

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  035092	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/19/2025
NAME OF PROVIDER OR SUPPLIER  Bella Vita Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  5125 North 58th Avenue Glendale, AZ 85301	

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)
<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on clinical record review, staff and resident/resident representative interviews, the facility failed to ensure that residents and/or the resident's representative (RR) were notified in writing of transfer to another facility for 2 of 5 sampled residents (#21, and #14). Failure of notification had the potential to affect the resident and their RR by not having clear knowledge of where and why the resident was transferred.</p> <p>Findings include:</p> <p>-Regarding Resident #21</p> <p>Resident #21 was originally admitted on [DATE] with diagnoses that included cerebral palsy, functional quadriplegia, tourettes and dysphagia.</p> <p>Review of the clinical record revealed a notice of proposed transfer/discharge document dated February 28, 2025 indicating that the resident ' s niece/representative was notified. There were no prior indications of discharge planning.</p> <p>Review of the resident ' s care plan dated February 19, 2017 indicated that the resident did not have an active discharge plan and wished to remain in the facility for long term care (LTC). There were no additions or corrections made to the care plan until the resident ' s discharge - dated March 3, 2025.</p> <p>Review of resident #21 ' s most recent Discharge Minimum Data Set (MDS) dated [DATE] identified that the resident was discharged on March 3, 2025 to another skilled nursing facility.</p> <p>Further review of the resident ' s MDS identified a Brief Interview for Mental Status (BIMS) summary score of 00 indicating severe cognitive impairment.</p> <p>A progress note dated March 3, 2025 at 15:57 p.m. revealed a discharge note, that the resident was admitted to the facility for custodial/long-term care services. The note identified that the reason for discharge was due to, being discharged to another facility.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted on March 19, 2025 at 11:54 a.m. with the resident ' s representative. The representative stated that Resident #21 could not consent on her own for a transfer. She further stated that the facility contacted her after the transfer was complete; and that, the reason for the transfer was because the facility would be undergoing construction; and that, the resident would not be able to return due to the long term care unit being changed to a memory care unit. The resident ' s representative also stated that the receiving facility now calls constantly due to the resident ' s behaviors which she does not understand why it was not communicated.</p> <p>-Regarding Resident #14</p> <p>Resident # 14 was admitted [DATE] with diagnoses that included chronic obstructive pulmonary disease, acute and chronic respiratory failure with hypoxia and hypercapnia, pneumonia and congestive heart failure.</p> <p>Review of the resident ' s care plan dated September 19, 2022 indicated that the resident wished to remain in the facility for LTC. There were no additions or corrections made until the resident ' s discharge - dated February 14, 2025.</p> <p>Review of the clinical record revealed a notice of proposed transfer/discharge document dated February 5, 2025 indicating that the resident ' s Daughter/representative and LTC case manager (CM) were notified. The document identified that the reason for discharge was that the resident ' s needs could no longer be met in the facility.</p> <p>Review of resident #14 ' s most recent Discharge Minimum Data Set (MDS) dated [DATE] identified that the resident was discharged on February 13, 2025 to another skilled nursing facility.</p> <p>Further review of the resident ' s MDS identified a Brief Interview for Mental Status (BIMS) summary score of 15 indicating no cognitive impairment.</p> <p>A progress note dated February 12, 2025 at 15:12 p.m. revealed a discharge note the reason for discharge was due to being discharged to another facility.</p> <p>An interview was conducted on March 19, 2025 at 10:04 a.m. with the resident ' s representative who was also her power of attorney (POA). The representative stated that the receiving facility notified her the day before that the resident would be transferred. She further stated that she reached out to the prior facility ' s social worker and was told that the facility had already contacted her regarding the transfer, but she knows that she had not talked to anyone. The resident ' s POA stated that she was told the transfer was due to renovations. She revealed that her mother did not want to move but the facility did not give her an option and simply transferred her. The POA stated that she did not receive any formal paperwork or notice nor did she give verbal consent; and that the facility just picked the place and sent her.</p> <p>An interview was conducted with the resident ' s insurance case manager on March 19, 2025 at 10:21 a.m. who stated that the social service director called to tell her that some residents would be moved out due to renovations that were being done. She stated that she was not made aware of these transfers until they were completed.