State of California - Health and Human Services Agency

Department of Public Health

SECTION 1424 NOTICE

CITATION NUMBER: 91-36526-0015402-S

Date: 09/20/2019 Time: 8:51 A

Type of Visit : Complaint Investig.

YOU ARE HEREBY FOUND IN VIOLATION OF APPLICABLE CALIFORNIA STATUTES AND REGULATIONS OR APPLICABLE FEDERAL STATUTES AND REGULATIONS

Incident/Complaint No.(s) : CA00643017

Licensee Name:	Vernon Healthcare Center, LLC		
Address:	1037 W. Vernon Avenue	Los Angeles, CA 90037	
License Number:	970000025	Type of Ownership:	Limited Liability Company

Facility Name:	VERNON HEALTHCARE CENTER		
Address:	1037 W Vernon Ave	Los Angeles, CA 90037	
Telephone:	(323) 232-4895		
Facility Type:	Skilled Nursing Facility		Capacity: 99
Facility ID:	970000050		

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS	PENALTY ASSESSMENT $2,000.00	DEADLINE FOR COMPLIANCE 9/20/19 11:59 p.m.

T22 DIV5 CH3 ART5-72523(a), 483.30(a)(1)(2), 483.15(c)(1)(i)(ii)(2)(i)-(iii), 483.15(c)(1)(i)(ii)(2)(i)-(iii)

CLASS B CITATION -- PATIENT CARE

F622
§483.15(c) Transfer and discharge-
§483.15(c)(1) Facility requirements-
(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless-
(A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;
(B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility.

§ 72523. Patient Care Policies and Procedures.
(a)Written patient care policies and procedures shall be established and implemented to ensure that patient-related goals and facility objectives are achieved.

The Department received a complaint on 6/24/19 regarding concerns of a resident (Resident 1), who required assistance with care, being discharged to an unlicensed care facility.

On 6/25/19, an unannounced complaint investigation was conducted at the facility.

Name of Evaluator:
Jessica Castillo
RN

Evaluator Signature :

Without admitting guilt, I hereby acknowledge receipt of this SECTION 1424 NOTICE

Signature :

Name :

Title : LVN / RN

NOTE: IN ACCORDANCE WITH CALIFORNIA HEALTH AND SAFTEY CODE, FAILURE TO CORRECT VIOLATIONS IS GROUNDS FOR SUSPENSION OR REVOCATION OF YOUR LICENSE

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS

Based on interview and record review, the facility failed to implement its policy and Resident 1's plan of care to ensure that a discharge was appropriate. Resident 1, who had a diagnosis of diabetes mellitus (high blood sugar) and was receiving insulin (man-made hormone that helps regulates the amount of glucose [sugar] in the blood), had a colostomy (surgical operation in which a piece of the colon is diverted to an artificial opening in the abdominal wall for bowel excretion), and a wound to her left lower extremity with bone exposed. Resident 1 was discharged to a transitional living facility (temporary housing that has no nursing staff). The facility's deficient practices included:

1. Failure to follow its policy titled, "Transfer and Discharge," which indicated that the Social Services Designee (SSD) and the Interdisciplinary Team ([IDT] group of medical professionals that coordinate, collaborate, and plan the delivery of care for residents) would determine if a discharge to a lower level of care (a resident only requires minimal assistance with care) was appropriate for Resident 1.

2. Failure to assess Resident 1 appropriately to ensure Resident 1 was medically stable and no longer required the services of a Skilled Nursing Facility (SNF).

3.Failure to adhere to Resident 1's care plan that stipulated Resident 1 would not be discharged until medically stable.

4. Failure to ensure Resident 1's physician (Physician 1) approved Resident 1's discharged to lower level of care.

These failures resulted in Resident 1, who required extensive assistance and supervision with medication administration, care, and activities of daily living (ADLs), being discharged to an unlicensed transitional living facility and her needs not being met.

