STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055957	A. Building B. Wing	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Santa Paula Post Acute Center	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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 40560 Based on observation, interview, and record review, the facility failed to follow physician orders and a care planned intervention for supplemental oxygen, for one of two sampled residents (Resident 1). These failures had the potential for Resident 1 to experience resipiratory complications and lack of oxygen throughout the body. Findings: During a review of Resident 1's Admission Record, undated, the Admission Record indicated in part, Resident 1 had diagnoses including chronic respiratory failure (a condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body) with hypoxia (low levels of oxygen in body tissues). During a concurrent observation and interview, on 8/14/24, starting at 1:15 p.m., with the Director of Staff Development (DSD 1), Resident 1 was observed wearing a nasal cannula (a medical device that provides supplemental oxygen through the nose). The DSD 1 confirmed Resident 1 was wearing a nasal canula and verbalized Resident 1 was receiving supplemental oxygen between two to three liters per minute. During a concurrent record review and interview, on 8/14/24, starting at 2:01 p.m., with the Assistant Director of Nursing (ADON 1), Resident 1's physician orders and care plan were reviewed. Resident 1's care plan indicated in part, Monitor 02 (oxygen) sats (Saturation) Q (every) shift. The ADON 1 verbalized Resident 1 did not have an active physician order for supplemental oxygen and there should have been one. The ADON 1 verbalized the facility could not provide documentation indicating staff were monitoring Resident 1's oxygen status each shift, from 7/15/24 through 8/13/24. During a review of the facility's policy and procedure (P&P) titled Administering Medications, undated, the P&P indicated in part, Medications are administered in a safe and timely manner, and as prescribed . Medications are administered in accordance with prescriber orders. During a review of the facility's policy and procedure titled, Oxygen Administration, dated 10/10, the P&P indicated in part, Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration .Review the resident's care plan to assess for any special needs of the resident. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055957	A. Building B. Wing	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Santa Paula Post Acute Center	250 March St Santa Paula, CA 93060

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure titled, Care Plans, Comprehensive Person-Centered, dated 3/22, the P&P indicated in part The comprehensive, person-centered care plan .Describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055957	A. Building B. Wing	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Santa Paula Post Acute Center	250 March St Santa Paula, CA 93060

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 40560 Based on observation, interview, and record review, the facility failed to ensure two medication carts were locked, when left unattended. These failures had the potential for residents, staff, visitors, and vendors, to have unauthorized access to medications and the potential for drug diversion. Findings: During a concurrent observation and interview, on 8/14/24, at 12:35 p.m., with Licensed Nurse (LN 1) an IV (intravenous) cart containing antibiotics was unlocked and unattended. The LN 1 verbalized the IV cart should have been locked while it was left unattended. During a concurrent observation and interview, on 8/14/24, starting at 3:29 p.m., with Licensed Nurse (LN 2) a medication cart was unlocked and unattended from 3:29 p.m., to 3:34 p.m. The LN 2 verbalized the medication cart should have been locked while it was left unattended. During a review of the facility's policy and procedure (P&P) titled, Security of Medication Cart dated 4/07, the P&P indicated in part, Medication carts must be securely locked at all times when out of the nurse's view.