STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055566	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coastal View Healthcare Center	4904 Telegraph Road 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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, interview, and record review, the facility failed to ensure the pureed lasagna recipe was prepared according to facility policy when the consistency was not smooth and contained lumps. Dietary Supervisor (DS) confirmed there were six residents (Residents 105, 42, 53, 70, 104, and 91) with physician-ordered puree diets who had potential to receive an inappropriate food texture. This failure had the potential to result in choking and aspiration (the inhalation of food or liquid into the lungs) for residents with swallowing difficulties. During a concurrent observation and interview on 12/16/25 starting at 11:15 a.m. with head cook (HC) in the kitchen, HC was observed preparing and arranging lunch meal trays in the hot box. HC stated the meals were ready to be served. During a concurrent observation and interview on 12/16/25 at 11:35 a.m. with Registered Dietician (RD) and DS, surveyor requested a spoon test of the pureed diet. RD assessed the pureed broccoli and confirmed it was smooth and free of lumps. When the RD assessed the pureed lasagna, the presence of lumps and small particles was observed. RD instructed the DS to further blend the lasagna until a smooth consistency was achieved and acknowledged the concern regarding the puree texture. During a follow up interview on 12/16/25 at 2:30 p.m. with DS, DS stated that the HC did not use the correct food processor for the pureed diet and acknowledged the concerns regarding the lasagna's consistency.During a review of the facility's policy and procedure (P&P) titled, Regular Puree Diet, dated 2025, the P&P indicated, Description: The pureed diet is a regular diet that has been designed for resident who have difficulty chewing and /or swallowing. The textured of the prepared pureed food items included in this diet should be smooth and free of lumps, holds their shape, while not being too firm or sticky, and should not weep.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a comprehensive person-centered care plan (plan of care) was developed and implemented that included measurable objectives and timeframes for the use of psychotropic medication (drugs that alter brain chemistry to affect mood, thoughts, and behavior) for one of 11 sampled residents (Resident 9). This failure had the potential for Resident 9's medical, physical, mental and psychosocial needs (emotional, social - interaction with people, mental and spiritual well-being) not being met. In addition, placed Resident 9 at risk for possible unwanted side effects being overlooked without the appropriate plan of care for monitoring and necessary interventions.Findings:During a review of Resident 9's Face Sheet (FS), dated 11/7/25, the FS indicated, Resident 9 was admitted to the facility on [DATE] with diagnoses including, anxiety disorder (a mental condition characterized by excessive, persistent worry, fear or nervousness), migraine (a type of intense headache pain), chronic pain syndrome, hypertension (elevated blood pressure), diabetes (problem with blood sugar control) and hemiplegia following cerebral infarction (paralysis of one side of the body after a stroke).During a review of Resident 9's Minimum Data Set (MDS - residents' assessment in a nursing home), dated 7/13/25, the MDS indicated, Resident 9's most recent re-entry to the facility after three days of hospitalization. Review of Resident 9's MDS, dated [DATE], Resident 9's Brief Interview for Mental Status (BIMS - a 0-15 point scale used in long-term care to quickly screen cognitive function) was 00, indicating, significant cognitive issues. During a review of Resident 9's Order Summary Report (OSR), and Medication Administration record (MAR), dated 12/25, Resident 9 was prescribed with an antianxiety medication (Buspirone) for anxiety disorder and antidepressant medication (Amitriptyline) prescribed for resident's migraine headache. Further review of Resident 9's clinical record indicated, no plan of care was initiated and implemented for Resident 9's antidepressant use since resident's re-admission to the facility.During a review of the document titled, Psychotherapeutic Medications: Risk and Benefits, dated 7/13/25, the document indicated, Antidepressant Potential Risks/Side Effects: sedation (state of sleepiness or being relaxed), drowsiness (excessive sleepiness), dry mouth, blurred vision, urinary retention (unable to fully empty the bladder), tachycardia (fast heart beat), muscle tremor (uncontrolled shakiness), agitation (feeling restless), headache, skin rash, photosensitivity (reaction to sunlight), excess weight gain. Special attention for: heart disease, glaucoma (eye condition), chronic constipation, seizure disorder (sudden burst of electrical activity