</p> <p>(continued on next page)</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted with a Licensed Practical Nurse (LPN/Staff #31) on March 19, 2025 at 12:29 p. m. The LPN demonstrated an ongoing discharge and stated that the process is case management/ the social worker will have all the paperwork ready. The paperwork will identify where the resident is going and around what time, she stated that she will then go over all the information with the resident and the patient will sign on the face sheet. The LPN stated that she will then check medications and ensure that correct medications are being sent with the resident or that the medications are discharged if appropriate. Staff #31 stated that prescriptions are also sent with the resident. She further stated that she will check the inventory sheet to ensure that residents are sent out with everything, as well as doing appropriate assessments like skin checks. The LPN stated that everything is scanned into the system and sent directly to the medical records supervisor. Staff #31 stated the discharge process starts with case management and social services; she mainly works on the actual discharge and assessments. The LPN stated that she ' s aware that there are renovations to turn the back half of the 400s unit into a walking dementia unit. She stated that a lot of residents were being transferred out and gave an estimate of 10 that she knew of, but was not sure of how far in advance residents and/or their representatives were notified.</p> <p>An interview was conducted with the Social Services Manager (SSM/Staff #19) on March 19, 2025 at 12:39 p. m. who stated that he does not handle skilled nursing discharges, just long-term care. The SSM stated that he initiates the discharge planning process when delivering the 30 day notice. He further stated that if they have a POA or family he will talk with them before the resident. Staff #19 stated that the process is different with LTC since residents are there long-term but if needed he will tell them that their needs cannot be met at the facility and provide them with a list of other facilities in the area. The SSM stated that there will be a packet sent out with the resident to the receiving facility. He stated that the 400s hall is currently being renovated and the 500s hall should be next. Staff #19 stated that the discharge process begins with a notice for transfer/discharge. Additionally, he stated that notifications are usually delivered 30 days before discharge. He then stated there should be consent whether from the resident or the representative to initiate the transfer and if that is not possible he will get verbal consent and sign off. When asked about the specific residents records the SSM stated he did not have access to them and stated that the Medical Records Director (MRD) would be able to provide them.</p> <p>An interview was conducted with the MRD (Staff #56) on March 19, 2025 at 12:53 p.m. with an additional corporation resource (Staff #72) present. When asked if she was able to retrieve the notices pertaining to the specific residents the MRD stated that she does not have access to them and was confused by what was being asked of her. The corporate resource then attempted to look into the requested transfer notices and accepted a formal request for those discharge records.</p> <p>(continued on next page)</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted with the administrator (Staff #7) on March 19, 2025 at 2:13 p.m. The administrator stated that with LTC residents the facility would try to talk with the family right away regarding the discharge. The residents might be in the facility for varied reasons. He further stated that many of the residents chose to be discharged /transferred themselves. Staff #7 stated that a lot of the long term residents want to transfer to be close to family so the facility tries to work and send referrals out to get things done. He also stated the facility tries to give a 30 day notice if the transfer/discharge is planned. The administrator stated that the facility had started renovations in January of 2025 and that it was communicated to the residents that the facility was not kicking anyone out. Staff #7 further restated that residents who left self-elected to leave the facility and go to another facility. The administrator stated the process is that the facility will notify and communicate with case managers, the ombudsman and family to ensure the residents are properly placed.</p> <p>Review of a facility policy obtained on March 19, 2025 and reviewed in July 2024 titled, Nursing Administration Section: Continuum of Care Subject: Discharge or Transfer states, A transfer and or discharge shall be considered for the following reasons as regulated by Federal, State and other Regulatory Agencies. 2. Transfer/discharge: Other Healthcare Facility B. Keep Resident/Family involved with all discharge planning.</p>		

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<p>F 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Plan the resident's discharge to meet the resident's goals and needs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on clinical record review, staff and resident/resident representative interviews, the facility failed to ensure that the resident and resident ' s representatives were a part of the discharge/transfer process for 4 of 5 sampled residents (#21, #32, #16 and #14).</p> <p>Findings include:</p> <p>-Regarding Resident #21</p> <p>Resident #21 was originally admitted on [DATE] with diagnoses that included cerebral palsy, functional quadriplegia, tourettes and dysphagia.</p> <p>Review of the resident ' s care plan dated February 19, 2017 indicated that the resident did not have an active discharge plan and wished to remain in the facility for long term care (LTC). There were no additions or corrections made to the care plan until the cancellation due to the resident ' s discharge date d March 3, 2025.