

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055566	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/28/2025
NAME OF PROVIDER OR SUPPLIER Coastal View Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39814</p> <p>Based on interview, record review and policy and procedure, facility failed to assure that each resident receives an accurate assessment, reflective of the resident's status at the time of the assessment when 10 of 10 sampled residents (Residents 1, 2, 3, 10, 11, 12, 13, 14, 15, 16, and 17), did not have vital signs monitored as prescribed by the physician for COVID-19 prevention.</p> <p>This failure had the potential to result in delayed assessment to detect COVID-19 symptoms, increased risk of exposure and spread within the facility, compromised care for residents, and heightened the vulnerability of residents to severe health outcomes.</p> <p>Findings:</p> <p>According to Fundamentals of Nursing ([NAME] et al; Elsevier: 2023 p. 318), Unit 4 Professional Standards in Nursing Practice .A code of ethics is a set of guiding principles that all members of a profession accept . The word responsibility refers to a willingness to respect one's professional obligations and to follow through. As a nurse you are responsible for your actions, the care you provide, and the tasks that you delegate to others .Accountability refers to answering for your own actions. You ensure that your professional actions are explainable to your patients and your employer.</p> <p>During a review of the facility's P&P titled, Vital Signs, Weights, Height, dated 1/14, the P&P indicated, Vital signs shall be taken and recorded in accordance with the resident's condition, current treatment plan, and as prescribed by the attending physician.</p> <p>During a review of Resident 1's Order Summary Report (Orders), the Orders indicated, Order Date .12/4/24 . Monitor Vital Signs every shift for COVID-19 Precaution.</p> <p>During a review of Resident 1's Medication Administration Record (MAR), dated January 2025, the MAR indicated that Resident 1 had duplicate vital sign entries recorded on the following occasions:</p> <p>1/10/25: Evening shift (3 p.m. to 11 p.m.) and the night shift (11 p.m. to 7 a.m.) on the same date: Blood Pressure (BP) 127/61, Temperature (T) 97.3 F, Pulse (P) 74, Respirations (R) 17, (S) 97%.</p> <p>1/11/25: Evening shift and 1/12/25 evening shift: BP 137/61, T 97.3 F, P 74, R 18, S 97%.</p> <p>1/15/25: Evening shift and night shift on the same date: BP 122/68, T 97.8 F, P 78, R 18, S 97%.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055566	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/28/2025
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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 2's Orders, the Orders indicated, Order Date .12/13/24 . Monitor Vital Signs every shift for COVID-19 precaution.</p> <p>During a review of Resident 2's MAR, dated January 2025, the MAR indicated that Resident 2 had duplicate vital sign entries recorded on the following occasions:</p> <p>1/1/25: Evening shift (3 p.m. to 11 p.m.) and day shift (7 a.m. to 3 p.m.) recorded BP 126/72, T 97.2 F, P 74, R 17, S 97%.</p> <p>1/3/25: Night shift (11 p.m. to 7 a.m.) and evening shift recorded BP 128/66, T 97.5 F, P 72, R 17, S 97%.</p> <p>1/4/25: Evening shift and day shift recorded BP 136/74, T 97.7 F, P 79, R 18, S 97%.</p> <p>1/6/25: Evening shift and day shift recorded BP 140/70, T 97.4 F, P 84, R 17, S 97%.</p> <p>1/10/25: Night shift and evening shift recorded BP 126/70, T 97.5 F, P 76, R 17, S 98%.</p> <p>1/12/25: Night shift and evening shift recorded BP 126/68, T 97.5 F, P 64, R 16, S 96%.</p> <p>1/13/25: Night shift and evening shift recorded BP 128/71, T 97.2 F, P 76, R 17, S 98%.</p> <p>1/14/25: Night shift and evening shift recorded BP 131/72, T 97 F, P 78, R 17, S 98%.</p> <p>1/15/25: Night shift and day shift recorded BP 124/74, T 97.3 F, P 83, R 17, S 97%.</p> <p>1/17/25: Evening shift and day shift recorded BP 124/74, T 97.6 F, P 78, R 17, S 97%.</p> <p>1/19/25: Night shift and evening shift recorded BP 124/76, T 97.5 F, P 64, R 16, S 97%.</p> <p>1/20/25: Night shift and evening shift recorded BP 128/76, T 97.2 F, P 76, R 18, S 98%.</p> <p>1/22/25: Night shift and evening shift recorded BP 130/74, T 97.6 F, P 82, R 17, S 97%.</p> <p>1/25/25: Night shift and evening shift recorded BP 131/75, T 97.2 F, P 76, R 17, S 97%.</p> <p>1/27/25: Night shift and evening shift recorded BP 127/73, T 97 F, P 79, R 18, S 97%.</p> <p>During a review of Resident 3's Orders, the Orders indicated, Order Date .1/24/25 . Monitor Vital Signs every 4 hours for COVID-19 Precaution for 14 days.</p> <p>During a review of Resident 3's MAR, dated January 2025, the MAR indicated that Resident 3 had duplicate vital sign entries recorded on the following occasions:</p> <p>1/24/25: 8 p.m. and 4 p.m. recorded BP 112/82, T 97.3 F, P 63, R 17, S 99%.</p> <p>1/25/25:</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>12 a.m. and 8 p.m. on 1/24/25 recorded BP 112/82, T 97.3 F, P 63, R 17, S 99%.</p> <p>12 p.m. and 8 a.m. recorded BP 139/78, T 97.6 F, P 68, R 17, S 98%.</p> <p>1/26/25: 4 a.m. and 12 a.m. recorded BP 126/72, T 97.2 F, P 84, R 17, S 97%.</p> <p>1/27/25:</p> <p>12 a.m. and 8 p.m. on 1/26/25 recorded BP 128/76, T 97.6 F, P 74, R 18, S 96%.</p> <p>4 a.m. and 12 a.m. recorded BP 128/76, T 97.6 F, P 74, R 18, S 96%.</p> <p>8 p.m. and 4 p.m. recorded BP 149/61, T 97.3 F, P 79, R 17, S 95%.</p> <p>1/28/25:</p> <p>12 a.m. and 8 p.m. on 1/27/25 recorded BP 149/61, T 97.3 F, P 79, R 17, S 95%.</p> <p>4 a.m. and 12 a.m. recorded BP 149/61, T 97.3 F, P 79, R 17, S 95%.</p> <p>During a review of Resident 10's Orders, the Orders indicated, Order Date .1/12/25 . Order Summary: Monitor Vital Signs every 4 hours for COVID-19 Precaution for 14 days THEN every shift for COVID-19 Precaution.</p> <p>During a review of Resident 10's MAR, dated January 2025, the MAR indicated that Resident 10 had duplicate vital sign entries recorded on the following occasions:</p> <p>1/13/25: 8 p.m. and 4 p.m. recorded BP 129/64, T 97.3 F, P 79, R 17, S 95%.