STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055042	A. BUILDING _____ B. WING _____	09/16/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ALTA VISTA HEALTHCARE & WELLNESS CENTRE	9020 GARFIELD STREET RIVERSIDE, CA 92503

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 0623 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**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 ensure for one of three sampled residents (Resident A), a written notification of transfer/discharge was provided to the office of the state long-term care ombudsman (advocate for residents of nursing homes), pursuant to state and federal regulations. This failure increased the potential for the ombudsman to not be aware or immediately involved with facility practices and activities related to the resident's transfer or discharge. Findings: On July 14, 2020, at 8:55 a.m., an unannounced visit was conducted to the facility for the investigation of a complaint related to transfer and discharge rights. Resident A's record was reviewed. Resident A was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The admission history and physical, dated May 7, 2020, indicated the resident can make needs known but cannot make medical decisions. There was no family member or responsible party listed on the resident's profile/face sheet. The untitled care plan, dated May 4, 2020, indicated, Resident requires personal alarm when in: wheelchair, bed due to at risk for elopement (incident when a resident leaves the facility without authorization or supervision necessary for his or her safety) . The nurse's notes, dated May 5, 2020, at 1:56 a.m., indicated, N/A (new admit) resident .hospitalized for [REDACTED]. Was previously incarcerated for 20 yrs., but became incompetent due to injuries from fight . Resident is ambulatory, alert, but confused. Resident is easily agitated. Resident is not very cooperative with staff so anyone attending resident must use caution . Resident may attempt elopement so ambulation must be supervised. Resident will have WanderGuard (a monitoring device with an alarm) . The nurse's notes, dated May 5, 2020, at 3:30 a.m., indicated, .alert with confusion, able to verbalize needs. WanderGuard placed on patient's (L) (left) leg . The discharge care plan, dated May 8, 2020, indicated, Resident wants to be discharged to: uncertain . The minimum data set (MDS- a comprehensive assessment tool), dated May 11, 2020, indicated, .Brief Interview for Mental Status (BIMS - screening test used for mental and cognitive status) score of 3 out of 15 (a score of 0-7 indicates severe cognitive impairment). A physician's behavioral note, dated June 8, 2020, indicated, .Patient doesn't speak much, he is easily confused, much clarification and calming required . The physician's order, dated June 17, 2020, at 1:00 p.m., indicated, D/c (discharge) to (name of skilled nursing facility (SNF) 1) . today . The social service progress notes, dated June 17, 2020 (no documented time), indicated, SW (social worker) assisting resident with transfer to another SNF, faxed referral to (name of SNF 1) for consideration for temporary SNF placement . A discharge summary/post-discharge plan of care was completed and signed by Registered Nurse Supervisor on June 17, 2020. There was no documented evidence of a written notice of transfer/discharge provided to the resident or the ombudsman related to the planned discharge on June 17, 2020. A physician's order, dated June 18, 2020, at 11:00 a.m., indicated, Hold discharge order to (name of SNF 1) The social service progress notes, dated June 18, 2020 (no documented time), indicated, SW followed up with resident's transfer status and was made aware that resident is unable to be admitted to (SNF 1) at this time. SW to continue efforts to find alternatives d/t (due to) current Covid mitigation plan. The nurse's notes, dated June 18, 2020, at 11:00 a.m., indicated, DON (Director of Nursing) informed RN (registered nurse) to hold d/c order to (name of SNF 1) per MD (physician). There was no physician's order or nurse's notes of the resident's discharge from the facility on June 21, 2020. The undated physician's discharge summary, indicated, .discharge date : 6/21/20 . Discharge to: (SNF 2) . DC planning for (SNF 1): 6/17/2020. DC cancelled on 6/18/2020. DC diverted to (SNF 2) temporarily . On July 14, 2020, at 10:28 a.m., Resident A's record was reviewed with the Social Services Director (SSD) and confirmed there was no nurse's notes and physician's order in the resident's record regarding his discharge from the facility on June 21, 2020. She stated the resident was supposed to be discharged to SNF 1 on June 17, 2020, but was cancelled at the last minute. The resident was then referred to SNF 2. On July 14, 2020, at 1:59 p.m., the district office received faxed documents from the facility, which included nurse's notes and physician's order regarding the resident's discharge. These documents were not previously present during the onsite closed chart review. On July 14, 2020, at 2:30 p.m., the Medical Records Director (MRD) was interviewed regarding the new documents received. She confirmed the documents were not in the chart during record review as they were found in the DSD office. She stated the documents were given to her by the DSD. On July 17, 2020, at 11:05 a.m., the SSD was interviewed regarding the facility's process on notice of transfer and discharge. She stated the notice of transfer and discharge is given to the resident or representative upon discharge. She stated the white (original form) goes to the patient and the