

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055041	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/09/2026
NAME OF PROVIDER OR SUPPLIER The Beach Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of two sampled residents (Resident 1) did not miss her hemodialysis ([HD] a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) treatments as ordered and failed to implement Resident 1's care plan which included monitoring Resident 1 for changes in level of consciousness, abnormal vital signs (essential measurements taken by the healthcare team providers to check the body's most basic and life sustaining functions), heart and lung sounds, edema (swelling caused by excess fluid building up in the body's tissues). These failures resulted in Resident 1 presenting to the dialysis center on 2/16/2026 with facial and generalized body edema. Resident 1 was above the prescribed target weight of 63 kilograms ([kg] metric unit of measurement for mass/weight), weighing 74 kilograms. These failures had the potential for Resident 1 to have pulmonary edema (excess fluid buildup in the lungs, making it difficult to breathe), hypertension ([HTN] high blood pressure, hyperkalemia (a condition in which the level of potassium in the blood is higher than normal), irregular heartbeat, and death. Findings: During a review of Resident 1's admission Record (Face Sheet), the Face sheet indicated Resident 1 was admitted to the facility on [DATE]. Resident 1 had diagnoses including joint (where to or more bones meet) replacement surgery (a procedure in which a surgeon removes the damaged parts of a joint and replaces them with an artificial joint) and end stage renal disease ([ESRD] irreversible kidney failure) with hemodialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney/kidneys have failed).During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 2/25/2026, the MDS indicated Resident 1 was able make decisions that were reasonable and consistent and required partial/moderate assistance (helper does less than half the effort) to supervision or touching assistance (helper provides verbal cues and/or touching/steadying and or contact guard assistance) for her Activities of Daily Living ([ADLs] activities such as bathing, dressing, and toileting a person performs daily).During a review of Resident 1's Order Summary Report (Physician's Orders) dated 3/9/2026, the Physician's Orders indicated an order was placed for Resident 1 to receive hemodialysis on Monday, Wednesday and Friday scheduled at 7:40 a.m. with a transportation pick up at 7:30 a.m., ordered on 2/12/2026.During a review of Resident 1's untiled Care Plan dated 2/13/2026, the Care Plan indicated Resident 1 needed dialysis related to ESRD with goals including Resident 1 will have no signs and symptoms of complications related to fluid overload and will maintain a normal weight. The Care Plan's interventions included Resident 1 was to receive HD every Monday, Wednesday, and Friday and monitor Resident 1 for change of condition including changes in level of consciousness, vital signs, heart and lung sounds, edema (swelling caused by excess fluid trapped in the body's tissues) and reporting to the primary care physician.During a review of Resident 1's Clinical Records for 2/2026, there was no documentation indicating Resident 1 was dialyzed on 2/13/2026 and 2/14/2026. There was no documentation indicating License Nurses identified, monitored, and/or assessed Resident 1 for complications related to missed HD treatments on 2/13/2026 and 2/14/2026. During a telephone interview on 3/4/2026 at 9:55 a.m., Resident 1's Emergency Contact (EC) 1 stated Resident 1 was scheduled for HD on 2/13/2026 but missed the (continued on next page)</p>

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 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>treatment because transportation did not pick her up. EC 1 stated the dialysis center scheduled an additional treatment 2/14/2026, which was also missed due to the same transportation issue. EC 1 stated she was concerned Resident 1 would retain excess fluids because Resident 1's kidneys were no longer functioning on their own. During an interview and concurrent record review on 3/6/2026 at 3:25 p.m., Registered Nurse Supervisor (RNS) 1 stated when Resident 1 was admitted on [DATE], the Admissions Coordinator (AC) informed her that Resident 1's HD appointment and transportation had been arranged. RNS 1 stated on 2/13/2026 during the 7a.m. to 3 p.m. shift, Resident 1 informed her that she missed her HD appointment because transportation had not been arranged. RNS 1 confirmed she did not assess or monitor Resident 1 for a change of condition after the missed treatment. RNS 1 stated she should have assessed Resident 1, notified the primary