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	10/31/2024

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

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(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** 40560 Based on observation, interview, and record review, the facility failed to maintain a homelike environment in one resident room and two shower rooms. This failure had the potential to negatively impact residents. Findings: During an interview 10/30/24, at 10:40 a.m., with the maintenance assistant (MS 1), the MS 1 was asked if the facility was up to date with repairs. The MS 1 verbalzied yes. During an observation on 10/30/24, starting at 10:45 a.m., the facility was toured. During the tour one unoccupied room (room [ROOM NUMBER]) had wall damage with peeling paint and a damaged bathroom door frame. During an interview on 10/30/24, at 10:50 a.m., with MS 1, the MS 1 confirmed the wall damage and door frame damage in room [ROOM NUMBER]. During a concurrent observation and interview, on 10/30/24, starting at 4:09 p.m., with Environmental Services Director (ES 1), the facility's two shower rooms were toured. The east side shower room had a door frame in disrepair while the west side shower room had broken tiles along the wall's baseboards. The ES 1 confirmed the items in disrepair for both shower rooms and verbalzied they would need to be fixed. During a review of the facility policy titled Resident Rooms and Environment dated 1/1/12, indicated in part The facility provides residents with 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056379	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/31/2024
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(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** 32661 Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person focused care plan for 2 of 5 sampled residents when: 1. Resident 65's preference for warm drinking water was not identified in the resident's careplan. This failure resulted in the resident storing warm water via water [NAME] at the bedside by self , with no facility assessment if ok with medications and other dietary intake /food/meal. 2. Resident 40's interdisciplinary team (IDT) nutrition care plan (detailed plans of care created by representatives from several medical disciplines or specialties) did not contain clear and resident specific measurable objectives with the input of the resident and/or responsible party (RP) on their goals and desired outcomes related to Resident 40's weight and 2b. Ensure risks of refusal of a renal diet (for kidney disease) were explained to the RP for informed decision making. This failure resulted in unclear, weight maintenance goal and could impede the IDT from effectively monitoring, evaluating, and revising the care plan, as appropriate, to ensure care needs would not go unrecognized and unmet. Failure to discuss risks of refusal of a therapeutic diet with the RP to support informed decision making was not implementing person-centered care planning. Findings: 1. During initial observation tour and concurrent interview, on 10/29/24, at 7:36 a.m., in room [ROOM NUMBER]-1, Resident 65 had no water pitcher on her bedside table. However, a 20 oz. (ounce) metal [NAME] with a lid was observed on the bedside table. Resident 65 said she prefers to drink only warm water and has requested staff for warm water instead of the cold water served in the water pitchers. Staff said they do not serve warm water, only cold water. Resident 65 indicated , wheeling self via wheelchair to the water dispenser to get the warm water. In an interview with the Dietary Supervisor (DS 1), on 10/30/24, at 11:50 a.m., regarding Resident 65's preference for warm water, being told warm water was not served, and resident having to get the warm water herself from the water dispenser, DS 1 said he was not aware of any of it. Review of Resident 65's Care Plan for Dehydration intervention indicated, Educate the resident/family/caregivers on importance of fluid intake. The comprehensive care plan did not include resident's preference for warm water. Review of the facility Policy and Procedure titled Resident Rights, dated 1/1/12, indicated in part, IV. In order to facilitate resident choices, Facility staff will: B. Gather information about the resident's personal preferences on initial assessment and periodically thereafter, and document these preferences in the medical record; and C. Include information gathered about the resident's preferences in the care planning process. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	27157 2. During a concurrent interview and record review on 10/30/24 at 09:57 a.m. with Licensed Nurse (LN) 1, Resident 40's Nutrition Long Term Care Plan (NCP), initiated on 4/17/23 and last revised on 5/3/24 was reviewed. The NCP indicated, Focus .Admit Wt [weight] 139.6 lbs [pounds].Hx [history] of large weight trend fluctuations.Weight loss of 6.9 lbs in 1 month (as of 8/3/23), 10/5/23 weight loss 12.7 in 1 month, 10/16/23 - [loss of] 8.2 lb/[within] 30 days, -17 lb/10.7%/90 days, November 2023 -13.4 weight gain in a month, December 2023 weight loss 7.9 lb in one month.Goal: The resident will maintain adequate nutritional status as evidenced by maintaining weight.through review date.12/29/2024. LN 1 stated the goal was to maintain weight, maintain her ideal weight. LN 1 was asked what the resident's ideal weight was, and LN 1 stated from the NCP, I can't tell. LN 1 stated the NCP was unclear as she was unsure of what weight the facility was trying to maintain for Resident 40. During a concurrent interview and record review on 10/30/24 at 02:48 p.m. with Director of Nursing (DON), Resident 40's NCP initiated on 4/17/23 and last revised on 5/3/24 was reviewed. The NCP indicated, Goal: The resident will maintain adequate nutritional status as evidenced by maintaining weight.through review date.12/29/2024. DON stated the goal for Resident 40 was to maintain weight. DON was asked what weight was to be maintained? DON stated, Maybe it's the weight before, or maybe it's the base line weight goal upon admission. DON confirmed the NCP had not contained clear direction to IDT members related to weight maintenance goal when there was no resident specific weight or weight range goal documented on the NCP. DON verified lack of clear weight maintenance goal could impede effective monitoring and evaluating as to whether the weight goal was being maintained or not. During a concurrent interview and record review on 10/30/24 at 02:48 p.m. with DON, DON was asked to review Resident 40's nutrition assessment (NA), dated 4/29/24, completed by the Registered Dietitian (RD). After the DON reviewed the NA, DON stated, The weight to be maintained is 141 -157 lbs. DON verified the NCP was not clear on the specific weight maintenance goal for