

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 12/19/2025
NAME OF PROVIDER OR SUPPLIER Oxnard Manor Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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** Based on interview and record review, the facility failed to accurately assess one out of five sampled residents (Resident 6) skin integrity for pressure ulcers (PU - injury to skin and tissue resulting from prolonged pressure). This failure resulted in inaccurate assessment documentation and had the potential for Resident 6's identified care needs to go unmet. During review of the facility's policy and procedure (P&P) titled, Skin Integrity Management, dated 6/27/24, the P&P indicated in part, 1. Assessments a. A Licensed Nurse will complete a skin evaluation when there is a change in skin integrity. b. A Licensed Nurse will complete the skin evaluation weekly. 2. Skin Integrity Treatments c. The physician and responsible party will be notified when there is a change in the condition of the pressure injury or skin integrity condition. 3. Licensed Nurses will document the effectiveness of current treatment for skin integrity problems in the resident's medical record on a weekly basis. During review of Resident 6's admission Record (AR) dated 12/19/25, the AR indicated the resident was admitted to the facility on [DATE] with diagnoses that include metabolic encephalopathy (brain dysfunction caused by a chemical imbalance where the brain struggles to work), speech and language deficits following cerebral infarction (the death of brain tissue from a lack of blood flow, oxygen, and nutrients due to a blocked artery in the brain, often from a blood clot), and sepsis (an overactive response to an infection that damages its own tissues, organs, and systems, leading to potential organ failure and death if not treated rapidly). During review of Resident 6's medical records, the admission skin assessment dated [DATE] indicated resident was admitted with a PU on the coccyx (small triangular bone on the base of the spinal column) stage 2 (a shallow open ulcer, with partial-thickness skin loss, and a red/pink base or intact/ruptured blister). The minimum data set (MDS - a comprehensive assessment that helps nursing home staff identify health problems and track the improvement or decline of those problems) dated 11/17/25 indicated Resident 6 had unhealed PU's but section M0300 (current number of unhealed PU's/injuries at each stage) indicated 0 for all PU stages. The interdisciplinary team (IDT - a group of professionals from different fields who collaborate closely, share knowledge, and work interdependently to create a unified, patient-focused care plan) note dated 11/13/25 indicates the PU on the coccyx was evaluated by the facility's wound physician and reclassified as unstageable (full-thickness skin loss where the wound bed is covered by yellow, tan, green, or gray dead tissue and debris or a brown/black scab falling away of dead skin hiding the true depth of the wound) and then reclassified again on 11/26/25 as stage 4 (full-thickness tissue loss where skin, fat, and underlying muscle, tendon, or bone are exposed, creating a deep, open wound and high risk of infection). Further review of Resident 6's following medical records indicate the PU on the coccyx was categorized as stage 2: on Nursing long-term care nursing evaluations dated 11/14/25, 11/21/25, 11/28/25, 12/5/25, 12/12/25; on Nursing skin assessments dated 11/14/25, 11/18/25, 11/19/25, 11/21/25, 11/25/25, 11/28/25, 12/4/25, 12/5/25, 12/8/25; on SBAR (Situation, Background, Assessment, Recommendations - a communication tool used to concisely convey an individual's current problem, relevant history, evaluation, and what needs to be done) dated 11/18/25, 11/19/25, and on 11/25/25. During a concurrent interview and record review on 12/18/25 at 3:45 p.m. with the Director of Nursing (DON), Resident 6's progress notes were reviewed. The DON (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 056379
		If continuation sheet Page 1 of 6

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	acknowledged there was a discrepancy in the pressure ulcer staging between the admission skin assessment, the IDT notes, the weekly nursing skin assessments, NLTCE's, and SBAR's. DON further stated that the electronic medical system carries over the initial skin assessment performed on the date of admission to future nursing skin assessments which may be a contributing factor to the discrepancies in the PU staging assessments.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide respiratory care services consistent with professional standards of practice for one of five sampled residents (Resident 52) when the oxygen order was not implemented as ordered by the physician. This failure had the potential to place Resident 52 at risk for difficulty breathing. Review of [NAME] and [NAME], Tenth Edition, Elsevier, Fundamentals of Nursing, page 609 in the section titled, Medication Administration, indicated, If there is any question about a medication order because it is incomplete, illegible, vague, or not understood, contact the health care provider before administering the medication. During review of Resident 52's admission Record (AR) dated 12/18/25, the AR indicated the resident was admitted to the facility on [DATE] with diagnoses that include acute and chronic respiratory failure with hypoxia (low oxygen) and hypercapnia (high carbon dioxide) (lungs