carbonless copy paper (type of coated paper designed to transfer information written on the front onto sheets beneath) remains in the chart. She stated the document is faxed to the ombudsman to notify their office of the resident's discharge. On July 17, 2020, at 11:27 a.m., the Ombudsman was interviewed regarding Resident A and stated their office did not receive any document from the facility regarding the resident's transfer and discharge. She stated they were not aware of the planned or actual discharge of Resident A. She further stated the ombudsman office was not notified of the resident's discharge. On July 17, 2020, at 3:46 p.m. the district office received additional faxed documents from the facility, which included a fax transmission log document of a notice of transfer and discharge. The document indicated a confirmation fax of a notice of transfer and discharge sent to the ombudsman's office on June 22, 2020, at 1:22 p.m. The documents faxed did not identify which resident information or documents were provided to the ombudsman. On July 17, 2020, at 4:25 p.m., the Medical Record Staff (MRS) was interviewed regarding Resident A's notice of transfer and discharge. She stated there was no document of a notice of transfer and discharge in the resident's record. On July 17, 2020, at 4:29 p.m., Resident A's record in SNF 2 was reviewed with their Director of Nursing (DON) and confirmed there was no notice of transfer and discharge on file from SNF 1. On July 17, 2020, at 5:04 p.m., the district office received a faxed document from SNF 1 of Resident A's notice of transfer and discharge. This new document was not in the resident's record during the onsite record review and as previously confirmed with MRS. The document indicated, NOTICE OF TRANSFER / DISCHARGE . Resident Name . Notification Date: 6/18/2020 . Person notified: IDT (interdisciplinary team- group of health care professionals) . Effective Date: 6/21/2020 . Transfer/Discharge to: (name of SNF 2) . This notice is to inform you that transfer/discharge is necessary for the following reason: . the transfer or discharge is appropriate because your health has improved sufficiently so that you no longer require services provided by the facility . (signed by:) Facility Representative's Signature 6/21/2020 . copy to: (marked) State LTC (long-term care) Ombudsman Office Date: (date blank) . On July 20, 2020, at 9:48 a.m., a follow-up onsite visit was conducted to the facility to review the additional faxed documents received after the initial onsite visit and record review. On June 20, 2020, at 10:20 a.m., Resident A's record was reviewed with the SSD and compared the documents received by the ombudsman office. The SSD confirmed the previous fax confirmation of the notice of transfer and discharge, dated June 22, 2020, at 1:22 p.m. that was faxed to the district office, belonged to Resident B, and not for Resident A. The facility was unable to provide a documented evidence of a confirmation fax report to the ombudsman regarding Resident A's discharge. The facility was also unable to provide the

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 -** Few	(continued... from page 1) original or carbonless copy of the notice of transfer and discharge for Resident A. On July 20, 2020, at 3:16 p.m., the notice of transfer discharge documents for the month of June 2020 was again reviewed with the ombudsman. In a concurrent interview with the ombudsman, she stated their office did not receive any notice of any planned or actual discharge for Resident A. The ombudsman further stated they were not involved with the resident's discharge from the facility. The facility's policy and procedure titled, Notice of Transfer/Discharge, dated October 2017, was reviewed and indicated, .Before the transfer or discharge occurs, the facility must notify the resident and, if known, the responsible party, and Ombudsman of the transfer and reasons for the transfer, and document in the resident's clinical record . When the resident is being discharged home or to another facility, the facility representative will complete the Notice of Proposed Transfer and Discharge form, and provide it to the resident, responsible party and Ombudsman prior to the transfer or discharge . The California Health & Safety Code, Section 1439.6, indicated, .if a resident is notified in writing of a facility-initiated transfer or discharge from a long-term health care facility, the facility shall also send a copy of the notice to the local long-term care ombudsman at the same time notice is provided to the resident or the resident's representative . The copy of the notice shall be sent by fax machine or email, as may be directed by the local long-term care ombudsman, unless the facility does not have fax or email capability, in which case the copy of the notice shall be sent by first-class mail, postage prepaid. A facility's failure to timely send a copy of the notice shall constitute a class B violation, as defined in subdivision (e) of Section 1424. The California Assembly Bill No. 940, Chapter 274, indicated, An act to add Section 1439.6 to the Health and Safety Code, relating to long-term health care facilities . Approved by Governor (on) September 25, 2017 . This bill would require a long-term health care facility to notify the local long-term care ombudsman if a resident is notified in writing of a facility-initiated transfer or discharge from the facility, as specified. The bill would provide that a failure to timely provide a copy of that notice would constitute a class B violation for purposes of a department-issued citation.