

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555163	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/17/2024
NAME OF PROVIDER OR SUPPLIER Shoreline Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 5225 South J St Oxnard, CA 93033	

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)
<p>F 0837</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility.</p> <p>40560</p> <p>Based on record review and interview, the facility failed to obtain a physician order, prior to providing one of two sampled residents (Resident 1) with psychological services.</p> <p>This failure had the potential for Resident 1 to receive services not approved by a physician.</p> <p>Findings:</p> <p>During a concurrent record review and interview, on 9/17/24, starting at 11:01 a.m., with the Health Information Manager (HIM 1) Resident 1 ' s medical record was reviewed. When asked if Resident 1 was receiving psychological services while at the facility, the HIM 1 verbalized yes. Resident 1 ' s medical record indicated Resident 1 had received psychological services from 11/1/23 to 7/17/24. The HIM 1 could not provide documentation indicating Resident 1 ' s physician had written an order for Resident 1 to receive psychological services.</p> <p>During an interview on 9/19/24, at 1:48 p.m., with the Director of Nursing (DON 1), the DON 1 verbalized the facility could not provide documentation indicating Resident 1 ' s physician had written and order for psychological services.</p> <p>During a review of the facility ' s policy and procedure titled F250 Social Services dated 11/16, indicated in part Providing or arranging provision of needed counseling services .An MD order is required.</p>

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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