

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555770	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/05/2026
NAME OF PROVIDER OR SUPPLIER Camarillo Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 205 Granada Street 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain a facility wall inside rooms [ROOM NUMBERS], occupied by residents were free from scuff marks, multiple scratches and uneven texture. This failure had the potential to affect the overall sense of an orderly, clean home environment for the occupying residents of both rooms. During a concurrent interview and record review, on 6/5/26, beginning at 8:37 a.m., with the Maintenance Director (MD), the MD verbalized the maintenance department in part relies on staff to report environmental concerns to them. The MD verbalized at each nursing station there was a maintenance binder where staff could write down items that need to be fixed/addressed. Both maintenance logs were reviewed which indicated there were no current items that needed to be fixed/addressed. The MD verbalized nothing needed to be fixed, according to both maintenance logs. During a concurrent observation and interview, on 6/5/26, beginning at 8:42 a.m., with the MD, the facility was toured. In room [ROOM NUMBER] and room [ROOM NUMBER] a section of wall was observed in a state of disrepair with multiple scratches, scuff marks and irregular texture. The MD verbalized both walls were in a state of disrepair and would need to be puttied and painted to be fixed. The MD verbalized staff should have logged the sections of wall in disrepair in the maintenance binder. During a review of the facility's policy and procedure titled Safe and Homelike Environment dated 12/25, indicated in part In accordance with residents' rights, the facility will provide a safe, clean, comfortable, and homelike environment.		

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure that the comprehensive care plan was developed and implemented for two of the 10 sampled residents (Resident 41 and Resident 11). 1. Resident 41 had no care plan with interventions due to the medical diagnosis related to Cannabis Abuse. 2. Resident 11's care plan interventions related to restorative nursing assistance (RNA) exercises/services were not consistently completed/documented. 1. During a concurrent record review and interview, on 6/5/26, beginning at 1:45 p.m., with the Assistant Director of Nursing (ADON) Resident 41's care plan and medical diagnosis was reviewed. Resident 1's Face Sheet indicated a diagnosis of Cannabis Abuse, Uncomplicated, with an onset date of 5/6/26. The ADON verbalized and confirmed Resident 1 did not have a care plan or interventions for the Cannabis Abuse, Uncomplicated diagnosis. During an interview on 6/5/26, at 1:59 p.m., with the Director of Nursing (DON), the DON verbalized Resident 1 should of had a care plan with interventions due to the medical diagnosis related to Cannabis Abuse. During a review of the facility's policy and procedure for Subject: Care Planning dated 11/24, indicated in part It is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive person-Centered Care Plan for each resident based on resident's needs to attain or maintain his or her highest practicable, physical, mental, and psychosocial well-being. 2. On 6/2/26 at 10:46 a.m. in room [ROOM NUMBER] C, Resident 11 was observed sitting in the wheelchair; caregiver instructions were posted on the wall that indicated, Bed mobility: MI (minimal independence-needs assistive device and extra time), one person assist; Transfers: SBA (standby assist-requires a caregiver to be present for safety), one person assist. During a review of Resident 11's clinical record (CR), Resident 11 was admitted to the facility on [DATE] with diagnoses that included fracture (broken bone) of right lower leg; abnormalities of gait (pattern of walking) and mobility (ability to move independently). A review of Resident 11's quarterly MDS (a comprehensive assessment tool) assessment, dated 5/6/26 indicated Resident 11 required: set up for eating, oral hygiene, upper body dressing, and personal hygiene; supervision assistance with toileting hygiene, showering, lower body dressing, transfer and walking; moderate assistance in putting on and taking off footwear. A review of Resident 11's order summary report (active orders) indicated physician order for RNA to: perform BLE (bilateral lower extremities) AAROM (active assisted range of motion-receive partial assistance) EX's x 10 REPS (repetitions) on all planes QD (daily) 5x a week, every day shift and to perform BUE (bilateral upper extremities) AROM (active range of motion-without any outside assistance) EX's x 10 REPS on all planes QD 5x a week, every day shift. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 11's care plan, titled, ADL Self Care Performance . dated 9/1/25, indicated interventions including: RNA to perform BLE AAROM EX's x 10 REPS on all planes QD 5x a week and RNA to perform BLE AAROM (typo- it should be BUE AROM) EX's x 10 REPS on all planes QD 5x a week. During a concurrent interview and record review with the assistant director of nursing (ADON) and director of rehab (DOR) on 6/5/26 at 3:47 PM, Resident 11's RNA records revealed incomplete RNA services, with one out of five times missing for week one [2/1/26-2/7/26] and 2 missing for week two [2/8/26-2/14/26] of February 2026. Furthermore, RNA services were not provided two out of five times in week three [5/15/26-5/21/26] and three out of five times in week four [5/22/26-5/28/26] of May 2026. A review of the document Task for BUE and BLE RNA from 5/8/26 to 6/3/26 indicated that the staff documented 5 to 10 minutes spent providing the ROM, however there was no documentation stating how many repetitions each exercise were conducted for BLE and BUE. There were no other documents provided to explain why RNA services were incomplete in February and May 2026. The ADON and DOR confirmed missing/incomplete documentation. A review of the facility policy and procedures (P&P) titled Range of Motion dated 12/2025, the P&P indicated, .Preventive care will be provided so that resident will not experience a reduction in range of motion.RNAs will perform ROM exercises on some residents while ADLs are performed as a nursing measure.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interview and record review, the facility failed to ensure the care plan for cognitive impairment/dementia, for one out of five sampled residents (Resident 1), was updated and revised after a significant change of condition. This failure had the potential to result in Resident 1 not receiving care based on current health status and at risk for unmet care needs. Findings: During a concurrent interview and record review on 6/4/26, at 9:30 a.m., with the minimum data set nurse (a specialized registered nurse who assesses, monitors, and comprehensively documents the health status of residents in skilled nursing facilities- MDS 1), Resident 1's medical record was reviewed. Resident 1's Care Plan for cognitive impairment/dementia indicated on 10/10/25 the BIMS (brief interview for mental status) score was 10 out of 15. MDS 1 verbalized Resident 1 was sent to the hospital and came back to the facility on 1/19/26. MDS 1 verbalized completing a comprehensive assessment on 1/21/26. MDS 1 verbalized Resident 1 had a decline in cognition, communication, and ADL (activities of daily living) decline. MDS 1 verbalized this was a significant change in Resident 1's condition. MDS 1 verbalized Resident 1's cognitive care plan should have been updated 14-21 days after the change of condition assessment. MDS 1 verbalized the care plan should have been updated in January of 2026 and further acknowledged the cognitive care plan had not been updated since 10/10/25. MDS 1 stated, I updated the CAA (care area assessment) worksheet but did not update the care plan and I should have. During a review of Resident 1's CAA Worksheet, dated 2/4/26, indicated in part. Resident 1 has impaired cognition as evidenced by having a BIMS score of 1 out of 15 (ARD-assessment reference date on 1/21/26) which is a decline from her baseline. At risk for fluctuating cognition related to diagnosis of SDAT (Senile Dementia of the Alzheimer Type-a progressive, irreversible, cognitive decline in older adults), recent illness and aging process. During a review of the Centers for Medicare & Medicaid Services Resident Assessment Instrument (CMS's RAI) Manual indicated in part. A significant change is a decline or improvement in a resident's status that: 1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions. 2. Impacts more than one area of the resident's health status. 3. Requires interdisciplinary review/and or revision of the care plan.		

