

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 07/02/2026
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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow nursing standards of practice when duplicate medication orders were not clarified with the physician prior to administration for one (1) of two (2) sampled residents (Resident 1). This failure resulted in confusion and a medication error resulting in Resident 1 receiving three (3) extra doses of medication jeopardizing Resident 1's health and safety. Findings: During a review of [NAME] and [NAME], Tenth Edition, Elsevier, Fundamentals of Nursing, page 609 in the section titled, Medication Administration, indicated, If there is any question about a medication order because it is incomplete, illegible, vague, or not understood, contact the health care provider before administering the medication. During a review of the facility's policy and procedure (P&P) titled, Medication Errors and Adverse Reactions, dated 4/2025, the P&P indicated that, It is the policy of this facility that medication errors and adverse drug reactions must be reported to the resident's attending physician. Medication error means the observed or identified preparation or administration of medications or biologicals which is not in accordance with: The prescriber's order; Manufacturer's specifications (not recommendations) regarding the preparation and administration of medication or biological; or Accepted professional standards and principles which apply to professionals providing services. Accepted professional standards and principles include the various practice regulations in each State, and current commonly accepted established by national organizations, boards and councils. During a review of Resident 1's Face Sheet (FS), dated 7/2/26, the FS indicated that Resident 1 was admitted to the facility on [DATE]. During Resident 1's stay in the facility, Resident 1 was diagnosed with anxiety disorder on 5/27/21. During a review of Resident 1's Minimum Data Set (MDS - Resident's assessment in a nursing homes), dated 4/3/26, the MDS indicated that, Resident 1 had a BIMS of 15 (cognitively intact), diagnosis of anxiety disorder (a mental condition characterized by excessive, persistent and irrational worry, fear or dread), and received a medication for anxiety while in the facility. During a review of Order Summary Report (OSR), dated 6/2026, the OSR indicated a duplicate order for Lorazepam (type of medication to treat anxiety) 1 milligram (mg - unit of measurement) by mouth to be given one time a day every Tuesday, Thursday and Saturday to be administered 30 minutes before dialysis due to Resident 1's overly concern with his medical condition. There were 2 physician's orders for Lorazepam, dated 12/20/25 and 5/1/26. Further review of the OSR indicated that Resident 1's dialysis treatment time was from 9:30 a.m. until 1:15 p.m. During a review of the Medication Administration Record (MAR), dated 6/2026, the MAR indicated that duplicate orders for Lorazepam 1 mg were both signed on 6/16/26, and was administered at 8:00 a.m. During a review of Resident 1's Controlled Drug Record (CDR), dated 5/19/26, the CDR indicated that Resident 1 were administered Lorazepam 1 mg on 6/16/26, 2 doses at 7:38 in the morning and 2 doses at 2:00 in the afternoon. During a concurrent interview and record review on 7/2/26, at 1:41 p.m. with the Assistant Director of Nursing (ADON), the OSR, MAR, CDR and the facility's P&P were reviewed. The ADON stated that that during the course of the investigation on 6/16, the Licensed Vocational Nurse (LN 1) reported administering 2 doses of Lorazepam at 7:38 a.m. Additionally, LN 1 explained that 2 more doses were given to Resident 1 when the resident was picked up for dialysis. The second 2 doses of Lorazepam were signed administered in CDR by LN 1 at (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	2:00 p.m. upon return of Resident 1 from dialysis. LN 1 further explained that the presence of duplicate medication orders in Resident 1's clinical record made her confused. The ADON admitted that a medication error occurred for the administration of Lorazepam to Resident 1. The ADON stated that the duplicate medication orders should have been clarified with the physician prior to administration and was not. During interview on 7/2/26, at 3:45 p.m. with the Director of Nursing (DON), the DON acknowledged the error in medication administration and record keeping.		