Resident 40 and should have been to be person-centered care with measurable objectives. During a review of CMS (Centers for Medicare & Medicaid Services) the comprehensive care plan should include measurable objectives defined as the ability to be evaluated or quantified. During a review of Resident 40's Multidisciplinary Care Conference (MCC), dated 10/13/23, the MCC indicated, .Current Weight: 141.1 lbs, Goal Body Weight (lbs.): maintain weight. During a review of Resident 40's Multidisciplinary Care Conference (MCC), dated 10/16/24, the MCC indicated, Resident 40 weighed 160.9 lbs. and the Goal Body Weight category listed on the form was blank. The category titled Current goals indicated to maintain weight. (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 interview and record review on 10/31/24 at 11:02 a.m. with RD, RD stated it was the nursing responsibility to document the goals on the NCP. RD reviewed Resident 40's NCP, last revised on 5/3/24, and verified the goal of maintain weight was general and not detailed sufficiently to be resident specific to effectively monitor. RD reviewed Resident 40's NA, dated 4/29/24, and verified Goal Weight indicated n/a, and Usual Weight indicated 141 - 157 lbs. RD stated she usually does not assess, nor document, a goal weight for residents residing at the facility out of concern a facility may be cited if the goal weight was not maintained or achieved. In addition, RD stated she does not involve the resident and/or RP to obtain resident and/or RP's goals and preferences related to a resident's weight goal for person-centered care. However, in this case, Resident 40's NA, dated 4/29/24, indicated, Nutritional Goal: No significant, unplanned weight changes outside of UBW [usual body weight] range. During a review of the facility's policy and procedure (P&P) titled, Evaluation of Weight Nutritional Status, dated 11/16/22, the P&P indicated, The facility will work to maintain an acceptable nutritional status for residents by: c. Defining and implementing interventions for maintaining, or improving nutritional status that are consistent with resident needs, goals, and recognized standards of practice. Review of the facility Policy and Procedure titled Resident Rights, dated 1/1/12, indicated in part, IV. In order to facilitate resident choices, Facility staff will: B. Gather information about the resident's personal preferences on initial assessment and periodically thereafter, and document these preferences in the medical record; and C. Include information gathered about the resident's preferences in the care planning process. During a review of the facility's P&P titled, Comprehensive Person-Centered Care Planning, dated 8/24/23, the P&P indicated, Policy: The Facility will provide person-centered, comprehensive, and interdisciplinary care that reflects best practice standards for meeting health, safety, psychosocial, behavioral, and environmental needs of residents in order to obtain or maintain the highest physical, mental, and psychosocial well-being.the comprehensive care plan will also be reviewed and revised.as appropriate or necessary. 2b. During an observation on 10/28/24 at 12:30 p.m. in Resident 40's room, Resident 40's meal tray card was located on her meal tray that was on her bedside table positioned in front of her. Resident 40's meal tray card indicated her diet order was CCHO (consistent carbohydrate diet for diabetes) mechanical soft (to make it easier to chew and swallow foods, reducing the risk of choking). During a review of Resident 40's Admission Record (AR), the AR indicated Resident 40 was readmitted to the facility on [DATE]. During a review of Resident 40's Order Summary Report (OSR), dated 4/17/23, the OSR indicated, Hemodialysis [a treatment that filters waste and excess fluid from your blood when your kidneys can no longer perform that function] every Tues [Tuesday]-Thurs [Thursday]-Sat [Saturday]., Diet: CCHO mechanical soft texture. (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 interview and record review on 10/31/24 at 10:12 a.m. with RD, Resident 40's Nutrition Review (NR), dated 10/11/23 was reviewed. The NR indicated, .Her diet was liberalized to CCHO mech [mechanical] soft due to her preference and refusal to follow more restrictive diet [a renal diet]. Risks have been explained but she prefers to continue current plan. Dx [diagnosis] moderate dementia but she states that she understands risks. Therapeutic diet (CCHO mech soft) . RD stated Resident 40's RP was not involved in decision making, to include informing RP of risks and benefits, of omitting a therapeutic renal diet. RD stated she was not aware there was a requirement to involve the resident and/or RP in the decision-making process related to therapeutic diet recommendations and/or weight goals for a resident. During a review of Resident 40's History and Physical (H&P), dated 4/20/23, the H&P indicated, This resident can make needs known but can not make medical decisions. Surrogate decisionmaker: Family. During a review of Resident 40's Multidisciplinary Care Conference (MCC), dated 10/13/23, the MCC indicated, Current Diet: Mechanical Soft CCHO.Attendance in review/meeting.k. Family was left blank indicating family was not present. The facility's MCC were reviewed from 10/13/23 through 10/16/24. The MCC, dated 10/16/24, indicated the family was present as evidenced by a check mark under k. Family. The MCC, dated 10/16/24, indicated, Current Diet: Mechanical Soft CCHO.9a. Resident/Family: a. Expectation/Concerns: Daughter states she is familiar with Res. [resident] diet and has no questions. This documentation was at least a year later after Resident 40's most recent re-admission to the facility and lacked documentation that risks and benefits of lack of a therapeutic renal diet were specifically explained. During a review of Resident 40's Nutrition Long Term Care Plan (NCP), initiated on 4/17/23, revised on 12/1/23 and last revised on 5/3/24, was reviewed. The NCP indicated, Focus: .Risk for malnutrition related to: On therapeutic diet, on mechanically altered diet.Interventions: .Provide education to resident, responsible party.regarding special care needs, .explain consequences of refusal, CCHO-Standard portion diet Mechanical Soft. During a review of the facility's policy and procedure (P&P) titled, Comprehensive Person-Centered Care Planning, dated 8/24/23, the P&P indicated, .Interdisciplinary Team (IDT) a. The IDT team may include but is not limited to the following individuals: v. To the extent practicable, the resident and the resident's representative(s).f. Each resident and/or resident representative will actively remain engaged in his or her care planning process through the resident's rights to participate in the development of, and be informed in advance of changes in the plan of care.

