STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055237	A. BUILDING _____ B. WING _____	**09/21/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VICTORIA HEALTHCARE AND REHABILITATION CENTER	**340 VICTORIA STREET COSTA MESA, CA 92627**

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 0552 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that residents are fully informed and understand their health status, care and treatments.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and medical record review, the facility failed to notify the resident's representative of the medication changes, treatment changes, and multiple resident room changes for one of two sampled residents (Resident 1). This failure had the potential to prevent Resident 1's representative from participating in treatment decisions. Findings Closed medical record review for Resident 1 was initiated on 8/6/20. Resident 1 was admitted to the facility on [DATE], and discharged on [DATE]. On 9/15/20 at 1125 hours, an interview was conducted with Family Member A. Family Member A stated shortly after Resident 1 was admitted to the facility, he became confused and had episodes of hallucinating. Family Member A stated when she spoke to Resident 1 he was confused, believing he was in another state. Family Member A stated she felt Resident 1's medications may have caused Resident 1's confusion and hallucinations. Family Member A informed the facility staff Resident 1 was confused and not in a position to make decisions regarding his care and treatment. Family Member A stated she informed facility staff to coordinate Resident 1's care with Family Member B (resident's spouse) who was Resident 1's representative and should not rely on Resident 1 to make medical decisions due to the change in his mental status. Family Member A stated she informed facility staff that if the facility was unable to reach Family Member B, then the facility was to contact her. Family Member A stated facility staff failed to notify and consult with either Family Members A or B for changes to Resident 1's medications and treatments. Family Member A stated the facility also failed notify the family of multiple resident room changes for Resident 1. Family Member A stated after the facility consistently failed to notify and consult Resident 1's family for the medication, treatment and room changes, the family then decided to take Resident 1 home. Family Member A stated she notified the facility's Long-Term Care Ombudsman of the facility's failure to notify Resident 1's representative of the medication changes, treatment changes, and resident room changes. Family Member A stated after the Long-Term Care Ombudsman contacted the facility, the DON contacted Family Member A. Family Member A stated she told the DON the facility failed to notify Resident 1's family of the changes to Resident 1's treatments, and the facility needed to do so. Family Member A stated the DON informed her due to the COVID-19 pandemic, the facility was extremely busy, and it was difficult for the facility to keep on top of things. On 9/15/20 at 1139 hours, an interview was conducted with the Ombudsman. The Ombudsman stated Family Member A contacted her regarding concerns she had at Resident 1's facility. The Ombudsman stated Family Member A informed her the facility failed to contact Resident 1's representative for the changes regarding Resident 1's care decisions, which included the changes to Resident 1's antibiotic regimen. The Ombudsman stated she then contacted the facility's DON and discussed the need for the facility to communicate Resident 1's care decisions with Resident 1's representative. a. On 8/6/20 at 1542 hours, an interview and concurrent closed medical record review for Resident 1 was conducted with LVN 1. LVN 1 stated Family Member B was Resident 1's representative and the facility needed to notify Family Member B of changes in Resident 1's condition, treatment and medication regimen, and room changes. Review of the physician's orders [REDACTED]. Review of Resident 1's medical record showed no documentation Family Member B was notified. Review of the physician's orders [REDACTED]. Review of Resident 1's medical record showed no documentation Family Member B was notified. Review of the physician's orders [REDACTED].* Cleanse Resident 1's left anterior lower leg wound with normal saline, pat dry, and apply vitamins A & D for 21 days. * Cleanse Resident 1's 2nd toe open wound with normal saline, pat dry, and apply [MEDICATION NAME] cream 1/%, then cover with dry dressing daily for 21 days. There was no documentation to show Family Members A or B were notified of the treatment orders. Review of the physician's progress notes dated 6/19/20 at 0807 hours, showed Resident 1 reported having hallucinations and felt the hallucinations were due to an antibiotic he was prescribed. Review of Resident 1's progress notes dated 6/20/20 at 1429 hours, showed an order to discontinue ertapenem (antibiotic medication) and start [MEDICATION NAME] (antibiotic medication). There was no documentation to show Family Members A or B were notified of the medication changes. b. Resident 1 had a room change on 6/12, 6/14, and again on 6/18/20. There was no documentation to show Family Members A or B were notified of the room changes. On 8/6/20 at 1542 hours, an interview and concurrent closed medical record review for Resident 1 was conducted with LVN 1. LVN 1 stated Family Member B was Resident 1's representative and the facility needed to notify Family Member B of changes in Resident 1's condition, treatment and medication regimen, and room changes. LVN 1 verified the above findings and stated the resident's family should have been notified of changes to Resident 1's treatment and medication regimen, and Resident 1's room changes. On 8/6/20 at 1628 hours, and interview and concurrent closed medical record review for Resident 1 was conducted with the DON. The DON verified the above findings and stated Family Member B should have been notified of all of the changes in room, medication, and treatment.

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