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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** Based on record reviews and interviews, the facility failed to ensure the provision of resident care and services were performed within acceptable standards of nursing practice for two of eight sampled residents (Residents 12 and 66) when: 1. Physician orders and instructions were not followed for Resident 12.2. Comprehensive and timely pain assessments/reassessments were not performed for Resident 66.3. The timing of insulin (a hormone that lowers the level of glucose [simple sugar]) injections (forcing medication into the body using needle and syringe) for Resident 45 was not followed per physician's prescription instructions. These failures had the potential to compromise Residents 12 and 66's health and safety from unsafe nursing care practices and had the potential to cause dangerous drops in Resident 45's blood sugar level. Findings: 1. During a review of Resident 12's Face Sheet, dated 6/5/26, the FS indicated in part that Resident 12 is a [AGE] year-old female who was admitted to the facility on [DATE] with admitting diagnoses including Type 2 Diabetes Mellitus with Diabetic Chronic Kidney Disease (a group of diseases that affect how the body uses blood sugar which can lead to kidney damage) and Hypertensive Chronic Kidney Disease with End Stage Renal Disease (a condition where long-term, uncontrolled high blood pressure damages the small blood vessels in the kidney). During a review of Resident 12's Order Summary Report (OSR), dated 6/5/26, the OSR indicated the following physician orders: ACCUCHECK (check blood sugar [BS]) and NOTIFY MD if BS is less than (<) 70 or greater than (>) 250, two times a day for Diabetes Mellitus (ordered 3/19/26); Midodrine Hydrochloride (HCl) (a medication used to treat hypotension or low blood pressure [BP]) oral tablet five (5) milligram (mg) give one (1) tablet by mouth three times a day (TID) for HYPOTENSION, HOLD for systolic blood pressure (SBP - the top number in a BP reading) > 120 (ordered 3/19/26); and Valsartan (a medication used to treat hypertension [HTN] or high BP) oral tablet 80 mg, give 0.5 (half) tablet by mouth one time a day for HTN, HOLD FOR SBP < 108 (ordered 3/19/26). During a review of Resident 12's Medication Administration Records (MARs) for April 2026, the accuracy of staff documentation in the administration for physician's orders: ACCUCHECK, NOTIFY MD if BS < 70 or > 250 . and Midodrine HCl 5 mg three times daily . HOLD for SBP > 120 were reviewed. The MAR, for the ACCUCHECK . order indicated Resident 12's blood sugar readings of 262 and 271 at 1630 (4:30 p.m.) hours on 4/8/26 and 4/22/26, respectively; however, no evidence was found in the clinical record that these results were reported to the physician as directed. Additionally, a review of the MAR for the Midodrine HCl order revealed administration of the medication at scheduled times when resident blood pressure exceeded the threshold for holding the dose. Specifically, Resident 12 received the 0900 (9 a.m.) dose on 4/14/26 (BP: 124/70), 4/15/26 (BP: 132/68), 4/24/26 (BP: 136/60), and 4/26/26 (BP: 124/70). The 1300 (1 p.m.) dose was administered on 4/1/26 (BP: 130/60), 4/10/26 (BP: 124/72), and 4/14/26 (BP: 124/70). The 2100 (9 p.m.) dose was given on 4/2/26 (BP: 122/73), 4/7/26 (BP: 125/62), 4/9/26 (BP: 130/60), and 4/24/26 (BP: 128/66), despite blood pressure readings indicating the medication should have been withheld. (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 12's MARs for May 2026, the accuracy of staff documentation in the administration for physician's orders: ACCUCHECK NOTIFY MD if BS < 70 or > 250, Midodrine HCl 5 mg three times a day&mdash;HOLD for SBP > 120, and Valsartan 80 mg 0.5 tablet&mdash;HOLD FOR SBP < 108 were reviewed. The ACCUCHECK. review found that on 5/16/26 at 1630 (4:30 p.m.), Resident 12's blood sugar reading was 296, yet there was no record indicating physician notification as required by order. For the Midodrine HCl. order, documentation showed administration on instances where systolic blood pressures exceeded the threshold: specifically, for the 1300 doses on 5/22/26 (BP 136/72) and 5/27/26 (BP 134/76), and for the 2100 doses on 5/1/26 (BP 124/70) and 5/18/26 (BP 126/74), which did not adhere to prescribed instructions. Additionally, review of