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	04/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shoreline Care Center	5225 South J Street Oxnard, CA 93033

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure staff knocked and announced their presence prior to entering a resident's room for one of six sampled resident (Resident 5).This failure had the potential to negatively impact the residents' dignity and right to privacy, and cause embarrassment, discomfort or loss of respect.Findings:During an observation on 4/21/26 at 11:02 a.m., the Maintenance Assistant (MA) was observed entering room [ROOM NUMBER] without knocking on the door or announcing presence. Resident 5 was observed lying in bed. The MA proceeded into the room without obtaining permission to enter.During an interview on 4/21/26 at 11:05 a.m. outside the south dining room with MA, MA stated I usually enter if the door is open. I don't always knock because I'm just there to do something quickly.During an interview on 4/22/26 at 4:32 p.m. with the Director of Nursing (DON), DON stated, The facility expectation is for all staff to knock and announce themselves prior to entering residents' rooms to promote resident dignity and privacy.During an interview on 4/23/26 at 4:10 p.m. with the Director of Staff Development (DSD), DSD stated All staff should knock before entering residents' rooms.During a review of the facility's policy and procedure (P&P) titled Nursing Administration, under the section Resident Rights with the subject Dignity and Privacy, the policy states that it is the policy of the facility that all residents be treated with kindness, dignity, and respect. Subpart 3 states that residents shall be examined and treated in a manner that maintains the privacy of their bodies. A closed door or drawn curtain shields the Resident from passer-by. People not involved in the care of the Resident shall not be present without the residents' consent while they are being examined or treated. Staff members shall knock before entering the Resident's room.

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on interview and record review, the facility failed to ensure one of eight sampled residents (Resident 26) had the Preadmission Screening and Resident Review (PASRR-an evaluation to confirm that an individual has a mental illness) Determination Report recommended specialized services (services that exceed the services ordinarily provided by the nursing facility) for psychotherapy/counseling implemented. This failure had the potential to result in Resident 26 having increased psychiatric symptoms.During a review of the facility's policy and procedure (P&P) titled, PASRR, dated 5/2025, the P&P indicated, It is the policy of this facility to ensure that each resident is properly screened using the PASRR specified by the State. Evaluation must be completed by an approved state contractor, and a Determination made by the appropriate MI [mental illness] . state authority. During a concurrent interview and record review on 4/23/26 at 2:14 p.m., with the Director of Nursing (DON), Resident 26's PASRR Individualized Determination Report (PASRR-IDR), dated 1/4/22, was reviewed. The PASRR-IDR indicated, Recommended Specialized Services. Psychotherapy/Counseling. Individual and/or group and/or family treatment provided by a licensed mental health professional. DON stated the facility social services is not a licensed mental health professional. DON further stated the recommended service is not being provided.

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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** Based on observation, interview, and record review, the facility failed to ensure:1. One of four behavior-emotional sampled residents (Resident 51) had a comprehensive care plan (CP) that included an intervention that was not implemented and an intervention that was not supportive of Resident 51's CP goal. This failure resulted in Resident 51's psychosocial needs not being met.2. One of eight Preadmission Screening and Resident Review (PASRR-an evaluation to confirm that an individual has a mental illness) sampled residents (Resident 26) had the PASRR recommendations incorporated into their CP and had interventions (actions to be taken to maintain or improve a goal) that were measurable and clearly identified what was being measured. This failure resulted in Resident 26's psychosocial needs not being met. 1. During a review of the facility's policy and procedure (P&P) titled, Comprehensive Person-Centered Care Planning, dated 1/2026, the P&P indicated, It