can't oxygenate blood or remove carbon dioxide effectively), chronic obstructive pulmonary disease (COPD - a condition involving constriction of the airways and difficulty or discomfort in breathing), and dependence on supplemental oxygen. During an observation inside Resident 52's room on 12/16/25 at 2:30 p.m., Resident 52 was in bed without a nasal cannula (a device used to administer oxygen). On 12/17/25 at 12:30 p.m. the resident was observed in the dining room not wearing a nasal cannula or on oxygen therapy while waiting for lunch to be served. During an interview on 12/18/25 3:20 p.m. with Resident 52, the resident stated oxygen is not used when the resident is out of bed. Resident 52 stated the nasal cannula was placed over the resident's head at night. During a concurrent interview and record review on 12/18/25 at 3:30 p.m. with Licensed Vocational Nurse (LN 1) and Registered Nurse (LN 2), Resident 52's oxygen order was reviewed. The physician's oxygen order read Oxygen at 2L/min (liters - a metric unit of capacity or volume per minute) via NC (nasal cannula) to keep O2 (oxygen) Sat (saturation) at/above 92% for COPD. LN 1 said the resident is ok without oxygen, only needs it at night but acknowledged the oxygen order did not specify if O2 should be continuous or PRN. LN 2 acknowledged the oxygen order was inadequate and stated it should be clarified with the physician. During a concurrent interview and review on 12/18/25 3:35 p.m. with the Director of Nursing (DON), Resident 52's oxygen order was reviewed. DON acknowledged the order should specify if PRN (as needed) or continuous and in lieu of that information missing the resident should always be on continuous oxygen via nasal cannula unless PRN is specified in the order. The facility policy and procedure titled Oxygen Procedure undated indicated, Patients that require oxygen as ordered by a physician will be placed on an oxygen concentrator or oxygen tank. Oxygen therapy will be administered as ordered. During review of the facility's policy and procedure (P&P) titled, Physician Orders, dated 12/28/22, the P&P indicates in part, 4. Treatment orders will include the following: a. A description of the treatment - including the treatment site (if applicable). B. The frequency of the treatment and duration of order (when appropriate). C. The condition or diagnosis for which the treatment is ordered. Other orders will include clear and complete description to provide clarity on the physician's plan of care.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure two of eleven sampled residents (Resident 10 and Resident 52) received the necessary treatment and monitoring for pressure ulcers (PU - damage to the area of the skin caused by pressure) when: 1. A PU was not measured or documented in Resident 10's medical record after the resident was re-admitted to the facility. 2a. A wound consultation and physician treatment orders were not requested for the care of bilateral stage 2 PU's (shallow, open ulcers, with partial-thickness skin loss, and a red/pink base or intact/ruptured blisters) on the right and left buttocks of Resident 52. 2b. The admission skin assessment, nursing long-term care evaluations (NLTCE - assessments to determine an individual's need for assistance with daily activities, assessing their physical, cognitive, and psychosocial health to plan care), and weekly skin assessments had inconsistent and discrepant documentation of Resident 52's PU's and/or skin integrity issues that ranged from having no PU's, to PU's on bilateral buttocks stage 2, moisture associated skin damage (MASD), or an open area to coccyx. During review of the facility's policy and procedure (P&P) titled, Skin Integrity Management, dated 7/231/25, the P&P indicated in part, , A Licensed Nurse will complete a skin evaluation when there is a change in skin integrity. 2. Skin Integrity Treatments a. Treatments to pressure injuries or other skin integrity conditions will be ordered by the physician. b. Consultation from a wound care physician may be obtained upon an order from the attending physician. e. Treatments administered will be documented in the resident medical record. 3. Licensed Nurses will document the effectiveness of current treatment for skin integrity problems in the resident's medical record on a weekly basis. 1. During record review, Resident 10 was re-admitted to the facility on [DATE], with a Stage 3 (full thickness skin loss where the wound extends through the skin into the fatty [subcutaneous] tissue) coccyx (small triangular bone at the base of the spinal column) pressure ulcer. Admitting records revealed no wound measurements was done by the admitting nurse on the day of re-admission or the wound treatment nurse the next day as per facility practice for admissions and re-admissions of Resident 10's Stage 3 coccyx pressure ulcer. During an interview, on 11/19/25, at 9:52 a.m., with the Director of Nursing (DON), in the DON's office, the DON searched the medical records for wound measurements for the re-admission on [DATE]. The DON said she cannot locate any wound measurements for the re-admission on [DATE] nor any wound measurements completed after 24 hours. The DON stated, There were no wound measurements done. 2a. During review of Resident 52's admission Record (AR) dated 12/18/25, the AR indicated the resident was admitted to the facility on [DATE] with a Braden Score (clinical tool used to assess the risk of developing