

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER <b>555163</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED <b>06/15/2020</b>
NAME OF PROVIDER OF SUPPLIER <b>SHORELINE CARE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP <b>5225 SOUTH J ST OXNARD, CA 93033</b>	
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 0689  <b>Level of harm</b> - Minimal harm or potential for actual harm  <b>Residents Affected</b> - Few	<b>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</b>  Based on record review, observation, and interview, the facility failed to ensure the utilization of proper transfer techniques for one of two sampled residents (Resident 1). This facility failure had the potential to result in injury from unsafe transfers. Findings: The facility policy and procedure titled Transfer Activities dated 2006, indicated Obtain assistance of another individual if necessary for safe transfer. During a review of Resident 1's Minimum Data Set (MDS) (federally mandated process for clinical assessment of all residents in Medicare or Medicaid certified nursing homes) dated March 17, 2020, Section G-Functional Status indicated Resident 1 required extensive assistance of two or more persons for transfers. During a concurrent observation and interview with Resident 1 on 5/28/2020, at 3:47 P.M., Resident 1 was observed sitting in wheelchair at side of the bed. Resident 1 stated The Nursing Assistant (NA 1) had me on the lift to the bed. He pulled my right arm very hard to turn me to the left, it was painful, then pushed my left hip hard and I had to hold on to the rail. During an interview with Resident 1 on 6/04/2020, at 4:02 P.M., Resident 1 stated, He used the lift by himself, usually it's fine but he was rushed that day. During an interview with NA 1 on 6/04/2020 at 3:45 P.M., NA 1, stated, I know (Resident 1) is supposed to have two people, but I am comfortable doing it alone so I just do. During an interview with the Director of Staff Development (DSD) on 6/04/2020 at 3:55 P.M. the DSD stated I teach all staff that anyone who needs to use a lift to transfer requires two staff for safety.		
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.