is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive person-centered care plan for each resident. to meet a resident's. mental and psychosocial needs that are identified in the comprehensive assessment. During an observation on [DATE] at 10:42 a.m., in Resident 51's room, Resident 51 was in bed, in a hospital gown, anxious, tearful, and repeating the statement, I don't want to die. During a review of Resident 51's Minimum Data Set (MDS-a federally mandated, standardized evaluation tool) Comprehensive Assessment section D, titled, Mood, dated [DATE], the MDS indicated, Little interest or pleasure in doing things. frequency. nearly every day. Feeling down, depressed, or hopeless. frequency. half or more of the days. Trouble falling or staying asleep, or sleeping too much. frequency. half or more of the days. Feeling bad about yourself - or that you are failure or have let yourself or your family dawn. frequency. nearly every day. During a concurrent interview and record review on [DATE] at 10:52 a.m., with medical records (MR), Resident 51's care plan report (CP) titled, At risk for depression r/t [related to] Admission, dated [DATE] was reviewed. The CP indicated, Arrange for psych [psychiatric] consult [consultation], follow up as indicated. Observe for side effects of anti-depressant medication. MR reviewed Resident 51's medical record and stated there was no evidence of a psychiatric consultation. MR further stated there was no order for an antidepressant. During a concurrent interview and record review on [DATE] at 11:30 a.m., with Director of Social Services (SS), Resident 51's CP titled, At risk for depression r/t Admission, dated [DATE] and Order Summary Report (OSR), were reviewed. SS stated the CP intervention for a psychiatric consultation was not followed and the intervention for observing the side effects of antidepressant medication did not apply to Resident 51. 2. During a review of the facility's policy and procedure (P&P) titled, Comprehensive Person-Centered Care Planning, dated 1/2026, the P&P indicated, Interventions - are actions, treatments, procedures, or activities. Measurable - is the ability to be evaluated or quantified. The facility IDT will develop and implement a. care plan for each resident's needs identified. any specialized services as a result of PASARR recommendation. During a concurrent interview and record review on [DATE] at 2:14 p.m., with the Director of Nursing (DON), Resident 26's:PASRR Individualized Determination Report (PASRR-IDR), dated [DATE], was reviewed. The PASRR-IDR indicated, Recommended Specialized Services. Psychotherapy/Counseling. Individual and/or group and/or family treatment provided by a licensed mental health professional.Care Plan Report (CPR) titled, [Resident 26's name] has Potential for a behavior problem r/t [related to] Schizophrenia [a type of mental illness] AEB [as evidenced by] auditory or visual hallucinations, initiated [DATE] and last revised [DATE], was reviewed. The CP indicated, Interventions. Administer medications as ordered. Monitor/document for side effects and effectiveness. Behavior Symptoms. Document behaviors.DON stated the facility social services is not a licensed mental health professional. DON also stated the PASRR recommended service is not incorporated into the care plan. DON further stated the interventions do not identify the medication to (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	be administered/monitored, what behaviors to be documented/monitored, or the frequency of documenting.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of five sampled residents (Resident 133), had a care plan (CP- an individualized plan for consistently managing a resident's care needs) reviewed and revised by the interdisciplinary team (IDT-a group of medical professionals who work together with the resident to develop a CP) after an assessment of Resident 133's ability to comply with the facility's smoking policy. This failure resulted in Resident 133 storing his smoking material in an unsafe location and becoming belligerent to staff who tried to enforce the smoking policy.During a review of the facility's policy and procedure (P&P) titled, Comprehensive Person-Centered Care Planning, dated 1/2026, the P&P indicated, It is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive person-centered care plan for each resident. The resident's comprehensive care plan will be reviewed and/or revised by the IDT after each assessment. During a review of the facility's P&P titled, Smoking Policy, dated [DATE], the P&P indicated, If IDT determines that the resident is unable to