pressure ulcers [bedsores], based on six categories: sensory perception, moisture, activity, mobility, nutrition, and friction/shear, with scores of 18 or less typically signaling at-risk status, prompting interventions) of 16 and later changed to 14. During review of Resident #52's admission skin assessment (ASA) dated 11/04/25, the ASA indicated the resident was admitted with bilateral buttock stage 2 PU's. The PU on the right buttock measured 2.5 centimeters (cm - a metric unit of length equal to one hundredth of a meter) length, 3 cm wide, 0.1 cm depth with no undermining or tunneling and the second PU on the left buttock measured 2 m length, 3 cm wide, and 0.02 cm depth with no undermining or tunneling. Further review of the following progress notes also indicated Resident 52 had bilateral buttock stage 2 PU's: Nursing Long-Term Care Evaluations (LTCNE - assessments to determine an individual's need for assistance with daily activities, and their physical, cognitive, and psychosocial health to plan care) dated 11/18/25, 11/25/25 12/1/25, 12/9/25, and 12/16/25. Skin Assessments dated 11/11/25 12/1/25, 12/8/25, and 12/9/25. During a concurrent interview and review on 12/18/2025 at 3:35 p.m. with DON, Resident 52's admission skin assessment, order summary, and nursing progress notes were reviewed. DON acknowledged Resident 52 had a stage 2 pressure ulcer on the right and left buttock on admission and that no wound consultation and physician treatment orders were in the resident's medical record for the bilateral stage 2 PU's on the (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	buttocks. 2b. During review of Resident 52's NLTCE's dated 11/18/25, 11/25/25 12/1/25, 12/9/25, and 12/16/25 and weekly skin assessments dated 11/11/25 12/1/25, 12/8/25, and 12/9/25 indicate Resident 52 has bilateral stage 2 PU's on bilateral buttocks. Further review of Resident 52's following medical records indicate different skin assessment information with no mention of the bilateral buttock stage 2 PU's:Nursing progress notes dated 11/07/25, 11/08/25, 11/09/25, 11/11/25, and 11/12/25 indicate the resident is on monitoring for moisture associated skin damage (MASD) on bilateral buttocksChange in Condition (CIC) dated 11/23/25, nursing progress notes dated 11/24/25 11/25/25, 11/26/25, 11/27/25, and weekly skin assessments dated 11/18/25 and 11/25/25 indicate resident was noted with open area/lesion to coccyx. During a concurrent interview and review on 12/19/25 at 10:32 a.m. with the Director of Nursing (DON), Resident 52's progress notes were reviewed. DON acknowledged there was a discrepancy in the pressure ulcer staging between the various types of skin assessments.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of three residents (Resident 108), reviewed for arbitration (a contract in which two or more parties agree to resolve disputes through a private arbitration process instead of pursuing litigation in court) agreement, understood the documents signed during admission to the facility. This failure resulted in Resident 108 signing a facility agreement without a full understanding of resident rights and options. During a review of the facility's admission Record this indicated, Resident 108 was admitted to the facility on [DATE] with diagnoses that included infection following a procedure. Another document titled Social Services Assessment dated 12/11/25 indicated Resident 108 had a BIMS (Brief Interview for Mental Status) score of 15 which indicated Resident 108 had no cognitive (pertaining to memory, judgement and reasoning ability) deficits. During a concurrent observation and interview on 12/18/25 at 11 a.m., with Resident 108, Resident 108 was observed in his room, lying in bed, and was talking to a family member on the phone. When asked about documents signed upon admission, Resident 108 stated being not fully aware of what was signed, unaware of what an Arbitration Agreement was, there was no copy of the agreement to thoroughly read it, and no knowledge that the agreement can be canceled within 30 days after signing it. The family member on the phone also confirmed to not have information and knowledge of documents signed by Resident 108 on admission. Resident 108 further stated it was presented to him at a time when he was incoherent (confused, not fully aware, or unable to think clearly) from medications when he transferred to the facility. Resident 108 expressed wishes to talk to the Admissions person again to have a better understanding of the arbitration agreement. During an interview on 12/19/25 at 1:05 p.m., with the Director of Admissions (DOA), DOA stated as the one in charge of presenting the Arbitration Agreement; and that Resident 108's arbitration agreement was signed electronically on 12/08/25. The DOA was not able to provide documented evidence that showed the arbitration agreement was explained to Resident 108 and that a copy of the agreement was provided to Resident 108. The DOA further stated it was important to fully explain the details of any contracts/agreements to the residents and to provide copies of what they signed. A review of the facility's policy titled Arbitration Agreements dated 05/26/23, this indicated in part, 3. If the facility presents an arbitration agreement to a Resident, the person presenting the arbitration agreement will: a. Explain the agreement in a form and manner that they understand; and b. Confirm that the Resident understands the agreement.		