| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555701 | A. Building<br>B. Wing | 01/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Simi Healthcare Center | 5270 E Los Angeles Ave<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46884<br><br>Based on interview and record review, the facility failed to revise a care plan for one of three sampled residents (Resident 1) after Resident 1 fell while at the facility and sustained injuries.<br><br>This facility failure placed Resident 1 at a higher risk for fall and injury.<br><br>Findings:<br><br>During a review of Resident 1's Face Sheet, the Face Sheet indicated, Resident 1 was initially admitted to the facility on [DATE] and last readmitted on [DATE] with diagnoses that included, cerebral palsy (a group of disorders that affect a person's ability to move and maintain balance and posture), epilepsy (seizure - uncontrolled body movements), encounter for attention to gastrostomy ([g-tube] a tube used to provide an alternative route for delivering nutrition, fluids, and medications directly to the stomach), dysphagia (difficulty swallowing), Chronic Obstructive Pulmonary Disease (lung disease causing restricted airflow and breathing problems), chronic respiratory failure with hypoxia (the lungs are unable to adequately oxygenate the blood over a prolonged period, leading to low oxygen levels in the blood (hypoxia) and potentially other complications), quadriplegia (loss of the ability to move arms and legs), and legal blindness.<br><br>During a review of Resident 1's Minimum Data Set (MDS - a standardized assessment and care-screening tool), dated 11/25/2024, the MDS indicated, impairment on both sides of upper and lower extremities, uses a wheelchair, total dependence (helper does all the activities for the resident) in all functional abilities, and always incontinent (no voluntary control of bowel and bladder).<br><br>During a concurrent telephone interview and record review on 3/11/2025 at 11:36 a.m. with the Director of Nursing (DON), Resident 1's Care Plan, date initiated 11/21/2024 and incident note, dated 1/11/2025 were reviewed. The Care Plan indicated, (Resident 1) is at risk for falls. Interventions included, Follow facility fall protocol. The DON verbalized the interventions on this care plan were in place before Resident 1's fall on 1/11/2025. DON stated, There's no care plan for the actual incident for the fall or a revision to the initial care plan. The incident note dated 1/11/25, indicated, Resident 1 was found face down on the floor next to the bed by the CNA and it appeared Resident 1 fell out of bed. Resident 1 had a noted abrasion on the right temple at hairline, bruising on right side of forehead above right eye, and redness on left knee. Doctor's orders received to send Resident 1 to the ER.<br><br>(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 |
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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a review of the facility's policy and procedure (P&P) titled, Falls - Clinical Protocol, [undated], the P&P indicated, Assessment and recognition 1. The physician will help identify individuals with a history of falls and risk factors for falling . Cause identification 1) For an individual who has fallen, the staff and practitioner will begin to try to identify possible causes within 24 hours of the fall. 3) The staff and physician will continue to collect and evaluate information until either the cause of the falling is identified, or it is determined that the cause cannot be found or is not correctable . Treatment management 1) Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address the risks of clinically significant consequences of falling . 2) If underlying causes cannot be readily identified or corrected, staff will try various relevant interventions, based on assessment of the nature or category of falling, until falling reduces or stops or until a reason is identified for it's continuation .<br><br>During a review of the facility's P&P titled, Managing falls and fall risk, dated 4/26/23, the P&P indicated, Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling . Resident centered approaches to managing falls and fall risks. 5) If falling recurs despite initial interventions, staff will implement additional or different interventions or indicate why the current approach remains relevant . 7) In conjunction with the attending physician, staff will identify and implement relevant interventions (e.g. hip padding or treatment of osteoporosis as applicable) to try to minimize serious consequences of falling . Monitoring subsequent falls and fall risk 1) The staff will monitor and document each resident's response to interventions intended to reduce falling or risks of falling. |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46884<br><br>Based on observation, interview, and record review, the facility failed to follow their policies and procedures to one of three residents (Resident 1) when:<br><br>1. Medications were left unsecured and unsupervised.<br><br>2. Medications were administered by a Licensed Nurse (LN 3) that LN 2 had prepared without verifying doctor's orders. LN 2 signed the Medication Administration Record (MAR).<br><br>3. Doctor's order was not followed during administration of a medication.<br><br>4. Medication was administered through a gastrostomy tube without verification of placement.<br><br>5. Oxygen tubing was not labelled.<br><br>These facility failures had the potential for Resident 1 to experience negative outcomes.