STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055353	A. Building B. Wing	03/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shoreline Healthcare Center	4029 East Anaheim Street Long Beach, CA 90804

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49862 Based on observation, interview and record review, Licensed Vocational Nurse (LVN) 1 failed to administer medication on time in accordance with written orders of the attending physician for five of five reviewed residents This deficient practice of failing to administer medications in accordance with the physician orders increased the risk of Residents 1,2, 3,5, and 6 may experience adverse reactions, complications, that could lead to a decline in the residents' condition, harm, or hospitalization . Findings: During concurrent observation, interview and record review on 3/3/2025 at 11:09 p.m., with LVN 1 and the Director of Nursing (DON), inspected Medication Cart #1 after medication administration. Observed Resident 1,2,3,5, and 6, 9 a.m. medications were not given at scheduled time. Reviewed Medication Administration Record (MAR) for Resident 1,2,3,5, and 6 and was not signed (documented) as given). LVN 1 stated medications of Resident 1,2,3,5,6 was not given at 9a.m.LVN 1 stated she will notify Resident 1,2,3,5, and 6 physicians that their medications were not given on time as ordered. During a review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including essential hypertension (condition characterized by persistently elevated blood pressure without an identifiable underlying cause.), chronic pain syndrome (is a condition characterized by persistent pain that lasts for more than 3 months.), major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with your daily). During a review of Resident 1's Minimum Data Set ([MDS], a resident assessment tool) dated 10/01/2024, the MDS indicated Resident 1 needed partial assistance from another person to complete activities of daily living (ADL). During a review of Resident 1's Physician Order Summary Report, the Physician Order Summary Report indicated orders as follows: 1, Amitriptyline HCl (medication to treat depression) oral tablets 25 milligram (mg-unit of measurement), give one time a day for depression manifested by decreased interest in performing ADL. (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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2, Furosemide (water pill) oral tablet 40 mg, give one tab daily for hypertension (HTN) . 3.MultlvItamln Women 50+ oral tablet gives one tablet daily 4, Nicotine patch 24 hour, apply 1 patch transdermal (into the skin) one time a day for smoking cessation. 5, Rifaximin (antibiotic- treat infection) oral 550 mg one tablet a day for hepatic encephalopathy (loss of brain function when liver does not remove toxins from blood) 6, Midodrine HCL oral tabs, 5 mg give three times a day for hypotension (low blood pressure) During a review of Resident 2's Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including essential hypertension, hyperlipidemia (high levels of fats (lipids) in the blood), and type 2 diabetes mellitus (disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2 had moderate cognitive (ability to think, understand, learn, and remember) impairment. The MDS also indicated Resident 2 need partial/moderate assistance (helper does less than half the effort) with ADLs. During a review of Resident 2's Physician Order Summary Report , the Physician Order Summary Report indicated orders as follows: 1, Aspirin 81 mg, 1 tablet give 1 capsule one time a day for deep vein thrombosis (blood clot) prophylaxis. 2.Bisoprolol Fumarate (medication for high blood pressure) 5 mg oral tablet one time a day for HTN. 3. Lidocaine pain relief external patch 4%, apply to affected area one time day for pain and remove per schedule. 4, Losartan potassium (blood pressure medication) oral tablet 25 mg, give 0.5 mg tablet orally one time a day. 5.Apixaban (prevent blood clot) oral tablet 5 mg by mouth every 12 hours. 6.Niacinamide orally 500 mg give one tablet twice a day for supplement. During a review of Resident 3's Admission Record, the Admission Record indicated Resident 3 s was admitted to the facility on [DATE] with diagnoses essential hypertension, hyperlipidemia, and cardiomegaly (refers to an enlarged heart. During a review of Resident 3's MDS dated [DATE], the MDS indicated Resident 3's had severe cognitive impairment. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 3's Physician Order Summary Report, the Physician Order Summary Report indicated orders as follows: 1, Metoprolol ER (blood pressure medication) oral tablets 25 mg, one time a day for HTN During a review of Resident 5's Admission Record, the Admission Record indicated Resident 5 was admitted to the facility on [DATE] with diagnoses including essential hypertension, major depressive disorder, and seizures (sudden uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness) During a review of Resident 5 's MDS dated [DATE], the MDS indicate Residents 5's is cognitively intact. During a review of Resident 5's Physician Order Summary Report, the Physician Order Summary Report indicated orders as follows: 1. Amlodipine Besylate oral 10 mg, give one tablet orally one time a day for high blood pressure. 2. Aspirin 81 mg, 1 tablet give 1 capsule one time a day. 3.Duloxetine HCl capsule delayed release particles 30 mg, give 2 capsule by mouth one time a day for neuropathic pain (chronic pain condition). 4.gylcolax powder, given 17 gram by mouth one time a day for bowel care. 5. Juven oral packet, give 1 packet orally by mouth for wound healing. 6.Levaquin tablets 500mg (levofloxacin-antibiotic) give one by mouth for positive for proteus mirabilis microorganism to right foot wound 7. Lidoderm External patch 5% apply to left upper extremity topically one time daily for pain Active order date 02/07/2025 8. Losartan potassium oral 100mg, give one tab once a day for hypertension 9, heparin sodium (blood thinner) injection solution 500 unit/ml, inject one dose twice a day for DVT prophylaxis. 10, Keppra oral tablets 500mg, give one tab twice a day for seizures 11, Senna S oral tablet 8.6-50mg, give 2 tabs twice a day for constipation. 12.Gabepentin [NAME] 400mg, give one tablets three times a day for neuropathic pain. 13, Hydralazine HCl oral tablets 10 mg, give 2 tabs four times a day for hypertension. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 6's Admission Record, the Admission Record indicated Resident 6 was admitted to the facility on [DATE] with diagnoses including essential hypertension, muscle weakness (is a condition characterized by a decrease in muscle strength) and cardiomegaly. During a review of Resident 6's MDS dated [DATE], the MDS indicated Resident 6 had moderate cognitive impairment. During a review of Resident 5's Physician Order Summary Report, the Physician Order Summary Report indicated orders as follows: 1. Folic acid 1 mg by mouth daily for supplement. 2. Valsartan-Hydrochlorothiazide oral 320-25mg, give one tablet one times a day for hypertension. 3. Metoprolol ER oral tablets 50mg, daily for HTN 4. flagyl oral tablet 500mg, give one tab by mouth daily x 7 days for clostridium difficult (infection) prophylaxis. 5. Florastor (gastrointestinal supplement) oral Capsule 250 mg. 6, Senna S oral tablet 8.6 mg, give 2 tablets twice a day for constipation. During an interview on 03/04/2025 at 10:41 a.m., with LVN 1. LVN 1 stated on 03/03/2025 she was behind with her medication administration. LVN 1 stated she thought she was done with all medication administration on all residents. LVN 1 stated she should check the medication cart and do medication reconciliation to all resident after medication administration to ensure all residents received their medication. LVN 1 stated she informed Resident 1,2,3,5 and 6's physician, and informed that residents did not receive their 9 a.m., medications During an interview on 03/04/25 at 1:49 p.m. with the DON, the DON stated, if resident missed their daily routine medication it had a potential risk adverse reactions including blood pressure under control that can lead to stoke (lack of adequate blood supply to the brain) and other complications depending on the missed medications. During a review of the facility's policies and procedures (P&P) titled Administering of Drugs, revised in 05/2007, the P&P indicated It is the policy of this facility that medication shall be administered as prescribed by the attending physician. 1. Medication must be administered in accordance with written orders of the attending physician 2. The nurse administrating the medication must recorded such information on the residents MAR before administrating the next residents.

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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. 49862 Based on observation, interview and record review, the facility failed to label with an open date, when a multi-dose vial of Humulin N (a medication that lowers levels of glucose-sugar in the blood to manage diabetes mellitus-DM - high blood sugar) 100 IU vial (10 milliliter [ml-unit of measurement]) was opened, in medication cart #2. This deficient practice had the potential for loss of efficacy of residents' insulin, had the potential for unintentional medication administration of possibly expired medications for residents. Findings: During a concurrent observation and interview on 3/3/2025 at 12:31 p.m., with Licensed Vocational Nurse (LVN 2) of medication cart #2, observed a vial opened vial of Humulin R 100 IU vial 10ml, (Lot number D767980A, expiration date of august 2027) was found in the medication cart without an open date label. LVN 2 stated whoever opened the Humulin R vial, should have placed an open date on the label. LVN 2 stated she was not the one that open the Humulin R vial and no knowledge on when it was open. LVN 2 stated she will discard the Humulin R vial and call pharmacy for a new insulin for safety. During an interview on 03/04/25 at 1:49 p.m. with the Director of Nurses (DON), the DON stated the Humulin R will be discarded and new insulin are being ordered. The DON stated insulin should be label with an open and expired date, if not, no one will know when it was open and need to be discarded.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 49862 Based on observation, interview, and record review, Licensed Vocational Nurse (LVN 2) failed to take off used gloves and wash hands after performing blood sugar check to resident. This failure had the potential to result in cross contamination (the physical movement or transfer of harmful bacteria from one person, object, or place to another) and place the residents at risk for the spread of infection. Findings: During an observation and interview on 03/03/25 at 12::31 a.m. with Licensed Vocational Nurse (LVN2), LVN 2 was observed finishing blood sugar check, witness by surveyor and Director of Nursing (DON) leaving resident room, with used dirty gloves after performing blood sugar check and went down the hallway towards her medication cart to dispense the lancets used to do blood sugar check. LVN 2 admits she supposed to take off her used gloves and wash her hands before leaving the room and not to walk outside the room with dirty used gloves in the hallway. LVN 2 stated I should bring my cart closer by the room door where I was doing my blood sugar check, I am not supposed to walk with used gloves in the hallway, am supposed to wash my hands or use alcohol-based hand sanitizer before walking out of the room. LVN 2 stated there was a sharp container on each med cart that I should use instead of walking out of the room with used gloves. LVN 2 stated she forgot and it is infection control issues. During an interview with the Infection Preventionist Nurse (IPN) on 03/04/2025 at 12:12 p.m., IP nurse stated staff should not come out of the room with used or dirty gloves. IP nurse stated medication cart should be close in the room when doing any procedure like blood sugar check because there was a sharp container and hand sanitizer on top of each medication cart for infection control prevention. During an interview on 03/04/25 at 1:49 p.m., with the DON. The DON stated used gloves should not be allowed in the hallway, there are tendency for staff to get distracted and touch something else. The DON stated staff supposed to wash their hands before and after resident care. During a review of the facility's policy and procedure dated 10/2022, titled Infection Control, indicated Hand hygiene is one of the most effective measures to spread of infection. Using an alcohol-based hand rub containing at least 62% alcohol; or alternative, soap and water for the following situations: 2.b, before and after direct contact with residents .after contact with blood or bodily fluids.