

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 01/10/2025
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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39111 Based on interview and record review, the facility failed to ensure two of four licensed nurses (LN 1 and LN 4) who administered medications to residents were verified as competent (a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics that an individual needs to perform work roles or occupational functions successfully) to perform medication administration/medication management. This deficient practice had the potential for medications to be administered to Resident 1 and other residents in an unsafe manner. Findings: A review of Resident 1 ' s Admission Record indicated he was admitted on [DATE] with the diagnosis of low back pain. On 1/10/25 at 1:35 P.M., an interview was conducted with LN 3. LN 3 stated all LNs should be evaluated for competency to administer medications in a safe manner to residents. LN 3 stated, It ' s not like we ' re passing out candy. A review of Resident 1 ' s physician order dated 10/18/24 and medication administration record (MAR) dated 1/10/25, indicated the resident was to receive Norco (hydrocodone-acetaminophen) oral tablet 5-325 milligrams (a controlled pain medication [a drug with high abuse potential]) daily at noon. (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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/10/25 at 2:05 P.M., a joint observation, interview, and record review, was conducted with licensed nurse (LN) 1. Resident 1 's Norco 5-325 medication card for noon administration was observed with LN 1. There were 18 pills left in the medication card. A review of Resident 1 's Controlled Drug Record (CDR) for Norco 5-325 noon dose indicated the last dose that was signed out was at noon on 1/8/25. LN 1 stated she was not the assigned nurse on 1/9/25 but was taking care of Resident 1 today (1/10/25). LN 1 stated she gave Resident 1 his noon Norco 5-325 but did not sign it out on the CDR. LN 1 then signed Resident 1 's CDR for the 1/10/25 noon dose of Norco 5-325. LN 1 stated Resident 1 was scheduled to receive Norco 5-325 routinely at noon. LN 1 reviewed Resident 1 's MAR dated 1/9/25 and stated it was documented that the resident received Norco 5-325 at noon. LN 1 stated this was not correct and that if it had been administered to Resident 1 on 1/9/25, then there would have been 17 pills left in the medication card and not 18. LN 1 stated Resident 1 was not provided his routine Norco 5-325 on 1/9/25. LN 1 further stated she was a registry nurse (licensed nurse provided to the facility by a staffing agency). LN 1 stated she did not recall being assessed for medication administration/medication management competency by the facility or her registry agency. On 1/10/25 at 2:14 P.M., an interview was conducted with the director of staff development (DSD). The assistant to the director of staff development (ADSD) was also present. The DSD stated it was expected that LNs signed out on the resident 's CDR immediately when removing the controlled medication from the locked drawer. The DSD stated if registry nurses were being utilized in the facility, then their medication administration competency should have been evaluated or verified that the registry agency evaluated the LNs competency. The DSD stated LN 4, also a registry nurse, was the one who provided medications to Resident 1 on 1/9/25 and should have administered the resident 's Norco 5-325 at noon. The ADSD reviewed documents received from LN 1 and LN 4 's registry agencies. The ADSD stated there was no documentation the facility verified that the registry agency had evaluated LN 1 and LN 4 's competency to administer medications. The ADSD also stated there was no documentation a medication administration/medication management competency evaluation had been done for LN 1 and LN 4. The DSD stated the facility should have verified if LN 1 and LN 4 were competent to administer medications as it was a matter of resident safety. On 1/10/25 at 4:05 P.M., an interview was conducted with the assistant director of nursing (ADON). The ADON stated all LNs should have been assessed for competency to administer medications to residents and that this included registry staff. The ADON stated registry staff provided care and treatment to the residents and the facility was responsible for the outcome. The ADON stated the facility should have verified registry LNs were evaluated by the registry agency for competent medication administration/medication management. A review of the facility 's policy titled Staffing, Sufficient and Competent Nursing revised August 2022, indicated, Our facility provides sufficient numbers of nursing staff with the appropriate skills and competency necessary to provide nursing and related care and services for all residents . 