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	08/20/2024

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 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. 43256 Based on observation, interview and record review, the facility failed to follow physician orders for one of three sampled residents (Resident 1), as evidenced by: 1. Oxygen set at a flow rate of 3 liters per minute instead of 2 liters per minute. 2. Missing entries for G-tube (flexible hollow tube that is inserted into the stomach through abdomen used for nutrition and medication administration) 3. Dispensed blood pressure medication outside of the health parameters specifications. This failure had the potential for Resident 1's physical state to decline. Findings: 1. During an observation on 8/20/24 at 10:12 a.m., in Resident 1's room, Resident 1 was observed sleeping with a continuous flow of oxygen via nasal canula (mask) at a flow rate of 3 liters per minute. During a review of Resident 1's Physician's Orders, dated 8/19/24, the orders indicated Oxygen to be set at 2 liters per minute. During a concurrent observation and interview on 8/20/24 at 12:15 p.m., with Director of Nursing (DON) and Administrator in Resident 1's room, DON and Administrator confirmed the Oxygen set at 3 liters per minute and physician's orders were not followed. 2. During a review of Resident 1's Treatment Administration Record (TAR), dated August 2024, the TAR had missing staff initials in the box for G-tube site cleaning ordered for 2 times a day (at 7 a.m. and 7 p.m.) The missing entries were on 8/3/24 and 8/11/24 at 7:00 a.m. During an interview on 8/20/24 at 11:35 a.m. with DON, DON confirmed the missing entries and stated It's said if not documented then it isn't done. (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
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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. During a review of Resident 1's Physician's Orders, dated 8/2/24, the orders indicated, Midodrine 5 milligrams (medication which increases blood pressure) Give 2 tablets via G-tube two times a day for HYPOTENSION *HOLD IF SBP >110 (Hold if Systolic Blood Pressure (SBP) top number of blood pressure is above 110 millimeters of mercury. During a concurrent interview and record review on 8/20/24 at 12:10 p.m., with DON, Resident 1's MAR, dated August 2024 was reviewed. The MAR indicated licensed staff initials in the box for Resident 1's Midodrine were administered 18 doses from a period of 8/3/24-8/20/24 with SBP recorded being above 110. DON confirmed the orders were not followed when the medication was given when it was supposed to be held. During a review of the facility's policy and procedure (P&P) titled, Administering Medications, dated April 2019, the P&P indicated, Medications are administered in accordance with prescriber orders .The individual administering the medication initials the resident's MAR on the appropriate line . The P&P also indicates, If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR space provided for that drug and dose.