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	04/27/2026

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure Certified Nursing Assistant (CNA 1) documented Resident 1's refusal to allow belongings to be inventoried for one of three sampled residents (Resident 1). This failure resulted in the facility being unable to determine the contents of Resident 1's backpack, including the amount of cash Resident 1 later reported missing.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]. Resident 1 had diagnoses including chronic obstructive pulmonary disease ([COPD] a chronic lung disease causing difficulty in breathing) with acute exacerbation (sudden worsening of breathing symptoms), left lower limb cellulitis (a skin infection that causes swelling and redness), and muscle weakness (reduced muscle strength). During a review of Resident 1's History and Physical (H&P), dated 4/14/2026, the H&P indicated Resident 1 was able to make her own medical decisions.During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool), dated 4/17/2026, the MDS indicated Resident 1's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was moderately impaired. The MDS indicated Resident 1required partial to moderate assistance (helper does less than half the effort) from staff for eating, oral hygiene, and personal hygiene and required substantial to maximum assistance (helper does more than half the effort) from staff for toileting, bathing, and dressing. The MDS further indicated Resident 1 felt it was somewhat important to take care of her personal belongings or things.During a telephone interview on 4/24/2026 at 9:02 a.m., with the Complainant, the Complainant stated she visited Resident 1 at the facility regarding Resident 1's insurance recertification. The Complainant stated Resident 1 searched her backpack for paperwork and noticed a white envelope with an unknown amount of cash was missing from the backpack. The Complainant stated Resident 1 was admitted to a General Acute Care Hospital (GACH) on 4/10/2026 and transferred from the GACH to the facility on 4/13/2026. The Complainant stated Resident 1 did not notice the envelope was missing until the Complainant's visit on 4/22/2026. The Complainant stated Resident 1 recalled she went to the bank before her hospitalization on 4/10/2026 and withdrew approximately $200 in cash. The Complainant stated Resident 1 reported the white envelope contained an unknown number of $20 bills. The Complainant stated Resident 1 did not know when the money went missing and did not remember having the money while at the GACH.During a review of Resident 1's undated Resident Clothing and Possessions Form (Inventory List), the Inventory List indicated Resident 1 had the following items upon admission: one blouse, one sweater, four toilet articles, one pair of glasses, one pair of leggings, one backpack, one cell phone, one phone charger, one book (Bible), one cane, and important documents. The Inventory List did not indicate the contents of Resident 1's backpack nor was there documentation indicating Resident 1 refused to have the contents of the backpack inventoried. During a concurrent observation, interview, and record review on 4/24/2026 at 1:05 p.m., with Resident 1, while in Resident 1's room, the resident's Inventory List was reviewed. Resident 1 was observed sitting at her bedside with a flower-patterned backpack on the bedside table behind her. Resident 1 stated she was visited by a (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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	social worker on 4/22/2026 regarding insurance paperwork. Resident 1 stated she searched her backpack for the paperwork and discovered a white letter-sized envelope with money was missing from the backpack. Resident 1 stated she did not know how much money was missing. Resident 1 stated she recalled going to the bank before she went to the GACH and withdrew approximately $600 from the bank. Resident 1 stated she combined the $600 with money from another source to pay her rent. Resident 1 stated she withdrew several $20 bills and had money left over after she paid her rent, but she was unsure of the amount. Resident 1 stated she had the backpack while at the GACH. Resident 1 reviewed the items on the Inventory List and confirmed the items were in her possession. Resident 1 stated she remembered signing the Inventory List but did not remember informing the facility she had money in the backpack. Resident 1 stated she did not report the missing money to the facility. Resident 1 stated she was unsure whether the money went missing at the facility or at the GACH. Resident 1 stated she did not give the money to anyone for safekeeping. Resident 1 stated she last saw the money in the envelope approximately two days after she was admitted to the facility. Resident 1 stated the backpack was kept on the bedside table, and the backpack was not put away while she slept or when she left the room.During a telephone interview on 4/24/2026 at 2:08 p.m., with Family Member (FM) 1, FM 1 stated Resident 1 was self-responsible and FM 1was not present when Resident 1 was admitted to the facility. FM 1 stated Resident 1 had the backpack in her possession when she was transferred from the GACH to the facility. FM 1 stated the Complainant informed FM 1 on 4/22/2026 of Resident 1's missing money. FM 1 stated the Complainant advised her to pick up the remaining money Resident 1 still had in her possession for safekeeping. FM 1 stated she went to the facility with another family member on 4/22/2026 to retrieve Resident 1's money. FM 1 stated the money was counted with Resident 1 and Resident 1 had a total of $504 in her backpack. FM 1 stated Resident 1 informed her she also had she had a white envelope full of $20 bills that was missing from the backpack. FM 1 stated she took the $504 