in the brain), edema (swelling).During an interview on 12/17/25 at 2:30 p.m. with Medical Records (MRD 1 & 2), MRD 1 & 2 verified that all current care plans are filed in Resident 9's chart and the care plans that are already resolved are no longer in the resident's chart but are filed in the resident's overflow record. MRD 1 & 2 further verified that there is no other active plan of care filed elsewhere. During a concurrent interview and record review on 12/17/25 at 3:53 p.m. with the Minimum Data Set Coordinators (MDSC 1 & MDSC 2), the facility's policy and procedure (P&P) titled, Comprehensive Care Planning, dated 3/19, was reviewed. MDSC 1 verbalized that the MDSC is responsible for making sure that all residents' care plans are developed, reviewed and revised if necessary. MDSC 2 further verbalized that the antidepressant is prescribed for Resident 9's migraine headache and must have a care plan for monitoring for side effects of the medication. Both MDSC 1 & 2 acknowledged the missing care plan and was unable to provide additional proof of documentation for Resident 9's plan of care for antidepressant use.During a review of the facility's P&P titled, Comprehensive Care Planning, dated 3/19, the P&P indicated, It is the policy of this facility that a comprehensive resident-centered care plan be developed for each resident that includes measurable objectives and timeframes to meet each resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.The care plan must address the effective and person-centered care that meets professional standards for quality of (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care.The care plan is based upon the resident assessment, choices and advance directives, if any. Based upon the resident assessment the care plan may include.medical treatment/diagnostic testing based on the resident's choices/directives, symptom management, nutrition and hydration, activities/psychosocial needs.

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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 observation, interview, and record review, the facility failed to ensure services were provided in accordance with professional standards of practice when:1. Administering oxygen therapy without a valid physician order for one of six sampled residents (Resident 51). 2. Taking a blood pressure reading over a thick sweater for one of three sampled residents (Resident 55).This failure had the potential to result in placing the residents at risk for respiratory and circulatory (lung, heart, and blood/oxygen circulation) distress.1.During a review of Resident 51's admission Record (AR), the AR indicated Resident 51 is a [AGE] year-old female, admitted to the facility on [DATE] with diagnoses including: chronic pulmonary edema (buildup of fluid in the lungs. It causes shortness of breath and difficulty breathing), essential (primary) hypertension (high blood pressure with no single identifiable cause), unspecified dementia (a general term for significant cognitive decline [memory, thinking, problem-solving, language] severe enough to disrupt daily life), displaced fracture of base of neck of right femur (break of hip bone). During a record review of Resident 51's Situation, Background, Assessment, Recommendation (SBAR), dated 12/14/25, the SBAR indicated, Situation: Desaturation (the blood oxygen levels of a person drop below the normal 95-100%) and increased sleepiness. This started on 12/14/25. Background: Chronic pulmonary edema . pulse oximetry 87% on 4 LPM (liters per minute). The SBAR did not specify how the oxygen was being delivered to Resident 51. No physician order or documentation of physician notification or approval for this oxygen use was found in Resident 51's medical records. During an observation on 12/15/25 at 9:04 a.m. in Resident 51's room, Resident 51 was observed lying in bed with an oxygen mask positioned on forehead, while the oxygen concentrator was running above the marked maximum level of the flowmeter tube (5 LPM). During a concurrent observation and interview on 12/15/25 at 9:05 a.m. with Registered Nurse (RN) 5, RN5 could not tell the exact oxygen flow rate Resident 51 should be receiving. RN5 stated, 2–5 liters, I think. During a concurrent interview and record review on 12/17/25 at 10:17 a.m. with RN5, RN5 was unable to locate any physician orders for oxygen therapy prior to 12/15/25 in Resident 51's medical record. When asked how long Resident 51 had been on oxygen, RN5 stated, I don't know. Just since Monday, December 15th, I think. During a review of Resident 51's Medical Record indicated, a physician order was obtained by RN5 on 12/15/25 at 9:06 a.m. for Oxygen via NC/Mask at 2-5 LPM to keep O2 (oxygen) sat (saturation) above 90% as needed. During an interview on 12/17/25 at 10:45 a.m. with CNA2, CNA2 stated, (Resident 51) had been using oxygen for about one and a half to two weeks. The resident mostly used it at night, but for the last couple of days has been using it during the day too. During a concurrent interview and record review on 12/17/25 at 12:06 p.m., with the director of nursing (DON) and assistant director of nursing (ADON), the DON and ADON were unable to locate a physician order for oxygen therapy dated 12/14/25. The DON and ADON stated, Oxygen is considered a medication, a nurse cannot administer oxygen without a physician order. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Medication Administration, revised 4/2/25, the P&P indicated, Medications are to be administered in a safe and timely manner, as prescribed . Medications must be administered in accordance with physician orders. During a review of facility's P&P titled, Physician Services and Orders, revised 1/17, the P&P indicated, Drugs, biologicals, laboratory services, radiology, and other diagnostic services shall be administered only upon the written order of a person duly licensed and authorized to prescribe . All drug and biological orders shall be written, dated, and signed . Verbal orders must be recorded immediately in the resident's clinical record and include the date and time of the order. 2. Review of Heart Association (AHA) home blood pressure monitoring, dated 8/14/25 the AHA indicated, Don't take the measurement over clothes. Remove the clothing over the arm that will be used to measure blood pressure. During an observation on 12/16/25 at 9:19 a.m. in Resident 55's bedroom, Licensed Nurse (LN) 3 was observed taking a blood pressure reading on the left forearm of Resident 55 with the cuff over a thick sweater. The cuff popped open and LN 3 stated, I'm going to get a bigger cuff. At 9:22 a.m. LN 3 took the blood pressure again in the same location and over the thick sweater. During an Interview on12/16/25 at 9:26 a.m. with Resident 55, Resident 55 stated blood pressure, is taken with clothing at times. Resident 55 also noted when complimented on the sweater, It's nice and thick. During an interview on 12/17/25 at 12:34 p.m. with DON, DON stated, It is not acceptable to take a blood pressure reading over clothing, not a standard of practice.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation and interview, the facility failed to ensure timely reordering of a medication for one of three residents (Resident 48) when an opened and prescribed medication with a fill date of 8/23/25 was observed on the cart that should be ordered every 30 days. This failure resulted in resident not receiving his prescribed medication for the day. Findings:During a concurrent observation and interview on 12/16/2025 at 8:17 a.m. with Licensed Nurse (LN) 2 during medication administration for Resident 48. LN 2 stated will not give Resident 48 their nasal spray because a new bottle needs to be ordered through pharmacy. LN 2 stated the medication (fluticasone propionate Nasal spray for postnasal drip) was opened without an opened by date, indicating not knowing how long this medication had been opened. LN 2 confirmed, nurses are to mark the date of the medication when opened for the first time. If open date cannot be determined, then the medication is to be wasted. During a review of Resident 48's Medication Administration Record (MAR), dated September, October, November, and December 2025, the MAR indicated four refused doses in September and one refused dose in November. The remainder of the days indicated the resident received the medication, During an interview on 12/18/25 at 7:31 a.m. with Customer Service Representative (CSR) at facility's contracted pharmacy, the CSR confirmed the medication in question was a 30 day supply with expected monthly fill dates, but was only filled on 8/23/25 and 12/16/25. During a review of the facility's policy and procedure (P&P) titled, Ordering and Receiving Medications From the Dispensing Pharmacy, dated January 2022, the P&P indicated, Reorder medication five days in advance of need to assure an adequate supply is on hand.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure 1 of 11 sampled residents (Resident 9) was free from unnecessary medication. This failure had the potential to result in Resident 9 acquiring possible unexpected medical complications related to the administration of an antidepressant (medication that affects mood) without the necessary monitoring for effectiveness and adverse side effects (unwanted, harmful medical outcomes) of the medication.Findings:During a review of Resident 9's Face Sheet (FS), dated 11/7/25, the FS indicated, Resident 9 was admitted to the facility on [DATE] with diagnoses including, anxiety disorder (a mental condition characterized by excessive, persistent worry, fear or nervousness), migraine (a type of intense headache pain), chronic pain syndrome, hypertension (elevated blood pressure), diabetes (problem with blood sugar control) and hemiplegia following cerebral infarction (paralysis of one side of the body after a stroke).During a review of Resident 9's Minimum Data Set (MDS - residents' assessment