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| 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 06/30/2025 |
| NAME OF PROVIDER OR SUPPLIER Simi Healthcare Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 5270 East Los Angeles Avenue 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.

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on interview and record review, the facility failed to administer ordered morning medications, including sliding scale insulin, and failed to monitor blood glucose levels as ordered for one of seven sampled residents (Resident 1).</p> <p>This failure resulted in Resident 1 experiencing critically high blood glucose levels, becoming unresponsive, requiring emergency medical treatment, and ultimately dying following transfer to an acute care hospital.</p> <p>Findings:</p> <p>During a review of Resident 1's admission Record (AR), dated 6/3/25, the AR indicated, Resident 1 was admitted in the facility on 4/24/25 with diagnoses including, diabetes mellitus type 1 (DM 1, condition in which the body cannot produce insulin or produces so little that insulin therapy is required to survive), Parkinson's disease (a progressive neurological disorder that primarily affects movement, causing symptoms like tremors, stiffness, and slow movement), hypertensive heart disease with heart failure (a condition resulting from long-term, uncontrolled high blood pressure that specifically leads to heart failure).</p> <p>During an interview on 6/2/25 at 5:45 p.m. with Licensed Nurse (LN 4), LN 4 stated that on 5/3/25, the licensed staff scheduled to work the overnight shift from 11 p.m. - 7 a.m. called off, was not able to work the 11 p.m. - 7 a.m. shift on 5/3/25. LN 4 stated the nurses from 3 p.m. - 11 p.m. shift stayed until 2 a.m. per administrator approval. LN 4 confirmed there was no licensed nurse on the skilled unit (Resident 1's unit) from 2 a.m. to 7 a.m. on 5/4/25. LN 4 further stated the scheduled 5 a.m.- 6:30 a.m. medications were not administered to residents during that time. Review of the staffing schedules indicated, on 5/4/25 from 2 a.m. to 7 a.m. there were four CNAs on the skilled unit, no licensed nurses. The subacute unit had two CNAs, one Licensed Vocational Nurse and one Registered Nurse.</p> <p>During an interview on 6/3/25 at 1:35 p.m. with LN 2, LN 2 stated that on 5/3/25 they were scheduled to work the 3 p.m. - 11 p.m. shift. LN 2 stated that one of the night shift nurses called off around 7 p.m., followed by another night shift nurse at 10:30 p.m. Multiple calls and messages were sent to the Director of Nursing (DON), Director Staff Development (DSD, and Administrator to report the staffing issue, but no response was received. LN 2 stated around 1 a.m. they spoke with the Administrator who gave approval for them to leave at 2 a.m. LN 2 stated they informed the sub-acute nurses they were leaving the skilled unit at 2 a.m. per the Administrator's approval.</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>During a review of Resident 1's Physician's Order (PO), dated 4/24/25, the PO indicated, administer Insulin Lispro 100 UNIT/ML (milliliter) inject as per sliding scale: if blood glucose 151 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; &gt;400 = 12 units, subcutaneously (SQ, under the skin) before meals for DM (Diabetes Mellitus) at 6:30 a.m., 11:30 a.m. and 4:30 p.m.</p> <p>During a review of Resident 1's Medication Administration Record (MAR), dated 5/4/25 at 6:30 a.m., the MAR indicated, there was no documentation of insulin administration and blood glucose monitoring for that morning dose scheduled for 6:30 a.m. There was also no nursing progress note explaining the omission or indicating the physician was notified.</p> <p>During a review of Resident 1's PN, dated 5/4/25 at 9 a.m., the PN indicated, Resident is sleeping, unable to administer medication, There was no documentation of further attempts, no blood sugar check, and no physician notification.</p> <p>During a review of Resident 1's PN, dated 5/4/25 at 10:30, the PN indicated, Insulin Lispro Subcutaneous 100 UNIT/ML inject as per sliding scale . resident is sleeping, unable to administer medication. No documentation indicated that the blood glucose was checked.</p> <p>During a review of Resident 1's Care Plan (CP), dated 4/25/25, the CP indicated, Resident 1 had potential for hypoglycemia/hyperglycemia (low/high blood sugar) related to their DM 1 diagnosis. The CP Interventions included: Administer medication as ordered. Monitor blood sugar levels as ordered.