Valsartan. administration revealed the medication was given to Resident 12 on 5/29/26 despite a BP reading of 106/58, contrary to the order to hold for SBP < 108. During a concurrent interview and record review on 6/5/26 at 1:52 p.m. with the facility's Assistant Director of Nursing (ADON), staff documentation in Resident 12's MARs, for April and May 2026 was reviewed. The ADON was informed that inconsistencies were identified on the staff administration documentation relating to the orders, ACCUCHECK ., Midodrine HCl 5 mg ., and Valsartan 80 mg The ADON verified these discrepancies and acknowledged that staff had not followed the accompanying instructions by the physician for these orders on the specified dates and times. During a review of the facility's policy and procedures (P&P) titled Medication Administration (Med Pass), revised 2/2009, the P&P indicated in part, PROCEDURES. A. Basics of Med Pass. Pour-Pass-Chart &mdash; correctly prepare the med, give it correctly, then chart your action. Six (6) Rights, a. Right Resident, b. Right Medication, c. Right Dose, d. Right Route/Method, e. Right Time, and f. Right Documentation. The P&P also indicated that, E. Vital Signs &mdash; if there is a vital sign as part of the med order, make sure that it is taken by the med nurse just before the medication is administered. A review of [NAME] and Perry's 7th Edition of Mosby's Fundamentals of Nursing, on page 419 under the section titled Legal Implications in Nursing Practice, it is stated that Nurses are obligated to follow physician orders unless they believe the orders are in error or would harm clients. According to Nursing Fundamentals by [NAME], [NAME] and [NAME], second edition, 2010 p. 322, Documentation is the professional responsibility of all health care practitioners. It provides written evidence of the practitioner's accountability to the client, the institution, the profession, and society. 2. Review of The Joint Commission (is an independent non-profit organization that accredits and certifies healthcare facilities ranging from hospitals to nursing homes in the United States website, https://www.jointcommission.org/en-us/standards/national-performance-goals/pain-management accessed on 6/5/26, the Joint Commission indicated in part. If pain is identified, a comprehensive evaluation must be conducted.it must capture location, intensity, quality/character, frequency, aggravating/relieving factors, and impact on daily activities.standards of practice for pain assessment in a skilled nursing facility, require systematic screening, comprehensive baseline evaluation, and timely reassessment.staff must document pain intensity, location, and functional impact, and reassess within 30 to 60 minutes after administering any new analgesic or intervention. (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 66's Face Sheet, dated 6/2/26, indicated in part. Resident 66 had diagnoses of pain in right knee, pain in left knee, low back pain, and chronic pain syndrome. During a review of Resident 66's Physician Orders, dated 6/2/26, indicated to monitor pain level using the following scale; 0=No pain, 1-3=Mild, 4-6=Moderate, 7-10=Severe every shift. During a review of Resident 66's Physician Orders, dated 6/2/26, further indicated to give Norco 10-325 mg (a medication to relieve moderate to moderately severe pain) 1 tablet by mouth every 8 hours as needed (PRN) for moderate to severe pain. During a concurrent interview and record review on 6/4/26, at 2:51 p.m. with the assistant director of nursing (ADON), Resident 66's medical record was reviewed. Resident 66's medication administration record (MAR), dated 5/03/26, indicated Resident 66 received Norco 10-325, 1 tablet at 7:27 p.m. and the pain scale assessment was 7/10 (Moderate to Severe), prior to giving this medication. The MAR further indicated at 7:27 p.m., the follow-up code was Effective (E). Further review of Resident 66's Medication Administration Note dated 5/3/26 at 11:47 p.m., indicated the PRN administration was Effective and the follow-up pain scale was 0/10 (4 hours and 20 minutes later). The ADON verbalized if a resident is given pain medication, then the pain reassessment should be done within an hour and acknowledged the pain reassessment was late. Further review of the Medication Administrative Note did not indicate the location and or the type of pain. During