STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555323	A. BUILDING _____ B. WING _____	**06/15/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AVIARA HEALTHCARE CENTER	**944 REGAL ROAD ENCINITAS, CA 92024**

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 0625 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure information related to facility bed hold (holding or reserving a resident's bed while the resident was absent from the facility during hospitalization or therapeutic leave) was provided to one (Resident 1) resident's Responsible Party (designated person responsible for decision making when a resident is not capable of making decisions), when Resident 1 was transferred to the acute care hospital. As a result, the Responsible Party (family member) was not be informed in writing, a facility bed would remain available for Resident 1's return in order for Resident 1 to receive the necessary medical services. Findings: Resident 1 was readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Per the same Face Sheet, Resident 1 did not have the capacity to make decisions. Resident 1 was observed to be unresponsive on 1/8/20 during a lunch meal observation. Resident 1's physician ordered a transfer to the hospital for evaluation on 1/8/20. Resident 1's Responsible Party (RP) was not present at the facility during the incident or when Resident 1 was was transferred to the hospital. Per the Social Services Director (SSD) notes dated 1/10/20, a phone call was made to the RP, and per the note, the RP was exploring other options for discharge from the hospital. A follow up phone call was documented by the SSD on 1/21/20 (more than 7 days after Resident 1's transfer) to the RP to determine if Resident 1 was ready to return to the facility. The DON stated on 1/21/20 at 2 P.M., they had not made any attempt to email, mail or fax the Bed Hold document to the RP for Resident 1. The Bed Hold Policy and Notification document was reviewed on 2/10/20. One section of the policy, To be completed upon transfer does not contain any signatures for the Resident, RP, or facility. Per the facility policy Bed-Holds and Returns, undated, .Prior to transfers and therapeutic leaves, residents or resident representatives will be informed in writing of the bed-hold and return policy.

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.