STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055755	A. BUILDING _____ B. WING _____	**10/13/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SHARON CARE CENTER	**8167 WEST THIRD ST. LOS ANGELES, CA 90048**

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 0622 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure a physician evaluated, identified and documented the medical and discharge needs for two of six sampled residents (Residents 1 and 4). This deficient practice had the potential to result in Resident 1 (R1) and Resident 4 (R4) experiencing suffering, fear, and danger because of unmet medical needs. Findings: A review of R1's Admission Record, dated 7/21/20, indicated R1 was a [AGE] year-old male, admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. During an interview and a concurrent record review with the Administrator (ADM), on 8/18/20, at 11:10 AM, a review of R1's Enhance Care Program Discharge Note, written by Medical Doctor 1 (MD 1), dated 7/31/20, did not indicate a reason why MD1 ordered the facility to discharge R1. The ADM stated MD1 did not indicate a reason for ordering the facility to discharge R1. A review of R4's Admission Record, dated 7/27/20, indicated R4 was a [AGE] year-old man, admitted to the facility on [DATE] after developing a painful blood clot in his leg making it difficult to walk. During an interview and a concurrent record review with ADM, on 8/18/20 at 11:15 AM, a review of R4's Discharge Summary, written by Nurse Practitioner 1 (NP1), dated 7/23/20, did not indicate a specific reason why NP1 ordered the facility to discharge R4. An X mark was next to the words, The resident's health has improved sufficiently and no longer need the service provided by the facility. However there was no indication of what specific aspects of R4's health had improved. There was also no indication of what specific address to which NP1 ordered the facility to discharge R4. The ADM stated NP1 did not indicate what specific aspects of R4's health have improved, that would explain why NP1 ordered the facility to Discharge R4. The ADM stated the area designated for the specific address of the discharge location, was blank but should not be blank. The facility's policy and procedures titled, OPS404 Discharge and Transfer, dated 10/1/20, indicated, the Notice of Involuntary Discharge (NOID) must be consistent with state law and include: 3.2.1 reason for and effective date of transfer; 3.2.2 location of transfer (physical address); 3.4 a copy of the NOID is placed in the clinical record and a copy forwarded to the local district Ombudsman or other required state agency. The policy indicated 3.4.1 physician documentation will be included per federal and/or state regulation.
F 0623 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify six of six sampled residents (Residents 1, 2, 3, 4, 5 and 6) or the residents' responsible party, in writing, about the residents proposed transfer and discharge to an equal or lower level of care, at least 30 days before their discharges from the facility. This deficient practice denied the residents and their responsible parties of their right to appeal their discharges, seek advocacy from the Ombudsman office, or make safe and appropriate arrangements prior to the residents leaving the facility. Findings: A review of Resident 1's Admission Record, dated 7/21/20, indicated Resident 1 was a [AGE] year-old male, admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. During an interview and a concurrent record review with the Administrator (ADM) on 8/18/20, at 11:20 AM, a review of Resident 1's Notice of Transfer/Discharge, dated 7/30/20, indicated the facility gave Resident 1 a written notice of his impending discharge on the same day the facility discharged him, not at least 30 days before the facility discharged him. The ADM stated the facility should have given Resident 1 the written notice of his discharge at least 30 days before he was discharged as required by regulation. The ADM further stated it was important to give a resident a written notice of their impending discharge so they have time to appeal their discharge and plan for where they will go when they leave the facility. A review of R2's Admission Record, dated 8/25/20, indicated she was a [AGE] year old woman, admitted to the facility on [DATE] for an infection of her digestive system. During an interview and concurrent record review on 8/18/20 at 11:27 AM, a review of R2's medical record did not indicate the facility completed and gave to R2, a written notice of her impending discharge. The ADM stated that the facility should have, but did not, give R2 a written notice of her discharge at least 30 days before the facility discharged her, as required by regulation. The DON stated, If we did, we cannot find it in the chart. The ADM stated it was important to give a resident a written notice of their impending discharge so that they have time to appeal their discharge and plan for where they will go when they leave the facility. The DON stated it was important for the facility to keep a resident medical record organized and complete so that the resident can advocate for themselves and so that their healthcare providers can be aware of their medical status and medical needs. A review of R3's Admission Record, dated 8/25/20, indicated he was a [AGE] year old man, admitted to the facility on [DATE] to recover from a surgery on his hip. During a concurrent interview and record review on 8/18/20 at 11:25 AM, a review of R3's medical record did not indicate that the facility completed and gave to R3, a written notice of his impending discharge. The ADM stated that the facility should have, but did not, give R3 a written notice of his discharge at least 30 days before the facility discharged him, as required by regulation. The DON stated, If we did, we cannot find it in the chart. The ADM stated it was important to give a resident a written notice of their impending discharge so that they have time to appeal their discharge and plan for where they will go when they leave the facility. The DON stated it was important for the facility to keep a resident medical record organized and complete so that the resident can advocate for themselves and so that their healthcare providers can be aware of their medical status and medical needs. A review of R4's admission Record, dated 7/27/20, indicated R4 was a [AGE] year-old man, admitted to the facility on [DATE] after developing a painful blood clot in his leg that made walking difficult. During an interview and concurrent record review on 8/18/20 at 11:27 AM, a review of R4's Notice of transfer/Discharge, dated 7/27/20, there was no indication of the reason why the facility discharged R4, and there was no indication of the specific address of where the facility discharged R4, who the facility notified of R4's discharge or what specific date the facility discharged R4. The ADM stated those areas of the Notice of Transfer/Discharge were, blank, but they should have been filled in. The DON stated it was important for the facility to keep a resident medical record organized and complete so that the resident can advocate for themselves and so that their healthcare providers can be aware of their medical status and medical needs. A review of R5's Admission Record, dated 8/25/20, indicated R5 was a [AGE] year-old man, admitted to the facility on [DATE] to recover from a surgery related to [MEDICAL CONDITION]. During an interview and concurrent record review on 8/18/20 at 11:30 AM, a review of R5's Notice of transfer/Discharge, dated 7/7/20, there was no indication of the reason why a the facility discharged R5, or that the facility gave him a written notice of his impending discharge at least 30 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.