physician, and initiated monitoring Resident 1 to identify any worsening condition or potential complications related to the missed HD. RNS 1 stated she could not remember whether another HD treatment had been scheduled for that day or the following day. During an interview on 3/6/2026 at 4:05 p.m., the Dialysis Clinical Coordinator (DCC) stated Resident 1 missed the HD treatment on 2/13/2026 and extra day of treatment on 2/14/2026. The DCC stated on 2/16/2026, during a pre-dialysis assessment, Resident 1 was assessed with facial and generalized body edema and was over her target weight of 63 kg. The DCC stated Resident 1 weighed 74 kg (11 kg over her target weight). During an interview on 3/6/2026 at 4:44 p.m., the Admissions Coordinator (AC) stated prior to admitting Resident 1 to the facility she was informed by Resident 1's insurance case manager that Resident 1's HD and transportation were approved and arranged. The AC stated she should have confirmed Resident 1's pick up time with the transportation company to prevent Resident 1 from missing HD treatment. During an interview on 3/9/2026 at 9:30 a.m., the Case Manager (CM) stated she was able to confirm Resident 1's transportation on 2/13/2026 and had arranged an extra day of HD treatment for Resident 1 on 2/14/2026 at 1:45 p.m. with transportation pick up time at 12:30 p.m. The CM stated she informed RNS 1 of the HD and pick up time. The CM stated she documented it on the facility's communication board, so all staff were informed of Resident 1's HD appointment. During a telephone interview on 3/9/2026 at 10:42 a.m. RNS 4 stated she worked on 2/14/2026 at 7 a.m. to 3 p.m. shift but did not receive an endorsement from the outgoing shift on 2/13/2026 11 p.m. to 7 a.m. shift nor saw any notes on the communication board indicating Resident 1 had an appointment for HD that day. During an interview and concurrent record review on 3/9/2026 at 12:27 p.m., RNS 2 stated she worked on 2/13/2026 at 3 p.m. to 11 p.m. shift and was aware of Resident 1's extra HD treatment on 2/14/2026 and she endorsed this information to the licensed nurse assigned to Resident 1 on 2/13/2026 at 11p.m. to 7 a.m. shift. RNS 2 stated on 2/14/2026 at 3 p.m. to 11 p.m. shift, the family of Resident 1 (EC1) informed her that Resident 1 missed HD that day due to transportation not being available. RNS 2 stated and confirmed Resident 2 was not on any monitoring despite missing two hemodialysis appointments, no specific plan of care formulated for the missed hemodialysis nor was the primary physician notified. RNS 2 stated it was the responsibility of the licensed nurses to inform the primary physician and monitor Resident 1 for worsening of her condition. During an interview on 3/9/2026 at 1:19 p.m., the Director of Nursing (DON) stated Resident 1's HD schedule and transportation should have been confirmed and followed up by the AC and the CM to ensure smooth transition from the hospital to the facility to prevent missed opportunities for hemodialysis treatment. The DON stated the licensed nurses assigned to Resident 1's care should have initiated a change of condition and/or monitoring for Resident 1 when she initially missed her hemodialysis appointment on 2/13/2026 and continue monitoring, documenting Resident 1's progress for 72 hours and formulate a plan of care. The DON stated the licensed nurse should have called Resident 1's primary care physician when she missed her hemodialysis appointments to prevent delay of her care needs, should any complications arise. During a review of the facility's policy and procedure (P&P) titled, Transportation, Social Services, revised 12/2008, the P&P indicated the facility shall help arrange the residents' transportation as needed. During a review of the facility's P&P titled, End-Stage Renal Disease, Care (continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>of a Resident with, revised 9/2010, the P&P indicated the residents of the facility with ESRD shall be cared for according to the recognized standards of care. The P&P indicated the licensed nursing staff of the facility shall be trained to care for residents with ESRD and shall be able to recognize signs and symptoms of worsening condition and/or complications of ESRD. During a review of the facility's P&P titled, Change in a Resident's Condition or Status revised 5/2017, the P&P indicated the facility licensed nursing staff shall make detailed observation and gather relevant and pertinent information including information prompted by the Interact SBAR Communication and shall promptly notify the attending physician of any changes in the residents' medical and mental condition and/or status and any changes in their medical care or nursing treatments. The P&P indicated the licensed nurses of the facility shall record in the residents' medical record information relative to changes in the residents' medical/mental condition and such documentation of the change of condition shall include the following, but not limited to: a. documenting for at least 72 hours or longer if change of condition warrants b. documenting of vital signs each shift c. evident care plan d. interdisciplinary meeting as needed e. reassessment of the resident condition as needed f. COC and/ or SBAR will be completed as indicated.