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	04/15/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 35399 Based on observation and interview, the facility failed to maintain a safe and sanitary environment by ensuring the dining area corridor wall was intact, dry, and free of insects. This facility failure placed residents at risk of exposure to mold from humid or wet walls, which also attracted insects. Findings: During a concurrent observation and interview on 3/4/25 at 10:50 a.m. with charge nurse (CN) in the facility ' s dining corridor, a hole was observed on the wall of the corridor leading from the dining room to the medical records office. The bottom wall siding was detached from the wall creating an opening between the siding and the base of the wall. Several ants were observed going in and out of the hole through the opening in the damaged wall. There was visible damage on the wall area close to the corner. The wall damage was partially obscured by a lift device parked nearby. CN who was present at the time of the observation, confirmed the wall was damaged. CN was asked how long the wall had been damaged. CN stated I don ' t know. I had not noticed that before. During another concurrent corridor wall observation and interview with facilities director (FD) on 3/4/25 at 11:56 a.m., part of the wall had been opened exposing the inside of the wall where the material was observed to be wet. The inside material of the wall was touched and confirmed to be wet. The FD was asked the reason the inside of the wall was wet. FD stated, I don't know, we are working on it. The FD was asked to touch the inside of the wall to confirm the inside of the wall was wet. FD replied Yes, it's wet. But I don't know why, we are working on it. During an interview with the director of nursing (DON) on 3/4/25 at 1:05 p.m., DON was notified of the wet wall problem and concerns of mold inside the wall and the concern of ants observed going in and out of the hole through the damaged wall area. The DON acknowledged and confirmed the corridor wall was damaged with a hole or there's an open area on the wall.During further observation the damaged area was observed to be not blocked or covered with some caution tape or labeling indicating work repair is ongoing . The DON stated We are fixing it. We knew about it.

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 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. 35399 Based on record review and interview, the facility failed to; 1. Ensure the attending physician (MD1) for one of two sampled residents (Resident 1) conducted a review of resident's medications at each visit. 2. Ensure Resident 1's physician (MD 1) wrote, signed, and dated a progress note at each visit and note was in the resident's medical record. The facility's failures resulted in the physician's progress notes being inaccurate. Findings: 1. A review of the facility policy titled History and Physical, Physician Progress Notes, NP/PA Documentation, dated 11/24, indicated The physician should review the resident's total program of care, including medications . at each visit. During a concurrent review of Resident 1's medical record and interview with the medical records supervisor (MRS) on 3/4/25 at 12:05 p.m., the MRS was asked to provide all the providers (physician, NP, PA) visit notes for the year 2024. A review of MD 1 progress notes, dated 1/8/24, 4/3/24, 6/11/24, 8/14/24, 10/16/24, 1/15/25, and 2/14/25. The seven (7) progress notes indicated the resident was on the following medications: amlodipine (blood pressure B/P medication) 5 milligrams (mgs) tablet, amlodipine 5mg- benazepril 20 mg capsule by mouth daily, cephalexin (antibiotic) 250 mg capsule by mouth 4 times daily for 5 days, clonazepam (sedative) 0.5 mg tablet by mouth twice daily as needed, escitalopram (antidepressant) 10 mg tablet, furosemide (diuretic) 20 mg tablet by mouth once daily, gabapentin (anticonvulsant) 100 mg capsule by mouth twice daily, lisinopril (lowers B/P) 20 mg tablet, nitrofurantoin monohydrate/macrocrystals (antibiotic) 100 mg capsule by mouth twice daily, and sulfamethoxazole 800mg -trimethoprim 160mg (antibiotic) tablet by mouth every 12 hours. The nurse progress note, dated 2/26/24 at 7:45 p.m., indicated [psychiatrist's name] obtained new consent for increased dosage of Buspirone (antianxiety). The nurse progress note, dated 2/8/24 at 10:16 p.m., indicated [MD1's name] with order for the following: fleet enema insert one application rectally every 8 hours as needed for constipation if Dulcolax suppository not effective. Milk of magnesia suspension 400mg/5ml give 30 ml by mouth as needed for constipation. The nurse progress note, dated 2/6/24 at 6:38 p.m., indicated Received telephone order to clarify indication to Buspirone HCl tablet 5 mg give one tablet by mouth three times a day for anxiety. The nurse progress note, dated 3/27/24 at 6:39 p.m., indicated Received order from [physician's name] for vitamin D25, folate, vitamin B12 . (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The intradisciplinary team (IDT) note, dated 3/28/24 at 6:13 p.m., indicated Resident had an appointment with [physician's name] yesterday and receive additional orders for Valium (muscle spasms) 2.5 mg PO BID . [MD1's name] notified and receive telephone order for tomorrow Valium 2.5 mg by mouth two times a day . The nurse progress note, dated 4/23/24 at 8:09 a.m., indicated Received order from [MD1's name] to increase vitamin D 2000 units to BID. The nurse progress note, dated 4/23/24 at 8:41 p.m., indicated [MD1's name] with new order Buspirone HCl oral tablet 10 mg, give one tablet by mouth two times a day for anxiety. The nurse progress note, dated 5/1/24 at 12:45 p.m., indicated Received order from [MD1's name] for cipro (antibiotic) 250mg for five days R/T UTI. During a telephone communication with the director of nursing (DON) on 4/3/25 at 3:56 p.m., the DON was notified that upon review of Resident 1's physician's progress notes, the physician had not reviewed, documented and updated the medications the resident was taking, on his visit progress notes. All of the seven (7) progress