

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555478	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2025
NAME OF PROVIDER OR SUPPLIER Victoria Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 5445 Everglades Street 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** Based on interview and record review, the facility failed to ensure one of two sampled residents (Resident 2) was administered Cipro (antibiotic used to treat infections) within a reasonable amount of time after a new order.</p> <p>This facility failure had the potential to result in the progression of the infection to a severe infection or sepsis (a life-threatening infection).</p> <p>Findings:</p> <p>During a review of Resident 2's Progress Note (PN), dated 6/27/25 at 8:22 a.m., the PN indicated, Change in Condition . FOUL SMELLING URINE.</p> <p>During a review of Resident 2's PN, dated 6/27/25 at 4:20 p.m., the PN indicated, While passing meds resident noted with foul smelling urine.</p> <p>During a review of Resident 2's Physicians Order (PO), dated 6/27/25 at 4:53 p.m., the PO indicated a new order for Cipro to be given twice a day for a urinary tract infection (UTI). An additional note indicated it was for the same day delivery from the pharmacy.</p> <p>Review of Resident 2's Care Plan (CP) titled, [Resident 2's name] has foul smelling urine, initiated 6/27/25, the CP indicated, Interventions [action to be taken to improve the situation] . Cipro . Give 1 tablet by mouth two times a day for UTI for 7 days.</p> <p>Review of Resident 2's Medication Administration Record (MAR), dated Jun 2025, the MAR indicated a new order for Cipro dated 6/27/25 at 8:44 p.m. The MAR also indicated an x in the block for the 6/27/25 at 5 p.m. dose. There was no other mark to indicate that the Cipro was administered on 6/27/25 or that the administration time was adjusted for the first dose.</p> <p>Review of [NAME] et al., eleventh edition, Elsevier, Fundamentals of Nursing, page 643, in the section titled, Medication Administration, indicated, Each agency has a recommended time schedule for medications ordered at frequent intervals. You can alter these recommended times if necessary or appropriate.</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 concurrent interview and record review on 7/3/25 at 4:15 p.m. with the Assistant Director of Nursing (ADON), Resident 2's PN dated 6/27/25 at 8:22 a.m. and 4:20 p.m., PO dated 6/27/25 at 4:53 p.m., and MAR dated Jun 2025 were reviewed. ADON stated the Cipro was not taken out of the Emergency Medication Kit because the nurse was waiting for the delivery of the Cipro from the pharmacy. ADON also stated the computer automatically inputs the time to give the Cipro and that was why Resident 2 did not receive the first dose of the medicine until the next day. The nurse did not adjust the time of the first dose. ADON further stated the facility will educate the nurses to adjust the time of the first dose when appropriate.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Emergency Medication/Medication Shortages/Unavailable Medications, dated 11/2024, the P&P indicated, If the medication dose is to be administered as an emergency or within 4 hours, per physician's order, and is not immediately available in the resident's medications supply, facility nurse should immediately obtain the medication from the Emergency Medication Supply to administer the dose . If the next available delivery causes delay or a missed dose in the resident's medication schedule, facility nurse should obtain the medication from the Emergency Medication Supply to administer the dose.</p>		