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F 0623 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) before the facility discharged him. The ADM stated that the facility should have, but did not, give R5 a written notice of his discharge at least 30 days before the facility discharged him, that also indicated the specific reason why the facility discharged him, as required by regulation. The ADM stated it was important to give a resident a written notice of their impending discharge so that they have time to appeal their discharge and plan for where they will go when they leave the facility. A review of Resident 6's Admission Record, dated 8/25/20, indicated the resident was a [AGE] year-old woman, admitted to the facility on [DATE] to recover from a surgery on her blood vessels. During a concurrent interview and record review on 8/18/20 at 11:35 AM, a review of Resident 6s Notice of Transfer/Discharge, dated 7/24/20, there was no indication of the reason why the facility discharged Resident 6 or that the facility gave her a written notice of her impending discharge at least 30 days before the facility discharged her. The ADM stated the facility should have, but did not, give Resident 6 a written notice of her discharge at least 30 days before the facility discharged her, that also indicated the specific reason why the facility discharged her, as required by regulation. The ADM stated it was important to give a resident a written notice of their impending discharge so that they have time to appeal their discharge and plan for where they will go when they leave the facility.
F 0661 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge.** Based on interview and record review, the facility failed to develop a written Discharge Summary for three of six sampled residents (R1, R4, and R6) that explained the treatment the facility provided to them, how they responded to the treatment, what medications they should continue to take, and how they should take the medications after the facility discharged them. This deficient practice had the potential to result in R1, R4 and R6 and their responsible parties not understanding their medical status at the time of the their discharges from the facility and therefore not understanding if or when they should seek medical help, and not taking the medications they needed, or not taking their medications correctly, which could have resulted in pain, suffering and / or death. Findings: During an interview and concurrent record review on 8/18/20 at 11:40 AM, a review of R1's medical record did not indicate the facility and physician developed a Discharge Summary for R1. The ADM stated the facility and a physician should have but did not develop, a Discharge Summary for R1 that explained the care the facility provided, how R1 responded to the treatment, and explained what medications R1 should continue to take and how to take them. The ADM stated it was important for the facility and a physician to develop a Discharge Summary for residents that explained what medications they should take and how to take them, and that explained the care the facility provided to them and how they responded to the care. The DON stated that if a Discharge Summary was developed for R1, We can't find it. The DON stated it was important for the facility to keep a resident medical record organized and complete so that the resident can advocate for themselves and so that their healthcare providers can be aware of their medical status and medical needs. During an interview and concurrent record review on 8/18/20 at 11:45 AM, a review of R4's Discharge Summary, written by Nurse Practitioner 1 (NP 1), dated 7/23/20, did not explain the treatment the facility provided, how R4 responded to the treatment, or explained what medications R4 should continue to take and how to take them. The ADM stated that NP1 did not but should have developed a Discharge Summary for R4 that explained the treatment that the facility provided, The DON stated that if a Discharge Summary was developed for R1, We can't find it. The DON stated it was important for the facility to keep a resident medical record organized and complete so that the resident can advocate for themselves and so that their healthcare providers can be aware of their medical status and medical needs. During an interview and concerrent record review on 8/18/20 at 11:50 AM, a review of Resident 6s Discharge Summary, dated 7/24/20, did not explain the care that the facility provided, how R4 responded to the treatment, or explained what medications Resident 6 should continue to take and how to take them. The DON stated Resident 6's Discharge Summary did not indicate the specific address to which the facility discharged the resident and that the area designated for that specific address was blank. The DON stated all documentation in a resident's medical record should be complete. The facility's policy and procedures titled, OPS404 Discharge and Transfer, dated 10/1/20, indicated while the discharge planning process is an interprofessional care team responsibility, the registered nurse is ultimately responsible to ensure there is a safe. and coordinated discharge and transfer plan in place for the patient. A Center must immediately inform the patient/resident representative, consult with the patient's physician, and notify when there is a decision to transfer or discharge the patient from the Center. The patient and resident representative must be notified in writing and in a language and manner they understand. A Notice of Involuntary Discharge (NOID) must be provided at least 30 days in advance of a proposed involuntary discharge (facility initiated). Individuals admitted to the Center will not be involuntarily transferred or discharged except for the following specified reasons: Notice must be made as soon as practicable before transfer or discharge when: The safety or health of individuals in the Center would be endangered. The patient's health improves sufficiently to allow a more immediate transfer or discharge; An immediate transfer or discharge is required by the patient's urgent medical needs; A patient has not resided in the Center for 30 days. Copies of all discharge and/or transfer documentation will be maintained in the medical record. The interprofessional care team will provide sufficient preparation and orientation to the patient prior to transfer or discharge. The Center Executive Director (CED) or designee will ensure systems are implemented to provide appropriate documentation to the patient and resident representative prior to the transfer or discharge. 3.1 A NOID or state specific discharge form must be provided at least 30 days in advance of the proposed discharge to the patient, family member, or legal representative.