safely store their smoking materials. smoking products will be kept in a secured cabinet, only accessible to staff. Upon quarterly review by the IDT, or any time a significant change of condition occurs, smoking residents will be re-assessed as to their ability to smoke safely. and their ability to understand and comply with facility smoking policy. During a concurrent observation and interview on [DATE] at 4 p.m. with Resident 133 in their room, a green lighter was observed on their bedside table. Resident 133 stated the lighter belonged to him and he uses it when he smokes. During a concurrent observation and interview on [DATE] at 4:10 p.m. with a licensed nurse (LN3) in Resident 133's room, Resident 133 had a green lighter on his bedside table. LN3 stated it should not be there. Resident 133 became belligerent and was yelling at LN3, Leave my fucking stuff alone. During a review of Resident 133's Care Plan Report (CP) titled, [Resident 133's name] is at risk for injury due to smoking, dated [DATE], the CP indicated, Goal: Resident will Adhere to the Tobacco/Smoking Policies of the Facility. Interventions [actions to prevent a negative outcome] . Conduct Smoking Safety Evaluation on admission and PRN [as needed]. No revisions were made to the CP. During a review of Resident 133's IDT - Care Plan Review (IDT - CPR), dated [DATE] at 1:34 p.m., the IDT - CPR indicated, Person-Centered Assessment and Risk Assessment tools . were completed as a basis to establish the Resident's Plan of Care. [NAME] all that apply [Smoking Safety Evaluation was not marked]. During a review of Resident 133's progress note (PN) titled, Social Services, dated [DATE] at 3:26 p.m., the PN indicated, SS [social services] met with resident to review facility smoking policy. Resident refused to sign smoking policy. During an interview on [DATE] at 4:30 p.m. with the Director of Social Services (SS), SS stated SS saw a message about Resident 133 refusing to sign the last smoking policy review. SS also stated Resident 133's smoking care plan was not reviewed at Resident 133's last IDT meeting. SS further stated, I think it fell through the cracks.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure an appropriate audiology (hearing) referral was implemented for one of 35 sampled residents (Resident 136) with hearing impairment. This failure resulted in a delay in the provision of care, treatment, and services for all residents requiring a referral for care.During a review of the facility's policy and procedure (P&P) titled, Hearing Services, dated 11/2011, the P&P indicated, The resident will be referred as needed for a hearing evaluation. The SSD will keep at least one hearing amplifier available for new residents who are hard of hearing or as a temporary intervention if a resident's hearing aid is missing or lost.During a review of Resident 136's admission Record (AR), dated 4/24/2026, the AR indicated, Resident 136 was admitted in the facility on 1/7/2026 with diagnoses including, muscle weakness, gastrostomy tube (tube inserted through the belly that brings nutrition directly to the stomach), and type 2 diabetes mellitus (a condition where your body either doesn't produce enough insulin, or your cells don't respond properly to insulin). The Minimum Data Set (MDS) dated [DATE] indicated a Brief Interview of Mental Status (BIMS) score of 15, reflecting cognitive intact.During an interview on 4/21/26 at 3:16 PM, Resident 136 stated that he has difficulty of hearing and needs a hearing aid. Resident 136 reported that they informed facility staff of his hearing problem and no action had been taken.During a review of Resident 136's Physician Orders (PO), dated 1/7/2026, the PO indicated, May have hearing consultation with follow up treatments as indicated.During a review of Resident 136's Social Services Assessment (SSA), dated 1/8/2026, the SSA indicated, no hearing aids, but sometimes hard to hear.During an interview on 4/24/2026 at 8:48 AM, with Social Services (SS), stated that when a resident reports hearing problems and there is a physician's order for a hearing consultation, social services department is responsible for following up with the resident regarding the consultation.During an interview on 4/24/2026 at 10:00 AM, with Director of Nursing (DON), the DON stated that follow-up is required when a resident reports difficulty hearing. The DON confirmed there was no documentation to support that a follow-up or referral had been completed for Resident 136. DON further stated that the facility does not provide hearing amplifies for a new resident experiencing hearing loss.

