State of California - Health and Human Services Agency

Department of Public Health

SECTION 1424 NOTICE

CITATION NUMBER: 91-36526-0015182-S

Date: 07/03/2019 Time: 3:58pm

Type of Visit : Complaint Investig.

Incident/Complaint No.(s) : CA00639074

YOU ARE HEREBY FOUND IN VIOLATION OF APPLICABLE CALIFORNIA STATUTES AND REGULATIONS OR APPLICABLE FEDERAL STATUTES AND REGULATIONS

Licensee Name:	Vernon Healthcare Center, LLC		
Address:	1037 W. Vernon Avenue	Los Angeles, CA 90037	
License Number:	970000025	Type of Ownership:	Limited Liability Company

Facility Name:	VERNON HEALTHCARE CENTER	
Address:	1037 W Vernon Ave Los Angeles, CA 90037	
Telephone:	(323) 232-4895	
Facility Type:	Skilled Nursing Facility	Capacity: 99
Facility ID:	970000050	

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS	PENALTY ASSESSMENT $2,000.00	DEADLINE FOR COMPLIANCE 7/3/19 11:59 p.m.

483.15(e)(1)(2), T22 DIV5 CH3 ART5-72523(a)

CLASS B CITATION -- PATIENT RIGHTS

§ 72523. Patient Care Policies and Procedures.
(a)Written patient care policies and procedures shall be established and implemented to ensure that patient-related goals and facility objectives are achieved.
F626
§483.15(e)(1) Permitting residents to return to facility.
A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following.
(i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident-
(A) Requires the services provided by the facility; and
(B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services.
(ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges.
§483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the

Name of Evaluator:
Jessica Castillo
RN

Evaluator Signature: [signature]

Without admitting guilt, I hereby acknowledge receipt of this SECTION 1424 NOTICE

Signature: [signature]
Name: CHAIM "ISAAC" SHABAT
Title: ADMINISTRATOR

NOTE: IN ACCORDANCE WITH CALIFORNIA HEALTH AND SAFTEY CODE, FAILURE TO CORRECT VIOLATIONS IS GROUNDS FOR SUSPENSION OR REVOCATION OF YOUR LICENSE

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS

time of return, the resident must be given the option to return to that location upon the first availability of a bed there.

The Department received a complaint on 5/24/19 regarding a refusal to readmit a resident.
An unannounced complaint investigation was conducted on 5/25/19.

Based on interview and record review, the facility failed to follow its policy to ensure that a resident's right was not denied when they failed to adhere to its Bed Hold Agreement and not initially re-admitting Resident 1 back to the facility from a general acute care hospital (GACH) within the seven-day bed hold.

As a result, Resident 1's readmission was delayed and was unable to return to his original room and bed.

A review of Resident 1's admission record (Face Sheet) indicated the resident was a 49 year-old male who was admitted to the facility on 5/14/19. Resident 1's diagnoses included schizophrenia (a chronic and severe mental disorder that affects how a person thinks, feels, and behaves), combativeness, and delusions (beliefs that conflict with reality). The admission record indicated Resident 1 was conserved (legal protection for someone who cannot properly provide for his or her own personal needs for physical health, medical care, food, clothing, or shelter).

A review of Resident 1's physician telephone order, dated 5/22/19 and timed at 2 a.m., indicated that Resident 1 was transferred by a police officer and placed on a hold.

A review of Resident 1's Physician's Discharge Summary, dated on 5/22/19, indicated that the health and safety of individuals in the facility were endangered by Resident 1's increased aggression and agitation, with the threatening and assaulting of staff. The discharge summary indicated that Resident 1 was discharged to the GACH's urgent care.

A review of Resident 1's Notice of Transfer/Discharge, dated 5/22/19, indicated that the transfer or discharge was necessary for Resident 1's welfare and the resident's needs were not able to be met at the facility. The transfer sheet indicated that Resident 1's conservator (guardian appointed by a judge) was notified on 5/21/19.

