STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555379	A. BUILDING _____ B. WING _____	**04/10/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ASISTENCIA VILLA REHABILITATION AND CARE CENTER	**1875 BARTON ROAD REDLANDS, CA 92373**

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 0626 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to determine if one of the three sampled residents meet the requirements for discharge prior to refusing Resident A to return to the facility after hospitalization . This failure had the potential to result in psychological harm and delay of treatment at the skilled level for Resident A. Findings: An unannounced visit was conducted on January 29, 2020 at 1:50 PM to investigate a complaint regarding Admission, Discharge and Transfer Rights. During an interview with Admissions Director (AMD) on January 29, 2020 at 3:11 PM, he stated Resident A threatened to kill herself and since Resident A had only been in the facility for about a week, we are not required to take them back. During an interview with the Director of Nursing (DON) on January 29, 2020 at 3:55 PM, the DON stated the decision not to admit Resident A back was because of the things that she said when she was here (at the facility), the details of how she was going to kill herself . The DON stated they should probably have gone out to talk to her and assess her . when Resident A was ready for discharge. She stated the facility decided not to take Resident A back without seeing the clearance or documentation from the hospital. She stated it was decided in one of their morning meetings not to accept the resident back. A record review of Detail Admission / Discharge Report, dated from November 1, 2019 thru January 29, 2020, the report indicated Resident A was admitted on [DATE] and discharged on [DATE]. A record review of Archived Referrals, dated January 21, 2020, under Communication with the (name of the general acute care facility), the messages dated January 13, 2020 indicated the facility declined to accept Resident A back when she was ready to return to the facility.

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.