STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055041	A. Building B. Wing	12/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Beach Post-Acute	2725 Pacific Avenue Long Beach, CA 90806

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 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. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, facility staff failed to provide implement post fall interventions for one of three sample residents (Resident 1). Facility failed to: 1. Ensure Resident 1's bed was maintained in the lowest position to help prevent additional falls. This deficient practice placed Resident 1, identified as a fall risk, at increased risk for further falls and potential injury. Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), hemiparesis (a condition that causes partial paralysis or weakness on one side of the body) following intracranial hemorrhage (a bleeding inside the skull from a ruptured blood vessel) affecting left dominant side. During a review of Resident 1's Minimum Data Set ([MDS] resident assessment tool), dated 11/24/2025, the MDS indicated Resident 1's had severe cognitive impairment for daily decision-making. The MDS indicated Resident 1 was dependent (helper does all of the efforts, resident does none of the efforts to complete the activity) with transfers between surfaces, including from bed to chair and from chair to bed (or wheelchair). During a concurrent observation and interview on 12/26/2025 at 2:00 pm with Resident 1, Resident 1 was observed in bed, alert but confused. At the time of observation, the bed was in the highest position. Resident 1 stated that she remembered falling on the floor while trying to clean the carpet and move items around. She told staff not to do that again and called for help. Resident 1 was unable to recall the exact date or location of the fall. During the observation and interview, Certified Nursing Assistant (CNA) 1 was present in Resident 1's room and assisted resident with personal care. After completing care, CNA 1 left the room without lowering the bed to the lowest position for safety. CNA 1 did not return to Resident 1's room to place the bed in lowest position for safety. The bed remained in the highest position until the surveyor exited the room. During an interview on 12/26/2025 at 2:13 pm with CNA 2, CNA 2 stated she was assigned to Resident 1 on 12/11/2025, the day the resident fell. CNA 2 reported that she did not witness the fall but found Resident 1 lying sideways on the floor in her room. CNA 2 reported Resident 1 stated she fell from her wheelchair while trying to turn off the television. CNA 2 noted that Resident 1 experiences intermittent confusion but was able to communicate and follow instructions well prior to the fall on 12/11/2025. During a concurrent observation and interview on 12/26/2025 at 2:45 pm with the Registered Nurse Supervisor (RNS) in Resident 1's room, the bed was observed in the highest position. The RNS stated that he was aware of Resident 1's fall incident and that the intervention implemented after the fall was to keep the bed in the lowest position and relocate Resident 1 near the nursing station. The RNS acknowledged that the bed should remain in the lowest position for safety, even though the residents require assistance with turning and repositioning. He stated while they did not expect the resident to attempt getting out of bed, leaving the bed in the highest position could lead to another fall. The RNS stated that staff will be re-educated through in-service training to always keep beds in the lowest position. During a follow-up phone interview on 12/26/2025 at 3:38 pm with CNA 1, CNA 1 stated that when she last saw Resident 1, the bed was in the lowest position, and she did not know who left the bed in the highest position. When asked why she left the bed in the highest position after assisting the resident in the surveyor's presence, CNA 1 explained that she was rushing to attend to another resident. CNA 1 suggested that licensed staff might have raised the bed for medication administration or treatment. CNA 1 stated it was important to always keep the bed in the lowest position for safety and to prevent another fall. During an interview on 12/26/2025 at 4:20 pm with the Director of Nursing (DON), the DON stated that fall prevention in-service training has been conducted with all staff and was ongoing. The DON stated she was surprised that Resident 1's bed was found in the highest position, given that the resident was identified as a fall risk. The DON stated that keeping the bed in the lowest position was one of the interventions in place. She stated that she will monitor staff compliance and continue reinforcing in-service education to ensure adherence to safety measures. During a review of the facility policy and procedure (P&P) revised on 3/1/ 2018, titled Falls and Falls Risk, managing the P&P indicated The staff will monitor and document each resident's response to intervention intended to reduce falling or the risks of falling