STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056379	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oxnard Manor Healthcare Center	1400 West Gonzales Road Oxnard, CA 93036

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and Policy and Procedure (P/P)facility failed to ensure a resident receiving Hemodialysis ((HD-procedure done by a trained professional to remove waste and excess fluids from the body when the kidneys stop working properly) received care and services consistent with professional standards of practice for one of three sampled residents (Resident 1)when:1. Pre and post dialysis evaluation was not completed2. A total inspection of an arteriovenous (AV) shunt (fistula, is a surgically created direct connection between an artery and a vein, typically in the arm, for long-term hemodialysis access) site area for color, warmth, redness, edema, and drainage was not done and documented. This failure resulted in Resident 1 developing a severe infection that required interventions. According to the American Nurses Association (ANA). (2021). Standards of practice. Nursing: Scope and Standards of Practice (3rd ed.) (pp. 53 - 66). First principle of documentation: 1. Documentation Characteristics: Accessible, Accurate and relevant, Auditable, Clear, concise, comprehensive, and thoughtful. Accuracy in nursing assessments is the collection of reliable and precise data that reflects the patient's true health status. During a review of Resident 1's admission Record (AR), dated 1/29/26 the AR indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included End Stage Renal Disease (ESRD - final stage of permanent kidney failure whereby requiring regular dialysis or a transplant for survival) and dependence on renal dialysis. During a review of Resident 1's Order Summary (OS) dated 2/12/25, the OS indicated Resident 1 had hemodialysis on Mondays, Wednesdays, and Fridays.During a review of Resident 1's OS dated for 1/29/2026 with a start order date of 3/24/24, the OS indicated, If bleeding occurs at AV shunt RUA (Right Upper Arm) any time after dialysis, apply pressure with clean gauze for 5-10 minutes.repeat until bleeding stops. If this intervention does not control the bleeding, notify MD.During a review of Resident 1's medical records titled, Pre-Dialysis Evaluation, B. Dialysis Unit to Complete, comments were written by the dialysis nurses on the access site assessment for the following dates of treatment:12/23/25 Dressing left on HD access.12/28/25 Dressing left on HD access since 12/26.must be removed to prevent clotting/damage to the access.1/5/26 Remove HD dressings tonight! Dressings from 12/26 were left on.1/12/26 Please remove fistula dressing 1 to 2 hours post HD to avoid problems with fistula site.1/16/26 Dressing left on from last treatment. Must be removed before bed.1/19/26 ‘Swabbed wound on access. Dressing left on since 1/16/26 and dressing damp left raw skin & sore.1/23/26 .Swabs done on access on 1/19 growth for staph aureus and pseudomonas aeruginosa (both bacteria that can cause an infection).During a review of Resident 1's medical records titled, Post Dialysis Evaluation, dated 12/23/25, 12/28/25, 1/5/26, 1/12/26, 1/16/26, and 1/23/26, there was no documentation to show dressings applied at the dialysis center after Resident 1's treatments were removed by the facility's receiving nurses.During a review of Resident 1's medical record titled Microbiology Report (A report that help identify bacteria, fungi, or viruses from clinical specimens to diagnose infections and guide treatment) result date of 1/24/26 (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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated, Culture Wound.Access Site.Collected 1/19/26.Organism Pseudomonas aeruginosa (a major opportunistic pathogen, frequently causing severe, antibiotic-resistant), heavy growth and Staphylococcus aureus (a germ found on people's skin), moderate growth. In addition, the physician ordered Vancomycin and Ceftazidime (both antibiotics). During a review of Resident 1's Order Summary Report dated 1/21/26 the OS indicated Resident 1 had a physician appointment on 1/26/26 for possible infection R (right) upper AV shunt.During review of Resident 1's Care Plan (CP), dated 3/26/24, the CP indicated The resident needs hemodialysis related to End Stage Renal Disease. Nursing interventions included: Check and change dressing daily at access site. Document.Monitor/document/report PRN (as needed) any signs/symptoms (s/sx) of infection to access site: Redness, swelling, warmth, or drainage.Monitor /document/report PRN for s/sx of the following: Bleeding, hemorrhage, bacteremia, septic shock.During a review of Resident 1's medical record, there was no documentation to show Resident 1's dialysis access site had been monitored for infection since a growth result of bacteria was detected and was started on new antibiotic therapy.During a concurrent interview and record review on 1/29/26 at 1:46 p.m. with Licensed Nurse (LN 1), LN 1 stated being assigned familiar with Resident 1. LN 1 stated the process for post dialysis included entering notes in the medical record, if there were any, and to remove the dialysis dressing 1 hour after the resident arrives. LN1 acknowledged the Post Dialysis Evaluations dated 12/28/25, 1/7/26, 1/19/26, and 1/26/26 were signed by LN 1 and that there was no documentation to show the dressings applied at the dialysis center after Resident 1's treatments were removed.During a concurrent phone interview and record review on 2/3/26 at 3:34 p.m. with Licensed Nurse (LN 3), LN 3 confirmed to have been assigned and being familiar with Resident 1. Resident 1's pre-dialysis assessments dated 1/5/26, 1/19/26, and 1/26/26 were reviewed. LN 3 acknowledged the access site assessments performed by staff were discrepant from the dialysis center and that the resident's access site could not change so drastically during transport from the facility to dialysis. LN 3 stated the access site was assessed as being within normal limits (WNL) when there were other options in the electronic health record to better describe Resident 1's AVF site such as redness, swelling, pain, bleeding, or skin discoloration but those options were not selected. And LN 3 acknowledged, not to be aware the dressing on Resident 1's AVF site was the dressing from the previous dialysis session and confirmed there were no observations done to monitor for signs of