STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555770	A. Building B. Wing	01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Camarillo Healthcare Center	205 Granada St Camarillo, CA 93010

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50657 Based on interview and record review, the facility failed to ensure appropriate and necessary information was communicated to the receiving home health agency (HHA) for a safe ,effective transition/continuance of care when the HHA was not informed of Resident 1's pressure ulcers and moisture associated skin damage (MASD) in the groin, scrotal, and perirectal areas. This failure resulted in Resident 1's responsible party not knowing of the skin condition, delaying the necessary skin treatment until HHA came and did the assessment finding a stage 2 (skin opening on the first layer of skin). Findings: During a review of Resident 1's, Admission Record (AR), dated 01/15/25, the AR indicated Resident 1 was admitted on [DATE] with diagnoses including, pneumonia, acute respiratory failure with hypoxia, acute pulmonary edema, other abnormalities of gait and mobility, dysphagia, mild cognitive impairment, history of falling, and other diagnoses. Resident 1 was discharged to home on 01/09/25 at 18:39 with home health agency (HHA) services. During an interview with Resident 1's caretakers (C1 and C2) on 01/13/25 at 14:41 pm, C1 and C2 stated they were unaware Resident 1 had a bed sore. They were informed by the HHA nurse that R1 had a bed sore stage 2 on the base of the spine. During a review of the Skin Ulcer Non-Pressure Weekly, dated 01/09/25, indicated: o Left upper thigh with dry scab (abrasion), no reopening and no s/sx of infection - stable o BUE scattered purplish reddish discoloration, no skin breakdown and no progression - stable o RLQ purplish discoloration, no skin breakdown, and no progression - stable o Bilateral groin, redness/rash, no skin breakdown, and no progression - stable o Scrotal, redness/rash, no skin breakdown, and no progression - stable o Additional Documentation/Comments: (continued on next page)

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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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	S Peri-rectal redness (MASD), no skin breakdown and no progression - stable S Facial redness/rash, peeling dry flaky skin, no progression - stable During a review of the Skin Pressure Ulcer Weekly, dated 01/09/25, indicated pressure ulcer review: o Site #1: Right heel, dark reddish discoloration, stage (suspected deep tissue injury) SDTI, no skin break down - stable o Site #2: Left heel, dark reddish discoloration, SDTI, no skin break down - stable o Site #3: Sacrum, 3 cm x 3 cm, stage 1, no skin breakdown - stable During an interview with Social Services Director (SSD) on 01/15/25 at 15:45 pm, SSD stated that social services faxed the following documents of Resident 1 to the receiving HHA provider: face sheet, physician orders for PT/OT, home health aid and RN services, medication list, H&P, skin assessments, and hospital records. During a phone interview with on 01/23/25 at 09:20 am with HHA Director of Patient Care Services (DPCS), DPCS stated the HHA received Resident 1's referral information on 01/09/25 but they did not receive any skin assessments or orders for wound care. DPCS stated the HHA nurse identified R1 has a stage 2, open, pressure ulcer measuring 1 cm x 1 cm x 0.2 cm on sacrum. During a review of the order summary report that was faxed to the HHA dated 01/09/25, the order summary did not have any wound care instructions. During a follow-up interview with SSD on 01/28/25 at 14:30 pm, SSD stated R1's skin assessments were faxed to the HHA separate from the initial referral but does not have a way of confirming it was faxed. During a follow-up interview on 01/29/25 at 09:07 am with the HHA Chief Operating Officer (CEO), CEO stated the HHA did not receive a separate fax/email from CHC regarding the skin assessment/pressure ulcers for R1. Review of [NAME] and [NAME], Eleventh Edition, Fundamentals of Nursing, page 394 in the section titled, Handling and Disposing Information, indicated, Health care agencies and departments should have policies for the use of fax machines that specify .the process used to verify that information was sent to and received by the appropriate person or persons.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50657 Based on interview and medical record review, the facility failed to communicate necessary information to a resident, the resident representative, and to the continuing care provider at the time of an anticipated discharge to one of one resident (Resident 1). This failure had the potential to result in provision of inappropriate and untimely care. Findings: During a review of Resident 1's, Admission Record (AR), dated 01/15/25, the record indicated Resident 1 was admitted on [DATE] with diagnoses including, pneumonia, acute respiratory failure with hypoxia, acute pulmonary edema, other abnormalities of gait and mobility, dysphagia, mild cognitive impairment, history of falling, and other diagnoses. Resident 1 was discharged to home on 01/09/25 at 18:39. During a review of nursing notes for Resident 1, dated 1/09/25 at 09:20, titled Discharge Summary, indicated, Instructions for Ongoing Care: .Treatments: Facial redness/rash, apply clotrimazole cream 1% and monitor for progression. bilateral groin, scrotal, and perirectal area redness/rash (MASD), apply barrier cream, monitor for progression and skin breakdown, sacrum redness, apply barrier cream and monitor for skin break down. Left and right heel dark reddish discoloration, apply A&D oint (ointment) and monitor for skin breakdown. Left upper thigh with dry scab (abrasion); monitor for reopening and s/sx (signs and symptoms) of infection. BUE (bilateral upper extremities) scattered purplish reddish