</p> <p>During a review of Resident 1's SBAR Communication Form (SBARCF), dated 5/4/25, the SBARCF indicated, Resident 1 was found unresponsive at 10:30 a.m. and could not be aroused by verbal or tactile stimuli. Initial oxygen saturation (a measure of how much oxygen is carried in your blood) was 73% then increased to 97% within one minute after administering oxygen via non-rebreather mask. Blood glucose results were unable to read, glucometer displayed HI. Physician was notified and recommended to send Resident 1 to emergency room (ER).</p> <p>During a review of Resident 1's hospital records titled, Emergency Department Reports (EDR), dated 5/4/25, the EDR indicated, Brought in by Advanced Life Support (ALS) ambulance from [name of skilled nursing facility] for hyperglycemia and altered mental status since this morning . Patient in on nonrebreather (oxygen mask designed to deliver high concentrations of oxygen to a patient), unresponsive to verbal and painful stimuli. Glucose read high, &gt;650.</p> <p>During a review of Resident 1's hospital records titled, Discharge Summaries Notes, dated 5/6/25 at 10:32 a. m., the Notes indicated, Palliative care consulted due to poor prognosis. admitted to ICU (intensive care unit) for further evaluation. Patient was evaluated by palliative care and family decided on comfort care. Patient passed away shortly after. Resident 1 passed on 5/5/25 with final diagnoses including, acute hyperkalemia (high potassium levels), respiratory failure, acute kidney injury, altered mental status, cardiac arrest, and diabetes ketoacidosis (a serious, potentially life-threatening complication of diabetes where the body produces excess ketones due to a lack of insulin).</p> <p>(continued on next page)</p> | | |

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| <p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>During an interview on 6/3/25 at 8:15 a.m. with Licensed Nurse (LN) 1, LN 1 stated when she arrived for her 7 a.m. shift on 5/4/25, the night Certified Nursing Assistant (CNA) informed her that no licensed nurse was on duty between 2 a.m. and 7 am. LN 1 stated there was no handoff report, and she did not know whether Resident 1 received the scheduled 6 a.m. medications. LN 1 further stated she did not check Resident 1's blood sugar until the resident became unresponsive around 10 a.m., and the glucometer displayed a reading of HI. LN 1 observed Resident 1 was sleeping and snoring, but unresponsive to tactile stimulation. LN 1 further stated that morning was not able to give Resident 1 his medications because he had been sleeping. Also, the CNA informed her (LN 1) that Resident 1 had refused eating breakfast.</p> <p>During an interview on 6/25/25 at 5:18 p.m. with Licensed Nurse Supervisor (LNS), LNS stated on 5/4/25 around 10 a.m., Resident 1 was found unresponsive and non-arousable. LNS stated the physician was notified, and Resident 1's blood glucose was checked. The glucometer displayed a reading of HI. An ambulance was called and upon arrival, paramedics confirmed the same HI glucose reading. LNS stated that when she arrived for her 7 a.m. shift, there was no licensed nurse present on the skilled unit. LNS attempted to contact the DON, DSD, and Administrator to report the overnight staffing issues, but no response was received.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, dated 12/2016, the P&P indicated, The comprehensive, person-centered care plan will: describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.</p> <p>During a review of the facility's P&P titled, Administering Medication, dated April 2019, the P&P indicated, Medications are administered in a safe and timely manner, and as prescribed . Medications are administered in accordance with prescribed orders, including any required time frame.</p> | | |

