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	10/24/2024

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 ' s Licensed Nurses (LNs) failed to complete a neurological examination (neuro check, evaluation of a patient ' s central nervous system that may include the use of lights, reflex hammers, and an example is checking the blood pressure) for Resident 1 after a Certified Nursing Assistant (CNA) 1 witnessed another resident (Resident 2) incurred physical assault to Resident 1. This failure resulted to incomplete monitoring of Resident 1 and the potential of Resident 1 ' s decline after he was physically assaulted. Findings: On 10/7/24, the Department received a facility reported incident (FRI) related to Resident-to-Resident Abuse. On 10/16/24, an unannounced visit to the facility was conducted. Resident 1 was admitted to the facility on [DATE], with diagnoses which included traumatic bleeding of the cerebrum after a fall, per the facility's Admission Record. On 10/16/24, a review of Resident 1's history and physical (H&P) completed by the attending physician, dated 9/30/24, indicated, .Impression/ Problem List, 1. The patient is elderly .who had a fall with traumatic intracranial hemorrhage (bleeding) .Goal to keep systolic blood pressure (SBP) less than 140 . On 10/16/24, a review of Resident 1 ' s minimum data set (MDS - a federally mandated assessment tool), dated 10/8/24, indicated Resident 1 was dependent to staff in his activities of daily living (ADL like hygiene, toileting, bathing .) and functional abilities like 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). On 10/16/24 at 11:24 A.M., an interview was conducted with LN 1. LN 1 stated he was familiar with Resident 2 having mood swing change, being aggressive, and being combative. LN 1 stated he was not working when the reported incident happened. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(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	On 10/16/24 at 11:49 A.M., an interview was conducted with LN 2. LN 2 stated Resident 1 and Resident 2 shared the same room. LN 2 stated Resident 1 was non-verbal, did not know what was going on, was bedbound and was dependent to the staff. LN 2 stated Resident 1 communicated needs by becoming restless when needed an incontinence brief changed. LN 2 stated Resident 2 was alert and oriented times 3-4 (someone who is alert and oriented to person, place, time, and event), claimed Resident 1 was talking about him and tended to become verbally and physically aggressive. LN 2 stated there was a reported incident between Resident 1 and Resident 2 when Resident 2 allegedly hit Resident 1 in the head with an empty pitcher. LN 2 stated she was not present when the incident happened. On 10/16/24, a review of Resident 1 ' s neuro check sheet was conducted. There were missed blood pressure entries as followed: -10/6/24 at 1450 (2:50 P.M.) -10/7/24 at 1:50 A.M. -10/7/24 at 5:50 A.M. -10/7/24 at 9:50 A.M. -10/7/24 at 1:50 P.M. On 10/16/24 at 12:08 P.M., a concurrent review of Resident 1 ' s neuro checks sheet and an interview was conducted with the Director of Nursing (DON). The DON stated on 10/6/24, he received a report that Resident 2 was allegedly found agitated, and aggressive in Resident 1 and Resident 2 ' s shared room. The DON stated per the report, CNA 1 witnessed Resident 2 had thrown water and had hit Resident 1 in the head. The DON stated the LN initiated neuro check on Resident 1. The DON stated there were missed blood pressure entries in Resident 1 ' s neuro check sheet. The DON stated the neuro check should have been completed to include the resident ' s blood pressures. The DON stated it was important for the LNs to monitor the resident ' s blood pressure to ensure there was no change in resident ' s status in between monitoring. On 10/24/24 at 10:28 A.M., a telephone interview was conducted with CNA 1. CNA 1 stated she witnessed Resident 2 threw water to Resident 1 and swung his arms towards Resident 1 with an empty water pitcher. CNA 1 stated she already gave her report to the DON. On 10/24/24, a second attempt to conduct a telephone interview to LN 3 was conducted. LN 3 did not answer the call and did not return the call. A policy was requested. There was no policy provided related to ensuring the importance of completion of neuro checks.