

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 04/10/2025
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)
<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** 35399</p> <p>Based on record review and interview the facility failed to ensure nursing staff implemented one of four sampled residents (Resident 1) gastrostomy/Jejunostomy feeding tube (G-tube-surgically placed tube that delivers nutrition, fluids, and medications directly into the stomach, bypassing the mouth and esophagus), care recommendations and Physician's orders regarding flushing of the tube.</p> <p>The facility's failure resulted in Resident's G-tube getting clogged frequently.</p> <p>Finding:</p> <p>Review of [NAME] and [NAME], 7th Edition, Mosby's Fundamentals of Nursing, page 419 in the section titled, Legal Implications in Nursing Practice indicates, Nurses are obligated to follow physician order unless they believe the orders are in error or would harm patients (residents)</p> <p>A complaint was submitted to the California Department of Public Health (CDPH) on 3/3/25 alleging a Resident has presented to the hospital multiple times because the staff at the facility are . clogging the resident's feeding tube.</p> <p>During an onsite visit to facility on 3/5/25, a record review for Resident 1 was conducted. Record indicated Resident 1 is a [AGE] year old, diagnosis include left hemiparesis (paralysis), dysphasia (impairment of the power to speak or to understand speech, as a result of brain injury), gastrostomy tube, glioblastoma multiforme (a highly aggressive and malignant brain tumor that originates from glial cells, which support and protect neurons in the brain).</p> <p>During a review of change of condition (COC) dated 9/24/24 at 6:51 p.m., the COC indicated 1/17/25 at 9:30 a.m., 2/1/25 at 1:59 a.m., and 3/1/25 at 7:52 a.m., The gastrostomy/Jejunum tube (G-tube) is clogged.</p> <p>During a review of Nurses Progress Note dated 10/18/24 at 1:47 a.m., indicated resident returned to the facility from [hospital name] hospital at about 7:40 p.m. Instructions for facility to manage feedings included in discharge education to provide to staff. 1. Only jejunostomy feeds and water through the port. 2. Flush jejunostomy port with 60 ml water at least every 6 times daily or every four (q4) hours. 3. Gastrostomy port can be used for water and medications including crushed medications. 4. Flush gastrostomy port with 60 ml water every time after administering medications.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 055957	If continuation sheet Page 1 of 4

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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 record review and interview with the director of nursing (DON) on 3/6/25 at 2:55 p.m., the DON was asked the reason the hospital's recommendations for G-tube management were not implemented at the facility. The DON stated, We did, we got a (physician) order, the instructions were transcribed on the electronic medication administration record e-MAR as a for your information (FYI). The e-MAR for October, November, December 2024, January and February 2025 were reviewed with the DON. The five e-MAR records were noted to be blank without indications the instructions were implemented. The DON acknowledged and confirmed the e-MAR records were blank therefore indicating these instructions were not carried out by the licensed nurses. The DON stated, I agree, if the e-MARs are not signed off by the nurses that means they did not perform what the instructions say to do.</p> <p>Review of [NAME] and [NAME], Tenth Edition, Fundamentals of Nursing, page 365 in the section titled, Informatics and Documentation, indicated, Documentation is a key communication strategy that produces a written account of pertinent data, clinical decisions and interventions, and patient (resident) responses in a health record. Documentation in a patient's health record is a vital aspect of nursing practice.</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35399</p> <p>Based on record review and interview, the facility failed to:</p> <ol style="list-style-type: none"> 1. Ensure one of four sampled residents (Resident 1) gastrostomy/Jejunostomy feeding tube (G-tube-surgically placed tube that delivers nutrition, fluids, and medications directly into the stomach, bypassing the mouth and esophagus), was managed properly. 