STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055566	A. BUILDING _____ B. WING _____	**05/18/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COASTAL VIEW HEALTHCARE CENTER	**4904 TELEGRAPH RD VENTURA, CA 93003**

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 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure: 1. Resident 1's skin assessments of the left lateral malleolus were accurate to reflect proper staging (description of depth). 2. An accurate assessment was completed for Resident 1's right heel. This deficient practice had the potential for Resident 1's care and services not be accurately identified that could affect the resident's health status and well being. Findings: During a review of Potter and Perry, 7th Edition, Mosby's Fundamentals of Nursing, page 243, in the section titled, Data Documentation indicated The timely, thorough, and accurate documentation of facts is necessary when recording client data. If you do not record an assessment finding or problem interpretation, it is lost and unavailable to anyone else caring for the client .the American Nurses Association Nursing's Social Policy Statement (2003) mandate, or require, accurate data collection and recording as independent functions essential to the role of the professional nurse. During a review of the National Pressure Injury Advisory Panel's (NPIAP) NPIAP Staging Poster, dated September 2016, accessed at https://cdn.ymaws.com/npiap.com/resource/resmgr/NPIAP-Staging-Poster.pdf, the Staging Poster indicated, a stage I pressure ulcer is Intact skin with a localized area of non-blanchable [DIAGNOSES REDACTED] (area of redness that does not become pale when pressure is applied), which may appear differently in darkly pigmented skin . A deep tissue pressure injury (DTI) is intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or [MEDICATION NAME] separation revealing a dark wound bed or blood filled blister .The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. 1. During a concurrent interview and record review on 1/23/20, at 5:30 p.m., with the director of nursing (DON), a record review the Wound/Skin Healing Record for Resident 1, dated 12/20/19, 12/27/19, and 1/1/20 and Physician's (MD) orders dated 12/20/19 and 12/23/19 were reviewed. The Wound/Skin Healing Record indicated, Resident 1 had a 2.5 cm by 2.9 cm stage I pressure ulcer on the left lateral malleolus. On 12/27/19, the Wound/Skin Healing Record indicated a deep tissue injury (DTI) of two cm by two cm. On 1/1/20, the Wound/Skin Healing Record indicated a DTI of one point five (1.5) cm by 1.5 cm. The DON was unable to find MD orders for the wound care on admission. The DON indicated unsure why there was no order written until 12/23/19. The DON further stated if the wound then staged as DTI MD should be notified and treatment modified. The DON was unable to find any changes to MD treatment orders. During a concurrent interview and record review on 3/17/20, at 11:45 am, with a licensed nurse (LN1), a record review of the Wound/Skin Healing Record for Resident 1, dated 12/20/19, 12/27/19, and 1/1/20 was reviewed. LN1 stated there was a mistake in the documentation by documenting the wound it as DTI. The wound continued to be a Stage 1 pressure ulcer and was pink with some redness around area. LN1 agreed a late entry in Resident 1's medical record should have been completed to correct the documentation. 2. During a record review the Nurses' Admission Record for Resident 1, dated 12/20/19, the Nurses' Admission Record indicated, on admission, Resident 1 was noted to have a three (3) cm by three cm stage I pressure ulcer on the right heel. During a concurrent interview and record review on 1/23/20, at 5:30 p.m., with the director of nursing (DON), a record review the Wound/Skin Healing Record for Resident 1, dated 12/20/19, 12/27/19, and 1/1/20 and Physician's (MD) orders dated 12/20/19 and 12/23/19 were reviewed. There was no documentation on the Wound/Skin Healing Record indicating Resident 1 had a stage 1 pressure ulcer on the right heel. Further the Daily Skilled Nurse's Notes dated 12/23/19 through 1/3/20, documented a stage 1 left heel pressure ulcer, but failed to document anything about the right heel pressure ulcer. The DON confirmed no documentation regarding right heel pressure ulcer and stated Staff should be completely and accurately filling out areas on daily skilled notes .including skin assessments .
F 0686 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide care in accordance with professional standards of practice for one of four sampled residents (Resident 1), when an area of broken skin on Resident 1's sacral coccyx (tailbone area) was not accurately assessed following a fall. This facility failure had the potential for Resident 1 not to receive appropriate interventions and care services. Findings: During a review of Potter and Perry, 7th Edition, Mosby's Fundamentals of Nursing, page 1282, in the section titled, Classification of Pressure Ulcers indicated in part, Stage II: Partial-thickness skin loss involving epidermis (outermost layer of skin), dermis (second and thickest layer of the three major layers of skin), or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater. During a review of the National Pressure Injury Advisory Panel's (NPIAP) NPIAP Staging Poster, dated September 2016, accessed at https://cdn.ymaws.com/npiap.com/resource/resmgr/NPIAP-Staging-Poster.pdf, the Staging Poster indicated, a Stage III pressure injury involves full-thickness loss of skin. During a review of undated Resident Face Sheet for Resident 1, the Resident Face Sheet indicated, Resident 1 admitted on [DATE] with admission [DIAGNOSES REDACTED]. Resident 1 transferred to the general acute care hospital (GACH) on [DATE]. During a review of the GACH Nursing Admission for Resident 1, dated 1/5/20, the nursing admission indicated Resident 1 had a Stage III pressure ulcer to the coccyx (tailbone area). During a review of the 72-hour Fall Monitoring form, dated 1/1/20, the 72-hour monitoring form indicated Resident 1 had an unwitnessed fall at 11 p.m. The documented injuries included minimal blee to scab on R (right) elbow and abrasion to sacral coccyx. During a concurrent interview and record review on 1/23/20, at 5:30 p.m., with the director of nursing (DON), stated I don't know about pressure ulcer on (Resident 1). The treatment nurse has gone home for the day so no one here to ask. A review of the Daily Skilled Nurse's Notes for Resident 1, dated 1/2/20, the daily skilled nurse's notes indicated abrasion to sacral coccyx. A review of the Weekly Summary for Resident 1, dated 1/2/20, failed to document complete skin assessment. The DON was unable to find documentation of a skin assessment of the abrasion and agreed there should have been. The DON further indicated staff should be completely completely and accurately filling out areas .on weekly summary reports including skin assessments and confirmed there were incomplete entries. During a concurrent interview and record review on 3/17/20, at 11:45 am, with a licensed nurse (LN1), LN1 indicated that Resident 1 was only at facility for a short time. LN1 was unable to find documentation of a skin assessment by nursing for the abrasion on the coccyx and agreed there should have been a skin care assessment completed. During a review of the facility's policy and procedure titled Pressure Injury aka Pressure Sore Management, dated 10/2017, indicated, Assess the pressure injury(s) pressure sore(s) for location, size (measure length, width and depth .Determine the injury or sores current stage of development. a root cause analysis should be done for each pressure sore .The facility's pressure injury aka pressure sore risk assessment tool is to be completed to assess a resident's pressure injury aka pressure sore risk .whenever there is a significant change in the resident's condition or functional ability. In addition, licensed nurses shall assess skin weekly as part of their weekly summaries.
F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.**

