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	04/18/2025

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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. 40560 Based on interview and record review, the facility failed to change a hearing aid filter for one of three sampled residents (Resident 1) per instructions from an outside clinic. This failure had the potential for Resident 1's hearing aid to be less effective, potentially impacting Resident 1's ability to hear and communicate. Findings: During a concurrent interview and record review, on 4/16/25, beginning at 3:30 p.m., with the Health Information Manager (HIM 1) and Assistant Director of Nursing (ADON 1), Resident 1's medical record was reviewed. Resident 1 had an appointment at an outpatient clinic on 2/27/25, where Resident 1 returned to the facility with new hearing aids. The outside clinic provided instructions to change the hearing aid filter once a month. The HIM 1 and ADON 1 verbalized Resident 1's hearing aid filter should have been changed on 3/27/25, but it did not happen until 4/8/25. The ADON 1 verbalized the facility could not provide documentation indicating when it received Resident 1's office visit summary with care instructions for Resident 1's 2/27/25 outpatient clinic visit. Resident 1's Progress Notes dated 4/2/25, indicated the facility was not aware Resident 1's hearing aid needed a filter change until 4/2/25, when Resident 1's responsible party requested for Resident 1's hearing aid filter to be changed.

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

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	04/18/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40560 Based on interview and record review, the facility failed to follow its scabies (a contagious skin disease marked by itching and small raised red spots, caused by mites) protocol for one of three sampled Residents (Resident 1). This failure had the potential for scabies to spread throughout the facility. Findings: During a concurrent interview and record review, on 4/17/25, at 1:50 p.m., with the Assistant Director of Nursing (ADON 1), Resident 1's medical record was reviewed. Resident 1's medical record indicated Resident 1 was seen by a Dermatologist (a medical practitioner specializing in the diagnosis and treatment of skin disorders) on 4/4/25, where Resident 1 was suspected to have scabies. Resident 1 was prescribed Permethrin 5% cream (a medication commonly used to treat scabies). The ADON 1 verbalized the facility could not provide documentation indicating it placed Resident 1 on enhanced barrier precautions on 4/4/25, upon return to the facility, when Resident 1 was suspected of having scabies. During a concurrent interview and record review, on 4/17/25, at 2:48 p.m., with the Infection Preventionist (IP 1), Resident 1's medical record and scabies protocol were reviewed. The IP 1 verbalized and confirmed Resident 1 should have been placed on isolation precautions upon return to the facility on [DATE], with suspected scabies, but was not. The IP 1 was asked if the IP 1 had developed a contact identification list, when Resident 1 returned to the facility on [DATE], with suspected scabies. The IP 1 verbalized no. The IP 1 verbalized and confirmed facility nursing staff had not received any training on how to recognize and report residents with signs and symptoms consistent with scabies infestation. When asked what scabies protocol the facility utilized/adhered to, the IP 1 provided the document Prevention and Control of Scabies in California Healthcare Settings dated 8/20. The document indicated in part, Contact isolation precautions should be instituted until the suspected (or preliminary) diagnosis has been confirmed and appropriately treated or ruled out .The scabies prevention, control and outbreak management program should include training all physicians, nurses and other HCP (health care personnel) to recognize and report any patient/resident with signs and symptoms consistent with scabies infestation .As soon as a possible case of scabies is identified, the IP (infection preventionist) should develop a contact identification list.