2. Ensure licensed nursing staff was educated on the management of G-tube. <p>The facility's failures resulted in Resident 1's G tube having problems for six (6) months without any resolution to the tube problem and staff education regarding G-tube management was not provided to licensed nursing staff.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. A complaint was submitted to the California Department of Public Health (CDPH) on 3/3/25 alleging a Resident has presented to the hospital multiply times because the staff at the facility are breaking, pulling and clogging the resident's feeding tube. <p>During an onsite visit to facility on 3/5/25, a record review for Resident 1 was conducted. Record review indicated Resident 1 is a [AGE] year-old, diagnosis include left hemiparesis (paralysis), dysphasia (impairment of the power to speak or to understand speech, as a result of brain injury), gastrostomy tube, glioblastoma multiforme (a highly aggressive and malignant brain tumor that originates from glial cells, which support and protect neurons in the brain).</p> <p>The change of condition COC, dated 9/24/24 at 6:51 p.m., indicated The Jejunum is clogged.</p> <p>The COC, dated 10/2/24 at 7:40 p.m., indicated Resident pulled out GJ tube around 1600.</p> <p>The COC, dated 10/12/24 at 1:43 p.m., indicated Dislodged of G-tube.</p> <p>The COC, dated 10/15/24 at 10:59 a.m., indicated GJ tube dislodged.</p> <p>The COC, dated 10/17/24 at 9:57a.m., indicated Tear in GJ tube balloon.</p> <p>The COC, dated 10/30/24 at 3:58 p.m., indicated g-tube dislodged.</p> <p>The COC, dated 12/5/24 at 7:30 a.m., indicated J-tube dislodged.</p> <p>The COC, dated 12/18/24 at 2:59 p.m., indicated Accidentally pulled out g-tube during shower.</p> <p>The COC, dated 12/25/24 at 2:00 p.m., indicated J-G tube dislodgment.</p> <p>The COC, dated 1/17/25 at 9:30 a.m., indicated J tube clog.</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The COC, dated 2/1/25 at 1:59 a.m., indicated Resident Jejunum tube was clogged.</p> <p>The COC, dated 2/14/25 at 2:15 p.m., indicated J- tube ruptured during flushing.</p> <p>The COC, dated 3/1/25 at 7:52 a.m., indicated Resident J- tube clogged.</p> <p>During a review of the electronic medication administration record (e-MAR) and physician's medications orders for March 2025, indicated most of the medications were in capsule and tablet form.</p> <p>During a concurrent record review and interview with the director of nursing (DON) on 3/6/25 at 2:25 p.m., the DON was asked if having frequent problems with a gastrostomy tube (G-tube) clogging, pulling and tearing was common for residents with G- tube. The DON stated No, normally residents do not have these many problems with their G-tube. I don't know what's going on with this resident's (Resident 1) G-tube. Communicated to DON that if a resident has G-tube problems the issues are resolved in a couple of months, however, it has been six months and the resident's G-tube problems have not been resolved. DON stated, I know, six months is too long. The DON was asked for the rationale most of the resident's medications are in capsule and tablet form when the G-tube is clogging frequently. DON stated I don't know .</p> <p>2. During a concurrent review of the facility's 2024 education binder and concurrent interview with the department of staff development person (DSD) on 3/5/25 at 1:00 pm., the entire education binder information was reviewed with DSD person to conclude that in 2024 the DSD did not perform any education regarding the management of enteral feeding including G-tube management. The DSD acknowledged and confirmed no G-tube management education was provided to staff.</p> <p>During an interview with the facility's director of staff development (DSD) on 3/6/25 at 10:30 a.m., the DSD presented an in-service sign in sheet dated 5/31/24 indicating the staff was educated on enteral feeding. The education content included head of bed elevated during feeding, medications administration . tubing labelling, formula, following MD orders, nurses check placement, patency, and flushing. The in-service sign in sheet indicated 32 staff attended the education. However, only one was a registered nurse and one was the assistant director of nursing, no licensed nursing staff were in attendance to this education. Communicated to DSD that most of the attendees were certified nursing assistants (CNAs). The DSD stated Yes . Therefore, confirming licensed nursing staff did not attend this education.</p>