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

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.

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F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure one of four residents' (Resident 1) Medical record had complete and accurate documentation. Based on interview and record review, the facility failed to ensure clinical documentation was complete and accurate when: 1. Daily skilled nurse's notes were missing or not complete. 2. Nursing weekly summary for 1/2/20 was not complete for skin assessment and elimination (removal of urine or stool from the body). These facility failures had the potential for the inability of the interdisciplinary team and clinicians to obtain a picture of the residents' progress, including their response to treatments and services, changes in their condition, plan of care goals, objectives and interventions. Findings: During a review of Potter and Perry, 7th Edition, Mosby's Fundamentals of Nursing, page 243, in the section titled, Data Documentation indicated The timely, thorough, and accurate documentation of facts is necessary when recording client data. If you do not record an assessment finding or problem interpretation, it is lost and unavailable to anyone else caring for the client .the American Nurses Association Nursing's Social Policy Statement (2003) mandate, or require, accurate data collection and recording as independent functions essential to the role of the professional nurse. During a review of undated Resident Face Sheet for Resident 1, the Resident Face Sheet indicated, Resident 1 admitted on [DATE] with admission [DIAGNOSES REDACTED]. Resident 1 transferred to the general acute care hospital (GACH) on [DATE]. During a review of the GACH History and Physical (H&P) for Resident 1, dated 1/5/20, the H&P indicated Resident 1 was admitted with [MEDICAL CONDITION] with a likely source of urinary tract infection. 1. During a concurrent interview and record review on 1/23/20, at 5:30 p.m., with the director of nursing (DON), review of the Daily Skilled Nurse's Notes for Resident 1, dated 12/23/19 through 1/5/20 were reviewed. The Daily Skilled Nurse's Notes were missing the description and color of the urine on 12/23/19, 12/2[DATE]9, 12/25/19, 12/26/19, and 1/4/20. There were no Daily Skilled Nurse's Notes of [DATE], 12/31/19, and 1/1/20. The DON confirmed missing daily skilled nurse's notes and blank or incomplete entries.The DON further indicated staff should be completely completely and accurately filling out areas on daily skilled notes including .urinary sections. 2. During a record review of Treatments Flowsheets (TAR) for Resident 1 dated 12/20/19 through 1/5/20, the TAR indicated Resident 1 daily wound care ordered for the left knee, right heel, left lateral malleolus (outer side of ankle), left inner malleolus (inner side of ankle), and sacral coccyx (the area of the tailbone). The TAR further indicated Resident 1 had a foley catheter (sterile tube that is inserted into the bladder to drain urine) in place. During a concurrent interview and record review on 1/23/20, at 5:30 p.m., with the director of nursing (DON), review of the Weekly Summary for Resident 1, dated 1/2/20 was reviewed. The weekly summary was missing a complete skin assessment including the areas of right heel, left lateral malleolus, left inner malleolus, and sacral coccyx. The weekly summary was also missing any assessment of the elimination section including information about the foley catheter or color and odor of urine. The DON confirmed the weekly summary was incomplete. The DON stated staff should be completely and accurately filling out areas .weekly summary reports including skin assessments and urinary sections.