3. Staff must demonstrate the skills and techniques necessary to care for resident needs including (but not limited to) the following areas . m. Medication management (continued on next page)		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to ensure two of four licensed nurses (LN 1 and LN 4) who administered medications to residents were verified as competent (a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics that an individual needs to perform work roles or occupational functions successfully) to perform medication administration/medication management. This deficient practice had the potential for medications to be administered to Resident 1 and other residents in an unsafe manner. Findings: A review of Resident 1's Admission Record indicated he was admitted on [DATE] with the diagnosis of low back pain. On 1/10/25 at 1:35 P.M., an interview was conducted with LN 3. LN 3 stated all LNs should be evaluated for competency to administer medications in a safe manner to residents. LN 3 stated, It's not like we're passing out candy. A review of Resident 1's physician order dated 10/18/24 and medication administration record (MAR) dated 1/10/25, indicated the resident was to receive Norco (hydrocodone-acetaminophen) oral tablet 5-325 milligrams (a controlled pain medication [a drug with high abuse potential]) daily at noon. On 1/10/25 at 2:05 P.M., a joint observation, interview, and record review, was conducted with licensed nurse (LN) 1. Resident 1's Norco 5-325 medication card for noon administration was observed with LN 1. There were 18 pills left in the medication card. A review of Resident 1's Controlled Drug Record (CDR) for Norco 5-325 noon dose indicated the last dose that was signed out was at noon on 1/8/25. LN 1 stated she was not the assigned nurse on 1/9/25 but was taking care of Resident 1 today (1/10/25). LN 1 stated she gave Resident 1 his noon Norco 5-325 but did not sign it out on the CDR. LN 1 then signed Resident 1's CDR for the 1/10/25 noon dose of Norco 5-325. LN 1 stated Resident 1 was scheduled to receive Norco 5-325 routinely at noon. LN 1 reviewed Resident 1's MAR dated 1/9/25 and stated it was documented that the resident received Norco 5-325 at noon. LN 1 stated this was not correct and that if it had been administered to Resident 1 on 1/9/25, then there would have been 17 pills left in the medication card and not 18. LN 1 stated Resident 1 was not provided his routine Norco 5-325 on 1/9/25. LN 1 further stated she was a registry nurse (licensed nurse provided to the facility by a staffing agency). LN 1 stated she did not recall being assessed for medication administration/medication management competency by the facility or her registry agency. On 1/10/25 at 2:14 P.M., an interview was conducted with the director of staff development (DSD). The assistant to the director of staff development (ADSD) was also present. The DSD stated it was expected that LNs signed out on the resident's CDR immediately when removing the controlled medication from the locked drawer. The DSD stated if registry nurses were being utilized in the facility, then their medication administration competency should have been evaluated or verified that the registry agency evaluated the LNs competency. The DSD stated LN 4, also a registry nurse, was the one who provided medications to Resident 1 on 1/9/25 and should have administered the resident's Norco 5-325 at noon. (continued on next page)		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The ADSD reviewed documents received from LN 1 and LN 4's registry agencies. The ADSD stated there was no documentation the facility verified that the registry agency had evaluated LN 1 and LN 4's competency to administer medications. The ADSD also stated there was no documentation a medication administration/medication management competency evaluation had been done for LN 1 and LN 4. The DSD stated the facility should have verified if LN 1 and LN 4 were competent to administer medications as it was a matter of resident safety. On 1/10/25 at 4:05 P.M., an interview was conducted with the assistant director of nursing (ADON). The ADON stated all LNs should have been assessed for competency to administer medications to residents and that this included registry staff. The ADON stated registry staff provided care and treatment to the residents and the facility was responsible for the outcome. The ADON stated the facility should have verified registry LNs were evaluated by the registry agency for competent medication administration/medication management. A review of the facility's policy titled Staffing, Sufficient and Competent Nursing revised August 2022, indicated, Our facility provides sufficient numbers of nursing staff with the appropriate skills and competency necessary to provide nursing and related care and services for all residents . 