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F 0689 Level of Harm - Minimal harm or potential for actual harm 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** Based on observation, interview, and record review, the facility failed to ensure one of five sampled residents (Resident 133), had their smoking privileges restricted when they refused to comply with the facility smoking policy to store their cigarette lighter in a secure box. This failure had the potential to result in avoidable accidents by other residents having access to the lighter. During a review of the facility's policy and procedure (P&P) titled, Smoking Policy, dated [DATE], the P&P indicated, If IDT [interdisciplinary team is a group of medical professionals who work together with the resident to focus on resident-centered care] determines that the resident is unable to safely store their smoking materials or require supervision to smoke safely, smoking products will be kept in a secured cabinet, only accessible to staff. Upon quarterly review by the IDT. smoking residents will be re-assessed as to their ability to smoke safely. and their ability to understand and comply with facility smoking policy. During a concurrent observation and interview on [DATE] at 4 p.m. with Resident 133 in their room, a green lighter was observed on their bedside table. Resident 133 stated the lighter belonged to him and he uses it when he smokes. During a concurrent observation and interview on [DATE] at 4:10 p.m. with a licensed nurse (LN3) in Resident 133's room, Resident 133 had a green lighter on his bedside table. LN3 stated it should not be there. Resident 133 became belligerent and was yelling at LN3, Leave my fucking stuff alone. During an interview on [DATE] at 4:30 p.m. with the Director of Social Services (SS), SS stated SS saw a message about Resident 133 refusing to sign the last smoking policy review. SS also stated Resident 133's smoking care plan was not reviewed at Resident 133's last IDT meeting. SS further stated, I think it fell through the cracks. During a review of Resident 133's Care Plan Report (CP- an individualized plan for consistently managing a resident's care needs) titled, [Resident 133's name] is at risk for injury due to smoking, dated [DATE], the CP indicated, Goal: Resident will Adhere to the Tobacco/Smoking Policies of the Facility. Interventions [actions to prevent a negative outcome] . Conduct Smoking Safety Evaluation on admission and PRN [as needed]. No revisions were made to the CP. During a review of Resident 133's IDT - Care Plan Review (IDT - CPR), dated [DATE] at 1:34 p.m., the IDT - CPR indicated, Person-Centered Assessment and Risk Assessment tools . were completed as a basis to establish the Resident's Plan of Care. [NAME] all that apply [Smoking Safety Evaluation was not marked] . Social Service Plan of Care. Resident appears to be adjusting well to facility without significant mood or behavioral concerns at this time. During a review of Resident 133's Progress Note (PN), titled, Social Services, dated [DATE] at 3:26 p.m., the PN indicated, SS met with resident to review facility smoking policy. Resident refused to sign smoking policy.

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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** Based on observation, interview, and record review, the facility failed to ensure the observance of infection control practices and protocols for one of six sampled residents (Resident 140), when 1. a foley catheter dignity bag (a discreet pouch/bag to keep/hide urine drainage bags for privacy and dignity) was observed in contact with the floor and 2. the facility stored outdated food products in the kitchen refrigerator.These failures had the potential to result in a significant infection control risk such as a catheter associated urinary tract infection (CAUTI) and food-born illness to all residents. 1) During an observation, on 4/21/26, at 9:43 a.m., in room [ROOM NUMBER]A, Resident 140 was lying in bed. The bed was positioned at its lowest setting. Foley catheter urine tubing was observed on the left side of the bed, with the urine collection bag placed inside a dignity bag. The urine dignity bag bottom was in contact with the floor. During an interview, on 4/21/26, at 1:49 p.m. , with the Wound Care Nurse (WCN), in front of the DSD's (Director of Staff Development) office. The WCN was shown a picture of Resident 140's dignity bag's bottom in contact with the floor. The WCN looked at the picture and stated, The dignity bag should not be touching the floor. The WCN agreed with the finding. During an interview with the Director of Nursing (DON), on 4/21/26, at 1:55 p.m., in the DON's office, the DON was shown the picture of Resident 140's dignity bag's bottom in contact with the floor. The DON said the dignity bag should not be in contact with the floor. The DON agreed with the finding. During a review of the facility's policy and procedure titled, Catheter Care, Policy, revised 8/2025, indicated,. To promote hygiene, comfort and decrease risk of infection for catheterized residents. According to the National Library of Medicine, Chapter 21 Facilitation of Elimination, To prevent the development of a urinary tract infection, the bag should not be permitted to touch the floor. 