STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555701	A. BUILDING _____ B. WING _____	**08/24/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIMI VALLEY CARE CENTER	**5270 E LOS ANGELES AVE 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 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure services provided by the nursing facility meet professional standards of quality.** Based on record review and interview, the facility failed to ensure: 1. a licensed nurse (LN 1), obtained a physician's order for Tylenol (a medication used to reduce fever and for pain relief) before it was administered to one resident (Resident 1) and, 2. the LN1 documented the medication administration as per professional standards of practice and per the facility's policy and procedure. These failures placed Resident 1 at risk for negative outcomes when LN 1 practiced medication administration outside of their scope of practice and not per the professional standards of practice. Findings: The, Fundamentals of Nursing, by Potter and Perry, Eighth Edition, on page 336, under the section, Physicians' Orders, indicated, Nurse follow physician orders unless they believe the orders are in error or harm patients During Resident 1's clinical record review and a concurrent interview with the director of nursing (DON), on 8/18/20 at 4:50 p.m., the SBAR (a communication note), dated 3/19/20 at 3:48 p.m., indicated Resident 1 had a fever of 100.4 degrees, the nurse practitioner (NP) was notified and the NP recommended to administer Tylenol every 6 hours as needed. The, Nurses Note, created by LN 1 on 3/19/20 at 1:50 p.m., indicated Resident 1 had a fever of 100.4 degrees and Tylenol was given .The March 2020, electronic Medication Administration Record [REDACTED]. The DON was asked to provide the Physician/NP Tylenol medication order. The DON reviewed Resident 1's medical record and stated, I agree there is no order for Tylenol (medication) by the doctor. And the nurse did give Tylenol on 3/19/20. The facility's policy and procedure titled, Administering Medications, dated 4/10, indicated, Medications shall be administered in a safe and timely manner and as prescribed .3. Medications must be administered in accordance with the orders .12. The individual administering the medications must initial the resident's MAR, on the appropriate line, after giving each medication. The facility's policy and procedure titled, Charting and Documentation, dated April, 2008, under the section titled, Policy Interpretation and Implementation, indicated, 1. All observations, medications administered, services performed, etc., must be documented in the resident's clinical records.
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure staff provided a shower or bed bath to one total dependent resident (Resident 1) frequent enough to maintain Resident 1's comfort. This failure resulted in Resident 1 being upset for not getting bathed frequent enough to feel comfortable. Finding: During an interview with Resident 1, on 3/25/20 at 2:41 p.m., Resident 1 indicated she had only received one bed bath since she had been admitted to the facility on [DATE]. During Resident 1's clinical record review and concurrent interview with the director of nursing (DON) on 8/18/20 at 12:45 p.m., the Face Sheet (Resident's profile) confirmed Resident 1 was admitted on [DATE]. Resident 1's [DIAGNOSES REDACTED]. The MDS (comprehensive assessment), dated 3/21/2020, indicated Resident 1 required, Extensive Assistance with activities of daily living (ADLs) and was, Totally Dependent for bathing. The certified nursing assistant (CNA's), ADL Flow sheet for March 2020, indicated the first bed bath was provided on 3/23/20, five days after admission. The DON agreed according to the CNAs, ADL Flow sheet, Resident 1 received her first bed bath after five days of admission. During further record review of Resident 1's clinical record and a concurrent interview with the DON, on 8/18/20 at 4:50 p.m., the DON acknowledged most people/residents bathe daily at home. The facility's policy and procedure titled, Shower/Tub Bath, revised 10/10, indicated, The purposes of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin.

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

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.