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	12/17/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40610 Based on observation, interview and record review, the facility failed to ensure respect and dignity was provided to a resident (Resident 1) when Certified Nursing Assistant (CNA) 1 did not render Resident 1's request of a clean bowl for her breakfast cereals and pointed at Resident 1 to have thrown cereals into bathroom toilet bowl. As a result, Resident 1 felt disrespected and was upset with the incident. In addition, this failure had the potential for Resident 1 to feel low self-esteem. Cross Reference to F 812. Findings: On 12/17/24, the Department received a complaint related to residents' rights. On 12/17/24, an unannounced visit to the facility was conducted. A review of Resident 1's Admission Record indicated Resident 1 was admitted to the facility on [DATE]. A review of Resident 1's minimum data set (MDS - a federally mandated resident assessment tool), dated 11/4/24, Resident 1 had a Brief Interview for Mental Status (BIMS, ability to recall) score of 15/15, (a score of 13 to 15 suggests the patient is cognitively [process of acquiring knowledge and understanding] intact, 8 to 12 suggests moderately impaired and 0 to 7 suggests severe impairment). (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/17/24 at 11:40 A.M, an observation and an interview were conducted with Resident 1 in her room. Resident 1 was sitting up in a wheelchair watching news in her tablet. Resident 1 stated she had an issue in the morning during breakfast. Resident 1 stated she did not get a cottage cheese for breakfast and asked her assigned CNA (CNA 1) to bring her a clean bowl for her cereals. Resident 1 stated she kept her own cereal and only wanted a bowl. Resident 1 stated CNA 1 came back with a bowl, and with cereal in it. Resident 1 stated the bowl CNA 1 was giving her had food debris in it. Resident 1 stated she did not like to take the bowl and requested the CNA to get her a bowl from the kitchen. Resident 1 stated CNA 1 went to the bathroom, heard CNA 1 discarded the cereals in the toilet bowl, rinsed the bowl in the bathroom sink and gave it to her (Resident 1). Resident 1 stated, I know what I heard .I was expecting her to give me a clean bowl. I don't want her giving me a bowl with cereal in it and clean the bowl in the bathroom. I know what is going on, how about the other patients who cannot speak for themselves? Resident 1 stated, I was angry that she pulled something like that. That is not acceptable, and I feel upset about it. She seems like she did not give me respect by giving that used bowl on me and dumping the cheerios [sic] in the toilet bowl which we used for toileting. On 12/17/24 at 11:57 A.M., an observation was conducted in Resident 1's bathroom. There were floating cereals and paper towel in the toilet bowl. On 12/17/24 at 12:03 P.M., an interview was conducted with CNA 1. CNA 1 stated she had Resident 1 for 30 minutes in the morning on 12/17/24. CNA 1 stated Resident 1 was upset because she (Resident 1) did not get what she wanted for breakfast, and she asked for a bowl. CNA 1 stated Resident 1 had her own supply of cereal in her closet. CNA 1 stated she got a bowl with cereals in it and gave it to Resident 1. CNA 1 stated Resident 1 did not like to accept the bowl with cereals in it. CNA 1 stated Resident 1 was upset because she did not get what she wanted . CNA 1 stated I did not throw the cheerios [sic] in the toilet bowl. It might be her who threw it there. On 12/17/24 at 12:10 P.M., a joint observation of Resident 1's bathroom and an interview were conducted with CNA 1. There were floating cereals and paper towel in the toilet bowl. CNA 1 stated she threw the cereals in the resident's trash bin. CNA 1 went to dig Resident 1's trash bin in the presence of Resident 1. CNA 1 stated there is nothing here. I threw it (cereals) here. When asked who threw the cereals in the toilet bowl, CNA 1 stated there was a confusion, and I might have dumped it there. CNA 1 stated there was a confusion since she had to help Resident 1's roommate. CNA 1 stated, I know she was upset because she did not get the cottage cheese. On 12/17/24 at 12:41 P.M., a joint observation of Resident's bathroom and an interview was conducted with the Infection Preventionist (IP). The IP stated CNA 1 should have gotten a clean bowl from the kitchen. The IP stated The cheerios in the toilet bowl was not acceptable. That was disrespectful to the resident and that was an infection control issue. On 12/17/24 at 1:20 P.M., a joint observation of Resident's bathroom and an interview was conducted with the Director of Nursing (DON). The DON stated there were cereals there and It should be not like that. The DON stated, We don't throw food in the toilet bowl for infection control practices, and we don't lie. The DON stated, It is also a dignity issue, we should respect their rights. (continued on next page)