<br><br>Findings:<br><br>During a review of Resident 1's Face Sheet, the Face Sheet indicated, Resident 1 was initially admitted to the facility on [DATE] and last readmitted on [DATE] with diagnoses that included, cerebral palsy (a group of disorders that affect a person's ability to move and maintain balance and posture), epilepsy (seizure - uncontrolled body movements), encounter for attention to gastrostomy ([g-tube]a tube used to provide an alternative route for delivering nutrition, fluids, and medications directly to the stomach), dysphagia (difficulty swallowing), Chronic Obstructive Pulmonary Disease (lung disease causing restricted airflow and breathing problems), chronic respiratory failure with hypoxia (the lungs are unable to adequately oxygenate the blood over a prolonged period, leading to low oxygen levels in the blood (hypoxia) and potentially other complications), quadriplegia (loss of the ability to move arms and legs), and legal blindness.<br><br>During a record review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care-screening tool), dated 11/25/2024, the MDS indicated, impairment on both sides of upper and lower extremities, uses a wheelchair, total dependence (helper does all the activities for the resident) in all functional abilities, and always incontinent (no voluntary control of bowel and bladder).<br><br>1. During an observation on 1/25/2025 at 7:03 p.m. in Resident 1's room, LN 2 stood next to a bedside table at the foot of Resident 1's bed. On the bedside table were six medication cups, five contained a medication, and one was without medication. LN 2 exited Resident 1's room, walked across the hallway, through the nursing station, into another room and closed the door. Approximately one minute later, LN 2 returned to Resident 1's room.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a telephone interview on 3/11/2025 at 11:36 a.m. with Director of Nursing (DON), DON was asked when medications are pulled, what is the correct process to give those medications to a resident, DON stated, If a resident is not ready, then they have to take the medications back to the cart and label them and store them. DON further stated, medications should not be left unattended, That is not our standard of practice.<br><br>During a review of the facility's policy and procedure (P&P) titled, Daily work assignments, [undated], the P&P indicated, All nursing service personnel shall follow daily work assignments and perform assigned duties in accordance with professional standards of practice and facility policy . 5) All licensed nursing personnel and other support staff must perform all assigned duties in accordance with their respective job description and facility policy.<br><br>2. During a concurrent observation and interview on 1/25/2025 at 7:15 p.m. with LN 3 in Resident 1's room, LN 2 was in Resident 1's room next to a bedside table with six labeled medication cups, five contained medications, one without medication. LN 3 entered Resident 1's room and administered the five medications that were in the medication cups, one at a time, reading off the names of the medications that were handwritten on the medication cups prior to administering each one. LN 3 verbalized normally doesn't administer medications that someone else has pulled. LN 3 stated, I didn't read (Resident 1's) MAR today, but I read it before. It normally doesn't change, but I know (LN 2) read it, because (LN 2) wouldn't have taken out the meds otherwise.<br><br>During a concurrent telephone interview and record review on 3/11/25 at 11:36 a.m. with DON, Resident 1's MAR, dated January 2025 was reviewed. The MAR indicated LN 2 initialed administering the following medications for Resident 1: 1700 (5 p.m.) one medication, 1800 (6 p.m.) four medications, 1900 (7 p.m.) three medications, 2100 (9 P.m.) four medications. DON was asked if it would be safe practice to have one nurse pull medications and another nurse give those medications to the resident, DON stated, That is not our standard of practice unless they are both there during the preparation and both of them are checking the MAR or the PCC (Point Click Care electronic medical record system) and they are checking the actual medication supply. This second nurse (LN 3) did not do the med pass per protocol. DON further stated, We would go with the initials on the MAR. So the initials don't match who gave the medications. As you observed, it was given by another nurse.<br><br>During a review of the facility's P&P titled, Administering medications, [undated], the P&P indicated, 10) The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dose, right time and right method (route) of administration before giving the medication. 11) The following information is checked/verified for each resident prior to administering medications: a. Allergies to medications; and b. Vital signs, if necessary. 12) The expiration/beyond use date on the medication label is checked prior to administering.<br><br>During a review of the facility's P&P titled, Administering medications, [undated], the P&P indicated, 22) The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones. 23) As required or indicated for a medication, the individual administering the medication records in the resident's medical record: g) The signature and title of the person administering the drug.<br><br>3. During an observation on 1/25/2025 at 7:03 p.m. in Resident 1's room, LN 2 used a syringe to withdrawal liquid medication from a medication cup, attached the syringe to Resident 1's gastrostomy tube and pushed the medication into Resident 1's gastrostomy tube.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 1/25/2025 at 7:15 p.m., with LN 3, LN 3 verbalized medications are administered by gravity in gastrostomy tubes, and you flush 10 milliliters of water in between each medication.<br><br>During a concurrent telephone interview and record review on 3/11/2025 at 11:36 a.m. with the DON, Resident 1's Order Summary Report, undated, was reviewed. The Order Summary Report indicated, no doctor's orders to administer a medication through a gastrostomy tube as a push. The DON verbalized medications are given by gravity through a gastrostomy tube unless there's a doctor's order for a slow push, sometimes they (doctors) order that you may administer a medication with a slow push, but usually it's by gravity. The DON further stated, I didn't see an order for a slow push and our policy is by gravity. The DON verbalized sometimes it could be a verbal order, but even a verbal order has to reflect in the physician's orders.