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	04/17/2025

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 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. 43745 Based on interview and record review, the facility failed to ensure individual financial records were provided to residents on a quarterly basis. This failure had the potential to violate the residents' rights to be routinely informed of their personal funds account activity. Findings: During an interview on 4/14/25: at 11:26 a.m. with Resident 10 and Resident 13, Residents 10 and 13 verbalized that the facility held their personal funds for safekeeping. Residents 10 and 13 were informed that a facility usually deposited resident personal funds into a bank account specifically created for the resident. When asked if the facility had provided them with a copy of their account statements or any documentation of their account activities, both residents verbalized they have not. During an interview on 4/16/25 at 3:48 p.m. with business office staff (BOS), BOS verbalized only providing an account statement if a resident requested an update and does not provide resident account statements on a regular basis. BOS was informed of regulatory requirements that in addition to requests, resident account statements must be provided on a quarterly basis. BOS stated, We will start doing that. During an interview on 4/16/25 at 4:24 p.m., the Director of Nursing (DON), DON was informed of the finding and acknowledged that the facility will start providing individual account statements on a quarterly basis. During a review of the facility's policy and procedures (P&P) titled, Accounting and Records of Resident Funds, dated 4/2021, the P&P indicated in part, . 5) Individual accounting records are made available to the resident through quarterly statements and upon request

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 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 50707 Based on observation, interview, and record review, the facility failed to ensure the most current survey results and the plan of correction was posted in a place readily accessible to residents and the public. This failure had the potential for the residents, family and their legal representatives to not be fully informed of the facility's deficient practices and how they were corrected. Findings: During a concurrent observation and interview on 4/15/25 at 3:58 p.m., with the Administrator Assistant (AA) the survey results binder was observed stored in a file organizer mounted high on the wall outside of the medical records office in the east wing hallway. AA acknowledged the survey results binder is not easily accessible to residents in wheelchairs, and it should be placed in a location where residents can review it without having to ask for help. During a concurrent interview and record review on 4/16/25 at 4:45 p.m., with the Director of Nursing (DON), the survey results binder was reviewed. The survey results binder included the results of complaints, and the last recertification survey conducted from 3/18/24 to 3/21/24. The DON was not able to find the plan of correction in the binder. DON stated the plan of correction is not in the binder for residents and visitors to review and acknowledged it should be. During a review of the facility's policy and procedure (P&P) titled Survey Results, Examination of, (undated), the P&P indicated, 2. A copy of the most recent standard survey, including any subsequent extended surveys, follow-up revisits reports, etc , along with state approved plans of correction of noted deficiencies, is maintained in a 3-ring binder located in an area frequented by most residents, such as the main lobby or resident activity room.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 39912 Based on observation, interview, and record review, the facility failed to ensure privacy curtains were in good condition for one of four sampled residents (Resident 54). This facility failure had the potential for the patient's privacy to be compromised. Findings: During an initial tour of Resident 54's room on 4/14/25 at 11:00 am., the privacy curtain on the right side of the resident's bed was observed to have large tears on multiple areas. During an interview with the licensed nurse (LN) 2 on 4/14/25 at 12:34 pm, LN2 acknowledged the curtain needs to be replaced. During an interview with the maintenance supervisor (MS) on 4/14/25 at 2:40 pm, the MS indicated housekeeping is the one in charge of maintaining the curtains. During an interview with the housekeeping supervisor (HS) on 4/14/25 at 3:39 pm, the HS acknowledged the tears on the privacy curtain. The facility policy and procedure titled Maintenance Service dated December 2009 indicates Maintenance service shall be provided to all areas of building, grounds and equipment.