STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055957	A. BUILDING _____ B. WING _____	C 08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANTA PAULA POST ACUTE CENTER	250 MARCH ST SANTA PAULA, CA 93060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during the investigation of a complaint. Complaint Number: CA00913676 The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility. One deficiency was issued for complaint number CA00913676 at F658.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to follow physician orders for one of three sampled residents (Resident 1), as evidenced by: 1. Oxygen set at a flow rate of 3 liters per minute instead of 2 liters per minute. 2. Missing entries for G-tube (flexible hollow tube that is inserted into the stomach through abdomen used for nutrition and medication administration) 3. Dispensed blood pressure medication outside of the health parameters specifications. This failure had the potential for Resident 1's	F 658	F658: Services Provided Meet Professional Standards Corrective Action DON/Designee checked the record of Resident #1. Resident was assessed and evaluated, and no acute respiratory distress noted. The order of Oxygen was verified as 2LPM and immediately set the oxygen concentrator to 2L/min via nasal cannula. DON/Designee provided a 1:1 inservice and education to the treament nurse assigned to resident regarding documentation of GT care & treatment provided to resident in the Treatment Administration record (TAR)in a timely manner. DON/Designee provided a 1:1 inservice to the LN regading the proper documentation of administering Medication to resident Re: Midodrine ensuring that parameters are being followed accordingly based on Physician order. Resident condition was stable and Blood Pressure is within normal parameters.	08/20/2024 08/21/2024 08/20/2024

10/10/24 POC approved Jurisdiction HHS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Admin Assistant | (X6) DATE: 09/30/2024

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

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F 658	Continued From page 1 physical state to decline. Findings: 1. During an observation on 8/20/24 at 10:12 a.m., in Resident 1's room, Resident 1 was observed sleeping with a continuous flow of oxygen via nasal canula (mask) at a flow rate of 3 liters per minute. During a review of Resident 1's "Physician's Orders", dated 8/19/24, the orders indicated Oxygen to be set at 2 liters per minute. During a concurrent observation and interview on 8/20/24 at 12:15 p.m., with Director of Nursing (DON) and Administrator in Resident 1's room, DON and Administrator confirmed the Oxygen set at 3 liters per minute and physician's orders were not followed. 2. During a review of Resident 1's "Treatment Administration Record (TAR)", dated August 2024, the TAR had missing staff initials in the box for G-tube site cleaning ordered for 2 times a day (at 7 a.m. and 7 p.m.) The missing entries were on 8/3/24 and 8/11/24 at 7:00 a.m. During an interview on 8/20/24 at 11:35 a.m. with DON, DON confirmed the missing entries and stated "It's said if not documented then it isn't done." 3. During a review of Resident 1's "Physician's Orders", dated 8/2/24, the orders indicated, "Midodrine 5 milligrams (medication which increases blood pressure) Give 2 tablets via G-tube two times a day for HYPOTENSION *HOLD IF SBP >110 (Hold if Systolic Blood	F 658	IDENTIFICATION OF OTHERS: DON/Designee checked other residents with order of special device such as Oxygen either via tank or concentrator to ensure orders are properly in place & correct Liter of oxygen are in place , no other residents were negatively impacted with this deficient practice. DON/Designee checked other residents with GT care and treament and orders were documented in the Treatment Administration Record accrdingly by the Licensed Nurses. There was no any other residents were negatively impacted with this deficient practice. DON/Designee checked other residents with Midodrine order and Licensed Nurses documented the physician order accordingly and no other residents were negatively impacted with this deficient practice. Residents with this medication were stable.	08/20/2024 08/20/2024 08/20/2024

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F 658	Continued From page 2 Pressure (SBP) top number of blood pressure is above 110 millimeters of mercury. During a concurrent interview and record review on 8/20/24 at 12:10 p.m., with DON, Resident 1's MAR, dated August 2024 was reviewed. The MAR indicated licensed staff initials in the box for Resident 1's Midodrine were administered 18 doses from a period of 8/3/24-8/20/24 with SBP recorded being above 110. DON confirmed the orders were not followed when the medication was given when it was supposed to be held. During a review of the facility's policy and procedure (P&P) titled, "Administering Medications", dated April 2019, the P&P indicated, "Medications are administered in accordance with prescriber orders...The individual administering the medication initials the resident's MAR on the appropriate line..." The P&P also indicates, "If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR space provided for that drug and dose.	F 658	MEASURES TO PREVENT RECURRENCE: DON/Designee provided in-service to licensed nurses regarding the policy and procedure of Administering Medication in a safe and timely manner and as prescribed with the emphasis on the following: - Medications are administered in accordance with prescriber orders, including any required time frame. - The individual administering medications verifies the resident's identity before giving the resident his/her medications. Methods of identifying the resident schedule: a) Checking identification band b) Checking photograph attached to medical record c)If necessary, verify resident identification with other facility personnel. - The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next one. - Medication errors are documented,reported and reviewed by the QAPI committee to inform process changes and or the need of the staff training.	