A review of Resident 1's Face Sheet (Admission Record) indicated Resident 1, was a 71 year-old female, who was admitted to the facility on 4/5/19. Resident 1's diagnoses included diabetes mellitus, asthma (condition in which one's airway become inflamed making it difficult to breathe), and depression (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life).

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS

A review of Resident 1's Minimum Data Set (MDS), a resident assessment and care planning tool, dated 4/12/19, indicated Resident 1's cognition (thought process) was intact and had no memory problems. The MDS indicated Resident 1 required limited assistance of a one-person physical assist for bed mobility, transfers, eating, dressing, personal hygiene and toileting. According to the MDS, Resident 1 had an indwelling urinary catheter (tube inserted into the bladder to drain urine) and a colostomy bag.

A review of Resident 1's Interdisciplinary Team (IDT) note, dated 4/16/19, indicated that the discharge plan could not be initiated because Resident 1 required assistance with medication management and performance of activities of daily living (ADL).

A review of Resident 1's care plan, dated 5/1/19 and titled, "Discharge," indicated the resident wanted to be discharged to a lower level of care facility. The goal was to discharge Resident 1 when medically stable. The staff's approach included to follow-up with Resident 1 to ensure an understanding of the plan and answer any additional questions Resident 1 may have.

A review of Resident 1's care plan, dated 4/7/19 and titled, "Activities of Daily Living," indicated Resident 1 had cellulitis (a bacterial skin infection) of the left lower extremity and required assistance with dressing, transferring, personal hygiene, and toileting. The goal was for Resident 1 to improve in ADL self-performance. The staff's interventions included to provide assistance with ADL care as needed.

A review of Resident 1's Wound Assessment and Plan, dated 4/25/19, indicated Resident 1 had a left lower anterior leg non-healing wound with full thickness of tissue affected and bone exposure. Resident 1 was receiving wound care treatment after having the wound debrided on 4/18/19 (removal of non-viable tissue from the wound bed to encourage wound healing) of Alginate (used as foam, clotting agents and gauze in absorbable surgical dressings and packing) after wound cleanse with normal saline every day.

A review of a Physician Telephone Order, dated 5/2/19 and timed at 8 a.m., indicated to discharge Resident 1 to a transitional living home and follow-up with home health services for home evaluation, diabetic teaching, insulin administration, blood sugar

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checks daily, and colostomy care.

A review of Resident 1's "Physician Discharge Summary," dated 5/2/17 and signed by the physician on 6/27/19 (over a month later), indicated that Resident 1's health had improved sufficiently and no longer needed the services provided by the skilled nursing facility.

On 6/25/19 at 9:28 a.m., during an interview, the Social Services Designee (SSD) stated that for residents to be transferred to a lower level of care they were to be medically stable. The SSD stated that the IDT identified that Resident 1 reached her maximum goal for discharge.

On 8/6/19 at 1:54 p.m., during a telephone interview, Resident 1's physician (Physician 1) stated that he never authorized the transfer of Resident 1 to a lower level of care facility. Physician 1 stated that he addressed his concerns with the facility's staff regarding discharging residents to lower level of care facilities when they continued to require skilled nursing services.

On 8/22/19 at 2:48 p.m., during a concurrent interview and review of Resident 1's wound assessment, the Administrator In Training (AIT) and the SSD stated Resident 1 was discharged to a transitional living facility with an opened wound as indicated by Resident 1's last wound assessment.

A review of the facility's policy and procedures, revised on 10/2017, and titled, "Transfer and Discharge," indicated that the social service designee with the interdisciplinary team and the primary physician would determine if the discharge was appropriate for a resident. The social services would coordinate and complete an assessment and develop a planned program for the resident's discharge to a lower level of care.

