

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555323	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/26/2024
NAME OF PROVIDER OR SUPPLIER Aviara Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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** Based on interview and record review, the facility failed to develop a person-centered care plan for anticoagulant use (a medication that thins the blood, in order to prevent blood clots from forming or becoming larger) for one of three residents, (Resident 1) reviewed for comprehensive care plans. This failure had the potential for staff to provide inconsistent care, and to put Resident 1 at a higher risk of bleeding. Findings: Resident 1 was admitted to the facility on [DATE], with diagnoses which included encephalopathy (a disease that affects brain function), per the facility 's admission Record. Resident 1 ' s clinical record was reviewed on 12/23/24: According to the physician orders, dated 12/11/24, administer enoxaparin (a medication used to prevent blood clots from forming in the blood vessels of the legs), injection, 40 milligrams/0.4 milliliters once a day for deep vein thrombosis (blood clots in the legs) prevention. According to the nurses note, dated 12/12/24 at 9:41 A.M., Resident 1 was sent to the hospital for bleeding at her G-Tube (gastrointestinal tube- a tube surgically inserted into the stomach in order to deliver nutrition) site. There was no documented evidence a person-centered care plan had been developed for anticoagulant therapy. An interview was conducted with Licensed Nurse 1 (LN 1) on 12/23/24 at 11:50 A.M. LN 1 stated care plans for anticoagulant therapy should always be developed to ensure monitoring and consistent care of the resident. LN 1 stated if a care plan was not developed for anticoagulant therapy, the resident was at risk of bleeding, because no one was monitoring for bleeding. LN 1 stated nurses were responsible for developing and implemented care plans to identify problems or the risk of problem occurring. (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	An interview was conducted with LN 2 on 12/23/24 at 11:56 A.M. LN 2 stated care plans were a road map to provide care for residents. LN 2 stated care plans were important to identify problems, set goals, interventions, and for staff to provide consistent care. LN 2 stated if a care plan was not developed for a resident on anticoagulant, there was the potential for bleeding, which could cause harm, because no one was monitoring for the risk of bleeding. An interview and record review was conducted with the Director of Staff Development (DSD), on 12/23/24 at 12:05 P.M. The DSD stated in-services were provided to LNs last month on the importance of developing care plans. The DSD stated care plans should be individualized comprehensive assessments, that identified potential or actual problems. The DSD reviewed Resident 1 ' s clinical record and could find no evidence a care plan had been developed for anticoagulant therapy. The DSD stated a anticoagulant therapy care plan should have been developed by staff, so they could be monitoring Resident 1 for bleeding or potential problems related to bleeding. An interview and record review was conducted with the Director of Nursing (DON) on 12/23/25 at 12:16 P.M. The DON stated care plans provided staff with a communication tool for providing consistent care. The DON reviewed Resident 1 ' s care plans, and stated a care plan had not been developed for anticoagulant therapy, and it should have been. The DON stated by not developing a care plan, Resident 1 was at risk for bleeding, and staff being delayed with identifying it. According to the facility ' s policy, titled Care Plans, Comprehensive Person Centered, dated March 2022, .7. The comprehensive person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished; .e. reflects current recognized standards of practice for problem areas and conditions .		