Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555163	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shoreline Care Center	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)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48668 Based on interview and record review, the facility failed to accurately complete a Minimum Data Set (MDS) Assessment (an assessment tool) for one of two residents (Resident 1). As a result, the elopement risk assessment did not accurately reflect Resident 1's status. Findings: A review of Resident 1's face sheet indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including unspecified dementia (signifies memory loss, impaired thinking). During the interview on 2/28/25 at 1:45 p.m., with a Certified Nurse Assistant (CNA2), CNA2 stated there was an instance in January 2025 when Resident 1 went outside the main entrance door in South station by following a visitor who was going out when the door opened. CNA2 reported the incident to charge nurse. During a review of Resident1's Medication Administration Record (MAR) dated February 2025, under behavior monitoring, this indicated two episodes of anxiety (one episode on 2/4 and another on 2/6), and one episode of paranoia (suspiciousness) on 2/2. During a concurrent interview and record review on 3/7/25 at 11:50 a.m., with Nurse Supervisor (NS 3), NS 3 confirmed to have completed the elopement risk assessment for Resident 1 on 1/10/25 and the evaluation indicated Resident 1 was not at risk for elopement. NS 3 stated not reviewing any records and only based the evaluation completed to the best of her knowledge of the resident through an interview and acknowledged not reviewing past evaluations, the resident's history and other pertinent information from other staff. During an interview on 3/12/25 at 3:05 p.m. with the Social Services Assistant (SSA), SSA confirmed to have completed the Quarterly Minimum Data Set Section E- Behavior assessment on 1/7/25. SSA acknowledged not checking the MAR dated January 2025 for behavior monitoring for Resident 1. A review of the facility's policy and procedure (P&P) titled Behavioral Health Services, dated October 2022, the P&P indicated, the facility utilizes the comprehensive assessment process for identifying and assessing a resident's mental and psychosocial status and providing person-centered care which includes but not limited to obtaining history from medical records, the resident, and as appropriate the resident's family regarding mental, psychosocial, and emotional health.

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48668 Based on interview and record review, the facility failed to ensure interventions of a behavioral care plan was implemented for one of two residents (Resident 1). This failure resulted in increased behavioral episodes of aggression, anxiety and paranoia (suspiciousness) for Resident 1. Findings: A review of the facility's Admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including unspecified dementia (signifies memory loss, impaired thinking). A review of Resident1's initial psychiatric evaluation by a practitioner dated 8/8/25, this indicated Resident1 was in the hospital due to code 5150 (danger to self and others), struck another resident on admission day, was easily agitated, and was given 1:1 care (1 staff assigned solely to Resident1). A review or Resident 1's care plan dated 8/6/24, indicated focused care on anxiety manifested by aggressiveness or wandering/pacing agitated behavior, and poor impulse control with the goals of reducing anxiety, to keep self and others safe, with interventions that include but not limited to provide reassurance, redirection or diversion, to administer anti-anxiety medication as ordered, refer to psychiatrist for possible medication adjustment and to reassess and evaluate the appropriateness of current psychotropic medication regimen. During a review of Resident's 1 Medication Administration Record (MAR) dated February 2025, it indicated that on 2/12/25 anxiety episodes were observed four times during morning shift, 2 times during evening shift, and two times during night shift, and paranoia (suspiciousness) three times in morning shift, two times in evening, and two times at night shift. Additionally, on 2/13/25 anxiety episodes were observed six times during morning shift, two times during evening shift, and two times during night shift, and paranoia (suspiciousness) four times in morning shift, two times in evening, and two times at night shift. However, there was no documented evidence that staff provided non-pharmacological approach prior to medication administration or administered medication (Lorazepam 0.5 mg tablet every six hours) as needed for anxiety. During the interview on 3/14/25 at 3:55 p.m., with Licensed Nurse (LN5), LN 5 stated that during the afternoon shift (3pm to 11pm), Resident 1 had said I want to go home, someone was out to get me prompting LN 5 to enter 2 behavior episodes in the MAR under behavior monitoring dated February 2025. LN 5 further stated not calling the physician for the behaviors. During the interview on 3/15/25 at 5:22 a.m., NS 2 stated during the night shift (11 pm to 7 am), she helped Charge Nurse (CN 1) entered a behavior monitoring observation for Resident 1 in the MAR dated 2/12 and 2/13 for behaviors manifested as restlessness (pacing back and forth), and a belief that someone will get him. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the interview on 3/15/25 at 4:15 p.m., LN 2 stated not administering the antianxiety medication because Resident 1 calmed down with redirection but acknowledged there was no documentation of the nonpharmacological interventions done and not calling the physician for the increased episodes in behavior. During an interview on 3/18/25 at 1 p.m., with the Psychiatry Practitioner (PP), PP stated not receiving a call from the facility staff on 2/12 and 2/13 and could have ordered for medication if the increased episodes in Resident 1's behavior was reported by staff. A review of facility's policy and procedure (P&P) titled Resident Assessment, dated 2006, P&P under Care Plan Documentation Guidelines indicated, Nursing service has the overall responsibility to coordinate care among all disciplines to achieve the established goals.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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** 48668 Based on observation, interview and record review, the facility failed to: Provide adequate supervision for one of two sampled residents (Resident 1) to prevent accidents. Additionally, the facility failed to: -Accurately assessed Resident 1's risk for elopement. -Follow interventions for the administration of anti-anxiety medications. -Call the physician/medical practitioner for change in condition (increased agitation) to seek appropriate care intervention for Resident 1. -Place Resident 1 in a room farther away from the fire exit door which opens to a busy street. These failures resulted in Resident 1 opening an exit door on 2/14/25 between 5:30 a.m. to 5:35 a.m., walked to a busy street, was hit by a moving vehicle, sustained fatal injuries, and was pronounced dead at a local hospital on 2/14/25 at 6:40 a.m. Findings: A review of Resident 1's face sheet indicated Resident 1 was a [AGE] year old male, admitted to the facility on [DATE] with diagnoses including unspecified dementia (signifies memory loss, impaired thinking), psychotic disturbance (a mental health condition characterized by a loss of touch with reality), mood disturbance (prolonged periods of sadness, irritability, or extreme highs), and anxiety (feeling of fear, dread, and uneasiness) per the facility's Admission Record. A review or Resident 1's care plan dated 8/6/24, indicated anxiety manifested by aggressiveness or wandering/pacing agitated behavior, and poor impulse control with the goals of reducing anxiety, to keep self and others safe. Interventions include to provide reassurance, redirection or diversion, to administer anti-anxiety medication as ordered, refer to psychiatrist for possible medication adjustment and to reassess and evaluate the appropriateness of his current psychotropic medication regimen. A review of Resident 1's care plan included a focus area initiated on 10/28/2024, indicated the Resident 1 had struck another resident using an empty coffee cup. Interventions included instructions to keep the residents away from each other when in a common area (initiated 10/18/2024). The care plan also indicated a focus area revised on 12/19/2024, of the Resident having episodes of physical aggression related to dementia and poor impulse control. The care plan further indicated Resident 1 had hit another resident on 12/19/2024. Interventions to analyze the time of day, place, circumstances, triggers, and what Resident 1's behavior (initiated 12/15/2024); monitor the resident for behaviors of aggressiveness and document the behavior (initiated 12/15/2024); intervene when the resident becomes agitated (initiated 12/15/2024); and indicated the resident was to receive one-to-one staff supervision, pending an interdisciplinary team (IDT) review (initiated 12/19/2024). (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the IDT notes dated 1/14/25 , indicated the IDT met following an incident involving the resident grabbing another resident by the jacket and pushing the other resident against a wall. Per care plan dated 1/14/25, to refer for Psych evaluation to review medications for possible adjustment. During a review of Resident 1's psychiatric practitioner's (PP) progress notes dated 2/5/25, indicated Resident was seen for ongoing episodes of physical striking out at other residents, resident is secured in the facility's south wing due to the risk of elopement, self-harm or the need for extensive supervision. During an interview on 2/28/25 at 1:45 p.m., with a certified nurse assistant (CNA2), CNA2 stated there was an instance in January 2025 when Resident 1 went outside the main entrance door in South station by following a visitor who was going out when the door opened. During an interview on 3/7/25 at 11:50 a.m., with Nurse Supervisor 3 (NS 3), NS 3 confirmed she did the elopement risk assessment of Resident 1 on 1/10/25 and evaluated him without elopement risk. NS 3 confirmed not reviewing any records and only based her evaluation to the best of her knowledge of the resident through interview but admitted not reviewing past evaluations, history and other pertinent information. During an interview on 3/8/25 at 12:15 a.m., CNA1 stated that Resident 1 was able to get out of the facility between 5:30 a.m. and 5:35 a.m. on 2/14/25. Resident 1 just got up from bed, went outside room [ROOM NUMBER], Resident 1 pushed the rear emergency exit door (few steps from room [ROOM NUMBER] door), alarm went off, Resident 1 stepped out the door on to the U-shaped