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	12/11/2025

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 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow their policy on having a Physician order in place upon admission related to self-catheterization for one of three residents (Resident 1) reviewed for intermittent catheterization. (a technique where a thin tube is inserted into the bladder through the urethra to drain urine). This failure had the potential to cause harm to Resident 1's health. Findings.A review of the facility's admission Record indicated Resident 1 was admitted on [DATE] with diagnoses which included Flaccid Neuropathic Bladder (a condition where the bladder's nerves are damaged causing losing the ability to empty properly) and Fracture of the Thoracic Vertebra (vertebrae in the middle of the vertebral column). On 12/11/2025 at 11 A.M., an interview and record review with Licensed Nurse (LN) 1 was conducted. LN 1 stated according to Resident 1's daughter, Resident 1 had done intermittent catheterization at home. LN 1 stated there was no Physician order to have Resident 1 perform an intermittent catheterization of herself in Resident 1's medical record. LN 1 stated it was important to have a Physician order in place to provide proper care and treatment to Resident 1, as the Physician order acted as a guide and helped to prevent complications in Resident 1's plan of care and treatment. A record review of Resident 1's Minimum Data Set (MDS- a federally mandated assessment tool) dated 11/19/25 indicated Resident 1's brief interview for mental status (BIMS) score was 05 which indicated Resident 1 had impaired cognition (thought process). A record review of Resident 1's MDS section H -bladder and bowel dated 11/19/25 indicated H0100-d- intermittent catheterization On 12/11/25 at 11:55 A.M., an interview and record review with the Assistant Director of Nursing (ADON) was conducted. The ADON stated Resident 1 did not have a Physician order to intermittently do self-catheterization. The ADON stated it was always important to have a Physician order in all of the residents records in the facility including Resident 1 to guide nursing staff in the plan of care of the residents leading to better health outcomes and preventing complications. On 12/11/25 at 4 P.M., an interview with LN 2 was conducted. LN 2 stated Resident 1 did intermittent catheterization a couple of times per shift when LN 2 was assigned to Resident 1. LN 2 stated a Physician order was important to provide safety for Resident 1 and a guide for Resident 1's plan of care. A review of the facility's undated policy , titled Physicians Orders, indicated 2. A Physician's order in needed for all diets, therapies, and other treatments.

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

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	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aviara Healthcare Center	944 Regal Road Encinitas, CA 92024

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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 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 resident centered care plan for one of three residents (Resident 1) when Resident 1 did not have specific interventions such as an intermittent catheterization. (a technique where a thin tube is inserted into the bladder through the urethra to drain urine)This failure had the potential to cause serious complications and could harm Resident 1's health. Findings.A review of the facility's admission Record indicated Resident 1 was admitted on [DATE] with diagnoses which included Flaccid Neuropathic Bladder (a condition where the bladder's nerves are damaged causing losing the ability to empty properly) and Fracture of the Thoracic Vertebra (vertebrae in the middle of the vertebral column). On 12/11/2025 at 11 A.M., an interview and record review with Licensed Nurse (LN) 1 was conducted. LN 1 stated according to Resident 1's daughter, Resident 1 did intermittent catheterization at home on herself. LN 1 stated Resident 1's care plan was not specific and did not mention an intervention regarding intermittent catheterization. LN 1 stated it was important to have a resident centered care plan develop to help guide and act as communication to the nursing staff in Resident 1's treatment and plan of care . A record review of Resident 1's Minimum Data Set(MDS- a federally mandated assessment tool) dated 11/19/25 indicated resident 1's brief interview for mental status (BIMS) score was 05 which indicated Resident 1 had impaired cognition (thought process). On 12/11/25 at 11:55 A.M., an interview and record review with the Assistant Director of Nursing (ADON) was conducted. The ADON stated a care plan was important for all staff to know Resident 1's plan of care preventing confusion amongst staff. The ADON stated Resident 1 was transferred to the acute hospital on [DATE] due to altered mentation which included not being able to catheterize herself intermittently.On 12/11/2025 at 4 P.M., an interview with LN 2 was conducted. LN 2 stated a care plan acts as a basis of care and acts as a communication to nursing staff with regards to Resident 1's care. A review of the facility's policy dated March 2022 , titled Care Plans, Comprehensive Person-Centered, indicated 4. each resident's comprehensive person-centered care plan is consistent .with his or her plan of care 7. includes the services that are to be furnished to attain the resident's rights highest well-being.