discoloration; monitor for skin breakdown and progression. RLQ (right lower quadrant) purplish discoloration; monitor for skin breakdown and progression. During an interview on 01/13/25 at 2:41 pm with caretaker (C2), C2 stated that her and her brother picked up Resident 1 at the facility. Her brother was taken into the directors' office to sign paperwork while she got Resident 1 ready. She states the facility never provided her with any discharge information. During a review of nursing notes for Resident 1, dated 1/09/25 at 03:18 pm, the note nurse's note indicated Approached daughter to sign discharge paperwork, stated not right now. Daughter went to room with resident and certified nursing assistant (CNA) to have resident changed into different clothes. Daughter took resident and left without signing paperwork or medications. Social services contacted son and daughter. Daughter stated if she has time will come back later today. During an interview on 01/15/25 at 03:19 pm with licensed vocational nurse (LN1), LN1 stated the facility provides education to the resident or care provider regarding care and treatments that will be needed post-discharge when they go over the discharge paperwork. Since R1's daughter did not sign the discharge paperwork, the facility did not go over any of the discharge information. (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/15/25 at 12:34 pm with Director of Nursing (DON), DON stated DON at R1's family left without signing the discharge paperwork. DON acknowledged R1 did not receive discharge information because the daughter and resident left before they were able to go over the discharge paperwork. Review of the facility's policy and Procedure (P&P) titled Discharge or Transfer dated 07/29/2010 indicate .D. Provide copies of: Advance directives, current physician orders, provide medications, if applicable . During a review of the Order Summary Report that was emailed to home health agency (HHA) for Resident 1, dated 01/09/25 at 09:09 am, did not have information related to: Bilateral groin, scrotal and perirectal area redness/rash (MASD); apply barrier cream. Monitor for progression and skin break down Left and right heel dark reddish discoloration; apply A&D ointment and monitor for skin break down Sacrum redness, apply barrier cream and monitor for skin breakdown BUE scattered purplish reddish discoloration; monitor for skin breakdown and progression Left upper thigh with dry scab (abrasion); monitor for reopening and s/sx of infection RLQ purplish discoloration; monitor for skin breakdown and progression During an interview on 01/23/25 at 09:20 am with Director of Patient Services (DPCS), DPCS stated the HHA received the referral for home services on 01/09/25 via email including R1's face sheet, MD orders for home health, order summary dated 01/09/25, H&P, PT/OT & Rehab notes from Adventist SV Hospital, and CHC PT/OT notes. DPCS stated they did not receive information regarding Resident 1 having pressure ulcers. DPCS verified the order summary received and confirmed there were no indications for skin wound care. DPCS stated that R1 has a stage 2 pressure ulcer measuring 1 cm x 1 cm x 0.2 cm on sacrum.

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. 50657 Based on interview and record review, the facility failed to ensure a Late Entry documentation policy and procedure (P&P) met professional standards of timely documentation when P&P titled Late Entry, indicated in part There is not a time limit to writing a late entry. This resulted in a twelve-day delay of discharge planning notes to be available in the medical record of one of one resident (Resident 1). This failure has the potential for staff to add late entries without regards to timeframe or validity on the source of information and compromise timely continuity of care to the residents. Findings: During an interview on 01/15/25 at 12:34 with Director of Nursing (DON), DON acknowledged Resident 1 did not receive discharge information and left facility without signing discharge paperwork. The DON deferred further questions to the staff, social services director (SSD) and licensed nurse (LN2), that handled the discharge process whom she said were not available for interviews. Requested facility Discharge policy, the discharge paperwork that should have been signed by R1 or R1's representative, and social services notes. At 13:26 pm, DON had not produced the requested documents. On 01/15/25 at 15:45 pm the Social Services Director (SSD), SSD approached surveyor with social services notes. During a concurrent interview and record review on 01/15/25 at 15:45 pm with Social Services Director (SSD), the social services notes indicated all notes were Late Entries entered on 01/15/25. SSD stated the entries were from conversations with Resident 1's responsible representative and home health agencies regarding discharge planning. The social services notes indicated conversations started on 01/03/25 and ended on 01/13/25. SSD acknowledged all entries were made prior to meeting with this HFEN. SSD states staff are allowed to do this per facility policy. On 01/15/25 at 16:10 pm the documentation requirements policy was requested from the Administrator (ADM). At 16:30 pm the ADM was not able to produce the policy requested. On 01/21/25 at 08:42 am left message for ADM and DON to follow-up on the requested documentation requirements policy. The policy was received via email on 01/21/2025 11:22 am. During a review of the facility's policy and procedure (P&P) titled, Late Entry, [undated], the P&P indicated It is the policy of this facility to use a late entry to the information in the clinical record, when a pertinent entry was missed or not written in a timely manner. Procedures: 4. When using late entries, document as soon as possible. There is not a time limit to writing a late entry. (continued on next page)