</p> <p>1/14/25: 8 p.m. and 4 p.m. recorded BP 136/64, T 97.3 F, P 71, R 17, S 95%.</p> <p>1/15/25: 12 p.m. and 8 a.m. recorded BP 114/65, T 97.1 F, P 72, R 18, S 96%.</p> <p>1/16/25:</p> <p>12 a.m. and 8 p.m. recorded BP 132/77, T 97.5 F, P 78, R 17, S 97%.</p> <p>4 a.m. and 12 a.m. recorded BP 132/77, T 97.5 F, P 78, R 17, S 97%.</p> <p>12 p.m. and 8 a.m. recorded BP 136/69, T 97.8 F, P 71, R 18, S 97%.</p> <p>8 p.m. and 4 p.m. recorded BP 128/70, T 97.5 F, P 70, R 17, S 97%.</p> <p>1/17/25:</p> <p>12 p.m. and 8 a.m. recorded BP 110/66, T 97.8 F, P 68, R 17, S 96%.</p> <p>8 p.m. and 4 p.m. recorded BP 116/61, T 97.3 F, P 79, R 18, S 95%.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1/18/25: 12 p.m. and 8 a.m. recorded BP 111/66, T 97.4 F, P 68, R 17, S 97%. 8 p.m. and 4 p.m. recorded BP 120/69, T 97.3 F, P 74, R 18, S 95%.</p> <p>1/19/25: 12 p.m. and 8 a.m. recorded BP 119/62, T 97.8 F, P 72, R 17, S 96%. 8 p.m. and 4 p.m. recorded BP 129/59, T 97.3 F, P 87, R 18, S 97%.</p> <p>1/21/25: 12 a.m. and 8 p.m. on 1/20/25 recorded BP 112/56, T 97.6 F, P 73, R 17, S 96%. 4 a.m. and 12 a.m. recorded BP 112/56, T 97.6 F, P 73, R 17, S 96%. 8 p.m. and 4 p.m. recorded BP 109/64, T 97.3 F, P 89, R 18, S 96%.</p> <p>1/22/25: 12 a.m. and 8 p.m. on 1/21/25 recorded BP 109/64, T 97.3 F, P 89, R 18, S 96%. 4 a.m. and 12 a.m. recorded BP 109/64, T 97.3 F, P 89, R 18, S 96%. 12 p.m. and 8 a.m. recorded BP 115/65, T 97.6 F, P 70, R 17, S 97%. 8 p.m. and 4 p.m. recorded BP 118/72, T 97 F, P 69, R 17, S 97%.</p> <p>1/23/25: 12 a.m. and 8 p.m. on 1/22/25 recorded BP 118/72, T 97 F, P 69, R 17, S 97%. 4 a.m. and 12 a.m. recorded BP 118/72, T 97 F, P 69, R 17, S 97%. 12 p.m. and 8 a.m. recorded BP 114/62, T 97.5 F, P 72, R 18, S 96%. 8 p.m. and 4 p.m. recorded BP 106/61, T 97.3 F, P 89, R 17, S 95%.</p> <p>1/24/25: 12 a.m. and 8 p.m. on 1/23/25 recorded BP 106/61, T 97.3 F, P 89, R 17, S 95%. 4 a.m. and 12 a.m. recorded BP 106/61, T 97.3 F, P 89, R 17, S 95%. 12 p.m. and 8 a.m. recorded BP 117/63, T 97.5 F, P 72, R 18, S 96%.</p> <p>(continued on next page)</p>

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>8 p.m. and 4 p.m. recorded BP 122/64, T 97.3 F, P 78, R 17, S 95%.</p> <p>1/25/25: 12 p.m. and 8 a.m. recorded BP 118/65, T 97.6 F, P 70, R 17, S 96%.</p> <p>1/26/25:</p> <p>4 a.m. and 12 a.m. recorded BP 101/63, T 97.4 F, P 76, R 18, S 98%.</p> <p>Night shift and 4 p.m. recorded BP 106/60, T 97.3 F, P 68, R 16, S 95%.</p> <p>1/27/25: Night shift and evening shift recorded BP 106/61, T 97.3 F, P 79, R 17, S 95%.</p> <p>During a review of Resident 11's Orders, the Orders indicated, Order Date .1/22/25 . Order Summary: Monitor Vital Signs every 4 hours for COVID-19 Precaution for 14 days THEN every shift for COVID-19 Precaution.</p> <p>During a review of Resident 11's MAR, dated January 2025 and February 2025, the MAR indicated that Resident 11 had duplicate vital sign entries recorded on the following occasions:</p> <p>1/23/25:</p> <p>4 p.m. and 12 p.m. recorded BP 136/74, T 97.4 F, P 76, R 18, S 98%.</p> <p>8 p.m. and 4 p.m. recorded BP 136/74, T 97.4 F, P 76, R 18, S 98%.</p> <p>1/24/25:</p> <p>4 a.m. and 12 a.m. recorded BP 154/94, T 97.2 F, P 74, R 16, S 98%.</p> <p>12 p.m. and 8 a.m. recorded BP 146/70, T 97.9 F, P 70, R 20, S 96%.</p> <p>o 8 p.m. and 4 p.m. recorded BP 131/66, T 97.8 F, P 64, R 16, S 100%.</p> <p>1/25/25: 4 a.m. and 12 a.m. recorded BP 124/76, T 97.8 F, P 74, R 18, S 98%.</p> <p>1/26/25: 12 p.m. and 8 p.m. recorded BP 128/70, T 97.8 F, P 70, R 18, S 97%</p> <p>1/27/25:</p> <p>4 a.m. and 12 a.m. recorded BP 121/62, T 98.4 F, P 71, R 18, S 98%.</p> <p>8 p.m. and 4 p.m. recorded BP 146/70, T 97.5 F, P 70, R 17, S 98%.</p> <p>1/28/25: 8 p.m. and 4 p.m. recorded BP 139/66, T 98.1 F, P 77, R 18, S 97%.</p> <p>1/29/25:</p> <p>(continued on next page)</p>

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>12 a.m. and 1/28/25 at 8 p.m. recorded BP 139/66, T 98.1 F, P 77, R 18, S 97%.</p> <p>4 a.m. and 12 a.m. recorded BP 139/66, T 98.1 F, P 77, R 18, S 97%.</p> <p>8 p.m. and 4 p.m. recorded BP 164/79, T 97.7 F, P 88, R 18, S 98%.</p> <p>1/30/25: 12 p.m. and 8 a.m. recorded BP 138/78, T 97.9 F, P 88, R 18, S 97%.</p> <p>1/31/25: 12 p.m. and 8 a.m. recorded BP 118/72, T 97.9 F, P 80, R 18, S 98%.</p> <p>2/1/25:</p> <ul style="list-style-type: none"> o 4 a.m. and 12 a.m. recorded BP 140/78, T 97.9 F, P 88, R 20, S 97%. <p>12 p.m. and 8 a.m. recorded BP 138/75, T 98.1 F, P 75, R 19, S 98%.</p> <p>8 p.m. and 4 p.m. recorded BP 141/78, T 97.8 F, P 87, R 20, S 98%.</p> <p>2/2/25: 4 a.m. and 12 a.m. recorded BP 138/76, T 97.5 F, P 78, R 18, S 97%.</p> <p>2/3/25: 12 p.m. and 8 a.m. recorded BP 135/73, T 97.4 F, P 78, R 19, S 97%.</p> <p>During a review of Resident 12's Orders, the Orders indicated, Order Date .2/3/25 .Order Summary: Monitor Vital Signs every 4 hours for COVID-19 Precaution for 14 days THEN every shift for COVID-19 Precaution.</p> <p>During a review of Resident 12's MAR, dated February 2025, the MAR indicated that Resident 12 had duplicate vital sign entries recorded on the following occasions:</p> <p>2/4/25: 4 a.m. and 12 a.m. recorded BP 131/74, T 98.4 F, P 76, R 16, S 97%.</p> <p>2/5/25:</p> <p>4 a.m. and 12 a.m. recorded BP 128/70, T 97.6 F, P 70, R 18, S 97%.</p> <p>8 p.m. and 4 p.m. recorded BP 94/64, T 97.8 F, P 78, R 18, S 96%.</p> <p>2/6/25: 12 p.m. and 8 a.m. recorded BP 117/67, T 97.7 F, P 74, R 16, S 95%.</p> <p>2/8/25: 8 p.m. and 4 p.m. recorded BP 100/62, T 97.8 F, P 90, R 18, S 96%.</p> <p>2/10/25:</p> <p>4 a.m. and 12 a.m. recorded BP 120/82, T 97.6 F, P 88, R 20, S 97%.</p> <p>8 p.m. and 4 p.m. recorded BP 112/70, T 97.5 F, P 97, R 17, S 97%.</p> <p>2/11/25: 8 p.m. and 4 p.m. recorded BP 94/57, T 97.4 F, P 88, R 20, S 95%.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2/13/25: 12 p.m. and 8 a.m. recorded BP 107/80, T 97.9 F, P 90, R 18, S 96%.