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	11/04/2024

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38512 Based on interview and record review, the facility failed to initiate and implement care plans for two of two residents reviewed for care plans (Residents 1 and 2). This failure had the potential for staff to not be aware of the care needs for the residents. Findings: 1. Resident 1 was admitted to the facility on [DATE] with diagnoses to include an amputation (surgical removal), per the Admission Record. On 10/2/24 at 1:38 P.M., an interview was conducted with Licensed Nurse (LN) 1. LN 1 stated she had provided wound care to Resident 1 and was familiar with her care. LN 1 stated Resident 1 was admitted for treatment of the stump so the surgical site could heal. Per LN 1, Resident 1 did not follow instructions to avoid pressure to the stump so it would heel. LN 1 stated she had gone into Resident 1 ' s room several times and had seen her resting the stump on the bed, with the wound in contact with the mattress and bedding. On 10/2/24, a record review was conducted. A Nurses progress note, dated 9/25/24 at 2:13 P.M., indicated Resident 1 had removed her own dressing. Per the progress note, the nurse provided education to Resident 1 regarding the importance of leaving the dressings on and allowing nurses to remove and change the dressings to assist with wound healing. Resident 1 responded that she would not promise to leave the wound dressing in place. Care plans for Resident 1 were reviewed. No care plan for noncompliance was identified. On 10/2/24, a concurrent interview and record review was conducted with the Director of Nursing (DON). Care plans were reviewed for Resident 1, but no care plan for noncompliance was identified. The DON stated the facility should have created a care plan so that staff was aware of Resident 1 ' s behaviors, and they would be prepared to monitor and assist Resident 1 as necessary. 2. Resident 2 was admitted to the facility on [DATE] with diagnoses to include dementia (a progressive state of decline in mental abilities), per the Admission Record. (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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/2/24 at 1:35 P.M., an interview was conducted with LN 1. LN 1 stated she had been assigned to Resident 2 and she was familiar with his care. LN 1 stated it was difficult to provide care to Resident 2 because he had dementia, and he would bite and scratch staff who attempted to provide his wound care treatments. A record review was conducted on 10/2/24. A Nurses note, dated 9/3/24 at 9:55 A.M., indicated Resident 2 was combative and forgetful. A Nursing admission assessment note, dated 9/4/24 at 4:23 P.M. indicated Resident 2 was refusing assessment, kicking and biting staff. On 10/2/24 at 4:23 P.M., a concurrent interview and record review was conducted with the DON. The DON reviewed care plans for Resident 2 and stated he could not locate a care plan for noncompliance, or combative behavior. The DON stated a care plan was how the facility made sure the resident ' s needs were met, and helped to keep the resident safe. Per an undated facility policy, titled Care Plans, Comprehensive Person-Centered, A comprehensive, person-centered care plan should include measurable objectives and timetables to meet the resident ' s physical, psychosocial and functional needs .when possible, interventions should address the underlying source of the problem .should review and update the care plan .

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38512 Based on interview and record review, the facility failed to ensure nursing staff provided and documented treatment of wounds for two of two residents reviewed for wound care (Residents 1 and 2). As a result, Residents 1 and 2 were at risk for worsening skin conditions. Findings: 1. Resident 1 was admitted to the facility on [DATE] with diagnoses to include an amputation (surgical removal), per the Admission Record. On 10/2/24 at 1:38 P.M., an interview was conducted with Licensed Nurse (LN) 1. LN 1 stated she had provided wound care to Resident 1 and was familiar with her care. LN 1 stated Resident 1 was admitted for treatment of the stump so the surgical site could heal. Per LN 1, Resident 1 had fallen on the stump while in the facility, and had developed a small wound on the stump, below the surgical site. LN 1 stated the doctor had written new orders for staff to treat the known surgical site on the stump, as well as the new wound. Per LN 1, Resident 1 also had a rash on her buttocks due to moisture, which required treatment. On 10/2/24, a record review was conducted. Physician ' s orders, dated 9/7/24, indicated Resident 1 was to receive a treatment of an ointment on the buttocks twice daily until the moisture-related rash resolved (twice daily for 19 days). The September Treatment Administration Record (TAR, a document signed by nurses once a treatment had been provided) indicated Resident 1 had not received the ointment on the buttocks eight of the 38 times it was indicated. No code or explanation was given on the TAR. Physician ' s orders, dated 9/23/24, indicated Resident 1 was to receive a treatment of multiple medications and a dressing to cover the new wound on the stump daily until 9/25/24 (once daily for two days). The September TAR indicated Resident 1 had not received any treatment to the stump on 9/24/24 or 9/25/24. A nurses ' progress note, dated 9/26/24 at 1:30 P.M. indicated the dressing covering Resident 1 ' s stump and wound was soaked with blood, and the surgical site had opened. A nurses ' progress note, dated 9/26/24 at 7:40 P.M. indicated Resident 1 was sent out to the hospital for further evaluation. 2. Resident 2 was admitted to the facility on [DATE] with diagnoses to include dementia (a progressive state of decline in mental abilities), per the Admission Record. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/2/24 at 1:38 P.M., an interview was conducted with LN 1. LN 1 stated she had provided wound care to Resident 2 and was familiar with his care. Per LN 1, it was important to perform the wound care as ordered to assist in healing. LN 1 stated Resident 2 was on a special mattress, but was confused and sometimes would hit or try and bite staff while they were doing his wound treatments. LN 1 stated the wound care orders were for three times a day, to be done each shift of nurses. On 10/2/24, a record review was conducted. Physician ' s orders, dated 9/6/24, indicated Resident 2 was to have wound treatments to five different skin sites every Monday, Wednesday and Friday. The September TAR indicated no treatments were done three of 10 of those days. Physician ' s orders, dated 9/6/24, indicated Resident 2 ' s skin areas with bruising were to be monitored daily. The September TAR indicated no monitoring was done four of 23 days. Physician ' s orders, dated 9/6/24, indicated Resident 2 was to have dressings applied to his skin daily for six days. The September TAR indicated no dressings were applied one of the six days. Physician ' s orders, dated 9/6/24, indicated Resident 2 was to have treatments to his buttocks three times a day for 23 days (69 times). The September TAR indicated no treatments were done 22 of the 69 times. On 10/2/24 at 1 P.M., a concurrent interview and record review was conducted with the Director of Nursing (DON). The DON stated nurses should follow the physician ' s order for all wound care. The DON reviewed the TARs for Residents 1 and 2, and stated, It is the responsibility of the treatment nurse and the other nurses to complete the wound care as ordered by the physician. The TAR should have been signed at the time treatment was given, and without this documentation, I am unable to conclude the treatment was completed as ordered. This could cause the wounds to worsen. No policy regarding wound care documentation was provided.