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	02/17/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide a quality living environment for one of the four sampled residents (Resident 1) when Resident 1 was placed in a bed in front of a flood-prone exit door. This deficient practice resulted in Resident 1's clothing becoming wet and had the potential for unnecessary damage to her clothing, which could cause emotional distress to Resident 1. Findings:During a review of Resident 1's admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including displaced transverse fracture (when a bone is broken horizontally into two pieces, and the pieces have separated) of the right patella (kneecap).During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 2/3/2026, the MDS indicated Resident 1's cognition (the ability to think and reason) was moderately impaired and required supervision or touch assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activities) by staff to complete her activities of daily living ([ADLs] activities such as bathing, dressing and toileting a person performs daily).During an observation on 2/17/2026 at 2:13 p.m. in Resident 1's room, Resident 1's bed was observed with the head of the bed positioned halfway blocking an exit door which had a sign indicating, Exit WARNING!! ALARM WILL SOUND EMERGENCY EXIT ONLY! Resident 1 was observed placing a towel on the back of a chair which was located next to her bed, then continued to hang one pair of pants and two shirts on top of the towel.During an interview on 2/17/2026 at 2:13 p.m., Resident 1 stated she has been in her current bed for about six to seven days. Resident 1 stated on 2/16/2026 her clothing became wet when water flooded the floor. Resident 1 stated the water probably came in from under the exit door because it was raining. Resident 1 stated when her clothes became wet, she feared they could develop mildew and odors, so she hung them on the chair to dry. During a concurrent observation and interview on 2/17/2026 at 3:15 p.m. and subsequent interview at 4:53 p.m., with the Maintenance Supervisor (MS) in Resident 1's room, the Exit Door was observed unlocked. The MS was observed pressing the push bar (panic hardware, allowing fast, easy egress (exit) during emergencies by pushing a horizontal bar which releases the latch) and opened the door, which lead to a back patio area. The MS stated the flooding by Resident 1's bed was reported to him the previous day, after it had already occurred. The MS stated when he arrived in the room, the housekeeper had already mopped the area and towels had been placed to absorb the remaining water, and the floor was mostly dry by the time he assessed it. The MS stated the flooding occurred because of heavy rain allowed water to enter the room from under the exit door and some of Resident 1's clothing became wet because she kept her belongings on the floor. The MS stated he did not make any changes to the door to prevent any future flooding of water into the room. During an interview on 2/17/2026 at 4:59 p.m., the Director of Nursing (DON) stated the flooding near Resident 1's bed was reported to her today (2/17/2026) and stated that having an exit door (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	by the bed could impact the resident's safety.During an interview on 2/17/2026 at 5:30 p.m., the Administrator (ADM) stated her belongings would not have been wet if her bed was not positioned by the exit door. The ADM stated Resident 1 will be moved to another bed assignment.During a review of the facility's Policy and Procedure (P&P) titled Resident's Rights, dated 10/2016, the P&P indicated residents have the right to a safe, clean, comfortable and homelike environment.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a safe and unobstructed egress and flooding of water from under the exit door for four of four sampled residents (Resident's 1, 3, 6 and 7) when staff positioned Resident 1's bed partially blocking the exit door and when heavy rain allowed water to enter through the exit door, creating an unsafe exit route. This deficient practice had the potential to impede the safe evacuation for Residents 1, 3, 6, and 7 during an emergency and placed residents, staff and visitors to slip and fall from the water on the floor. Findings:a. During a review of Resident 1's admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with diagnosis including displaced transverse fracture (when a bone is broken horizontally into two pieces, and the pieces have separated) of the right patella (kneecap). During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 2/3/2026, the MDS indicated Resident 1's cognition (the ability to think and reason) was moderately impaired and required supervision or touch assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activities) by staff to complete her activities of daily living ([ADLs] activities such as bathing, dressing and toileting a person performs daily).During a review of Resident 1's Census List (resident information of