inflammation, infection and or inspection of the shunt site area for color, warmth, redness, edema, and drainage.During a concurrent phone interview and record review on 2/3/26 at 4:03 p.m. with Licensed Nurse (LN 4), Resident 1's Pre-dialysis records dated 12/25 through 01/26 were reviewed. LN 4 confirmed to have been assigned and involved in the care of Resident 1 during when the resident had pre and post dialysis appointments. However, pre or post dialysis assessments were not performed on the days she was assigned to Resident 1 on 12/21/25, 12/28/25, 1/7/26, and 1/16/26, and 1/23/26 for Resident 1. Further interview with LN 4 revealed that dialysis dressing must be removed by the receiving nurse after 2 hours from arrival and LN 4 claimed to have assumed the dressings found on Resident 1's AVF site were for treatment provided by the facility. LN 4 state she was not aware the dressing on Resident 1's AVF site was the dressing from the previous dialysis session and acknowledged, there were no observations done to monitor for signs of inflammation, infection and or inspection of the shunt site area for color, warmth, redness, edema, and drainage,During a concurrent interview and record review on 2/19/26 at 10:21 a.m. with Director of Nursing (DON), Resident 1's Pre-dialysis records dated 12/25 through 01/26 were reviewed. DON confirmed the post dialysis dressing should be removed 4 - 6 hours after dialysis. DON confirmed dialysis center communicated to the facility on multiple occasions when Resident 1 had returned to dialysis with the dressing from the previous dialysis treatment and (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the risks it can cause to the AVF site.During a review of the facility's policies and procedures (P&P) titled, Dialysis Management, dated 3/24, the P&P indicated, The facility should assure that each resident receives care and services consistent with professional standards of practice. 3. A pre and post dialysis evaluation will be completed by the licensed nurse. 4. Vascular Access Site.b. Assessing, observing and documenting care of access sites daily, as applicable, such as.iii. Skin integrity (waxy skin, ulcerations, drainage from incisions) .vii. Evidence of infection at the surgical site, such as drainage, redness, tenderness at incision site, fever.During a review of the facility's P&P titled Arteriovenous Shunt Care, revised 01/12, indicated, . I. Observe for signs of inflammation, infection and obstruction.Inspect total shunt site area for color, warmth, redness, edema and drainage, once per shift

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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** Based on interview and record review, the facility failed to ensure licensed nurses (LNs) were competent in providing quality of care for one of three sampled residents (Resident 1) when a comprehensive assessment and individualized care plan was not completed related to Resident 1's change of condition (new onset of infection).This failure had resulted in Resident 1's signs and symptoms of infection not monitored by staff and had the potential to develop complications. During a review of Resident 1's admission Record (AR), dated 1/29/26 the AR indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included End Stage Renal Disease (ESRD - final stage of permanent kidney failure whereby requiring regular dialysis or a transplant for survival) and dependence on renal dialysis (procedure done by a trained professional to remove waste and excess fluids from the body when the kidneys stop working properly). During a review of Resident 1's Order Summary (OS) dated 2/12/25, the OS indicated Resident 1 had hemodialysis on Mondays, Wednesdays, and Fridays. During a review of Resident 1's OS dated 3/24/24, the OS indicated, If bleeding occurs at AV shunt arteriovenous fistula (AVF- a surgical connection between an artery and a vein used for dialysis) RUA (Right Upper Arm) any time after dialysis, apply pressure with clean gauze for 5-10 minutes.repeat until bleeding stops. If this intervention does not control the bleeding, notify MD.During a review of Resident 1's medical record titled Microbiology Report (a report that help identify bacteria, fungi, or viruses from clinical specimens to diagnose infections and guide treatment) result date of 1/24/26 indicated, Culture Wound.Access Site.Collected 1/19/26.Organism Pseudomonas aeruginosa (a major opportunistic pathogen, frequently causing severe, antibiotic-resistant), heavy growth and Staphylococcus aureus (a germ found on people's skin), moderate growth. In addition, the physician ordered Vancomycin and Ceftazidime (both antibiotics). During a review of Resident 1's medical record, there was no documentation to show a comprehensive assessment and an individualized care plan with interventions was done for Resident 1's new onset of infection on the dialysis access site and that it had been monitored for signs and symptoms of infection/complication since the start of a new antibiotic therapy. In addition, there was no documentation on Resident 1's change of condition related to the infection. During a concurrent phone interview and record review on 2/3/26 at 2:19 p.m. with Licensed Nurse (LN 2), LN 2 confirmed there was no change of condition in the Resident 1's medical record for the positive growth result and antibiotic therapy. LN 2 stated a change of condition should have been initiated but was not. During a concurrent phone interview and record review on 2/3/26 at 3:34 p.m. with Licensed Nurse (LN 3), LN 3 confirmed to have been assigned and was familiar with Resident 1. LN 3 acknowledged that the receiving nurse did not initiate a change of condition when dialysis staff communicated that the resident had positive bacterial cultures and was receiving antibiotics. During a review of the facility's policy and procedure titled, Change in Condition, dated 08/22, indicated, .2. The Licensed Nurse will assess the change of condition and determine what nursing interventions are appropriate. a.i Notification to the Physician/APP will include a summary of the condition change and an assessment of the resident's vital signs and system review focusing on the condition and/or signs and symptoms for which the notification is required utilizing a SBAR format (situation, background, assessment, recommendation) .4. Reporting Information to the Physician/APP.b. Reporting Laboratory and Diagnostic results .