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 01/23/25 at 16:08 pm with Director of Nursing (DON), DON stated she does not have a document that specifically states that policy titled Late Entry was reviewed by the governing body. DON stated she only has a sign-in sheet of the QAPI meeting when the team reviews nursing policies. Review of the sign-in sheet titled Annual Policy and Procedure Approval dated 2024 indicated The Patient Care Policy Committee Meeting is held in conjunction with the QAPI Committee Meeting. The policy manuals are approved in their entirety at least annually. Changes between annual meetings can be made and approved as needed. The Administrator, Director of Nursing, and Medical Director (or their designees) can also sign off on policies if the policies need to be implemented between meetings. The DON stated she does not have any documentation on the date that policy Late Entry was implemented and/or revised. Review of Pelaia, R. (2013, September 1), Advancing the Business of Healthcare (AAPC), titled Medical Record entries: What is timely and reasonable? Retrieved January 30, 2025, from https://www.aapc.com/blog/25667-medical-record-entries-what-is-timely-and-reasonable/#:~:text=Delayed%20entries%20within%20a%20reasonable,at%20the%20time%20of%20service.%E2%80%9D indicated Medicare expects the documentation to be generated at the time of service or shortly thereafter. Delayed entries within a reasonable time frame (24 to 48 hours) are acceptable for purposes of clarification, error correction, the addition of information not initially available, and if certain unusual circumstances prevented the generation of the note at the time of service.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50657 Based on interview and record review, the facility failed to maintain a complete medical record in accordance with accepted professional standards and practices for one of one sampled resident (Resident 1), when Resident 1's medical record did not have discharge planning notes. This failure had the potential to cause miscommunication and confusion amongst members of the healthcare team and not implementing discharge care planning affecting the resident's continuity of care. Findings: During a review of Resident 1's, Admission Record (AR), dated 01/15/25, the record indicated Resident 1 was admitted on [DATE] with diagnoses including, pneumonia, acute respiratory failure with hypoxia, acute pulmonary edema, other abnormalities of gait and mobility, dysphagia, mild cognitive impairment, history of falling, and other diagnoses. Resident 1 was discharged to home on 01/09/25 at 18:39 with home health services. During an interview on 01/15/25 at 12:34 with Director of Nursing (DON), DON stated Resident 1 left with his family without signing the discharge paperwork. After requesting copies of the facility's Discharge policy and the social services notes, DON deferred further questions to the staff that participated in the discharge process which she identified as the Social Services Director (SSD) and Licensed Vocational Nurse (LN2). When asked to speak to them DON stated LN2 comes into work at 15:00 pm and the SSD was not available at this time. During a concurrent interview and record review on 01/15/25 at 15:45 pm with Social Services Director (SSD), record review of the social services notes indicated all notes were Late Entries entered on 01/15/25, six days after Resident 1 was discharged from facility, and 14 minutes prior to meeting with HFEN. SSD acknowledged all entries were made right before meeting with HFEN. SSD states staff are allowed to do this per facility policy. During a review of the facility's policy and procedure (P&P) titled, Late Entry, [undated], the P&P indicated It is the policy of this facility to use a late entry to the information in the clinical record, when a pertinent entry was missed or not written in a timely manner. Procedures: 1. Identify the new entry as a late entry. 2. Identify or refer to the date and incident for which late entry is written. 3. If the late entry is used to document an omission, validate the source of additional information as much as possible. 4. When using late entries, document as soon as possible. There is not a time limit to writing a late entry. Review of National Association of Social Workers (NASW), 2016, NASW Standards for Social Work Practice in Health Care Settings, page 36 in Standard 10 titled, Record Keeping and Confidentiality indicated, Social workers practicing in health care settings shall maintain timely documentation that includes pertinent information regarding client assessment, and intervention, and outcomes, and shall safeguard the privacy and confidentiality of client information. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Pelaia, R. (2013, September 1), Advancing the Business of Healthcare (AAPC), titled Medical Record entries: What is timely and reasonable? Retrieved January 30, 2025, from https://www.aapc.com/blog/25667-medical-record-entries-what-is-timely-and-reasonable/#:~:text=Delayed%20entries%20within%20a%20reasonable,at%20the%20time%20of%20service.%E2%80%9D, indicated Medicare expects the documentation to be generated at the time of service or shortly thereafter. Delayed entries within a reasonable time frame (24 to 48 hours) are acceptable for purposes of clarification, error correction, the addition of information not initially available, and if certain unusual circumstances prevented the generation of the note at the time of service. Review of [NAME] and [NAME], Tenth Edition, Fundamentals of Nursing, page 365 in the section titled, Informatics and Documentation, indicated, Documentation is a key communication strategy that produces a written account of pertinent data, clinical decisions and interventions, and patient responses in a health record. Documentation in a patient's health record is a vital aspect of nursing practice.