admission and discharge) dated 2/17/2026, the Census List indicated Resident 1 was assigned to her current bed since 2/12/2026.During an observation on 2/17/2026 at 2:13 p.m. in Resident 1's room, Resident 1's bed was observed with the head of the bed positioned halfway blocking an exit door which had a sign indicating, Exit WARNING!! ALARM WILL SOUND EMERGENCY EXIT ONLY! During an interview on 2/17/2026 at 2:13 p.m., Resident 1 stated she has been in her current bed for about six to seven days. Resident 1 stated on 2/16/2026 her clothing became wet when water flooded the floor. Resident 1 stated the water probably came in from under the exit door because it was raining. Resident 1 stated when her clothes became wet, she feared they could develop mildew and odors, so she hung them on the chair to dry.b. During a review of Resident 3's Face Sheet, the Face Sheet indicated Resident 3 was admitted to the facility on [DATE] with diagnosis including cerebral infarction ([stroke] loss of blood flow to a part of the brain). During a review of Resident 3's MDS dated [DATE], the MDS indicated Resident 3's cognition was severely impaired and was fully dependent on staff to complete her ADLs. c. During a review of Resident 6's Face Sheet, the Face Sheet indicated Resident 6 was admitted to the facility on [DATE] hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness or reduced ability to move on one side of the body) following a cerebral infarction affecting the right dominant side. During a review of Resident 6's MDS dated [DATE], the MDS indicated Resident 6's cognition was severely impaired and required substantial/maximal assistance or partial/moderate assistance from staff to complete her ADLs. d. During a review of Resident 7's Face Sheet, the Face Sheet indicated Resident 7 was admitted to the facility on [DATE] with diagnosis including urinary tract infection (UTI). During a review of Resident 7's MDS dated [DATE], the MDS indicated Resident 7's cognition was severely impaired and required substantial/maximal assistance or partial/moderate assistance from staff to complete her ADLs.During an observation on 2/17/2026 at 2:13 p.m. in Resident's 1, 3, 6, and 7's room, Resident 1's bed was observed with the head of the bed positioned halfway blocking an exit door which had a sign indicating, Exit WARNING!! ALARM WILL SOUND EMERGENCY EXIT ONLY! During a review of the facility's undated Disaster and Evacuation Plan, the facility's Disaster and Evacuation Plan indicated there was an exit door located in Resident's 1,3,6, and 7's room which lead to a back patio. During a concurrent observation and interview on 2/17/2026 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	at 3:15 p.m. and subsequent interview at 4:53 p.m., with the Maintenance Supervisor (MS) in Resident's 1, 3, 6, and 7's room, the Exit Door was observed unlocked. The MS was observed pressing the push bar (panic hardware, allowing fast, easy egress (exit) during emergencies by pushing a horizontal bar which releases the latch) and opened the door, which lead to a back patio area. The MS stated Resident 1's bed was partially blocking the exit door, and her bed would have to be moved so the exit door was fully accessible for persons to exit in an emergency. The MS stated the flooding by Resident 1's bed was reported to him the previous day, after it had already occurred. The MS stated when he arrived in the room, the housekeeper had already mopped the area and towels had been placed to absorb the remaining water, and the floor was mostly dry by the time he assessed it. The MS stated the flooding occurred because of heavy rain allowed water to enter the room from under the exit door and some of Resident 1's clothing became wet because she kept her belongings on the floor. The MS stated he did not make any changes to the door to prevent any future flooding of water into the room. During an interview on 2/17/2026 at 4:59 p.m., the Director of Nursing (DON) explained that even though the exit door by Resident 1's bed is marked as an exit on the floor map, it is not included in the emergency exit plan, and staff are not trained to use it during emergencies. The DON stated the flooding near Resident 1's bed was reported to her on 2/17/2026 and stated that having an exit door by the bed could impact the resident's safety.During an interview on 2/17/2026 at 5:30 p.m., the Administrator (ADM) stated the door by Resident 1's bed is not considered an emergency exit and Resident 1's bed is usually more to the right of the door. The ADM stated Resident 1 will be moved to another bed assignment. During a review of the facility's Policy and Procedure (P&P) titled, Fire and Disaster Policy/Procedure, dated 11/29/2018, the P&P indicated the facility is equipped with two or more exit ways, they are remote from each other and are identified on the floor plans posted throughout the facility. The P&P indicated it is the responsibility of all personnel to always keep exit ways clear, exit doors should never be blocked, not even for a few moments.