</p> <p>2/14/25: 8 p.m. and 4 p.m. recorded BP 122/71, T 97.5 F, P 81, R 18, S 96%.</p> <p>During a review of Resident 13's Orders, the Orders indicated, Order Date .2/3/25 .Order Summary: Monitor Vital Signs every 4 hours for COVID-19 Precaution for 14 days THEN every shift for COVID-19 Precaution.</p> <p>During a review of Resident 13's MAR, dated February 2025, the MAR indicated that Resident 13 had duplicate vital sign entries recorded on the following occasions:</p> <p>2/4/25:</p> <p>o 12 p.m. and 8 a.m. BP 127/85, T 97.3 F, P 79, R 18, S 97%.</p> <p>o 8 p.m. and 4 p.m. BP 132/65, T 97.3 F, P 84, R 19, S 97%.</p> <p>2/8/25: 4 a.m. and 12 a.m. BP 130/74, T 97.6 F, P 85, R 18, S 97%.</p> <p>2/9/25: 4 a.m. and 12 a.m. BP 124/67, T 97.6 F, P 88, R 20, S 98%.</p> <p>2/10/25: 4 a.m. and 12 a.m. BP 137/78, T 97.3 F, P 76, R 20, S 98%.</p> <p>2/14/25: 8 p.m. and 4 p.m. BP 126/75, T 97.5 F, P 80, R 18, S 97%.</p> <p>2/15/25:</p> <p>12 a.m. and 2/14/25 at 8 p.m. BP 126/75, T 97.5 F, P 80, R 18, S 97%.</p> <p>4 a.m. and 2/14/25 at 12 a.m. BP 126/75, T 97.5 F, P 80, R 18, S 97%.</p> <p>o 12 p.m. and 8 a.m. BP 130/72, T 97.6 F, P 70, R 21, S 97%.</p> <p>2/17/25: 4 a.m. and 12 a.m. BP 119/78, T 97.9 F, P 78, R 19, S 99%.</p> <p>2/28/25: night and evening BP 112/70, T 97.8 F, P 98, R 18, S 97%.</p> <p>During a review of Resident 14's Orders, the Orders indicated, Order Date .1/11/25 . Order Summary: Monitor Vital Signs every 4 hours for COVID-19 Precaution for 14 days THEN every shift for COVID-19 Precaution.</p> <p>During a review of Resident 14's MAR, dated January 2025, the MAR indicated that Resident 14 had duplicate vital sign entries recorded on the following occasions:</p> <p>1/11/25: 8 p.m. and 4 p.m. BP 149/65, T 97.3 F, P 61, R 17, S 98%.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1/12/25: 12 p.m. and 8 a.m. BP 136/64, T 97.4 F, P 70, R 17, S 96%. 8 p.m. and 4 p.m. BP 149/68, T 97.3 F, P 68, R 18, S 98%.</p> <p>1/13/25: 8 p.m. and 4 p.m. BP 152/66, T 97.3 F, P 56, R 17, S 97%.</p> <p>1/14/25: 8 p.m. and 4 p.m. BP 155/82, T 97.3 F, P 61, R 17, S 96%.</p> <p>1/15/25: 12 p.m. and 8 a.m. BP 121/66, T 97.7 F, P 78, R 17, S 96%.</p> <p>1/16/25: 4 a.m. and 12 a.m. BP 136/62, T 98.3 F, P 62, R 16, S 98%. 12 p.m. and 8 a.m. BP 136/64, T 97.4 F, P 70, R 17, S 96%. 8 p.m. and 4 p.m. BP 122/70, T 97.5 F, P 70, R 17, S 97%.</p> <p>1/17/25: 12 p.m. and 8 a.m. BP 116/78, T 97.8 F, P 74, R 17, S 96%. 8 p.m. and 4 p.m. BP 152/62, T 97.3 F, P 79, R 18, S 97%.</p> <p>1/18/25: 12 p.m. and 8 a.m. BP 129/70, T 97.5 F, P 70, R 18, S 96%. 8 p.m. and 4 p.m. BP 146/64, T 97.3 F, P 87, R 17, S 95%.</p> <p>1/19/25: 8 p.m. and 4 p.m. BP 147/64, T 97.3 F, P 74, R 18, S 95%.</p> <p>1/21/25: 12 a.m. and 1/20/25 8 p.m. BP 159/56, T 97.3 F, P 69, R 17, S 96%. 8 p.m. and 4 p.m. BP 146/61, T 97.3 F, P 89, R 18, S 96%.</p> <p>1/22/25: 4 a.m. and 12 a.m. BP 135/82, T 98.6 F, P 77, R 16, S 98%. 12 p.m. and 8 a.m. BP 124/66, T (missing), P 66, R 18, S 97%.</p> <p>1/23/25: (continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER Coastal View Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4904 Telegraph Rd Ventura, CA 93003	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>4 a.m. and 12 a.m. BP 127/62, T 97.1 F, P 72, R 17, S 97%.</p> <p>12 p.m. and 8 a.m. BP 121/71, T 76 F (?), P 76, R 19, S 96%.</p> <p>8 p.m. and 4 p.m. BP 142/64, T 97.6 F, P 89, R 17, S 97%.</p> <p>1/24/25:</p> <p>12 a.m. and 1/23/25 8 p.m. BP 142/64, T 97.6 F, P 89, R 17, S 97%.</p> <p>12 p.m. and 8 a.m. BP 116/65, T 97.5 F, P 65, R 17, S 97%.</p> <p>8 p.m. and 4 p.m. BP 139/64, T 97.3 F, P 74, R 18, S 96%.</p> <p>1/25/25:</p> <p>4 a.m. and 12 a.m. BP 125/62, T 98.3 F, P 84, R 16, S 98%.</p> <p>12 p.m. and 8 a.m. BP 119/76, T 97.6 F, P 68, R 17, S 97%.</p> <p>1/26/25: night shift and evening shift BP 132/72, T 97.5 F, P 74, R 18, S 96%.</p> <p>1/27/25 at night shift and evening shift BP 142/64, T 97.3 F, P 79, R 17, S 96%.</p> <p>During a review of Resident 15's Orders, the Orders indicated, Order Date .1/13/25 . Order Summary: Monitor Vital Signs every 4 hours for COVID-19 Precaution for 14 days THEN every shift for COVID-19 Precaution.</p> <p>During a review of Resident 15's MAR, dated January 2025 and February 2025, the MAR indicated that Resident 15 had duplicate vital sign entries recorded on the following occasions:</p> <p>1/14/25:</p> <p>4 a.m. and 12 a.m. BP 102/55, T 97.5 F, P 70, R 17, S 96%.</p> <p>12 p.m. and 8 a.m. BP 120/67, T 97.5 F, P 76, R 18, S 97%.</p> <p>8 p.m. and 4 p.m. BP 124/74, T 97.5 F, P 72, R 17, S 98%.</p> <p>1/15/25:</p> <p>12 a.m. and 1/14/25 8 p.m. BP 124/74, T 97.5 F, P 72, R 17, S 98%.</p> <p>4 a.m. and 12 a.m. 124/74, T 97.5 F, P 72, R 17, S 98%.</p> <p>8 p.m. and 4 p.m. 115/66, T 97.8 F, P 72, R 16, S 97%.</p> <p>(continued on next page)</p>

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1/16/25:</p> <p>4 a.m. and 12 a.m. BP 100/64, T 97.8 F, P 70, R 18, S 95%.</p> <p>8 p.m. and 4 p.m. BP 119/67, T 97.4 F, P 70, R 17, S 96%.</p> <p>1/17/25: 12 a.m. and 1/16/25 8 p.m. BP 119/67, T 97.4 F, P 70, R 17, S 96%.</p> <p>1/18/25: 12 p.m. and 8 a.m. BP 117/68, T 97.6 F, P 70, R 17, S 97%.</p> <p>1/19/25: 4 a.m. and 12 a.m. BP 122/67, T 97.6 F, P 68, R 18, S 96%.</p> <p>1/20/25:</p> <p>4 a.m. and 12 a.m. BP 98/58, T 98 F, P 68, R 16, S 95%.</p> <p>8 p.m. and 4 p.m. BP 114/62, T 97.2 F, P 75, R 17, S 97%.</p> <p>1/21/25: 4 a.m. and 12 a.m. BP 125/67, T 97.2 F, P 75, R 17, S 97%.</p> <p>1/22/25: 4 a.m. and 12 a.m. BP 112/60, T 97.2 F, P 77, R 18, S 97%.</p> <p>1/24/25:</p> <p>4 a.m. and 12 a.m. BP 100/60, T 97.8 F, P 68, R 18, S 96%.</p> <p>8 p.m. and 4 p.m. BP 125/70, T 97.2 F, P 72, R 17, S 97%.</p> <p>1/25/25: 4 a.m. and 12 a.m. BP 118/66, T 97.5 F, P 70, R 17, S 97%.</p> <p>1/26/25:</p> <p>4 a.m. and 1/27/25 12 a.m. BP 134/72, T 97.5 F, P 74, R 18, S 97%.</p> <p>8 a.m. and 4 a.m. BP 134/72, T 97.5 F, P 74, R 18, S 97%.</p> <p>1/27/25: 4 a.m. and 12 a.m. BP 112/61, T 97.4 F, P 68, R 17, S 97%.