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	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40610 Based on interview, and record review, the facility failed to ensure a resident was provided care and treatment in accordance with professional standards of practice for one of three sampled residents (Resident 1), identified as high fall risk when; 1. staff failed to implement fall preventions for Resident 1, 2. a Licensed Nurse (LN 1) failed to complete a neurological examination (neuro check, evaluation of a patient ' s central nervous system that may include the use of lights and reflex hammers) for Resident 1 after an unwitnessed fall, and failed to communicate to the incoming shift nurse about Resident 1 ' s fall, and 3. LN 1 failed to notify Resident 1 ' s responsible party (RP) of fall incident. These failures resulted to Resident 1 ' s fall, incomplete monitoring of Resident 1, and the resident ' s RP was not made aware of Resident 1 ' s fall. Findings: On 9/5/24, the Department received a complaint related to quality of care. On 9/16/24, an unannounced visit to the facility was conducted. Resident 1 was admitted to the facility on [DATE], with diagnoses which included fracture (break in bone) of the sacrum (a shield-shaped bony structure located at the base of the lumbar vertebrae that is conected to the pelvis), a history of fall, and Parkinson ' s disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), per the facility's Admission Record. The same Admission Record indicated, the resident ' s family member (FM) was the responsible party (RP). On 9/16/24, a review of Resident 1's minimum data set (MDS - a federally mandated assessment tool), dated 8/17/24, indicated, Resident 1 had the ability to express ideas and wants, and understand others. Per the MDS, Resident 1 ' s mobility (roll left and right, sitting to lying, lying to sitting on side of bed, sit to stand, chair/ bed to chair transfer, and toilet transfer) was coded as dependent to the staff. The same MDS indicated, Resident 1 could walk 10 feet with maximum staff assistance. (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/16/24, a review of Resident 1 ' s physician order dated 8/16/24, indicated the staff to inform the family of the resident ' s health status including his medical condition. On 9/23/24, a review of Resident 1 ' s hospital course progress notes, dated 8/12/24, indicated Resident 1 was a high fall risk. On 9/19/24 at 10:49 A.M., a telephone interview with Licensed Nurse (LN) 2 was conducted. LN 2 stated she worked on 8/17/24 night shift (11 P.M. to 7 A.M). LN 2 stated she was not familiar with Resident 1 since the resident was new to the facility. LN 2 stated there was no communication provided to her related to Resident 1 ' s fall. LN 2 stated on early morning of 8/18/24, she found Resident 1 unresponsive and was shaking uncontrollably. LN 2 stated she called LN 4 to observe Resident 1 and called the paramedics. Per LN 2, after the paramedics took Resident 1 to the hospital, she and LN 4 found out Resident 1 fell prior to their shift. Per LN 2, upon further investigation, she found out Resident 1 fell on the day of admission (8/16/24) as his first fall, and on 8/17/24, was his second fall. LN 2 stated she was not informed about Resident 1 ' s falls. LN 2 stated when she found Resident 1 in his room, there was no bed alarm and no fall mats by the resident ' s bed. LN 2 stated there was no neuro check that was communicated to her by the prior nurse (LN 1). LN 2 stated there was no indication that Resident 1 ' s RP was notified about Resident 1 ' s fall on two events. On 9/19/24 at 11:49 A.M., a telephone interview with LN 4 was conducted. LN 4 stated on the morning of 8/18/24, LN 2 called her to assess Resident 1 because he (Resident 1) was unresponsive and was continuously seizing. LN 4 stated she noted Resident 1 had skin tears and bleeding in his arm. LN 4 stated she and LN 2 were not familiar with Resident 1. LN 4 stated the paramedics arrived and gave Resident 1 some intramuscular medication, but Resident 1 ' s seizure did not stop. LN 4 stated after the paramedics left with Resident 1, she and LN 2 found out Resident 1 fell prior to their shift. Per LN 4, there was no fall mat by Resident 1 ' s bed. LN 4 stated the prior shift nurse (LN 1) did not communicate Resident 1 ' s fall and neuro check was not initiated for Resident 1 after the fall. LN 4 stated when she and LN 2 called Resident 1 ' s RP, they were told the RP was not notified of the resident ' s two fall events. On 9/19/24 at 5:26 P.M., a call was placed to LN 1 but did not answer call and did not return the call. On 9/23/24, a review of Resident 1 ' s neuro checks indicated, Resident 1 had a fall on 8/16/24 and a neuro check was initiated. On 9/23/24, a review of Resident 1 ' s LNs progress notes were conducted. There was no LN progress note indicating Resident 1 fell on [DATE] and that his RP was notified. On 9/23/24, a review of Resident 1 ' s LNs progress notes dated 8/17/24 at 9:56 P.M., LN 1 documented Resident 1 was found on the floor. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/25/24 at 4:48 P.M., a telephone interview with the Director of Nursing (DON) was conducted. The DON stated Resident 1 had two fall events (8/16/24 and 8/17/24). The DON stated there should have been fall prevention measures for high fall risk residents. The DON stated the LN should have communicated to the incoming shift nurse about Resident 1 ' s fall and should have initiated a new neuro check. The DON also stated LN 1 should have informed Resident 1 ' s RP about Resident 1 ' s falls. The DON stated his expectations was for the staff to communicate any events that occurred to the residents for resident safety. The DON stated the staff should notify the resident ' s RP of the resident ' s health status so they were aware of what was going on with the resident. On 9/26/24, a review of the facility ' s policy titled, Falls and Fall Risk, Managing, revised March 2018, indicated, Based on previous evaluation and current data, the staff will identify interventions related to the resident ' s specific risks and causes to try to prevent the resident from falling .when a resident is found on the floor, a fall is considered to have occurred . On 9/26/24, a review of the facility ' s policy titled, Health, Medical Condition .Informing Residents of, revised February 2001, indicated, Each resident is informed of his or her total health status, medical condition .1 . If a resident has an appointed representative, the representative is also informed .