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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056489	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hollywood Premier Healthcare Center	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 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prepare residents for a safe transfer or discharge from the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49881 Based on interview and record review, the facility failed to provide and document preparation and orientation to ensure a safe and orderly facility-initiated discharge for one of two sampled residents (Resident 1). Resident 1 and/or Family Member 1 (FM 1) were not involved in the post-discharge planning process. There was no post discharge plan developed for 24 hours prior to Resident 1's discharge and the post discharge plan was not reviewed with Resident 1 and FM 1. This deficient practice had a potential for Resident 1 to have an unsafe facility-initiated discharge. Findings: A review of Resident 1's Admission Record indicated the resident was originally admitted to the facility on [DATE] with diagnoses including systemic lupus erythematosus (chronic disease that causes the body's immune system to attack healthy tissues and cells), schizophrenia (a mental illness that is characterized by disturbances in thought), prediabetes (condition where your blood sugar levels are higher than normal but not yet high enough to be diagnosed as diabetes), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). The Admission Record indicated FM 1 was Resident 1's responsible party. A review of Resident 1's care plan regarding the expectation to remain in the facility and had potential to go to a board and care / home was revised 6/8/2024. The care plan intervention indicated to provide family, resident, and or responsible agents with a post discharge plan of care. A review of the Social Service Evaluation dated 8/5/2024 indicated Resident 1 and FM 1 would participate in discharge planning and that the Resident's preferred discharge plan was a long term care facility. A review of Resident 1's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 9/24/2024 indicated the resident was cognitively intact (able to understand and make decisions). According to a review of Resident 1's Notice of Discharge and 30 Day Notice to Quit indicated Resident 1 and the responsible person were notified on 10/2/2024 of Resident 1's effective date of discharge as 11/1/2024. The Notice of Discharge and 30 Day Notice to Quit indicated the reason for discharge was because the resident's health had improved sufficiently so the resident no longer needed the services provided by the facility. The Notice of Discharge and 30 Day Notice to Quit indicated a witness of delivery signature dated 10/2/2024 signed by the facility receptionist. (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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NAME OF PROVIDER OR SUPPLIER Hollywood Premier Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 5401 Fountain Ave. Los Angeles, CA 90029	

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1's Interdisciplinary Team (IDT, a team of health care professionals, which include the facility's medical director, Director of Nursing (DON), social worker, registered nurse, and other staff as needed who work together to establish plans of care for residents) Note dated 10/3/2024 indicated at around 2:50 PM, FM 1 came in the facility and discussed the plan of discharge to an assisted living, FM 1 received the notice of discharge, and was given the flyer of the assisted living. The IDT note indicated the FM 1's plan was to go home and work on a new home for Resident 1. The note indicated while FM 1 was working on the home, the assisted living or board and care were offered for the resident. The note indicated the flyer and notice of discharge was accepted. During an interview on 10/30/2024 at 11:28 AM, the Administrator (ADM) stated the plan was to discharge Resident 1 on 11/1/2024 to a lower level of care and it was a facility-initiated discharge. During a phone interview on 10/30/2024 at 12:12 PM, FM 1 stated he was Resident 1's responsible party and that the facility receptionist gave him a packet of discharge papers for Resident 1, but could not recall the date. FM 1 stated he received a flyer with information about one facility but could not recall the date. The FM 1 stated he would like to take Resident 1 home, but needed one to two months to find a home and he informed the social worker he needed extra time. FM 1 stated he was not involved in selecting a new location for discharge and that he might have been invited to a discharge meeting but could not recall. FM 1 stated he was not offered any tours of the facilities in the discharge paperwork and he believed the plan was for Resident 1 to be discharged on [DATE] but would need to look at the paperwork. During an interview on 10/30/2021 at 1:29 PM, the DON stated after review of Resident 1's electronic health record there was no documentation to show FM 1 received the 30 day notice of discharge on 10/2/2024. The DON confirmed there was an IDT Note dated 10/3/2024 indicating FM 1 received the 30 day notice of discharge. The DON stated FM 