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 12/18/2019

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 The following reflects the findings of the California Department of Public Health during an abbreviated standard survey. Complaint # CA00661463. No deficiency identified. Complaint # CA00660524. One deficiency issued. The investigation was limited to the specific complaint and does not represent the findings of a full inspection of the facility. Representing the California Department of Public Health: Health Facilities Evaluator Nurse 29270.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.	F 578		1/17/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/16/2020

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.

POC accepted [signature] / HFEA 1/22/20

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F 578	Continued From page 1 (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview, and record review the facility failed to complete a Physician Orders for Life-Sustaining Treatment (POLST) for one of three residents (1). As a result, this failure had the potential for Resident 1 to receive the incorrect care in the event of an emergency. Findings: Resident 1 was readmitted to the facility on 12/2/18, per the facility's Face Sheet. Per the same Face Sheet, Resident 1 had designated a Family Member (FM) as her Power of Attorney (POA) to make health care decisions.	F 578	F578 Resident 1□s Physician Orders for Life-Sustaining Treatment (POLST) was reviewed on 12/19/2019. The Medical Records Assistant audited all in-house residents with POLST on 12/24/2019 to ensure that all information is completed. No other individuals were affected by the practice. The DON and designee initiated an in-service on 12/23/2019 for Medical Records and Licensed nurses related to completing the POLST if one is indicated. The Medical record department will conduct monthly audit x 3 months on completion of POLST. The finding will be reported to the DON for correction. The	

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F 578	Continued From page 2 On 10/24/19 at 9 A.M., FM 1 was interviewed by phone. FM 1 stated, there was an error in the POLST form for Resident 1. On 11/15/19, an unannounced visit was made to the facility. On 11/15/19 at 2:45 P.M., a request was made to the Director of Nurses (DON) for all of the POLST forms available for Resident 1. Two POLST forms were presented. POLST form one was dated 10/27/16, however a second POLST was presented signed by the POA but the form was undated in the signature block of the form. The first POLST, designed the Medical Interventions as, Selective Treatment. The second POLST had a change in the Medical Interventions to a lesser level of care for, Comfort-Focused Treatment. On 11/15/19 at 4:15 P.M., the DON stated the second POLST was not dated, and not complete. On 11/15/19 at 4:20 P.M., the DON stated she was unable to locate a policy for the completion of the POLST, however the, "Direction for Health Care Provider" on the back of the form were utilized by the facility. Per the form directions, "...Using POLST, any incomplete section of POLST implies full treatment for that section."	F 578	DON and/or designee will report trends at the quarterly Quality Assurance Committee until issue resolved.	