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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** 32661 Based on record review and interview, the facility failed to ensure a resident 's (Resident 127) electronic medical record (eMAR - a digital version of a resident's medication administration) was accurately signed or accurate documentations were entered when a medication was administered or not administered as ordered by the physician . This failure has the potential for resident not to received the medications as ordered essential for quality of life and well being . Findings: 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. Review of [NAME] and [NAME], 6th Edition, Mosby's Fundamentals of Nursing, page 847 in the section titled, Medication Administration indicated, After administering a medication, the nurse records it immediately on the appropriate record form. The nurse never charts a medication before administering it. Recording immediately after administration prevents errors. Review of [NAME] and [NAME], seventh Edition, Mosby's Fundamentals of Nursing, page 336 in the section titled, Physician's Orders indicates, Nurses follow physician orders unless they believe the orders are in error or harm clients. Therefore you need to assess all orders, and if you find one to be erroneous or harmful, clarification from the physician is necessary. During a review of Resident 127s medical record (MR), the MR indicated the resident is undergoing dialysis treatments (procedure that removes waste products and excess fluids from the body when kidneys are unable to function) every Tuesday, Thursday, and Saturday with a contracted dialysis center. Pick up time from the facility was at 2:15 p.m. and resident arrives back at 7 p.m. Review of the resident's eMAR for the month of October 2024, revealed the following: - On 10/22/24 (Tuesday), an order for Lidocaine - Prilocaine External Cream 2.5 - 2.5% for 1 p.m. (an anesthetic cream used on the skin to cause numbness or loss of feeling before certain medical procedures) was to be applied to the dialysis access site (right upper arm AV fistula [a surgical connection between an artery and a vein that provides access to the bloodstream for dialysis]) topically (skin) prior to dialysis in preparation for dialysis needle cannulation (large needle insertion into the arytery) . The eMAR had no indication lidocaine was administered on 10/22/24 prior to 2:15 p.m. when Resident 127 was picked up for dialysis treatment. On 10/24/24 (Thursday), a scheduled medication Clonidine HCl (hydrochloride) 0.1 mg. (milligram [medication for hypertension]), for 5 p.m. was signed as given/administered with blood pressure and pulse reading listed. Record review indicated, Resident 127 was out of the facility on 10/24/24 at 5 pm and was at the dialysis clinic for dialysis treatment . (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/24/24 (Thursday), a scheduled medication Miralax Oral Powder 17 GM/scoop (for bowel management), for 5 p.m. was signed as given/administered. Resident 127 was out of the facility and in the dialysis clinic on 10/24/24 at 5 pm. On 10/24/24 (Thursday), a scheduled medication Calcium Acetate 667 mg. (a medication used to control phosphate [type of salt/electrolyte] levels to get them from going too high in dialysis patients) for 5:30 p.m., was signed as given/administered. On 10/24/24 (Thursday), a scheduled medication Hydralizine HCl 100 mg. (for hypertension) for 5 p.m. was signed as given/administered with blood pressure and pulse reading listed. Resident 127 was in dialysis at this time. Record review of the facility's P&P (Policy and Procedure), titled Medication-Administration, dated 1/1/12, indicated in part . Purpose: To ensure the accurate administration of medications for residents in the Facility . Policy: Medication will be administered directed by a Licensed Nurse and upon the order of a physician or licensed independent contractor . and Administration Of Medications: A. ii. Medications and treatments will be administered as prescribed to ensure compliance with dose regulations. During an interview with the director of nursing (DON), on 10/31/24 at 9:36 a.m., the DON concurred with the findings. The DON was not able to offer additional information about the lidocaine nor administered prior to dialysis pick up of Resident 127 on 10/22/24 at 2:15 p.m., and why was the eMAR signed on 10/24/24 at 5 p.m. stating the following medications were administered : Clonidine HCl (hydrochloride) 0.1 mg. (milligram [medication for hypertension]), for 5 p.m. Miralax Oral Powder 17 GM/scoop (for bowel management), for 5 p.m. Calcium Acetate 667 mg. (a medication used to control phosphate [type of salt/electrolyte] levels to get them from going too high in dialysis patients) for 5:30 p.m. Hydralizine HCl 100 mg. (for hypertension) for 5 p.m., when the resident was out of the facility for a dialysis treatment .

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32661 Based on observation, interview, and record review, the facility failed to ensure 1 of 4 sampled residents (Resident 65) who was hard of hearing, was assessed and assisted in obtaining a hearing device while admitted in the facility to facilitate adequate communication. This failure has the potential for the resident's needs to be not attended and understood by staff . Findings: During an observation and interview on 10/29/24, at 7:39 a.m., in room [ROOM NUMBER]-1, Resident 65 was observed seated in a wheelchair at the bedside. Resident 65 stated, You have to come nearer and speak louder, I can't hear very well, I left my hearting aids at home as , I don't want it to be lost. Review of the medical record for Resident 65 indicated the following : - facility care plan initiated 6/12/24 indicated At risk for miscommunication r/t: Impaired hearing. Interventions included Discuss with resident/family concerns of feelings regarding communication difficulty. Monitor/document for physical/nonverbal indicators of discomfort or distress and follow up as needed. Monitor/document/report PRN any changes in: Ability to communicate, Potential contributing factors for communication problems, Potential for improvement. - appointment for Audiology consult was scheduled on 10/29/24 at 11:45 a.m., recommendation was to return after 6 months for follow up appointment. No other documentations were noted in Resident's 127 medical record indicating any actions/ plans in place to address the resident's hard of hearing condition . No documentation was noted regarding the existence of a hearing aid at home . Review of the facility Policy and Procedure titled Care of Deaf or Hearing Impaired Resident, dated 1/1/12, indicated in part . B. Hearing aid (when indicated) i. Ask resident if they have a hearing aid. If so, ask family member to bring it. During an interview on 10/29/24 around 10 a.m. the social worker said, There is an ongoing audio consult. The Socual worker was not able to add more information regarding resident's hearing aids at home.