</p> <p>2/1/25:</p> <p>evening shift and day shift BP 116/74, T 97.3 F, P 70, R 17, S 97%.</p> <p>night shift and evening shift BP 116/74, T 97.3 F, P 70, R 17, S 97%.</p> <p>During a review of Resident 16's Orders, the Orders indicated, Order Date .1/15/25 . Order Summary:</p> <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER Coastal View Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Monitor Vital Signs every 4 hours for COVID-19 Precaution for 14 days THEN every shift for COVID-19 Precaution. During a review of Resident 16's MAR, dated January 2025 and February 2025, the MAR indicated that Resident 16 had duplicate vital sign entries recorded on the following occasions:</p> <p>1/17/25: 4 a.m. and 1/17/25 12 a.m. BP 134/78, T 97.6 F, P 99, R 20, S 97%.</p> <p>1/18/25: 4 a.m. and 1/18/25 12 a.m. BP 131/81, T 98.6 F, P 98, R 18, S 98%.</p> <p>1/19/25: 12 p.m. and 1/19/25 4 a.m. BP 122/76, T 97.8 F, P 100, R 18, S 97%.</p> <p>1/21/25: 12p.m. and 1/21/25 4 a.m. BP 117/72, T 97.4 F, P 70, R 20, S 98%.</p> <p>8 p.m. and 1/21/25 4 p.m. BP 152/82, T 97.6 F, P 100, R 21, S 96%.</p> <p>1/22/25: 12 p.m. and 1/22/25 4 a.m. BP 120/72, T 98 F, P 92, R 18, S 97%.</p> <p>1/26/25: 4 a.m. and 1/26/25 12 a.m. BP 111/66, T 97.6 F, P 77, R 21, S 98%.</p> <p>12 p.m. and 1/26/25 4 a.m. BP 131/69, T 97.6 F, P 81, R 21, S 98%.</p> <p>1/27/25: 4 a.m. and 1/27/25 12 a.m. BP 108/66, T 97.2 F, P 64, R 18, S 97%.</p> <p>1/28/25: 8 p.m. and 1/28/25 4 p.m. BP 132/72, T 97.6 F, P 80, R 18, S 98%.</p> <p>1/29/25: 12 p.m. and 1/29/25 4 p.m. BP 119/62, T 97.5 F, P 89, R 18, S 98%.</p> <p>1/31/25: night shift and 1/31/25 day shift BP 126/73, T 97.5 F, P 78, R 19, S 98%.</p> <p>2/9/25: night shift and 2/9/25 evening shift BP 128/61, T 97.3 F, P 82, R 20, S 97%.</p> <p>2/11/25: evening shift and 2/11/25 day shift BP 126/74, T 97.5 F, P 80, R 18, S 98%.</p> <p>2/14/25: night shift and 2/14/25 evening shift BP 139/65, T 97.8 F, P 78, R 20, S 97%.</p> <p>During a review of Resident 17's Orders, the Orders indicated, Order Date .1/15/25 . Order Summary: Monitor Vital Signs every 4 hours for COVID-19 Precaution for 14 days THEN every shift for COVID-19 Precaution.</p> <p>During a review of Resident 17's MAR, dated January 2025 and February 2025, the MAR indicated that Resident 17 had duplicate vital sign entries recorded on the following occasions:</p> <p>1/15/25: 8 p.m. and 4 p.m. BP 98/60, T 97.9 F, P 78, R 20, S 96%.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1/16/25: 4 a.m. and 1/15/25 8 p.m. BP 98/60, T 97.9 F, P 78, R 20, S 96%.</p> <p>1/17/25: 8 p.m. and 4 p.m. BP 138/88, T 97.8 F, P 68, R 18, S 98%.</p> <p>1/18/25: 12 p.m. and 8 a.m. BP 119/63, T 97.9 F, P 63, R 18, S 97%.</p> <p>8 p.m. and 4 p.m. BP 100/60, T 98 F, P 60, R 18, S 97%.</p> <p>1/19/25: o 4 a.m. and 12 a.m. BP 115/72, T 97.6 F, P 82, R 16, S 96%.</p> <p>o 8 p.m. and 4 p.m. BP 122/62, T 97.7 F, P 85, R 18, S 97%.</p> <p>1/20/25: 12 p.m. and 8 a.m. BP 118/60, T 97.9 F, P 78, R 17, S 97%.</p> <p>1/21/25: 4 a.m. and 12 a.m. BP 130/66, T 97.6 F, P 83, R 16, S 96%.</p> <p>8 p.m. and 4 p.m. BP 139/74, T 97.3 F, P 68, R 17, S 97%.</p> <p>1/22/25: 12 a.m. and 4 p.m. BP 139/74, T 97.3 F, P 68, R 17, S 97%.</p> <p>4 a.m. and 12 a.m. BP 139/74, T 97.3 F, P 68, R 17, S 97%.</p> <p>12 p.m. and 8 a.m. BP 121/66, T 97.8 F, P 74, R 18, S 96%.</p> <p>8 p.m. and 4 p.m. BP 126/72, T 97.1 F, P 79, R 17, S 98%.</p> <p>1/23/25: 12 a.m. and 01/22/25 8 p.m. BP 126/72, T 97.1 F, P 79, R 17, S 98%.</p> <p>4 a.m. and 12 a.m. BP 126/72, T 97.1 F, P 79, R 17, S 98%.</p> <p>12 p.m. and 8 a.m. BP 119/76, T 97.5 F, P 78, R 18, S 97%.</p> <p>8 p.m. and 4 p.m. BP 124/63, T 97.3 F, P 62, R 17, S 96%.</p> <p>1/24/25: 12 a.m. and 01/23/25 8 p.m. BP 124/63, T 97.3 F, P 62, R 17, S 96%.</p> <p>(continued on next page)</p>

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>12 p.m. and 8 a.m. BP 119/69, T 97.6 F, P 78, R 17, S 98%.</p> <p>8 p.m. and 4 p.m. BP 124/61, T 97.3 F, P 74, R 18, S 96%.</p> <p>1/25/25:</p> <p>4 a.m. and 12 a.m. BP 126/62, T 98.3 F, P 77, R 18, S 98%.</p> <p>12 p.m. and 8 a.m. BP 117/76, T 97.6 F, P 78, R 17, S 96%.</p> <p>1/26/25: 4 a.m. and 12 a.m. BP 130/74, T 97.5 F, P 74, R 16, S 97%.</p> <p>1/27/25:</p> <p>4 a.m. and 12 a.m. BP 128/68, T 97.3 F, P 74, R 16, S 96%.</p> <p>8 p.m. and 4 p.m. BP 129/61, T 97.3 F, P 79, R 17, S 96%.</p> <p>1/28/25: 8 p.m. and 4 p.m. BP 129/64, T 97.3 F, P 74, R 17, S 96%.</p> <p>1/29/25: 12 p.m. and 8 a.m. BP 122/67, T 97.8 F, P 70, R 17, S 97%.</p> <p>2/5/25: evening shift and day shift BP 120/64, T 97.6 F, P 65, R 16, S 98%.</p> <p>2/8/25: night shift and evening shift BP 122/67, T 97.2 F, P 79, R 19, S 97%.</p> <p>2/9/25: night shift and 02/09/25 at evening shift BP 130/72, T 97.5 F, P 77, R 16, S 97%.</p> <p>2/13/25: night shift and 02/13/25 at evening shift BP 118/61, T 97.3 F, P 74, R 18, S 97%.</p> <p>2/20/25: night shift and 02/20/25 at evening shift BP 124/64, T 97.6 F, P 68, R 18, S 97%.</p> <p>2/21/25: night shift and 02/21/25 at evening shift BP 122/64, T 97.3 F, P 79, R 18, S 98%.</p> <p>2/25/25:</p> <p>Evening shift and 02/25/25 at day shift BP 121/69, T 97.3 F, P 74, R 17, S 96%.</p> <p>Night shift and 02/25/25 at evening shift BP 121/69, T 97.3 F, P 74, R 17, S 96%.</p> <p>During an interview on 3/12/25 at 3:05 p.m. with a licensed nurse (LN3), LN3 stated, It's not possible to have exactly the same vital signs recorded four, eight, and twelve hours apart.</p> <p>During an interview on 3/12/25 at 3:45 p.m. with the Director of Nursing (DON), DON stated it is probably not possible to have duplicated vital signs. DON also stated, judgment should be used, and vital signs should be repeated if they were found to be identical.</p> <p>(continued on next page)</p>

