STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555478	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Victoria Care Center	5445 Everglades St 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 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. 39814 Based on interview and record review, the facility failed to ensure two of two sampled residents (Residents 1 and 2), had interventions (actions to be taken) on their care plans (an outline of the care the facility will provide to the resident) related to pressure ulcers(bedsores) to include: a) Ensuring heels of the feet were offloaded (the practice of reducing pressure) from the bed for Residents 1 and 2. b) Identifying a frequency for turning and repositioning (helping move or reposition to relieve pressure) for Residents 1 and 2. c) Identified an amount of fluid intake for Resident 2. These failures resulted in worsening of a pressure ulcer (Resident 2), had the potential to result in worsening of pressure ulcers (Resident 1) and fluid overload (too much water [Resident 1]). Findings: During a review of the facility's policy and procedure (P&P) titled, Pressure Ulcer/Non-pressure Ulcer, dated 11/2023, the P&P indicated, Information regarding the presence of pressure ulcer(s) may be considered a significant change depending on stage of pressure ulcer . and care plan will be completed. This must be done as soon as a pressure ulcer(s) is identified. a) Review of the National Pressure Injury Advisory Panel (NPIAP) website, https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/1a._pressure-injury-preventi.pdf, accessed on 10/17/24, indicated, Pressure Injury Prevention Points . REPOSITIONING AND MOBILIZATION . Ensure that the heels are free from the bed. During a review of Resident 1's Care Plan (CP), titled, [Resident 1 name] has Left heel blanchable (skin becomes pale or white after pressure is applied)redness at risk for skin breakdown (Upon Admission), dated 4/9/24, the CP did not include an intervention to offload the heel from pressure causing surfaces. (continued on next page)

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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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 2's CP, titled, [Resident 2 name] has Right heel redness at risk for skin breakdown (Upon Admission), dated 7/7/24, the CP did not include an intervention to offload the heel from pressure causing surfaces. During a review of Resident 2's CP, titled, [Resident 2 name] has Left heel redness at risk for skin breakdown (Upon Admission), dated 7/7/24, the CP did not include an intervention to offload the heel from pressure causing surfaces. During a concurrent interview and record review on 10/16/24 starting at 2 p.m. with Assistant Director of Nursing (ADON), Residents 1 and 2's CPs were reviewed. ADON stated the interventions do not include offloading the heels and they should. b) Review of the National Pressure Injury Advisory Panel (NPIAP) website, https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/1a._pressure-injury-preventi.pdf, accessed on 10/17/24, indicated, Choose a frequency for turning based on the support surface in use, the tolerance of skin for pressure and the individual ' s preferences. During a review of Resident 1's CP titled, [Resident 1 name] has pressure ulcer (SACROCOCCYGEAL [tailbone] STAGE 2 [partial-thickness skin loss]) r/t [related to] limited mobility, dated 12/14/23, the CP indicated, Interventions . Turn and reposition. During a review of Resident 2's CP titled, [Resident 2 name] has pressure ulcer (Right Buttock, Stage 1 [redness, skin intact]) r/t limited mobility, at risk for skin breakdown (Upon Admission), dated 7/4/24, the CP did not include an intervention for turning and repositioning. During a review of Resident 2's CP titled, [Resident 2 name] has pressure ulcer (Left Buttock, Stage 1) r/t limited mobility, at risk for skin breakdown (Upon Admission), dated 7/7/24, the CP did not include an intervention for turning and repositioning. During a review of Resident 2's CP titled, Has potential for pressure ulcer development r/t bed mobility problem, incontinence, advanced age, HOB [head of bed] elevated, DX (diagnosis): CHF (congestive heart failure [heart pumping problem]) / Resp. [respiratory] failure/ Cardiomegaly (enlarged heart)/ Pulmonary (lung) edema (fluid buildup in the lungs)/ Rhinovirus (common cold)/ Pulmonary HTN (high blood pressure in the lungs)/ Pleural effusion (buildup of fluid around the lungs) / Crest Syndrome (autoimmune disease)/ CAD (heart disease)/ HTN (high blood pressure)/ BPH (enlarged prostate)/ Vit B12 anemia (lack of healthy red blood cells)/ Anxiety/ depression, dated 7/10/24, the CP indicated, Interventions . Needs monitoring/reminding/assistance to turn/reposition. During a concurrent interview and record review on 10/16/24 starting at 2 p.m. with Assistant Director of Nursing (ADON), Residents 1 and 2's CPs were reviewed. ADON stated the interventions do not include a frequency for turning and repositioning and they should. c) During a review of Resident 2's Physician Order (PO), dated 7/4/24 at 8:13 p.m., the PO indicated, 1500 ML (milliliters) FLUID RESTRICTION BREAKDOWN AS FOLLOWS: AM/NURSING 360ML AM/DIETARY 240ML PM/NURSING 360ML LUNCH MEAL DIETARY 120ML NOC/Nursing 180ML DINNER DIETARY 240 ML every shift, (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 2's CP titled, [Resident 2 name] has pressure ulcer (Right Buttock, Stage 1) r/t limited mobility, at risk for skin breakdown (Upon Admission), dated 7/4/24, the CP indicated, Interventions . Encourage fluid intake and assist to keep skin hydrated. During a concurrent interview and record review on 10/16/24 starting at 2 p.m. with Assistant Director of Nursing (ADON), Resident 2's PO and CP were reviewed. ADON stated the intervention was not resident specific because it did not include the amount of fluid to be encouraged and it should.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39814 Based on interview and record review, the facility failed to ensure one of two sampled residents (Resident 2) had an accurately documented skin assessment. This failure resulted in Resident 2 having an inaccurate resident care history. Findings: During a review of Resident 2's Admission Record (AR), the AR indicated Resident 2 was admitted to the facility on [DATE] and discharged on [DATE]. Resident 2's primary diagnosis was Congestive heart failure (heart cannot pump enough blood to meet the body ' s needs). During a review of Resident 2's Initial Admission Record (IAR), dated 7/4/24 at 7:18 p.m., the IAR indicated, Perineal (area between the anus and genitals) redness . bilateral groin (area where the upper thighs meet the lowest part of the abdomen) redness . bilateral buttocks (gluteal) redness. During a review of Resident 2's Change in Condition Evaluation (CiCE), dated 8/19/24, the CiCE indicated, OPEN BED SORE TO COCCYX [tail bone area] . This started on 8/19/24 . Skin Evaluation . No changes observed. During a review of Resident 2's Skin Pressure Ulcer Weekly (SPUW), dated 8/22/24 at 7:39 p.m., the SPUW indicated, Pressure Ulcer Review SITE 1 . Initial Eval . Present on admission . Yes . Onset Date . 8/18/24 . Site . Coccyx. During a concurrent interview and record review on 10/16/24 at 3 p.m. with the Assistant Director of Nursing (ADON), Resident 2's SPUW, CiCE and IAR were reviewed. The IAR indicated the coccyx pressure ulcer (PU) was not present on admission. The CiCE indicated the coccyx PU started on 8/19/24. The SPUW indicated the coccyx PU was present on admission and date of onset was 8/18/24. ADON stated the date of onset was 8/19/24 and the SPUW was an error. During a review of the facility's policy and procedure (P&P) titled, Documentation and Charting, dated 11/2023, the P&P indicated, It is the policy of this facility to provide . A complete account of the resident's care, treatment, response to the care, signs, symptoms, etc., as well as the progress of the resident's care in an accurate and chronological/timely manner.