in a nursing home), dated 7/13/25, the MDS indicated, Resident 9's most recent re-entry to the facility after three days of hospitalization. Review of Resident 9's MDS, dated [DATE], Resident 9's Brief Interview for Mental Status (BIMS - a 0-15 point scale used in long-term care to quickly screen cognitive function) was 00, indicating, significant cognitive issues. During a review of Resident 9's Order Summary Report (OSR), and Medication Administration record (MAR), dated 12/25, Resident 9 was prescribed with an antianxiety medication (Buspirone) for anxiety disorder and antidepressant medication (Amitriptyline) prescribed for resident's migraine headache. Both OSR and MAR indicated that Resident 9 was monitored for the adverse effect of the antianxiety medication but not for the antidepressant. Further review of the Resident 9's clinical record from August to November 2025, no monitoring was found for the adverse side effect for the antidepressant use.During a review of the document titled, Psychotherapeutic Medications: Risk and Benefits, dated 7/13/25, the document indicated, Antidepressant Potential Risks/Side Effects: sedation (state of sleepiness or being relaxed), drowsiness (excessive sleepiness), dry mouth, blurred vision, urinary retention (unable to fully empty the bladder), tachycardia (fast heart beat), muscle tremor (uncontrolled shakiness), agitation (feeling restless), headache, skin rash, photosensitivity (reaction to sunlight), excess weight gain. Special attention for: heart disease, glaucoma (eye condition), chronic constipation, seizure disorder (sudden burst of electrical activity in the brain), edema (swelling).During a concurrent interview and record review on 12/17/25, at 3:53 p.m. with the Minimum Data Set Coordinators (MDSC 1 & MDSC 2), Resident 9's Order Summary Report from August to December 2025 and the facility's policy and procedure (P&P) for psychotropic medication were reviewed. The P&P indicated, there should be documentation of monitoring for adverse complications in the resident's clinical record. MDSC 1 stated, Residents on psychotropic medication must be monitored for effectiveness and adverse effects from the medication. Both MDSC 1 & 2 confirmed the missing documentation from August to December 2025.During an interview on 12/18/25 at 11:30 a.m. with the Administrator (ADM), the ADM verbalized discussing Resident 9's psychotropic medication used with the Director of Nursing (DON) stating Resident 9 must be monitored regardless of the indication of the psychotropic medication. The ADM further acknowledged the missing documentation in Resident 9's clinical record.During a review of the P&P titled, Psychotropic Drug Treatment, dated 9/17, the P&P indicated in part, 1. Psychotropic drugs include antianxiety agents, antidepressants, hypnotics, antipsychotics and other drugs that affect behavior. 2. While certain individuals may require these medications for optimal functioning, others may experience a decline in function or may become chemically restrained with excessive doses.6. Facility staff will document episodes of behavior, the impact of the medication on behavior and the presence or absence of side effects. 7. Facility staff will monitor for side effects, reduce dosage to the minimum required and, when possible, discontinue the use of such medications.c. Documentation in the clinical record that the resident is being monitored for adverse complications.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure dietary staff followed sanitary food handling practices when male staff were working in the kitchen without using beard nets. This failure increased the potential risk for contamination in the food service area. During an observation on 12/15/25 at 8:50 a.m. in the kitchen, two male kitchen staff were observed handling tray carts and washing dishes without beard nets covering their facial hairs. During an interview on 12/15/25 at 9:05 a.m. with Kitchen Staff (KS) 1, KS 1 stated he does not use a beard net when working in the kitchen and only wears one when preparing food. During an interview on 12/15/25 at 9:10 a.m. with Kitchen Staff (KS) 2, KS 2 stated he does not use beard net while in the kitchen unless he is preparing food.During an interview on 12/15/25 at 9:15 a.m. with Dietary Supervisor (DS), DS confirmed that the male kitchen staff with facial hair are required to wear beard nets while working in the kitchen. During a review of the facility's policy and procedure (P&P) titled, Dress Code, dated 2023, the P&P indicated, Personal hygiene and appropriate dress are a very important part of the total appearance of the Food & Nutritional Services Department. All clothing should be in good repair. Appearance is very important in maintaining a high standard of food services. Hat for hair, if hair is short, which completely covers the hair. Hair net for hair, if hair is long. If applicable, beards and mustaches (any facial hair) must wear beard restraints.