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/13/25 at 7:45 a.m. with the Administrator (ADM), the ADM stated the previous night, the DON and the ADM discovered the use previous vitals option on the MAR computer screen. They worked with corporate that night to have the option removed from the MAR charting area, ensuring it is no longer available for nurses to use.</p> <p>During a concurrent interview and record review on 3/22/25 at 2:30 p.m. with LN9, the MARs for Residents 11, 12, 13, 16, and 17, dated January 2025 and February 2025, were reviewed. The MARs indicated, duplicate vital signs documented with LN9 ' s initials. LN9 stated they had maybe, utilized the insert previous vitals option on the MARs when entering the vital signs. LN9 further stated that knowingly entering inaccurate information could be regarded as falsifying medical records. LN9 additionally stated the proper procedure is to follow the doctor ' s orders.</p> <p>During a concurrent interview and record review on 3/22/25 at 3 p.m. with LN8, the MARs for Residents 11, 12, 15, 16, and 17, dated January 2025 and February 2025, were reviewed. The MARs indicated, duplicate vital signs documented with LN8's initials. LN8 stated the use previous vitals option was available for use. LN8 further stated discomfort discussing the matter, after which the interview was concluded.</p> <p>During a concurrent interview and record review on 3/22/25 at 3:20 p.m. with LN16, the MARs for Residents 2, 13, and 15, dated January 2025 and February 2025, were reviewed. The MARs indicated, duplicate vital signs documented with LN16's initials. LN16 stated the MARs had an option to insert previous vitals, which had resulted in the duplication of vital signs. LN16 further stated that the doctor's orders required the monitoring of vital signs, and the duplication of vital signs was not in compliance with those orders.</p> <p>During a concurrent interview and record review on 3/22/25 at 4 p.m. with LN17, the MAR for Resident 15, dated January 2025, was reviewed. The MAR indicated, duplicate vital signs documented with LN17's initials. LN17 stated they did not recall whether they had used the insert previous vitals option on the MAR. LN17 also stated they do not review previously recorded vitals, stating, I don't like to get into other nurses' business. However, LN17 agreed that good nursing practice when monitoring vital signs involves reviewing previous vital signs to identify any concerns that may need to be reported to the doctor.</p> <p>During an interview and record review on 3/22/25 at 4:45 p.m. with LN11, the MAR for Resident 2, dated January 2025, was reviewed. The MAR indicated, duplicate vital signs documented with LN11's initials. LN11 stated, I don't know how that happened.</p> <p>During an interview and record review on 3/23/25 at 10:05 p.m. with LN18, the MAR for Resident 16, dated January 2025, was reviewed. The MAR indicated, duplicate vital signs documented with LN18's initials. LN18 stated, I may have inserted the last recorded vital signs. LN18 further stated the doctor's orders for monitoring vital signs as part of COVID-19 prevention should have been followed.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview and record review on 3/23/25 at 10:45 p.m. with LN20, the MARs for Residents 3, 10, 11, 13, 15, 16, and 17, dated January 2025 and February 2025, were reviewed. The MARs indicated, duplicate vital signs documented with LN20's initials. LN20 stated they had used the insert previous vitals option available on the MAR due to high workload, noting that newly admitted residents required vital sign monitoring every four hours, which exceeded what could reasonably be completed in a single shift. LN20 further stated awareness of documenting inaccurate vital signs. LN20 also stated it was like falsifying medical records.</p> <p>During an interview and record review on 3/23/25 at 11:10 p.m. with LN14, the MARs for Residents 10, 11, 12, 13, 14, 16, and 17, dated January 2025 and February 2025, were reviewed. The MARs indicated, duplicate vital signs documented with LN14 ' s initials. LN14 stated they had used the insert previous vitals option. LN14 further stated vital sign monitoring was a doctor's order and admitted they should have followed the doctor order. LN14 also stated they were aware that duplicating the vital signs was like falsifying medical information. LN14 explained this occurred due to the volume of work exceeding what could be completed within the shift.</p> <p>During an interview and record review on 3/23/25 at 11:45 p.m. with LN6, the MARs for Residents 1, 2, 3, 10, 11, 13, 14, 15, 16, and 17, dated January 2025 and February 2025, were reviewed. The MARs indicated, duplicate vital signs documented with LN6's initials. LN6 stated that they had used the insert previous vitals option. LN6 further stated they resorted to this method to save time, noting that newly admitted residents required vital sign monitoring every four hours and citing an inability to complete all tasks within the shift.</p> <p>Several attempts were made to interview licensed nurses (LN4, LN5, LN7, LN10, LN12, LN13, LN15, LN19, and LN21) and to review the MARs dated January 2025 and February 2025 for Resident ' s 1, 2, 3, 10, 11, 12, 13, 14, 15, 16, and 17, which contained duplicate vital signs documented with their initials. However, these individuals were unavailable for interview.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39814</p> <p>Based on interviews, record reviews and facility policy and procedure, the facility failed to ensure three of three sampled residents (Residents 1, 2, and 3), had their care plans (CP - written document that outlines the specific nursing interventions and goals for a patient's care, based on their assessed needs and diagnoses) revised to include the fall prevention recommendations made by the Interdisciplinary Team (IDT -a health care team familiar with the resident and their needs).</p> <p>These failures resulted in Residents 1, 2, and 3's evolving needs for fall prevention not being met and potentially leading to preventable falls.