

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055719	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/24/2025
NAME OF PROVIDER OR SUPPLIER Ventura Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 4020 Loma Vista 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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43745</p> <p>Based on record review and interview, the facility failed to ensure physician orders were followed and appropriately implemented for one of three sampled residents (Resident 1) when:</p> <ol style="list-style-type: none"> 1. Blood pressure (BP) parameters were not followed, as ordered, prior to Resident 1 receiving the medication Carvedilol (a medication used to lower BP). 2. The physician was not notified, as ordered, of Resident 1's elevated blood sugar levels on two occasions. <p>These failures had the potential to result in the inappropriate delivery of care and services to the resident affecting health and safety.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During a review of Resident 1's Admission Record (AR), dated 3/24/25, the AR indicated, Resident 1 was an [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including, interstitial pulmonary disease (a group of diseases that irritate, inflame or scar the lungs and supporting air sacs), drug or chemical induced diabetes mellitus with hyperglycemia (occurs as a side effect of certain medications that makes the blood sugar consistently high) and essential primary hypertension (HTN - high blood pressure). <p>During a review of Resident 1's Order Summary Report (OSR), dated 3/24/25, the OSR indicated, the physician order, Carvedilol oral tablet 6.25 mg (milligram), give 6.25 mg by mouth two times a day for HTN, HOLD SBP < 110 (hold for systolic blood pressure less than 110), give with food, dated 8/15/24.</p> <p>During a review of Resident 1's Medication Administration Record (MAR), for 8/1 - 8/31/24, the MAR indicated administration documentation of, Carvedilol 6.25 mg .on 8/20/24 for the 9 a.m. dose, the medication was held due to vitals were outside the parameters for administration .on 8/22/24 for the 9 a.m. dose, the medication was given.</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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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1's Weights and Vitals Summary (WVS), dated 8/9 - 9/2/24, and Progress Notes (PN), dated 8/20 - 8/23/24, the WVS indicated that . On 8/20/24, there was no BP reading documented for Resident 1 at 9 a.m. to justify holding off the resident's Carvedilol dose . On 8/22/24 at 9:11 a.m., the WVS indicated the resident's BP reading was 97/52 and the resident received his 9 a.m. Carvedilol dose. Resident 1's PN failed to show documentation to justify these discrepancies.</p> <p>During a concurrent interview and record review on 3/24/25 at 5:25 p.m. with the Assistant Director of Nursing (ADON) and Director of Staff Development (DSD), Resident 1's clinical record was reviewed. ADON and DSD verified the administration and documentation discrepancies found in Resident 1's MAR (dated 8/1 - 8/31/24), WVS (dated 8/9 - 9/2/24) and PN (dated 8/20 - 8/23/24) pertaining to the resident's Carvedilol 6. 25 mg 9 a.m. doses on 8/20/24 and 8/22/24 respectively. ADON acknowledged that staff should have paid more attention to details.</p> <p>2. During a review of Resident 1's OSR, dated 3/24/25, the OSR indicated, the physician order, Humulin R injection solution (Insulin Regular Human - a medication used to lower blood sugar), inject as per sliding scale (a dosing scale used to determine how much insulin to give depending on the blood sugar level) . 371+ = 12 units (for blood sugar level 371 and above, give 12 units), CALL MD . subcutaneously (injected into the tissue layer between the skin and muscle) three times a day before each meal, dated 8/8/24.</p> <p>During a review of Resident 1's MAR, dated 8/1 - 8/31/24, the MAR indicated administration documentation of, Humulin R injection solution . 371+ = 12 units, call MD . On 8/22/24 at 1630, Resident 1 received 12 units for a blood sugar level of 513 . On 8/23/24 at 1130, Resident 1 received 12 units for a blood sugar level of 383.</p> <p>During a review of Resident 1's PN, dated 8/20 - 8/23/24, the PN failed to indicate documentation that Resident 1's physician was notified of the resident's elevated blood sugar levels on 8/22/24 and 8/23/24 respectively.</p> <p>During a concurrent interview and record review on 3/24/25 at 5:30 p.m. with ADON, Resident 1's MAR (dated 8/1 - 8/31/24) and PN (dated 8/20 - 8/23/24) were reviewed. ADON verified Resident 1's elevated blood sugar levels on 8/22/24 and 8/23/34 respectively and acknowledged that staff should have notified the physician of these elevated blood sugar levels, as ordered.</p> <p>During a review of the facility's policy and procedures (P&P) titled, Medication Administration, dated 5/2019, the P&P indicated in part, POLICY: It is the policy of the facility that medications for residents be administered in a safe and timely manner, and as prescribed . PROCEDURE . Medications must be administered in accordance with physician orders, including any required time frame . The licensed nurse should also check prior to administration . vital signs, if necessary.</p>		