STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555458	A. Building B. Wing	05/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glenwood Care Center	1300 North C St Oxnard, CA 93030

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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** 49405 Based on record review and interview, the facility failed to ensure interventions in the comprehensive care plan for two of 10 sampled residents (Residents 70 and 5) were implemented when: 1. Monitoring of Resident 70's intake and output (process of tracking the amount of fluid) was not completed. 2. Monitoring for bleeding complications was not implemented and documented in the clinical record of Resident 5 who is taking the anticoagulant medication Apixaban (a medication used to prevent and treat blood clots). These failures had the potential to result in the inappropriate delivery of care and services for these residents and their needs not being met. Findings: 1. During a review of Resident 70's Order Summary dated [DATE], indicated, a physician order was placed [DATE], Intake [the amount of fluid a person drinks or receives via gastrostomy tube(GT)] and output [the amount of fluid that exits the body] monitoring d/t gastrostomy tube [a tube surgically inserted into the stomach for a person to receive food, liquids and medications] use every shift [AM - morning shift, PM - afternoon shift, NOC - night shift] . and Intake and output monitoring d/t gastrostomy tube use every evening shift PM shift to tally all intake and output within 24 hours. During a review of Resident 70's Medication Administration Record (MAR) dated [DATE] - [DATE], indicated Intake and output monitoring d/t gastrostomy tube use every shift on [DATE] NOC shift and on [DATE] PM shift there was no documentation of intake and output. During a review of Resident 70's MAR dated [DATE] - [DATE], indicated, Intake and output monitoring d/t gastrostomy tube use every shift PM to tally all intake and output in 24 hours, there was no documentation of 24-hour input and output on dates [DATE], [DATE] and [DATE]. During a concurrent interview and record review on [DATE] at 3:20 p.m. with Director of Nursing (DON), the Order Summary dated [DATE] was reviewed. The Order summary indicated that two orders for intake and output monitoring were ordered [DATE]. DON acknowledged that the orders should be carried out and documented on the MAR. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on [DATE] at 3:20 p.m. with Director of Nursing (DON), the [DATE]/,d+[DATE] - [DATE] dated was reviewed. The MAR indicated that Intake and output monitoring d/t gastrostomy tube use every shift on [DATE] NOC shift and on [DATE] PM shift was missing documentation of intake and output and the Intake and output monitoring d/t gastrostomy tube use every shift PM to tally all intake and output in 24 hours, was missing documentation of 24-hour input and output totals on dates [DATE], [DATE] and [DATE]. The DON confirmed that the interventions were not completed for the dates listed and acknowledged that these should have been completed. During a review of the facility 's policy and procedure titled, MAR and TAR Documentation, dated ,d+[DATE], indicated in part, POLICY: It is the policy of this facility that medication and treatment records shall reflect the administration as prescribed by the physician. 43745 2. During a review of Resident 5's Admission Record (AR), dated [DATE], the AR indicated in part Resident 5 was a [AGE] year-old female who was admitted to the facility on [DATE], with admission diagnoses including supraventricular tachycardia (a heart rhythm disorder that causes a very fast or erratic heartbeat), diverticulitis (inflammation of irregular bulging pouches in the wall of the large intestines) and restless leg syndrome (a condition that causes a very strong urge to move the legs). During a concurrent interview and record review with the facility's MDS (Minimum Data Set - a standardized assessment tool that measures health status in nursing home residents) Coordinator (MDSC), on [DATE] at 3:38 p.m., Resident 5's clinical record was reviewed. MDSC verified in Resident 5's Order Summary Report (OSR), Care Plan Report (CPR), and Medication Administration Record (MAR), that the resident is currently taking the medication, Apixaban oral tablet 5 mg (milligram), give one tablet by mouth two times a day for NSTEMI (Non-ST-elevation myocardial infarction [a type of heart attack where there is a partial of complete blockage of a coronary artery, leading to a reduced blood flow and oxygen to the heart muscle]) prophylaxis. The CPR also indicated the intervention, Monitor/document/report to MD PRN (as needed) s/sx (signs and symptoms) of anticoagulant complications: blood-tinged or frank blood in urine, black tarry stools . bruising, bleeding There was no monitoring documentation found in the resident's medical record. MDSC acknowledged that staff should have entered the monitoring intervention in the resident's order summary so it can be signed off. During an interview with the facility's Administrator (ADM) on [DATE] at 4:44 p.m., ADM was informed that a care plan intervention to monitor for bleeding complications for Resident 5 who is currently taking the medication Apixaban was not implemented. ADM acknowledged the finding. During a review of the facility's policy and procedures (P&P) titled, Management of Anticoagulant Therapy, dated ,d+[DATE], the P&P indicated in part, POLICY: It is the policy of this facility that management of anticoagulant therapy involves use of laboratory results, physician orders, the MAR and monitoring of adverse side effects. The P&P also indicated, PROCEDURES: 1) Residents on anticoagulant/antiplatelet therapy will be monitored for possible side effects which include: a) Passing blood in the urine, b) Passing blood when the resident is having a bowel movement, c) Severe bruising, d) Prolonged nosebleeds

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49405 Based on interviews, record review and facility policy and procedure, the facility failed to ensure one of five sampled residents (Residents 55), care plan (CP - written document that outlines the specific nursing interventions and goals for a patient's care, based on their assessed needs and diagnoses) was revised after a fall. This failure had the potential for Resident 55's evolving needs for fall prevention to go unmet and potentially leading to preventable fall. Findings: During an interview on 05/28/25 at 3:30 p.m. with Resident 55, Resident 55 stated, that he had a fall this morning when he stood up from the wheelchair to put his jacket on and the wheelchair slid back. Resident 55 stated that he did not sustain injury but that this was his 3rd fall in the facility. During a review of Resident 55's Care Plan (CP) dated 05/29/25, the CP indicated that a CP was created and initiated for Has had an actual fall on 5/29/25 by the Director of Staff Development (DSD). During a concurrent interview and record review on 05/29/25 at 4:50 p.m. with Director of Nursing (DON), Resident 55's CP was reviewed. The DON stated that when a resident sustains a fall in the facility the CP should be updated on day of the event and acknowledged that Resident 55's CP was not updated to include the actual fall that occurred 5/28/25 stating that the CP should have been updated. During a concurrent interview and record review on 05/30/25 at 10:19 a.m. with Director of Staff Development (DSD), Resident 55's Progress Notes (PN) dated 04/30/25 - 05/31/25 and CP dated 05/29/25 were reviewed. The PN indicated, Resident 55 was a [AGE] year-old male, with history including but not limited to, Type 2 Diabetes (a chronic condition leading to elevated blood sugar), Paroxysmal Atrial Fibrillation (an irregular heart rhythm), anemia (the body does not have enough healthy red blood cells) and difficulty in walking. DSD stated on 5/28/25 at approximately 10:30 a.m. Resident 55 had an unwitnessed fall. DSD stated that he was the nurse that completed the post fall assessment of Resident 55 on 05/28/25. DSD stated that the post fall assessment and CP were not entered into the electronic health record (EHR) until 05/29/25 at 11:23 p.m., 36 hours after the fall. DSD acknowledges that the Post Fall Assessment and CP should have been completed in EHR when the incident happens. During a review of the facility's policy and procedure (P&P) titled, Fall Prevention, dated 05/2025, indicated in part, PROCEDURES: . 3. If a resident sustains a fall, a post fall assessment, including recommendations and care plan changes will be completed . 8. Care plans will be revised and/or updated to reflect changes in interventions.

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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** 49405 Based on observation, interview, and record review, the facility failed to ensure care and services were delivered according to policies and procedures (P&P) for three of 15 sampled residents (Residents 9, 55 and 8) when: 1. The Change of Condition (COC) after the fall was not documented in a timely manner as required by facility policy for Resident 55. 2. The blood pressure (BP) parameter set by the physician when to hold the medication Hydralazine HCl (medication used to lower blood pressure) was not followed for Resident 9. 3. The call light was not placed within reach for Resident 8. These failures had the potential to result in unsafe nursing practices and compromise the health and safety of the affected residents. Findings: 1. During a concurrent interview and record review on 05/30/25 at 10:19 a.m. with Director of Staff Development (DSD), Resident 55's Progress Notes (PN) dated 04/30/25 - 05/31/25 was reviewed. The PN indicated, Resident 55 was a [AGE] year-old male, with history including but not limited to, Type 2 Diabetes (a chronic condition leading to elevated blood sugar) Paroxysmal Atrial Fibrillation (an irregular heart rhythm), anemia (the body does not have enough healthy red blood cells) and difficulty in walking. DSD stated on 5/28/25 at approximately 10:30 a.m. Resident 55 had an unwitnessed fall. DSD stated that the Change of Condition (COC - any incident or change from a residents norm) were not entered into the electronic health record (EHR) until 05/29/25 at 11:23 p.m., 36 hours after the fall. DSD acknowledges that the COC should be done when the incident happens [05/28/25]. During a concurrent interview and record review on 05/30/25 at 10:19 p.m. with DSD, the facility's policy and procedure (P&P) titled Change of Condition Reporting, dated 05/2025 was reviewed. The P&P indicated in part, . 4. All nursing actions will be documented in the licensed progress notes as soon as possible after the resident needs have been met. The DSD acknowledges that Resident 55 needs were met immediately after the fall and that the COC should have been documented at that time per facility policy. 43745 2. During a review of Resident 9's Admission Record (AR), dated 5/30/25, the AR indicated in part Resident 9 was a [AGE] year old male who was initially admitted to the facility on [DATE] with admission diagnoses including essential hypertension (high blood pressure), Type II Diabetes Mellitus (a chronic disease where the body either doesn't produce enough insulin or can't properly use the insulin it produces leading to high blood sugar levels) and Chronic Kidney Disease (a condition where the kidneys are damaged and cannot function properly over a prolonged period). (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 9's Order Summary Report (OSR), dated 5/30/25, the OSR indicated the medication order, Hydralazine HCl tablet 25 mg (milligram) give one table by mouth four times a day for hypertension, hold if SBP (systolic blood pressure) less than 110, (Order Date: 2/28/25). During a review of Resident 9's Medication Administration Record (MAR), dated 5/1/25 - 5/31/25, the MAR, under the medication Hydralazine HCl tablet 25 mg ., indicated that the BP parameter set by the physician when to hold the medication was not followed when: On 5/18/25 for the 2100 (9 p.m.) dose, Resident 9 received the medication with a BP reading of 108/79; on 5/22/25 for the 1300 (1 p.m.) dose, Resident 9 received the medication with a BP reading of 108/68; and on 5/23/25 for the 1300 (1 p.m.) dose, Resident 9 received the medication with a BP reading of 105/68. During a concurrent interview and record review on 5/30/25 at 10:54 a.m., with the Director of Nursing (DON), Resident 9's MAR, dated 5/1/25 - 5/31/25 was reviewed. The section of the MAR under the medication order, Hydralazine HCl tablet 25 mg . was reviewed and DON acknowledged that staff did not follow the blood pressure parameter prescribed by the physician on the specific administration dates and times noted above. DON stated, Nurses should follow professional standards when administering the medication. During a review of the facility's P&P titled, MAR (Medication Administration Record) and TAR (Treatment Administration Record), dated 10/2010, the P&P indicated in part, POLICY: It is the policy of this facility that medication and treatment records shall reflect the administration as prescribed by the physician. During a review of the facility's P&P titled, Medication Administration, dated 5/2025, the P&P indicated in part, Essential Points . 