STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056433	A. BUILDING _____ B. WING _____	**07/16/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VERMONT HEALTHCARE CENTER	**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)
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's business office (billing/accounting) failed to ensure funds were conveyed upon discharge to one sampled resident's (Resident A) responsible party (RP). This deficient practice resulted in $175.00 being held for approximately one year. Findings: A review of Resident A's Admission Records indicated the resident was admitted to the facility on [DATE] and discharged on [DATE]. A review of the facility's Transaction Report, dated 7/10/2020, indicated Resident A's RP was refunded a total of $8,925.00 with an outstanding balance of $175.00 due back to Resident A's RP. On 7/8/2020 at 4:44 p.m., during an interview, the Billing Director (BD) stated Resident A was a private pay resident and the facility required that Resident A pay for the entire amount of stay in advance. The BD stated Resident A's RP gave a deposit of $10,850.00 for 31 days at $350.00 per day. The BD stated Resident A had two days remaining coverage through Medicare and a supplemental insurance that was billed for the co-pay. The BD stated upon Resident A's discharge from the facility, a refund of $8925.00 was credited back to the RP's credit card and once Medicare and the supplemental insurance were paid there was an additional refund owed to the RP of $175.00. The BD stated she spoke to Resident A's RP regarding the refund but neglected to follow through and send it to her. The BD stated a refund for $175.00 would be sent out immediately. A review of the facility's policy and procedure (P/P) titled, Rent/Refund/Bad Debt Collection, dated 12/15/17, indicated if the renter dies or is hospitalized or transferred and does not return to the facility or has been discharged , a refund check will be issued to the resident/representative/estate trustee/estate heir or legatee within fourteen (14) days.

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.