STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035126	A. BUILDING _____ B. WING _____	**07/28/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LIFE CARE CENTER OF NORTH GLENDALE	**13620 NORTH 55TH AVENUE GLENDALE, AZ 85304**

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 clinical record review, staff interviews and facility policies and procedures, the facility failed to ensure that one resident (#1) was not transferred to an emergency room as a unnecessarily for the resident's welfare when the needs of the resident could have been met at the facility. The deficient practice could result in increased risk to the resident's emotional and physical well-being due to unnecessary travel. Findings include: Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A nursing note entered July 5, 2020 at 10:30 p.m. by a Registered Nurse (staff #10). She stated she was notified by the transfering skilled nursing facility where the resident used to live (sister facility). The resident had been tested prior to his transfer to Life Care Center of North Glendale (LCCNG) and the result is a positive COVID-19 test. She stated the resident, resident's spouse and the physician were notified of the positive COVID-19 test. A clinical record review for resident #1 revealed that on July 6, 2020, the resident did not have any documentation of a change of condition. The resident's vital signs were all within normal limits. There was no documentation of the resident having a decline related to COVID-19 diagnosis. A nursing note entered on July 6, 2020 at 5:28 p.m. stated the doctor, resident and resident's spouse was notified that the resident would not be transferred back to his former nursing home today and the transportation was canceled per the direction of the Director of Nursing (DON/staff #36). Instead the resident was transferred by ambulance to a hospitalER on [DATE] at 10:30 p.m There is no documentation that there was a physician order [REDACTED]. A nursing note entered on July 6, 2020 at 11:09 p.m. by a RN (staff #22) stated the resident was being transferred. She stated she had received an order from the DON to transfer resident #1 to the (name of hospital) ER due to a COVID-19 positive test result. She stated the doctor, resident and resident family were notified, paperwork was prepared and report was called to the hospital ER which was multiple miles from the facility. If this was an emergent transfer, the facility has a hospital next door that would have been more appropriate. A review of the ETransfer form revealed the reason for the transfer on July 6, 2020 was due to an abnormal lab result (positive COVID-19 result). The resident was alert and orientated to person, place, time and situation. The transfer form indicated the resident was having chills and some coughing (which was not noted earlier when the vitals were within normal range). A health status note entered on July 7, 2020 at 3:45 a.m. by a RN (staff #44), she stated the resident returned to the facility from the ER via stretcher. The resident's respirations were clear, even and unlabored. The resident's oxygen saturation was 96% on room air. It would appear that the resident was not symptomatic on her return An admission Minimum Data Set (MDS) was completed on July 13, 2020. The resident had a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact. The resident did not have [MEDICAL CONDITION] or any behaviors. The resident required extensive assistance by at least one staff member for bed mobility, dressing and toilet use. The resident required limited assistance by at least one staff member for transfers, locomotion on the unit and personal hygiene. The resident required the use of a wheelchair and a limb prosthesis. The resident did not require the use of oxygen. The resident had [DIAGNOSES REDACTED]. An interview was conducted with the Director of Nursing (staff #36) and the Administrator (staff #58) on July 28, 2020 at 10:40 a.m. The DON stated that a non-emergent transfer is initiated when the doctor, resident and (if applicable) the family are all in agreement. The facility will make all of the arrangements for transfers. She stated the resident will have a physician order [REDACTED]. She stated the EInteract transfer form is usually initiated for a change of condition. She stated this form is completed prior to an ER transfer. She stated the staff should complete a progress note for the discharge that includes a resident assessment. Again, no doctor's order was provided to the surveyors for the transfer of resident #1 to the ER due to the positive COVID-19 test. The interview continued and the DON stated that if a resident with COVID-19 had a change in condition they would be transferred out of the facility. She stated these changes could include a decrease in oxygen saturation, shortness of breath and sometimes chest pain. She stated that usually those residents would be transferred via 911. She stated the staff would document the vital signs and a progress note that would include the nurse to nurse report at the accepting facility. If sent by 911 the emergency personnel know to go to the closest hospital for care. The DON (staff #36) stated resident #1 was transferred to the ER because she had a positive COVID-19 test. She stated the resident was transferred because she felt the facility was not able to safely care for the resident. She stated the resident's condition did not change, the resident did not have a decline in condition for the transfer. She also stated she did not order a transfer for the resident. She stated she is not a doctor and cannot write orders. The Administrator (staff #58) stated the original plan for the resident was to be transferred back to her former facility earlier that day. She stated the other nursing home had notified the facility that because of their current census and staffing, they could not re-admit the resident at this time. She stated they had been instructed by state and federal agencies to move COVID-19 positive residents way from the general population. She stated the facility's COVID unit that night only had one nurse and no Certified Nursing Assistant. She stated after an exhausted effort to have staff come in, the lack of staff available from the sister facility and no registry staff available they felt the only option was to transfer the resident to the ER. An interview was conducted with the DON and Administrator on July 28, 2020 at 11:50 a.m. The administrator stated the resident was transferred to a hospital ER farther away because it was closer to their sister facility that the resident was going to be transferred to earlier. She stated the thought was that when the resident was discharged from the ER, she could go back to the nearby sister facility. She stated that while There was a hospital closer next door, but their plan was to get the resident as close to the sister facility as possible and this was told to the ER doctor from the transfering nurse. They had thought she could stay in the ER until a bed opened up at the sister facility. The facility took their problem and transferred it to the hospital ER and made the resident their problem even as the resident's condition did not warrant the transfer to a higher level of care. The administrator stated that because of the late hour, a phone call to the county to address the staffing issues was not an option. She stated that they have called in the past and are only able to leave a voicemail after hours. The facility policy titled Transfers and Discharges included that as members of the interdisciplinary team, Social Services and Nursing staff participate in all transfers and discharges. Transfers and discharges will be handled appropriately to ensure proper notification and assistance to residents and families in accordance with federal and state-specific regulations. The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless it is necessary for the resident's welfare and the resident's needs cannot be met in the facility. When the facility transfers or discharges a resident the facilty must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. The

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 0622 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) documentation in the resident's medical record must include the basis for the transfer and the facility attempts to meet the resident needs. The documentation must show what specific resident needs cannot be met.
