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 _____	**06/02/2020**

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 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide appropriate isolation precautions for one resident (Resident 2) by co- horting the resident with Resident 1 who has [MEDICAL CONDITION] ([MEDICAL CONDITION] -a bacterium that can cause symptoms ranging from diarrhea to life-threatening inflammation of the colon). This facility failure had the potential for Resident 2 to develop [MEDICAL CONDITION] . Findings: During an observation on 4/10/20 at 2:30 p.m., the facility had no residents on isolation. Review of the complaint received by the Department on 4/10/20 indicated , Resident 2 was co-horted with Resident 1 who had C.Diff. During a review of Resident 1's medical record the hospital laboratory report dated 3/21/20, indicated Resident 1 was positive for [MEDICAL CONDITION]. The attending physician (AP) documented at the bottom of the report, Contact Isolation, [MEDICATION NAME] 500 mg.every 6 hours for 10 days, (anti infective) and [MEDICATION NAME] (anti fungal) 500mg every 8 hours for 10 days. During a review of the document titled, Physician Order Report, dated 4/1/20 - 4/30/20 indicated orders for [MEDICATION NAME] and [MEDICATION NAME] as indicated on the laboratory report. During a review of the document titled, Care Plan, dated 3/21/20 indicated [MEDICAL CONDITION] as a problem. Review of the facility policy and procedure titled, Infection Control, [MEDICAL CONDITION], dated 10/2019, indicated, Residents with active diarrhea diagnosed as having CDI should be placed in Contact Isolation .Patients can be grouped (cohorted) with other residents with [MEDICAL CONDITION]. During an interview on 4/10/20 at 2:45 p.m. with the Infection Preventionist (IP), the IP stated, Resident 1 was diagnosed with [REDACTED]. Resident 1 remained in the same room with Resident 2 who did not have [MEDICAL CONDITION]. According to Fundamentals of Nursing, 7th Edition by Potter-Perry, page 663, a patient with [MEDICAL CONDITION] requires contact isolation, and should be in a private room, or cohorted with other patients with [MEDICAL CONDITION].

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.