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	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shoreline Care Center	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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on interview and record review, the facility failed to ensure care and services provided met professional standards and principles for one of two residents (Resident 1) when mild swelling was observed on Resident 1's left hip five days after the fall incident which was not documented or monitored.This failure had the potential to result in Resident 1's care being compromised without the appropriate nursing follow-up monitoring and documentation in place.Findings:According to ANA's (American Nurses' Association) book titled, Principles for Nursing Documentation (Guidance for Registered Nurses), copyright 2010, the guidance indicated, in part, Clear, accurate, and accessible documentation is an essential element of safe, quality, evidence-based nursing practice. Documentation of nurses' work is critical as well for effective communication with each other and with other disciplines .Nurses document their work and outcomes for a number of reasons: the most important is for communicating within the health care team and providing information for other professionals .to support the ability of the health care team to ensure informed decisions and high-quality care in the continuity of patient care.During a review of Resident 1's clinical record, Resident 1 was admitted to the facility under hospice care with the diagnosis of Vascular dementia (decline in thinking, memory and reasoning caused by damaged blood vessels), anemia (a blood condition), physical debility (physical general weakness) and COPD (lung disease).During a review of the Minimum Data Set (MDS - a required residents' assessment in a nursing home), dated 12/10/25, the MDS indicated that Resident 1's cognitive skills (mental status) was severely impaired and never or rarely make decisions. During a review of the document titled, Change of Condition Evaluation (COC), dated 1/4/26, the COC indicated, Resident 1 had unwitnessed fall, without injury, without swelling. Resident 1 complaint of pain in the left elbow and left hip. Further review of the COC indicated a notification to Resident 1's responsible party (RP) and the physician with an order for pain medication.During a review of the Nursing Progress Notes (NPN), dated 1/4 to 1/12/26, the NPN indicated that paramedics were called and the RP was offered for Resident 1 to be transferred to the hospital, but the RP refused the transfer and x-ray be taken. On 1/9/26, a slight swelling was observed on Resident 1's left hip and an x-ray was taken. Further review of the NPN, a documentation indicating RP's refusal to send Resident 1 to the hospital. No follow-up documentation was found if Resident 1's swollen left hip was being monitored.During an interview on 1/15/26, at 12:28 p.m. with the Certified Nursing Assistant (CNA 1), CNA 1 verbalized arriving in Resident 1's room on 1/4, when Resident 1 had a fall. CNA 1 confirmed caring for Resident 1 at the time of fall and there were no skin discoloration and swelling were observed during care. The CNA further verbalized taking care of Resident 1 after the fall up until when a slight swelling was observed on the left hip on 1/9 and reported the observation to the nurse. During an interview on 1/15/26, at 1:32 p.m. with the Licensed Vocational Nurses (LN 1), LN 1 acknowledged checking Resident 1's left hip after receiving an order for an x-ray from the hospice agency physician. LN 1 admitted not initiating the COC assessment electronically since a COC assessment was already initiated on (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/26. During an interview on 1/22/26, at 2:38 p.m. with LN 2, LN 2 verbalized that a COC and the follow up nurses' notes must be initiated electronically in PCC (Point Click Care - an electronic site for clinical documentation used by the facility). LN 2 further verbalized that without the COC, the 72 hours follow up monitoring for Resident 1's swollen left hip would not be monitored and documented.During a concurrent interview and record review on 1/26/26, at 3:57 p.m. with the Assistant Director of Nursing (ADON), the Interdisciplinary Team notes (IDT), and NPN were reviewed. The ADON acknowledged the 1/9 observation on Resident 1's mild left hip swelling. The ADON further acknowledged the missing COC and 72-hour follow-up monitoring and documentation. The ADON was not able to provide proof of documentation if Resident 1's swollen left hip was monitored by the nurses. During a review of the facility's policy and procedure (P&P) titled, Change in Condition Reporting, dated 8/25, the P&P indicated in part, .Acute Medical Change.4. All nursing actions, physician contacts and resident assessment information will be documented in the nursing progress notes.Follow up.1. The licensed nurse responsible for the Resident will continue assessment and documentation every shift for at least seventy-two (72) hours or until condition has stabled.