home with her. FM 1 stated she was unaware Resident 1 had money in her backpack and Resident 1 did not know how much money was in the envelope.During an interview on 4/24/2026 at 3:04 p.m., with the Social Services Director (SSD), the SSD stated the facility completes an Inventory List of the resident's personal property upon admission. The SSD stated the resident's property is reviewed with the residents and a CNA, then documented on the Inventory List. The SSD stated the resident and/or responsible party signs and dates the Inventory List for verification. The SSD stated if a resident's personal property came up missing, the facility would review the resident's Inventory List. The SSD stated the facility bases the resident's personal property on the Inventory List, but if the missing item was not on the Inventory List, the facility would still investigate the missing property. The SSD stated she was not aware of Resident 1 reporting missing money. The SSD stated when a resident's personal property was missing, the missing property should be reported to her right away.During an interview on 4/24/2026 at 3:36 p.m., with the Director of Staff Development (DSD), the DSD stated the inventory was completed upon admission or the next day, and the facility followed up to ensure the Inventory List was completed. The DSD stated a chart review was completed to ensure the Inventory List was completed. The DSD stated nursing staff were trained on how to complete the Inventory List for residents. The DSD stated all Inventory Lists were required to be dated. The DSD stated the CNA should have asked Resident 1 what was inside the backpack. The DSD stated the CNA should have notified the charge nurse or Registered Nurse (RN) if Resident 1 refused to have the contents of the backpack inventoried. The DSD stated the refusal should have been documented on the Inventory List and in the Nursing Progress Notes. The DSD stated the Charge Nurse (unknown), or Registered Nurse (unknown) would have encouraged and educated Resident 1 regarding the importance of inventorying the contents of the backpack, so if anything came up missing, the facility could replace the missing items.During a concurrent interview and record review on 4/24/2026 at 4:01 p.m., with CNA 1, Resident 1's Inventory List was reviewed. CNA 1 stated she completed Inventory Lists for new admissions during her shift. CNA 1 stated she brought the Inventory List to the resident's room and (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	informed the resident she would inventory the resident's personal belongings. CNA 1 stated she asked residents if she could open bags or backpacks. CNA 1 stated if a resident agreed, CNA 1 checked the contents of the bag or backpack, and if a resident refused, CNA 1 reported the refusal to the charge nurse. CNA 1 reviewed Resident 1's Inventory List and acknowledged she did not date the Inventory List. CNA 1 stated she remembered the Inventory List was completed on Resident 1's first day of admission. CNA 1 stated she checked the backpack on the Inventory List but did not go inside the backpack because Resident 1 refused. CNA 1 stated she lifted Resident 1's backpack and noticed the backpack was heavy, but Resident 1 stated the backpack only contained important documents. CNA 1 stated Resident 1 informed her she did not have money or a wallet inside the backpack. CNA 1 stated she reported Resident 1's refusal to a Charge Nurse but did not remember who the charge nurse was. CNA 1 stated Resident 1 was by herself when CNA 1 completed the Inventory List. CNA 1 stated she did not document Resident 1's refusal to have the backpack contents inventoried on the Inventory List. CNA 1 stated she should have documented the refusal and admitted it was her mistake. CNA 1 stated it was important to document the refusal because the resident may have something important in the backpack, and it was not documented on the Inventory List.During a review of Resident 1's Nursing Progress Notes, dated 4/13/2026, there was no documentation indicating Resident 1 refused to have the contents of the backpack inventoried during the admission inventory process nor documentation indicating staff educated Resident 1 regarding the importance of inventorying the contents of the backpack.During an interview on 4/27/2026 at 4:39 p.m., with the Director of Nursing (DON), the DON stated it was important to document the contents of Resident 1's backpack or document Resident 1's refusal to have the backpack inventoried. The DON stated it was important to document education provided to Resident 1 regarding the importance of having her belongings inventoried to prevent missing items. The DON stated it was important to document the contents of Resident 1's backpack because the facility was unable to determine how much money Resident 1 had. The DON stated nursing staff should have documented Resident 1 was educated regarding the risks of keeping valuables in a backpack at bedside when the backpack contents were not inventoried. The DON stated staff should document the contents of a resident's belongings or document the resident was educated regarding the risks of not inventorying items left at bedside.During a review of the facility's Policy and Procedure (P&P) titled, Guidelines for admission Documentation, revised 8/2020, the P&P indicated it was the responsibility of the nursing center to account for all personal belongings of the resident. The P&P indicated a personal inventory list was made on admission and became part of the chart. The P&P indicated family and/or the resident was cautioned about keeping valuables in the rooms. During a review of the facility's P&P titled, Theft & Loss, revised 1/2013, the P&P indicated a written resident personal property inventory was recorded on an appropriate form upon the resident's admission.