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1) who was experiencing pain, pain level (an eleven point scale where pain is rated from zero to 10; 0=no pain, 1-3=mild pain, 4-6=moderate pain, and 7-10=severe pain, and 10=worst imaginable pain) was accurately documented by Licensed Vocational Nurse (LVN) 1. This deficient practice resulted in Resident 1's pain level not being identified and had the potential for delayed pain relief and impaired communication among facility staff. Findings: During a review of Resident 1's admission Record (Face Sheet), the Face sheet indicated Resident 1 was admitted to the facility on [DATE]. Resident 1 had diagnoses including joint (where two or more bones meet) replacement surgery (a procedure in which a surgeon removes the damaged parts of a joint and replaces them with an artificial joint) and end stage renal disease ([ESRD] irreversible kidney failure) with hemodialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney/kidneys have failed). During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 2/25/2026, the MDS indicated Resident 1 was able make decisions that were reasonable and consistent and required partial/moderate assistance (helper does less than half the effort) to supervision or touching assistance (helper provides verbal cues and/or touching/steading and or contact guard assistance) for her Activities of Daily Living ([ADLs] activities such as bathing, dressing, and toileting a person performs daily). During a review of Resident 1's Order Summary Report (Physician's Orders) dated 3/9/2026, indicated Resident 1 had the following orders: 1. Assess Resident 1's pain level every shift, ordered on 2/12/2026. 2. Hydrocodone-Acetaminophen (an opioid prescribed and used to relieve moderate to severe pain) 5/325 milligrams ([mg] a unit of mass of one thousandth of a gram, used in medicine) one tablet by mouth every four hours as needed for moderate pain (pain level from 4 to 6) and severe pain (pain level from 7 to 10), ordered on 2/13/2026. During a review of Resident 1's untitled Care Plan dated 2/13/2026, the Care Plan indicated Resident 1 was at risk for adverse consequences related to use of opioids (strong pain-relief medications that work by blocking pain signals in the brain and body) related to left hip hemiarthroplasty (a surgery where only one part of a joint, usually the ball of the hip is replaced with an artificial implant) with goals including Resident 1's pain will be managed. The Care Plan's interventions indicated assessing and monitoring Resident 1's pain level every shift and addressing Resident 1's choices in managing her pain. During a review of Resident 1's Weights and Vitals Summary ([vital signs] basic measurements that show how well the body is working, such as temperature, pulse, breathing rate, and blood pressure) dated 2/15/2026 and timed at 9:19 a.m., the Weight and Vitals Summary indicated Resident 1's blood pressure (a measure of the force that your heart uses to pump blood around your body) was 94/60 millimeters of mercury ([mmHg] a standard unit of measurement for pressure specifically for blood pressure) and a heart rate (the number of times the heart beats per minute to pump blood throughout the body) of 70 beats per minute. During a review of Resident 1's Medication Administration Record (MAR) a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) dated 2/2026, the MAR indicated Resident 1's pain level was to be monitored every shift. The MAR indicated Resident 1 had a recorded pain level of 3 on 2/15/2026 during the day shift. During a review of Resident 1's MAR dated 2/2026, the MAR indicated Resident 1 was to receive Hydrocodone-Acetaminophen 5/325 mg one tablet by mouth every four hours as needed for moderate pain (pain level 4-6) and severe pain (pain level 7-10). The MAR indicated Resident 1 received one tablet of Hydrocodone-Acetaminophen 5/325 on 2/15/2026 at 11:01 a.m. During a telephone interview on 3/4/2026 at 10:35 a.m., Resident 1 stated one morning, a few hours after breakfast (unable to specify the date and time) she informed LVN 1 that her pain was getting worse, but LVN 1 did not pay attention to her. Resident 1 stated LVN 1 was standing by her (continued on next page)</p>		

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