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| <p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>Based on interview and record review, the facility failed to ensure 24-hour licensed nursing staff coverage in the skilled nursing unit as required to meet the nursing related care needs for a total census of 73 Residents.</p> <p>This failure resulted in a five-hour period without licensed nurse coverage in the skilled nursing unit, placing residents at risk for delayed assessments, interventions, and unmet care needs.</p> <p>Findings:</p> <p>During a review of the facility's policy and procedure (P&P) titled, Staffing, Sufficient and Competent Nursing dated 8/2022, the P&P indicated, Licensed nurses and certified nursing assistants are available 24 hours a day, seven (7) days a week to provide competent resident care services including: a. assuring resident safety; b. attaining or maintaining the highest practicable physical, mental and psychosocial well-being of each resident; assessing, evaluating, planning and implementing resident care plans; d. responding to resident needs.</p> <p>During a review of the facility's Nursing Staffing Assignment and Sign-In Sheet, for the skilled nursing unit, dated 5/4/25, Shift start 12:00 AM - 7: 00 AM indicated the two assigned licensed nurse had CI (called in) written next to their names. A third name was handwritten on the log without an employee signature. Further review of the records indicated that two licensed nurses from the evening shift (5/3/25, 3 p.m. -11 p.m.) extended their shift and stayed only until 2 a.m.</p> <p>During an interview on 6/2/25 at 5:45 p.m. with Licensed Nurse (LN 4), LN 4 confirmed that the two licensed nurses scheduled to work the 11 p.m. to 7 a.m. on 5/3/25 -5/4/25 shift called out. LN 4 stated that the afternoon shift nurses stayed until 2:00 a.m., leaving the skilled nursing unit without licensed nurse coverage from 2 a.m. to 7 a.m., approximately five hours for the total of 73 residents.</p> <p>During an interview on 6/3/25 at 1:34 p.m. with LN 2, LN 2 stated she worked the 3 p.m. to 11 p.m. shift on 5/3/25. When the night shift nurses called out, LN 2 and another nurse attempted to contact the Director of Nursing and the Director of Staff development but received no response. LN 2 stated that they contacted the Administrator, who stated he would find a replacement, but no one arrived. LN 2 stated that they informed the sub-acute unit nurses that there would be no licensed nurse on the skilled unit before leaving at 2 a.m.</p> <p>During an interview on 6/24/25 at 12:15 p.m. with the Staffing Scheduler (SS), SS stated that she wrote CI next to the names of two nurses who had called - in for the 12 a.m. - 7 a.m. shift on 5/4/25. SS further stated that it was a mistake for writing the third name on the staffing schedule and confirmed that the reason there was no employee signature next to that name was because the individual did not work on the skilled unit. SS stated that she wrote the name down without verifying it.</p> | | |

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| <p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Ensure that residents are free from significant medication errors.</p> <p>Based on observation, interview, and record review, the facility failed to administer prescribe insulin doses and monitor blood glucose levels as ordered for five of seven sampled residents (Residents 2, 3, 4, 5, and 6).</p> <p>These failures resulted in missed critical diabetic treatment and placed all five residents at risk for serious complications, including hyperglycemic, hyperglycemia, and acute changes in condition.</p> <p>Findings:</p> <p>1. During a review of Resident 2's admission Record (AR), dated 6/18/25, the AR indicated, Resident 2 was admitted in the facility on 5/14/24 with diagnoses including, but not limited to, diabetes mellitus type 2 (DM 2, a condition where your body either doesn't produce enough insulin, or your cells don't respond properly to insulin), hemiplegia and hemiparesis following cerebral infarction (a conditions that can occur after a stroke, leading to weakness or paralysis on one side of the body).</p> <p>During a review of Resident 2's Physician Orders (PO), dated 6/16/24, the PO indicated, to administer Novolin (Insulin) R (regular) injection solution 100 units/ml (milliter), Regular inject as per sliding scale: 151 - 199 = 3 units; 201 - 249 = 4 units; 251 - 299 = 7 units; 301 - 349 = 10 units; 351 - 400 = 12 units; greater than 400 = 14 units of blood sugar/call doctor of medicine (MD). subcutaneous (SQ, under the skin) per sliding scale every 6 hours for DM 2 management.</p> <p>During a review of Resident 2's Medication Administration Record (MAR), dated 5/4/25, the MAR indicated, no documentation of insulin administration or blood sugar levels for the 6 a.m., morning dose. Further review of Resident 2's nursing progress notes for the same day showed no documentation explaining the missed dose and no evidence that the physician was notified of the omission.