13) Hold medication based on parameter as ordered by physician 50707 3. During a review of Resident 8's Admission Record (AR), dated 5/29/25, the AR indicated Resident 8 was admitted on [DATE] with diagnoses that include legal blindness (severe vision loss), generalized muscle weakness, and need for assistance with personal care. During a concurrent observation and interview on 5/27/25 at 4:02 p.m., with Licensed Nurse (LN) 1 in Resident 8's room, Resident 8 was observed sitting in a wheelchair by the window. The call light was observed pinned to the top of the bed, out of Resident 8's reach. LN 1 stated Resident 8 is blind, confirmed the call light is not within reach, and it should be. During a review of the facility's policy and procedure (P&P) titled Call Light/Bell, dated 11/2024, the P&P indicated 5. Place the call device within resident's reach before leaving the room.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 50707 Based on observation, interview and record review, the facility failed to ensure the controlled drug record for Lorazepam (a prescription medication to treat anxiety that has a potential for abuse, misuse, and can lead to dependence) was accurate for Resident 547. This failure resulted in an inaccurate count and had the potential for drug diversion (the illegal distribution or abuse of controlled prescription drugs) of controlled medications. Findings: During a review of the facility's policy and procedure (P&P) titled Narcotic Count dated 11/2024, the P&P indicated 2. After the supply is counted and justified, each nurse must record the date and his/her signature verifying that the count is correct. During a concurrent interview and record review on 5/27/25 at 3:00 p.m., with Licensed Nurse (LN) 3, the Controlled Drug Record - Liquids (CDRL) was reviewed for Resident 547's medication Lorazepam. The CDRL indicated that there was a balance of 22.0 milliliter (mL) of liquid Lorazepam. During a concurrent observation and interview on 5/27/25 at 3:00 p.m., with Licensed Nurse (LN) 3 in the Medication Room at Station 1, a bottle of liquid Lorazepam 2 milligrams (mg) per mL for Resident 547 was observed in the refrigerator. The bottle of Lorazepam showed 21mL of liquid remaining in the bottle. LN 3 confirmed the count sheet is incorrect and stated no, it isn't at 22mL and it should be.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50707 Based on observation, interview, and record review, the facility failed to ensure: 1. Expired medications were discarded and not available for use for one sampled resident (Resident 5) and two unsampled residents (Resident 1 and Resident 79). 2. The medication refrigerator temperature was monitored twice a day per facility policy when storing vaccines. These failures had the potential for residents to receive expired and ineffective medications. Findings: 1. During a concurrent observation and interview on 5/29/25 at 3:05 p.m., with the Assistant Director of Nursing (ADON) in the nurses' station two, the following medication were observed to be expired in the medication cart 2: Two bubble packs of Trazodone (a medication used to treat depression) for Resident 79. One packet of DuoNeb (a medication that helps breathing) for Resident 5. Two boxes of Hydrocortisone Suppository (a medication used to treat inflammation) for Resident 1. One box of Bisacodyl Suppository (a medication that loosen stools and increase bowel movements) for all residents to use. ADON stated all the above-mentioned medications are expired and should have been discarded. During a review of the facility's policy and procedure (P&P) titled Storage of Medications dated May 2022, the P&P indicated Expiration Dating (beyond-use dating): G. All expired medications will be removed from the active supply and destroyed in the facility, regardless of amount remaining. 2. During a review of the facility's policy and procedure (P&P) titled Storage of Medications dated May 2022, the P&P indicates, Temperature . F. The Facility should check the refrigerator or freezer in which vaccines are stored, at least two times a day, per CDC guidelines. During a concurrent observation and interview on 5/29/25 at 2:31 p.m., with the Assistant Director of Nursing (ADON), in the medication storage room [ROOM NUMBER], a bottle of Prevnar 20 (a vaccine that helps protect against pneumonia- an infection of the lungs) for Resident 35 was observed stored in the refrigerator. ADON confirmed vaccines are stored in the medication refrigerator. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 5/29/25 3:46 p.m., with ADON, the Refrigerator Temperature Log (RTL) dated May 2025 for Medication room [ROOM NUMBER] was reviewed. The RTL indicated the refrigerator temperature is checked once a day. The ADON confirmed the temperatures of the refrigerator are monitored once a day during the night shift. ADON acknowledged the refrigerator temperatures should have been checked twice a day and they were not.

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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. 43745 Based on observation, interview, and record review, the facility failed to ensure temperature and humidity levels in the dry food storage room were properly monitored and documented. This failure had the potential to result in inaccuracies of information which can affect interventions to increase the shelf-life (the length of time that a commodity may be stored without becoming unfit for use , consumption or sale) of the stored food items. Findings: During a concurrent observation and interview, on 5/24/25 at 9:20 a.m., with the facility's Dietary Supervisor (DS) in the kitchen's dry food storage room, an installed analog indoor thermometer with hygrometer (a device that measures indoor temperature and humidity levels) was observed. The temperature and humidity levels read 70 F (degrees Fahrenheit) and 68% (percent) respectively. When asked to review the temperature and humidity log for the current month, DS stated, We only create a log when the temperature inside the room feels warmer than normal . when the temperature reads over 80 F. During an interview with the facility Administrator (ADM) and DS on 5/28/25 at 11:43 a.m., ADM and DS acknowledged that the dry food storage room and humidity level readings should be properly monitored, and the readings documented and/or logged by staff so that accurate information is available in case a corrective action is required. During a review of the facility's policy and procedures (P&P) titled, Storage of Food and Supplies, dated 2023, the P&P indicated in part, PROCEDURES FOR DRY STORAGE . 1) The storeroom should be well-lighted, well-ventilated, cool, dry, and clean at all times. Thermometer should be placed in all storage areas and checked frequently. Recommended temperature is 50 F - 85 F, if dry food storage goes above 85 F, take corrective action

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32661 Based on observation, interview, and record review, the facility failed to: 1. Ensure N95 masks provided for use to staff and visitors were not expired; and 2. Ensure staff followed proper infection control procedures when Licensed Nurse (LN) 2 did not remove personal protective equipment (PPE - clothing and equipment that is worn or used to provide protection against infectious agents) before exiting Resident 101's room. This failure had the potential to significantly reduce the effectiveness of PPE and compromise infection prevention practices. Findings: During an observation on [DATE], starting at 7:46 a.m., the following were observed: Isolation carts containing N-95 (type of mask) PPE located at the front entrances of the following Covid-19 designated rooms 124, 126, 201, 202, 203, 204, 206, 208, 212, 214, 219, and the lobby receptionist area. All had expired N95 face masks. There were 21 positive Covid-19 residents in the facility. All facility staff assigned to the designated rooms were observed wearing N-95 masks. Visitors were encouraged to wear a face mask by the receptionist. There were two different brands of N-95 masks observed. The brand 3M N-95 masks had an expiration date of [DATE], and brand BYD N-95 mask, had an expiration date of [DATE]. During an interview with the Administrator (ADM), on [DATE], at 9 a.m., the ADM stated, he has a memo from CDC (Centers for Disease Control and Prevention - a U.S Federal agency. The leading national public health institute in the United States) regarding extended use from shelf life of N-95 masks. ADM also added that Public Health said the same thing. During a review of the documents received from the ADM, the documents indicated the following. The memo from CDC, dated [DATE], titled Strategies for Conserving the Supply of N-95 Filtering Facepiece Respirators, indicated in part, Crisis Capacity Strategies .use of respirators beyond the designated shelf life for healthcare delivery .Consider using NIOSH (National Institute for Occupational Safety - a Federal Agency responsible conducting research and making recommendations for prevention of work-related injury, illness, disability, and death) approved N-95 respirators beyond the designated shelf life for care of patients with diseases for which a respirator is recommended during their care (e.g. Covid-19, Tuberculosis, Measles, Varicella). During record review of the document/email from Public Health, dated [DATE] the document indicated in part, The strategies for conserving the supply of N-95 filtering facepiece respirators/healthcare workers/CDC designate this intervention for crisis situations. The facility should communicate to licensing that they have reached this point. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the ADM, on [DATE], at 2 p.m., in the reception area, explained that the CDC memo and the Public Health email specified the approved extended use of N-95 masks past their shelf life only during the declared emergency. ADM agreed that current use was not supported. 50707 2. During a review of Resident 101's Clinical Record (CR), the CR indicated Resident 101 had a diagnosis of COVID-19 (a contagious viral infection that affects breathing) and was on transmission-based precautions (precautions involve using PPE to prevent the spread of infections). During a concurrent observation and interview on [DATE] at 8:55 a.m., with LN 2, LN 2 was observed wearing an isolation gown, mask and face shield while preparing medication outside of Resident 101's room. LN 2 stated Resident 101 was on transmission-based precautions for COVID-19. LN 2 confirmed the PPE was not removed before exiting Resident 101's room and it should have been removed. During an interview with the Infection Preventionist (IPN) on [DATE] at 9:02 a.m., IPN acknowledged LN 2 did not remove PPE before exiting Resident 101's room and should have. During a review of the facility's policy and procedure titled, IPCP Standard and Transmission-Based Precautions, dated ,d+[DATE], the P&P indicated Procedure b. Personal protective equipment (PPE): ii. [NAME] (put on) PPE upon room entry, then doff (remove) and properly discard PPE and perform hand hygiene before exiting the patient room to contain pathogens.