

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555223	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/10/2025
NAME OF PROVIDER OR SUPPLIER  St. John's Hospital Camarillo D/P Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 2309 Antonio Ave Camarillo, CA 93010	

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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45741</b></p> <p>Based on interview and record review, the facility staff failed to ensure the Physician was notified of a Weight variance of five pounds or more for 1 of 23 sampled residents (Resident 25's) when the weight record was examined and noted that the resident experienced a significant 14 percent weight loss in less than two months.</p> <p>This failure resulted in a delay in the need to alter treatment significantly to Resident 25.</p> <p>Findings:</p> <p>During a review of Resident 25's Admission Record (AR), dated 4/7/25, the AR indicated, Resident 25 was admitted on [DATE] with diagnoses that includes Amyotrophic Lateral Sclerosis (progressive disease that causes muscle weakness and paralysis), Quadriplegia ( paralysis that affects all a person's limbs and body from the neck down), and Ileus (intestine can't push food and waste out of your body).</p> <p>During a review of Resident 25's Weight Record, the weight record indicated, on 2/24/25, Resident 25's weight was recorded as 69 kilograms. The resident refused to be weighed in March, and on 4/2/25, Resident 25's weight was recorded as 59.9 kilograms.</p> <p>During a concurrent interview and record review on 4/9/25 at 2:20 p.m. with Registered Dietitian (RD1), the weight record was examined. RD1 calculated the difference between Resident 25's recorded weights on 2/24/25 and 4/2/25 and noted that the resident experienced a significant 14 percent weight loss in less than two months. RD1 further stated that the weight loss had not been previously identified.</p> <p>During a concurrent interview and record review on 4/9/25 at 3:05 p.m. with Nurse Informatics (NI), the nursing daily progress note for Resident 25 was reviewed. NI confirmed that there was no documentation indicating that the doctor had been notified regarding the resident's weight loss.</p> <p>During an interview on 4/9/25 at 4:20 p.m. with Registered Nurse (RN 2), the RN 2 stated that it is their practice to notify the doctor about significant weight loss in residents.</p> <p>During an interview on 4/10/25 at 10:00 a.m. with the Case Manager (CM) 2, the CM 2 acknowledged that the doctor should have been notified immediately regarding Resident 25's weight loss.</p> <p>(continued on next page)</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
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<p>F 0580</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&amp;P) titled, Resident Height and Weight Monitoring, Sub-Acute Care Unit, dated 10/2023, the P&amp;P indicated, Weight variance of five pounds or more will be communicated to the physician and registered dietician for further review and subsequent evaluation will be documented as warranted.</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>45741</p> <p>Based on observation, interview, and record review the facility failed to ensure care plan interventions were implemented for one of 23 sampled residents (Resident 25).</p> <p>This failure had the potential to result in Resident 25 needs not being met.</p> <p>Findings:</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Comprehensive Person Centered Care Plan, dated 3/2025, the P&amp;P indicated, Discipline providing care, treatment or services to the residents are required to review and contribute to the resident's care plan . the comprehensive person centered care plan will address: the services that are to be furnished to attain or maintain the residents highest practicable physical, mental and psychosocial well-being.</p> <p>During a review of Resident 25's Admission Record (AR), dated 4/7/25, the AR indicated, Resident 25 was admitted in Long Term Care (LTC) on 2/24/25 with diagnoses including but not limited to, Amyotrophic Lateral Sclerosis (progressive disease that causes muscle weakness and paralysis), quadriplegia ( paralysis that affects all a person's limbs and body from the neck down), and ileus (intestine unable to move food and waste effectively).</p> <p>During a review of Resident 25's Facility Order Summary Report, dated 4/7/25, the Order Summary indicated, an order dated 2/24/25 for Resident 25 to be weight monthly.</p> <p>During a review of Resident 25's Weight Record, the weight record indicated, on 2/24/25, Resident 25's weight was recorded as 69 kilograms. The resident refused to be weighed in March, and on 4/2/25, Resident 25's weight was recorded as 59.9 kilograms.</p> <p>During a review of Resident 25's Care Plan (CP), titled Enteral Feeding (delivering nutrition directly into the stomach or small intestine through a tube) included an outcome to monitor for weight change more than 5% in 1 month and listed an intervention to consult a dietitian for caloric intake needs, as needed.</p> <p>During a concurrent interview and record review on 4/9/25 at 2:20 p.m. with Registered Dietitian (RD1), Resident 25's weight record was reviewed. RD1 calculated the difference between Resident 25's weight on 2/24/25 and 4/2/25 and stated that the resident experienced a significant 14 percent weight loss in less than two months. RD1 further stated that no action had been taken regarding the resident's current weight, as they were not aware of it.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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>44589</p> <p>The facility failed to ensure medication is correctly labelled according to the physician's order and was sent to the pharmacy when medication discrepancy is found for 1 of 3 unsampled residents (Resident 64).</p> <p>This failure had the potential to result in a medication administration error.</p> <p>Findings:</p> <p>During a review of Resident 64's Physician Progress Notes (PPN), dated 4/7/25, the PPN indicated, Resident 64 had a diagnosis of Diabetes (a condition where the body cannot regulate blood sugar properly). Complicated by Retinoplathy (any disease of the retina, the light-sensitive tissue at the back of the eye).</p> <p>During a review of Resident 64's Active Order Profile (AOP), dated 4/4/25, the AOP indicated, Resident 64 is to receive 25 Units (unit of measurement) subcutaneously injection BID.</p> <p>During the medication observation on 4/4/25, at 8:00 a.m. with the Licensed Vocational Nurse (LN 1), LN 1 picked up the bottle of Insulin (a medication that helps to process sugar from food to energy) inside the medication cart, and then read the eMAR (electronic Medication Administration Record). The insulin bottle packaging instruction indicated, 28 units subcutaneous injection ( fatty tissue underneath the skin) at bedtime. On the other hand, the eMAR indicated, 25 units subcutaneous BID (twice a day). Another Licensed Nurse (LN 2) was called to verify the physician's order and the insulin bottle packaging instructions for Resident 64 with LN 1. And both confirmed and agreed that Resident 64 had an incorrect insulin packaging instruction and instructed LN 1 to inform the pharmacy.</p> <p>During an interview on 4/8/25, at 9:30 a.m. with the Registered Nurse (RN 2), the RN 2 verbalized, that the assigned nurse were responsible with informing the pharmacy when inaccurate or a discrepancy in the eMAR with medication on hand was detected. Once the pharmacy is informed, the medication is sent to the pharmacy for repackaging or the medication can be re-ordered with the correct label.</p> <p>During a concurrent record review and interview on 4/9/25 at 11:56 a.m. with RN 2, Resident' 64's electronic Active Order Profile was reviewed, indicated Resident 64's order for 28 units of Lantus/Glargine insulin (type of insulin) started on 3/17/25, was changed to 30 units on 3/26/25, 35 units on 3/29/25, and 25 units on 4/4/25. RN 2 acknowledged that the insulin order had been changed several times and the pharmacy must be informed.</p> <p>RN 2 further acknowledged the medication discrepancy and was unable to provide proof of documentation that pharmacy had been informed of the discrepancy between the eMAR and the packaging instruction on the bottle of insulin medication.</p> <p>(continued on next page)</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/9/25, at 2:10 p.m. with the Case Manager (CM 2), CM 2 acknowledged and verbalized that the medication must be sent to the pharmacy for repackaging to reflect current physician's insulin order.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Medication Administration, dated 9/2000, the P&amp;P indicated in part, 7. If there is a discrepancy between the eMAR and the label or medication packaging, check the physician's order before administering the medication. a. If the label is wrong or missing a bar code, send the medication to the pharmacy for re-labelling or repackaging. b. If there is a change of direction and medication can still be used, send the medication to the pharmacy for re-labelling or repackaging.</p>

