

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/28/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055957	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2024
NAME OF PROVIDER OR SUPPLIER Santa Paula Post Acute Center		STREET ADDRESS, CITY, STATE, ZIP CODE 250 March St Santa Paula, CA 93060	
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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 35399 Based on record review and interview the facility failed to ensure nursing staff notified the physician and the responsible party (RP) of Resident 1's change of condition (COC) within 24 hours per their policy and procedure. The facility's failure resulted in the resident's RP and physician not being notified of resident's COC in a timely manner placing the resident at risk of deterioration and causing harm to resident. Finding: A review of Resident 1's medical record was conducted on 6/13/24. The document titled SBAR/COC , dated 5/29/24 at 3:51 p.m., indicated resident had a change of condition due to having loose stools which was discovered on 5/29/24. However, the nursing staff (LVN) did not notify the physician and RP of resident's condition until 6/3/24 at 9:00 a.m., which was 5 days after the COC occurred. During a concurrent review of the SBAR/COC document and interview with the DON on 6/13/24 at 3:15 p.m., the DON acknowledged and confirmed the licensed vocational nurse (LVN) did not follow their policy regarding notification to physician and RP when there's a change of condition. DON stated Yes, I agree they should have been notified within 24 hours. The facility's policy and procedure titled Change in a Resident's Condition or Status , dated 2/2021 indicated Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status . Except in medical emergencies, notifications will be made within 24 hours of a change occurring in the resident's medical/mental condition or status.		

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 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. 35399 Based on record review and interview, the facility failed to ensure Resident 1's assessments were performed by a registered nurse (RN) to meet professional scope of practice and standards of practice. The facility's failures place resident at risk of not being assessed appropriately and potentially resulting in harm to resident. Finding: 1. According to the Nursing Practice Act, Business & Professions Code, Chapter 6, Nursing Section 2725 indicates, .(b) The practice of nursing within the meaning of this chapter means those functions, including basic health care, that help people cope with difficulties in daily living that are associated with their actual or potential health or illness problems or the treatment thereof, and that require a substantial amount of scientific knowledge or technical skill . RN is accountable for an ongoing comprehensive assessment that includes data collection (LVN data collection contribution), analysis, and drawing conclusions/making judgments in order to: formulate diagnoses and update diagnoses, formulate or change the plan of care, decide on specific activities to implement the plan of care, prioritize and coordinate delivery of care, delegate to nursing care competent staff to deliver required care . RN uses scientific knowledge and experience to make clinical judgments/assessments about observed abnormalities and changes based on a series of complex, independent and collaborative decision-making activities Set priorities for implementation of nursing care, priorities regarding urgency of patient concerns . LVN is not prepared by formal education to make RN level nursing judgments/assessments that include independent analysis, synthesis, and decision-making. RN is responsible for collecting (LVN data collection), analyzing, and collaborating with all information sources to ensure a comprehensive written plan of care that is based on current standards of safe practice. According to the Scope of Vocational Nursing Practice, section 518.5 indicates, The licensed vocational nurse performs services requiring technical and manual skills which include the following: (a) Uses and practices basic assessment (data collection), participates in planning, executes interventions in accordance with the care plan or treatment plan, and contributes to evaluation of individualized interventions related to the care plan or treatment plan. The data collection performed by the LVN is integrated to the data collection the RN collects to analyzed, synthesized, and make decisions regarding patient/residents' care as outlined above. During a concurrent review of Resident 1's document titled Admission/Readmission Data Collection , dated 03/17/24 and interview with the director of nursing (DON) on 6/13/24 at 1:38 p.m., the DON reported this document is the resident's initial assessment performed upon readmission to facility from the hospital. The document consisted of an assessment of resident's body systems i.e., neurological, respiratory, cardiovascular, gastrointestinal, urinary, physical functioning (musculoskeletal), skin .status. The initial assessment was conducted by two licensed vocational nurses (LVNs). The DON confirmed this and stated Yes, this initial readmission assessment was done by the treatment nurse (LVN), assessing the skin, and another nurse (LVN) did the rest of the assessment. (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the resident's documents titled SBAR/COC , dated 6/4/24 at 10:54 a.m., indicated resident had a change of condition (COC) due to altered mental status necessitating patient being transferred to the hospital emergency department (ED). SBAR/COC, dated 6/1/24 at 2:07 p.m., indicated resident had significant weigh loss in 1 week. SBAR/COC, dated 5/29/24 at 3:51 p.m., indicated resident was having loose stools. SBAR/COC, dated 4/03/24 at 9:25 a.m., indicated resident was having difficulties breathing with an elevated blood pressure and heart rate. SBAR/COC, dated 03/22/24 at 10:42 a.m., indicated resident sustained a skin tear. SBAR/COC, dated 03/20/24 at 1:30 p.m., indicated resident was having diarrhea episodes. The DON confirmed the SBAR/COC documents are resident's assessments and were conducted by LVNs. The SBAR/COC document consisted of resident's assessment of all the body systems. Communicated to the DON Resident 1's assessments were conducted by an LVN without having an RN validate the assessments and/or cosign the assessments. It is not within the LVN scope of practice to perform assessments independently. The DON acknowledged this and stated, I understand. I will check . and if we have to change our practice, we will.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35399 Based on record review and interview, the facility failed to ensure staff monitor Resident 1's intake and output and evaluated resident's hydration status as ordered by the physician. The facility's failure places the resident at risk of dehydration without staff identifying it. Finding: A review of Resident 1's medical record was conducted on 6/6/24 and 6/13/24. Resident 1 was a [AGE] year-old male readmitted to facility after have a cholecystectomy (gallbladder removal). The March, April, and May Order Summary Report (Physician's Orders) document indicated Initiate intake/output (I/O) for hydration every shift. Nursing Progress Note, dated 3/20/24 at 7:31 p.m., indicated, Resident had diarrhea X 4 (episodes) today. Nursing Progress Note, dated 3/21/24 at 2:53 p.m., indicated, Monitoring for having diarrhea X 3. The March ADL- Bowel Continence flow chart documentation indicated resident had loose bowel movements daily from 3/20/24 to 3/30/24. The April ADL- Bowel Continence flow chart documentation indicated resident had loose bowel movements on 4/1/24, 4/2/24, from 4/7/24 to 4/10/24, on 4/15/24, 4/16/24, from 4/20/24 to 4/23/24 and 4/28/24. The May ADL- Bowel Continence flow chart documentation indicated resident had loose bowel movements on 5/3/24, from 5/5/24 to 5/7/24, on 5/9/24, 5/10/24, 5/12/24, 5/14/24, 5/16/24, 5/17/24, from 5/19/24 to 5/21/24, 5/23/24, 5/26/24, 5/28/24, and 5/31/24. The June ADL- Bowel Continence flow chart documentation indicated resident had loose bowel movements from 6/2/24 to 6/4/24. The March, April, May and June Intake and Output measurement flow sheets were patient's fluid amount, that was intake and output, is documented contained numbers, characters, numerous days were left blank, the information on these flow sheets was confusing and did not make sense. (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the March, April, May and June Intake and Output measurement flow sheets and concurrent interview with the director of nursing (DON) and the medical records clerk (MRC) on 6/13/24 at 4:00 p.m., the DON was asked to assist in deciphering the In & Out documentation on these flow sheets. The DON was not able to explain the documentation on these flow sheets. DON called on the MRC to assist in figuring out what the documentation on these flow sheets meant. The MRC and DON spend time analyzing these flow sheets however they were not able to explain which was the intake fluid amount and the output fluid amount per shift. The DON and MRC were asked what was the fluid amount the resident consumed (intake) in 24 hours? What was the fluid amount, the resident excreted (output) in 24 hours? Where is the calculation of the net or differences of amount of fluid in 24 hours to evaluate if resident is dehydrated or well hydrated. The DON and MRC acknowledged not knowing what the information documented on these flow sheets was or meant. The DON was not able to figure out based on the documentation if the resident had received enough fluid intake to maintain hydrated. The DON acknowledged no staff had reviewed the documentation to evaluate if resident was being hydrated appropriately. Communicated to DON it was concerning that DON was not able to figure out, based on information documented, on these flow sheets, what the information meant. The nursing staff will not be able to understand the information documented therefore this place the resident at risk of being dehydrated without the staff knowing.		