A review of Resident 1's physician's telephone order, dated 5/22/19, and timed at 2:10

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS
	a.m., indicated no bed hold for Resident 1. On 5/25/19 at 11:08 a.m., during an interview, the Intern Director of Nursing (IDON) stated that Resident 1 was taken by a police officer and placed on hold from the facility on 5/22/19. The IDON stated that someone called on 5/24/19 and stated that Resident 1 was in urgent care and was ready to return to the facility. The IDON stated that they notified CM 1 that they could not care for Resident 1 because of his behaviors and needed a different facility. The IDON stated that they re-admitted Resident 1 on 5/24/19, after they were informed by CM 1 that they were going to notify the Ombudsman (an official appointed to investigate individuals' complaints against maladministration, especially that of public authorities) of the refusal to readmit the resident. The IDON stated that they were aware of the seven (7) day bed hold upon transfer of a resident, but because of Resident 1's aggressive behaviors towards the staff, he was not appropriate to be in the facility. On 5/24/19 at 4:55 p.m., during a telephone interview, the GACH's Case Manager 1 (CM 1) stated that the facility's Administrator (ADM) refused to readmit Resident 1 after being cleared for discharge by the GACH's psychiatrist (a physician who specialized in the treatment and diagnosis of mental illnesses) on 5/23/19 (one day after transfer to the GACH). A review of the facility's undated policy titled, "Bed Hold Agreement," and signed by Resident 1's conservator, indicated that the facility would hold Resident 1's bed/space during the resident's absence from the facility. The facility failed to ensure that a resident's right was not denied when they failed to follow its Bed Hold Agreement and not re-admitting Resident 1 back to the facility from a GACH. As a result, Resident 1's readmission was delayed and was unable to return to his original room and bed. The above violations had a direct relationship to the health, safety, or security of Resident 1.

POC accepted
36526 7/3/19 @ 4:25pm
SC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055167	A. BUILDING ______ B. WING ______	06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERNON HEALTHCARE CENTER	1037 W Vernon Ave, Los Angeles, CA 90037-2416 LOS ANGELES COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	The following reflects the findings of the Department of Public Health during a Complaint Investigation visit: CLASS B CITATION -- PATIENT RIGHTS 91-36526-0015182-S Complaint(s): CA00639074 Representing the Department of Public Health: Surveyor ID # 36526, RN The inspection was limited to the specific facility event investigated and does not represent the findings of a full inspection of the facility. § 72523. Patient Care Policies and Procedures. (a)Written patient care policies and procedures shall be established and implemented to ensure that patient-related goals and facility objectives are achieved. F626 §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid		"Preparation and/or execution of this plan of correction, does not constitute admission or agreement by the provider, of the truth of the facts alleged or the conclusions set forth in this statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of Health and Safety code section 1280 and 42CFR et seq". This Plan of Correction constitutes the facility's credible allegation of compliance. **F626** **How Corrective Action will be accomplished for residents affected:** Resident 1 was readmitted on 5/24/19, and was transferred out the following day via MD order for behavioral management. Resident now resides at another facility.	7/3/19

Event ID:6O8X11 7/3/2019 2:39:44PM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 7/3/19

By signing this document, I am acknowledging receipt of the entire citation packet, Page(s). 1 thru 5

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. Except for nursing homes, the findings 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.

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	nursing facility services. (ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. The Department received a complaint on 5/24/19 regarding a refusal to readmit a resident. An unannounced complaint investigation was conducted on 5/25/19. Based on interview and record review, the facility failed to follow its policy to ensure that a resident's right was not denied when they failed to adhere to its Bed Hold Agreement and not initially re-admitting Resident 1 back to the facility from a general acute care hospital (GACH) within the seven-day bed hold. As a result, Resident 1's readmission was delayed and was unable to return to his original room and bed. A review of Resident 1's admission record (Face Sheet) indicated the resident was a 49 year-old		**Identification of Residents with the Potential to be Affected:** No Residents were affected by this practice **Measures to Prevent Recurrence:** Administrator in-serviced Admissions Director, Director of Nursing, and Social Service on 6/12/19 regarding allowing a resident who had been transferred to GACH to return to the facility, in accordance with Title 22 regulation §72520. The Administrator also reviewed with members of in-service the procedure outlined for the involuntary discharging of residents who qualify under under §483.lS(c)(l)(i)(C). In cases where a resident has been sent to the hospital via physician order for behavioral reasons multiple times, DON/Designee will review hospital notes, with Medical Director as needed, on what	

Event ID:6O8X11 7/3/2019 2:39:44PM

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

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	Resident 1's bed/space during the resident's absence from the facility. The facility failed to ensure that a resident's right was not denied when they failed to follow its Bed Hold Agreement and not re-admitting Resident 1 back to the facility from a GACH. As a result, Resident 1's readmission was delayed and was unable to return to his original room and bed. The above violations had a direct relationship to the health, safety, or security of Resident 1.			