2. During a concurrent observation and interview in the facility kitchen on 4/21/26 at 9:44 a.m. with the Dietary Assistant Supervisor (DAS), multiple food and liquid items stored in the kitchen refrigerators were observed with use by dates ranging from 4/17/26 through 4/20/26. The DAS acknowledged that the items were past their use by dates. The DAS continued to state that these items should not have remained in the refrigerators and should have been discarded. During a review of the facility's policy and procedure (P&P) titled, Labeling and Dating of Foods, dated 2023, the P&P indicated, The Use By date will be the absolute date in which the food must be consumed or discarded by the facility.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observation, interviews and record review, the facility failed to ensure compliance with required equipment maintenance standards when: 1. Medication refrigerators were not maintained at the proper temperatures and safe dry conditions 2. The kitchen ice machine was not maintained in safe and sanitary working conditionThese failures had the potential to result in compromising the integrity and potency of refrigerated medications and exposing residents to contaminated ice from an improperly maintained ice machine.1. During an observation, on 4/22/26, at 10:15 a.m., in the North Station medication room, the medication refrigerators' thermometer recorded a temperature at 40 degrees Fahrenheit (normal acceptable range +36 to 46 degrees Fahrenheit [2 to 8 degrees Celsius]). There was no thermometer in the freezer to record the freezer temperature (normal +5 degrees Fahrenheit or colder [-15 degrees Celsius]). The freezer compartment, positioned at the top of the medication refrigerator, was undergoing defrosting, resulting in water dripping down and accumulating on the medications stored at the lower section. The medication packaging appeared saturated and damp; additionally, a black metal box exhibited rust on its handle hinges, and water was found pooled within the insulin medication container. During an interview, on 4/22/26, at 10:20 a.m., in the North Station medication room, with licensed nurse 2 (LN 2), LN 2 inspected the medication refrigerator and confirmed that the freezer was defrosting even with the temperature was within range. LN 2 acknowledged the medication packaging were saturated/damp, the black metal box exhibited rust on its handle hinges and water was pooled within the insulin medication container. LN 2 said they were not aware the medication refrigerator was defective. During an interview, on 4/22/26, at 10: 35 a.m., in the North Station medication room, with the Environmental Services Director [ESD]), the ESD said he was not aware the medication refrigerator was defective. ESD said he will call the Pharmacy to request a new medication refrigerator since it is the Pharmacy's property. ESD said he never inspected or performed any preventive maintenance (PM) or had any maintenance logs on the medication refrigerator since it was the Pharmacy's property. During an interview, on 4/222/26, at 11 a.m., in the DON's office, the DON said the medication refrigerator was the facility's property and not that of the pharmacy. The DON said the EDM was misinformed about who owned the refrigerator. During a review of the facility's policy and procedure titled, Medications Refrigerators, revised 08/2025,, indicated, 1. Refrigerator's maintenance will be done by nursing and maintenance on a routine basis. Nursing staff will defrost and clean refrigerator weekly. Maintenance staff will inspect refrigerator and ensure its functionality per nursing staff request. 2. During an observation and inspection of the ice machine on 04/21/26 at 10:20 a.m. in the side room kitchen area, a white tissue test was performed on the lower stainlessˆsteel bin inside the unit of the ice dispenser. After wiping the inside of the ice dispenser, the tissue showed a moderate amount of yellowish residue. In addition, the ice within the machine was observed to contain black speckles. The Dietary Assistant Supervisor (DAS) and Environmental Services (ES) staff were present during this inspection and validated these findings. During an interview on 04/21/26, at 10:24 a.m., with ES, ES stated that the ice machine is cleaned (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	monthly. ES further explained that the machine is sanitized using Nugon, which is poured into the ice dispenser to initiate the sanitizing process and flush the system. ES reported that all ice is removed and the interior of the machine is cleaned during this procedure. ES also verbalized that they did not know why the ice dispenser was found to be dirty. During a review of the manufactures' manual, titled Scotsman Ice System dated 12/14, the Scotman Ice System Installati9on and User's Manual for Modular Cuber indicated: It is the User's responsibility to keep the ice machine and ice storage bin in a sanitary condition. The manual states that without human intervention, sanitation will not be maintained. It further specifies that ice machines also require occasional cleaning of their water systems with a specifically designed chemical. This chemical dissolves mineral build up that forms during the ice making process.