</p> <p>During a review of Resident 2's Care Plan (CP), dated 11/26/24, the CP indicated, Resident 2 has Diabetic Medication. The CP interventions included, administer diabetes medication as ordered by doctor; monitor and document for side effects and effectiveness, and monitor side effects and effectiveness.</p> <p>2. During a review of Resident 3's AR, dated 6/19/25, the AR indicated, Resident 3 was admitted in the facility on 6/18/20 with diagnoses including, but not limited to, DM 2, and heart failure.</p> <p>During a review of Resident 3's PO, dated 6/16/24, the PO indicated, to administer Novolin R injection solution 100 unit/ml, Regular inject as per sliding scale: 151 - 200 = 3 units; 201 - 250 = 5 units; 251 - 300 = 7 units; 301 - 350 = 9 units; 351 - 400 = 11 units; &gt;400 = 13 units, SQ, before meals and at bedtime for DM 2. Call MD if blood sugar above 400 or below 70.</p> <p>During a review of Resident 3's MAR, dated 5/4/25, the MAR indicated, no documentation of insulin administration or blood sugar levels for the 6:30 a.m., morning dose. Further review of Resident 3's progress notes for the same day, showed no documentation explaining the missed dose and no evidence that the physician was notified of the omission.</p> <p>(continued on next page)</p> | | |

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| <p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>During a review of Resident 3's CP, dated 10/14/24, the CP indicated, Resident 3 had DM 2 manifested by hyperglycemia/hypoglycemia (low/high blood sugar) episodes. The CP interventions included, Administer diabetes medication as ordered by doctor . Labs fasting serum blood sugar as ordered by doctor.</p> <p>3. During a review of Resident 4's AR, dated 6/18/25, the AR indicated, Resident 4 was admitted in the facility on 1/31/25 with diagnoses including, but not limited to, diabetes mellitus type 2, and chronic kidney disease (kidneys are damaged and cannot filter blood as well as they should).</p> <p>During a review of Resident 4's PO, dated 2/1/25, the PO indicated, to administer Insulin Lispro solution 100 unit/ml, Regular inject as per sliding scale: 151 - 199 = 1 units; 201 - 249 = 2 units; 251 - 299 = 3 units; 301 - 349 = 4 units; SQ, before meals and at bedtime for DM 2. Blood sugar less than 60 or greater than 400, call MD.</p> <p>During a review of Resident 4's MAR, dated 5/4/25, the MAR indicated, insulin administration and blood glucose monitoring columns for 6:30 a.m. dose were blank. Further review of Resident 4's progress notes for the same day showed no documentation explaining the missed dose and no evidence that the physician was notified of the omission.</p> <p>During a review of Resident 4's CP dated 10/14/25, the CP indicated, Resident 4 has DM medication. The CP interventions included, Administer medication as ordered . obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated.</p> <p>4. During a review of Resident 5's AR, dated 6/18/25, the AR indicated, Resident 5 was admitted in the facility on 4/22/25, diagnoses including, but not limited to, diabetes mellitus type 2, and left tibia fracture (a broken left shinbone).</p> <p>During a review of Resident 5's PO, dated 2/1/25, the PO indicated, to administer Insulin Regular solution 100 unit/ml, Regular inject as per sliding scale: 151 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; &gt;400 = 10 units; &gt;400 = 12 units, and call MD. SQ, before meals and at bedtime for DM 2.</p> <p>During a review of Resident 5's MAR, dated 5/4/25, the MAR indicated, the insulin administration and blood glucose monitoring columns for 6:30 a.m. dose were blank. Further review of Resident 5's nursing progress notes for the same day showed no documentation explaining the missing dose and no evidence that the physician was notified of the omission.</p> <p>During a review of Resident 5's CP, dated 4/23/25, the CP indicated, Resident 5 has DM medication. The CP interventions included, Administer medication as ordered.</p> <p>5. During a review of Resident 6's AR, dated 6/19/25, the AR indicated, Resident 6 was admitted in the facility on 2/4/25 with diagnoses including, but not limited to, diabetes mellitus type 2, and osteomyelitis (a bone infection, usually caused by bacteria).</p> <p>During a review of Resident 6's PO, dated 2/1/25, the PO indicated, to administer Insulin Lispro solution 100 unit/ml, Regular inject as per sliding scale: 151 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; &gt;400 = 10 units, SQ, before meals and at bedtime for DM 2.</p> <p>(continued on next page)</p> | | |