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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** 32661 Based on observation, interview, and record review, the facility failed to ensure post dialysis assessment and ongoing communication between the facility was completed after 1 of 4 sampled residents (Resident 127), returned from dialysis and failing to communicate with the contracted dialysis company when Resident 127 was sent from the dialysis clinic to the hospital. This failure had the potential to result in undetected complication(s) of dialysis and compromise the safety and well being of the resident. Findings: During an observation on 10/28/24, at 11:25 a.m., inside room [ROOM NUMBER]-1, the dialysis binder book (binder book residents bring to and from dialysis containing forms and information from facility to dialysis clinic and vice versa) of Resident 127 was on the bedside table. Resident 127 indicated the binder book has been in the room since 10/26/24 (Saturday) when resident arrived back from dialysis. The dialysis form inside the binder dated 10/26/24 indicated, 11. Comments or special instructions post dialysis: Give Tylenol 650 mg. d/t pain to right leg. Post dialysis note indicated resident received pain medication from the dialysis clinic. No other documentations were noted if the resident's pain on the right leg was relieved by Tylenol or not . No post dialysis vital signs were also noted documented post dialysis . Review of the facility's Policy and Procedure, titled Dialysis Management, dated 3/27/24, indicated in part .3. A pre and post dialysis evaluation will be completed by the licensed nurse. Further review of Resident 127's dialysis record, indicated on 10/19/24, Resident 127 while at dialysis treatment , had a change of condition and was sent to the hospital . The facility had no record of any follow up, regarding the resident's hospitalization . During an interview with the administrator, on 10/29/24, at 10 a.m.,the administrator concurred that no documentation was received by the facility from the dialysis clinic nor was documentation requested by the facility from the dialysis clinic regarding Resident 127's transfer to the hospital. Review of the facility's contract with the dialysis clinic titled, SNF OUT PATIENT DIALYSIS SERVICES AGREEMENT, signed by the facility on 11/19/12 and signed by the dialysis company on 11/27/12, indicated in part, B. Obligations of the ESRD Dialysis Unit and/Company, D. To provide to the Nursing Facility information on all aspects of the management of the ESRD Resident's care related to the provision of Services, including direction on management of medical and non-medical emergencies, including, but not limited to, bleeding, infection, and care of dialysis site.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27157 Based on observation, interview, and record review, the Registered Dietitian (RD) failed to ensure her skill set related to nutrition assessments was current when standards of practice were not implemented as follows: 1. The RD utilized a method to assess the nutritional needs for elderly residents classified as obese that had the potential to promote weight loss, and was not in accordance with professional standards of practice, without obtaining and/or discussing Resident 53's and/or responsible party (RP) weight goal or preference and potential risks of weight loss for informed decision making for one of one sampled residents (Resident 53). 2. The RD was unaware an unstageable (a full-thickness skin and tissue loss where the extent of damage is not clear because the wound is covered by eschar [a hardened, dead tissue that forms a scab-like covering over wounds] or slough [yellow/white material in the wound bed] pressure injury (a localized area of skin and tissue damage caused by prolonged or severe pressure) was treated as a Stage 3 (Stage 3 pressure injuries extend through the skin into deeper tissue and fat) or Stage 4 pressure injury (A full-thickness tissue loss that exposes bone, tendon, or muscle) per professional standards of which had the potential for a delay in an accurate nutrition assessment and timely nutrition interventions to meet the increased nutritional needs for residents referred to her as an unstageable pressure injury, in general. 3. The RD did not inform the RD at the dialysis center that one of one sampled resident's (Resident 40) did not have a diet order for a renal diet (for kidney disease). As a result, the RD failed to ensure the development of resident care policies and procedures to ensure that the facility provides care and services in accordance with current standards of practice that provide clinical and technical direction to meet the nutritional needs of residents for quality of care. Lack of implementing standards of practice for nutritional assessments for residents categorized as obese, and for those presenting with an unstageable pressure injury had the potential to impact a pattern of residents residing at the facility. Findings: 1. During a review of Resident 53's Admission Record (AR), the AR indicated an original admitted [DATE] and a re-admitted [DATE], and Resident 53 was [AGE] years old. During an interview on 10/31/24 at 10:27 a.m., with RD, RD stated it was her usual practice to assess the daily calorie needs for obese residents based off of an adjusted body weight for resident's with a BMI (Body Mass Index -a calculated value that estimates body fat based on a person's height and weight.) greater than 30 and who were 150% (percent) of their ideal body weight (IBW), including for elderly residents with limited mobility. RD stated, otherwise she used a resident's actual body weight with a predictive equation titled The Mifflin-St Jeor equation to assess daily energy (calorie) needs for residents, including for elderly residents. (continued on next page)

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	056379	A. Building B. Wing	10/31/2024

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