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy titled, Dignity, revised February 2021, indicated, Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem, Policy Interpretation and Implementation, 1. Residents are treated with dignity and respect at all times, 2. The facility culture supports dignity and respect for residents by honoring resident goals, choices, preferences, values and beliefs. This begins with the initial admission and continues throughout the resident's facility stay .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40610 Based on observation, interview and record review, the facility failed to ensure safe and sanitary measures were met while preparing and distributing food for a resident (Resident 1), when Certified Nursing Assistant (CNA) 1 discarded cereals into the toilet bowl and did not flush the toilet bowl in Resident 1's bathroom. This finding had the potential to expose Resident 1 and her roommate to unsafe and unsanitary food practices that could lead to illness and infection. Cross Reference to F 550. Findings: On 12/17/24, the Department received a complaint related to residents' rights. On 12/17/24, an unannounced visit to the facility was conducted. A review of Resident 1's Admission Record indicated Resident 1 was admitted to the facility on [DATE], with diagnoses which included Sjogrens's syndrome (autoimmune disorder, in which the immune cells mistakenly attack and destroy healthy cells). A review of Resident 1's minimum data set (MDS - a federally mandated resident assessment tool), dated 11/4/24, Resident 1 had a Brief Interview for Mental Status (BIMS, ability to recall) score of 15/15, (a score of 13 to 15 suggests the patient is cognitively [process of acquiring knowledge and understanding] intact, 8 to 12 suggests moderately impaired and 0 to 7 suggests severe impairment). On 12/17/24 at 11:40 A.M, an observation and an interview were conducted with Resident 1 in her room. Resident 1 was sitting up in a wheelchair watching news in her tablet. Resident 1 stated she had an issue in the morning during breakfast. Resident 1 stated she did not get a cottage cheese for breakfast and asked her assigned CNA (CNA 1) to bring her a clean bowl for her cereals. Resident 1 stated she kept her own cereal and only wanted a bowl. Resident 1 stated CNA 1 came back with a bowl, and with cereal in it. Resident 1 stated the bowl CNA 1 was giving her had food debris in it. Resident 1 stated she did not like to take the bowl and requested the CNA to get her a bowl from the kitchen. Resident 1 stated CNA 1 went to the bathroom, heard CNA 1 discarded the cereals in the toilet bowl, rinsed the bowl in the bathroom sink and gave it to her (Resident 1). Resident 1 stated, I know what I heard .I was expecting her to give me a clean bowl. I don't want her giving me a bowl with cereal in it and clean the bowl in the bathroom. I know what is going on, how about the other patients who cannot speak for themselves? Resident 1 stated the cereal is still in the toilet bowl. Resident 1 stated it was an infection issue because CNA 1 just rinsed the bowl from another patient. Resident 1 stated it was not acceptable. On 12/17/24 at 11:57 A.M., an observation was conducted in Resident 1's bathroom. There were floating cereals and paper towel in the toilet bowl. (continued on next page)

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/17/24 at 12:03 P.M., an interview was conducted with CNA 1. CNA 1 stated she had Resident 1 for 30 minutes in the morning on 12/17/24. CNA 1 stated Resident 1 was upset because she (Resident 1) did not get what she wanted for breakfast, and she asked for a bowl. CNA 1 stated Resident 1 had her own supply of cereal in her closet. CNA 1 stated she got a bowl with cereals in it and gave it to Resident 1. CNA 1 stated Resident 1 did not like to accept the bowl with cereals in it. CNA 1 stated Resident 1 was upset because she did not get what she wanted . CNA 1 stated I did not throw the cheerios in the toilet bowl. It might be her who threw it there. On 12/17/24 at 12:10 P.M., a joint observation of Resident 1's bathroom and an interview were conducted with CNA 1. There were floating cereals and paper towel in the toilet bowl. CNA 1 stated she threw the cereals in the resident's trash bin. CNA 1 went to dig Resident 1's trash bin in the presence of Resident 1. CNA 1 stated there is nothing here. I threw it (cereals) here. When asked who threw the cereals in the toilet bowl, CNA 1 stated there was a confusion, and I might have dumped it there. CNA 1 stated there was a confusion since she had to help Resident 1's roommate. CNA 1 stated she should have not thrown the cereals in the toilet bowl because it was an infection control issue. On 12/17/24 at 12:20 P.M., a joint observation of Resident 1's bathroom and an interview were conducted with the Maintenance Director (MAD). There were floating cereals and paper towel in the toilet bowl. The MAD stated, That was not acceptable. On 12/17/24 at 12:41 P.M., a joint observation of Resident's bathroom and an interview was conducted with the Infection Preventionist (IP). The IP stated the cereals in the toilet bowl was not acceptable because it was an infection issue. On 12/17/24 at 1:20 P.M., a joint observation of Resident's bathroom and an interview was conducted with the Director of Nursing (DON). The DON stated there were cereals there and It should be not like that. The DON stated, We don't throw food in the toilet bowl for infection control practices. A review of the facility's policy titled, Food Preparation and Service, revised 2001, indicated, .Policy Interpretation and Implementation .Food Service, means the processes involved in actively serving food to the resident . Food Distribution and Service .12. Food that has been served to residents without temperature controls .will be discarded . The policy did not indicate food disposal in the toilet bowl.