STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555876	A. Building B. Wing	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alta Healthcare Center of Camarillo	6000 Santa Rosa Road Camarillo, CA 93012

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 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** 44589 Based on observation, interview and record review, the facility failed to develop and implement a comprehensive person-centered plan of care for 2 of 13 sampled residents (Residents 7 & 193) when: 1. Resident 7 had missing care plans for pressure injuries (an injury that breaks down the skin and underlying tissue) on the sacral (tail bone) and left heel and a wound on the right anterior (in front of) leg. 2. Resident 193's bed rail was used while in bed. These failures placed the residents at risk of not having their care needs met. Findings: 1. During facility tour observation on 5/19/25 at 9:30 a.m. in room [ROOM NUMBER], Resident 7 was wheeled inside the room by the Certified Nursing Assistant (CNA 1). Resident 7 was observed with multiple skin discoloration on both upper and lower extremities and a dry dressing on the right leg. During a review of Resident 7's electronic record, the Minimum Data Set (MDS - standardized resident assessment in the nursing home) record was reviewed. The MDS record indicated, Resident 7 was originally admitted on [DATE] and was readmitted back to the facility on [DATE]. Review of Resident 7's Admission Record (AR), dated 5/19/25, the AR indicated, Resident 7 was admitted to the facility due to Aphasia following cerebral infarction (brain condition due to lack of oxygen supply that affects the ability to communicate), Urinary Tract Infection (infection in urine), and Atrial Fibrillation (heart rhythm disorder). During a review of the document titled, Admission/Readmission Screen and Baseline Care Plan (ARSBCP), dated 5/8/25, the ARSBCP skin assessment indicated, Resident 7 was admitted with left heel pressure DTI (a type of pressure ulcer with damage to the underlying soft tissues caused by prolonged pressure), stage 2 sacrum pressure injury (a shallow open ulcer with a red or pink wound bed), right anterior leg trauma wound, right heel skin fissure (a crack or a small cut in the skin), bilateral upper and lower extremities (arms and legs) skin discoloration. (continued on next page)

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	During a review of Resident 7's Order Summary Report (OSR), dated 5/8/25, the OSR indicated, a physician's order for treatment of the left Heel DTI, stage 2 pressure injury, right leg trauma wound, right heel skin fissure, and to monitor the bilateral arms and legs multiple skin discolorations for skin breakdown. During a review of Resident 7's Treatment Administration Record (TAR), dated 5/2025, treatment was done daily on Resident 7's sacral area, left heel, right leg, and the completed treatment order for the right heel fissure. During a review of the Wound Specialist Progress Notes (WSPN), dated 5/14/25, the WSPN indicated, Resident 7 was evaluated for the stage 2 sacral pressure injury, left heel DTI pressure injury, and the right anterior leg traumatic wound. During a review of Resident 7's Care Plan (CP - the plan how to provide care), dated 5/9/25, there was no plan of care found to address Resident 7's sacral, left heel and right leg wound noted. During a concurrent interview and record review on 5/21/25 at 10:50 a.m. with the MDS coordinator (MDSC), Resident 7's ARSBCP, OSR, TAR, and CP were reviewed. MDSC stated there was no CP initiated for left heel DTI, sacral pressure injury and right leg traumatic wound. MDSC acknowledged the initial skin CP was not initiated when Resident 7s' admission MDS assessment was completed. During an interview on 5/22/25 at 1:14 p.m. with the Director of Nursing (DON), the DON acknowledged Resident 7's missing CP for Resident 7's sacral, left heel and right leg wound. During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, dated 12/2026, the P&P indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident .2.The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment .8. The comprehensive, person-centered care plan will: a. Include measurable objectives and timeframes; b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial wee-being .12. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required comprehensive assessment . 51644 2. During a review of Resident 193's admission record (AR), the AR indicated an admitted [DATE] with diagnoses that includes dementia (a term for a decline in mental ability severe enough to interfere with daily life) with other behavioral disturbance, unspecified psychosis (a condition where a person experiences psychotic symptoms but does not meet the full criteria for any specific psychotic disorder), need for assistance for personal care and rhabdomyolysis (a breakdown of muscle tissue). During an observation on 5/19/25 at 11:45 a.m., in Resident 193's room, the resident was out of room, the bed was observed with small bilateral bedrails (a bar that is mounted on the side of a bed to provide support and/or prevent someone from falling out of bed) in a raised position. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent record review and interview on 5/20/25 at 1:30 p.m., with the Registered Nursing Supervisor 1 (RNS1), RNS1 confirmed, there were no care plan in place for Resident 193's bilateral bedrail implementation. During a concurrent record review and interview on 5/21/2025 at 11:10 a.m. with the DON, the DON acknowledged the lack of care plan for bedrails stated it will be updated right away. During a concurrent observation and interview on 5/22/25 at 11:30 a.m. with Certified Nursing Assistant (CNA 2), the CNA 2 stated that Resident 193 had the bedrails since admission. During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, dated 12/2026, the P&P indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident .2.The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment .8. The comprehensive, person-centered care plan will: a. Include measurable objectives and timeframes; b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial wee-being .12. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required comprehensive assessment .

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51644 Based on observation, interview, and record review, the facility failed to assess the risk of entrapment (the state of being caught in between something) prior to the use of bilateral bedrails for 1 of 13 sampled residents (Resident 193). This failure had the potential to result in avoidable injuries to the resident. Findings: During a review of Resident 193's Admission Record (AR), the AR indicated, Resident 193 was admitted to the facility on [DATE] with diagnoses that included, unspecified psychosis (a condition where a person experiences psychotic symptoms but does not meet the full criteria for any specific psychotic disorder), dementia (a term for a decline in mental ability severe enough to interfere with daily life) with other behavioral disturbance and need for assistance for personal care. During an observation on 5/19/25 at 11:45 a.m., in Resident 193's room, the resident's bed was observed with small bilateral bedrails in a raised position. During a concurrent record review and interview with the registered nursing supervisor 1 (RNS1), RNS1 was unable to locate the completed assessment for risk of entrapment in Resident 193's health record. During a concurrent record review and interview on 5/21/2025 at 11:10 a.m., with the director of nursing (DON), DON acknowledged the assessment for risk of entrapment was not completed and stated, We'll work on it right away. During a concurrent observation and interview on 5/22/25 at 11:30 a.m., with a certified nursing assistant 2 (CNA2), in Resident 193's room, CNA2 stated that Resident 193 had these bedrails since admission. CNA2 further demonstrated how to pull/put up/down the bilateral side rails and stated, Only staff can put these bedrails up or down .because there is a lock (knob) that residents can't pull. During a review of the facility's Policy and Procedure (P&P) titled Proper Use of Side Rails, revised December 2016, the P&P indicated: When used for mobility or transfer an assessment will be made to determine the resident's risk of entrapment and reason for using side rails .

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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** 48668 Based on observation, interview, and record review, the facility failed to ensure the order for pain medication management (Tylenol and Hydrocodone-Acetamenophen) was clarified with the physician with the correct pain parameters in relation to pain level in 1 of 13 sampled residents (Resident 201). This failure had the potential for Resident 201's pain to be mismanaged. Findings: During a concurrent observation and interview on 5/20/25 at 11:04 a.m. with Resident 201, Ressident 201 was observed in bed, alert and oriented to time, place, and situation. Resident 201 stated is having chronic back and leg pain and had multiple spinal surgeries and is on multiple pain medications. During a review of Resident 201's Face Sheet, dated 5/18/25, the Face Sheet indicted, Resident 201 was admitted to the facility on [DATE] with diagnoses that included, Spondylolisthesis (a condition where one vertebra in the spine slips out of place) and Personal history of other diseases of the Musculoskeletal system and connective tissue. During a concurrent interview and record review on 5/22/25 at 10:45 a.m. with Licensed Nurse (LN 6), Resident 201's Medication Administration Record (MAR), dated 5/18/25. the MAR indicated, an order for Tylenol tablet 325 miligram (mg) 2 tablets by mouth (PO) every 6 hours (Q6hrs) as needed (PRN) for a pain level of 4-6, not to exceed 3000 mg in 24 hours and Hydrocodone-acetaminophen 5 mg-325mg, give 1 tablet PO every 4 hours PRN for pain level of 4-6, and not to exceed 4 gm per day with a start date of 5/18/25. Licensed Nurse (LN 6) confirmed the orders had the same pain levels and can confuse the nurse on which medication to administer to the resident during pain management. During an interview on 05/22/25 at 11:15 a.m. with the Director of Nursing (DON), DON stated that the order was written in error. DON stated that without clarification from the doctor, these medication orders had the potential for the resident to receive duplicate medications. During a review of facility's policy and procedure (P&P) titled, Reconciliation of Medications on Admission, dated July 2017, the P&P indicated, If there is a discrepancy or conflict in medications, contact the admitting and/or the attending physician.

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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** 51644 Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe and sanitary environment for 1 of 13 sampled residents (Resident 35) when oxygen and nebulizer tubings in use were not labelled and dated to determine when next to change the tubings. This failure had the potential to result in the transmission of infection to the resident. Findings: During a review of Resident 35's Admission Record (AR), the AR indicated, Resident 35 was admitted on [DATE] with diagnoses that included, pulmonary embolism (a blood clot that blocks and stops blood flow to an artery in the lung) and dependence on supplemental oxygen and nebulizer treatment. During a concurrent observation and interview on 5/19/25 at 9:50 a.m., with a licensed nurse (LN5) in Resident 35's room, Resident 35's nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) connected to an oxygen concentrator (a medical device used to deliver oxygen) and a nebulizer air tubing with aerosol mask (a small machine that converts liquid medication into a fine mist [aerosol] that can be inhaled) were not unlabeled. LN5 confirmed that both the nasal cannula and nebulizer air tubing for Resident 35 were missing dates and acknowledged, without the dates, there is no way of determining when the tubings should be replaced. During a review of the facility's Policy and Procedure (P&P) titled Oxygen Administration, with a revised date of 10/22/2024, the P&P indicated: - 5.b. Change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated. - 5.d. If applicable, change nebulizer tubing and delivery devices every 72 hours or per facility policy and as needed if they become soiled or contaminated.