3. Staff must demonstrate the skills and techniques necessary to care for resident needs including (but not limited to) the following areas . m. Medication management		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39111 Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 1) received his routine pain medication as ordered. This failure had the potential for Resident 1 to experience pain. Findings: A review of Resident 1 ' s Admission Record indicated he was admitted on [DATE] with the diagnosis of low back pain. On 1/10/24 at 1:26 P.M., an interview was conducted with Resident 1 ' s family member (FM) 1. FM 1 stated there was difficulty receiving Resident 1 ' s scheduled pain medication on time. FM 1 stated Resident 1 would often text her to let her know he had not received his scheduled pain medication. FM 1 stated she would have to come to the facility to make sure Resident 1 received his pain medication. A review of Resident 1 ' s physician order dated 10/18/24 and medication administration record (MAR) dated 1/10/25, indicated the resident was to receive Norco (hydrocodone-acetaminophen) oral tablet 5-325 milligrams (a controlled pain medication [a drug with high abuse potential]) daily at noon. On 1/10/25 at 2:05 P.M., a joint observation, interview, and record review, was conducted with licensed nurse (LN) 1. Resident 1 ' s Norco 5-325 medication card for noon administration was observed with LN 1. There were 18 pills left in the medication card. A review of Resident 1 ' s Controlled Drug Record (CDR) for Norco 5-325 noon dose indicated the last dose that was signed out was at noon on 1/8/25. LN 1 stated she was not the assigned nurse on 1/9/25 but was taking care of Resident 1 today (1/10/25). LN 1 stated she gave Resident 1 his noon Norco 5-325 but did not sign it out on the CDR. LN 1 then signed Resident 1 ' s CDR for the 1/10/25 noon dose of Norco 5-325. LN 1 stated Resident 1 was scheduled to receive Norco 5-325 routinely at noon. LN 1 reviewed Resident 1 ' s MAR dated 1/9/25 and stated it was documented that the resident received Norco 5-325 at noon. LN 1 stated this was not correct and that if it had been administered to Resident 1 on 1/9/25, then there would have been 17 pills left in the medication card and not 18. LN 1 stated Resident 1 was not provided his routine Norco 5-325 on 1/9/25. On 1/10/25 at 4:05 P.M., an interview was conducted with the assistant director of nursing (ADON). The ADON verified with the admission department that Resident 1 had not left the facility at any time on 1/9/25. The ADON stated Resident 1 ' s Norco 5-325 scheduled at noon was a routine pain medication that had to be administered every day at noon. The ADON stated Resident 1 should have received his Norco 5-325 at noon on 1/9/25. The ADON further stated this could have caused Resident 1 to experience pain. A review of the facility ' s policy titled Administering Medications revised April 2019, indicated, .4. Medications are administered in accordance with the prescriber orders, including any required time frame (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	51619 Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 1) received his routine pain medication as ordered. This failure had the potential for Resident 1 to experience pain. Findings: A review of Resident 1's Admission Record indicated he was admitted on [DATE] with the diagnosis of low back pain. On 1/10/24 at 1:26 P.M., an interview was conducted with Resident 1's family member (FM) 1. FM 1 stated there was difficulty receiving Resident 1's scheduled pain medication on time. FM 1 stated Resident 1 would often text her to let her know he had not received his scheduled pain medication. FM 1 stated she would have to come to the facility to make sure Resident 1 received his pain medication. A review of Resident 1's physician order dated 10/18/24 and medication administration record (MAR) dated 1/10/25, indicated the resident was to receive Norco (hydrocodone-acetaminophen) oral tablet 5-325 milligrams (a controlled pain medication [a drug with high abuse potential]) daily at noon. On 1/10/25 at 2:05 P.M., a joint observation, interview, and record review, was conducted with licensed nurse (LN) 1. Resident 1's Norco 5-325 medication card for noon administration was observed with LN 1. There were 18 pills left in the medication card. A review of Resident 1's Controlled Drug Record (CDR) for Norco 5-325 noon dose indicated the last dose that was signed out was at noon on 1/8/25. LN 1 stated she was not the assigned nurse on 1/9/25 but was taking care of Resident 1 today (1/10/25). LN 1 stated she gave Resident 1 his noon Norco 5-325 but did not sign it out on the CDR. LN 1 then signed Resident 1's CDR for the 1/10/25 noon dose of Norco 5-325. LN 1 stated Resident 1 was scheduled to receive Norco 5-325 routinely at noon. LN 1 reviewed Resident 1's MAR dated 1/9/25 and stated it was documented that the resident received Norco 5-325 at noon. LN 1 stated this was not correct and that if it had been administered to Resident 1 on 1/9/25, then there would have been 17 pills left in the medication card and not 18. LN 1 stated Resident 1 was not provided his routine Norco 5-325 on 1/9/25. On 1/10/25 at 4:05 P.M., an interview was conducted with the assistant director of nursing (ADON). The ADON verified with the admission department that Resident 1 had not left the facility at any time on 1/9/25. The ADON stated Resident 1's Norco 5-325 scheduled at noon was a routine pain medication that had to be administered every day at noon. The ADON stated Resident 1 should have received his Norco 5-325 at noon on 1/9/25. The ADON further stated this could have caused Resident 1 to experience pain. A review of the facility's policy titled Administering Medications revised April 2019, indicated, .4. Medications are administered in accordance with the prescriber orders, including any required time frame		