</p> <p>Review of the clinical record revealed a notice of proposed transfer/discharge document dated February 28, 2025 indicating that the resident ' s niece/representative was notified. There were no prior indications of discharge planning.</p> <p>Review of resident #21 ' s most recent Discharge Minimum Data Set (MDS) dated [DATE] identified that the resident was discharged on March 3, 2025 to another skilled nursing facility.</p> <p>Further review of the resident ' s MDS identified a Brief Interview for Mental Status (BIMS) summary score of 00 indicating severe cognitive impairment.</p> <p>A progress note dated March 3, 2025 at 15:57 p.m. revealed a discharge note, that the resident was admitted to the facility for custodial/long-term care services. The note identified that the reason for discharge was due to ' being discharged to another facility. '</p> <p>An interview was conducted on March 19, 2025 at 11:54 a.m. with the resident ' s representative. The representative stated that Resident #21 could not consent on her own for a transfer. She further stated that the facility contacted her after the transfer was complete but did not mention the transfer at all before.</p> <p>-Regarding Resident #14</p> <p>Resident # 14 was admitted [DATE] with diagnoses that included chronic obstructive pulmonary disease, acute and chronic respiratory failure with hypoxia and hypercapnia, pneumonia and congestive heart failure.</p> <p>Review of the resident ' s care plan dated September 19, 2022 indicated that the resident wished to remain in the facility for LTC. There were no additions or corrections made to the care plan until the cancellation of the care plan due to resident ' s discharge date d February 14, 2025.</p> <p>(continued on next page)</p>		

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<p>F 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the clinical record revealed a notice of proposed transfer/discharge document dated February 5, 2025 indicating that the resident ' s Daughter/representative and LTC case manager (CM) were notified. There were no prior indications of discharge planning in the clinical record.</p> <p>Review of resident #14 ' s most recent Discharge Minimum Data Set (MDS) dated [DATE] identified that the resident was discharged on February 13, 2025 to another skilled nursing facility.</p> <p>Further review of the resident ' s MDS identified a Brief Interview for Mental Status (BIMS) summary score of 15 indicating no cognitive impairment.</p> <p>A progress note dated February 12, 2025 at 15:12 p.m. revealed the reason for discharge was due to ' being discharged to another facility. '</p> <p>An interview was conducted on March 19, 2025 at 10:04 a.m. with the resident ' s representative who was also her power of attorney (POA). The representative stated that the receiving facility notified her the day before that the resident would be transferred. She further stated that she reached out to the prior facility ' s social worker and was told that the facility had already contacted her regarding the transfer, but she stated that she had not talked to anyone. She revealed that her mother did not want to transfer but the facility did not give her an option and transferred her. The POA stated that she did not receive any formal paperwork or notice nor did she give verbal consent; and that the facility just picked the new facility and sent her.</p> <p>An interview was conducted with the resident ' s insurance case manager on March 19, 2025 at 10:21 a.m. who stated that she was not made aware of the transfer until they were completed.</p> <p>-Regarding Resident #16</p> <p>Resident #16 was admitted [DATE] with diagnoses that included chronic obstructive pulmonary disease, chronic respiratory failure with hypoxia, hypertensive chronic kidney disease, diabetes and dementia.</p> <p>Review of the resident ' s care plan dated January 16, 2017 indicated that the resident wanted to discharge home with family in Alabama and noted that this was an unrealistic goal stating she will remain in the facility for LTC. There were no additions or corrections made to the care plan until the cancellation of the care plan due to resident ' s discharge date d February 18, 2025.</p> <p>Review of the clinical record revealed a notice of proposed transfer/discharge document dated February 14, 2025 indicating that the resident ' s sister/representative was notified. There were no prior indications of discharge planning in the clinical record.</p> <p>Review of resident #16 ' s most recent Discharge Minimum Data Set (MDS) dated [DATE] identified that the resident had a planned discharge on [DATE] to another skilled nursing facility.</p> <p>Further review of the resident ' s MDS identified a Brief Interview for Mental Status (BIMS) summary score of 15 indicating she was cognitively intact.</p> <p>A progress note dated February 17, 2025 at 17:00 p.m. revealed a discharge note that identified that the reason for discharge was ' being discharged to a skilled nursing facility. '</p> <p>(continued on next page)</p>