notes had the same medications documented which was incorrect because resident's medications had changed throughout last year. DON acknowledged and stated Ok. 2. A review of the facility policy titled History and Physical, Physician Progress Notes, NP/PA Documentation, dated 11/24, indicated physician progress notes must be written, signed, and dated with each visit . at least every 30 days for the first 90 days after admission and at least once every 60 days thereafter. During a concurrent review of Resident 1's medical record and interview with the medical records supervisor (MRS) on 3/4/25 at 12:05 p.m., the MRS was asked to provide all the providers (physician, NP, PA) visit notes for the year 2024. The MRS reported there are no physician progress notes for 2024 in hard copy of the medical record nor in the electronic medical record, for this resident. The MRS contacted the physician (MD1) over the phone to asked physician to send the resident's visit notes for the entire year of 2024 to the facility. During a telephone interview with Resident 1's physician (MD1) on 3/4/25 at 12:15 p.m., MD 1 confirmed he had not sent any of resident's visit progress notes for the entire year of 2024, to the facility. MD 1 reported he uses a system at his office to create and stored the resident's visit progress notes. MD 1 was asked if the facility MRS have access to that system to print out the resident's progress notes. MD 1 replied No, he does not. Communicated to MD 1 the facility needed to have the resident's physician's progress notes after the visit. MD 1 stated Yes, I know. I know. Yes, I agree. My progress notes need to be in the resident's record after each visit. I will send them now, all notes for 2024, for [MRS's name] to print them out for you. During another interview with the MRS on 3/4/25 at 2:35 p.m., MRS handed over some papers indicating these were all the 2024 physician notes. The papers consisted of physician's notes dated 1/8/24, 4/3/24, 6/11/24, 8/14/24, 10/16/24, 1/15/25, and 2/14/25. The MRS was asked again, if these were all the physician's notes, for this resident, for the year 2024. MRS confirmed and stated Yes, these are all of them for 2024. This is all [MD 1's name] sent me. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the physician progress note, dated 1/8/24 at 4:00 p.m., indicated the note was created/encounter performed, documented, reviewed and signed by [MD 1's name] on 3/4/25 at 1:14 p.m. The amendment was closed by [MD 1's name] on 3/4/25 at 1:19 p.m. A review of the physician progress note, dated 4/3/24 at 3:00 p.m., indicated the note was created/encounter performed, documented, reviewed and signed by [MD 1's name] on 3/4/25 at 1:32 p.m. A review of the physician progress note, dated 6/11/24 at 2:00 p.m., indicated the note was created/encounter performed, documented, reviewed and signed by [MD 1's name] on 3/4/25 at 1:44 p.m. A review of the physician progress note, dated 8/14/24 at 11:00 a.m., indicated the note was created/encounter performed, documented, reviewed and signed by [MD 1's name] on 3/4/25 at 1:59 p.m. A review of the physician progress note, dated 10/16/24 at 8:00 a.m., indicated the note was created/encounter performed, documented, reviewed and signed by [MD 1's name] on 3/4/25 at 2:07 p.m. A review of the physician progress note, dated 1/15/25 at 8:00 a.m., indicated the note was created/encounter performed, documented, reviewed and signed by [MD 1's name] on 3/4/25 at 2:24 p.m. A review of the physician progress note, dated 2/14/25 at 2:00 p.m., indicated the note was created/encounter performed, documented, reviewed and signed by [MD 1's name] on 3/4/25 at 2:27 p.m. During a telephone communication with the director of nursing (DON) on 4/3/25 at 3:56 p.m., the DON was notified that upon review of Resident 1's physician's progress notes, notes had discrepancies as to when the notes were performed. The DON said OK.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. 35399 Based on record review and interview, the facility failed to ensure one of two sampled residents (Resident 1) physician conducted visits at least once every 60 days and timely within the 10 days of the required date of the visit. The facility ' s failure resulted in the resident not being evaluated timely thus potentially having a negative outcome. Findings: During a concurrent review of Resident 1 ' s medical record and interview with the medical records supervisor (MRS) on 3/4/25 at 12:05 p.m., the MRS was asked to provide all the providers (physician, NP, PA) visit notes for the year 2024. The MRS reported none of the physician ' s visit notes were in the medical record, for this resident. The MRS contacted the physician (MD1) over the phone to asked physician to send the resident ' s visit notes for the entire year of 2024 to the facility. During another interview with the MRS on 3/4/25 at 2:35 p.m., MRS handed over some papers indicating these were all the 2024 physician notes. The papers consisted of physician ' s notes dated 1/8/24, 4/3/24, 6/11/24, 8/14/24, 10/16/24, 1/15/25, and 2/14/25. The MRS was asked again, if these were all the physician ' s notes, for this resident, for the year 2024. MRS confirmed and stated Yes, these are all of them for 2024. This is all [MD 1 ' s name] sent me. A review of the physician ' s visit notes indicated the physician visited the resident on 1/8/24 and then on 4/3/24, the timeframe between visits was 86 days apart. Further review of the visit notes indicated the physician visited the resident of 10/16/24 and then on 1/15/25, the timeframe between visits was 91 days apart. During a concurrent review of the facility policy titled History and Physical, Physician Progress Notes, NP/PA Documentation, dated 11/24 and interview with the director of nursing (DON) on 3/4/25 at 3:43 p.m., the policy indicated physician progress notes must be written .each visit . at least every 30 days for the first 90 days after admission and at least once every 60 days thereafter. DON acknowledged and confirmed residents shall be seen or visited at least once every 60 days and a progress note must be written with each visit.