STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555701	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Simi Healthcare Center	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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to keep a resident free from hazards and provide the necessary monitoring and supervision for a resident with known diagnoses with Claustrophobia (an anxiety disorder characterized by an intense, irrational fear of confined or enclosed spaces) when a resident eloped from facility through the room window without staff notification for one of three sampled residents (Resident 1). This failure placed the resident at risk for serious injury and harm. During a review of Resident 1's admission Record (AR), Resident 1 was admitted to facility on 1/23/25 with diagnoses including, Altered Mental Status (a change in a person's normal thinking or awareness), Nontraumatic Chronic Subdural Hemorrhage (a slow developing collection of old blood on the surface of the brain that happens without a recent injury often due to fragile blood vessels), Type 2 diabetes mellitus (chronic metabolic disorder characterized by insulin resistance and relative insulin deficiency, leading to high blood sugar), Paroxysmal Atrial Fibrillation (a heart rhythm problem where the heart suddenly beats fast and irregularly, then returns to normal on its own), and Claustrophobia (an anxiety disorder characterized by an intense, irrational fear of confined or enclosed spaces).During an interview with the Director of Nursing (DON) and Administrator (ADM) on 3/19/26 at 2:40 p.m. DON stated that at approximately 5:00 a.m. on 3/19/26, Licensed Nurse (LN 1) called to inform her of a possible elopement. Per DON, LN 1 reported to DON she had completed her medication pass around 4:30 a.m. at which time Resident 1 was observed still in bed. When the Certified Nursing Assistant (CNA 1) conducted rounds shortly thereafter, Resident 1 was again reported to be present in her room. A while later, Resident 1 was discovered missing from the unit with exact time unknown. Paramedics arrived at the facility and informed staff that Resident 1 was found outside, sitting in the facility parking lot. Resident 1 was subsequently taken to the emergency room (ER) for further evaluation related to complaints of leg pain, though no visible injuries or bleeding were noted. Following this incident, DON and ADM instructed staff to account for all other residents in the facility.During a phone interview on 3/19/26 at 3:00 p.m. with LN 1, LN 1 stated that Resident 1 was last seen in bed at approximately 4:30 a.m., during the medication pass. LN 1 claimed, she was not aware of how or when Resident 1 had the ability to open or manipulate the window latch.A review of Resident 1's Progress Notes dated 12/11/25, showed that Resident 1 had a diagnosis of Claustrophobia and a review of Resident 1's Care Plan (CP) did not reveal any documentation addressing the resident's diagnosis of claustrophobia or interventions tailored to manage triggers associated with an intense, irrational fear of confined or enclosed spaces.During an observation of a facility tour on 3/19/26 at 2:10 p.m. Resident 1's bedroom window was observed to have an easy latch mechanism that allowed the window to be fully opened without any restriction.During a concurrent observation and interview on 3/19/26 at 2:35 p.m. with the Maintenance Manager (MM) and DON in Resident 1's room, the MM demonstrated that the window slid completely open using a simple latch mechanism requiring minimal force. Subsequent inspection of adjacent rooms in the same hallway showed identical, easy-latch mechanisms on windows with no safety stop, restrictor or alarm systems in place, presenting a potential exit risk without staff notification.A review of facility's policy and procedure (P&P) revised March 2019 and titled Wandering (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and Elopement the P&P states, The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. A review of facility's P&P titled Safety and Supervision of Residents, dated 2017, the P&P indicated, Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting processes; QAPI reviews of safety and incident/accident data; and a facility-wide commitment to safety at all levels of the organization.