident representative about preferences upon admission prior to initiation of treatment/therapy and/or during initial interdisciplinary (IDT) meeting. Preferences may include bathing, grooming and clothing.		

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure Licensed Vocational Nurse (LVN) 1 did not prepare medication for two of two sampled residents (Resident 4 and 5) on one tray with intentions of administering them by giving the medications to the residents sequentially (doing things in a set order, one after the other). This deficient practice resulted in LVN 1 attempting to administer Resident 4 and Resident 5's medications literally together had the potential for Resident 4 and 5 to receive the incorrect medication. Findings: a. During a review of Resident 4's admission Record (Face Sheet), the Face Sheet indicated Resident 4 was admitted to the facility on [DATE]. Resident 4 had a diagnosis of osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage). During a review of Resident 4's Minimum Data Set ([MDS] a resident assessment tool) dated 7/23/2026, the MDS indicated Resident 4's cognition was intact and he required substantial/maximal assistance (helper does more than half the effort) from facility staff to complete his activities daily living ([ADLs] activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 4's Physician's Order dated 3/16/2026, the Physician's Order indicated Resident 4 was to receive Hydrocodone-Acetaminophen (medication to treat moderate to severe pain) 10-325 milligrams ([mg] metric unit of measurement, used for medication dosage and/or amount) one tablet every 4 hours as needed for severe pain. b. During a review of Resident 5's admission Record (Face Sheet), the Face Sheet indicated Resident 5 was admitted to the facility on [DATE]. Resident 5 had a diagnosis of liver cancer. During a review of Resident 5's MDS dated [DATE], the MDS indicated Resident 5's cognition was intact and he required substantial/maximal assistance from facility staff to complete his ADLs. During a review of Resident 5's Physician's Order dated 7/29/2026, the Physician's Order indicated Resident 5 was to receive Oxycodone Hydrochloride (HCl) 5 mg to every eight hours for pain. During a medication administration observation on 7/30/2026 at 2:26 p.m., with LVN 1, LVN 1 was observed carrying two medication cups with one pill in each cup and two cups of water on one silver tray. LVN 1 proceeded to Resident 4 and 5's room (they were roommates). LVN 1 entered the resident's room and saw that Resident 5 was being transferred from her wheelchair to her bed and stated she would administer Resident 4's medication since Resident 5 was busy. LVN 1 proceeded to administer Resident 4's medication. Resident 5 was still busy being transferred to her bed, LVN 1 stated she would come back to administer the medication when Resident 5 was ready. During an interview on 7/30/2026 at 2:28 pm, LVN 1 stated she knew both residents (Residents 4 and 5) well and had cared for them for some time, so she saw no issue with preparing and administering their medications together. During an interview on 7/31/2026 at 1:28 p.m., the Director of Nursing (DON) stated medications should be prepared and given to just one resident at a time, because preparing medication for multiple residents simultaneously could result in administering the wrong medication to the wrong resident. During a review of the facility's undated Policy and Procedure (P/P) titled Medication Administration the (P/P) indicated medications are administered at the time they are prepared and are not pre-poured. Medications are administered without necessary interruptions.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure Licensed Vocational Nurse (LVN 1) stored Oxycodone (a Schedule II [a drug that has as high risk for abuse and severe physical or psychological dependence) used to treat moderate to severe pain and has a high risk for abuse and dependence) in a secured double locker drawer. This deficient practice had the potential to result in loss, theft, misuse or diversion (the illegal transfer, distribution, or use of a legally prescribed controlled substance for a purpose other than what the prescriber intended) of Resident 5's Oxycodone medication. Findings: During a review of Resident 5's admission Record, (Face Sheet), the Face Sheet indicated Resident 5 was admitted to the facility on [DATE]. Resident 5 had a diagnosis of liver cancer. During a review of Resident 5's Minimum Data Set ([MDS] a resident assessment tool) dated 7/17/2026, the MDS indicated Resident 5's cognition was intact and he required substantial/maximal assistance from facility staff to complete his ADLs. During a review of Resident 5's Physician's Order dated 7/29/2026, the Physician's Order indicated Resident 5 to receive Oxycodone hydrochloride (HCl) oral tablet 5 milligrams ([mg] metric unit of measurement, used for medication dosage and/or amount) every eight hours for pain. During an observation on 7/30/2026 at 2:26 p.m., LVN 1 was seen placing a medication cup with Resident 5's Oxycodone in a single-locked drawer of the medication cart. During an interview on 7/30/2026 at 2:28 p.m., LVN 1 stated Oxycodone should be stored in a double-locked narcotic drawer to prevent unauthorized access. During an interview on 7/31/2026 at 1:28 p.m., the Director of Nursing (DON) stated Scheduled II medications should be secured in a double locked drawer. During a review of the facility's Policy and Procedure (P/P) titled Controlled Drug Storage dated 1/2026, the P/P indicated Schedule II medications shall be kept under double lock drawer.		

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observation, interview, and record review, the facility failed to ensure two of five sampled thermostats (an automatic device used to control and regulate temperature) were powered on and in working condition. This deficient practice resulted in the inability to regulate the facility's temperatures in certain areas of the facility and had the potential for residents' room temperatures to uncontrolled. Findings: During an interview on 7/30/2026 at 11:38 a.m., Resident 1's Responsible Party (RP) stated it was always hot in Resident 1's room and the facility provided a fan for him because there was no working air conditioning. During an observation on 7/30/2026 at 2:48 p.m., with the Maintenance Supervisor (MS), two thermostats were observed to be off; with black screen and no visible power to the thermostat. During an interview on 7/30/2026 at 2:50 p.m., and a subsequent interview on 7/31/2026 at 9:36 a.m., the MS stated the thermostats should be on and working so temperatures in the residents' rooms were controlled/regulated to prevent residents from being too hot or too cold. He was unsure how often the thermostats should be checked. During a review of the facility's Policy and Procedure (P/P) titled Thermostat and Indoor Temperature Control dated 1/2026, the P/P indicated the facility shall maintain comfortable and safe temperatures levels throughout all resident occupied areas.		