

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555875	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/18/2024
NAME OF PROVIDER OR SUPPLIER  Channel Islands Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  3880 via Lucero Santa Barbara, CA 93110	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37886</b></p> <p>Based on record review and interview, the facility failed to ensure that one of the three sampled residents (Resident 1) was treated with respect and dignity when Resident 1's personal belongings were relocated to another room.</p> <p>This failure created a situation whereby resident1's right to retain and use personal possessions was prevented.</p> <p>Findings:</p> <p>During a review of Resident 1's (R1) Clinical Record (CR) on 7/11/24 at 11:30 AM. The CR revealed Resident 1 was admitted to the facility on [DATE] with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD - lung disease that causes obstructed air flow from the lungs), Congestive Heart Failure (CHF - heart's capacity to pump blood can't keep up with the body's need), pneumonia (infection of the lungs).</p> <p>During a review of Resident 1's inventory of personal effects (IPE-belonging list), dated 6/10/24, the IPE indicated, R1's personal items included cell phone/cord/charger and reading glasses.</p> <p>During a review of Resident 1's Nursing Progress Notes (NPN) dated 6/15/24, the NPN indicated, .Resident had episode of agitation and made verbal accusations towards staff . Resident stated that his phone was taken away from him. However, staff later found his phone in another room with the eyeglasses, charger but phone was returned to the resident .</p> <p>During an interview with a licensed nurse (RN1) on 7/11/24 at 1:13 PM, RN1 confirmed that Resident 1 had complained about his missing items. However, there was some miscommunication that night due to Resident 1 being initially COVID positive but night shift staff were not aware the resident was done with the ten days isolation protocol. The Certified Nursing Assitant (CNA) transferred his stuff to another room. Which was later found and returned to Resident 1's room.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled Resident Rights, the P&amp;P indicated, It is the policy of this facility that all resident rights be followed per State and Federal guidelines . The Resident has the right to keep and use personal . possessions in the nursing center as space permits unless doing so would infringe upon the rights or safety of other residents .</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 555875
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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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 37886</p> <p>Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person focused care plan for one of the three sampled residents(Resident 1) when activities of daily living (ADL) self-care deficit nursing needs were not addressed.</p> <p>This failure placed Resident 1 at risk of not having care needs met secondary to no plan in place.</p> <p>Findings:</p> <p>During a review of Resident 1's (R1) Clinical Record (CR) on 7/11/24 at 11:30 AM. The CR revealed Resident 1 was admitted to the facility on [DATE] with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD - lung disease that causes obstructed air flow from the lungs), Congestive Heart Failure (CHF - heart's capacity to pump blood can't keep up with the body's need), pneumonia (infection of the lungs).</p> <p>During a review of Resident 1's Comprehensive Care Plan (CP) dated 6/10/24, CP indicated, Resident1 had ADL self-care deficit related to .muscle weakness, unsteady gait .CHF ., with interventions, Resident 1 requires staff assistance to wash hands, adjust clothing, clean self, transfer onto toilet, transfer off toilet, and to use toilet.</p> <p>During a review of Resident 1 ' s admission Minimum Data Sheet (MDS - an assessment tool), dated 6/16/24, the MDS indicated that R1 has moderate cognitive impairment; continence of both bowel and bladder; and R1 required one person ' s assistance to complete his ADLs such as toileting.</p> <p>During a review of the facility ' s policy and procedure (P&amp;P) titled Care Planning revised 11/2023, the P&amp;P indicated, It is the policy of this facility that the interdisciplinary team (IDT) shall . implement a comprehensive person-centered care plan for each resident, consistent with the resident ' s rights, that includes measurable objectives and timeframes to meet a resident ' s medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37886</b></p> <p>Based on record review and interview, the facility failed to ensure that one (Resident 1) of the three sampled residents received services (bathroom help) to maintain grooming and personal hygiene. Resident 1 was not assisted to the availability of a urinal ( bedside portable plastic receptable for male urine) for over an hour after requesting assistance with toileting and ended up wetting/urinating on self.</p> <p>This failure had the potential to weaken resident 1 ' s bladder muscles and could raise risk of moisture associated skin damage (MASD) if exposed to various body wastes and fluids over an extended period of time.</p> <p>Findings:</p> <p>During a review of the facility policy and procedure (P&amp;P) titled ADL, Services to carry out reviewed 1/2024, the P&amp;P indicated, .Residents who are unable to carry out activities of daily living will receive necessary services, on a daily and as needed basis, to maintain . grooming and personal hygiene .</p> <p>During a review of the complaint report [Number], received 7/3/24, the report indicated, .Resident 1 (R1) was concerned that when he needed assistance by the staff that they would not listen to him. R1 provided the reporter [Name] with examples of how he was not being listened to such as his mattress being uncomfortable, not getting his toothbrush for him to brush his teeth in a timely manner, the television not working, not getting his urinal bottle for over an hour causing him to urinate on himself, staff would not follow through with his requests when they would respond to his room or be upset that he was requesting for assistance .</p> <p>During a review of Resident 1 ' s (R1) closed Clinical Record (CR) on 7/11/24 at 11:30 AM. The CR revealed R1 had been admitted to the facility on [DATE] for post-acute (hospital) care therapy, with diagnoses including, but not limited to, chronic obstructive pulmonary disease (COPD - lung disease that causes obstructed air flow from the lungs), congestive heart failure (CHF - heart ' s capacity to pump blood can ' t keep up with the body ' s need), pneumonia (infection of the lungs), muscle weakness, unsteadiness on feet, and need assistance with personal care. R1 had been discharged home on 6/21/24.</p> <p>During a review of R1 ' s admission Minimum Data Sheet (MDS - an assessment tool), dated 6/16/24, the MDS indicated that R1 has moderate cognitive impairment; no behaviors; continence of both bowel and bladder; and the resident required one person ' s assistance to complete his ADLs such as toileting.</p> <p>During a review of R1 ' s care plan (CP), initiated 6/10/24, the CP indicated, R1 had ADL self-care deficit related to .muscle weakness, unsteady gait .CHF ., with interventions including but not limited to, R1 requires staff assistance to wash hands, adjust clothing, clean self, transfer onto toilet, transfer off toilet, and to use toilet. R1 had actual impairment to skin integrity related to coccyx deep tissue injury (DTI) with intervention including but not limited to, keep body parts from excessive moisture.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 7/11/24 at 11:41 AM with Resident 2 (R2) in his room [Room number]. R2 was asked regarding request for ADLs assistance, staff response and wait times. R2 stated, call lights wait times on the average is 15 minutes or more. So, I just do it. They are busy.</p> <p>During an interview with Resident 3 (R3) in front of his room [Room number] on 7/11/24 at 2:19 PM. When asked about the staff 's response to his call for assistance and wait times. R3 verbalized, I had to wait 20 minutes before the staff responded, sometimes longer. I wish it was quicker. I waited a long time for my pain medication; it happened twice.</p>		