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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 056489 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 09/09/2020 |
| NAME OF PROVIDER OF SUPPLIER HOLLYWOOD PREMIER HEALTHCARE CENTER | | STREET ADDRESS, CITY, STATE, ZIP 5401 FOUNTAIN AVE. LOS ANGELES, CA 90029 | |
| 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 0569 Level of harm - Minimal harm or potential for actual harm Residents Affected - Few | Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that within 30 days from discharge trust funds and a final account of one of two sampled residents (Resident 1) were conveyed to the resident or the resident's representative. Resident 1's representative requested the facility, multiple times, for the money in the resident's account. The money was returned after the surveyor intervened. This deficient practice resulted in unnecessary delay of the resident's funds. Findings: On 8/20/2020 at 3:45 p.m., during an interview, Family Member 1 (FM 1) stated the facility had not given the money from Resident 1's trust account since discharge on 4/1/2020. FM 1 said she had called several times and sent emails after this time regarding this matter but there was no response. FM 1 provided copies of emails to the facility on [DATE], 6/5, 6/29 and 7/27/2020 requesting Resident 1's funds. A review of Resident 1's Admission Record (Face Sheet) indicated Resident 1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set (MDS - standardized assessment and care-screening tool) dated 1/16/2020, indicated Resident 1 had impaired decision-making and memory problems. Resident 1 required one-person extensive assistance with transfer, dressing, and personal hygiene. A review of the Social Services Assessment, dated 1/17/2020, indicated FM 1 was the surrogate decision-maker. A review of Resident 1's physician's orders [REDACTED]. On 8/20/2020 at 4:20 p.m., during an interview, the Business Office Staff (Staff 1) and the Social Services Director (SSD) stated Resident 1 had been discharged from the facility on 4/2/2020 and was not readmitted to the facility. Staff 1 stated the resident had the amount of \$1824.32 in a trust account. A review of the facility's undated policy and procedures titled, Refunds, indicated within thirty days of a resident's discharge or death, the facility will refund the resident's personal funds and provide a final accounting of those funds to the resident, the resident's representative or to the resident's estate, as applicable. | | |
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | | TITLE (X6) DATE | |

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.