</p> <p>Findings:</p> <p>During a review of the facility's Monthly Falls Tracking Sheet (MFTS), dated 12/24 and 1/25, the MFTS indicated:</p> <ul style="list-style-type: none"> - Resident 1 fell on [DATE] and 1/13/25. - Resident 2 fell on [DATE], 12/11/24, 12/31/24, 1/7/25, and 1/27/25. - Resident 3 fell on [DATE] three times. <p>During a review of Resident 1's IDT Conference (IDTC), dated 1/6/2025, the IDTC indicated, Date of Incident: 1/4/2025 .Time of Incident: 8:30 pm .IDT meeting conducted to discuss resident on S/P [status post] fall and risk for fall and contributing factors that can cause falls resulting in injury .IDT Recommendations include .2. Continue Bed in lowest position when resident in bed .4. To use non-skid socks . 8. Treatment as ordered . 10. Bowel and Bladder re-training program.</p> <p>During a review of Resident 1's IDTC, dated 1/14/2025, the IDTC indicated, Date of Incident: 1/13/2025 . Time of Incident: 8:45 AM .IDT meeting conducted to discuss resident on S/P fall and risk for fall and contributing factors that can cause falls resulting in injury .IDT Recommendations include .2. Continue Bed in lowest position when resident in bed .4. To use non-skid socks.</p> <p>During a review of Resident 1's CPs, titled:</p> <ul style="list-style-type: none"> - Risk for Falls/Injury, dated 11/20/24, last updated 1/13/25, - Impaired Physical Mobility, dated 11/20/24, last updated 11/24/24, and - Fall, dated 1/4/25, last updated 1/4/25, <p>The CPs indicated IDTC recommendations made on 1/6/25, numbered 2, 4, 8, and 10, and IDTC recommendations made on 1/14/25, numbered 2 and 4, were not incorporated into the CPs.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Coastal View Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4904 Telegraph Rd Ventura, CA 93003	
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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 2/6/25 at 7:55 p.m. with the Director of Nursing (DON), the facility's P&P titled, Falls by A Resident, was reviewed. The DON also reviewed Resident 1's IDTCs dated 1/6/25 and 1/14/25, as well as the CPs titled, Risk for Falls/Injury, dated 11/20/24, Impaired Physical Mobility, dated 11/20/24, and Fall, dated 1/4/25. The DON stated recommendations 2, 4, 8, and 10 from the IDTC on 1/6/25 and recommendations 2 and 4 from the IDTC on 1/14/25 were not incorporated into any of the care plans. The DON also stated recommendation 8 from the IDTC on 1/6/25 should have specified the ordered treatment. Additionally, the DON stated being unaware of a form called Post-Fall Assessment as referenced in the P&P, and there was no documentation confirming Resident 1's CPs had been updated.</p> <p>2. during a review of Resident 2's IDTC, dated 12/11/24, the IDTC indicated, Date of Incident: 12/10/24. Time of Incident: 5:15 pm .IDT meeting conducted to discuss resident on S/P fall and risk for fall and contributing factors that can cause falls resulting in injury .IDT Recommendations include .2. Continue Bed in lowest position when resident in bed. 3. Continue to anticipate needs, provide clutter-free environment at all times. 4. Continue to use non-skid socks. 5. Continue Floor Mat to both sides of bed.</p> <p>During a review of Resident 2's IDTC, dated 12/12/24, the IDTC indicated, Date of Incident: 12/11/24. Time of Incident: 1:15 pm .IDT meeting conducted to discuss resident on S/P fall and risk for fall and contributing factors that can cause falls resulting in injury .IDT Recommendations include .2. Continue Bed in lowest position when resident in bed. 3. Continue to anticipate needs, provide clutter-free environment at all times. 4. Continue to use non-skid socks. 5. Continue Floor Mat to both sides of bed .9. Bolster Mattress to each side of bed.</p> <p>During a review of Resident 2's IDTC, dated 1/2/25, the IDTC indicated, Date of Incident: 12/31/24. Time of Incident: 10:15 AM .IDT meeting conducted to discuss resident on S/P fall and risk for fall and contributing factors that can cause falls resulting in injury .IDT Recommendations include .2. Continue Bed in lowest position when resident in bed. 3. Continue to anticipate needs, provide clutter-free environment at all times. 4. Continue to use non-skid socks. 5. Continue Floor Mat to both sides of bed .9. Bolster Mattress to each side of bed. 10. X-ray for pain to neck.</p> <p>During a review of Resident 2's IDTC, dated 1/8/25, the IDTC indicated, Date of Incident: 1/7/25. Time of Incident: 7:30 pm .IDT meeting conducted to discuss resident on S/P fall and risk for fall and contributing factors that can cause falls resulting in injury .IDT Recommendations include .2. Continue Bed in lowest position when resident in bed. 3. Continue to anticipate needs, provide clutter-free environment at all times. 4. Continue to use non-skid socks. 5. Continue Floor Mat to both sides of bed .9. Bolster Mattress to each side of bed. 10. Bed against the wall.</p> <p>During a review of Resident 2's IDTC, dated 1/28/25, the IDTC indicated, Date of Incident: 1/27/25. Time of Incident: 6:40 pm .IDT Recommendations include .2. Continue Bed in lowest position when resident in bed. 3. Continue to anticipate needs, provide clutter-free environment at all times. 4. Continue to use non-skid socks. 5. Continue Floor Mat to both sides of bed .9. Bolster Mattress to each side of bed. 10. Bed against the wall continue .12. X-ray to Left hand.</p> <p>During a review of Resident 2's CPs, titled, Impaired Physical Mobility, dated 11/23/24, last updated 11/24/24, and Fall, dated 1/27/25, last updated 1/27/25, the CP's indicated the IDTC recommendations made on 12/11/24 numbered 2-5, 12/12/24 numbered 2-5 and 9, 1/2/25 numbered 2-5 and 9-10, 1/8/25 numbered 2-5 and 9-10, and 1/28/25 numbered 2-5, 9-10, and 12, were not incorporated into the CPs.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 2/6/25 at 7:55 p.m. with DON, the DON reviewed Resident 2's IDTC dated 12/11/24; 12/12/24; 1/2/25; 1/8/25; and 1/28/25, as well as CPs titled Impaired Physical Mobility, dated 11/23/24, and Fall, dated 1/27/25. DON stated none of the IDT meeting recommendations were included in the CPs, though they should have been. DON further stated there was an absence of documentation indicating that Resident 2's CPs had been updated.