STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056489	A. BUILDING _____ B. WING _____	**06/18/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0625 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide Resident 1 with written information specifying the duration of the bed-hold upon transfer or soon after transfer to General Acute Care Hospital 1 (GACH 1). This deficient practice resulted in Resident 1 being deprived of exercising his right to a bed-hold and his right to return to the facility. Findings: A review of Resident 1's Admission Record indicated the facility admitted Resident 1 on 1/25/2012 with [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set (MDS - standardized assessment and care-screening tool) dated 4/3/2020, indicated Resident 1 was confused, was unable to make decisions and needed one-person physical assistance with transfers, eating, walking, and personal hygiene. A review of Resident 1's Change of Condition (COC) form dated 5/26/2020, time at 5:34 p.m. indicated Resident 1 was hitting and yelling at staff multiple times. Resident 1 threw juice and a food tray at staff. Resident 1's Psychiatric Nurse Practitioner was notified, and the NP ordered to transfer Resident 1 to GACH 1. A review of Resident 1's Nursing Progress Notes dated 5/26/19, at 10:16 p.m., indicated Resident 1 was transferred to GACH 1 via ambulance. On 5/28/2020, at 3:03 p.m., during an interview, the Interim Director of Nursing (IDON) stated Resident 1 was transferred to GACH 1 because of his aggressive behavior. IDON stated GACH 1 called the facility on 5/27/2020 to inform them Resident 1 was ready to return but the facility declined to readmit because the facility became an approved (by the Health Officer of the Public Health Department) Designated COVID-19 (Coronavirus disease, highly contagious [MEDICAL CONDITION] infection) facility. The IDON stated they were only accepting residents positive for COVID-19. The IDON stated Resident 1 will not be readmitted because he tested negative for COVID-19. On 5/29/2020, at 3 p.m., during a telephone interview, the Business Office Manager stated the facility did not provide Resident 1 with a Bed-hold notification upon transferred to GACH 1 because Resident 1 tested negative for COVID-19. A review of the facility's Coronavirus Protocol, revised on 5/13/20, indicated the facility would be converted to a COVID-19 Designated and the goal was admitting COVID-19 positive residents only. The Protocol indicated the facility was currently divided into two sections, COVID-19 positive residents and COVID-19 negative residents and patients under investigation (PUIs). The facility would transfer all the COVID-19 negative residents to 11 different facilities within their network and same level of care. During a telephone interview on 6/2/2020, at 2:21 p.m., the Administrator stated the Bed-hold policy did not apply to Resident 1 because Resident 1 did not have COVID-19. Although Resident 1 had lived in the facility since 1/25/2012 (over eight years), the Administrator did not make arrangements to have Resident 1 readmitted to the facility in an area not affected by COVID-19 and prepare Resident 1 to transfer or discharge within the regulatory requirements. The administrator stated if Resident 1 was readmitted , he could get infected with COVID-19. A review of the facility's policy on Bed Hold Notification, dated 1/2014, indicated the facility shall inform the resident or the resident's representative in writing of their right to exercise the bed hold provision of seven days at the time of admission and at the time of transfer for hospitalization or therapeutic leave. A copy of the Notice will be a part of the resident's health record at the time of transfer. A review of the local Public Health Department document titled, Coronavirus Disease 2019 Facility Transfers and Home Discharge Guidelines, Patient Transfer Criteria from Hospitals dated 4/23/20, indicated for residents who originated from a long-term care (LTC) facility experiencing an outbreak, if the resident's departure was less than 14 days prior, residents should be allowed to return to the facility. While facilities are closed to new admissions, they are not closed to returning asymptomatic residents within the 14-day period exposure.
F 0626 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure Resident 1, who was living at the facility for over eight years and had MediCal benefits, was permitted to return to the facility after General Acute Care Hospital 1 (GACH 1) was ready to discharge and send Resident 1 back to the facility on [DATE]. This deficient practice resulted in Resident 1 to remain hospitalized waiting to find placement at another facility. Findings: A review of Resident 1's Admission Record (Face Sheet) indicated the facility admitted Resident 1 on 1/25/2012 with [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set (MDS - standardized assessment and care-screening tool) dated 4/3/2020, indicated Resident 1 was confused, was unable to make decisions and needed one-person physical assistance with transfers, eating, walking, and personal hygiene. A review of Resident 1's Change of Condition (COC) form dated 5/26/2020, time at 5:34 p.m. indicated Resident 1 was hitting and yelling at staff multiple times. Resident 1 threw juice and a food tray at staff. Resident 1's Psychiatric Nurse Practitioner was notified, and the NP ordered to transfer Resident 1 to GACH 1. A review of Resident 1's Nursing Progress Notes dated 5/26/19, at 10:16 p.m., indicated Resident 1 was transferred to GACH 1 via ambulance. On 5/28/2020, at 3:03 p.m., during an interview, the Interim Director of Nursing (IDON) stated Resident 1 was transferred to GACH 1 because of his aggressive behavior. IDON stated GACH 1 called the facility on 5/27/2020 to inform them Resident 1 was ready to return but the facility declined to readmit because the facility became an approved (by the Health Officer of the Public Health Department) Designated COVID-19 (Coronavirus disease, highly contagious [MEDICAL CONDITION] infection) facility. The IDON stated they were only accepting residents positive for COVID-19. The IDON stated Resident 1 would not be readmitted because he tested negative for COVID-19. During a telephone interview on 6/2/2020, at 2:21 p.m., the Administrator stated the Bed-hold policy did not apply to Resident 1 because Resident 1 did not have COVID-19. Although Resident 1 had lived in the facility since 1/25/2012 (over eight years), the Administrator did not make arrangements to have Resident 1 readmitted to the facility in an area not affected by COVID-19 and prepare Resident 1 to transfer or discharge within the regulatory requirements. The administrator stated if Resident 1 was readmitted , he could get infected with COVID-19. On 6/13/2020, at 3:45 p.m., during a telephone interview, the Registered Nurse Supervisor (RNS) confirmed Resident 1 was not readmitted to the facility. On 6/15/2020 at 4:05 p.m., during a telephone interview with GACH 1's Social Worker, she indicated Resident 1 remained at the hospital waiting for the facility to readmit him. The Social Worker stated there was a discharge order for Resident 1 to return to the facility. A review of the facility's Coronavirus Protocol, revised on 5/13/20, indicated the facility would be converted to a COVID-19 Designated and the goal was admitting COVID-19 positive residents only. The Protocol indicated the facility was currently divided into two sections, COVID-19 positive residents and COVID-19 negative residents and patients under investigation (PUIs). The facility would transfer all the COVID-19 negative residents to 11 different facilities within their network and same level of care. A review of the local Public Health Department document titled, Coronavirus Disease 2019 Facility Transfers and Home Discharge Guidelines,

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 0626 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) Patient Transfer Criteria from Hospitals dated 4/23/20, indicated for residents who originated from a long-term care (LTC) facility experiencing an outbreak, if the resident's departure was less than 14 days prior, residents should be allowed to return to the facility. While facilities are closed to new admissions, they are not closed to returning asymptomatic residents within the 14-day period exposure. A review of the facility's policy and procedure on Readmission to the Facility, revised on 3/2017, indicated residents who have been discharged to the hospital or for therapeutic leave will be given priority in readmission to the facility. If it is determined that a resident who was transferred with an expectation that he or she cannot return to the facility, he or she will be discharged accordingly to the Discharge Policy.