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<p>F 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Another progress note dated February 17, 2025 at 17:00 p.m. revealed the resident was discharged from the facility to the receiving facility.</p> <p>An interview was conducted on March 19, 2025 at 1:49 p.m. with the resident ' s representative. The representative stated that she had not talked with her sister in 2 months and that the resident suffered from short term memory loss and would forget to call. She further stated that the facility did not reach out to her to notify her of the transfer and she was completely unaware that they even initiated the transfer.</p> <p>-Regarding Resident #32</p> <p>Resident #32 was originally admitted on [DATE] with diagnoses that included end stage renal disease, chronic hypertensive kidney disease and type 2 diabetes.</p> <p>Review of the resident ' s care plan dated October 17, 2017 indicated that the resident wanted to remain in the facility for LTC. There were no additions or corrections made to the care plan until the cancellation of the care plan due to resident ' s discharge date d February 21, 2025.</p> <p>Review of the clinical record revealed a notice of proposed transfer/discharge document dated February 14, 2025 indicating that the resident ' s son/representative was notified. There were no prior indications of discharge planning in the clinical record.</p> <p>Review of resident #32 ' s most recent Discharge Minimum Data Set (MDS) dated [DATE] identified that the resident had a planned discharge on [DATE] to another skilled nursing facility.</p> <p>Further review of the resident ' s MDS identified a Brief Interview for Mental Status (BIMS) summary score of 15 indicating the resident was cognitively intact.</p> <p>A progress note dated February 19, 2025 at 18:07 p.m. revealed a discharge note that identified that the reason for discharge was due to ' being discharged to a skilled nursing facility. '</p> <p>Another progress note dated February 17, 2025 at 17:00 p.m. revealed the resident was discharged from the facility to the other.</p> <p>An interview was conducted on March 19, 2025 at 11:37 a.m. with Resident #32. The resident stated that he did not have a plan for discharge and he had wanted to remain in the facility. He further stated that the facility told him he was going to transfer due to renovations.The resident then stated that he was transferred to the new facility.</p> <p>An interview was conducted with a Licensed Practical Nurse (LPN/Staff #31) on March 19, 2025 at 12:29 p. m. The LPN demonstrated an ongoing discharge and stated that the process is case management/ the social worker will have all the paperwork ready. The paperwork will identify where the resident is going and around what time, she stated that she will then go over all the information with the resident and the patient will sign on the face sheet. Staff #31 stated the discharge process starts with case management and social services; she mainly works on the actual discharge and assessments.</p> <p>(continued on next page)</p>		

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<p>F 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview was conducted with the Social Services Manager (SSM/Staff #19) on March 19, 2025 at 12:39 p. m. He stated that he does not handle skilled nursing discharges, just long term care. The SSM stated that he initiates the discharge planning process when delivering the 30 day notice. He further stated that if they have a POA or family he will talk with them before the resident. Staff #19 stated that the process is different with LTC since residents are there long term but if needed he will tell them that their needs cannot be met at the facility and provide them with a list of other facilities in the area. The SSM stated that there will be a packet sent out with the resident to the receiving facility. Staff #19 stated that the process for discharge begins with a notice for transfer/discharge. In addition he stated that notifications are usually delivered 30 days before discharge. He then stated there should be consent whether from the resident or the representative to initiate the transfer and if that is not possible he will get verbal consent and sign off.</p> <p>An interview was conducted with the MRD (Staff #56) on March 19, 2025 at 12:53 p.m. with an additional corporation resource (Staff #72) present. When asked if she was able to retrieve the notices pertaining to the specific residents the MRD stated that she does not have access to them and was confused by what was being asked of her. The corporate resource then attempted to look into the requested transfer notices and accepted a formal request for those discharge records, he also stated that 30 day notices are not applicable in all cases of transfers/discharges.</p> <p>An interview was conducted with the administrator (Staff #7) on March 19, 2025 at 2:13 p.m. The administrator stated that with LTC residents the facility would try to talk with the family right away regarding the discharge. The residents might be in the facility for varied reasons. He further stated that many of the residents chose to be discharged /transferred themselves. Staff #7 stated that a lot of the long term residents want to transfer to be close to family so the facility tries to work and send referrals out to get things done. He also stated the facility tries to give a 30 day notice if the transfer/discharge is planned. The administrator stated that the facility had started renovations in January of 2025 and that it was communicated to the residents that the facility was not kicking anyone out. Staff #7 further restated that residents who left self-elected to leave the facility and go to another facility. The administrator stated the process is that the facility will notify and communicate with case managers, the ombudsman and family to ensure the residents are properly placed.</p> <p>Review of a facility policy obtained on March 19, 2025, Issued May of 2007 and reviewed in July 2024 titled, Nursing Administration Section: Continuum of Care Subject: Discharge or Transfer states, A transfer and or discharge shall be considered for the following reasons as regulated by Federal, State and other Regulatory Agencies. 2. Transfer/discharge: Other Healthcare Facility B. Keep Resident/Family involved with all discharge planning.</p>