</p> <p>c. During a review of Resident 3's IDTC, dated 1/28/2025, the IDTC indicated, Date of Incident: 1/27/2025. Time of Incident: 1:00 pm . IDT meeting conducted to discuss resident on S/P fall and risk for fall and contributing factors that can cause falls resulting in injury . IDT Recommendations include .2. Continue Bed in lowest position when resident in bed .4. Continue to use non-skid socks.</p> <p>During a review of Resident 3's IDTC, dated 1/29/2025, the IDTC indicated, Date of Incident: 1/27/2025. Time of Incident: 3:40 pm . IDT meeting conducted to discuss resident on S/P fall and risk for fall and contributing factors that can cause falls resulting in injury . IDT Recommendations include .2. Continue Bed in lowest position when resident in bed . 4. Continue to use non-skid socks.</p> <p>During a review of Resident 3's IDTC, dated 1/29/2025, the IDTC indicated, Date of Incident: 1/27/2025. Time of Incident: 7:40 pm .IDT meeting conducted to discuss resident on S/P fall and risk for fall and contributing factors that can cause falls resulting in injury . IDT Recommendations include .2. Continue Bed in lowest position when resident in bed . 4. Continue to use non-skid socks.</p> <p>During a review of Resident 3's CPs, titled, Impaired Physical Mobility, dated 1/24/25, last updated 1/27/25, Risk for Falls/Injury, dated 1/24/25, last updated 1/27/25, and Fall, dated 1/27/25, last updated 1/27/25, the CP's indicated the IDTC recommendations made on 1/28/25 numbered 2 and 4, 1/29/25 numbered 2 and 4, and 1/29/25 numbered 2 and 4, were not incorporated into the CPs.</p> <p>During a concurrent interview and record review on 2/6/25, at 8:30 p.m., the DON reviewed Resident 3's IDTCs dated 1/28/25 and 1/29/25 along with CPs titled, Impaired Physical Mobility, dated 1/24/25; Risk for Fall/Injury, dated 1/24/25; and Fall, dated 1/27/25. DON stated not all recommendations were incorporated into the CPs and stated they should have been included.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Falls by A Resident, dated 7/17, the P&P indicated, It is the policy of the facility that if a resident sustains a fall . A care plan or and update to an existing care plan will then be generated .Purpose: A post fall assessment will also be completed .Procedure: The licensed nurse will complete the form . Document on the post fall assessment that the care plan was updated to reflect an action plan or approaches developed for prevention of falls.</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39814</p> <p>Based on interview and record review, the facility failed to provide a safe environment and care services for 1 of 3 residents (Resident 3) in accordance with the facility's policies and procedures related to falls by failing to:</p> <ul style="list-style-type: none"> - Provide Resident 3, after three incidents of falls, a post fall re-assessment and revision of care plan after each fall incident - Notify/alerted a physician that Resident 3 was on an anticoagulant (blood thinner) medication that increased the risk of bleeding. <p>These deficient practices placed Resident 3 at an increased risk of complications.</p> <p>Findings:</p> <p>A review of Resident 3's medical record revealed a [AGE] year-old male, admitted to the facility on [DATE], with diagnoses that included unspecified Atrial fibrillation (AFib -a common heart rhythm disorder that required blood-thinning medication to prevent blood clots) and generalized weakness. Resident 3 had three falls during the afternoon and evening and ultimately passed away the following morning on 1/28/25.</p> <p>During a review of Resident 3's Fall Risk Evaluation dated 1/24/2025, this indicated Resident 3's fall risk score was 17. A score of 10 and greater indicated the resident should be considered at high risk for potential falls.</p> <p>During a review of Resident 3's care plan: Risk for Falls/ Injury dated 1/24/25 indicated Resident 3 was at risk for further falls/injury related poor balance/gait, limited mobility, history of falls.</p> <p>During a review of Resident 3's Order Summary Report dated 1/24/25, this indicated to ambulate with assistance every shift.</p> <p>During a review of Resident 3's Initial Nursing History and assessment dated [DATE], this indicated Resident 3's functional status: A. Transfers-Able to transfer with 2 persons, B: Ambulation -able to ambulate with 2 persons, with device (front wheel walker- FWW).</p> <p>During a review of Resident 3's care plans (CP), which outlined the specific care required and to be provided, titled, Risk for Bleeding/Ecchymosis [bruising], dated 1/24/25, the CP indicated, At risk for bleeding/Ecchymosis r/t [related to] .use of anticoagulant medication . Heparin Sodium .Handle resident gently and carefully during positioning and transfers.</p> <p>During a review of the facility's Monthly Falls Tracking Sheet dated 1/25, this indicated Resident 3 fell on [DATE] three times.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 3's SBAR (situation, background, appearance, review and notify), dated 1/27/25 at 3 p.m., the SBAR indicated, SITUATION . unwitnessed fall .1/27/25 .BACKGROUND . Medication Alerts . [none indicated] .REVIEW AND NOTIFY . [physician name] made aware .1/27/25 . 1:15 p.m.</p> <p>During a review of Resident 3's SBAR, dated 1/27/25 at 3:55 p.m., the SBAR indicated, SITUATION .1/28/25 late entry for 1/27/25 .witnessed fall .BACKGROUND . Medication Alerts . [none indicated] .REVIEW AND NOTIFY . Primary Care Clinician Notified [none indicated].</p> <p>During a review of Resident 3's SBAR, dated 1/27/25 at 7:55 p.m., the SBAR indicated, SITUATION . 