a concurrent interview and record review on 6/4/26, at 2:55 p.m. with the ADON, Resident 66's medical record was reviewed. Resident 66's medication administration record (MAR), dated 5/27/26, indicated Resident 66 received Norco 10-325, 1 tablet at 3:57 p.m. and the pain scale assessment was 7/10 (Moderate to Severe), prior to giving this medication. The MAR further indicated at 3:57 p.m., the follow-up code was Effective (E). Further review of Resident 66's Medication Administration Note dated 5/28/26 at 12:09 a.m., indicated the PRN administration was Effective and the follow-up pain scale was 0/10 (8 hours and 12 minutes later). The ADON acknowledged the pain reassessment was late and further verbalized the facility policy does not indicate a time frame when pain should be reassessed. Further review of the Medication Administrative Note did not indicate the location and or the type of pain. During a review of the facility's policy and procedure (P&P) titled, Pain Management dated 4/2012, the P&P indicated in part. Purpose: the facility assists each resident with pain to maintain or achieve the highest practicable level of well-being and functioning by: screening to determine if the resident has been or is experiencing pain.comprehensively assessing the pain.Procedures: Assessment: 1. The resident will be assessed for pain: B. Any change from the initial pain assessment form to reflect the resident's current pain status will be reflected in the plan of care thereafter.C. Every shift recorded on the MAR.D. Upon development of new symptoms of acute or chronic pain that has not been previously assessed. 3. During an observation and concurrent interview with Resident 45 on 6/2/26 at 10:21 a.m. in room [ROOM NUMBER]B, Resident 45 expressed concerns about the timing of the insulin he receives from (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the nursing staff that they give it to him after he had eaten. During a review of Resident 45's clinical record (CR), this indicated, Resident 45 was admitted to the facility with diagnoses including but not limited to diabetes mellitus type 2 (chronic metabolic disease characterized by high blood sugar). A review of Resident 45's quarterly MDS (a comprehensive assessment tool) assessment, dated 2/27/26, indicated Resident 45 was cognitively intact. A review of resident 45's order summary report (active orders) indicated physician order for the following medications: 1) Lispro (fact-acting) insulin to be injected subcutaneously (SQ) before meals per sliding scale. The sliding scale directed the following doses based on finger stick blood sugar measurements: 0-150: 0 units (u); 151-200: 2 u; 201-250:1u; 251-300:2u; 301-350:3 u; 351-400:4u; 401+:5u; below 80 and above 400 notify MD. 2) Lispro (fact-acting) insulin 3 units to be injected SQ with meals. 3) Lispro (fact-acting) insulin to be injected SQ at bedtime per sliding scale. The sliding scale directed the following doses based on finger stick blood sugar measurements: 0-200: 0 u; 151-200: 2 u; 201-250:1u; 251-300:2u; 301-350:3 u; 351-400:4u; 401+:5u; below 80 and above 400 notify MD. 4)Lantus (long-acting) insulin 12 units to be injected SQ every 12 hours. A review of the mealtime hours for station 2, where Resident 45's room was located, revealed the following mealtimes: Breakfast at 7:35AM, lunch at 12:15 PM, and dinner at 5:00 PM. A review of Resident 45's electronic medication administration record (eMAR) dated 6/2026, this indicated: -Lispro insulin before meal injection solution was scheduled at 0630, 1130 and 1630 hours. -Lispro insulin with meals injection solution was scheduled at 0715, 1215 and 1715 hours. -Lispro insulin at bedtime injection solution was scheduled at 2100 hour. -Lantus insulin every 12 hours injection solution was scheduled at 0900 and 2100 hours. A review of Resident 45's eMAR-location of administration report indicated that the Lispro insulin with meals injection solution scheduled at 07:15 a.m. on 6/1/26 was administered at 09:34 a.m. and the Lispro insulin with meals injection solution scheduled at 07:15 a.m. on 6/2/26 was administered at 10:40 a.m., which were administered more than two hours of the scheduled time. During a concurrent interview and record review with the assistant director of nursing (ADON) on (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, interview, and record review, the facility failed to ensure an accurate, effective system for monitoring parameters of nutritional status when the quantity of consumption for therapeutic (to cure or restore to health) liquid nutritional supplements were not documented for one of five sampled residents (Resident 10). This facility failure of not documenting the accurate amount of therapeutic supplements taken had the potential to ineffectively evaluate nutritional interventions and delay an alternative nutrition approach, if necessary, to help prevent or minimize a potential negative outcome and possible continued weight loss for Resident 10. Findings: During an interview on 6/2/26, at 10:40 a.m., with Resident 10, Resident 10 verbalized having weight loss for some unknown reason. Resident 10 verbalized eating her meals and is taking supplemental calorie shakes. During a review of Resident 10's Physician Orders, dated 6/2/26, indicated to give Resident 10. Ensure one time per day for supplement 237 cc (or 8 fluid ounces) by mouth. to give House Supplement two times a day for nutritional support 4 fluid ounces by mouth with lunch and dinner. During a review of Resident 10's Physician Orders, dated 6/2/26, indicated to record Resident 10's intake each shift: record daily intake in ml/cc. During a review of Resident 10's Care Plan for Nutrition indicated in part. Resident 10 is at an increased risk for malnutrition or potential nutritional problem related to: at risk for weight loss, dehydration, fluid and electrolyte imbalance due to polypharmacy, dysphagia, and therapeutic diet. On 1/7/26 Nutrition/Hydration Annual: Medium Risk 5.0. On 2/10/26 Resident 1 weight was 139 pounds. On 4/10/26 Resident 1 had weight loss and was 133 pounds. On 5/20/26 weight loss was 127 pounds. in three months had 8.6% weight loss. Interventions indicated in part. Ensure one time a day for supplement of 237 cc (or 8 fluid ounces) by mouth. House Supplement with meals for nutritional supplement Vanilla flavor. if eats less than 75%, offer meal replacement. monitor and report to physician for any signs and symptoms of decreased appetite and unexpected weight loss. monitor/record/ report to physician signs and symptoms of malnutrition and significant weight loss. provide, serve diet as ordered. Monitor intake and record each meal. House supplement BID (twice a day) for nutritional support. During a review of Resident 10's Nutritional Interdisciplinary Team Update dated 5/20/2026, indicated in part. Resident 10 weight 127, 8.6 % weight loss in three months, average meal intake 51-100% . Progress: lost 4 pounds in a week, and had a significant weight loss of 12 pounds in three months and 20 pounds in 6 months. po (by mouth) intake is fair getting multiple supplement. recommended continuing with current plan of care, nursing to encourage po intake of meals and supplements. will continue to monitor po intake and weights. During a review of the facility's policy and procedure (P&P) titled, Weight Change Protocol dated 2023, the P&P indicated in part. Early identification of a weight problem and possible causes can minimize complications. the following criteria define significant or insidious weight changes. 7.5% weight loss or gain in 3 months. the facility RD will assess, nutritionally diagnosis, suggest interventions, monitor, and evaluate the success of the interventions. Assessment: Nutrition content of the diet provided and percent of intake for multiple days. calculate energy, protein, and fluid needs using parameters as in the initial assessment. Determine if the: diet order is appropriate to meet the goal. intake of the resident will be sufficient to meet needs or goals. Interventions: Diet supplementation (preferred between meals unless requested with meals). Monitors: a care plan is to be developed stating the problems, the goal, and the approaches, interventions to accomplish the goal. Evaluation: the evaluation process is done again if there is another significant weight change. interventions are changed if not effective. The facility policy does not address documenting the amount (cc/ml) of therapeutic supplement consumed by the resident. During a review of the Journal of (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Camarillo Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 205 Granada Street 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.			