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 10/31/24 at 11:10 a.m. with RD, Resident 53's Nutritional Risk Assessment (NA), dated 9/30/24 was reviewed. The NA indicated, on 9/5/24, Resident 53 weighed 181. 2 pounds (lbs.), BMI was 34.2, Goal Weight was listed as N/A, and Usual Weight was listed as unknown. RD stated she does not typically put a goal weight thus N/A meant not available, and Usual Weight was typically based on the resident's history of weights at the facility but was left blank. The NA indicated Estimated Nutritional Needs Weight - AdjBW [adjusted body weight] 136 lbs. obese BMI above IBWR (ideal body weight range) 90-132 lbs. 172.6% IBW AdjBW 136 lbs. used for needs r/t [related to] obesity and >150% IBW. Rt [resident] unable to report UBW [usual body weight] and trends since admit are inconsistent. RD noted the resident had recent weight gain as compared to Resident 53's previous admission, however RD stated her goal for Resident 53 was to maintain weight. The NA indicated Nutritional Goal: No significant, unplanned weight changes and maintain.for weight maintenance. RD stated she assessed Resident 53's calorie needs based on 136 lbs., which was 45 lbs. less than her actual body weight (a 25% significantly less difference than her current body weight), and that had the potential to promote unplanned weight loss. RD confirmed assessing nutritional needs based on a weight that was 45 lbs less than Resident 53's actual weight could be contradictory to Resident 53's nutrition plan of care to promote weight maintenance. RD stated that was her usual practice for performing nutrition assessments for residents who were 150% of their IBW without considering the residents goals and preferences, and without discussing with the MD in which it could promote weight loss. During a review of American Academy of Nutrition And Dietetics, Nutrition Care Manual 2023, under category of, Unintended Weight Loss for the Older Adult, the reference indicated, Unintended weight loss often results in protein-energy undernutrition as the older adult loses critical lean body mass and is more prone to pressure ulcers, infections, immune dysfunction, anemia, falls resulting in hip fractures, and other conditions . During an interview on 10/31/24 at 11:20 a.m. with RD, RD stated that if she had a consult referral for an elderly resident who had a 5% weight loss in one month, 7.5% weight loss in 7 months or 10% weight loss in 6 months for unplanned weight loss she would be concerned. RD stated it was standards of practice for geriatric nutrition to strive to prevent unplanned weight loss to prevent a loss of lean body mass that could lead to functional decline, and increased risk for pressure injuries, for example. During a review of AND's Nutrition Care Manual (NCM), dated 2024, under the heading of Determination of Energy Needs in Obese Individuals indicated the Mifflin-St Jeor equation was found to be the most reliable, predicting equation for both nonobese and obese individuals when used with a person's actual body weight [not adjusted body weight]. During a review of AND's NCM, dated 2024, under the heading What body weight is the proper one to use in resting metabolic rate equations?, indicated, When calculating resting metabolic rate in overweight or obese people, actual body weight should be used.Use of adjusted body weight will result in underestimation [of energy needs]. During an interview on 10/31/24 at 11:10 a.m. with the RD, RD verified standards of practice was not implemented when performing nutrition assessments for the obese elderly which could affect the accuracy of assessments and had the potential to promote unintended weight loss for elderly resident's residing at the facility who were nutritionally assessed based on an adjusted body weight when considered obese. (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P) titled, Evaluation of Weight Nutritional Status, dated 11/16/22, the P&P indicated, The facility will work to maintain an acceptable nutritional status for residents by: a. Assessing the resident's nutritional status and the factors that put the resident at risk of not maintaining acceptable parameters of nutritional status.c. Defining and implementing interventions for maintaining, or improving nutritional status that are consistent with resident needs, goals, and recognized standards of practice.Significant weight loss (2% in one week, 5% &/or 5 lb. in one month, 7.5% in three months, or 10% in six months).Weight Variance Committee will: 1. Identify and implement appropriate interventions. During a review of the facility's policy and procedure (P&P) titled, Nutritional Evaluation, dated 5/19/22, the P&P indicated, Purpose: To assess a Resident's food and nutritional needs.The registered dietitian will provide recommendations in narrative and identify any risk factors for weight loss. The P&P lacked adequate directives and criteria based on professional standards of quality to ensure nutrition assessments were performed within accepted standards of clinical practice and regulations. During a review of the contract between the contracted RD and the facility, dated 9/20/16, the contract indicated, Appendix A: Dietary Consultant Services, 1. Assess dietary policies and procedures and assist in the development and/or revision of such policies and procedures as needed. 2. During a review of Resident 28's Admission record (AR), the AR indicated Resident 28 was admitted to the facility on [DATE], after a stroke (blood vessel ruptured in the brain) and had a diagnosis of type 2 Diabetes (a chronic disease that occurs when the body does not produce enough insulin or does not use insulin properly). During an interview on 10/31/24 at 9:48 a.m. with RD, RD stated the facility refers all pressure ulcers Stage 1 through Stage 4 including unstageable pressure injuries to the RD. RD stated it was her usual practice to perform a nutrition assessment for an unstageable pressure injury the same way she would for a Stage 1 pressure injury. RD stated Resident 28 was already assessed for daily protein needs at 1 - 1.2 g per kg of body weight for her multiple small diabetic ulcers and therefore she did not need to-reassess her daily protein needs at that time, after a unstageable pressure injury was referred to her. During a concurrent interview and record review on 10/31/24 at 9:52 a.m. with RD, Resident 28's Note Text: Skin review (NSR), dated 8/7/22 was reviewed. The NSR indicated Right ischium [large bone in the lower part of the hip] stage 4.Rt's [resident's] average po intake > [greater than] 75% [consumption of meals], likely meeting estimated needs for wound healing (140 [error noted]-1715 kcals/day (30-35 kcals [calories]/kg) and 60-73 g PRO [protein]/ [per] day (1.25-1.5 g/kg) and 1225-1470 cc/day [water needs for hydration] (25-30 cc/kg)). During an interview on 10/31/24 at 9:54 a.m. with RD, RD stated that her practice for a nutrition assessment, and nutrition plan of care, would differ from an unstageable pressure ulcer that she considers the same as a Stage 1 pressure injury in terms of assessing daily calories and protein needs from a Stage 3 or 4 pressure injury which she would assess daily calorie needs at 35 kcal/kg and protein usually at 1.5 g protein/kg or more, dependent on a resident's condition/labs/diagnosis that may dictate otherwise. (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of professional standards of practice according to the American Academy of Nutrition & Dietetics's (AND) Nutrition Care Manual (NCM), the NCM indicated .the provision of medical nutrition therapy with the goal of optimizing nutritional intakes and preventing or correcting