STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055719	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ventura Post Acute	4020 Loma Vista 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 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 observation, interview, and record review, the facility failed to ensure care plan interventions were implemented for one of five sampled residents (Resident 6). This failure had the potential to result in Resident 6's needs not being met. Findings: During a review of Resident 6's admission Record (AR), dated 6/11/25, the AR indicated, Resident 6 was admitted [DATE] with diagnoses including but not limited to, Cerebral Infarction (a condition in which blood flow to part of the brain is blocked or reduced), and Aphasia (a language disorder affecting communication). During a concurrent observation and interview on 6/11/25 at 9 a.m. with Resident 6, the resident was observed in bed, awake and alert, making eye contact but not responding to questions. No communication board was present at the bedside. During an interview on 6/11/25 at 9:05 a.m. with a Certified Nursing Assistant (CNA), CNA stated she was not aware of communication tools such as picture aids and relied on gesture to communicate with Resident 6. During an interview on 6/11/25 at 10:45 a.m. with Licensed Nurse (LN 2), LN 2 stated that Resident 6 is non-verbal, and relied on gestures for communication. LN 2 acknowledged that communication binders with pictures are available in the facility but admitted they had not been used with Resident 6. During a review of Resident 6's Care Plan (CP), a care plan titled Long Term Aphasia the approach plan indicated, Encourage resident to communicate via gestures/non -verbal cues, communication board. During a review of the facility's policy and procedure (P&P) titled, Comprehensive Care Planning, dated 3/2019, the P&P indicated, The care plan must include measurable objectives and time frames and describe the services that are to be furnished to attain or maintain the resident's highest practicable level of well-being.

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

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 06/12/2025
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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observations, interviews, and record reviews, the facility failed to ensure fingernail care was provided for 3 of 16 sampled residents (Residents 9, 43, and 45). This failure had the potential to negatively affect their self-esteem, comfort, and personal hygiene. Findings: During a concurrent observation and interview on 6/10/2025 at 9:15 a.m. with Resident 9, the resident was observed with visibly long fingernails. Resident 9 stated she is unable to cut her fingernails, and her nails have not been cut for a few weeks. During a concurrent observation and interview on 6/11/25 at 9:10 a.m. with Certified Nursing Assistant (CNA), CNA observed Resident 9's fingernails and stated they needed to be trimmed. During a concurrent observation and interview on 6/10/25 at 9:37 a.m. with Resident 43, the resident was observed with visibly long brown colored fingernails. Resident 43 stated her fingernails had not been cut for several weeks, and she would like them trimmed. During a concurrent observation and interview on 6/11/25 at 10:45 a.m. with Licensed Nurse 2 (LN 2), LN 2 checked Resident 43's fingernails and acknowledged they need to be clean and trimmed. She further stated that nail trimming is part of the CNAs' hygiene and grooming responsibilities. During an interview on 6/11/2025 at 10 a.m., with the Director of Staff Development (DSD), DSD stated that CNAs trim residents' fingernails as part of their grooming and basic care needs. DSD further stated that residents' nails should not be untrimmed. During a concurrent observation and interview on 6/9/25 at 3:17 p.m. with Resident 45, the resident was observed with long and yellow fingernails. Resident 45 stated his fingernails are long and thinks the staff trimmed his nails one week ago. During an observation and interview on 6/11/25 at 10:23 a.m. with CNA, CNA observed resident 45's fingernails and stated, They're kind of long, I would say a trim is needed. CNA stated there isn't a specific time frame for nail trims as it's up to the judgment of the CNA as needed. During an observation and interview on 6/11/25 at 10:28 a.m. with LN 2, LN 2 stated, The nails are too long, I'll request the CNA to trim them. LN also confirmed this resident doesn't refuse care and nail trimming should have been done as necessary. During a review of the facility's policy and procedure (P&P) titled, Quality of Care, Routine Monitoring and Scope of Services, dated 1/2017, the P&P indicated, If a resident is unable to carry out activities of daily living, they are to be provided services to maintain good nutrition, grooming and personal and oral hygiene.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure one of four sampled residents (Resident 14) received consistent professional care as a dialysis resident when the resident's dialysis access site was not assessed pre and post dialysis. In addition, licensed nurses documented in error. This failure had the potential for Resident 14 to have unassessed complications and resulted in an inaccurate medical record. Findings: During an observation on 6/9/25 at 8 a.m. in room [ROOM NUMBER], Resident 14 was preparing for dialysis. Resident 14 had a right chest catheter for dialysis access and a left lower arm AVF (Arteriovenous fistula - surgically made connection between an artery and a vein for dialysis). During a review of Resident 14's dialysis binder book (a binder containing records of pre and post dialysis forms documenting pre and post dialysis assessments) and eMAR (electronic Medical Record - an electronic medication administration record system that helps ensure medications and monitoring are administered reliably), the eMAR dated June 2025 indicated, Check shunt site: Right chest for Bruit (a whooshing or swishing sound heard through the stethoscope indicating blood flow in the AVF) and Thrill (a palpable vibration felt on the AVF to indicate blood flow). If Bruit changes in regularity and depth notify MD immediately every shift for monitoring. Resident 14's dialysis binder indicated between 4/3/25 through 6/6/25: No access site assessment of left AV shunt for thrill & bruit for pre-dialysis 18 times. No access site assessment of left AV shunt for thrill & bruit for post-dialysis 19 times. During a review of Resident 14's eMAR, the eMAR indicated, June 1 through June 9, 2025, licensed nurses documented Resident 14's right chest catheter as having bruit and thrill. Dialysis catheters do not have bruit and thrill. During a concurrent interview and record review on 6/10/25 with the director of nurses (DON), Resident 14's dialysis binder book and eMAR were reviewed. The DON concurred that the pre and post dialysis forms and monitoring order in the eMAR were incomplete, inaccurate and erroneous. During a review of the facility's policy and procedure (P&P) titled, Dialysis Care, dated 2/2018, the P&P indicated, Shunt sites are to be checked for patency every shift and Pre-Dialysis Checklist: b. Information regarding the type of access site and the condition of the access site and dressing. Post Dialysis Checklist: The Post Dialysis Checklist part of this form is to be completed by the facility upon return of the resident. Information to be documented includes b. Information regarding the type of access site and condition of the dressing and access site. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the American Nurses Association (ANA). (2021). Standards of practice. Nursing: Scope and Standards of Practice (3rd ed.) (pp. 53 - 66). First principle of documentation: 1. Documentation Characteristics: Accessible, Accurate and relevant, Auditable, Clear, concise, comprehensive, and thoughtful. Accuracy in nursing assessments is the collection of reliable and precise data that reflects the patient's true health status.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one emergency drug supply kit (e-kit) was secured when not in use. This failure had the potential to allow unauthorized personnel access to emergency drug supply. Findings: During an observation on 6/10/25 at 9:48 a.m. in Medication room [ROOM NUMBER], one e-kit was found to be unsealed with a delivered by pharmacy date of 6/8/25. Upon further observation, this e-kit contained but not limited to, antibiotics and blood pressure medications. During an interview on 6/10/25 at 9:49 a.m. with License Nurse (LN 1), LN 1 stated the e-kit should be secured with a zip tie and confirmed when received by pharmacy, the receiving nurse needed to verify the e-kit is locked before acceptance. During an interview on 6/10/25 at 9:52 a.m. with Director of Nursing (DON), DON stated this was inspected a few days ago by the Nursing Supervisor and it should have been secured with a zip tie. DON stated, It's expected the receiving nurse to check every pharmacy delivery upon receipt. During a review of the facility's policy and procedure (P&P) titled, Medication Ordering and Receiving from Pharmacy, dated April 2008, the P&P indicated, Upon arrival at the facility, the courier delivers the medication directly to a licensed nurse. Furthermore, The pharmacy should be notified within 24 hours regarding any discrepancies with respect to medication delivery.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on interview and record review, the facility failed to ensure the ice machine was properly and routinely sanitized according to facility policy and procedures (P&P) and manufacturer's service manual. This failure had the potential to result in the growth of harmful microorganisms which can cause foodborne illness to its vulnerable residents. Findings: During a concurrent interview and record review on 6/9/25 at 10:40 a.m., with the Assistant Dietary Supervisor (ADS), ADS verbalized that the facility's Maintenance Supervisor (MS) was in charge of the ice machine maintenance. The facility form titled, Bi-Monthly Ice Machine Cleaning Log, dated 11/8/24 through 5/23/25, which was posted on the side of the ice machine, was reviewed. The log indicated, the ice machine was cleaned twice a month using a nickel-safe ice machine cleaner (a specially formulated food-grade product for removing scale deposits from ice makers having nickel-plated or tin-plated evaporators), rinsed with water, and the filters cleaned. There was no information mentioned in the log regarding sanitization procedures performed on the ice machine. During a review of the facility's P&P titled, Ice Machine Cleaning Procedures, dated 2023, the P&P indicated in part, POLICY: The ice machine needs to be cleaned and sanitized monthly . PROCEDURE: . 3) Clean inside the ice machine with a sanitizing agent per the manufacturer's instructions. Add instructions to your policies or use manufacturer's procedures to clean and sanitize the machine. During a concurrent interview and record review on 6/10/25 at 8:47 a.m. with MS, the Bi-Monthly Ice Machine Cleaning Log, dated 11/8/24 through 5/23/25, was reviewed. MS verbalized that he only cleaned the ice machine using the nickel-safe ice machine cleaner and was not aware that there was a separate sanitization procedure. MS was also not aware that the facility's, Ice Machine Cleaning Procedures P&P required the ice machine to be sanitized monthly. During a concurrent interview and record review on 6/10/25 at 9:25 a.m. with the facility Administrator (ADM) and Director of Nursing (DON), ADM was also not aware that the ice machine sanitization was separate from the cleaning procedure. ADM reviewed the MANITOWOC (ice machine brand) Service Manual . Section 4 - Maintenance, dated 5/2005, which indicated the ice machine cleaning (which required a specific cleaning solution) and sanitization (which required a specific sanitizing agent) were two separate procedures. ADM and DON acknowledged that MS should have been sanitizing the ice machine as well.