STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055256	A. BUILDING _____ B. WING _____	**09/28/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LOMPOC VALLEY MEDICAL CTR COMP CARE CTR D/P SNF	**216 N THIRD STREET LOMPOC, CA 93436**

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 0676 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide the recommended adaptive equipment for one of two sampled residents (Resident 1). This facility failure resulted in Resident 1 using a regular one handled cup instead of a weighted two handled mug to drink coffee, contributing to mild bilateral [MEDICAL CONDITION] by spilled coffee. During a concurrent observation and interview with Resident 1 on 8/20/2020, at 1:20 p.m. in the dining room, observed Resident 1 with a hand tremor, drinking coffee in a regular one handled coffee cup. When asked about the incident of spilled coffee, Resident 1 stated I was sitting here and I reached for my cup of coffee. I bumped it and it spilled. It hurt when it landed on my legs. I've never spilled anything before, it was a fluke. During an interview on 8/20/2020, at 1:39 p.m. with the Activity Assistant (AA), the AA stated, I was serving coffee and Resident 1's tablemate waved to me to come and pointed indicating Resident 1 had spilled coffee on their lap and floor. I asked Resident if it burnt her legs, and Resident 1 replied, I think so, a little. I took her right to her nurse. During a concurrent interview and record review, on 8/20/2020, at 2:10 p.m., with Dietary Director (DD), Resident 1 had a notice sent to the kitchen from the occupational therapist (OT) dated 4/24/2020 that indicated change for adaptive equipment: two handled mug. REMARKS: Patient to use weighted two handle mug for all meals due to increased tremor/spilling of liquids. The DD confirmed that Resident 1 had a weighted two handled mug recommended by the OT, and it was not provided.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE