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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055597	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maywood Acres Healthcare	2641 South C St Oxnard, CA 93033

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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** 50132 Based on observation, interview, and record review, the facility failed to ensure the policy on checking resident room temperatures was implemented for three of nine sampled residents (Resident 45, 50 and 78). This failure placed residents at risk to have an environment were the room temperatures were not regulatred and folloiwed for a comfortable daily living . Findings: During a concurrent observation and interview on 8/19/24, at 10:28 a.m., in room [ROOM NUMBER], Resident 50 was observed lying in bed with no clothes on and a bed sheet that covered the legs. Resident 50 stated, It's too hot in here. I don't want to wear any clothes. During a concurrent observation and interview on 8/19/24, at 03:37 p.m., in room [ROOM NUMBER], Resident 78 had two small fans blowing towards her. Resident 78 stated, It gets hot in here, so I have two fans to blow air on me and I still get hot because it's just hot air blowing on me. During a concurrent observation and interview on 8/20/24, at 09:55 a.m., in room [ROOM NUMBER], Resident 45 was observed using a fan that was attached to the siderail of the bed. Resident 45 stated, The room is too hot. During a concurrent interview and record review on 08/21/24, at 10:10 a.m., with the Maintenance Supervisor (MS), MS stated the room temperatures are checked and recorded daily at 10:00 a.m. A review of the Resident Room Daily Temperature Monitoring Log (RRDTML), dated August 2024, was conducted. The RRDTML did not have a time indication of when the temperature was taken. MS stated that there would be no way to know what time the temperature checks were done because there is no time written on the log. MS further stated that he was not aware if the policy had a specific time to check the temperature of the rooms. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 08/21/24 at 02:03 p.m. with MS, the facility's policy and procedure (P&P) titled, Heating, Ventilation and Room Temperatures, dated 10/3/2016 was reviewed. The P&P indicated, Maintenance Supervisor to check and record room temperatures between 12 noon and 4pm daily where temperature normally peaks. MS stated, Oh I didn't know, he has been using the same form that was given to him when he started working as an MS in January 2023. MS further stated he will start taking room temperatures at the time indicated per policy and develop a log with a place to record the time.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44589 Based on record review and interview, the facility failed to complete a CMS (Centers for Medicare & Medicaid Services) required discharged Minimum Data Set (MDS - an assessment tool and plan of care for residents in a nursing facility) assessment for one discharged resident (Resident 74). This failure resulted in an MDS discharge assessment not completed timely. Findings: During a review of the facility's policy and procedure (P&P) titled, Minimum Data Set (MDS) Assessment Schedule, dated May 2016, the P&P indicated in part, The facility shall adhere to Resident Assessment Instrument (RAI) Manual Assessment schedules as required by federal and state agencies .Resident Assessment Coordinator (RAC) is an RN (Registered Nurse) who is responsible for the effective and efficient interdisciplinary care coordination .and completion of a comprehensive plan of care from admission to discharge . During a review of Resident 74's Admission Record (AR), dated 8/21/24, the AR indicated, Resident 74 was admitted to the facility on [DATE] with diagnoses that included orthopedic aftercare of surgical amputation (surgical removal of a body part). During a review of Order Summary Report (OSR), dated 3/21/24, the OSR indicated, Resident 74 is to be discharged home on 3/23/23. During a review of the Nursing Progress Notes (NPN), dated 3/23/24, the NPN indicated, that Resident 74 was discharged home, and left the facility in a private car. During a concurrent record review and interview with the RAC/MDS Coordinator (MDSC), dated 8/21/24, at 9:50 a.m. Resident 74's MDS electronic record was reviewed. The MDS record indicated, an entry tracking, and Admission was completed and accepted by CMS, and a Discharge Assessment was 137 days overdue. The MDSC acknowledged being responsible for completion of the Resident 74's missed discharged assessment. MDSC further acknowledged, that she could have opened the assessment prior to resident's discharge and completed the assessment on time.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32661 Based on observation, interview, and record review, the facility failed to ensure an accurate assessment, reflective of the resident's status at the time of the assessment, was done for one of five (Resident 86) sampled residents. This failure resulted in an inaccurate assessment and had the potential to result in life threatening consequences for Resident 86. Findings: During an observation on 8/19/24, at 9:12 a.m., in room [ROOM NUMBER], Resident 86 was observed in bed, watching TV. Resident 86's left upper arm had an AV shunt (Arteriovenous [AV] shunt or fistula is a surgically created connection between an artery and a vein for dialysis [a medical procedure that removes waste and excess fluid from the blood when the kidneys are unable to do so] access/use). The left upper arm AV shunt/fistula was clean, had thrill (vibration/pulse caused by blood flowing through the shunt/fistula), skin over the AV shunt/fistula was clean and well moisturized. Resident 86 stated, I go for dialysis every Monday, Wednesday, and Friday at 12 noon. During a concurrent record review and interview with a registered nurse (RN1), on 8/20/24, at 9:18 a.m., in the nursing station, Resident 86's scheduled dialysis was Monday, Wednesday, and Friday at 12:40 p.m. The Dialysis Communication Record (record of pre, post dialysis [in dialysis clinic], and post dialysis [in facility upon arrival vital signs] dated 8/2/24, was missing Facility Pre and Post Dialysis Assessment vital signs. The Dialysis Communication Record dated 8/7/24, was missing Facility Pre-Dialysis Assessment vital signs. The Dialysis Communication Record dated 8/14/24, was missing Facility Post Dialysis Assessment vital signs. RN1 reviewed the records and confirmed that the vital signs were missing on the following dates and stated, It wasn't done. The MRD (Medical Records Director) reviewed the records and confirmed the vital signs were missing on the following dates. The MRD stated, It was missed. Record review of the facility Policy and Procedure (P&P), titled Hemodialysis Care, dated 5/22/13, indicated in part, While at the skilled facility: This facility has direct responsibility for the care of the resident, including the customary standard of care provided by the facility and the following resident assessment and dialysis management process, including: a. Conducting pre and post-dialysis assessment per facility protocol.

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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** 32661 Based on observation, interview and record review, the facility failed to develop a care plan for three of three residents (Resident 49, 86 and 54) related to: 1. A pad alarm that was considered as a restraint for Residents 49 and 86 2. A diagnosis of Hepatitis C (a liver disease caused by the hepatitis C virus, which is primarily transmitted through exposure to infectious blood or body fluids that contain blood) for Resident 54. These failures had the potential for Resident 49, 86 and 54 not to receive the appropriate care and services, based on problem areas identified. Findings: 1. During an observation on 8/19/24 at 9:18 a.m. and at 9:28 a.m., in Resident 86 and Resident 49 rooms respectively (room [ROOM NUMBER] B and room [ROOM NUMBER] A). Resident 86 was observed in bed, watching TV with a pad alarm (a pressure sensitive pad positioned beneath resident attached to a control unit that emits a loud alarm) attached to a control unit on the bed. Resident 49 was observed seated on a wheelchair, with a pad alarm attached to a control unit on her wheelchair. During a concurrent record review and interview with RN1 (Registered Nurse), on 8/20/24, at 9:18 a.m., in the nursing station, Residents 86 and 49 were missing care plans for their pad alarm restraints. Both RN1 and MRD (Medical records Director) reviewed Resident 86 and 49's medical records and concurred with the finding. RN1 stated, It was missed, while MRD stated, It was an oversight. 43019 2. During a review of the Admission Record (AR) of Resident 54, the AR indicated in part a diagnosis of Hepatitis C (a viral infection that causes liver swelling, called inflammation). During a review of clinical record of Resident 54, there was no documented evidence of a care plan regarding Hepatitis C. During an interview with Licensed Vocational Nurse (LVN) 3 on 8/20/24 at 12:30 p.m., LVN 3 validates that there is no care plan for Hepatitis C. During a review of the Policy and Procedure (P&P) titled, Care Plans, undated, the Care Plans indicated in part, 1. Assess the resident upon admission and initiate a care plan for the key problems or possible problems identifies. The care plan will be completed within seven days. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility Policy and Procedure (P&P) titled, Care Plans, undated, indicated in part, It is the policy of this facility to assure that all disciplines coordinate the care of each resident .6. After the Resident Assessment Protocol is completed, the care plan will be updated to include any additional information gained within seven days of completion . 7. Any changes in the resident's status will be put on the care plan as they occur.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40227 Based on observation, interview, and record review, the facility failed to ensure nursing staff demonstrated competency in medication administration when: 1. A licensed vocational nurse (LVN) 1 administered the wrong laxative (medication that treats constipation) to one unsampled resident (Resident 53). 2. Blood pressure and heart rate readings were not accurately documented for one of five sampled residents (Resident 68) prior to receiving the medication Carvedilol (medication to treat heart failure and high blood pressure after a heart attack). 3. Monitoring for medication side effects and bleeding complications was not implemented for one of five sampled residents (Resident 344) receiving the medication Apixaban (medication that prevents blood clots). These failures had the potential to harm these residents as a result of unsafe medication administration. Findings: 1. During a review of Resident 53's Admission Record (AR), dated 8/21/24, the AR indicated in part, Resident 53 was an [AGE] year-old male, who was admitted to the facility on [DATE], with admission diagnoses including history of seizures (a sudden, uncontrolled burst of electrical activity in the brain), and age-related physical debility. On 08/20/24 at 09:10 AM, an observation of the Medical Administration Task, with LVN1 was performed. LVN1 was observed to give Resident 53 a medication called Senna Plus (A medication used to treat constipation). Upon inspection of the bottle, the ingredients indicated Senna Plus contains Senna (a laxative) 8.6 mg (miligram) plus Docusate sodium (a stool softener) 50 mg. On 8/20/24 at 3:00 PM, a record review was performed for Resident 53 in the Electronic Medical Record (EMR), for the Order Summary Report (OSR), dated 8/20/24. The OSR indicated a medication order for Senna Oral Tablet 8.6 mg (Sennosides [also known as Senna]). On 8/20/24 at 3:30 PM, an interview and record review was conducted with LVN1. LVN1 logged into the EMR and pulled up the medication orders for Resident 53. LVN1 verified that the order was for Senna 8.6 mg PO (by mouth) QD (every day). LVN1 acknowledged that he gave the resident Senna plus. LVN1 stated that it was the correct medication. LVN1 was made aware that it is not the same medication because Senna plus also has docusate sodium 50 mg. LVN1 stated he believes this was the correct medication to give the resident. On 08/20/24 at 3:45 PM, an interview and observation was conducted with LVN1. LVN1 brought a bottle of Senna plus. LVN1 stated he went to his cart and verified that it was Senna plus that he gave Resident 53. LVN1 stated that Senna plus was the medication he gave Resident 53. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/20/24 at 04:25 PM an interview was conducted with the DON (Director of Nursing). The DON was made aware of the medication administration error of Senna Plus given to Resident 53 by LVN1. The DON acknowledged the medication administration error by LVN1. On 08/21/24 at 2:00 PM, an interview was conducted with LVN1. LVN1 stated he is aware he made a medication administration error. LVN1 stated, he should have taken his time and asked for clarification of the order and brought it to the attention of his DON for assistance. 43745 2. During a review of Resident 68's, AR, dated 8/22/24, the AR indicated in part, Resident 68 was a [AGE] year-old, male who was initially admitted to the facility on [DATE] with admission diagnoses including chronic kidney disease, chronic atrial fibrillation (irregular heart rhythm) and presence of a pacemaker (a small, battery-powered device that prevents the heart from beating slowly). During a review of Resident 68's, OSR, dated 8/22/24, the OSR indicated the medication order, Carvedilol oral tablet 6.25 milligrams (mg), Give one (1) tablet by mouth two times a day for HTN (hypertension - high blood pressure). Hold if SPB (systolic blood pressure - the top number in a blood pressure reading that measures the pressures in the arteries when the heart beats) is below 108 mmHg (millimeters of mercury - unit of measure for blood pressure) or HR (heart rate) below 55 bpm (number of beats per minute) with a start date of 7/27/24. During a concurrent interview and record review, on 8/21/24 at 2:20 p.m., with LVN1, Resident 68's, Medication Administration Record (MAR), for the month of 8/2024, was reviewed. When reviewing the administration record for Resident 68's Carvedilol, only four (4) blood pressure readings and no heart rate readings were documented. LVN1 verbalized that staff should have checked Resident 68's blood pressure and heart rate prior to administering Carvedilol and documented the readings in Resident 68's MAR. During a concurrent interview and record review, on 8/21/24 at 3 p.m., with DON, Resident 68's MAR, dated 8/2024, was reviewed. DON was informed that staff failed to accurately document Resident 68's blood pressure and heart rate readings prior to the resident receiving the medication Carvedilol and confirmed the finding after reviewing the resident's MAR. 3. During a review of Resident 344's, AR, dated 8/22/24, the AR indicated in part, Resident 344 was a [AGE] year-old, male who was admitted to the facility on [DATE] with admitting diagnoses including type 2 diabetes mellitus (a group of diseases that affect how the body uses blood sugar), end stage renal disease (a condition where the kidney reaches advanced state of loss of function), and chronic atrial fibrillation. During a review of Resident 344's, OSR, dated 8/22/24, the OSR indicated the medication order, Apixaban oral tablet , give one (1) tablet by mouth two times a day for AFIB (atrial fibrillation) with a start date of 8/14/24. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review, on 8/21/24 at 2:35 p.m., with LVN 1, Resident 344's MAR, for the month of 8/2024, was reviewed. When reviewing the administration record for Resident 344's Apixaban, the MAR failed to indicate accompanying monitoring orders for medication side effects and bleeding complications. LVN1 verbalized that there should have been monitoring orders entered while the resident is on this medication. During a concurrent interview and record review, on 8/21/24 at 3:05 p.m. with DON, Resident 344's MAR, dated 8/2024, was reviewed. DON was informed that no monitoring order for medication side effects and bleeding complications was entered for Resident 344's use of the medication Apixaban. DON confirmed the finding and verbalized that staff should have entered an accompanying monitoring order for this medication. During a review of the facility's policy and procedures (P&P), titled, Medication Administration General Guidelines, dated 2019, the P&P indicated in part, Procedures: Medication Preparation .3) Prior to administration, the medication and dosage schedule on the resident's MAR is compared in the medication label. If the label and MAR are different and the container is not flagged indicating a change in directions, or there is any other reason to question the dosage or directions, the physician's orders are checked for the correct dosage schedule. The P&P indicated further, Medication Administration .2) Obtain and record any vital signs necessary prior to medication administration . Documentation .8) Observe resident for medication actions/reactions and record on the PRN (as needed) effectiveness sheet as appropriate.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. 43019 Based on interview and record review, the facility failed to ensure monitoring for side effects and manifestation of behaviors was done for Mirtazapine (a drug used to treat depression) for one Resident (Resident 54). This failure had the potential for unrecognized side effects of the Mirtazapine and occurrence of manifested of behaviors. Findings: During a review of the Admission Record (AR) of Resident 54, the AR indicated a diagnosis of Major Depressive Disorder (a serious mental disorder that affects how a person feels, thinks, and act). During a review of the Order Summary Report (OSR) dated 8/20/24 for Resident 54, the OSR indicated in part, Mirtazapine Oral Tablet was prescribed on 4/24/24 for Depression manifested by lack of interest in food. During a review of the Resident 54's care plans dated 5/2/24, this indicated in part, interventions monitor for occurrences of depressive behavior every shift and update MD as needed and monitor/document side effects and effectiveness every shift. During a review of Resident 54's Medication Administration Record (MAR), for the month of August 2024, the MAR indicated, monitoring episodes of depression manifested by: lack of interest in food and/or poor meal intake every meals and record meal intake order and monitoring of side effects of the anti-depressant; however, this was initiated on 8/20/24. There was no other documentation that showed the facility staff had monitored the side effects and manifestation of behaviors for Resident 54 from 4/24/24 to 8/19/24. During an interview with 8/20/24 at 12:30 pm, Licensed Vocational Nurse (LVN) 3 confirmed there was no monitoring for behavior occurrences or side effects for Mirtazapine. During a review of Policy and Procedure (P&P) titled, Psychotropic Medications and Behavior Management, the Psychotropic Medications and Behavioral Management indicated in part D. Documentation Requirements: 4. Occurrences of behaviors for which psychotropic medications are in use will be entered with hash/hatch marks on the Monthly Behavior Monitoring Sheet and/or Medication Administration Record every shift.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 27157 Based on observation, interview, and record review, the facility failed to ensure two of two sampled resident's (Resident 19, Resident 1) therapeutic mechanical soft, chopped diet order was plated correctly in the kitchen in accordance with the physician's order and facility's planned menu/diet manual. As a result, of not implementing the chopped diet safely residents were at an increased risk of choking. Findings: 1. During a concurrent observation and interview on 8/19/24 at 11:12 a.m. with Registered Dietitian (RD), Resident 19's lunch meal was plated with chopped pieces of baked chicken that appeared larger than 1/2 [half inch] in size. Resident 19's lunch meal tray ticket indicated mechanical soft, chopped, renal [diet for kidney disease] diet order. Resident 19's meal tray was observed placed on the meal delivery cart for distribution by dietary aide (DA) 3. RD was asked to remove Resident 19's meal tray from the meal delivery cart and check it for accuracy. RD observed the size of the pieces of chopped chicken, and RD stated, The chopped diet is okay. RD was asked to review the facility's diet manual for direction on what size of food constitutes chopped. RD then informed DA 3 to place Resident 19's lunch meal tray back onto the meal delivery cart for distribution to Resident 19. During a concurrent interview and record review on 8/19/24 at 11:23 a.m. with the RD, in the presence of the Certified Dietary Manager (CDM), the facility's diet manual (DM), dated 1/9/24, was reviewed. The DM indicated, Mechanical Soft [diet] intended use: To provide a nutritionally adequate diet that requires a reduced amount of mastication [chewing]. Normally this order is for residents who have a limited chewing ability and intact swallowing ability., As with all diets, .mechanical soft diet should be individualized according to the resident's ability to masticate and swallow. If residents are experiencing swallowing issues, they should be assessed by Speech-Language Pathologist (SLP).Recommendations: All meat (such as beef, fish, poultry, and pork) should be ground or chopped.Definitions of Menu Terms: Chopped: 1/4 - 1/2 pieces. RD stated, Resident 19 pieces of chopped baked chicken were larger than 1/2 in size. RD stated the mechanical soft, chopped diet was not followed for Resident 19. During a review of Resident 19's Speech Therapy Treatment Encounter Note(s) (ST), dated 7/9/2024, the ST notes indicated, Pt [patient] was seen for Dysphagia tx [treatment for difficulty with swallowing]. Response to session interventions: d/c [discontinue] pureed [texture].and advance to Mech [mechanical] Soft/chopped. diet. MAX [maximum] instruct is needed to use swallow safety guidelines and decrease bit size. During a review of Resident 19's diet order (DO), dated 8/16/2024, the DO indicated, Order Summary: Double portion of mechanical soft/chopped renal diet. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 19's meal tray card (MTC) (individualized direction on how to plate/serve patient's meals), dated 8/19/24, the MTC indicated Consistency: Mechanical Soft, Chopped, Renal. There was no direction to dietary staff preparing Resident 19's meal tray in the kitchen to provide double portions to ensure the physician ordered diet was implemented. . 2. During an observation on 8/19/24 at 11:53 a.m., in the facility's dining room, Resident 1 was observed eating lunch. The lunch menu included chicken chow mein, spring roll, and scalloped cinnamon peaches. Resident 1's meal tray ticket indicated the resident was on an NAS (no added salt), CCHO (controlled carbohydrates) diet with mechanical soft, chopped consistency. The food served to Resident 1 was not chopped. During a concurrent observation and interview, on 8/19/24 at 11:58 a.m., with a licensed nurse (LN) 5, LN 5 verbalized that prior to serving the resident meals, nursing staff ensured the food served to the residents matched their prescribed diet and food consistency. After inspecting Resident 1's meal tray, LN 5 verified that the food was not chopped as indicated on the prescribed diet. During a review of Resident 1's RD Nutrition Assessment Readmission Note, dated 6/12/24, the note indicated in part Resident 1 was on a CCHO NAS mechanical soft chopped meat thin liquids diet. During a review of Resident 1's Minimum Data Set (MDS - a federally mandated process for clinical assessment of residents in nursing homes) Assessment, dated 6/15/24, Section K - Swallowing/Nutritional Status . Nutritional Approaches of the assessment indicated in part Resident 1 is on a mechanically altered diet - require change in texture. During a concurrent interview and record review on 8/19/24 at 11:26 a.m. with the CDM, in the presence of the RD, the facility's Utilization Review Committee Quarterly Meeting Attendance signature page, dated 1/9/24, was reviewed. CDM stated during that meeting was when the facility's diet manual was reviewed and approved. The signature page contained the signature for the CDM next to Dietary Supervisor. There was no RD signature nor line designated on the form with the title of RD to indicate the RD reviewed and approved the facility's diet manual. CDM stated, that was the approval signature page for the facility's diet manual. During a review of the facility's policy and procedure (P&P) titled, Section D: Food Production (FP), the P&P indicated, II. Food Preparation (Basic Guidelines); Policy: The preparation of food will be done following standard food handling techniques. Standardized recipes, quantity cookbooks, safe food handling procedures and an approved diet manual will be made available to assist Nutrition Services Employees. During a review of the facility's policy and procedure (P&P) titled, Tray Service Protocol, dated 2014, the P&P indicated, Policy: Food will be served in a manner that meets the individual needs of each resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055597	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maywood Acres Healthcare	2641 South C St Oxnard, CA 93033

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Section D: Food Production (FP), the P&P indicated, II. Food Preparation (Basic Guidelines); Policy: The preparation of food will be done following standard food handling techniques. Standardized recipes, quantity cookbooks, safe food handling procedures and an approved diet manual will be made available to assist Nutrition Services Employees. During a review of the facility's policy and procedure (P&P) titled, Tray Service Protocol, dated 2014, the P&P indicated, Policy: Food will be served in a manner that meets the individual needs of each resident.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 27157 Based on observation, interview, and record review, the facility failed to ensure resident's lunch was served in an attractive manner when the food items on the plate were similar color (brown) and the noodles were mushy when the food was hot held for a prolonged period of time prior to the lunch meal service. Three residents expressed dissatisfaction with the facility's food during the survey(Resident 48, Resident 43, Resident 2). As a result, hot holding food for a prolonged period of time was not a method of food preparation that conserves nutritive value or appearance. In addition, food that was served lacked a variety of color creating an unappetizing appearance and could cause less food intake and weight loss. Findings: .During a concurrent observation and interview on 8/19/24 at 08:37 a.m. with [NAME] 1 upon entrance into the kitchen to begin survey, steamtable was observed empty as breakfast meal had been completed. [NAME] 1 was observed cooking at the stove range, and [NAME] 1 stated she was preparing lunch for residents. During a concurrent observation and interview on 08/19/24 at 9:40 a.m. with [NAME] 1, in the kitchen, [NAME] 1 was observed stirring chow mein noodles in a large pot over the stove range. The chow mein noodles appeared to have cooked vegetables and the noodles appeared done. [NAME] 1 stated it was chicken chow mein. [NAME] 1 stated she had already cooked the chicken and the vegetables earlier that morning, and they were already added to the chow mein that she was stirring. During an interview on 8/19/24 at 9:50 a.m. with Resident 48, Resident 48 stated vegetables were mushy at lunch and dinner. Resident 48 stated he wished the kitchen staff would use more fresh vegetables, as he thought they primarily used frozen vegetables. During a review of Resident 48's Order Summary (OS), dated 5/9/24, the OS indicated, Regular Renal [for kidney disease] NAS [no added salt] CCHO [consistent carbohydrate] Diet. During a concurrent observation and interview on 08/19/24 at 011:14 a.m., in the kitchen, during trayline a lunch plate was plated with pureed texture food. There were only two items located on the white plate which was a round scoop size of a brown colored food, and another round scoop size of a brown colored food. No additional food/items were placed on the plate. RD stated it was a standard of practice in menu planning to include a variety of color to present the food in an appetizing manner. RD stated the chow mein had vegetables with color but they were pureed so the color was not visible. RD stated, the other pureed scoop of brown colored food was pureed Asian blend vegetables. RD acknowledged there was lack of color from the food located on the plate, as they were both brownish in color, as RD stated they had a little difference in the shade of brown. From observing the pureed food the two circled portions of food appeared brown in color and one could not distinguish what type of food it was without a menu in front of them detailing what it was. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's Spring/Summer - Week III menu, dated 8/19/24, the planned menu for puree texture indicated Pu [pureed] chicken chowmein, Pu Asian Blend Vegetables, Pu Scalloped cinnamon peaches. The pureed peaches were served in a small dessert dish that was placed on the tray, and not on the plate that only contained two round portions of brown colored food that had not appeared appetizing. During a concurrent observation and interview on 08/19/24 at 012:20 p.m., in the South hall way, with the RD, the test tray with a regular diet was observed. The chicken chow mein appeared mushy and the vegetables had small thin slices of carrots that appeared dull in color and overcooked. Overall, the regular diet appeared with slim amount of color and overall brown colored foods with mushy appearing noodles. The peaches were served in a dessert cup that was placed to the side and located on the meal tray, not on the meal plate. RD verified the noodles appeared mushy. One the two brown scoops of food on the pureed texture test tray appeared to resemble refried beans, but RD stated it was a pureed Asian vegetable blend. RD acknowledged the lunch meal was not varied in color which was a standards of practice in menu planning. During a review of an article published by Association of Nutrition & Foodservice Professionals (ANFP) titled Menu Planning Thinking Beyond Color, Flavor & Texture, dated February 2013, the article indicated, Everyone knows the basics - provide good-tasting, attractive dishes that feature a variety of colors and flavors. But think of other considerations when you develop your spring cycle menus. Appealing combinations, pleasant aromas, varied textures. During an interview on 8/19/24 at 3:40 p.m. with [NAME] 1 and [NAME] 2, [NAME] 1 stated she placed the cooked chicken chow mein noodles in the oven to hot hold them at about 9:45 a.m. Both [NAME] 1 and [NAME] 2 stated they were hot held in the oven at 350 degrees F until about 10:30 a.m. when they were then placed in the steam table to hot hold until lunch trayline began at about 11:00 a.m. During an interview on 8/19/24 at 3:45 p.m. with RD, in the presence of Certified Dietary Manager (CDM), the above interview was shared with RD and CDM and they were asked if there was a reason why staff had to prepare noodles and vegetables so early as they were done by 9:40 a.m. at the latest, on hot held at 350 degrees F in the oven, and RD stated, That's too early. I will talk to them. CDM stated that was still a cooking temperature, not hold holding. During a review of the facility's policy and procedure (P&P) titled, VII. Menu Posting, dated 2014, the P&P indicated, The [name of menu company] provides attractive daily and weekly menus for posting including non-select and select menu styles. During a review of the facility's policy and procedure (P&P) titled, Section D: Food Production (FP), the P&P indicated, II. Food Preparation (Basic Guidelines); Policy: The preparation of food will be done following standard food handling techniques. Standardized recipes, quantity cookbooks, safe food handling procedures and an approved diet manual will be made available to assist Nutrition Services Employees. During a review of the facility's recipe titled, Chicken Chow Mein (CCM), dated 3/13/24, the recipe indicated, Slice chicken into strips. Saute' chicken in oil until meat is browned. Add chicken stock to meat and simmer for 15-30 minutes, or until done. (The chicken was already cooked prior to 9:40 a.m.) The CCM recipe indicated when the chicken chow mein was done to Hold or serve hot at or above 140 degrees F. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, II. Food Preparation (Basic Guidelines), dated 2014, the P&P indicated, Saute'/Pan Fry:.In preparing meat, the finished product should be tender, juicy, tasty, and have a minimum of shrinkage. This is achieved by cooking or roasting slowly at low to moderate temperatures (275 - 350 degrees F).Vegetable Preparation; Vegetables should be prepared as close to serving time as possible.Vegetables are high in nutritive value and contribute to the attractiveness and acceptability of the meal. Care should always be taken to prevent destroying their nutritive value.Be careful not to overcook.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. 27157 Based on observation, interview, and record review, the facility failed to: 1. Ensure the door for one of one walk-in refrigerators in the kitchen was maintained in safe, operating condition when the door would not remain closed after being pushed shut. As a result, temperature abuse (lack of adherence to strict temperature control) could occur which could lead to food spoilage and/or growth of pathogens that placed the residents at an increased risk for foodborne illness. 2. Ensure there was an appropriate air gap between the dish machine drain and the floor sink drain to prevent contaminated water from backing up into the dish machine should a problem arise with the floor drain. Findings: 1. During a concurrent observation and interview on 08/19/24 at 8:59 a.m. with Registered Dietitian (RD) in the kitchen, inside a walk-in refrigerator was a large wall thermometer, and RD stated, it read 50 degrees F (Fahrenheit). During a concurrent observation and interview on 8/19/24 at 8:41 a.m. with RD and dietary aide (DA) 1, the RD obtained an individual sized milk carton from the walk-in refrigerator and took the internal temperature using the facility's digital thermometer, and RD stated, It's 53 degrees F. DA 1 stated the facility had not had a food delivery that morning. DA 1 showed the refrigerator temperature monitoring log that showed the refrigerator was at 41 degrees F or less, with not out of compliance days per the August 2024 log. DA 1 stated the dietary staff utilized the external thermometer that was affixed to the walk-in refrigerator to record the temperatures on the log. During a concurrent observation and interview on 8/19/24 at 09:16 a.m. with RD and DA 1, DA 1 stated the external thermometer to the walk-in refrigerator indicated 53 degrees F. RD and DA 1 observed the door not completely shut at that time, as the door was on the outside of the latch/hinge although dietary staff were observed shutting the refrigerator door completely when exiting the refrigerator earlier. DA 1 pointed to a sign on the wall next to the walk-in refrigerator that reminded staff to shut the door to the refrigerator. RD acknowledged there was a problem with the door that prompted dietary staff to put up a sign for dietary staff to always check to make sure the door was shut. During an interview on 08/19/24 at 9:15 a.m. with the Dietary Manager (DM), DM stated she put the sign up for staff reminding them to shut the door to the walk-in refrigerator because it tended to not shut easily. DM stated if the door could remain closed the refrigeration unit was able to maintain appropriate temperature for food safety. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 08/19/24 at 9:40 a.m. with maintenance supervisor (MS) in the kitchen, MS observed the door to the walk-in refrigerator. MS stated about two months ago he put a strip at the bottom of the door hoping that would get the door to have a tighter seal and stay shut. MS stated he had not been back to follow up to ensure the strip fixed the problem. MS was asked if he thinks there was anything that could be done for the door to get it to function properly. MS stated he might be able to work on the door hinges to help or he might need to call a refrigeration company. During an observation on 08/19/24 at 11:12 a.m. in the kitchen, all dietary staff were observed working at trayline (assembly of resident lunch meal trays). During a concurrent observation and interview on 08/19/24 at 12:10 p.m. with DA 1 in the kitchen, while the dietary staff continued to work on trayline, DA 1 was available to go observe the refrigerator to see who the manufacturer was. Concurrently, the refrigerator door was observed not shut all the way, as the door was observed outside of the latch, and there was a visible gap in which you could see inside the walk-in refrigerator. DA 1 stated dietary staff would shut the door and upon return the door could be found not completely shut, again. In addition, from a distance, such as from trayline, the door appeared to be shut because it was a dark brown/blackish colored door and was not visible from a short distance that the door was not closed. During a concurrent interview and record review on 8/19/24 at 3:45 p.m. with MS, invoices (Inv) from an outside service for refrigeration, air conditioning and heating were reviewed. An Inv, dated 4/15/24 indicated, Other-Labor/Service PM [preventative maintenance] service on refrigeration and ice machine equipment. clean out condenser coils, check door gaskets. An Inv, dated 8/7/24, indicated, Other-Labor/Service PM service on refrigeration., clean out condenser coils, check door gaskets. MS was asked what check door gaskets written on the invoice meant. MS stated that the outside vendor had not left recommendations related to the door of the walk-in refrigerator. MS 1 stated there were no manufacturer labels on the refrigerator, and he did not know who the manufacturer was, as it was a very old refrigerator. The refrigerator's manufacturer's guidelines were unable to be obtained for review. During an interview on 08/19/24 at 04:07 p.m. with Administrator (Admin), Admin was informed of the observations above starting with the internal thermometer indicated 50 degrees F and the refrigerator door observed to be outside of the latch after observing dietary staff shutting the door, as if the door gradually opens on its own. Admin was informed due to the door not functioning properly the concern was temperature abuse occurring throughout the day, had the potential to accumulate to four hours in the danger zone which could place the residents at risk for foodborne illness. The Admin stated he understood and did not have any questions. During a review of the facility's policy and procedure (P&P) titled, Interior Maintenance, undated, the P&P indicated, Dietary Inspection Procedures:.a) Vacuum (or blow out) coils on large refrigerators quarterly to prevent dangerous collection of dirt and dust, b) Clean condenser and lubricate motors as designated in manufacturer's instructions, c) Check door gaskets, d) Refrigerator temperature should be 36 degrees F - 40 degrees F. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the Food and Drug Administration Food Code Annex (FDAFCA), dated 2022, the FDAFCA indicated, Proper maintenance of equipment to manufacturer specifications helps ensure that it will continue to operate as designed. Failure to properly maintain equipment could lead to violations of the associated requirements of the Code that place the health of the consumer at risk. For example, refrigeration units in disrepair may no longer be capable of properly cooling or holding time/temperature control for safety foods at safe temperatures. (4-501.11 Good Repair and Proper Adjustment) 2. During an observation on 8/19/24 at 8:39 a.m. in the kitchen, observed dietary aide (DA) 2 operating the low temperature (temp) dishmachine. A black plastic pipe was observed draining wastewater from the low temp dishmachine. The outlet end of the black plastic pipe was near the floor of the floor sink drain. There was not an appropriate air gap observed between the outlet end of the waste pipe and the flood-level rim of the floor sink drain. During a concurrent observation and interview on 08/19/24 at 09:29 a.m. with maintenance supervisor (MS), MS observed the low temp dishmachine in use. MS stated the copper pipe, and the black plastic pipe was connected to the dish machine. MS stated the black pipe was primarily used to drain water from the dish machine. MS was asked if the drainpipes had an appropriate air gap. MS stated he did not know what an appropriate air gap should be per a plumbing code nor the FDA food code. During a concurrent observation and interview on 8/19/24 at 9:31 a.m., with Registered Dietitian (RD), RD observed the black pipe connected to the dishmachine and RD stated, there was not an appropriate air gap in accordance with the FDA food code and there was potential for backflow of contaminated water to go back up through the pipe and contaminate dishes. During a review of the facility's policy and procedure (P&P) titled, Interior Maintenance, undated, the P&P indicated, Dietary Inspection Procedures: .Check major kitchen equipment, and plumbing connections and drains. Service per manufacturer's recommendations. During a review of the Food and Drug Administration (FDA) Food Code (FDAFC), dated 2022, the FDAFC indicated, An air gap between the water supply inlet and the flood level rim of the plumbing fixture, equipment, or nonfood equipment shall be at least twice the diameter of the water supply inlet and may not be less than 25 mm (1 inch). (FDA Food Code 5-202.13 Backflow Prevention, Air Gap.) During a review of the FDA Food Code Annex (FDAFCA), dated 2022, the FDAFCA indicated, Providing an air gap between the water supply outlet and the flood level rim of a plumbing fixture or equipment prevents contamination that may be caused by backflow. (FDA Food Code Annex 5-202.13)