| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555323 | A. BUILDING _____ B. WING _____ | C 08/24/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| AVIARA HEALTHCARE CENTER | 944 REGAL ROAD ENCINITAS, CA 92024 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 000 | INITIAL COMMENTS<br><br>The following reflects the findings of the California Department of Public Health during an abbreviated survey for the investigation of one anonymous complaint.<br><br>Representing the California Department of Public Health: Health Facilities Evaluator Nurse 36765.<br><br>The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility.<br><br>Complaint number: CA 00794891<br>Category: Accident<br>One Deficiency was cited for CA 00794891 | F 000 | | |
| F 689 SS=D | Free of Accident Hazards/Supervision/Devices<br>CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review, the facility failed to implement measures to prevent the elopement of one Resident (1) from the facility.<br><br>This failure had the potential for the Resident to elope from the facility and not be safe.<br><br>Findings: | F 689 | | |

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

Electronically Signed — Jill Padrigan RN/Interim DON — 9/15/22

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.

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| F 689 | Continued From page 1<br><br>Resident 1 was admitted to the facility on 3/28/22 with diagnoses that included a fractured left acetabulum (hip) and a fractured left pelvis bone per the facility's Admission Record.<br><br>On 7/17/22, Resident 1 eloped from the facility and walked approximately 1 mile from the facility. Resident 1 eloped from the facility through a back door of the facility which leads directly to the parking lot and then to the street. The door was left unlocked by staff who were moving supplies into the building. Resident 1 was located by the facility administrator and returned to the facility.<br><br>A review of Resident 1's medical record was conducted on 8/2/22 at 12: 05 P.M. The Interdisciplinary Team (IDT) note, dated 7/30/22, indicated, "... educate staff on the importance of locking the gate near the Red Zone, and, keep gate locked..."<br><br>An interview was conducted with the director of nursing (DON), the assistant director of nursing (ADON), the social services director (SSD) and the case manager (CM) on 8/2/22 at 12:35 P.M. The ADON, the SSD and the CM all stated Resident 1 was able to leave through the door in the back of the building that was left open.<br><br>The DON stated, "After the first episode of elopement, we determined Resident 1 went out the back door; we put a touch alarm on the door. On the 17th, the door was left open and Resident 1 went out." Additionally, the DON stated, "The weakness in our plan was the door, that is how he got out." | F 689 | | |

F 000 The following reflects the findings of the California Department of Public Health during an abbreviated survey for the investigation of one anonymous complaint. Representing the California Department of Public Health: Health Facilities Evaluator Nurse 36765. The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility.

Complaint number: CA 00794891 Category: Accident One Deficiency was cited for CA 00794891 F 689 Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.

The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and

§483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by: F 689 SS=D Based on observation, interview and record review, the facility failed to implement measures to prevent the elopement of one Resident (1) from the facility. This failure had the potential for the Resident to elope from the facility and not be safe.

In the complaint number: CA 0079891 Category 1 deficiency F 689 Free of accident Hazards/Supervision Devices, the facility must ensure that 1. the resident environment remains as free of accident hazards as is possible 2. each resident receives adequate supervision and assistance devices to prevent accidents.

Plan of Correction:

1. After the elopement of resident 1 through the back gate, the facility has maintained the back gate locked, which was initially the exit for staff when a red zone was established. The back gate was initially used as access to an area used by the staff as a designated break area. Since the incident, the break room was then relocated to a room within the red zone, which was a single room, 409, where staff who worked the red zone took their breaks. The exit for the red zone was also relocated towards the back exit of the 400 hallways which kept the back gate locked through the time when facility had a red zone. The facility also has updated the mitigation plan that if a red zone is established, 409 will be the designated break room and the 400 exit will be the designated exit for staff working in the red zone. Furthermore, Maintenance will include a daily log to ensure that the back gate will continue to be locked which will be effective 9/1/22. Results of findings will be reported to QA once a month and Quarterly.
2. Resident 1 continues to be in Arcadia in room, far from the exit, in room 108A. He continues to wear the wander guard on his RLE and is monitored daily for placement, and skin breakdown related to wander guard use. Resident is also currently on the list for possible discharge pending on ALW program. He also continues to participate in activities of choice, and has not had any episodes of exit seeking or elopement since the incident.