STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056379	A. BUILDING _____ B. WING _____	**04/06/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
OXNARD MANOR HEALTHCARE CENTER	**1400 W GONZALES RD OXNARD, CA 93030**

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 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.** Based on observation, interview, and record review, the facility failed to maintain a safe environment for residents and staff when two nails were observed sticking out of wood on the bottom of a cabinet. This facility failure had the potential to result in resident or staff injury. Findings: During an observation and concurrent interview with the director of nursing (DON) on 3/3/20 at 12:00 p.m., at the east nursing station, two nails were sticking out of the bottom of a cabinet. The DON agreed the nails were sharp and could be a hazard if someone bumped them. During an interview on 3/3/20 at 12:30 p.m., the maintenance supervisor ([CONDITION]) acknowledged the two nails sticking out of the cabinet were a safety issue and should be fixed. [CONDITION] explained his job responsibilities include weekly rounds of the nursing stations, but he acknowledged that he did not inspect that area. A review of the facility's policy titled, Maintenance Service, revised 1/1/12, indicated: I. The Maintenance Department is responsible for maintain the buildings, grounds, and equipment in a safe and operable manner at all times. II. Functions of the Maintenance Department may include, but are not limited to: .B. Maintaining the building in good repair and free from hazards.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** Based on observation, interview, and record review, the facility failed to maintain a safe and sanitary environment for residents and staff when: A. Sterile water used for [MED]gen administration and other clean supplies used for resident care were observed stored in dirty, unsealed cabinet spaces alongside used personal items. B. Two emergency eye wash stations were not disinfected weekly according to facility policy and procedure. These facility failures had the potential to spread infection to residents and staff. Findings: A. During an observation and concurrent interview with the maintenance supervisor ([CONDITION]) on 3/3/20 at 12:30 p.m., at the east nursing station, the cabinet underneath the sink contained two bottles of opened sterile water, brown and black pieces of debris, stains and corrosion on the water pipes. The [CONDITION] agreed there was dirt in the cabinet and the water line was corroded. [CONDITION] further acknowledged the two sterile water bottles were open. During an observation and concurrent interview with [CONDITION] on 3/3/20 at 12:40 p.m., the cabinet under the sink in the west nursing station had cracks and holes in it. The [CONDITION] agreed there was a hole in the cabinet and explained it lead to the inside of the wall. The [CONDITION] stated, We can't have a hole in the wall, and further acknowledged there was risk of products being exposed to whatever was behind the wall. During an interview on 3/3/20 at 1:30 p.m., licensed nurse (LN 2) verbalized the sterile water stored under the sink was used to add humidity to [MED]gen for residents receiving supplemental [MED]gen. LN 2 acknowledged the two bottles of sterile water should not have been stored in the cabinet under the sink. LN 2 further acknowledged the sterile water is supposed to be kept in the treatment cart or medication cart in order to protect residents from getting an infection. During an interview on 3/3/20 at 4:50 p.m., the director of nursing (DON) agreed the two bottles of sterile water containers should not have been stored under the sink at the east nursing station. A review of the facility's policy titled, Infection Control-Policies and Procedures, revised 1/1/12, indicated in part Maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public. B. During an observation and concurrent interview with the [CONDITION] on 3/3/20 at 12:40 p.m., at the west nursing station, emergency eye wash and eye piece covers were coated with brown residue. The [CONDITION] confirmed the eye wash was not clean enough to use. The [CONDITION] explained that the maintenance duties include checking the eye wash stations weekly but could provide no documentation the checks were performed. During an observation and concurrent interview with certified nursing assistant (CNA 1) on 3/3/20 at 1:15 p.m., at the east nursing station, emergency eye wash and eye piece covers were seen coated with brown residue. CNA 1 confirmed the rubber eye piece covers contained sediment and acknowledged they needed to be replaced. During an interview on 3/3/20 at 1:20 p.m., licensed nurse (LN 1) acknowledged the eye wash at the west nursing station looked dirty and would not feel comfortable using it. During an interview on 3/3/20 at 1:30 p.m., licensed nurse (LN 2) acknowledged the residue on the eye wash at the east nursing station was a combination of dirt and a buildup of salt. LN 2 further acknowledged the eye was not clean enough to use and could cause an eye infection from bacteria. During an interview on 3/3/20 at 1:40 p.m., the housekeeping staff (HS) stated that the west nursing station eye wash Does not look like it's been cleaned good. The HS used a cleaning brush and was able to remove the dirt from the eye wash. During an interview on 3/3/20 at 4:50 p.m., the DON acknowledged the eye wash stations were supposed to be cleaned by housekeeping staff. A review of the facility's policy titled, Housekeeping - Staff Areas, revised 1/1/12, indicated that the Housekeeping Department is responsible for cleaning staff areas including nursing stations. A review of the Direct Supply manufacturer's instructions for the facility's eye wash stations, provided by the [CONDITION] and dated 3/3/20, indicated in part Verify protective eyewash covers are properly positioned, clean and intact . Verify that eye wash stations are disinfected weekly.

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

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.