

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 05/28/2025
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)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview, and record review the facility failed to ensure infection control procedures were followed when:</p> <p>A. Staff did not tie plastic trash bags while transporting to the utility room, did not cover the trash bins, and trash bins were overflowing causing a foul smell in the utility room,</p> <p>B. a Licensed Nurse (LN) 2 did not wear a gown for Resident 6 with enhanced barrier precautions (EBP - involves gown and glove use during high-contact resident care activities for residents [example: residents with chronic wounds]) during a wound treatment observation, and,</p> <p>C. Newly admitted residents were not tested for tuberculosis (TB, infectious lung disease) testing upon admission.</p> <p>These failures had the potential for cross contamination and spread of infection between residents and staff.</p> <p>Findings:</p> <p>A. On 5/28/25 at 11:20 A.M., an observation was conducted in the utility room near nurses' station 1. A certified nursing assistant (CNA) went to the utility room with untied clear plastic bag containing trash. The CNA placed the untied clear plastic bag on top of the trash bin with no lids noted. The trash bin was overflowing. The room had foul smell.</p> <p>On 5/28/25 at 11:22 A.M., a follow up observation was conducted in the utility room near nurses' station 1. Another CNA went to the utility room with untied clear plastic back containing trash. The CNA placed the untied clear plastic bag on top of the pile of trash in the utility room.</p> <p>On 5/28/25 at 11:23 A.M., an observation was conducted in the utility room near nurses' station 2. Foul odor was noted going to the utility room in nurses' station 2. Two residents were sitting in their wheelchair in front of the nurses' station 2. Attempted to interview the two residents but the two residents just looked and did not respond to questions.</p> <p>(continued on next page)</p>

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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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 5/28/25 at 11:33 A.M., a joint observation of the utility room near nurses' station 2 and an interview was conducted with the Housekeeping Supervisor (HS). The clear plastic bags were piled in a gray trash bin. The gray trash bins did not have lids on it. The HS stated the CNAs were responsible for throwing the trash from the residents' room to the utility room. The HS stated the CNAs should have tied the plastic bags containing the trash and closed the trash bins with their lids. The HS stated even though the utility room was closed, the CNAs were required to tie the trash bags and closed the lids of the trash bins.</p> <p>On 5/28/25 at 11:42 A.M., a joint observation of the utility room near nurses' station 1 and an interview was conducted with the HS. The utility room near nurses' station 1 had clear plastic trash bags that were piled on top of the overflowing opened gray trash bins. The HS stated, The CNAs are supposed to tie the clear plastic trash bags before even taking the trash out to the utility room and were supposed to put the lids on the gray trash bins for infection control purposes.</p> <p>On 5/28/25 at 11:49 A.M., a joint observation of the utility room near nurses' station 1 and an interview was conducted with the Director of Staff Development (DSD). The utility room near nurses' station 1 had clear plastic trash bags that were piled on top of the overflowing opened gray trash bins. The DSD stated, They (staff) should be tying the plastic before they put the trash in the bins and closed the lids for infection control.</p> <p>On 5/28/25 at 2:34 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated the expectation was for the staff to ensure the plastic trash bags should have been tied prior to transport to the utility room and closed the lids of the trash bins to control odors and for infection control.</p> <p>A review of the facility's policy titled, Homelike Environment, revised 2/2021, indicated, Residents are provided with a safe, clean, comfortable and homelike environment . 2. The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a. clean, sanitary and orderly environment .f. pleasant, neutral scents .</p> <p>B. A review of Resident 6's admission Record indicated Resident 6 was readmitted to the facility on [DATE], with diagnoses which included a pressure ulcer (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) of Resident 6's sacrum.</p> <p>A review of physician's order on 4/29/25 for Resident 6 indicated, Enhanced barrier precautions during high contact resident care activities secondary to Sacrum Pressure wound, every shift for Infection Prevention.</p> <p>On 5/28/25 at 12:38 P.M., an observation was conducted of Licensed Nurse (LN) 2 provide wound treatment to Resident 6. Resident 6 had an EBP sign posted by the entrance of Resident 6's room. LN 2 prepared the treatment supplies and placed at Resident 6's bedside table. LN 2 provided wound treatment to Resident 6's sacrum without a gown.</p> <p>On 5/28/25 at 12:46 P.M., an interview was conducted with LN 2. LN 2 stated Resident 6 was on EBP, and staff were required to wear gloves and gown when providing direct care to the residents. LN 2 stated she forgot to wear a gown. LN 2 stated when providing wound treatment to Resident 6, she should have worn a gown to prevent spread of infection.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 5/28/25 at 2:34 P.M., an interview was conducted with the DON. The DON stated the expectation was for the staff to follow the procedures on EBP when providing care and treatment to the residents on EBP for infection control and to protect the residents because residents were prone of getting an infection.</p> <p>A review of the facility's policy titled, Enhanced Barrier Precautions, revised 12/2024, indicated, Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug-resistant organisms (MDROs) to residents .1. Enhanced barrier precautions (EBPs) refer to infection prevention and control interventions designed to reduce the transmission of multi-drug-resistant organisms (MDROs) during high contact resident care activities .7. EBPs employ targeted gown and glove use .8. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include .j. wound care (any skin opening requiring a dressing) .</p> <p>C1. A review of Resident 13's admission Record indicated Resident 13 was admitted to the facility on [DATE].</p> <p>On 5/28/25 at 1:49 P.M., a joint review of Resident 13's clinical record and an interview was conducted with the Infection Preventionist (IP). The IP stated there was no TB test given to Resident 13 when he was admitted to the facility on [DATE]. The IP stated TB test should have been given to screen newly admitted residents upon admission for safety and prevent spread of TB disease. The IP stated the residents were vulnerable to the disease and could have been easily spread.</p> <p>C2. A review of Resident 14's admission Record indicated Resident 14 was admitted to the facility on [DATE], with diagnoses which included immunodeficiency (decreased ability of the body to fight infections and other diseases).</p> <p>On 5/28/25 at 1:49 P.M., a joint review of Resident 14's clinical record and an interview was conducted with the IP. The IP stated there was no TB test given to Resident 14 when she was admitted to the facility on [DATE]. The IP stated Resident 14 received the TB test on 5/23/25. The IP stated TB test should have been given to screen newly admitted residents upon admission for safety and prevent spread of TB disease. The IP stated the residents were vulnerable to the disease and could have been easily spread.</p> <p>On 5/28/25 at 2:34 P.M., an interview was conducted with the DON. The DON stated the expectation was for the LNs to screen the newly admitted residents for TB. The DON stated the TB test should be done on the resident's day of admission due to TB was infectious and early detection could prevent spread of TB to residents and staff.</p> <p>A review of the facility's policy titled, Tuberculosis, Screening Residents for, revised 8/2019, indicated, This facility shall screen all residents for tuberculosis infection and disease (TB). Individuals identified with active TB disease shall be isolated from other residents and ancillary staff and transported to an appropriate care facility as soon as possible . 1. The admitting nurse will screen referrals for admission and readmission for information regarding exposure to or symptoms of TB .6. Screening of new admissions or readmissions for tuberculosis infection and disease is in compliance with State regulations .</p>		