FORM APPROVED

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 _____	10/13/2011

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) COMPLETE DATE
A 000	Initial Comments	A 000		

The following represents the findings of the California Department of Public Health during an investigation of a complaint:

Complaint #: CA00284636 and CA00284586

Inspection of the facility was limited to the specific allegation reported and does not represent the findings of a full inspection of the facility.

Representing the California Department of Public Health:

HFEN Fed ID # 29270 / State ID # 2445

A 968 T22 DIV5 CH3 ART5-72541 Unusual Occurrences

Occurrences such as epidemic outbreaks, poisonings, fires, major accidents, death from unnatural causes or other catastrophes and unusual occurrences which threaten the welfare, safety or health of patients, personnel or visitors shall be reported by the facility within 24 hours either by telephone (and confirmed in writing) or by telegraph to the local health officer and the Department. An incident report shall be retained on file by the facility for one year. The facility shall furnish such other pertinent information related to such occurrences as the local health officer or the Department may require. Every fire or explosion which occurs in or on the premises shall be reported within 24 hours to the local fire authority or in areas not having an organized fire service, to the State Fire Marshal.

This RULE: is not met as evidenced by:
Based on interview, and record review, the facility failed to report an unusual occurrence, to the

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The statements made on this plan of corrections are not an admission to and do not constitute an agreement with the alleged deficiencies herein.
To remain in compliance with all federal and state regulations, the facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility's credible allegation of compliance. The alleged deficiencies cited have been or will be corrected by the date or dates indicated.

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No other patients were affected 11/28/11

The license nurses and/or Department Managers on duty will verbally report Incidents to the Administrator, Director of Nurses and/or Assistant Director's of Nurse the Administrator & Director of Nurse will review to determine if an unusual occurrence is required to be reported in the allotted 24 hours to CDPH.

License Nurses and Managers have been in-serviced on the requirement for notifying Administrator and Director of Nurse of all incidents and required reporting of unusual occurrences, timely per procedure.

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	11/21/11

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A 968	Continued From Page 1	A 968		

Department, when the facility was unable to redirect a patient behavior; Patient 1 wandered out of the facility and onto a freeway ramp.

Findings:

Per the Resident Admission Record, Patient 1 was admitted to the facility on 4/4/08 with diagnoses to include Alzheimer's disease (a decrease in memory).

Per the facility's event records dated, 9/25/11 at 12:20 P.M., Patient 1 wandered out of the facility and 2 facility staff attempted to redirect Patient 1 to return to the facility. Because Patient 1 would not return to the facility, facility staff stayed with Patient 1 to protect her from harm. Patient 1 walked through the facility parking lot to the street, and on to a freeway ramp, approximately 3/4 of a mile from the facility.

Patient 1 struck Licensed Nurse 1 at least twice, when she tried to redirect Patient 1.

Because staff was unsuccessful in redirecting Patient 1 and she was approaching the freeway, they phoned 9-1-1 for support.

The CHP (California Highway Patrol) officers assisted the nurses to secure Patient 1 at 12:42 P.M., and the CHP officers transferred Patient 1 to the acute care hospital for treatment.

The Department was made aware of the incident through 2 separate outside parties, when they phoned reports of the incident to the Department.

On 10/12/11, at 3 P.M. the facility policy entitled, Unusual Occurrence Reporting, dated December 2007, was reviewed with the Director of Nurses and the Administrator. According to the policy, the

The interdisciplinary team and managers will review the 24 hour report & incident reports daily and will notify the Administrator and Director of Nurses immediately of incidents/accident and Resident/Family concerns. The Administrator , Director of Nurses and or Assistant Director's of Nurses will review the incident and determine if the circumstances are unusual occurrence and report within the allotted 24 hours. Any deficient practices will be corrected immediately and reported to CDPH. CQI/QA will review incidents monthly and as needed, and will evaluate, educate and correct potential deficient practices immediately. Administrator will over see.

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A 968	Continued From Page 2 facility will report the following events, ..."h. Other occurrences that interfere with facility operation and affect the welfare, safety, or health of residents, employees or visitors". The Director of Nurses stated at 3:30 P.M. on 10/13/11, that the facility did not report the incident to the Department per the required facility policy.	A 968		