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50657 Based on interview and record review, the facility failed to follow up on positive Level I Preadmission Screening and Resident Reviews (PASRR-mental disability assessment) for two of eight sampled residents (Residents 34 and 43). This failure had the potential to result in the residents not followed up for mental health screening post admission and not being adequately assessed to receive recommended care and treatment. Findings: 1. During a review of Resident 34's Admission Record (AR) indicated, the resident was admitted to the facility with a history of diagnoses that include unspecified psychosis (when someone has delusions or hallucinations), unspecified mood affective disorder (mood disturbances that cause significant distress or impairment), and schizophrenia (mental disorder characterized by hallucinations, delusions, and disorganized thinking, speech, and behavior). During a review of document titled, Department of Health Care Services (DHCS) letter, with the subject of Notice of PASRR (Pre-admission Screening and Resident Review) Level I Screening Results dated 8/7/24 for Resident 34 indicated, Positive for SMI (serious mental illness). Further record review of document titled, DHCS letter, with the subject of Notice of Attempted Evaluation, dated 8/07/24, for Resident 34 indicated, Unable to complete Level II evaluation .Facility staff were unresponsive to two or more separate attempts of communication within 48 hours of the Level I Screening . The case is now closed. To reopen, the facility must resubmit a new Level I screening. A review of Resident 34's clinical records showed no new level I PASRR was done after the 8/7/24 recommendation by DHCS. During an interview with the Director of Nursing (DON) on 4/17/25 at 10:52 a.m., the DON acknowledged Resident 34 had a positive PASRR Level I and a PASRR Level II was not done. The DON stated Resident 34 was admitted directly to the facility from a hospital and was told by a representative at DHCS that the facility did not need to have Resident 34 complete a Level II PASRR. The DON could not procure any documentation from the State or DHCS indicating the Level II PASRR was not required. 51883 2. During a review of the medical record for Resident 43, on 4/16/25 the medical record indicated an admitted [DATE] with diagnoses including but not limited to 'Alzheimer's' (a progressive brain disorder that primarily was conducted. affects memory, thinking, and behavior), 'Dementia' (a decline in mental ability, particularly memory, thinking, and reasoning, that significantly impacts daily life), and 'unspecified psychosis' (a diagnosis assigned when someone experiences psychotic symptoms (delusions or hallucinations), but their symptoms don't fully meet the criteria for a specific psychotic disorder, or there's insufficient information to make a more specific diagnosis). (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of the pre-admission PASRR Level 1 Screening, dated 9/3/24 revealed Resident 43 was Positive (+) for Serious Mental Illness (SMI). Level II PASRR was not followed up on by facility. During a record review of a letter from The Department of Health Care Services (DHCS) dated 10/16/24, the letter stated, Facility staff were unresponsive to two or more separate attempts of communication within 48 hours of the Level I Screening. During an interview conducted with the DON on 4/16/25 at 9:01 a.m., the DON confirmed that facility's follow up was not made to DHCS because DON thought the case was closed, but acknowledged they should have followed up with DHCS. Further review of the medical record for Resident 43, it was noted that on 1/25/25, Resident 43 had a significant change in condition to Hospice (a type of specialized healthcare that focuses on providing comfort and support to individuals facing the end of life, particularly those with terminal illnesses), and a PASARR screening had not been initiated. During an interview with the DON on 4/15/25 at 1:41 p.m., the DON acknowledged that a PASRR Level I Screening should have been done earlier for Resident 43's significant change in condition. During a review of the facility's policy and procedure (P&P) titled, Admission Criteria (2001), the P&P indicated in part, . If the Level I screen indicates that the individual may meet the criteria for a MD (mental disorder), ID (intellectual disorder), or RD (related disorder), he or she is referred to the state PASARR representative for the Level II (evaluation and determination) screening process .

