R9-10-909. Transfer or Discharge

A. An administrator shall ensure that:

1. A resident is transferred or discharged if:

a. The nursing care institution is unable to meet the needs of the resident;

b. The resident's behavior is a threat to the health or safety of the resident or other individuals at the nursing care institution; or

c. The resident's health has improved and the resident no longer requires nursing care institution services; and

2. Documentation of a resident's transfer or discharge is maintained in the resident's medical records and includes:

a. The date of the transfer or discharge;

b. The reason for the transfer or discharge;

c. A 30-day written notice except in an emergency;

d. A notation by a physician or the physician's designee if the transfer or discharge is due to any of the reasons listed in subsection (A)(1); and

e. If applicable, actions taken by a staff member to protect the resident or other individuals if the resident's behavior is a threat to the health and safety of the resident or other individuals in the nursing care institution.

B. An administrator may transfer or discharge a resident for failure to pay for residency if:

1. The resident or resident's representative receives a 30-day written notice of transfer or discharge, and

2. The 30-day written notice includes an explanation of the resident's right to appeal the transfer or discharge.

C. Except in an emergency, a director of nursing shall ensure that before a resident is transferred or discharged:

1. A written plan is developed with the resident or the resident's representative that includes:

a. Information necessary to meet the resident's need for medical services and nursing services; and
b. The state long-term care ombudsman's name, address, and telephone number;

2. A discharge summary is:
   a. Developed by a staff member providing direct care and authenticated by the resident's attending physician or designee; and
   b. Documented in the resident's medical records;

3. The discharge summary includes:
   a. The resident's medical condition at the time of transfer or discharge;
   b. The resident's medical and psychosocial history;
   c. The date of the transfer or discharge; and
   d. The location of the resident after transfer or discharge;

4. A copy of the written plan is provided to the resident or the resident's representative and to the receiving health care institution.

D. If a resident is transferred to a hospital, the director of nursing shall ensure that medical records information and any other information necessary for the treatment of the resident is provided to the hospital.

Historical Note

Adopted effective February 17, 1995 (Supp. 95-1). Section repealed; new Section made by final rulemaking at 9 A.A.R. 338, effective March 16, 2003 (Supp. 03-1).