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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the Academy of Nutrition and Dietetics, titled Academy of Nutrition and Dietetics: Revised 2022 Standards of Practice and Standards of Professional Performance for Registered Dietitian Nutritionists (Competent, Proficient and Expert) in Adult Weight Management, dated 2022, indicated under the Nutrition Monitoring and Evaluation Standard 4, the Registered Dietitian (RD) evaluates the impact of the sum of all interventions on overall resident outcomes and goals. It further indicated under Standard 6.3 that the RD evaluates the effectiveness when they participate in evaluation and selection of new products (eg. Nutritional supplements, dietary supplements.). During a review of Resident 10's Meal Intake Record dated 6/1/2026-6/4/2026 indicated:On 6/1/26 at 11:06 a.m. 76%-100% was percentage of meal eaten.On 6/1/26 at 11:06 a.m. 76%-100% was percentage of meal eaten.On 6/1/26 at 9:09 p.m. 76%-100% was percentage of meal eaten.On 6/2/26 at 12:11 p.m. 76%-100% was percentage of meal eaten.On 6/2/26 at 1:55 p.m. 76%-100% was percentage of meal eaten.On 6/2/26 at 6:37 p.m. 76%-100% was percentage of meal eaten.On 6/3/26 at 7:30 a.m. 76%-100% was percentage of meal eaten.On 6/3/26 at 12:00 p.m. 76%-100% was percentage of meal eaten.On 6/3/26 at 5:30 p.m. 76%-100% was percentage of meal eaten.On 6/4/26 at 10:13 a.m. 76%-100% was percentage of meal eaten.On 6/4/26 at 2:05 p.m. 76%-100% was percentage of meal eaten. No differentiation of meal intake versus Ensure and House Supplement intakes. During a review of Resident 10's Intake and Output Record dated 6/1/2026-6/4/2026 indicated:On 6/1/26 on Day shift was 560 cc/ml fluid intakeOn 6/1/26 on PM shift was 550 cc/ml fluid intake On 6/1/26 on Night shift was 100cc/ml fluid intake On 6/2/26 on Day shift was 580 cc/ml fluid intakeOn 6/2/26 on PM shift was 600 cc/ml fluid intakeOn 6/2/26 on Night shift was 380 cc/ml fluid intakeOn 6/3/26 on Day shift was 540 cc/ml fluid intakeOn 6/3/26 on PM shift was 600 cc/ml fluid intakeOn 6/3/26 on Night shift was 260 cc/ml fluid intakeOn 6/4/26 on Day shift was 540 cc/ml fluid intake No differentiation of fluid intake versus Ensure and House Supplement intakes. During an interview on 6/4/26, at 3:45 p.m., with the registered dietician (RD), the RD was asked about documenting the intake of therapeutic supplements in Resident 10 ?s medical record. The RD verbalized therapeutic supplements do not have a separate documentation in the medical record. The RD verbalized the medication administration record (MAR) indicates the supplements are given to the resident. The RD verbalized the amount of therapeutic supplement intake is recorded with the total % of meal intake, however the documentation does not differentiate between the meal and the supplement. When asked how do you know or determine the therapeutic supplementation is effective when not knowing the total amount/quantity (cc/ml's) of supplementation consumed, the RD verbalized the resident lets me know if taking the supplements. The RD verbalized the kitchen staff let me know if supplements are being wasted. The RD further verbalized there is no documentation in the medical record on the quantity consumed of the therapeutic supplement by the resident. The RD further acknowledged there is no process for documenting the amount of PO (by mouth) intake of the therapeutic supplementation.During a review of the Academy of Nutrition and Dietetics Nutrition Care Manual (NCM), dated 2025, the NCM indicated in part. The amount and type of food, fluid, supplement and/or enteral [providing nutrition through a tube] or parenteral [providing nutrition through a vein] intake or infusion amounts should be monitored closely to ensure that the patient is meeting their nutritional requirements. These foods and liquids must be counted as part of daily fluid intake. Examples of fluids include the following: .oral nutritional supplements.For patients receiving oral nutritional supplements, supplement acceptance and tolerance should be documented in the medical record. Frequently and carefully monitor body composition including measured weight, weight change, body mass index and the ability to meet nutrition needs orally. Without appropriate monitoring by the RDN, patients can experience delayed wound healing and/or worsening of nutritional status.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow proper infection control practices and maintain a safe, and sanitary environment when: 1. One staff member was observed feeding two residents at the same time. 2. One staff member was observed handling resident food with bare hands. 3. Three direct care staff were observed not adhering to proper hand hygiene. These facility failures had the potential for cross contamination of microorganisms and had potential to spread infection to residents and jeopardizing the quality and safety of care. Findings: 1. During an observation on 6/3/26, at 12:00 p.m., in the main dining room, a certified nurse assistant (CNA 1) was observed feeding two residents at the same time. CNA 1 was using bare hands to touch utensils and feed one resident (Resident 83), then using same bare hands to touch the other resident's utensils (Resident 22) and proceeded to feed that resident. CNA 1 continued to feed both residents using bare hands. During a concurrent observation and interview, on 6/3/26, at 12:07 p.m., in the main dining room, with the registered dietitian (RD), the RD was informed of CNA 1 using bare hands to feed both residents and touching both utensils without using gloves or hand hygiene in between. The RD observed and acknowledged that this could be cross contamination and verbalized CNA 1 should only be feeding one resident at a time. During an interview on 6/4/26, at 9:24 a.m., with the infection preventionist (IP), the IP was informed of CNA 1 feeding two residents at the same time using bare hands. IP verbalized the staff should be feeding one resident at a time. During a review of the facility's policy and procedure (P&P) titled, Meal Service, Nursing Responsibilities dated 1/2026, the P&P indicated in part. To insure accurate and safe meal service. Procedures: 8. Assist resident with the dining process as needed. If indicated the resident will need assistance or encouragement with the meal, staff are to provide the necessary assistance and encourage meal and liquid intake. If resident needs to be spoon fed by staff, staff must sit next to resident and personalize the assistance as much as possible. One staff member to feed one resident. 2. During an observation on 6/2/26, at 11:55 a.m., in the main dining room, an assistant (Assist 1) was observed using bare hands to handle a resident's toast. During an interview on 6/4/26, at 9:25 a.m., with the infection preventionist (IP), the IP was informed of Assist 1 using bare hands when handling a resident's toast. The IP verbalized Assist 1 should not be touching food with bare hands and should have worn gloves. During a review of the facility's policy and procedure (P&P) titled, Food Handling undated, the P&P indicated in part. Food will be prepared and served in a safe and sanitary manner. Procedure: Food & Nutrition Services personnel should never use bare hand contact with any foods, ready to eat or (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	otherwise. 3.During an observation on 6/2/26 at 10:56 a.m., Staff 1 was seen waiting inside room [ROOM NUMBER]A as Staff 2 wheeled patient 137 into the room. The room had a washing station, and hand sanitizer is hanging on the left side (outside) of the door. Staff 1 and Staff 2 were heard discussing how to safely transfer Resident 137 from wheelchair to bed while referring to the caregiver alert instructions placed on the wall. Staff 2 wheeled out Resident 137 and requested assistance with the transfer from another staff member (Staff 3). Staff 1 and Staff 2 donned gloves without washing or sanitizing their hands. Staff 3 arrived to help with the transfer of the resident from wheelchair to bed, and Staff 2 offered Staff 3 with a couple of green gloves. Staff 3 donned gloves without washing his hands first. Staff 1, Staff 2, and Staff 3 used the Hoyer lift to transfer resident 137 to the bed. Staff 1 remained with Resident 137 and was seen wearing and removing gloves without washing or sanitizing her hands while carrying out resident's care. During an interview with the assistant director of nursing (ADON) on 6/5/26 beginning at 4:09 p.m., this finding was discussed and confirmed with the ADON. During a review of the facility's policy and procedure (P&P) titled Infection Prevention-Hand Hygiene undated, the P&P indicated, .This facility considers hand hygiene the primary means to prevent the spread of infection.Use an alcohol-based hand rub containing at least 62% alcohol; or alternatively, soap.and water.before and after contact with residents.before donning sterile gloves.after removing gloves.the use of gloves does not replace hand washing/hand hygiene.		