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 clinical record review, staff interviews and facility policy review, the facility failed to provide a written explanation of the transfer of resident #1 from the facility to a hospital emergency room . The deficient practice could result in residents being denied the opportunity to appeal the discharge. Findings include: Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A clinical record review revealed the resident signed on admission, the transfer risk and benefit form on June 30, 2020. A nursing note entered July 5, 2020 at 10:30 p.m. by a Registered Nurse (staff #10). She stated she was notified by the transfering skilled nursing facility (where the resident used to live, a sister facility). The resident had been tested prior to his transfer to Life Care Center of North Glendale (LCCNG) and the result is a positive COVID-19 test. She stated the resident, resident's spouse and the physician were notified of the positive COVID-19 test. Review of the clinical chart for resident #1 reveals a note that she was transferred by ambulance to a hospitalER on [DATE] at 10:30 p.m A review of the clinical record for resident #1 revealed that on July 6, 2020, the resident did not have any documentation of a change of condition. The resident's vital signs were all within normal limits. There was no documentation of the resident having a decline related to COVID-19 and there is no documentation that the physician wrote an order to have the resident transferred out of the facility. A nursing note entered on July 6, 2020 at 11:09 p.m. by a RN (staff #22) stated the resident was being transferred. She stated she had received an order from the DON to transfer resident #1 to the hospital ER near the sister facility due to a COVID-19 test result. She stated the doctor, resident and resident family were notified, paperwork was prepared and report was called. A review of the ETransfer form revealed the reason for the transfer on July 6, 2020 was due to an abnormal lab result. The resident was alert and orientated to person, place, time and situation. The transfer form indicated the resident was having chills and some coughing. There is no documentation that the resident was explained the risk and benefit for this transfer. There is no documentation that the resident signed a form showing her understanding of the need to be transferred because the facility was unable to safely care for the resident. There is no documentation that the Office of the State Long-Term Care Ombudsman was notified of the transfer. In the complaint from the ER that received the resident, they said she was asymptomatic and x-rays within normal limits. They contacted the transfering facility and told them that they would not be admitting the resident and she would be returning to them. A health status note entered on July 7, 2020 at 3:45 a.m. by a RN (staff #44), she stated the resident returned to the facility from the ER via stretcher. The resident's respirations were clear, even and unlabored. The resident's oxygen saturation was 96% on room air. An admission Minimum Data Set (MDS) was completed on July 13, 2020, days after the late night ER visit. The resident had a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact. The resident did not have [MEDICAL CONDITION] or any behaviors. The resident required extensive assistance by at least one staff member for bed mobility, dressing and toilet use. The resident required limited assistance by at least one staff member for transfers, locomotion on the unit and personal hygiene. The resident required the use of a wheelchair and a limb prosthesis. The resident did not require the use of oxygen. The resident had [DIAGNOSES REDACTED]. An interview was conducted with the Administrator (staff #58) on July 28, 2020 at 11:40 a.m. The administrator stated the resident signed the admission risk and benefit transfer form when she was admitted . She stated that is the only one on file but the resident was aware of the transfer and so was the resident's spouse. But no documentation in writing of why the resident was being transferred to the ER instead of going back to the sister facility wheres she was a resident before transfering to North Glendale facility. The big question here was the resident aware of the transfer to the ER late at night when she was supposed to go to the sister facility earlier during the day. The facility policy titled Transfers and Discharges included that as members of the interdisciplinary team, Social Services and Nursing staff participate in all transfers and discharges. Transfers and discharges will be handled appropriately to ensure proper notification and assistance to residents and families in accordance with federal and state-specific regulations. Before a facility transfers or discharges a resident, the facility must notify the resident and the resident's representative of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. Notice must be made as soon as practicable before transfer or discharge when an immediate transfer or discharge is required and when a resident has not resided in the facility for 30 days. The notice must have the reason for the transfer or discharge, the effective date of the transfer or discharge and a statement of the resident's appeal rights.