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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. 39912 Based on interview and record review the facility failed to ensure turning and repositioning intervention on the care plan (a document that summarizes how a patient's needs will be met, and their care will be managed) was implemented for one of four sampled residents (Resident 56). This facility failure had the potential for Resident 56 to develop a pressure sore (damage to the skin caused by constant pressure.) Findings: During a review of Resident 56's health record (HR), the HR indicated Resident 56 was admitted with a diagnosis of Parkinson's (movement disorder of the nervous system) disease and muscle weakness. Nursing summary dated 4/10/25 indicated Resident 56 is an extensive assist on physical functioning, bed mobility, transfer, eating, and toileting. Minimum Data Set (MDS) -a standardized assessment tool that measures health status in nursing home residents)) dated 2/28/25, Section GG Functional Abilities and Goals indicated, Resident 56 is a substantial/maximal assist for roll left and right, sit to lying, lying to sitting on the side of the bed, sit to stand, chair/bed to chair transfer. Care plan indicated risk and potential for skin breakdown with an intervention of turn and reposition every 2 hours. Turning and repositioning log indicate on these dates: 3/1925, 3/25/25, 3/28/25, 3/30/25. 4/1/25, 4/6/25, 4/8/25, 4/12/25 and 4/15/25 Resident 56 was not turned and repositioned every 2 hours. During a concurrent interview and record review with the director for staff development (DSD) on 4/16/25 at 12:18 pm, the DSD acknowledged Resident 56 was not turned every 2 hours. The facility policy and procedure titled Repositioning dated May 2013 indicates in part The purpose of this procedure is to provide for the evaluation of resident repositioning needs, to aid in the development of an individualized care plan for repositioning, to promote comfort for all bed or chair bound residents and to prevent skin breakdown and provide pressure relief for residents . Residents who are in bed should be on at least an every 2 hour repositioning schedule . Resident who are in a chair should be on an every hour repositioning schedule.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 43745 Based on observation, interview, and record review, the facility failed to ensure kitchen and food storage sanitation was maintained when: 1. The sanitizing solution used in the kitchen was not routinely tested for concentration when the solution gets replaced every two hours. 2. The ice machine cleaning and sanitization procedures were not done according to manufacturer guidelines. The facility's failure to implement proper sanitization practices placed vulnerable residents at increased risk of foodborne illnessFindings: 1. During a concurrent observation, interview, and record review on 4/14/25 at 9:50 a.m., inside the facility kitchen with the Interim Dietary Supervisor (IDS), IDS was observed performing a chemical concentration test of the kitchen sanitizing solution found in red containers. The chemical test measured 700 ppm (parts per million - a unit of measurement that describes the concentration of a substance in a solution or mixture). IDS mentioned the measurement should be at least 200 ppm as shown on the kitchen form Quaternary Ammonium (the chemical found in the sanitizing solution that is used to kill bacteria, viruses and molds) Log, dated April 2025. IDS also mentioned the sanitizing solution was replaced every two hours. When asked if staff performed chemical concentration testing every time the solution was replaced, IDS stated, We don't test it. During a review of the facility's policy and procedures (P&P) titled, Quaternary Ammonium Log Policy, dated 8/2023, the P&P indicated in part, POLICY: The concentration of the ammonium in the quaternary sanitizer will be tested to ensure the effectiveness of the solution . PROCEDURE . The replacement solution will be tested prior to usage 2. During a concurrent interview and record review on 4/14/25 at 2:40 p.m., with the facility's Maintenance Supervisor (MS), the Ice Machine Cleaning Log(s), from January 2025 - March 2025 were reviewed. The log indicated the following maintenance tasks performed on the ice machine: a) Clean fins of coil - use vacuum cleaner or cleaning solution, b) Lubricate all parts in accordance with manufacturer, c) Tighten all connections required, d) Check and clean lid gasket, e) Clean exterior of the machine. MS indicated he performed the cleaning tasks using Nickel Safe Ice Machine Cleaner (a food-grade product for removing scale deposits from ice makers) , and IMS-III Sanitizing Concentrate (chemical that prevents the growth of bacteria, mold and mildew within ice machines and dispensers) to sanitize the EXTERIOR of the ice machine ONLY. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the ice machine manufacturer's ICE Machine Cleaning and Sanitizing Instructions, undated, the instructions indicated the following steps: . 4) Add recommended amount of approved nickel safe ice machine cleaner to the water trough according to label instructions on the container, 5) Initiate the wash cycle at the ICE/OFF/WASH switch by placing the switch in the WASH position. Allow the cleaner to circulate approximately 15 minutes to remove mineral deposits, 6) Depress the purge switch and hold until the ice machine cleaner has been flushed down the drain and diluted by incoming water ., 10) Use an EPA (Environmental Protection Agency) approved food equipment sanitizer at the solution mix recommended by the sanitizer manufacturer, 11) Add enough sanitizing solution to fill the water trough to overflowing and place the ICE/OFF/WASH switch to the WASH position and allow to circulate for 10 minutes and inspect all disassembled fittings for leaks ., 12) Depress the purge switch and hold until sanitizer has been flushed down the drain