| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055167 | A. Building<br>B. Wing | 09/12/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Vernon Healthcare Center | 1037 W. Vernon Avenue<br>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 0627<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge.<br><br>(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 0627<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to:1 1. Ensure one of three sampled residents (Resident 1) who was transferred to a General Acute Care Hospital (GACH) on 8/15/2025 due to altered mental status ([AMS] - a significant change in a person's awareness, consciousness, and cognitive function, such as confusion, disorientation, drowsiness, or unresponsiveness) was readmitted to the facility when the GACH cleared him to return to the facility on 8/29/2025. This deficient practice resulted in Resident 1 remaining in the hospital for 14 days beyond the initial date of discharge. 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 on [DATE]. Resident 1's diagnoses included liver cirrhosis (a chronic liver disease characterized by the formation of scar tissue in the liver), chronic obstructive pulmonary disease ([COPD] - a chronic lung disease causing difficulty in breathing), and bipolar disorder (mood swings that range from the lows of depression to elevated periods of emotional highs). During a review of Resident 1's History and Physical (H&P), dated 7/7/2025, the H&P indicated, Resident 1 could make needs known but could not make medical decisions. During a review of Resident 1's Social Services Assessment, dated 7/28/2025, The Social Services Assessment indicated, Resident 1 had no active discharge plan to return to the community and to remained as long-term care resident. During a review of Resident 1's Minimum Data Set ([MDS] - a resident assessment tool), dated 8/15/2025, the MDS indicated, Resident 1 had modified independence in cognitive skills (problems with ability to think, use judgment, and reason) for daily decision making. The MDS indicated, Resident 1 was independent (resident completes the activity with no assistance from a helper) with eating, oral hygiene, and personal hygiene. During a review of Resident 1's Progress Notes, dated 8/15/2025 at 4:20 p.m., the Progress Notes indicated, Resident 1 was transferred to the GACH for altered mental status ([AMS] - a significant change in a person's awareness, consciousness, and cognitive function, such as confusion, disorientation, drowsiness, or unresponsiveness). During a review of Resident 1's GACH Discharge Planning Progress Note, dated 8/29/2025, the GACH Discharge Planning Progress Note indicated, Resident 1 had a discharge order to be back to the facility. The GACH Discharge Planning Progress Note, indicated the facility admission Director (AD) denied Resident 1 to be readmitted to the facility because there was no male bed available. During a review of Resident 1's GACH Discharge Planning Progress Note, dated 8/31/2025, the GACH Discharge Planning Progress Note indicated, the facility denied Resident 1 to be readmitted because there was no male bed available. During a review of Resident 1's GACH Discharge Planning Progress Note, dated 9/2/2025, the GACH Discharge Planning Progress Note indicated, the facility AD denied Resident 1 to be readmitted because there was no male bed available. During a review of Resident 1's GACH Discharge Planning Progress Note, dated 9/3/2025, the GACH Discharge Planning Progress Note indicated, the facility AD denied Resident 1 to be readmitted because there was no male bed available.During a review of Resident 1's GACH Discharge Planning Progress Note, dated 9/5/2025, the GACH Discharge Planning Progress Note indicated, the facility AD denied Resident 1 to be readmitted because there was no male bed available.During a review of Resident 1's GACH Discharge Planning Progress Note, dated 9/8/2025, the GACH Discharge Planning Progress Note indicated, the facility AD denied Resident 1 to be readmitted because there was no male bed available.During a concurrent interview and record review on 9/12/2025 at 10:00 a.m. with the AD, the facility's Daily Census Report from 8/29/2025 to 9/11/2025, were reviewed. The AD stated one male bed was available on 8/29/2025, 8/30/2025, 8/31/2025, 9/9/2025, 9/10/2025, and 9/11/2025. The AD stated she acknowledged she received a call from the GACH's discharge planner multiple times inquiring Resident 1's male bed availability. The AD stated Resident 1 was denied by the Administrator (ADM) to be readmitted to the facility. The AD stated she did not have any answer why the ADM denied Resident 1's readmission to the facility. The AD stated Resident 1 remained out of the facility as of 9/11/2025. During an interview on 9/12/2025 at 10:41 a.m., with the Director of Nursing (DON), the DON stated Resident 1 was transferred to the GACH on 8/15/2025 and Resident 1's last day of bed hold (a resident's right to keep a bed vacant and available for seven days after their transfer to the hospital in anticipation of their return to the facility) was 8/21/2025. The DON stated Resident 1 should have been allowed to come back to the facility even after the seven days bed hold for Resident 1's continuity of care and to prevent Resident 1 from feeling abandoned and social isolation. The DON stated the facility could meet the needs of Resident 1 and there was no reason to deny Resident 1's |