The facility failed to implement its policy and Resident 1's plan of care to ensure that a discharge was appropriate. Resident 1, who had a diagnosis of diabetes mellitus and was receiving insulin, had a colostomy, and a wound to her left lower extremity with bone exposed. Resident 1 was discharged to a transitional living facility. The facility's deficient practices included:

1. Failure to follow its policy titled, "Transfer and Discharge," which indicated that the SSD and the IDT would determine if a discharge to a lower level of care was

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	appropriate for Resident 1. 2. Failure to assess Resident 1 appropriately to ensure Resident 1 was medically stable and no longer required the services of a Skilled Nursing Facility (SNF). 3.Failure to adhere to Resident 1's care plan that stipulated Resident 1 would not be discharged until medically stable. 4. Failure to ensure Resident 1's physician (Physician 1) approved Resident 1's discharged to lower level of care. These failures resulted in Resident 1, who required extensive assistance and supervision with medication administration, care, and ADLs, being discharged to an unlicensed transitional living facility and her needs not being met. This violation had a direct relationship to the health, safety or security of Resident 1.

POC accepted 9/24/19 @ 8:15am
36526

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055167	A. BUILDING _____ B. WING _____	08/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERNON HEALTHCARE CENTER	1037 W Vernon Ave, Los Angeles, CA 90037-2415 LOS ANGELES COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	The following reflects the findings of the Department of Public Health during a Complaint Investigation visit: CLASS B CITATION -- PATIENT CARE 91-36526-0015402-S Complaint(s): CA00643017 Representing the Department of Public Health: Surveyor ID # 36526, RN The inspection was limited to the specific facility event investigated and does not represent the findings of a full inspection of the facility. F622 §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility. § 72523. Patient Care Policies and Procedures. (a)Written patient care policies and procedures shall be established and implemented to ensure that patient-related goals and facility objectives are achieved. The Department received a complaint on 6/24/19		"Preparation, submission and/or execution of this Plan of Correction does not constitute admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared, submitted and/or executed solely because it is required by the provision of federal and state law." **Corrective Actions:** Resident #1 is no longer in the facility. **How to Identify Other Residents:** A. On 5/23/19, the IDT members initiated review of residents who were discharged to lower level of care during the period of 05/01/19-05/22/19 for appropriateness of their discharges, who might have a potential to be affected with his finding. Any findings to be reported to Administrator and DON	09/22/19

Event ID:63W111 9/19/2019 11:04:46AM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature], RN | TITLE DON | (X6) DATE 09/23/19

By signing this document, I am acknowledging receipt of the entire citation packet, Page(s). 1 thru 7

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. Except for nursing homes, the findings 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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	regarding concerns of a resident (Resident 1), who required assistance with care, being discharged to an unlicensed care facility. On 6/25/19, an unannounced complaint investigation was conducted at the facility. Based on interview and record review, the facility failed to implement its policy and Resident 1's plan of care to ensure that a discharge was appropriate. Resident 1, who had a diagnosis of diabetes mellitus (high blood sugar) and was receiving insulin (man-made hormone that helps regulates the amount of glucose [sugar] in the blood), had a colostomy (surgical operation in which a piece of the colon is diverted to an artificial opening in the abdominal wall for bowel excretion), and a wound to her left lower extremity with bone exposed. Resident 1 was discharged to a transitional living facility (temporary housing that has no nursing staff). The facility's deficient practices included: 1. Failure to follow its policy titled, "Transfer and Discharge," which indicated that the Social Services Designee (SSD) and the Interdisciplinary Team ([IDT] group of medical professionals that coordinate, collaborate, and plan the delivery of care for residents) would determine if a discharge to a lower level of care (a resident only requires minimal assistance with care) was appropriate for Resident 1. 2. Failure to assess Resident 1 appropriately to		B. Director of Nursing or Designee did a 1:1 in-service with the Director of Social Service/ AIT on 5/24/19 regarding the following: • Discharge Planning discussion with resident or responsible party will be held by IDT during the initial baseline care plan conference or any changes in condition on the resident, as well as anticipated discharge from skilled rehabilitation therapy and skilled nursing that prohibits resident on being discharged to lower level of care • Discussion by IDT with resident or responsible party and updating the Primary MD for any changes in conditions, any caregiver needs, DME and home health needs for safe discharge of the resident, as well as other options of discharge destination • Nursing Supervisor or Designee will coordinate the educational teachings with the resident or responsible party needs prior to discharge of resident to lower level of care.	