malnutrition is an important role of the RDN [registered dietitian nutritionist/interchangeable with RD].The EPUAP/NPIAP/PPPIA [The European Pressure Ulcer Advisory Panel, National Pressure Injury Advisory Panel and Pan Pacific Pressure Injury Alliance] (EPUAP/NPIAP/PPPIA) Clinical Practice Guideline [CPG] recommends the completion of a comprehensive nutrition assessment for adults at risk of pressure injuries and malnutrition, as well as for all adults with a pressure injury. These professional standards of practice organization's defines unstageable pressure injury as a pressure ulcer [injury] with a full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. During a review of the facility's policy and procedure (P&P) titled, Skin Integrity Management, dated 6/27/24, the P&P indicated, 2. Skin Integrity Treatments: d. The dietary needs of the Resident will be evaluated by the registered dietitian upon any significant change in skin condition and any recommendations will be reviewed by the physician and orders obtained if appropriate. During a review of the facility's job description (JD) for Registered Dietitian, dated 10/9/23, the JD indicated, Summary: Provide Medical Nutrition Therapy.to ensure.that quality food service and nutritional care are being provided to residents by performing the following duties. Essential Duties and Responsibilities: Evaluates the Medical Nutrition Therapy needs of the residents and implements appropriate interventions to improve their nutritional status. During a review of the facility's policy and procedure (P&P) titled, Nutritional Evaluation, dated 5/19/22, the P&P indicated, Purpose: To assess a Resident's food and nutritional needs.The Dietitian will use information from the Resident's medical record to complete the nutritional evaluation upon admission, readmission, annually and upon significant change of condition, including but not limited to: E. Skin condition.O. Estimated nutritional needs range.Q. Any other information that will help to address the nutritional concerns of the resident. The P&P lacked adequate directives and criteria based on professional standards of quality to ensure nutrition assessments related to unstageable pressure injuries were performed within accepted standards of clinical practice and regulations in a timely manner, as evidenced by RD was unaware an unstageable pressure injury should be nutritionally assessed with a nutrition plan of care as if it was a Stage 3 or Stage 4 pressure injury, until the specific stage of pressure injury could be established by the wound nurse. During a review of the contract between the contracted RD and the facility, dated 9/20/16, the contract indicated, Appendix A: Dietary Consultant Services, 1. Assess dietary policies and procedures and assist in the development and/or revision of such policies and procedures as needed. 3. During a concurrent interview and record review on 10/31/24 at 10:23 a.m. with RD, Resident 40's Nutrition Review (NR), dated 10/11/23 was reviewed. The NR indicated, .Her diet was liberalized to CCHO mech [mechanical] soft due to her preference and refusal to follow more restrictive diet. Risks have been explained but she prefers to continue current plan. Dx [diagnosis] moderate dementia but she states that she understands risks. Therapeutic diet (CCHO mech soft) . RD reviewed her notes she conducted for Resident 40 related to Resident 40's attendance at the dialysis center, and RD stated she did not see any documentation in her notes with the Dialysis center RD (RD 2) of notification that Resident 40 was not on a renal diet (for kidney disease). (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephone interview on 10/31/24 at 10:28 a.m. with RD 2, in presence of RD, RD 2 stated she was not aware that Resident 40 was not receiving a renal diet at the facility she resides. RD 2 stated it was important for the collaboration of nutrition care plan so dialysis center could ensure diet orders were followed, and so the resident was receiving the same coordinated plan of care for clear, and consistent direction to the resident and/or RP (responsible party), as at times RD 2 would provide renal diet instruction to the residents who attend the dialysis center, when appropriate. Facility RD reviewed documentation that reflected RD had ongoing communication with RD 2 but stated, I missed that. RD stated she should have communicated Resident 40's diet order did not include a renal diet, per resident preference, to RD 2 to promote continuity of care. During a review of the facility's policy and procedure (P&P) titled, Dialysis Management, dated 1/25/24, the P&P indicated, The facility will arrange.a method of communication between the dialysis provider and the Facility.a. Diet and fluid restrictions will be followed as ordered.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45741 Based on observation, interview, and record review, the facility failed to follow the planned menu for therapeutic diets (part of the treatment for a disease or clinical condition, to eliminate, decrease, or increase certain substances in the diet or to provide mechanically altered food) when: 1. Resident 9, Resident 40 and Resident 26 received salad when prescribed a mechanical soft diet (to make it easier to chew and swallow foods, reducing the risk of choking) that was not on the mechanical soft diet menu. The Dietary Supervisor (DS) 1 confirmed the error had the potential to affect the following resident's prescribed a mechanical soft diet: Resident's 378, 54, 233, 4, 67, 21, 53, 14, 52, 42, 70, 129, 41, 127, 60, 49, 24, 349, 10, 27, 28, 30). 2. Resident 59's meal tray card (MTC) (MTC provided resident specific menu directions to staff on what to serve for a meal) was not followed for a lunch meal related to Resident 59's therapeutic renal diet (for kidney disease). These facility failures had the potential to place the resident's at increased risk of choking and or diminished nutrient intake for those on a mechanical soft diet, and to impede the health status of Resident 59. There were a total of 75 residents receiving meals from the main kitchen. Findings: 1. During an observation on 10/28/24 at 12:30 p.m. in Resident 40's room, Resident 40's MTC was located on her meal tray that was on her bedside table positioned in front of her. Resident 40's MTC indicated her diet order was CCHO (consistent carbohydrate diet for diabetes) mechanical soft (to make it easier to chew and swallow foods, reducing the risk of choking). Resident 40 lunch meal tray contained a bowl of salad (not finely chopped). During a review of the facility's planned menu for mechanical soft diet (MSD), the MSD indicated soft chopped vegetables. During a concurrent observation and interview on 10/28/24 at 12:47 p.m. with DS 1 in the dining room, Resident 9's lunch meal tray was located on the meal delivery cart for distribution. DS 1 was asked to check Resident 9's lunch meal tray for accuracy after LN 3 and LN 1 had checked Resident 9's lunch meal tray with no concerns. DS 1 removed the lid to the bowl that contained intact salad, and DS 1 stated the salad should not have been served and returned it to the kitchen. During a concurrent observation and interview on 10/28/24 at 12:50 p.m. DS 1 had a dietary aide go to the dining room to place a bowl of finely chopped salad onto Resident 9's meal tray. Concurrently, DS 1 was located in the kitchen and he was asked what soft chopped vegetables meant that was listed on the facility's planned menu under mechanical soft diet for lunch on 10/28/24. DS 1 stated the soft chopped vegetables for the mechanical soft diet meant finely chopped salad. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 10/28/24 at 12:52 p.m. in the dining room, Resident 26 MTC indicated mechanical soft diet. Resident 26 had a bowl of intact salad (not finely chopped) on her lunch meal tray. During an interview on 10/28/24 at 3:55 p.m., with DS 1, in the presence of corporate Certified Dietary Manager (CDM), DS 1 stated he called the company who wrote the facility's menus to ask what should have been served for the mechanical soft diet when the menu indicated soft chopped vegetables. DS 1 stated he was informed the planned menu for mechanical soft diet should have been cooked chopped carrots cooked so it's soft, and not raw lettuce salad even if finely chopped. During a review of the facility's dining manager menu (DMM), provided by DS 1, titled, Soft Chopped Vegetables, dated 2024, the DMM indicated, Ingredients, carrots .variations: may substitute other soft, chopped, cooked vegetables for carrots. During a review of the facility's diet manual (DM) titled, Dental Soft (Mechanical Soft) Diet, dated 2022, the DM indicated, The Dental Soft (Mechanical Soft) Diet is for individuals with limited or difficulty in chewing regular consistency foods .Food Guide: Not allowed raw or cooked vegetables difficult to chew. During a review of The International Dysphagia Diet Standardization Initiative (IDDSI), IDDSI diets are the only texture-modified diets professionally recognized such as with the American Academy of Nutrition and Dietetics and the American Speech-Language & Hearing Association ([NAME]). (https://cms.iddsi.org/media/aroundtheworld/usa/what-every-administrator-should-know-about-iddsi.pdf). These professional standards of practice organizations indicate the National Dysphagia Diet (NDD) which had the mechanical soft diets utilized at the facility are now obsolete. IDDSI Level 6 Soft & Bite Sized (SB6) diet is the current standards of practice for the no longer professionally recognized NDD mechanical soft diet (IDDSI (https://www.dysphagia-diet.com/Images/ComparisonChart-NDD_IDDSI.pdf). During a review of SB6 diet, SB6 diet included Soft, tender and moist.Bite-sized ' pieces no bigger than 1.5cm [centimeter] x [by] 1.5cm in size,.Vegetables steamed or boiled with final cooked size no bigger than 1.5cm x 1.5cm.Examples of foods to avoid.lettuce. (https://cms.iddsi.org/media/publications-iddsi/patienthandouts/english/adults/6_soft_bite_sized_adult_consumer_handout_30jan2019.pdf) 2. During a concurrent observation and interview on 10/28/24, at 12:10 p.m., with Licensed Nurse (LN), in the main dining, Resident 59's lunch meal tray was observed by the LN 1 on the meal delivery cart. LN 1 observed a carton of milk on Resident 59's meal tray. Resident 59's meal ticket indicated, Renal diet: wants 4oz regular Milk for breakfast only. LN 1 further verbalized that the carton of regular milk should not have been in Resident 59's meal tray. During a concurrent observation and interview on 10/28/24, at 12:12 p.m., with Dietary Supervisor (DS) 1, DS 1 reviewed the meal ticket in Resident 59's lunch meal tray. DS 1 removed the regular milk and replaced it with fruit drinks. DS 1 stated that the milk should not have been in Resident 59's lunch tray. During a review of the facility's menu, [NAME] Diet Spreadsheet (DS) the menu for renal diet indicated fruit drink. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P) titled, Menu, 4/1/2014, the P&P indicated, To ensure that the Facility provides meals to residents that meet the requirements of the Food and Nutrition Board of the National Research Council of the National Academy of Science .Food served should adhere to the written menu.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 45741 Based on observation, interview, and record review, the facility failed to ensure the pureed recipe for spaghetti with meat sauce was followed when the consistency was not a smooth, pudding or soft mashed potato consistency as directed in the recipe. Dietary Supervisor (DS) 1 verified there were eight residents (Resident 31, 11, 8, 6, 62, 72, 56, 3) with a puree diet order that had the potential to receive an inappropriate texture. This failure had the potential to result in choking and aspiration (food or liquid is breathed into the lungs, instead of being swallowed) in residents who experience difficulty swallowing. There was a total of 75 residents receiving meals from the main kitchen. Findings: During a concurrent observation and interview on 10/28/24, at 10:30 a.m., with the Head [NAME] (HC), HC was observed in the kitchen preparing pureed spaghetti with meat sauce for resident's lunch meal for those with a pureed diet order. HC placed the mixed spaghetti and meat into the food processor and added 1 cup of red sauce. After blending the food, HC transferred the processed spaghetti with meat sauce into a clean pan. HC stated that it was ready to be served. During a concurrent observation and interview on 10/28/24 at 10:36 a.m., with DS 1, DS 1 was asked to observe the texture of the pureed spaghetti and meat located in the clean pan. DS 1 stood a distance away from the pan of pureed spaghetti with meat sauce and stated it looked fine. DS 1 was asked to take a closer look and DS 1 verified there were still small noodle particles. DS 1 confirmed that the consistency was not like mashed potatoes and instructed HC to further puree the spaghetti and meat. HC returned the spaghetti and meat to the food processor for further blending, and HC 1 stated, Oh yeah, way better. DS 1 was asked to observe the texture of HC's second attempt to puree the spaghetti and meat. DS 1 requested the corporate Certified Dietary Manager (CDM), who was in the kitchen, to observe the spaghetti and meat texture. CDM stated that the consistency was still too textured and directed HC to continue blending until the spaghetti and meat was of a mashed potato consistency. During a review of the facility's recipe titled Pureed Spaghetti w/ [with] Meat Sauce, dated 2024, the recipe indicated, .achieve a smooth, pudding or soft mashed potato consistency. During a review of the facility ' s policy and procedure (P&P) titled, Therapeutic Diets, dated 6/1/2014, the P&P indicated, Purpose: To ensure that the facility provides therapeutic diets to residents that meet nutritional guidelines and physician orders.The Dietary Manager and Dietitian will observe meal preparation and serving to ensure that A. Each food item, served separately in the regular diet, is pureed and served separately for a pureed diet according to the menu spreadsheet and puree recipes. During a review of the facility's diet manual (DM) titled, Pureed Diet, dated 2022, the DM indicated, The pureed diet is designed for individuals who cannot chew foods of the Dental Soft consistency and /or difficulty swallowing.