

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 02/06/2026
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)		
<p>F 0627</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure a safe discharge for one of three sampled residents (Resident 1), who was a Regional Center client (a person with a developmental disability receiving care in a state-sponsored facility), with diagnoses including schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior) bipolar type (mood swings that range from the lows of depression [persistent feeling of sadness] to elevated periods of emotional highs), unspecified psychosis (mental health condition characterized by a loss of contact with reality), anxiety disorder (intense and persistent worry that is difficult to control and interferes with daily life) and seizures (sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness). The facility failed to: 1. Notify Resident 1's conservator (a court-ordered arrangement that appoints a responsible individual to manage the financial affairs, personal care, or both, of an adult who is unable to do so due to incapacity or severe disability) of Resident 1's discharge plan. 2. Ensure the conservator was actively involved in selecting the facility and consenting prior to discharging Resident 1 to a recuperative care home ([RCC] a temporary safe place for people to heal after discharge from the hospital) on 1/28/2026. 3. Ensure an Interdisciplinary (IDT) group of health care professionals who work together on the same plan of care) meeting was held to assess Resident 1's cognitive (ability to think, understand, learn, and remember), medical, physical, and psychosocial (emotional wellbeing) needs prior to discharging the residents to a lower level of care. 4. Ensure the RCC was notified by Licensed Vocational Nurse (LVN) 1 of Resident 1's medical condition including the resident's diagnoses, medications, history of wandering (walk around without any clear purpose or direction), and risk for falls/seizures prior to discharging the resident. These deficient practices resulted in Resident 1 being transferred to a RCC without proper discharge planning by the facility and without input or permission from Resident 1's Conservator to transfer Resident 1 to the RCC on 1/28/2026. On 1/30/2026 at 3:39 a.m., Resident 1 was found wandering approximately 9.1 miles from the RCC without any shoes on. Resident 1 was transported via the fire department to a General Acute Care Hospital (GACH). This placed Resident 1 at risk for experiencing uncontrolled seizures, falls, hallucinations (sights, sounds, smells, tastes, or touches that a person believes to be real but are not real), harsh weather conditions, environmental dangers including motor vehicle accidents, and assault. There was a likelihood Resident 1, did not receive any medication after she was discharged to the RCC. As of 2/20/2026 Resident 1 remains in the GACH. On 2/5/2026 at 2:44 p.m., an Immediate Jeopardy ([IJ] a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) was called in the presence of the facility's Administrator (ADM), Assistant ADM, Administrator in Training (A.I.T.), Director of Staff Development (DSD), and the Quality Assurance Nurse, due to the facility's failure provide</p> <p>(continued on next page)</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 056433
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