

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 08/07/2025
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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. (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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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on observation, interview, and record review, the facility failed to provide breakfast at a later time than the routinely scheduled breakfast time for 1 of 69 residents (Resident 33) when Resident 33 requested breakfast be delivered between 9-9:30 a.m. This failure resulted in Resident 33's food being cold and unpalatable by the time the resident woke up around 9-9:30 a.m. and had the potential to diminish Resident 33's autonomy and quality of life. Findings: During an interview on 8/4/25 at 11:30 a.m. with Resident 33 in the resident's room, Resident 33 stated she preferred to sleep late in the mornings. The facility delivers breakfast trays early. As a result, the food was cold and unpalatable by the time she woke up around 9-9:30 a.m. During an interview on 8/5/25 at 9:30 a.m. with certified nursing assistant 2 (CNA 2), CNA2 reported Resident 33 typically sleeps through breakfast and wakes up around 9:30 am. CNA 2 confirmed the tray is delivered early and left on the bedside table. During a concurrent observation and interview on 8/5/25 at 9:35 a.m. in Resident 33's room with Resident 33's private caregiver (PC), Resident 33 was asleep and the breakfast meal tray was on Resident 33's bedside table, untouched. Resident 33's PC stated Resident 33 does not like to eat breakfast early and that the issue has been raised with the facility before, but staff continue to deliver trays early and leave them at the bedside. During an interview on 8/6/25 at 2:15 p.m. with Resident 33 in the resident's room, Resident 33 stated by the time she wakes, the food has become 'cold and does not taste good anymore'. Resident 33 stated she asks for her food to be reheated or requests an alternative, but there are long delays and by the time food is provided, it is often close to lunchtime. As a result, she skips breakfast most days. Resident 33 added that this issue has created tension with her son, who calls daily to confirm whether she ate breakfast, and she stated that although she has repeatedly asked for her mealtime preference to be honored, the facility has not yet accommodated her request. During a review of Resident 33's History and Physical Examination (H&P), dated 2/24/25, the H&P indicated, Resident 33 had the mental capacity to understand and make decisions. During a review of Resident 33's Care Plan (CP), initiated 2/24/25, revised on 3/5/25 with the target date of 8/21/25, the CP indicated, resident . at risk for altered nutrition/hydration r/t: severe protein calorie malnutrition. with goal to respect resident right to choose/refuse meals, honor food/fluids preferences. During a phone interview on 8/5/25 at 12:29 p.m. with the Registered Dietician (RD), the RD stated the facility should honor residents' mealtime requests, As long as they are reasonable and within a two-hour window for food safety. This can be planned, like for dialysis residents. The RD also verbalized the facility should have care plans in place for Resident 33 to receive breakfast meal tray at her preferred breakfast time. During an interview on 8/6/25 at 2:30 p.m. with per diem dietary services supervisor (PD-DSS), PD-DSS stated Resident 33 gets served breakfast between 7:30 a.m. to 7:45 a.m. daily. During a concurrent interview and chart review on 8/5/25 at 3:16 p.m. with the Director of Nursing (DON), the DON attempted to locate any entries regarding Resident 33's preferred breakfast time in the resident's chart but was unable to locate any entries. After reviewing Resident 33's care plan, nutritional notes, and other sections of the chart, the DON stated, If there were any care plans regarding her preference for a later breakfast mealtime, they would be documented in the nutritional care plans, but they are not. During a review of facility's policy and procedure (P&P) titled, Meal Service, dated 2023, the P&P indicated, 6. However, resident preferences for mealtime shall be honored. 7. The goal is to serve cold food cold and hot food hot.</p>		

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<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to conduct a gradual dose reduction for psychotropic medications for 1 of 19 sampled residents (Resident 101). This failure had the potential to result in Resident 101 receiving unnecessary medication and having complications from the medication. Findings: During an observation on 8/5/25 at 12:42 p.m. Resident 101 was observed sleeping in bed. During a review of Resident 101's Face Sheet, the Face Sheet indicated, Resident 101 was admitted to the facility on [DATE] with diagnoses including, anxiety and traumatic brain injury. During an interview on 8/6/25 at 12:32 p.m. with Resident 101's Family Member (FM), the FM was concerned about Resident 101's medication regimen. FM stated Resident 101 sleeps during the day and is awake most of the night. FM further stated Resident 101 was taking a sleeping pill but did not know what time it was given. During a review of Resident 101's Order Summary Report, dated 8/7/25 the Order Summary Report indicated, an order dated 5/9/25 for Seroquel Oral Tablet (Quetiapine Fumarate) (antipsychotic medication used to treat several mental health conditions) Give 12.5 mg by mouth two times a day for Psychosis (a mental health condition characterized by a loss of contact with reality) m/b (manifested by) agitation/hitting, aggression to peers. During an interview on 08/06/25 at 4:46 p.m. with Director of Nursing (DON), DON was unable to locate the monthly medication reviews from the pharmacy for the months of May, June, and July 2025. DON stated no gradual dose reduction was documented for the months of May, June, and July 2025. During a review of the facility's policy and procedure (P&P) titled, Psychotropic Medication Use, dated July 2022, the P&P indicated, Residents on psychotropic medications receive gradual dose reductions (coupled with non-pharmacological interventions), unless clinically contraindicated, in an effort to discontinue these medications. During a review of the facility's P&P titled, Pharmaceutical Services Policy and Procedures Manual, dated 1/25, the P&P indicated, Resident-specific Drug Regimen Review (DRR) recommendations and findings shall be documented and acted upon by the facility and/or physician.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>Based on interview and record review, the facility failed to ensure one of four sampled residents (Resident 2) documentation in their medical record was accurate when wrongfully documenting that the resident is not currently on an antibiotic medication. This failure has the potential to create confusion upon health care team reviewing documentation and deciding the next best course of treatment. Findings: During a review of Resident 2's Physician's Orders, dated 6/16/25, the Physician's Orders indicated, Cephalexin Oral Capsule 500 MG (oral antibiotic medication) to be given 1 capsule by mouth two times a day for Pneumonia community acquired. During a review of Resident 2's Progress Notes, from 6/16/25 thru 8/5/25, the Progress Notes indicated, ten entries dated, 6/24, 6/28, 6/30, 7/7, 7/12, 7/29, 7/30, 7/31, 8/2, and 8/4/25 where nursing staff marked under special care that Resident 2 was not currently on antibiotics. During an interview on 8/6/25 at 11:46 a.m. with Assistant Director of Nursing (ADON), ADON confirmed Resident 2 is currently on antibiotics and the charting was not accurate. During a review of the facility's policy and procedure (P&P) titled, Charting and Documentation, Revised July 2017, the P&P indicated, Documentation in the medical record will be objective .and accurate.</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>Based on record review and interview, the facility failed to ensure one of six sampled residents (Resident 18) was assessed for a PASARR (Pre-admission Screening and Resident Review - a Federal Program that ensures individuals with serious mental illness, intellectual disabilities, or related conditions are placed in nursing facilities and receive necessary services) after a COC (change of condition) for mental illness. This failure resulted in Resident 18 not being properly evaluated and possibly referred to receiving care and services in the most integrated setting appropriate to their needs. Findings: During a review of Resident 18's Electronic Medical Administration Record (eMAR) [a digital record of all medications to be administered or has been administered to a resident] dated August 2025, the eMAR indicated, an order for Seroquel (a medication to treat mental health conditions) Oral tablet 125 mg. (milligrams) via G-tube (GT - a feeding tube inserted through the abdominal wall directly into the stomach) every 8 hours for Psychosis (a mental disorder characterized by a disconnection from reality). During a review of Resident 18's PASARR (Pre-admission Screening and Resident Review - a Federal Program that ensures individuals with serious mental illness, intellectual disabilities, or related conditions are placed in nursing facilities and receive necessary services), the most recent PASARR on record was dated 8/14/23. No recent PASARR was completed to reflect the order for Seroquel on 1/20/25. During a concurrent interview and record review on 8/4/25 at 3:38 p.m. with the Director of Nursing (DON), Resident 18's eMAR was reviewed. The most recent PASSAR document was dated 8/14/23. The DON concurred that the PASSAR dated 8/14/23 was the most recent PASSAR. The DON stated, The staff did not re-evaluate the resident (Resident 18) for a new PASSAR on 1/20/25. During a review of the facility's policy and procedure (P&P) titled, Pre-admission SCREENING RESIDENT REVIEW LEVEL 1 (PASRR), dated October 2018, the P&P indicated, VII. The facility MDS Coordinator is responsible to access and ensure updates to the PASRR is done per MDS guidelines.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>Based on interview and record review, the facility failed to ensure one of four sampled residents (Resident 1) care plan was implemented when Resident 1 had a change in condition and the monitoring was not documented in the residents medical record. This failure has the potential for changes in residents status to be missed and delay in proper medical intervention. During a review of Resident 1's Progress Notes dated 7/15/25, the Progress Notes indicated, Resident 1 had a change in condition (CIC) by pulling out his Gastrostomy Tube (G-tube, a feeding tube inserted through the abdominal wall directly into the stomach) during the day shift. The G-tube was reinserted at bedside on 7/15/25 during the p.m. shift. Resident 1 was placed on 72 hour CIC monitoring. Review of Resident 1's Progress Notes dated 7/15 to 7/17/25 indicated, one missing monitoring entry on 7/16/25 and three missing monitoring entries on 7/17/25. During an interview on 8/7/25 at 11:20 a.m. with Assistant Director of Nursing (ADON), ADON confirmed resident monitoring on a change of condition is for 72 hours and should be documented on all three nursing shifts. During a review of the facility's policy and procedure (P&P) titled, Change in a Resident's Condition or Status, dated February 2021, the P&P indicated, The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status.</p>		

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<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assist a resident in gaining access to vision and hearing services.</p> <p>Based on observation, interview, and record review, the facility failed to ensure one of six sampled residents (Resident 28), received proper treatment to maintain their vision. This failure resulted in a decline in Resident 28's vision and had the potential to result in adverse consequences. Findings: During a concurrent observation and interview on 8/4/25 at 9:16 a.m. with Resident 28, Resident 28 was observed squinting, having a difficult time watching TV. Resident 28 stated, I have requested for an eye appointment, but the facility won't get me one. During a review of Resident 28's Minimum Data Set (MDS), a standardized, comprehensive assessments used in nursing homes to evaluate the health, functional, and psychosocial status of residents, dated 11/9/24, the MDS indicated, Section B, vision was adequate. During a review of Resident 28's MDS Quarterly Assessment, dated 7/22/25, the MDS indicated, Section B, vision was moderately impaired. During a review of Resident 28's Order Summary Report, dated 8/7/2025, the Order Summary Report indicated, an Ophthalmologist Consult was ordered on 1/26/25 and another Ophthalmologist Consult was ordered on 8/4/25. There was no evidence in Resident 28's record an ophthalmologist consult was conducted. During an interview on 8/6/25 at 2 p.m. with the social services director (SSD), the SSD stated there was no documentation explaining why the ophthalmology consult for January was not done. During a review of the facility's policy and procedure (P&P) titled, Referrals, Social Services, dated 12/2008, the P&P indicated, Policy Statement: Social Services personnel shall coordinate most referrals with outside agencies . 4. Social services will document the referral in the resident's medical record.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>Based on observation, interview, and record review, the facility failed to ensure the availability of a reserve emergency tracheostomy tube (a curved, hollow tube inserted into the trachea [windpipe] to maintain an open airway) at bedside for one of six sampled residents (Resident 18). This failure had the potential to result in life threatening complications. Findings: During an observation on 8/4/25 at 10:19 a.m. in Resident 18's room, Resident 18 had a tracheostomy tube connected to a ventilator (a device that helps resident(s) breath by forcing air into their lungs when they are unable to do so on their own). On the left side of Resident 18's bed was a cupboard containing the ventilator, suction machine, nebulizer, suction supplies, and spare tracheostomy. However, there was only one spare tracheostomy instead of two. During a concurrent observation and interview on 8/4/25 at 10:40 a.m. with the respiratory therapist (RT 1), at the bedside of Resident 18, RT 1 stated they keep two emergency tracheostomy tubes at bedside (1 smaller size and 1 same size). RT 1 explained in case they have issues inserting the spare trach of the same size, they use a smaller trach. Resident 18 was missing one emergency tracheostomy tube of the same size (Shiley XLT 6.0). RT 1 stated the tracheostomy tubes at bedside are only used for emergencies. If used for any reason, it should be replaced immediately. In this case, someone used the emergency tracheostomy tube without replacing it. During a review of the facility's policy and procedure (P&P) titled, Tracheostomy Tube - Reserve Tube for Emergency Use, dated 5/1/24, the P&P indicated, Policy: The facility will maintain a tracheostomy tube of appropriate size at the bedside of all intubated residents in the case of accidental extubation (removing an endotracheal tube (ETT), decannulation (the process of removing the tracheostomy tube from a patient's neck) or other emergencies . III. Replace the reserve tube with a new one at the time of the monthly, routine tracheostomy or emergency tube change.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that 1. All medications stored in the facility's drug storage areas were available for use and had not expired. 2. Pharmaceutical E-Kits (Emergency Kits containing antibiotics, sedatives, pain medications in limited quantities intended for use when supplies are limited) were replaced after opening. These failures had the potential to affect the efficacy and availability of medications administered to residents. Findings:</p> <p>1. During a review of the facility's policy and procedure (P&P) titled, "Storage of Medications," dated 1/2025, the P&P indicated, "Outdated, contaminated, or deteriorated medications shall be immediately removed from stock";</p> <p>During a concurrent observation and interview on [DATE] at 10:58 a.m. with the Infection Preventionist (IP) in Station 1 Medication Room, storage cabinets and countertop baskets used for storage of medications were observed. The following six items were found to be expired:</p> <ol style="list-style-type: none"> 1. Normal Saline unit doses (sterile single use doses) two boxes expiration date 5/2023. 2. Phosphorus Supplement with Sodium and Potassium (used as a dietary supplement) expired date 7/2024. 3. Valproic Acid (used to treat certain types of seizures) two bottles expired dates [DATE] and [DATE]. 4. Lactulose (synthetic sugar used to treat constipation) one bottle expired date [DATE]. 5. Sucralfate (used to treat ulcers in the intestines) two bottles expired date [DATE]. 6. Mineral Oil (used to treat constipation) one bottle expired date 4/2024. <p>The IP confirmed the medications should have been disposed of per the facility's P&P.</p> <p>During a concurrent observation and interview on [DATE] at 3:37 p.m. with the IP at Medication Cart 1, one box of Bisacodyl (Dulcolax) (a laxative for constipation) was found with an expiration date of 6/2025. The IP confirmed the medication should have been disposed of per the facility's P&P.</p> <p>During a concurrent observation and interview on [DATE] at 3:48 p.m. with the IP at Medication Cart 2, the following two, unused containers were found to be expired:</p> <ol style="list-style-type: none"> 1. Ondansetron (used for nausea and vomiting) expiration date [DATE]. 2. Hyoscyamine (used to control irritable bowel) expiration date [DATE]. <p>The IP confirmed the medications should have been disposed of per the facility's P&P.</p> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. During a review of the facility's P&P titled, "Emergency Pharmacy Services/Emergency Kit," dated 1/2025, the P&P indicated, "Procedures; k. All kits must be replaced within 72 hours of opening;"</p> <p>During a concurrent observation and interview on [DATE] at 11:42 a.m. with Registered Nurse 2 (RN2) in the Medication Storage Room, one of three E-Kits was observed to be open.</p> <p>During a concurrent interview and record review on [DATE] at 11:48 a.m. with the IP and RN2, two billing slips were found inside of the open E-kits. The billing slips were dated [DATE] and [DATE]. RN2 stated, while referencing the electronic health record, that the "pharmacy had been called by the night shift on [DATE]". The IP acknowledged the replacement of the E-kit was beyond the 72 hours as indicated in the facility's P&P.</p> <p>During a concurrent interview and record review on [DATE] at 3:10 p.m. with Licensed Vocational Nurse 1 (LVN1), LVN2, and the IP, the E-kit on Cart 4 had been opened. The billing slip indicated the E-kit had been opened on [DATE] "day shift". LVN1 and LVN 2 stated, "Pharmacy had been called on [DATE] on the night shift". The IP acknowledged the replacement of the E-kit was beyond the 72 hours as indicated in the facility's P&P.</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to provide monthly medication reviews for the months of May, June, and July 2025 for 4 of 19 sampled residents (Residents 7, 101, 2, and 12). This failure has the potential to result in residents having side effects or adverse reactions to medications and the attending physician not to be notified.</p> <p>During a review of Resident 7's "admission Record (AR)," dated 8/5/25, the "AR" indicated, Resident 7 was admitted to the facility on [DATE] with diagnoses including, but not limited to colostomy status (a surgical procedure that creates an opening (stoma) in the colon, bringing it to the surface of the abdomen, to allow for the passage of stool when normal bowel function is disrupted), gastrostomy status (an opening into the stomach from the abdominal wall made surgically for the introduction of food), and neuromuscular dysfunction of the bladder (a condition where the nerves controlling the bladder and urinary sphincter muscles don't function properly).</p> <p>During a concurrent interview and record review, on 8/6/25 at 3:40 p.m. with the Director of Nursing (DON), Residents 7, 2 and 12's medical record was reviewed for evidence of the required monthly drug regimen (MRR) review by a licensed pharmacist. The DON was unable to locate any documentation of an MRR for Residents 7, 2 and 12 for the months of May, June, or July of 2025.</p> <p>During a review of Resident 101's Order Summary Report, dated August 7, 2025, the Order Summary Report indicated Seroquel oral tablet give 12.5 mg by mouth two times a day for Psychosis m/b agitation/hitting, aggression to peers.</p> <p>During a concurrent interview and record review, on 8/6/25 at 4:46 p.m. with the Director of Nursing (DON), Resident 101's medical record was reviewed for evidence of the required monthly drug regimen (MRR) review by a licensed pharmacist. The DON was unable to locate any documentation of an MRR for Resident 101 for the months of May, June, or July of 2025.</p> <p>During a review of the facility's policy and procedure (P&P) titled, "Monthly Drug Regimen Review," dated 1/2025, the P&P indicated, "The consultant pharmacist shall review the medication regimen of each resident at least monthly."</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>Based on observation, interview, and record review, the facility failed to ensure:1. Medications were stored in accordance with manufacturers' storage specifications and/or the facility's policies and procedures (P&P).2. Medication room storage temperatures were continually monitored.These failures had the potential to affect the efficacy and availability of medications administered to residents and alter the delivery of these medications. Findings:</p> <p>1. During a concurrent interview and record review on 8/4/2025 at 11:10 a.m. with the Infection Preventionist (IP), the manufacturers specifications for Bisacodyl (Dulcolax) (laxative used to treat constipation) and Acetaminophen (Tylenol) (pain reliever and fever reducer) suppositories (per rectum) were reviewed. The manufacturer's labels indicated:</p> <p>a. Bisacodyl 10 mg suppositories &ldquo;Store at temperatures below 25 degrees Celsius (C) (77 degrees Fahrenheit (F))&rdquo;;</p> <p>b. Acetaminophen 650 mg suppositories Store at 20-25 degrees C (68-77 degrees F)&rdquo;;</p> <p>The IP confirmed the thermometer hanging on the wall read 80 degrees F, which was warmer than the manufacturer's specifications.</p> <p>During a review of the facility's policy and procedure (P&P) titled, &ldquo;Storage of Medications, &rdquo; dated 1/2025, the P&P indicated, &ldquo;Storage Table: &ldquo;Levabuterol - use within 14 days of opening pouch&rdquo;; &ldquo;Budesonide &ndash; use within 14 days of opening pouch&rdquo;; &ldquo;Albuterol/Ipratropium &ndash; 7 days once removed from foil pack&rdquo;.</p> <p>During a concurrent interview and record review on 8/4/2025 at 3:48 p.m. with the IP, in the Subacute Medication Cart, the facility's P&P titled, Storage of Medications,&rdquo; was reviewed for inhalant medications (medications breathed in) and the manufacturer's specifications on the medication packaging. The following medications had opened foil protective packaging which had not been dated:</p> <p>1. Levalbuterol (used to prevent and treat narrowing of the airways) three boxes</p> <p>&ldquo;Once the foil ouch is opened, the vials should be used within two weeks. Once removed from the foil pouch the individual vials should be used within one week.&rdquo;;</p> <p>2. Budesonide (reducing swelling and inflammation) one box &ldquo;once foil is open, use ampules in two weeks.&rdquo;;</p> <p>3. Ipratropium Bromide and Albuterol (opens up airways in the lungs, making it easier to breathe) inhalation one box &ldquo;&hellip; Once removed from the foil pouch the individual vials should be used within one week&rdquo;.</p> <p>(continued on next page)</p>		

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 08/07/2025
NAME OF PROVIDER OR SUPPLIER Simi Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 5270 East Los Angeles Avenue Simi Valley, CA 93063	
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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The IP reviewed the specifications on the manufacturer packaging and confirmed the medications should have been dated and/or disposed of according to the facility's P&P and manufacturer specifications.</p> <p>2. During a concurrent interview and record review on 8/4/25 at 11:58 a.m. with the IP and the Director of Nursing (DON) the facility's "Daily Room Temperature Monitoring Log," dated April and May 2025 were reviewed. Temperature logs for the months of June, July, and the start of August 2025 were not available. The log indicated, temperatures were only recorded for four days for the month of April and nine days for the month of May.</p> <p>The IP confirmed the missing dates on the temperature monitoring logs and stated the Director of Nursing (DON) may have the missing months for June, July, and the start of August. The DON could not provide the missing temperature monitoring logs.</p> <p>During a review of the facility's policy and procedure (P&P) titled, "Storage of Medications," dated 1/2025, the P&P indicated, "Procedures, j. Medications requiring storage at "room temperature" shall be kept in temperatures ranging for 15 degrees C (59 degrees F) to 30 degrees C (86 degrees F)."</p>		

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<p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.</p> <p>Based on observation, interview, and record review, the facility failed to ensure there was a full time Director of Food and Nutrition Services (DFN) who met the federal and state's education qualification requirements to carry out the functions of the food and nutrition services. In addition, the facility failed to ensure the part-time contracted Registered Dietitian (RD) provided sufficient frequently scheduled consultation to the DFN to include overseeing kitchen sanitation, food preparation, meal service and food storage. This failure that had the potential to place 69 of 69 residents who received meals from the kitchen at an increased risk of foodborne illness and/or unmet nutritional needs. During an interview on 08/4/25 at 9 a.m. with Dietary Aide (DA) in the kitchen, DA stated they had a full-time dietary manager and there was an assistant manager, but both were off today.</p> <p>During an interview on 8/4/25 at 10:29 a.m. with per diem (was on site to help for a limited time) Dietary Services Supervisor (PD-DSS), PD-DSS stated the DFN that had worked at the facility for a year in the role of Dietary Manager (DM) was to take the Certified Dietary Manager (CDM) exam in June 2025 but did not. PD-DSS stated was aware the DM did not meet the federal nor state qualifications to function as the DFN (used interchangeably with DM) responsible for the daily management of foodservice operations. The DM called the facility that morning to quit. PD-DSS stated the facility called her on 8/4/25 to come to the facility to assist the kitchen staff and was not the facility's full time qualified DFN, the facility did not have a full-time RD but instead had a part-time contracted RD.</p> <p>During a telephone interview on 8/5/25 at 12:28 p.m. with RD, RD stated was a contracted RD to work part-time and was aware the DM who had worked at the facility for a year as a DM did not meet the federal or state qualifications as he still needed to take the CDM exam. RD stated the last time she completed oversight of the foodservice operations was in February 2025 that was documented on a form titled, "RD Monthly Kitchen Rounds Checklist (RDKRCL)," dated 2/26/25, in which a copy was provided to the Administrator. RD stated she did not provide sufficient frequently scheduled consultation to the DM to provide effective oversight over foodservice operation systems and did not follow up to ensure deficits noted on the RDKRCL, dated 2/26/25, were addressed to ensure processes were in place for the health and safety of residents. the</p> <p>During a review of "RDKRCL," dated 2/26/25, the RDKRCL indicated, "Menu, zero printed for staff . Check Food Handler exp [expiration] dates, CDM/ServSafe Manager?, zero substitution log found."</p> <p>During an interview on 8/5/25 at 12:54 p.m. with the Administrator (ADN), ADN stated he confirmed the person that had filled the role as DFN (DM) for the past year had not met the federal or state education requirements and was unqualified. ADN stated he had been at the facility for four weeks. ADN stated he had recently been informed by the RD that the last completed "RD Monthly Kitchen Rounds Checklist" was completed in February 2025. ADN stated RD had not provided sufficient frequently scheduled consultation to the DM and verified the person that had been the facility's DM during the past year was unqualified.</p> <p>(continued on next page)</p>		

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<p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 8/5/25 at 1:50 p.m. with Dietary Aide (2) and PD-DSS, DA 2 stated he had been assisting the DM but was not a CDM nor graduated from a state approved DSS (Dietary Services Supervisor) program. DA 2 stated he wanted to take the on-line program to become a CDM. PD-DSS stated DA 2 was a dietary aide.</p> <p>During a review of the facility's policy and procedure (P&P) titled, "Personnel Management," dated 2023, the P&P indicated, "Policy: A qualified FNS Director, chosen by the Administrator, is responsible for the total operation of the Food & Nutrition Services Department. All Food & Nutrition service is performed under their direction. Procedure: If a person is not a Registered Dietitian, they must meet the Federal and State laws and receive regular consultation from a Registered Dietitian or have met equivalent requirements."</p> <p>During a review of the facility's job description (JD) titled, "Position: FNS Director," dated 2018, the JD indicated, "Qualifications: Must meet the qualifications of a FNS Director as stated under State & Federal regulations. Duties and Responsibilities: The supervisor will confer regularly with the Administrator, Director of Nursing, and Dietary Consultant, and keep them informed of both the problems and progress of the Food & Nutrition Service Department. Is responsible for the preparation and service of all food and ensures that approved menus and accompanying recipes are followed. Is responsible for maintaining cleanliness of kitchen equipment and follows all department of health regulations. Review, update and follow policies and procedures."</p> <p>During a review of the facility's "Contractual Agreement (CA)," with the RD, dated 11/1/24, the CA indicated, "Consults with Administration regarding planning, Dietary Department policy development, establishing goals and principles and integrating the Dietary Department into the facility's total program. Supports the Director of Dietary Services in maintaining department standards of food selection, receiving, storage, preparation, and service as needed. Monitors food service operations to ensure conformance to nutritional, safety, sanitation and quality standards, as well as state and federal regulations. Maintains and provides written reports of each consultation visit including data, clinical tasks completed, sanitation inspection reports when completed, comments, goals and/or recommendations."</p>		

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<p>F 0802</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and manufacturer's instructions, the facility failed to have sufficient, competent dietary support staff to ensure sanitation and food safety in the kitchen when: sanitizing solution was not used consistently with the Environmental Protection Agency guidelines. This failure had the potential for the chemical sanitizers to be harmful and toxic to the residents. During a concurrent observation and interview on 8/4/25 at 2:55 p.m. with the Dietary Worker (DW) in the kitchen, DW demonstrated how to test the sanitizing solution located in a red bucket. DW placed a Hydrion QT [quaternary ammonium compound]-10 quaternary test strip into the prepared sanitizing solution located in the red bucket and immediately removed it. When asked about the manufacturer's required immersion time for the strip into the sanitizer solution, DW was unable to state the correct timeframe and stated, Probably right away or 3-4 seconds, or maybe its 5-10 seconds. During a concurrent observation and interview on 8/4/25 at 3 p.m. with Dietary Assistant 2 (DA2), DA2 demonstrated how to prepare a sanitizing solution by filling the red bucket about halfway with water and then pouring an unmeasured amount of [NAME] Chemicals Inc., Sani Tech ammonium chloride out of the 1 gallon (3.785 L) sized container directly into the red bucket. DA 2 did not measure the water temperature nor the quantity of sanitizer which was observed to be filled approximately a quarter way with the concentrated sanitizing solution and the rest of the red bucket was filled with an unmeasured quantity of water. DA 2 proceeded to dip a Hydrion QT-10 testing strip into the sanitizing solution that was just prepared located in the red bucket, immediately removed the testing strip. DA 2 stated the measurement matched the color - coded graph that indicated at least 400 parts per million (ppm) [a unit used to describe very small concentrations of a substance in a larger solution]. The color of the Hydrion QT-10 test strip appeared to be a darker, more concentrated color of green than what was displayed on the Hydrion QT-10 for 400 PPM, however, 400 PPM was the maximum PPM reading on the vial of chemistry strips making it not possible to determine if the concentration exceeded 400 PPM. During an interview on 8/4/25 at 3:10 p.m. with the PD-DSS, the PD-DSS confirmed that DA2 did not follow the manufacturer's guidelines for preparing the sanitizing solution and was likely too concentrated, creating the potential for toxic exposure. During a review of the manufacturer's instructions for the [NAME] Chemicals Inc. Sani Tech quaternary ammonium chloride concentrate used during demonstration by DA 2, the dilution directions indicated, Add 1-2 fluid ounces per 1 gallon of water to obtain 200-400 ppm (parts per million). Dilute the product to achieve 200-400 ppm when mixed in water with up to 650 ppm (parts per million) hardness (CaCO3). During a review of Hydrion QT-10 [which also had a label titled [NAME] Sani Tech] quaternary ammonium manufacture's guideline, the sanitizing testing solution instructions indicated, Dip the strip into the sanitizing solution for 10 seconds, then instantly match the resulting color with the color chart on the package to determine the concentration. The test solution should be between 65- and 75-degrees Fahrenheit. During a review of the FDA Food Code Annex (FDAFCA), dated 2022, the FDAFCA indicated, Chemical sanitizers are included with poisonous or toxic materials because they may be toxic if not used in accordance with requirements listed in the Code of Federal Regulations (CFR). Large concentrations of sanitizer in excess of the CFR requirements can be harmful because residues of the materials remain. It is critical to sanitization that the sanitizers are used consistently with the EPA [Environmental Protection Agency] -registered label.</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>Based on observation, interview, and record review, the facility failed to implement a vegetarian menu planned in advance with evaluation of nutritional adequacy for kitchen staff to follow for two of two sampled residents (Residents 23 and 38) to meet the resident's choices and special dietary needs in accordance with established national guidelines. This failure resulted in a lack of implementation of vegetarian menus with variety, standardized vegetarian recipes and evaluation for nutritional adequacy which had the potential to lead to deficits in some nutrients, vitamins and minerals adversely affecting residents' nutritional and/or medical status. During a concurrent observation and interview on 8/5/25 at 10:25 a.m. with Dietary Aide (DA) in the kitchen, DA was preparing cheese sandwiches with two yellow colored cheese slices. DA stated there was no recipe to follow on how to prepare a cheese sandwich.</p> <p>During an observation on 8/5/25 at 12:16 p.m. in the kitchen during lunch tray, Resident 23's lunch meal tray was observed to have a cheese sandwich with two slices of yellow colored cheese and was located on the meal delivery cart for distribution. Resident 23's meal tray card located on Resident 23's meal tray indicated, "Diet: Regular, NAS [no added salt] & Vegetarian . Devices: No Meats, Dislikes: No meats, Brussel Sprouts, Likes: Veggie Patties, Cheese, Sides ."</p> <p>During a concurrent observation and interview on 8/5/25 at 12:20 p.m. with per diem (was on site to help for a limited time) Dietary Services Supervisor (PD-DSS) in the walk-in refrigerator in the kitchen, a package of Swiss cheese labeled as "1 slice = 3 g [grams] protein [pro]" was observed. PD-DSS stated two slices of Swiss cheese was used for grilled cheese sandwiches (to provide 6 g pro). PD-DSS pointed to a zip lock bag that contained slices of American processed cheese that was no longer in its original package. PD-DSS stated the slices of American processed cheese was from the same manufacturer as the Swiss cheese and was used for the cheese sandwiches.</p> <p>During a telephone interview on 8/5/25 at 12:28 p.m. with Registered Dietitian (RD), the RD stated the facility's diet manual provided guidance to kitchen staff on food items to serve residents who prefer a vegetarian diet.</p> <p>During a review of Resident 23's "Order Summary (OS)," dated 6/10/25, the "OS" indicated, "Diet: NAS [no added salt] diet, regular texture, thin liquids. (vegetarian) three times a day."</p> <p>During a review of Resident 23's "History and Physical (H&P)," dated 6/11/25, the "H&P" indicated, Resident 23 had the mental capacity to understand and make decisions.</p> <p>During an interview on 8/6/25 at 1:45 p.m. with Resident 23, Resident 23 stated she had been a lifelong vegetarian, specifically following a lacto-ovo (consumed dairy and eggs) vegetarian diet. Resident 23 stated her meals at the facility often consisted of grilled cheese sandwiches. Resident 23 stated she was unaware that she could request alternative lacto-ovo vegetarian options. Resident 23 stated the quality of her meals appeared to vary depending on the kitchen staff on duty. For instance, when a certain cook was working, her meals were well-presented with fruit and vegetable sides. In contrast, at other times, the grilled cheese sandwiches were served without any side options.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Simi Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 5270 East Los Angeles Avenue Simi Valley, CA 93063	
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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 38's OS, dated 4/21/25, the OS indicated, "Diet: Fortified (added calories and/or pro) NAS Vegetarian Diet, Regular Texture, Thin Liquids, three times a day."</p> <p>During a review of Resident 38's H&P, dated 4/21/25, the H&P indicated, Resident 38 had the mental capacity to understand and make decisions.</p> <p>During an interview on 8/6/25 at 2 p.m. with Resident 38, Resident 38 stated she had been a vegetarian since 1989. Resident 38 stated she did not consume meat, fish, or chicken but did include eggs and dairy in her diet. Resident 38 stated the quality of her meals varied greatly depending on the cook on duty. Resident 38 stated she often received meals that consisted mostly of high-carbohydrate items such as cheese sandwiches and rice, and on some occasions, the meals lacked balance and variety. Resident 38 stated once she was served lasagna but could not find anyone to confirm whether it was vegetarian, so she skipped the meal. She expressed that she was not fully aware of her options and sometimes felt limited to basic items like peanut butter. Resident 38 stated she often ordered snacks such as fruit cups, pudding cups, popcorn, and cookies from Walmart to supplement her diet.</p> <p>During a concurrent interview and record review on 8/6/25 at 3:30 p.m. with RD and PD-DSS, the manufacturer's nutrition label for the facility's American processed cheese was reviewed. PD-DSS and RD stated the American processed cheese nutrition label indicated 2 slices of cheese together totaled 5 grams of protein and weighed .5 oz [ounce] per slice.</p> <p>During a concurrent interview and record review on 8/6/25 at 3:35 p.m. with RD and PD-DSS, the "Vegetarian Diets (VDs)" guidance from the facility's diet manual, last approved on 1/22/25, was reviewed. The "VDs" indicated, "Provide at meals: Lunch = 2 to 3 oz protein [pro] equivalent . Each food item is listed according to the equivalent of 1 oz. of protein: Cheese 1 oz. " RD stated only one ounce of cheese (combined total ounces of two slices of processed cheese used) was provided in the sandwich which provided only 5 grams of protein and was less than the "VDs" guidance to provide 2 to 3 oz pro per the facility's diet manual. In addition, RD stated the facility did not have, and did not implement, a vegetarian menu planned a week in advance and therefore she was unable to state whether the residents on a vegetarian diet were offered meals that would have met the recommended dietary allowances (RDA's) in accordance with established national guidelines.</p> <p>During a review of the policy and procedure (P&P) titled, "Menu Planning," dated 2023, the P&P indicated, " provides the seasonal menus with corresponding recipes . at least two weeks in advance. The menus are planned to meet nutritional needs of residents in accordance with established national guidelines, Physician's orders and, to the extent medically possible, in accordance with the most recent recommended dietary allowances of the Food and Nutrition Board of the National Research Council National Academy of Sciences. Menus are to be approved by the Facility Registered Dietitian prior to the beginning of each quarterly menu cycle, The menus are written as a four-week cycle, providing three meals per day. The menus provide a variety of foods in adequate amount each meal, Menus are planned to consider the religious, cultural, and ethnic needs of the resident population, as well as input received from residents . The facility's diet manual and the diets ordered by the physician should mirror the nutritional care provided by the facility."</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Simi Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 5270 East Los Angeles Avenue Simi Valley, CA 93063	
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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's diet manual (DM) titled, "Vegetarian & Vegan Diet," dated 2020, the "DM" indicated, "Description: The Academy of Nutrition & Dietetics recognizes that well planned vegetarian & vegan diets are consistent with good nutritional status. A careful diet history is needed to ensure healthy food practices and the correct type of vegetarian diet. Diet orders need to clarify the correct category . There are four general categories of adequate vegetarian diets: Vegans: Excluded are all animal products, Lacto-ovo-vegetarians use dairy products and eggs, Lacto-vegetarians use dairy items but not eggs and Semi-vegetarians consume some groups of animal foods but not all of them. Red meat is usually excluded."</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p>Based on observation, interview, and record review, the facility failed to provide a vegetarian alternate meal of similar nutritive value for one of one sampled resident (Resident 23) who received a cheese sandwich that provided 5 grams of protein versus the planned main entree of Hawaiian chicken provided approximately 21 grams of protein. Facility failure to have standardized vegetarian recipes and planned vegetarian alternatives to ensure nutritional adequacy placed residents who chose vegetarian diets at risk of decreased nutrient intake, decreased variety of choices and diminished quality of life. During a concurrent observation and interview on 8/5/25 at 10:25 a.m. with Dietary Aide (DA) in the kitchen, DA was preparing cheese sandwiches with two yellow colored cheese slices per sandwich. DA stated there was no recipe to follow to instruct on how to prepare the cheese sandwich.</p> <p>During an observation on 8/5/25 at 12:16 p.m. in the kitchen during lunch tray, Resident 23's lunch meal tray was observed to have a cheese sandwich with two slices of yellow colored cheese, and sides that were also on the planned menu for the regular, non-vegetarian diet consisting of rice pilaf, Asian vegetables and aloha fruit salad which was located on the meal delivery cart for distribution. Resident 23's meal tray card located on Resident 23's meal tray indicated, "Diet: Regular [texture], NAS [no added salt] & Vegetarian . Devices: No Meats, Dislikes: No meats, Brussel Sprouts, Likes: Veggie Patties, Cheese, Sides ."</p> <p>During a concurrent interview and record review on 8/6/25 at 3:30 p.m. with RD and per diem (limited time on site) Dietary Services Supervisor (PD-DSS), the manufacturer's nutrition label for the facility's American processed cheese was reviewed. PD-DSS and RD stated the American processed cheese nutrition label indicated one slice of cheese weighed .5 ounce and 2 slices of cheese totaled 1 ounce of cheese that provided 5 grams of protein.</p> <p>During a concurrent interview and record review on 8/6/25 at 3:35 p.m. with RD and PD-DSS, the "Vegetarian Diets (VDs)" guidance from the facility's diet manual (DM), last approved on 1/22/25, was reviewed. The "VDs" indicated, "Provide at meals: Lunch = 2 to 3 oz protein [pro] equivalent." The RD stated the VDs guidance from the facility's DM was not followed.</p> <p>During a concurrent interview and record review on 8/6/25 at 3:40 p.m. with RD and PD-DSS, the recipe titled "Hawaiian Flair Chicken," dated 2024, was reviewed. The recipe indicated, "Portion Size: 3 oz meat (3 oz protein)." RD stated one oz of meat was equivalent to 7 grams (g) of protein (pro), so the planned lunch main entree recipe directed the cook to serve 3 oz. of Hawaiian chicken which provided approximately 21 g of pro versus the cheese sandwich provided to Resident 23 as the main entree provided 5 g of pro and were not of similar nutritive value. RD and PD-DSS stated the facility did not have vegetarian menus and/or alternates planned in advance that were analyzed for nutritional adequacy, nor had vegetarian alternative standardized recipes to ensure resident's vegetarian food choices would be honored to meet their nutritional needs as they did for regular, non-vegetarian diet orders. RD and PD-DSS were unaware of the "Vegan" directions located on the bottom of the "Recipe: Hawaiian Flair Chicken," dated 2024, that indicated, "Prepare with cubed tofu in place of chicken. Use vegan sugar." That option was not prepared and available to residents as a choice for a vegetarian alternative for the lunch meal.</p> <p>(continued on next page)</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's policy and procedure (P&P) titled, "Food Substitutions for Residents Who Refuse The Meal," dated 2018, the P&P indicated, "Policy: Residents will be provided a suitable nourishing alternate meal after the planned, served meal has been refused."</p> <p>During a review of the facility's P&P titled, "Food Preparation," dated 2018, the P&P indicated, "Policy: Food shall be prepared by methods that conserve nutritive value, flavor and appearance. Procedure: The facility will use approved recipes, standardized to meet the resident census [an official count or survey of a population, typically recording various details of individuals]."</p>

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NAME OF PROVIDER OR SUPPLIER Simi Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 5270 East Los Angeles Avenue Simi Valley, CA 93063	

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Based on observation, interview, and record review, the facility failed to ensure sanitation and food safety in the kitchen when: 1. Multiple opened and prepared food items were unlabeled or undated in the reach-in-freezer, walk-in refrigerator and dry storage areas. 2. The walk-in refrigerator and dry storage room were not maintained in clean and sanitary condition, as evidenced by cracked fixtures, holes in the ceiling, debris on the floor and shelving, dust built up on fans and pipes, and visible black residue on walls. 3. Clean food service equipment was not handled and stored in a sanitary manner as evidenced by designating visibly soiled equipment as clean and handling clean rack of dishes with unwashed hands. These deficient practices had the potential to contribute to environmental cross-contamination, promote bacterial growth and lead to foodborne illness, thus placing 69 of 69 residents who consume facility prepared meals at risk. Findings: 1. During a concurrent observation and interview on 8/4/25 at 9:06 a.m. with the Dietary Aide (DA), a cardboard box of frozen broccoli in a blue plastic bag located in the reach-in freezer was not dated as to when opened. The DA stated an open date should be on the bag containing the broccoli, but it was missing. During a concurrent observation and interview on 8/4/25 at 9:07 a.m. with the DA, a box of opened, frozen diced carrots had a handwritten date of 7/30/25 on the cardboard. DA stated 7/30/25 was the date received at the facility when the box of frozen carrots was unopened. DA stated the bag of frozen carrots should have been dated once opened and was not. During a concurrent observation and interview on 8/4/25 at 9:42 a.m. with the DA, multiple cases of Mighty Shakes that contained individual sized Mighty Shakes, dated 7/31/25 were stored in the walk-in refrigerator. DA stated the date on the case, 7/31/25 was the received date to the facility in which the cases were placed in the freezer. There was no date indicating when the box that stored individual sized of unopened Mighty Shakes was placed in the refrigerator to begin thawing. DA stated the thaw process should have a date once begun to ensure the manufacturer's guidelines were followed that indicated the product must be consumed within 14 days of thawing. In this case, the thawing time had not exceeded the manufacturer's guidelines, however, without a dating mechanism in place there was potential for this to occur in the future and DA stated staff need to date the case of frozen Mighty Shakes once placed in the refrigerator. During a concurrent observation and interview on 8/4/25 at 9:48 a.m. with Dishwasher (DW 2), in the smaller chamber of the walk-in refrigerator, an 8-quart food container with a red lid containing a liquid substance at the 2-quart level, was missing a label. Yellow colored residue was noted on various parts of the container, particularly around the 5.5-liter or 6-quart markings. DW 2 stated the container stored chicken broth, and it should have been dated and was not. During a review of facility's policy and procedure (P&P) titled, Procedure for Freezer Storage, dated 2018, the P&P indicated, All frozen foods should be labeled and dated. During a review of facility's P&P titled, Labeling and Dating of Foods, dated 2020, the P&P indicated, All food items in the storeroom, refrigerator, and freezer need to be labeled and dated. Food delivered to the facility needs to be marked with a received date. Newly opened food items will need to be closed and labeled with an open date and use by date. All prepared foods need to be covered, labeled and dated. Leftovers will be covered, labeled and dated. 2. During a concurrent observation and interview on 8/4/25 at 9:15 a.m. with [NAME] 2 and DA, cracks were noted on the light fixture inside the dry storage room. In addition, several holes were observed on the ceiling next to the light fixture, as well as debris (some yellow in color) were seen scattered on the floor next to the food shelves. [NAME] 2 and DA confirmed and acknowledged the overall unkemptness of the dry storage room. During a concurrent observation and interview on 8/4/25 at 9:22 a.m. with [NAME] 2, in the dry storage room, a 22-quart (qt) sized bin containing cheerios filled to 16 qt was not dated. DW 2 stated the bin that stored cheerios should have been dated and was not. The lid of the bin had debris on it. [NAME] 2 removed the lid, examined it closely and stated, The lid needs to be scrubbed. During an observation on 8/4/25 at 9:32 a.m., the walk-in refrigerator had loaves of bread in original bags stored in close proximity under the ceiling pipes. The pipes were wrapped in black tape, with dust buildup observed around the fans and scattered on walls and ceiling. During a concurrent observation and interview on 8/4/25 at 9:35 a.m. with [NAME] 2, paint chipping and a black substance were noted on the wall behind milk racks. In addition, extensive buildup of dust along the walls and dark colored spots on the floor were observed within the walk-in refrigerator. [NAME] 2 scraped some residue off the wall and a visible black colored substance was noted on the tip of her fingernail she used to scrape with. [NAME] 2 acknowledged the overall lack of cleanliness. During a review of facility's P&P titled, Walls, Ceilings, and Light Fixtures, dated 2023, the P&P indicated, 1. Walls and ceilings must be free of chipped and/or peeling</p>		

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<p>F 0825</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or get specialized rehabilitative services as required for a resident.</p> <p>(continued on next page)</p>

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<p>F 0825</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide physical and occupational therapy for one of one sampled resident (Resident 101). This failure resulted in Resident 101 not receiving therapy and had the potential for the resident to not achieve their highest practicable level of function. Findings: During an interview on 8/5/2025 at 12:32 p.m. with Resident 101's family member (FM), the FM stated a Physical Therapy (PT) referral was done months ago but the insurance company stated they do not have any request. Resident 101's FM stated Resident 101 is not currently receiving PT or Occupational Therapy (OT). FM stated this issue has been brought up numerous times and she was told it was an insurance issue. FM states PT/OT will not work with Resident 101 because of the insurance issue. FM stated that the goal is to get Resident 101 strong enough to use a commode so the FM can take her home. During a record review of Resident 101's Progress Notes, dated [DATE], the Progress Notes indicated Diagnosis: Traumatic Brain Injury (brain dysfunction caused by an outside force), Anxiety Disorder, Unilateral Contusion of Lung (Bruising of the lung caused by an outside force), Traumatic Pneumothorax (Condition there air leaks into the space between the lung and the chest wall), Fracture of the lower end of right tibia (bone in the lower leg) , fracture of the right fibula (bone in the lower leg), and acute respiratory failure (occurs when the lungs cant properly exchange oxygen). Resident 101 arrived to facility 12/16/24 after sustaining a motor vehicle accident and sustaining a traumatic brain injury. Resident 101 was admitted to the skilled nursing unit at that time was dependent on a ventilator for breathing and a gastrointestinal tube for nutrition. Resident 101 is now able to breath on her own, no longer dependent on a ventilator for breathing and is able to eat and feed herself. Resident 101's g-tube was removed in March of 2025. During an interview on 8/5/25 at 12:15 p.m. with Physical Therapy Aid (PTA) and Occupational Therapy Aid (OTA), PTA stated Resident 101 is not receiving PT or OT at this time. OTA stated that in March Resident 101 was switched to the Restorative Nurse Assistant (RNA - focused on helping residents in long-term care facilities regain or maintain their functional abilities) program and the resident was fitted for splints for the nurses and family to place on Resident 101 daily. PTA stated that without the PT authorization Resident 101 cannot have PT services. PTA stated that Resident 101 will not improve without physical therapy. During a review of Resident 101's Order Summary Report, dated Aug. 7, 2025, the Order Summary Report indicated, an order dated 3/13/25 for OT QD 3x/wk x4wks (3 times a week for 4 weeks) for NMR, Therex (therapeutic exercise), ADL (Activities of Daily Living) training, splinting management. During a record review of the facility's document PT Evaluation & Plan of Treatment dated 3/13/25, the PT Evaluation & Plan of Treatment indicated in part Skilled PT services is indicated in order to maximize potential in reaching highest level of mobility and reduce burden of caregiver. Review of PT Evaluation & Plan of Treatment indicated Plan of Treatment Frequency: 3 time(s)/week Duration: 4 week(s). Potential for Achieving Rehab Goals: Patient demonstrates good rehab potential as evidenced by ability to follow multiple step directions. During an interview on 8/6/2025 at 8:42 a. m. with the Business Office Manager (BO), BO stated that on 3/20/25 the first request was placed with the insurance company for physical therapy authorization for services. BO stated a follow up was placed on 4/22/25 and the request is still pending. BO stated the wrong Current Procedural Terminology (CPT) code was approved in April by the insurance company and there has been no follow-up with the insurance company. BO stated that there should have been follow-up in April or May but she had not done so. Resident 101 has not received physical therapy because of this insurance issue. BO stated that Resident 101's condition could deteriorate because of the lack of physical therapy because it is not authorized by the insurance company. During a review of the facility's policy and procedure (P&P) titled, Physical Therapy or Occupational Therapy, [undated], the P&P indicated, Duties: Accurately screens, evaluates and treats patients; assures that patients admitted for treatment receive the needed therapy services and assures that services rendered are appropriately documented in the medical records.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure resident medical records were accurate and complete by not having a physician order for code status in place for 2 of 19 sampled residents, (Residents 7 and 2). This facility failure had the potential to result in residents receiving treatment inconsistent with their expressed wishes, including unwanted resuscitation in the event of cardiopulmonary arrest (heart suddenly stops pumping blood effectively, leading to a loss of consciousness and breathing). During a review of the facility's policy and procedure (P&P) titled, "Physician Orders for Life Sustaining Treatment (POLST), dated 9/2018, the P&P indicated, "If Do Not Attempt Resuscitation" is indicated on the POLST form, the licensed Nurse will write the order to support the Resident's wishes."</p> <p>During a review of Resident 7's "admission Record (AR)," dated 8/5/25, the "AR" indicated, Resident 7 was admitted to the facility on [DATE] with diagnoses including, but not limited to, vascular dementia (memory loss in adult), left femoral neck fracture (a break in the bone of the upper thigh, near hip joint) and acute respiratory failure with hypoxia (not enough oxygen in the blood).</p> <p>During a review of Resident 7's "POLST" dated 4/14/25, the POLTS indicated, "Do Not Attempt Resuscitation (allow natural death)."</p> <p>During a concurrent interview and record review on 8/4/25 at 12:14 p.m. with the Director of Nursing (DON), Resident 7's medical record was reviewed. The DON acknowledged there was no physician order for Do Not Resuscitate (DNR) and further stated that the DNR order should be entered in the electronic health records, (Point Click Care system).</p> <p>During a review of Resident 2's AR," dated 8/6/25, the "AR" indicated, Resident 7's original admission date to the facility was 6/18/20.</p> <p>During a review of Resident 2's "POLST" dated 10/25/24, the POLST indicated, "Do Not Attempt Resuscitation (allow natural death)."</p> <p>During a concurrent interview and record review on 8/6/25 at 3:10 p.m. with DON, Resident 2's medical record was reviewed. The DON acknowledged there was no physician order for Do Not Resuscitate and further stated that the DNR order should be entered in the electronic health records.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the observance of proper infection control practices for five of six sampled residents (Residents 5, 6, 18, 20, and 54) and 12 unsampled residents (Residents 16, 21, 27, 39, 45, 48, 53, 74, 80, 92, 95, 100, and 106). This failure had the potential to result in infectious outbreaks compromising the health, safety and welfare of residents, visitors, staff and the public. Findings:</p> <p>During an initial tour observation on 8/4/25, starting at 9:16 a.m., the following were noted:</p> <p>Resident 5 - Nebulizer plastic storage bag undated.</p> <p>Resident 6 &ndash; Nebulizer plastic storage bag undated.</p> <p>Resident 16 &ndash; Nebulizer plastic storage bag undated.</p> <p>Resident 18 &ndash; Nebulizer tubing and plastic storage bag undated.</p> <p>Resident 20 - Nebulizer tubing had no date. The plastic storage for nebulizer was dated 7/16/25. Yankauer (a rigid suction device) was undated, the plastic storage bag was dated 7/16/25.</p> <p>Resident 21 - Nebulizer plastic storage bag undated.</p> <p>Resident 27 - Urinary catheter bag undated.</p> <p>Resident 45 - Nebulizer tubing and plastic storage bag undated.</p> <p>Resident 48 &ndash; No date on urine bag.</p> <p>Resident 53 - Nebulizer plastic storage bag undated.</p> <p>Resident 54 - Nebulizer tubing and plastic storage bag undated.</p> <p>Resident 74 - Nebulizer plastic storage bag undated.</p> <p>Resident 80 - Nebulizer plastic storage bag undated.</p> <p>Resident 92 - Nebulizer plastic storage bag undated.</p> <p>Resident 95 - Nebulizer plastic storage bag undated.</p> <p>Resident 100 - Nebulizer plastic storage bag undated.</p> <p>Resident 106 - Suction cannister undated.</p> <p>During an interview on 8/4/25 at 10:40 a.m. with the respiratory therapist (RT), the RT concurred that everything should be labeled indicating the date it was changed.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility's policy and procedure (P&P) titled, Disposable Circuits and Supply Change, dated 5/1/24, the P&P indicated in part, "B. xii. Label the new circuits with date of change;" and "II. P. Label with date of change;".</p> <p>During a review of Resident 39's Physician Active Orders ([NAME]), dated 8/5/25, the [NAME] indicated, "Enhanced Barrier - precautions due to foley catheter, g-tube every shift ensure all staff wear proper PPE (Personal Protective Equipment- refers to specialized clothing and gear worn by healthcare professionals to minimize exposure to infectious materials, body fluids, and other hazards) when performing high contact activities.</p> <p>During a concurrent observation and interview on 8/4/25 at 11:19 a.m. with Resident 39, in the resident's room, a gastrostomy tube feeding and a urinary catheter were observed. There was no enhanced barrier precautions signage posted outside Resident 39's room and no PPE was available inside or outside the room. Resident 39 stated that she has had a colostomy on right upper abdomen, G-tube, and urinary catheter since admission to the facility.</p> <p>During a concurrent observation and interview on 8/5/25 10:56 a.m. with the Infection Preventionist (IP) in Resident 39's room, the IP stated that he was not sure of why Resident 39 was not on enhanced barrier precautions (EBP), and confirmed that there was an physician order for it. IP further stated that he will make sure that there's a PPE cart in Residents 39 room. IP was then observed placing the EBP signage outside the room.</p> <p>During a review of the facility's P&P titled, Multidrug - Resistant Organism, dated 8/2019, the P&P indicated, "Because environment surfaces and medical equipment, especially those in close proximity to the resident, may be contaminated, don gowns and gloves before or upon entry to the resident's room or cubicle.</p> <p>During a review of the facility's P&P titled, Personal Protective Equipment, dated 2018, the P&P indicated, "PPE required for transmission-based precautions is maintained outside and inside the resident's room, as needed.</p>		

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<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>Based on observation, interview, and record review, the facility failed to ensure call lights were within reach for 2 of 19 sampled residents (Residents 7 and Resident 2). This failure prevented residents from calling for assistance and had the potential for delays in receiving needed care. During a review of the facility's policy and procedure (P&P) titled, Answering the Call Light, dated 10/20, the P&P indicated, The purpose of this policy is to respond to the resident's requests and needs. When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident.</p> <p>During an observation on 8/4/25 at 10:10 a.m. Resident 7 was observed lying in bed with the call light clipped and secured near the electrical outlet, out of reach of Resident 7.</p> <p>During a concurrent observation and interview on 8/4/25 at 10:18 a.m. with Director of Nursing (DON), Resident 7's call light remained clipped and secured near the electrical outlet and out of reach of Resident 7. DON confirmed the call light was out of reach, then unclipped it and placed it on Resident 7's bed.</p> <p>During an observation on 8/4/25 at 10:24 a.m. Resident 2 was observed sleeping in bed, the call light was on the floor behind the bed and out of reach of Resident.</p> <p>During a concurrent observation and interview on 8/4/25 at 10:30 a.m. with DON, Resident 2's call light remained on the floor. DON placed Resident 2's call light next to the resident within reach and confirmed the call light should be accessible to the resident at all times in bed.</p>