

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 08/04/2025
NAME OF PROVIDER OR SUPPLIER Shoreline Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 5225 South J Street 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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (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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<p>F 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview and record review, the facility failed to readmit one of three sampled residents (Resident 1) after the resident was transferred to the veteran VA hospital for medication evaluation and adjustment. The facility's failure placed Resident 1 at risk of being admitted to another facility which is far from the wife's residence therefore unable to visit frequently. A complaint was received by the California Department of Public Health (CDPH) on 7/14/25 alleging that Resident 1 had been transferred to an acute care hospital for medication evaluation and adjustment. According to the information provided, a representative of the resident was informed by facility staff that the resident's bed would be held and that the resident would be readmitted to the facility following hospitalization. However, the facility subsequently declined to readmit the resident upon discharge from the hospital. During an interview on 7/14/25 at 12:15 p.m., with Resident 1's responsible person (RP - person who makes healthcare decisions for a patient who is unable), the RP reported that the facility declined to readmit Resident 1 following a hospital transfer. According to the RP, nursing staff notified them on 7/2/25 that Resident 1 would be transferred to [name of facility] for a medication evaluation and adjustment. The RP stated they were informed by facility staff that Resident 1 would be able to return following the hospital stay. However, the hospital case manager later informed the RP that the facility would not readmit Resident 1, and alternate placement would be required. During a review of Resident 1's Notice of Transfer or Discharge dated 7/2/25, the document indicated Resident 1 was transferred to [name of facility] on 7/2/25 at 2:40 p.m. The document indicated the transfer was necessary for Resident 1's welfare and that Resident 1's needs could not be met at the facility. However, there was no documentation indicating which needs could not be met. There was no documentation as to what attempts were made to meet Resident 1's needs. The sections were not completed on the document, these sections were left blank. During an interview on 7/17/25 at 2:23 p.m. with Licensed Vocational Nurse (LVN) 1, who transferred Resident 1 to [name of facility] on 7/2/25, LVN 1 stated that Resident 1 required a medication adjustment. LVN 1 confirmed marking/documenting on the transfer form that the transfer was necessary for Resident 1's welfare and that Resident 1's needs could not be met at the facility. Furthermore, when asked if the responsible person ([RP]) was informed there would be a Bed Hold (process of reserving a bed for a resident who is temporarily absent) for Resident 1, LVN 1 stated, Yes, I told the [RP] there was a bed hold for Resident 1 because that's our policy. During an interview on 7/16/25 at 12:30 p.m. with the Business Office Manager (BOM), the BOM was asked if information regarding private pay or reserve bed payment requirements was provided to the responsible person ([RP]) to hold the bed for Resident 1. The BOM stated, No, I did not. I did not have to because the resident was not going to be readmitted back. you need to speak with the administrator. During a telephone interview with the facility administrator (Admin) on 7/16/25 at 12:34 p.m., the Admin indicated the facility did not have to readmit Resident 1 because Resident 1 had attacked another resident. The Admin indicated the facility declined readmission due to Resident 1's behavior. Further review of Resident 1's Notice of Transfer or Discharge dated 7/2/25 did not indicate that Resident 1's transfer was due to the safety of individuals in the facility being endangered by the resident's clinical or behavioral status, or that the health of individuals in the facility would otherwise be endangered. A review of Resident 1's Physician's Discharge Summary dated 7/7/25, did not indicate that the reason Resident 1 was discharged was because the health and safety of individuals in the facility would be endangered. A review of the facility policy and procedure titled Admission, Transfer, Discharge and Bed-Holds, dated 12/2016, in the BED HOLD and readmission section of the policy indicates A resident, whose leave exceeds the bed hold period. will be allowed to return to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room, if the resident requires the services provided by the facility and is eligible for skilled nursing facility services.</p>		

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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p>(continued on next page)</p>