<br><br>During a review of the facility's P&P titled, Administering medications through an Enteral Tube, [undated], the P&P indicated, The purpose of this procedure is to provide guidelines for the safe administration of medications through an enteral tube . 25) Administer medication by gravity flow. a) Pour diluted medication into the barrel of the syringe while holding the tubing slightly above the level of insertion. b) Open the clamp and deliver medication slowly.<br><br>4. During a concurrent observation and interview on 1/25/2025 at 7:03 p.m. with LN 2, LN 2 pulled medications to administer to Resident 1. LN 2 used a syringe to draw up a liquid medication and attached the syringe to Resident 1's gastrostomy tube. LN 2 was asked what needs to be done before administering medication in a gastrostomy tube (g-tube), LN 2 stated, I don't have a stethoscope (a medical instrument used to listen to a person's heart or breathing) to listen to the four quadrants of (Resident 1's) tummy for the g-tube placement. LN 2 was asked how often LN 2 checks Resident 1's g-tube placement, LN 2 stated, I haven't had (Resident 1) before. When we give (Resident 1) medication, we're supposed to check. LN 2 was asked why do you check g-tube placement and is there a risk involved with administering medications through a g-tube, LN 2 stated, To make sure it's in the right place, and if it's not, we have to hold it and let the provider know. LN 2 further verbalized it's an aspiration risk. LN 2 then proceeded to administer the medication by using a syringe and pushing it through Resident 1's g-tube and then flushed Resident 1's g-tube with water. LN 2 was asked if Resident 1 was at risk right now with g-tube placement not being checked and a medication administered, LN 2 stated, No. When questioned about LN 2's previous statement regarding administering medication without checking g-tube placement is an aspiration risk, LN 2 stated, Yes, but I don't have a stethoscope right now to check. LN 2 held the syringe and picked up a second medication. LN 2 was asked if LN 2 wanted to go get a stethoscope before administering any more medications to Resident 1 through Resident 1's g-tube. LN 2 let out a sigh, set the medication down and exited the room. Approximately a minute later, LN 2 returned with a stethoscope. LN 2 used the stethoscope to listen to Resident 1's abdomen. LN 2 stated, There's no swooshing .I can't hear the placement of it. LN 2 picked up the syringe and a medication. When asked if LN 2 were to administer more medications through Resident 1's g-tube right now, would that be endangering Resident 1's health, LN 2 stated, I would say yes.<br><br>During a telephone interview on 3/11/2025 at 11:36 a.m. with the DON, the DON verbalized prior to administering medications through a g-tube, placement of g-tube should be checked by introducing air and using a stethoscope to listen for any swoosh heard in the stomach, and another way is to use a 60cc (cubic centimeter) syringe to check for residual (fluid or food that remains in the stomach after tube feeding).<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a review of Resident 1's MAR, dated January 2025, the MAR indicated, Enteral Feed Order every shift for G-Tube Enteral: Check tube placement before initiation of formula, medication administration, and flushing tube or at least q 8 hours. Start date 01/25/2025 0700.<br><br>During a review of Resident 1's Care Plan, date initiated 8/11/2024, the Care Plan indicated, (Resident 1) requires tube feeding r/t (related to) Dysphagia. The care plan interventions indicated, Check for tube placement and gastric contents/residual volume per facility protocol and record.<br><br>During a review of the facility's P&P titled, Administering medications through an Enteral Tube, [undated], the P&P indicated, The purpose of this procedure is to provide guidelines for the safe administration of medications through an enteral tube . Follow the administration guidelines in the policy entitled Administering Medications .7) This procedure is contraindicated if the tube is obstructed or improperly positioned, if the resident is vomiting, or if bowel sounds are absent . The following equipment and supplies will be necessary when performing this procedure. Stethoscope. 13) Assess the resident as indicated.<br><br>During a review of the facility's P&P titled, Administering medications, [undated], the P&P indicated, 4. Medications are administered in accordance with prescriber orders .<br><br>5. During a concurrent observation and interview on 1/25/2025 at 5:30 p.m. with LN 1 in Resident 1's room, Resident 1 was receiving oxygen through nasal cannula tubing (a thin, soft, flexible tube that connects the oxygen source to the nasal prongs, which are placed in the nostrils to deliver oxygen). No label was located on the nasal cannula tubing. LN 1 stated, Usually whoever applies it (nasal cannula) they put a label with the person's name, how many liters, date, time and frequency. LN 1 was asked how would they know how long the oxygen tubing has been in use, LN 1 stated, Usually the tubing should be labelled, but it's not. To be honest I don't know how long the oxygen tubing has been on.<br><br>During a telephone interview on 3/11/2025 at 11:36 a.m. with DON, DON stated, Our policy is to change it (oxygen tubing) every week and label with a date, to minimize the risk of accumulation of gunk and some dried mucus. DON was asked if oxygen tubing isn't labeled what should staff do, DON stated, They should always change it to a new one and label it.<br><br>During a review of the facility's policy and procedure (P&P) titled, Departmental (Respiratory Therapy) Prevention of Infection, [undated], the P&P indicated, The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment, including ventilators, among residents and staff .7) Change the oxygen cannulae and tubing every seven (7) days, or as needed. |