1/28/25 late entry for 1/27/25 . witnessed fall . BACKGROUND . Medication Alerts . [none indicated] . REVIEW AND NOTIFY .Primary Care Clinician . [none indicated]</p> <p>During a review of Resident 3's Order Summary Report (Orders), dated 1/28/25, indicated:</p> <ul style="list-style-type: none"> - Monitor for S/S [signs and symptoms] of bleeding .and notify MD and Family promptly. Order date 1/24/25. - Aspirin [used to prevent platelets from producing substances that promote clotting] 81 [81 milligrams] Oral Tablet Delayed Release (Aspirin) Give 1 tablet by mouth one time a day for CVA (stroke) PPX (prophylaxis to prevent)' Order date 1/24/25. - Heparin Sodium (Porcine) [used to slow down the body's clotting process] Injection Solution 5000 UNIT/ML [milliliter] (Heparin Sodium (Porcine)) Inject 5000 unit subcutaneously [into the fatty layer just beneath the skin] every 12 hours for DVT [deep vein thrombosis (blood clot)] PPX. Order date 1/24/25. <p>During a concurrent interview and record review on 2/6/25 at 5:49 p.m. with a licensed nurse (LN2), the facility's text, dated 1/27/25 at 2:12 p.m. was reviewed. LN2 stated that the physician was not informed of Resident 3's use of heparin. LN2 further stated that this information should have been communicated to the physician.</p> <p>During an interview on 2/6/24 at 5:55 p.m. with LN4, LN4 stated they did not notify the physician about the second and third fall because it would typically be expected for the physician to order an x-ray or refer a resident to the hospital following the first fall when Resident 3 said he hit his head against the siderails, especially if the resident is on a blood thinner like heparin, when asked why they did not notify the physician about the second and third falls. LN4 further stated there was less concern about the additional falls after the first fall, as Resident 3 had not undergone an x-ray or been sent to the hospital.</p> <p>During a concurrent interview and record review on 2/6/25 at 7:55 p.m., with the Director of Nursing (DON), the facility's P&P titled, Falls by A Resident, was reviewed. The DON further stated being unaware of a form called Post-Fall Assessment as referenced in the P&P. There was no evidence of documentation that Resident 3's CPs had been updated and post fall re-assessments have been completed.</p> <p>During a review of Resident 3's progress notes dated 1/28/25, this indicated that around 6 a.m., Resident 3 was found unresponsive, unable to obtain vital signs, cardiopulmonary resuscitation initiated, 911 was called, paramedics took over and called time of death at 6:39 a.m.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 2/13/25 at 2:37 p.m. with Resident 3's physician (PHY), PHY stated the messages did not indicate Resident 3 was on heparin. The PHY further stated not recalling that Resident 3 was on Heparin, when asked if Resident 3 being on a blood thinner would have resulted with sending the resident to the emergency room (ER), the PHY stated, I don't know. The PHY further stated, Well hindsight, referencing Resident 3's death the morning after the fall with head injury. The PHY also stated of not being informed about Resident 3's second or third fall incidents.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Falls by A Resident, dated 7/2017, P& P indicated, Significant information should be reported to the resident's attending physician and documented in the resident's clinical record.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Change of Condition, dated 3/21, the P&P indicated, It is the policy of this facility that any changes in a resident's condition be thoroughly assessed .A thorough assessment will include all important information related to the resident .Should assist the physician in determining the course of clinical management for the resident.</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>39814</p> <p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>Based on observation, interview, and record review, the facility failed to ensure timely responses to resident call lights.</p> <p>This failure had the potential for resident's needs going unmet and heightened the likelihood of falls within the facility.</p> <p>Findings:</p> <p>During a review of the facility's policy and procedure (P&P) titled, Call Lights, dated 1/2017, the P&P indicated, It is the policy of the facility to respond to the resident's requests and needs .Call lights should be answered promptly.</p> <p>During an observation on 2/3/25 at 3:42 p.m., in the hallway between room two and the nursing station, call lights for rooms two, three, and eight were illuminated on the nursing station panel and accompanied by a loud buzzing noise. At 3:50 p.m., the call light for room three remained unanswered.</p> <p>During an interview on 2/3/25 at 4 p.m. with a respiratory therapist (RT), RT stated that they sometimes answer call lights, explaining that this occurs when residents require suctioning, a procedure used to clear the airway and facilitate breathing.</p> <p>During an interview on 2/3/25, at 4:05 p.m., with Resident 6, Resident 6 stated that there is all the time an issue with staff responding to call lights. Resident 6 further stated that it typically takes 30 minutes to receive a response.</p> <p>During a concurrent observation and interview on 2/3/25, at 4:20 p.m., a licensed nurse (LN1) was present at the nursing station while the call light panel was actively buzzing for room six. LN1 did not respond to the call light and stated, I have three certified nursing assistants (CNAs) today. However, no CNAs were observed in the vicinity during this time.</p> <p>During an interview on 2/3/25, at 4:28 p.m., with LN1, LN1 was questioned about not responding to the prolonged buzzing of the call light for room six. LN1 rolled their eyes, took a deep breath, and stated, First of all, I'm doing an admission. LN1 offered no additional explanation.</p> <p>During an interview on 2/6/25, at 4:50 p.m., with the Director of Nursing (DON), DON stated that the expectation is for call lights to be answered timely, with timely defined as within five minutes. DON further stated that all staff members are responsible for responding to call lights.</p>		