

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555832	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/14/2025
NAME OF PROVIDER OR SUPPLIER  Clara Baldwin Stocker Home for Women		STREET ADDRESS, CITY, STATE, ZIP CODE  527 S Valinda Avenue West Covina, CA 91790	

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  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge.  (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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<p>F 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>F627INTENT These regulations and guidance address inappropriate discharges and:Ensure a facility does not transfer or discharge a resident in an unsafe manner, such as a location that does not meet the resident's needs, does not provide needed support and resources, or does not meet the resident's preferences and, therefore, should not have occurred. F627Based on observation, interview and record review, the facility failed to ensure Resident 1's discharge location met Resident 1's needs for family support and resources. This deficient practices led to an inappropriate discharge. Findings:During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted Resident 1 on 9/19/2025, with diagnoses that included pneumonia (lung infection) and history of falling. During a review of Resident 1's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 9/26/2025, the MDS indicated Resident 1 had intact cognition. 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) with toileting, lower body dressing and personal hygiene. Resident 1 required partial/moderate assistance with the following mobility, rolling left and right, sit to lying, lying to sitting on the side of the bed, sit-to-stand, chair/bed-to chair transfer, toilet transfer, and walking 10 feet. During a review of Resident 1's Physical Therapy Discharge Summary (PTDS) dated 10/2/2025, the PTDS indicated Resident 1 required supervision or touching assistance with bed mobility, transfers, residential mobility. During a review of Resident 1's Progress Notes (PN) dated 10/3/2025, the PN indicated Resident 1 was discharged to an assisted living facility (ALF 1). During an interview on 10/3/2025 at 5 PM, Licensed Vocational Nurse 1 (LVN 1) stated Resident 1's Family member (FM) 1 had stated they will file an appeal because Resident 1 was not ready for discharge. During an interview on 10/3/2025 at 5:31 PM, FM 1 stated, There were no choices offered regarding places to go upon discharge. FM 1 stated FM 1 tried to appeal the discharge decision, but unable to submit the appeal request due to the Federal Shutdown. FM 1 stated, ALF 1 was provided on 10/3/2025, on the day of discharge. FM 1 stated FM 1 went to ALF 1 on 10/3/2025 to check the place and ran out of time so FM 1 agreed to discharge Resident 1 to ALF 1. FM 1 stated Resident 1's Son was sick so it would have been better if there was an ALF closer to Resident 1's Son home so the Son would be able to visit Resident 1. During an interview on 10/7/2025 at 11:43 AM, the Case Manager (CM) stated Resident 1's discharge plan was to discharge Resident 1 to FM 1's home or placement. The CM stated FM 1 had stated it would depend on Resident 1's progress with therapy then Resident 1 could discharge to FM 1's home. The CM stated ALF 1 was the facility that was found for Resident 1 within 48 hours before Resident 1 was discharged. During an interview on 10/7/2025 at 1:40 PM, the CM stated FM 1 toured ALF 1 on 10/3/2025, on the day of Resident 1's discharge and agreed for Resident 1 to be transferred to ALF 1. The CM stated CM informed FM 1 if FM 1 did not agree to the transfer Resident 1 to ALF 1, FM 1 need to pay the facility for additional stay days at the facility until facility staff can find a safe place for Resident 1. During an interview on 10/7/2025 at 4:50 PM, the Social Services Director (SSD) stated it will either be the Senior Placement Agency or the Hospice Agency who would find placement for Resident 1, the SSD stated the SSD did not know what choices of ALF was offered to Resident 1 and FM 1. The SSD stated there was no documentation other options of ALFs were discussed with Resident 1 or FM 1. During an interview on 10/7/2025 at 5 PM, the Director of Nursing (DON) stated the facility needed to offer a list of ALFs to enable Resident 1 and FM 1 to make decision. The DON stated Resident 1's Son was sick and the DON understood why FM 1 would have wanted Resident 1 to be discharged to an ALF closer to this area (near the facility). During a review of the facility's Policy and Procedure (P&amp;P) titled, Discharge Summary and Plan, dated December 2016, the P&amp;P indicated residents transferring to another skilled nursing facility, or who are discharged to a home health agency, long-term care hospital or inpatient rehabilitation facility will be assisted in selecting a post-acute care provider that is relevant and applicable to the resident's goals of care and treatment preferences.</p>		