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview and record review, the facility failed to ensure physician's order to monitor the respiratory rate (RR - the number of breaths per minute) was followed for one of two residents (Resident 1) prior to administration of morphine sulfate (a highly controlled substance given for severe pain). This deficient practice had the potential to cause serious side effects including respiratory depression (slow, shallow, difficulty breathing).Findings:During a review of the facility's policy and procedure (P&P) titled, Medication Administration General Guidelines, undated, the P&P indicated in part, .B. Administration.2. Medications are administered in accordance with written orders of the attending physician.During a review of Resident 1's clinical record, Resident 1 was admitted to the facility under hospice care with the diagnosis of Vascular dementia (decline in thinking, memory and reasoning caused by damaged blood vessels), anemia (a blood condition), physical debility (physical general weakness) and COPD (lung disease).During a review of Resident 1's current Order Summary Report (OSR), dated 1/4, 1/7 and 1/14/26, the OSR indicated, the following information: Order date 1/4/26: Morphine Sulfate Oral Solution 10mg/5ml, give 0.25 ml by mouth every 8 hours as needed for severe pain (7 - 10/10 pain scale) hold if RR is less than 12. The medication was administered on 1/5 and 1/6/26. The order was discontinued on 1/7/26. Order date 1/7/26: Morphine Sulfate Oral Solution 10mg/5ml, give 0.25 ml by mouth every 4 hours as needed for severe pain (7 - 10/10 pain scale) hold if RR is less than 12. The medication was administered from 1/8 to 1/14/26. The order was discontinued 1/14/26. Order date 1/14/26: Morphine Sulfate Oral Solution 10mg/5ml, give 0.25 ml by mouth every 8 hours for severe pain hold if RR is less than 12. The medication was to be given routinely at 6 a.m., 2 p.m., and 10 p.m. The medication was administered on 1/14/26 at 10 p.m., and 1/15/26 at 6 a.m.During a review of Resident 1's Medication Administration Record (MAR), dated 1/4 and 1/7, and 1/14/26, the MAR indicated,Order dated 1/4/26: MS 10mg/5ml, to give 0.25ml by mouth every 8 hours as needed for severe pain 7-10/10 hold for RR less than 12. The medication was administered on 1/5 and 1/6/26 and the order was discontinued on 1/7/26. Order dated 1/7/26: MS 10mg/5ml, give 0.25 ml by mouth every 4 hours as needed for severe pain (7 - 10/10 pain scale) hold if RR is less than 12. The medication was administered from 1/8 to 1/14/26 and the order was discontinued 1/14/26.Order dated 1/14/26: MS 10mg/5ml, give 0.25 ml by mouth every 8 hours for severe pain hold if RR is less than 12. The medication was to be given routinely at 6 a.m., 2 p.m., and 10 p.m. The medication was administered on 1/14/26 at 10 p.m., and 1/15/26 at 6 a.m.There was no evidence Resident 1's RR was obtained prior to administration of the medication.During a concurrent interview and record review with Licensed Nurse (LN 2), dated 1/22/26, at 2:38 p.m. Resident 1's OSR and MAR were reviewed. LN 2 verbalized Resident 1's current order for morphine sulfate to be given routinely every 8 hours and not to give the medication if the RR is less than 12. LN 2 further verbalized checking Resident 1's RR before administering the medication. LN 2 was unable to provide evidence of documentation of Resident 1's RR and acknowledged the missing documentation.During a concurrent interview and record review dated 1/22/26 at 3:57 p.m. with the Assistant Director of Nursing (ADON), Resident 1's OSR and MAR were reviewed. The ADON stated the RR must be documented prior to the administration of the morphine sulfate and acknowledged the missing documentation.During a phone interview on 1/26/26 at 9:20 a.m. with the Director of Nursing (DON), the DON verbalized that the RR should have been included in the MAR so the resident's RR can be monitored before administration of the morphine sulfate. The DON further verbalized that the doctor's instructions are already in place and yet the nurses are not paying attention and did not clarify the MAR to include the RR. The DON acknowledged the missing documentation.