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 _____	**04/14/2020**

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 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure care was provided in accordance with professional standard for one of three sampled residents (Resident 1), when: 1. An antibiotic medication, ordered by the physician to treat an active infection, was not administered. 2. A high sodium lab value was not communicated to the physician. 3. Hydration status was not assessed as outlined in the plan of care. 4. A multivitamin was not administered in accordance with the physician's orders [REDACTED]. These failures had the potential to result in worsening of the Resident 1's conditions and a requirement for more treatment. Findings: During a review of the clinical record for Resident 1, the admission record indicated [DIAGNOSES REDACTED]. The discharge notes indicated Resident 1 was transferred to the general acute care hospital (GACH) on 3/2/20. A review of the GACH admission record dated 3/2/20 indicated the admitting [DIAGNOSES REDACTED]. 1. During a concurrent interview and record review on [DATE], at 3:41 PM with Licensed Nurse 1 (LN 1) the following physician orders [REDACTED]. LN 1 confirmed according to the February and March 2020 MAR ,[MED] was not documented as having been given. LN1 further confirmed, the risk of missing an antibiotic is worsening the problem. During an interview on 3/19/20, at 6:25 PM, the Medical Records Assistant (MRA) acknowledged according to Resident 1's February and March 2020 MAR, Resident 1 did not received the [MED]. During an interview on 4/7/20, at 2:48 PM, LN 2 acknowledged working the 3PM-11PM shift on 3/1/20 and remembers giving eye drops to Resident 1 but cannot be sure if [MED] was given. LN 2 stated there is a possibility it was not given. During an interview on 4/6/20, at 12:35 PM, the Director of Nursing (DON) acknowledged there is no documentation in the resident's clinical record that indicates a date and time [MED] was given. A review of the facility's care plan for Resident 1, titled, On (Antibiotic) Therapy, [MEDICATION NAME] for upper respiratory infection and cough, dated 2/29/20, indicated the plan for the resident's infection was to give mediations as ordered. A review of the facility's policy, titled, Medication Administration, revised 05/2019, indicated: Policy: It is the policy of the facility that medications for residents be administrated in a safe and timely manner, and as prescribed. A review of the faciity's policy, titled, Preparation and General Guildelines, effective October 2017, indicated:1) The individual who administers the medication dose records the admninistration on the resident's MAR indicated [REDACTED]. In no case should the individual who administered the medication report off-duty without first recording the administration of any medications. 2. During a concurrent interview and record review with LN 1 on [DATE], at 4:55 PM , Resident 1's labwork, collected and received on 2/25/20, indicated a high sodium level of 155 (normal range 136-148). LN 1 indicated it is a nursing responsibility to look at residents' lab results and ensure a physician responds to them, either with new orders, or by specifying there are no new order and it is important to follow up within the same day results are received for any high valued results. LN 1 confirmed there is no documentation in the clinical record confirming the physician was made aware of Resident 1's high sodium level. LN 1 further confirmed the lab results should have been followed up on and documentation should have been done. LN 1 stated, Electrolytes are really very important. During an interview on 4/6/20, at 12:35 PM, the DON indicated it is a nursing responsibility to follow up with the doctor after a high lab result is received, and according to Resident 1's clinical record, nursing staff did not follow up on the sodium level of 155 and should have. A review of the facility's care plan for Resident 1, titled, (Resident 1) is at risk for alteration in nutrition, dated 2/21/20, indicated, Labs as ordered and notify MD promptly of results. 3. A review of the Nutritional Risk Assessment for Resident 1, dated 2/17/20, indicated the resident was at high risk for malnutrition and dehydration. A review of the facility's care plan for Resident 1, titled, Dehydration, dated 2/17/20, indicated, Assess hydration status. The care plan also indicated to observe for signs and symptoms of dehydration, including decreased output. During a concurrent interview and record review on [DATE], at 3:41 PM, LN 1 agreed that, according to Resident 1's Intake and Output Record for 2/17/20 - 3/1/20, neither intake nor output was assessed on 21 out of 43 shifts. LN 1 acknowledged that there is no way to tell if Resident 1 had adequate fluid intake. 4. A review of Resident 1's Nutritional Assessment, done by the Registered Dietician (RD), dated 2/20/20, indicated the RD's plan was to add a multivitamin daily. A review of the facility's care plan for Resident 1, titled, Nutritional Status, indicated Resident 1 was at risk for alteration in nutritional status related to poor appetite, on mechanically altered diet, and at risk for weight loss, dehydration, skin alteration, and elimination problems. The care plan indicated, Supplements as ordered. During a concurrent interview and record review, the MRA acknowledged an active physician's orders [REDACTED]. The MRA agreed that, according to the Medication Flowsheet, the resident did not receive the multivitamin from 2/20/20-2/25/20. A review of the facility's undated baseline care plan for Resident 1, titled, Impaired Skin Integrity Manifested By: 2 stage II pressure ulcers, 2 deep tissue injuries, and bruising, indicated, Administer supplemental meds as ordered. A review of the facility's policy, titled, Medication Administration, revised 05/2019, indicated: Policy: It is the policy of the facility that medications for residents be administrated in a safe and timely manner, and as prescribed.

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.