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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview and record review, the facility failed to:1. Ensure two of three sampled residents (Resident 1 and 2) were provided with a written bed-hold notification upon transfer to general acute care hospitals. 2. Ensure Resident 1's wife was provided with the bed hold private payment information before the resident was transferred to the veteran (VA) emergency department (ED).These failures resulted in the residents not having a bed-hold and were at risk of not being able to return to the facility.1. A review of the facility's policy and procedure titled Admission, Transfer, Discharge and Bed-Holds, dated 12/2016, indicated Upon transfer or discharge, a notice of transfer and discharge, as well as the bed-hold notification will be completed and given to the resident at the time of transfer or discharge or as soon as practicable. In the BED HOLD and readmission section of the policy indicated the facility will notify the resident or resident representative at the time of admission and again prior to hospital transfer or therapeutic leave, of the bed hold and readmissions policies.a) A complaint was submitted to California Department of Public Health (CDPH) on 7/14/25 indicating Resident 1 was transferred to [name of facility] for a medication evaluation and adjustment. The complainant agreed to the transfer after being notified by the facility that the facility would save Resident 1's bed, and that Resident 1 would be re-admitted back to the facility. However, the facility declined to readmit Resident 1 back to the facility.During an interview with Resident 1's responsible person (RP - person who makes healthcare decisions for a patient who is unable) on 7/14/25 at 12:15 p.m., RP reported the facility did not provide a written bed-hold notice upon Resident 1's transfer to [name of facility].A record review for Resident 1 was conducted on 7/15/25. Resident 1's Notice of Transfer or Discharge dated 7/2/25 indicated Resident 1 was transferred to [name of facility] on 7/2/25 at 2:40 p.m. On the Part B, Bed Hold (process of reserving a bed for a resident who is temporarily absent) section of the document indicated a Bed hold was authorized for Resident 1. The document titled Bed Hold Notification dated 9/4/24 indicated on 9/4/24 the (first notice) admission bed hold notification was performed. The (second notice) bed hold section of the notice that was supposed to be completed upon transferring of the resident, was not completed, the section was blank.During an interview on 7/17/25 at 2:23 p.m., with licensed vocational nurse (LVN) 1 who transferred Resident 1 to [name of facility] on 7/2/25 indicated not remembering if the written bed hold notice (second notification) was provided to the Resident 1's RP.During an interview with the assistant director of nursing (ADON) on 7/23/25 at 11:18 a.m., ADON acknowledged the Bed Hold Notification Form was not completed and not provided to the resident or representative upon the resident's transfer to the hospital.b) A record review for Resident 2 was conducted on 7/15/25. The [name of facility] Notice of Transfer or discharge date d 6/30/25 document indicated Resident 2 was transferred to Saint John's Regional Medical Center at 5:05 a.m. On part B- Bed Hold Section of the document indicated a Bed-hold was authorized for this resident. The document titled Bed Hold Notification Form, dated 6/19/25, indicated on 6/19/25 the (first notice) admission bed hold notification was performed. The (second notice) bed hold section of the notice that was supposed to be completed upon transferring of the resident, was not completed, the section was blank.During an interview with the assistant director of nursing (ADON) on 7/23/25 at 11:18 a.m., ADON acknowledged the Bed Hold Notification Form was not completed and not provided to the resident or representative upon the resident's transfer to the hospital.2. A review of the facility policy and procedure titled Admission, Transfer, Discharge and Bed-Holds, dated 12/2016, in the BED HOLD and readmission section of the policy indicates The notification will include the duration of the bed hold allowance in which the resident is permitted to return and resume residence within the facility and the reserve bed- payment requirements.During an interview with Resident 1's RP on 7/14/25 at 12:15 p.m., RP reported the facility did not provide her with any bed-hold private payment information for the resident's bed to be reserved or held while resident was at the [name of facility]. During an interview with the business office manager (BOM) on 7/16/25 at 12:30 p.m., the BOM was asked if Resident 1's RP was provided with private pay or the reserve bed-payment requirements information to hold the bed for the resident. BOM stated No, I did not.</p>		