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	04/06/2026

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide supervision and assistance to prevent accidents for one of one residents reviewed for falls (Resident 1). The facility failed to:1. Ensure Resident 1 who was assessed as high fall risk and needs substantial/ maximal assistance with ambulation received assistance during ambulation on 3/19/2026 and 3/21/2026.This failure resulted in two unwitnessed falls in the hallway, including one fall causing a right elbow laceration, and placed Resident 1 at further risk for injury.Findings:During a review of Resident 1's admission Record (Face Sheet), the Face Sheet indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE]. The Face Sheet indicated Resident 1 with diagnoses of but not limited to abnormalities of the gait, and mobility, abnormal posture, end stage renal disease, (ESRD-irreversible kidney failure) and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing).During a review of Resident 1's Morse Fall Assessment (a tool used for healthcare professionals to assess a patient's risk of falling) dated 3/6/2026, the Morse Fall Assessment indicated Resident 1 had a prior history of falls, used a walker a assistive device), and was unable to ambulate without assistance. Resident 1's Fall Score was 85 (a score greater than of 45 indicating a high risk for falls).During a review of Resident 1's History and Physical (H&P), dated 3/09/2026, the H&P indicated Resident 1 had the capacity to make decisions for herself. During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool), dated 3/20/2026, the MDS indicated Resident 1 needed substantial to maximal assistance (helper does more than half the effort) with walking at least 10 feet in a room, corridor or small space, transferring, sitting, and standing. During a review of Resident 1's Care Plan, dated 3/7/2026, the Care Plan titled Resident 1's physical mobility related to unsteady gait and use of a rollator walker (a four-wheeled mobility aid designed to help users walk safely while offering resting options)indicated a focus for Resident 1's physical mobility related to unsteady gait and use of a rollator walker (a four-wheeled mobility aid with handlebars, brakes, and a seat, designed to help users walk safely while offering resting options). The Care plan indicated interventions to provide supportive care, assistance with mobility as needed. The Care Plan indicated a goal for Resident 1 was to remain free of complications related to immobility, including contractures (a stiffening/shortening at any joint), thrombus formation (the creation of a blood clot), skin breakdown, fall related injury through next review date (6/5/2026).During a review of Resident 1's Interdisciplinary Team (IDT- team members from different departments working together with a common purpose to set goals and make decisions that ensure residents receive the best care) Fall Progress Notes, dated 3/20/2026, the IDT-Fall Progress Notes indicated Resident 1 had a witnessed fall in Station 2's hallway. The IDT-Fall Progress Notes indicated Resident 1 was seen ambulating with her rollator-walker in the hallway, lost her balance and fell on the ground on her right side. The IDT-Fall Progress Notes indicated Resident 1 sustained a right inner elbow superficial laceration measures 0.1 centimeters by 1.1 centimeters with minimal bleeding. The IDT-Fall Progress Notes indicated Resident 1 complained of right arm pain. The IDT-Fall Progress Notes indicated Resident 1 refused pain management, appeared confused and stated a (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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	04/06/2026

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	desire to go home. The Notes indicated Resident 1 was left untouched on the ground until paramedics arrived. The IDT-Fall Progress Notes indicated due to Resident 1 increased confusion and attempt to exit in haste caused Resident 1 to lose balance and fall on her right side. The IDT-Fall Progress Notes indicated Resident 1 had a history of falls and gait and balance deficits. The Notes indicated Resident 1 had immediate interventions for the Falling Star Program (immediate identification and heightened monitoring for residents at the highest risk for falls), fall risk identifiers on the door and above the bed, referral to physical therapy (PT- licensed professional aimed in the restoration, maintenance, and promotion of optimal physical function) for fall management, continued physical therapy and occupational therapy (OT- profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities) with a focus on fall management.During an interview on 4/2/2026 at 2:09 p.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 1 experienced periods of confusion, needed assistance with walking, had weakness, and was a high fall risk. LVN 1 stated Resident 1 had an unwitnessed fall in the hallway on 3/19/2026 and a second unwitnessed fall in the hallway on 3/21/2026. LVN 1 stated Resident 1 could ambulate with a walker only when staff provided supervision. LVN 1 stated Resident 1's falls could have been avoided with proper supervision and a one-on-one sitter (continuous supervision for a resident to prevent falls, self harm, or disruption of medical devices).During an interview on 4/6/2026 at 11:00 a.m., with Certified Nursing Assistant (CNA) 1, CNA 1 stated she was assigned to Resident 1 on 3/21/2026. CNA 1 stated Resident 1 fell while using her walker and was found on the floor. CNA 1 stated the last time she saw Resident 1 on 3/21/2026 was at 9:00 p.m., when Resident 1 was walking in the hallway with her walker unassisted. CNA 1 stated Resident 1 was a high fall risk but did not assist her because she believed Resident 1 was fine walking without any help. CNA 1 stated Resident 1 remained at high risk for falls and injury, had been injured in a previous fall, Resident 1 should have assistance with walking.During an interview on 4/6/2026 at 11:33 a.m., with Registered Nurse Supervisor (RNS) 1, RNS 1 stated Resident 1 fell in the hallway on 3/19/2026 and sustained a right elbow laceration. RNS 1 stated Resident 1 had a history of falls, used a walker, and had a weak gait. RNS 1 stated Resident 1's fall assessment score was 85 (a score greater than of 45 indicating a high risk for falls) and the facility initiated the falling star program and visual checks to ensure Resident 1 was in bed. RNS 1 stated when staff saw Resident 1 ambulating in the hallway, they were expected to ask what she needed and encourage her to return to her room for safety and to avoid walking without assistance. RNS 1 stated CNA 1 should have assisted Resident 1 with walking on 3/21/2026 and that the fall could have been avoided.During an interview on 4/6/2026 at 12:06 p.m., with the Director of Nursing (DON), the DON stated Resident 1 had impaired mobility and fell walking alone in the hallway. The DON stated the fall was avoidable and CNA 1 should have been watching Resident 1 while walking in the hallway. The DON stated CNA 1 should have notified the licensed nurses' that Resident 1 was walking in the hallway alone.During a review of the facility's policy and Procedure (P&P), titled Falls and Fall Risk, Managing, dated 3/2018, the P&P indicated Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling.