STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555875	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Channel Islands Post Acute	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)
F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 41493 Based on interview, record review, and facility policy review, the facility failed to ensure residents with a positive Level I Preadmission Screening and Resident Review (PASRR) received a Level II evaluation. Specifically, after the cases for 2 (Resident #80 and Resident #5) of 5 residents reviewed for PASRR requirements were closed, the facility failed to resubmit Level I PASRRs to reopen the cases as directed by the Department of Health Care Services to ensure Level II evaluations were completed. Findings Included: A facility policy titled, PASRR, reviewed in 01/2024, revealed, It is the policy of this facility to ensure that each resident is properly screened using the PASRR specified by the State. 1. An Admission Record revealed the facility originally admitted Resident #80 on 01/24/2012 and readmitted the resident on 12/24/2022. According to the Admission Record, the resident had a medical history that included diagnoses of bipolar disorder, major depressive disorder, anxiety disorder, post-traumatic stress disorder (PTSD), and paranoid schizophrenia. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/22/2024, revealed Resident #80 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. The MDS indicated Resident #80 had active diagnoses that included non-Alzheimer's dementia, anxiety disorder, depression, bipolar disorder, and PTSD. Resident #80's care plan included a Focus area, revised on 12/30/2022, that indicated the resident was at risk for impaired cognitive function or impaired thought processes related to Parkinson's disease, dementia, bipolar disorder, schizophrenia , anxiety, depression, and PTSD. Resident #80's care plan also included a Focus area, revised on 10/28/2023, that indicated the resident had episodes of talking to their self, screaming, yelling, and cursing at others when passing by in the hallway. Resident #80's Order Summary Report, listing active orders as of 05/02/2024, revealed the following orders: - fluoxetine hydrochloride (an antidepressant) tablet 10 milligrams (mg), five tablets by mouth in the morning for depression with melancholy, with a start date of 05/02/2023; (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- haloperidol decanoate (an antipsychotic) 50 mg/milliliters (ml), inject 50 mg intramuscularly one time a day every one month starting on the fifteenth for one day for bipolar disorder with manic symptoms of increased agitation and aggressiveness, with a start date of 08/15/2023; - haloperidol tablet 10 mg, one tablet by mouth two times a day for paranoid schizophrenia, with a start date of 04/19/2024; - clonazepam (a benzodiazepine) tablet 0.5 mg, one and a half tablets by mouth in the morning for anxiety, with a start date of 03/20/2024; and - clonazepam tablet 1 mg, one tablet by mouth at bedtime for anxiety, with a start date of 03/29/2024. Resident #80's PASRR Level II letter from the state Department of Health Care Services, dated 01/06/2023, indicated that the previous Level I screening was completed on 12/29/2022. The letter indicated that the resident had a positive Level I screening, but the Level II evaluation was not scheduled due to the resident being isolated as a health or safety precaution. The letter indicated that the case was closed and instructed the facility to submit a new Level I to reopen the case. During an interview on 04/30/2024 at 12:52 PM, the Director of Nursing (DON) revealed he was in charge of PASRR screenings and was not sure why the evaluating agency indicated that the resident was unable to participate in the evaluation as they could have participated by phone. He stated that he did not look at the reason the evaluation was not completed. The DON stated he was not aware that a new Level I should have been completed after the Level II evaluation was closed. 2. An Admission Record revealed the facility admitted Resident #5 on 08/31/2011. According to the Admission Record, the resident had a medical history that included diagnoses of bipolar disorder, major depressive disorder, anxiety disorder, hydrocephalus (a build-up of fluid in the brain), traumatic brain injury, and schizoaffective disorder. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/21/2024, revealed Resident #5 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated that the resident was cognitively intact. The MDS indicated Resident #5 had active diagnoses that included anxiety disorder, depression, bipolar disorder, psychotic disorder, and schizophrenia. Resident #5's care plan included a Focus area, initiated on 08/20/2020, that revealed the resident was at risk for impaired cognitive function or impaired thought process related to psychotropic drug use, a history of traumatic brain injury, schizoaffective disorder, anxiety disorder, and bipolar disorder. Resident #5's care plan also included a Focus area, revised on 10/27/2022, that indicated the resident had schizoaffective disorder with aggressive statements and tendencies toward others. Resident #5's Order Summary Report, listing active orders as of 05/02/2024, revealed an active order for aripiprazole (an antipsychotic) oral tablet, 2 milligrams (mg) by mouth one time a day for schizoaffective disorder for aggressive statements and tendency towards others, with a start date 03/22/2024. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #5's PASRR Level II letter from the state Department of Health Care Services, dated 08/07/2023, indicated that the previous Level I screening was completed on 07/27/2023. The letter indicated that the resident had a positive Level I screening, but the Level II evaluation was not scheduled due to the resident being unable to participate in the Evaluation. The letter indicated that the case was closed and instructed the facility to submit a new Level I screening to reopen the case. During an interview on 04/30/2024 at 12:52 PM, the Director of Nursing (DON) revealed that he was in charge of the facility's PASRR process. He stated that he was not sure why the evaluating agency indicated that the resident was unable to participate in the Level II evaluation. He stated that he did not look at the reason the evaluation was not completed. Per the DON, he was not aware that a new Level I should have been completed after the Level II evaluation was closed.

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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. 45714 Based on observation, interview, record review, and facility document and policy review, the facility failed to ensure the residents' environment remained as free of accident hazards as possible when unsecured medications were observed in residents' rooms without staff present. This deficient practice affected 1 (Resident #33) of 3 sampled residents reviewed for accidents and 1 (Resident #65) of 2 sampled residents reviewed for choices. Findings included: A facility policy titled, Medication Administration-General, revised in 11/2023, revealed, 9. The person administering medication must remain with the resident until all medication has been swallowed. A facility policy titled, Accident Prevention and Intervention, revised in 11/2023, revealed, It is the policy of this facility that the resident environment remains as free of accident hazards as is possible and that each resident receives adequate supervision and assistance devices to prevent accidents. A facility policy titled, Storage of Medications, revised in 11/2023 , indicated, It is the policy of this facility that all medications and biologicals are stored in a safe, secure, and orderly manner. The policy indicated, 1. Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity controls. Only persons authorized to prepare and administer medications have access to locked medications. A document provided by the facility, dated 05/02/2024, revealed the facility identified four residents in the facility that wandered . 1. An Admission Record revealed the facility admitted Resident #33 on 09/27/2017 and readmitted the resident on 02/08/2024. According to the Admission Record, the resident had a medical history that included diagnoses of type two diabetes mellitus, gastro-esophageal reflux disease, and protein-calorie malnutrition. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/05/2024, revealed Resident #33 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident was cognitively intact. Resident #33's care plan revealed no care plan focus areas or interventions related to self-administration of medications. A review of Resident #33's medical record revealed no evidence the resident had been assessed to self-administer their medications. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #33's Order Summary Report, listing active orders as of 04/29/2024, contained an order, dated 03/14/2024, for Protonix delayed release (an acid suppressing medication) 20 milligrams (mg) by mouth daily. The Order Summary Report also contained an order, dated 04/11/2024, for Synjardy (a diabetic medication) 5-1000 mg by mouth twice daily. The Order Summary Report did not reflect an order for the resident to self-administer their medications. During an observation and interview on 04/29/2024 at 9:46 AM, Resident #33 was observed in bed, and two medications in two different medication cups were on the resident's bedside table. Resident #33 stated that the medications were for their stomach and diabetes. Resident #33 stated the nurse brought the medications to their room and left. The resident stated they would take the medications when they were ready to take them. During an observation and interview on 04/29/2024 at 9:50 AM, Licensed Vocational Nurse (LVN) #2 observed the two pills at Resident #33's bedside and stated the pills were left by LVN #3, the night nurse. She identified the two pills as Protonix and Synjardy. She stated that medications should not be left at the resident's bedside because it was a potential accident hazard. She stated she did not know if Resident #33 had an assessment to self-administer their medications. During a telephone interview on 04/30/2024 at 7:18 PM, LVN #3 stated he took care of Resident #33 on 04/28/2024. LVN #3 stated he gave Resident #33 Protonix on 04/28/2024 and allowed Resident #33 to take it on their own since they were alert and oriented. LVN #3 stated he trusted that Resident #33 would take the Protonix medication but admitted he did not know if they took the medication because they did not remain with the resident. LVN #3 stated he did not provide Resident #33 any diabetic medication because they were not scheduled on his shift. He stated residents should be assessed and be deemed clinically appropriate to self-administer medication, and he did not know if Resident #33 had a current self-administration assessment. LVN #3 stated he expected safe medication administration practices by ensuring all medications were taken by the resident while the nurse was in the resident's room. During an interview on 05/02/2024 at 8:12 AM, LVN #4 stated she worked on 04/28/2024 and provided Resident #33 their diabetic medication that day. She stated she watched Resident #33 take most of their medications but was unsure if Resident #33 took all their medications because Resident #33's roommate needed help, and she stepped away to help them. She stated she had been trained to stay with the resident during medication administration to ensure the resident took all their medications. She stated she expected safe medication administration practices to prevent accidents from happening. During an interview on 05/02/2024 at 7:35 AM, Physician Assistant (PA) #5 stated medications should be administered by a nurse and that the nurse should stay with the resident to ensure the resident took all their medications, did not choke, or give them to someone else. She stated medications should be locked in a medication cart when a resident did not have an order to self-administer medications. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/02/2024 at 8:34 AM, the Director of Nursing (DON) stated that he expected the nurse passing medications to not leave the resident until all medications were taken. He stated the potential consequence of not watching a resident take all their medications included that there was no assurance the medication was taken, negative side effects of not taking prescribed medication, and the potential for other residents to obtain the medications. The DON stated that they currently had no residents that were assessed to self-administer medications. He stated he expected safe medication administration practices to prevent accidents or hazards. During an interview on 05/02/2024 at 8:50 AM, the Administrator stated she expected nurses to follow physician orders and stay with the resident during medication administration to ensure the resident took all their medication, unless a resident was assessed and able to self-administer. She stated the potential negative consequences of a nurse not staying with the resident until all medications were taken were clinical outcomes or other residents obtaining and consuming the medication. She stated she expected safe medication practices to prevent accident hazards and potential negative outcomes of not taking medications as ordered by a physician. 31524 2. An Admission Record revealed the facility admitted Resident #65 on 02/08/2024. According to the Admission Record, the resident had a medical history that included diagnoses of spinal stenosis (spinal narrowing), spondylosis (degeneration of the bones and disks in the neck), and depression. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/13/2024, revealed Resident #65 had a Brief Interview for Mental Status (BIMS) score of 12, indicating the resident had moderate cognitive impairment. Resident #65's care plan revealed it did not include any information related to the storage of medications at the resident's bedside or the resident's ability to self-administer their medication. A review of Resident #65's medical records on 04/29/2024 revealed no records that indicated the resident had been assessed to self-administer their medications. Observation on 04/29/2024 at 9:41 AM revealed a bottle of Osteo-Biflex in Resident #65's room on a table beside their bed. Resident #65's Order Summary Report, listing active orders as of 04/29/2024, revealed it did not include an order for Osteo-Biflex or an order to store Osteo-Biflex at the resident's bedside. During an interview on 04/30/2024 at 1:27 PM, Resident #65 stated they started taking Osteo-Biflex about two months prior, when they were first admitted to the facility. Resident #65 further stated they told their physician about the supplement, who approved its use. During an interview on 05/02/2024 at 11:10 AM, the Director of Nursing (DON) stated he expected medications to be securely stored and inaccessible to residents. Per the DON, if a resident self-administered a medication, that medication should be stored in a secured lock box for resident safety. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/02/2024 at 11:15 AM, the Administrator stated medications should be stored securely in a locked medication cart or in a locked medication room. The Administrator further stated it was important to ensure all medications were locked and stored properly for accident prevention.