handicapped ramp that connects to the street. CNA1 described that while Resident 1 was walking towards the middle of the road; Resident 1 was struck by a car and fell face down to the ground and towards the side of the road. A review of the hospital's trauma progress note dated 2/14/25, indicated, Patient in full arrest after auto vs pedestrian with head trauma .Patient pronounced dead in trauma bay at 6:40 am. During an interview on 3/12/25 at 2:50 p.m., with Licensed Nurse (LN 3), LN3 stated that on 1/2/25, she observed Resident 1 being restless (pacing back and forth) and on 1/6/25, she observed Resident 1 with episode of being suspicious that someone will steal from him. A review of the record titled Elopement Evaluation dated 1/10/25, indicated Resident 1 was not at risk for elopement. During interview on 3/12/25 at 3:05 p.m., the License Nurse (LN 4) stated that on 1/4/25, Resident 1 was observed to have restlessness as manifested by pacing back and forth. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of Resident's 1 Medication Administration Record (MAR) dated February 2025, indicated on 2/12/25 anxiety episodes were observed four times during morning shift, 2 times during evening shift, and two times during night shift, and paranoia (suspiciousness) three times in morning shift, two times in evening, and two times at night shift. Moreover, on 2/13/25 anxiety episodes were observed six times during morning shift, two times during evening shift, and two times during night shift, and paranoia (suspiciousness) four times in morning shift, two times in evening, and two times at night shift. However, there were no indications that staff provided non-pharmacological interventions prior to medication administration, nor administered medication (Lorazepam 0.5 mg tablet every six hours) as needed for anxiety. During an interview on 3/14/25 at 3:55 p.m. with LN 5, LN 5 stated that during her afternoon shifts (3pm to 11pm) on 2/12/25 and 2/13/25, Resident 1 told LN 5, I want to go home, someone was out to get me prompting LN 5 to enter 2 behavior episodes in the MAR under behavior monitoring dated February 2025. LN 5 stated she did not call the physician for the behaviors. During an interview on 3/15/25 at 5:22 a.m., a Nursing Supervisor (NS 2), stated during the night shift (11 pm to 7 am) on 2/13/25, she helped Charge Nurse (CN 1) enter a behavior monitoring observation for Resident 1 in the MAR dated 2/12 and 2/13 for behaviors manifested as restlessness (pacing back and forth), and a belief that someone will get him. During an interview on 3/15/25 at 4:15 p.m., LN 2 stated during her morning shifts (7 am to 3 pm) on 2/12/25 and 2/13/25 not administering the antianxiety medication because Resident 1 calmed down with redirection but admitted there was no documentation of the nonpharmacological interventions done and stated not calling the physician for the increased episodes in behavior. During an interview on 3/18/25 at 1:00 p.m., the Psychiatric Practitioner (PP) stated not receiving a call from the facility staff on 2/12/25 and 2/13/25 and further stated he could have ordered medication if he was told of the increased episodes in Resident 1's behavior. A review of the facility's P&P titled Elopement and Missing Resident dated 12/17 indicated, It is policy to monitor and evaluate residents at risk for wandering and elopement. The Interdisciplinary Team (IDT) is responsible for identifying residents at risk for elopement, implementing preventative measures to reduce risk, and provide a process for action if an incident of elopement occurs . A review of the facility's policy and procedure (P&P) titled Resident Assessment, dated 2006, P&P under Care Plan Documentation Guidelines indicated, Nursing service has the overall responsibility to coordinate care among all disciplines to achieve the established goals. A review of the facility's P&P titled Behavioral Health Services, dated 10/22, this indicated, It is the policy of this facility to ensure all residents receive necessary behavioral health services to assist them in reaching and maintaining their highest level of mental and psychosocial functioning . 36708 (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 2/27/25 at 5:40 p.m., during a supervisory visit, a concurrent observation and interview was conducted with the Administrator (Admin), Director of Nursing (DON) and the Manager for Environmental Services (MES). The DON stated the South wing of the facility was not a 'secured unit' but a unit with doors with alarms. Further observations with the DON and MES were conducted. The 2nd fire exit door exit was observed and was towards end of hallway. Four resident rooms were close by, room [ROOM NUMBER] was where Resident 1 was, with 1:1 sitter and a roommate at the time. The DON stated the sitter sits by the door of the resident's room. A sign code pink was posted on exit door with information on what to do with resident elopement. The DON confirmed code pink referred to a resident trying to elope/have eloped. This fire exit door with STOP sign in red color, opens easily, loud alarms on when opened, leads to a ramp, and one gate, the other side is a fence (not high). Ramp was very close to the street (J St.). The DON stated this ramp was not used for ambulance transport, and was the door where Resident 1 used to exit to the street. The plan of correction submitted on 2/18/25 was observed and confirmed implemented.