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45741 Based on observation, interview, and record review, the facility failed to ensure sanitary practices when a dietary aide failed perform hand washing after touching dirty dishes and before handling clean dishes. This failure had the potential to result in cross contamination and foodborne illness to residents. Findings: During a concurrent observation and interview on 10/28/2024 at 8:58 a.m., with Dietary Aide (DA), DA 1 was observed in the kitchen on the dirty side of dish machine wearing gloves while scraping dirty dishes, using a high- pressure water sprayer to spray food debris off from the plate. Without changing gloves or washing hands, DA 1 moved to the clean side of the dish machine and handled clean dishes. The Dietary Aide (DA) 2 then informed DA 1 in Spanish that she had been observed moving from dirty side to the clean side of the dish machine without performing hand washing. DA 1 acknowledged that she did not wash her hands. DA 1 was asked if she had been trained to wash her hands after handling dirty dishes prior to handling clean dishes, DA 1 responded, no. During a concurrent interview and record review on 10/28/2024 at 9:10 a.m., with Dietary Supervisor (DS) 1, DS 1 stated that DA 1 should have washed her hands after handling dirty dishes and before handling clean dishes. When asked for DA 1's competency documentation, DS 1 reviewed DA 1's dietary employee file and stated, I do not have one done for DA 1 and I should have. During a review of the facility's policy and procedure (P&P) titled, Dietary Department -Infection Control, dated 6/4/2024, the P&P indicated, Proper hand washing: after handling soiled equipment or utensils . after engaging in any activities that contaminate the hands. During a review of the facility's policy and procedure (P&P) titled, Staff Competency Assessment, dated 3/17/2022, the P&P indicated, The purpose of completing assessment is to determine knowledge and /or performance of assigned responsibilities based on standard of practice .each department manager or supervisor will be responsible to see that staff have competency assessment performed for their respective staff.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056379	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/31/2024
NAME OF PROVIDER OR SUPPLIER Oxnard Manor Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1400 W Gonzales Rd 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 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. 49405 Based on interview and record review, the facility failed to ensure a medical record for one of 18 sampled residents (Resident 12) was updated to reflect the changes in a Physician Orders for Life-Sustaining Treatment (POLST). This failure had the potential to result in a life saving measure or preference of the resident, to be not carried out as ordered by the physician. Findings: During a concurrent interview and record review of Resident 12's Electronic Health Record (EHR) with the Minimum Data Set Nurse (MDS 1) on 10/29/24 at 12:29 p.m., Resident 12's EHR indicated that the POLST dated 07/11/23, indicated Resident had a POLST for a Full Code (to receive all resuscitative treatment). Another physician order dated 09/19/23 stated Resident 12 is a Do Not Resuscitate (DNR - no life sustaining resuscitation). MDS 1 indicated Resident 12's POLST should have been updated from 7/11/23 of Fullcode to 9/19/23 of DNR and entered into the resident's EHR. During a review of the facility Policy and Procedure (P&P) titled Physicians Orders for Life-Sustaining Treatment (POLST) Nursing Manual - General (no date), indicated, Purpose: To help ensure that the facility honors residents' treatment wishes concerning resuscitation and life-sustaining treatment . POLICY: VI. The facility . is required to treat an individual who has a POLST form according to the instructions in the POLST form . III.H. If the facility has electronic health records, the POLST form will be scanned and placed in the appropriate section of the health care record per facility policy. During a concurrent interview and record review with MDS 1 on 10/29/24 at 3:22 p.m. MDS 1 stated that there was an updated POLST form dated 09/19/23 that was completed indicating Resident 12's wishes be changed to DNR. MDS 1 acknowledged that this POLST form was not uploaded into the EHR record and confirmed that the facility did not follow their policy of the 09/19/23 form was not scanned into their EHR system.

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	10/31/2024

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. 40560 Based on record review and interview, the facility failed to provide an arbitration agreement (a legal contract that requires the parties in a dispute to resolve it through arbitration, rather than a lawsuit) to one resident (Resident 1), in a form and manner the resident or resident representative understood. This failure had the potential to violate Resident 1's rights. Findings: During a review of Resident 1's Minimum Data Set (MDS - a tool used to assess the health needs and functional capabilities of residents in nursing homes) indicated in part, Resident 1 preferred Spanish and needed/wanted an interpreter to communicate with health care staff. During a review of Resident 1's Arbitration Agreement dated 10/5/20, indicated in part, Resident 1's responsible party signed the arbitration agreement on 10/8/24. The agreement was entirely in English. During an interview on 10/29/24, at 12:16 p.m., with the Director of Admissions (DOA 1), the DOA 1 verbalized Resident 1's representative, who signed Resident 1's arbitration agreement, could not communicate in English. When asked if the arbitration agreement was provided to Resident 1's responsible party in Spanish, the DOA 1 verbalized the facility only provides the arbitration agreement in English. During an interview on 10/31/24, at 10:21 a.m., with the Administrator (Admin 1), the Admin 1 verbalized the arbitration agreement form should be provided in a language the resident or their representative can understand.