

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555701	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/03/2024
NAME OF PROVIDER OR SUPPLIER Simi Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 5270 E Los Angeles Ave Simi Valley, CA 93063	

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 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>47112</p> <p>Based on observation, interview, and record review, the facility failed to ensure the call light (a device used to let staff know assistance is needed) was in reach for one of two sampled residents (Resident 1).</p> <p>This failure had the potential for Resident 1 to not receive needed care.</p> <p>Findings:</p> <p>During a concurrent observation and interview on 9/3/24 at 10:45 a.m. with Resident 1, in the residences room, Resident 1 was observed sitting in wheelchair next to the bed, the call light was located on the far side of the bed next to the wall, where Resident 1 could not reach it. Resident 1 shook head no in response to if the call light could be reached.</p> <p>During an interview on 9/3/24 at 10:45 a.m. with the certified nursing assistant (CNA 1), CNA 1 verbalized, was in a hurry and forgot to move the call light.</p> <p>During an interview on 9/3/24 at 11:05 a.m. with the Director of Nursing (DON), DON verbalized, the call light should have been placed by the resident.</p> <p>During a review of the facility ' s policy and procedure (P&P) titled, Call Light Policy and Procedures, dated 5/6/24, the P&P indicated, The staff member will ensure that the resident is comfortable, call light is within reach and that the residents' need is answered before leaving the room.</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
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