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| <p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>During a review of Resident 6's MAR, dated 5/4/25, the MAR indicated, the insulin administration and blood glucose monitoring columns for the 6 a.m. dose were blank, indicating the blood sugar was not checked and the insulin was not given. Further review of Resident 6's progress notes for the same day showed no documentation explaining the missed dose and no evidence that the physician was notified of the omission.</p> <p>During a review of Resident 6's CP, dated 2/7/25, the CP indicated, Resident 5 had potential for hyperglycemia/hypoglycemia related to diagnosis of DM. The CP interventions included, Insulin Lispro Inject solution 100 unit/ml. inject as per sliding scale . monitor blood sugar levels as ordered.</p> <p>During an interview on 6/2/25 at 5:45 p.m., with Licensed Nurse (LN) 4, LN 4 confirmed that there was no licensed nurse in skilled unit from 2:00 a.m. to 7:00 a.m. on 5/4/25. LN 4 further stated that the scheduled 5:00 a.m. -6:30 a.m. medications were not administered to residents in skilled unit.</p> <p>During an interview on 6/30/25 at 11 a.m., with the Interim Director of Nursing (IDON), IDON acknowledged that the MARs for all five residents were left blank on 5/4/25 for 6:30 a.m. and confirmed they should not have been left blank. She stated that if the insulin was not administered and blood glucose was not monitored, staff should have documented the reason in the nursing progress notes.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, dated 12/2016, the P&P indicated, The comprehensive, person-centered care plan will: describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being</p> <p>During a review of the facility's P&P titled, Administering Medication, dated April 2019, the P&P indicated, Medications are administered in a safe and timely manner, and as prescribed . Medications are administered in accordance with prescribe orders, including any required time frame.</p> <p>During a review of the facility's P&P titled, Adverse Consequences and Medication Errors, dated April 2014, the P&P indicated, Examples of medication errors include: a. omission - a drug was ordered but not administered.</p> <p>During a review of the facility's P&P titled, Charting and Documentation, dated 4/2008, the P&P indicated, All observations, medications administration, services performed, etc , must be documented in the resident's clinical records.</p> | | |

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| <p>F 0940</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Develop, implement, and/or maintain an effective training program for all new and existing staff members.</p> <p>Based on interview and record review, the facility failed to ensure a licensed nurse (LN) was trained and competent in using the electronic Point Click Care (PCC, electronic health record system) for documentation and care coordination.</p> <p>This failure has the potential to result in incomplete, delayed, or missing documentation of resident care, placing the resident at risk for unmet care needs.</p> <p>Findings:</p> <p>During a review of the facility's policy and procedure (P&P) titled, Competency of Nursing Staff, dated 5/2019, the P&P indicated, Facility and resident-specific competency evaluations will be conducted upon hire, annually and as deemed necessary based on the facility assessment. Facility and resident-specific competency evaluations will include: a pre-post test for documentation issues; demonstrated ability to use tools, devices, or equipment used to care for residents.</p> <p>During an interview on 6/25/25 at 5:18 p.m. with Licensed Nurse Supervisor (LNS) 3. LNS stated they had not received any formal training on how to use the PCC, not even one hour of instruction.</p> <p>During an interview on 6/25/25 at 5:18 p.m. with the Interim Director of Nursing (IDON), IDON stated that all licensed staff should have received training on the PCC system and should be capable of using it. IDON stated the facility should maintain documentation of staff training and she would look into it.</p> <p>During an interview on 7/1/25 at 4:00 p.m. with the IDON, IDON stated there were no available records indicating staff had received PCC training.</p> | | |