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep all essential equipment working safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48380</p> <p>Based on observation, interview, and record review, the facility failed to maintain patient care equipment in safe operating condition when a residue build up was found inside of the ice machine panels.</p> <p>This failure had the potential for residents to Waterborne diseases (illnesses caused by consuming contaminated water).</p> <p>Findings:</p> <p>During a concurrent observation on 04/08/25 at 11:20 a.m. with the kitchen manager (KM), inspection of the ice machine was done and a pink residue and dark streaks of residue was observed in the panels of the ice machine using the white paper towel. The KM acknowledged and stated that there should be no residue found on panels.</p> <p>During a concurrent observation and interview on 04/08/25 at 02:25 p.m. with the Facility Maintenance Director ([NAME]), [NAME] acknowledged residue and stated that the filter needed to be changed.</p> <p>During a review of the facility's policy and procedure titled, Ice Machine Preventative Maintenance Procedure, undated, the policy and procedure indicated the facility has established procedures for Ice machine cleaning and sanitizing, check and clean (sanitize) ice an water dispenser for proper operation and check filter date and replace every 6 months at a minimum or sooner depending on usage.</p>

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>45741</p> <p>Based on observation, interview, and record review, the facility failed to ensure a safe, functional, and comfortable environment for 1 out of 23 sampled residents (Resident 36). When an extension cord with six sockets was mounted on the right upper side rail, approximately 12 inches from Resident 36's head while lying in bed.</p> <p>This failure creates an unsafe environment for the resident.</p> <p>Findings:</p> <p>During an observation on 4/7/26 at 10:09 a.m., in room W222-01, Resident was seen lying in bed with a blue extension cord with six sockets mounted on the right upper side rail, approximately 12 inches from Resident 36's head. Four bulky adapter devices were plugged into the extension cord, and the cord's power indicator light was lit, indicating that it was active.</p> <p>During a concurrent observation and interview on 4/7/25 at 11:00 a.m. with Maintenance (MT) in Residents 36's room, MT stated that the blue extension cord is used for medical equipment and not intended for the resident's personal use. MT further stated that no extension cord should be mounted on the side rail, as it poses electrical and fire hazards.</p> <p>During an interview on 4/7/25 at 11:05 a.m. with Registered Nurse (RN) 1, RN 1 stated that the blue extension cord should not be mounted on the upper side rails due to safety concerns and said she would inform Resident 36's nurse to remove the extension cord.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Extension Cords, dated 11/21/95, the P&amp;P indicated, .extension cords shall not be used: as a substitute for fixed wiring .where attached to building surfaces.</p>