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	ensure Resident 1 was medically stable and no longer required the services of a Skilled Nursing Facility (SNF). 3.Failure to adhere to Resident 1's care plan that stipulated Resident 1 would not be discharged until medically stable. 4. Failure to ensure Resident 1's physician (Physician 1) approved Resident 1's discharged to lower level of care. These failures resulted in Resident 1, who required extensive assistance and supervision with medication administration, care, and activities of daily living (ADLs), being discharged to an unlicensed transitional living facility and her needs not being met. A review of Resident 1's Face Sheet (Admission Record) indicated Resident 1, was a 71 year-old female, who was admitted to the facility on 4/5/19. Resident 1's diagnoses included diabetes mellitus, asthma (condition in which one's airway become inflamed making it difficult to breathe), and depression (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). A review of Resident 1's Minimum Data Set (MDS), a resident assessment and care planning tool,		C. On 5/24/19, the Director of Nursing or Designee initiated in-services for the Social Service staff and Licensed Nurses on the following: • Discharge Planning discussion with resident or responsible party will be held by IDT during the initial baseline care plan conference or any changes in condition on the resident, as well as anticipated discharge from skilled rehabilitation therapy and skilled nursing that prohibits resident on being discharged to lower level of care • Discussion by IDT with resident or responsible party and updating the Primary MD for any changes in conditions, any caregiver needs, DME and home health needs for safe discharge of the resident, as well as other options of discharge destination	

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	dated 4/12/19, indicated Resident 1's cognition (thought process) was intact and had no memory problems. The MDS indicated Resident 1 required limited assistance of a one-person physical assist for bed mobility, transfers, eating, dressing, personal hygiene and toileting. According to the MDS, Resident 1 had an indwelling urinary catheter (tube inserted into the bladder to drain urine) and a colostomy bag. A review of Resident 1's Interdisciplinary Team (IDT) note, dated 4/16/19, indicated that the discharge plan could not be initiated because Resident 1 required assistance with medication management and performance of activities of daily living (ADL). A review of Resident 1's care plan, dated 5/1/19 and titled, "Discharge," indicated the resident wanted to be discharged to a lower level of care facility. The goal was to discharge Resident 1 when medically stable. The staff's approach included to follow-up with Resident 1 to ensure an understanding of the plan and answer any additional questions Resident 1 may have. A review of Resident 1's care plan, dated 4/7/19 and titled, "Activities of Daily Living," indicated Resident 1 had cellulitis (a bacterial skin infection) of the left lower extremity and required assistance with dressing, transferring, personal hygiene, and toileting. The goal was for Resident 1 to improve in ADL self-performance. The staff's interventions included to provide assistance with ADL care as needed.		• Nursing Supervisor or Designee will coordinate the educational teachings with the resident or responsible party needs prior to discharge of resident to lower level of care. **Measures to Prevent Recurrence** A. Upon admission, resident discharge planning will be initiated by Social Service staff with resident or responsible party. B. Resident's clinical record will be reviewed by IDT during Discharge Planning and 3 days prior to the anticipated discharge to verify that the resident's current ADL functions and skin conditions will be appropriate to the Discharge location as planned by resident/responsible party and IDT.	

