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	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Camarillo Healthcare Center	205 Granada St 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)
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40469 Based on interview and record review the facility failed to ensure an identified pressure ulcer (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) with care issues was assessed and documented for one of two sampled residents (Resident 2). This failure had the potential to impede the treatment and interventions of the existing pressure ulcers which can result in deterioration affecting the overall medical condition of Resident 2. Findings: Review of [NAME] and [NAME], 7th Edition, Mosby's Fundamentals of Nursing, page 243 in the section titled, Data Documentation indicates, Observation and recording of client status is a legal and professional responsibility. The nurse practice acts in all states and the American Nurses Association Nursing's Social Policy Statement (2003) mandate, or require, accurate data collection and recording as independent functions essential to the role of the professional nurse. During a review of Resident 2's medical record, the following were identified. 1. Right buttock pressure ulcer identified on 8/10/24 was not assessed. During an interview and concurrent record review on 3/11/25 at 1:56 p.m. with the assistant director of nursing (ADON) and treatment nurse (TN), Resident 2's LN (Licensed Nurse) Skin Ulcer Non-Pressure Weekly dated 7/21/24 through 8/15/24 were reviewed. No assessment for the right buttock pressure ulcer identified on 8/10/24 was located. Both the ADON and the TN1 confirmed, The initial LN-Skin Ulcer Non-Pressure Weekly of Resident 2's right buttock skin pressure injury/pressure ulcer discovered 8/10/24 was not done and should have been done. 2. Incomplete assessments of pressure ulcers identified from 8/10/24 to 8/15/24. (continued on next page)

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

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	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Camarillo Healthcare Center	205 Granada St 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)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and concurrent record review on 3/11/25 at 2:14 p.m. with TN, Resident 2's LN-Skin Ulcer Non-Pressure Weekly dated from 7/21/24 through 8/15/24 indicated, aside from the right buttocks pressure ulcer identified on 8/10/24, additional pressure ulcers were identified on the Resident 2's left buttocks and sacrum (tailbone). The LN-Skin Ulcer Non-Pressure Weekly dated 8/15/24 indicated, no staging of the type and depth of wound, measurements, drainage, odor, wound edges, and surrounding tissue were assessed for Resident 2's pressure injuries on the right and left buttocks and sacrum (tailbone). TN indicated, The 8/15/25 LN-Skin Ulcer Non-Pressure Weekly nursing assessment of Resident 2's right and left buttock and sacrum were not staged and the assessments were not done correctly. 3. Resident 2 refused to be turned and repositioned. During a concurrent interview and record review on 3/11/25 at 2:14 p.m. with the director of nursing (DON), Resident 2's Progress Notes dated 7/21/24 through 8/19/24 indicated Resident's refusal to be turned. The DON acknowledged writing the progress notes dated 8/19/24, which directed staff to encourage Resident 2 to turn and reposition in response to their refusal. Further review of the Progress Notes indicated no assessments were located or documented about Resident 2's refusal to turn and reposition. When DON was asked about the missing assessments, no answer was offered. During a review of the facility's policy and procedure titled, Nursing Assessment, Ongoing dated 1/2011, indicated in part, It is the policy of this facility to ensure each resident receives nursing services that include . continuing assessment of patient needs with input as necessary from health professionals involved in the care of the patient .The initial nursing assessment shall commence at the time of admission of the resident . The ongoing nursing assessment of the resident shall be written as often as the resident's condition warrants and shall include, but is not limited to: . increased problems that may cause injuries to self and others. Also, during a review of the facility's policy and procedure titled, Pressure Ulcers-Prevention and Management dated revised 11/2019, and accompanying, FAQ: Pressure Injury Staging* Hints & Tips dated 11/2020, indicated in part, Procedures: 1. Resident Assessment . B. Identify Risk factors such as: Resident refusal of some aspects of care and treatment . Skin assessment .change in condition recognized, evaluated, reported and addressed. C. Every week, each area will be evaluated, measured and documented on the Pressure Ulcer/Non-Pressure Ulcer record. D. It is the responsibility of the Treatment Nurse to do weekly measurements .2. Prevention Stabilize, reduce or remove underlying risk, monitor impact of interventions and modify interventions as appropriate . A. Repositioning .G. Documentation . H. Treatment .