1 was given three options of discharging facilities and she provided FM 1 with a flyer to one of the three discharging facilities. The DON stated the three facilities were assisted living. The DON stated she did not offer any tours of the facilities to Resident 1 or FM 1. During an interview with Receptionist 1 on 10/30/2024 at 3:38 PM, the receptionist stated she gave FM 1 a packet regarding discharge information for Resident 1 on 10/2/2024. Receptionist 1 stated she gave FM 1 the packet at about 11 AM when the FM 1 was signing into the visitor log. During a concurrent record review and interview with the DON on 10/30/2024 at 3:45 PM, the Visitor Daily Log and Visitor Log Book for 10/2 and 10/3/2024 were reviewed. The DON stated and confirmed there was no documentation in the log that FM 1 visited the facility on 10/2/2024. The DON confirmed FM 1 visited the facility on 10/3/2024 based on the Visitor Daily Log. The DON stated anybody in the facility can give a resident or the resident representative a 30 Day notice of discharge, but if a member of the IDT team was present, the appropriate person should be social services or nursing services. The DON stated social services and nursing were more knowledgeable and could explain and answer any questions regarding the discharge immediately. (continued on next page)

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent record review and interview with the DON on 10/30/2024 at 4 PM, the Transfer or Discharge, Facility Initiated Policy was reviewed. The DON stated based on the policy, a post discharge plan would be developed for each resident prior to his or her discharge and the plan would be reviewed with the resident, and/or his or her family, at least 24 hours before the residents discharge to another facility. The DON stated there was no documentation a post discharge plan was developed for Resident 1 or discussed with the resident or FM 1. During a concurrent record review and interview with the Social Service Director (SSD) on 10/31/2024 at 9:08 AM, Resident 1's electronic health record was reviewed. The SSD stated it was important to have a post discharge plan to ensure the resident and/or RR were aware of the discharge plan and the facility could address their concerns. The SSD stated FM 1 was given a flyer for one facility and was not offered a tour to the possible facilities. The SSD stated the Social Service department would usually help arrange a tour. The SSD stated it was important to offer the resident and/or the RR a tour of the potential facilities so they could pick a safe place for the resident. The SSD stated she did not discuss the appeal process for discharge with FM 1. The SSD stated she was an advocate for the residents, and it was important the resident and RR to know their rights including the appeal process for discharge. During a concurrent record review and interview with the DON on 10/31/2024 at 10:31 AM, Resident 1's electronic medical record was reviewed. The DON stated and confirmed there was no post discharge plan for Resident 1. The DON stated since 10/3/2024, there was no documentation of follow up with the Resident 1 or FM 1 regarding the discharge plan. The DON stated it was important to have a post discharge plan to discuss the discharge process with the resident and/or RR and provide instructions on medications, follow up appointments, and address resident concerns. The DON stated she did not discuss the appeal process for discharge with FM 1. The DON stated informing the resident and/or the RR of the appeal process should have been done when providing the 30 day notice of discharge packet. The DON stated it was important to show the resident and/or the RR where the appeal process information was in the packet. The DON stated it was important to discuss the appeal process with the resident and/or RR because it was the resident's right and if the resident or RR did not feel ready to discharge, they had an option to appeal the discharge. During an interview with the DON on 10/31/2024 at 10:35 AM, the DON stated there was no active physician's order for Resident 1 to be discharged . A review of the facility's policy and procedure titled, Transfer or Discharge, Facility Initiated, revised 10/2022 indicated once admitted to the facility, residents had the right to remain in the facility. The policy indicated facility-initiated transfers and discharges, when necessary, must meet specific criteria and require resident / representative notification and orientation, and documentation as specified in this policy. The policy under the section of Orientation for Transfer or Discharge (Planned) indicated a post-discharge plan was developed for each resident prior to his or her transfer or discharge. The plan would be reviewed with the resident, and/or his or her family, at least 24 hours before the resident's discharge or transfer from the facility. A member of the IDT would review the final post-discharge plan with the resident and family at least 24 hours before the discharge was to take place. A review of the facility's policy and procedure titled, Discharge Summary and Plan, revised 10/2016 indicated the resident / family would be involved in the post-discharge planning process and informed of the final post-discharge plan.