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	A review of Resident 1's Wound Assessment and Plan, dated 4/25/19, indicated Resident 1 had a left lower anterior leg non-healing wound with full thickness of tissue affected and bone exposure. Resident 1 was receiving wound care treatment after having the wound debrided on 4/18/19 (removal of non-viable tissue from the wound bed to encourage wound healing) of Alginate (used as foam, clotting agents and gauze in absorbable surgical dressings and packing) after wound cleanse with normal saline every day. A review of a Physician Telephone Order, dated 5/2/19 and timed at 8 a.m., indicated to discharge Resident 1 to a transitional living home and follow-up with home health services for home evaluation, diabetic teaching, insulin administration, blood sugar checks daily, and colostomy care. A review of Resident 1's "Physician Discharge Summary," dated 5/2/17 and signed by the physician on 6/27/19 (over a month later), indicated that Resident 1's health had improved sufficiently and no longer needed the services provided by the skilled nursing facility. On 6/25/19 at 9:28 a.m., during an interview, the Social Services Designee (SSD) stated that for residents to be transferred to a lower level of care they were to be medically stable. The SSD stated that the IDT identified that Resident 1 reached her maximum goal for discharge.		C. Any changes in conditions will be discussed with IDT members and licensed nurses and will be placed in the 24 hr communication book for follow through, as well as communicated with the resident's Primary MD. D. Social Service staff will notify the Primary MD of the discharge plans and the any Home Health, caregiver and DME needs. If resident is not safe to be discharged to the lower level of care, resident will be then be transfer to another SNF facility or continues to stay in the facility as custodial care. E. Social Service /Designee will follow up with discharged residents within 72 hours of discharge, 14 days post-discharge and 30 days post-discharge to ensure services set up upon discharge are still in place and that resident is safe.	

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	On 8/6/19 at 1:54 p.m., during a telephone interview, Resident 1's physician (Physician 1) stated that he never authorized the transfer of Resident 1 to a lower level of care facility. Physician 1 stated that he addressed his concerns with the facility's staff regarding discharging residents to lower level of care facilities when they continued to require skilled nursing services. On 8/22/19 at 2:48 p.m., during a concurrent interview and review of Resident 1's wound assessment, the Administrator In Training (AIT) and the SSD stated Resident 1 was discharged to a transitional living facility with an opened wound as indicated by Resident 1's last wound assessment. A review of the facility's policy and procedures, revised on 10/2017, and titled, "Transfer and Discharge," indicated that the social service designee with the interdisciplinary team and the primary physician would determine if the discharge was appropriate for a resident. The social services would coordinate and complete an assessment and develop a planned program for the resident's discharge to a lower level of care. The facility failed to implement its policy and Resident 1's plan of care to ensure that a discharge was appropriate. Resident 1, who had a diagnosis of diabetes mellitus and was receiving insulin, had a colostomy, and a wound to her left lower extremity with bone exposed. Resident 1 was discharged to a transitional living facility. The facility's deficient practices included:		F. During the AM Stand Up meeting daily (M-F), IDT will disccuss any residents scheduled for discharge and the resident's chart will then be reviewed by IDT and discussed with resident/ responsible party on any other needs resident require. **Monitoring** During the monthly QA meeting, the Social Service Director or Designee will give reports on residents' discharge to lower level of care. Any finding will be discuses by QA committee for further recommendations.	

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	1. Failure to follow its policy titled, "Transfer and Discharge," which indicated that the SSD and the IDT would determine if a discharge to a lower level of care was appropriate for Resident 1. 2. Failure to assess Resident 1 appropriately to ensure Resident 1 was medically stable and no longer required the services of a Skilled Nursing Facility (SNF). 3.Failure to adhere to Resident 1's care plan that stipulated Resident 1 would not be discharged until medically stable. 4. Failure to ensure Resident 1's physician (Physician 1) approved Resident 1's discharged to lower level of care. These failures resulted in Resident 1, who required extensive assistance and supervision with medication administration, care, and ADLs, being discharged to an unlicensed transitional living facility and her needs not being met. This violation had a direct relationship to the health, safety or security of Resident 1.			