| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055041 | A. Building<br>B. Wing | 05/08/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| The Beach Post-Acute | 2725 Pacific Avenue<br>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 0627<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge.<br><br>**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 (5) was permitted to return to the facility. The facility failed to:1.Readmit Resident 1 to the facility after Resident 5 was evaluated and cleared by general acute care hospital (IGACH) to return to the facility on [DATE].2.Implement facility's policy and procedure (P&P) titled, Bed-Holds (a resident's right to keep a bed vacant and available for seven days after their transfer to the hospital in anticipation of their return to the facility) and Returns, dated 10/2022, which indicated residents who seek to return to the facility after the state bed-hold period has expired are allowed to return to their previous room if available or immediately to the first available bed in a semi-private room.3. Ensure Resident 5 received the required bed hold policy and notification form at the time of his transfer on [DATE] to general acute care hospital (GACH).These deficient practices resulted in Resident 5 being denied the opportunity to return to the facility he had called home for four years and placed him at risk for emotional distress, disrupted continuity of care, delayed treatment and services, unsafe discharge placement, decline in physical and psychosocial wellˆbeing, and potential homelessness.<br>Findings:During a review of Resident 5's admission Record, the admission Record indicated Resident 5 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 5 with diagnoses including paraplegia (paralysis of two limbs), and depression (persistent feelings of sadness, emptiness, and a loss of interest in activities).During a review of Resident 5's History and Physical (H&P), dated [DATE], the H&P indicated, Resident 5 had the capacity to understand and make decisions.During a review of Resident 5's Minimum Data Set ([MDS], resident assessment tool), dated [DATE], the MDS indicated, Resident 5 was dependent (helper does all of the effort) for toileting and lower body dressing.During a review of Resident 5's Physician Order, dated [DATE], the Physician Order indicated, transfer Resident 5 to the hospital due to resistance while re-inserting foley catheter (medical device that helps drain urine from the bladder).During a telephone interview on [DATE] at 9:30 a.m., with the Director of Marketing and admission (DMA), the DMA stated she oversees readmissions at the facility. The DMA stated the GACH did not directly inform her that Resident 5 was cleared for discharge, and communication occurred instead between the GACH and the facility Admissions Coordinator. The DMA stated she met Resident 5 at his bedside at the GACH on [DATE]. She informed him that his bed hold had ended and that, if he returned to the facility, he would need to be readmitted to another room because the Maintenance Supervisor (MS) was performing repairs in his original room. She also told Resident 5 he would need a roommate if he returned. The DMA stated, Resident 5 became upset and began verbally threatening her. The DMA stated she explained the resident's admission rights to him, including his right to be readmitted to the facility and to his original room or the first available room, as the facility was considered his home. She stated there were available beds but not the resident's original room. The DMA stated the facility did not routinely review the census or bed availability at the time of readmissions. The DMA stated the facility did not assist Resident 5 with returning to the facility or locating another facility. She also stated she did not know the facility's responsibilities regarding a hospitalized resident's return once<br>(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 0627<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | medically cleared. The DMA stated she did not have an opinion about the potential effects on a resident when readmission was delayed or denied.During a concurrent interview and record review on [DATE] at 9:55 a.m., with the Maintenance Supervisor (MS), reviewed MS facility text messages from April and [DATE]. The text messages did not show any repair requests for Resident 5's room. The MS stated he handles all building repairs and the facility notifies him of needed repairs by text messages. The MS stated he does not keep a log, as all requests come through text. The MS stated he repaired the television and call light in Resident 5's room approximately three weeks ago and completed the repairs on the same day.During a concurrent interview and record review on [DATE] at 10:40 a.m., with the Director of Nursing (DON), reviewed the Facility Census dated [DATE], [DATE], and [DATE]. The census indicated Resident 5's room was available. The DON stated that room availability existed when Resident 5 was cleared for discharge from the GACH on [DATE]. The DON stated Resident 5 did not have a roommate before his transfer to the GACH due to prior incompatibility concerns. She reported Resident 5 had a previous altercation with a former roommate, which occurred approximately two years ago. The DON stated Resident 5 had also exhibited aggressive behaviors toward other residents in the past. The DON stated Resident 5 was transferred to the GACH on [DATE] because his foley catheter was dislodged and staff were unable to reinsert it. The DON stated when a resident was transferred to the GACH, the facility initiates the bed hold process and provides the resident and/or resident representative with the required transfer and bed hold documentation. She stated that the resident or representative is asked to sign forms acknowledging the transfer, bed hold status, and readmission rights. She also stated once the bed hold period expires, the resident may return to the next available appropriate bed, which may not be the original room. The DON stated there were no male/female bed restrictions, isolation requirements, or other barriers that would have affected Resident 5's readmission. She stated that the attending physician and 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) were not involved in the decision regarding Resident 5's readmission. The DON stated the facility did not issue Resident 5 the required bed hold policy and notification form at the time of transfer and was unable to explain why the documentation was not provided. She stated if a resident was unable to return to the facility after hospitalization, the resident could experience emotional distress, confusion, and disruption in continuity of care, which could lead to a decline in physical and psychosocial wellˆbeing.During a review of the facility's P&P titled, Bed-Holds and Returns, dated 10/2022, the P&P indicated, All residents/representatives are provided written information regarding the facility and state bed-hold policies, which address holding or reserving a resident's bed during periods of absence (hospitalization or therapeutic leave). Residents, regardless of payer source, are provided written notice about these policies at least twice: a. notice 1: well in advance of any transfer (e.g., in the admission packet); and b. notice 2: at the time of transfer (or, if the transfer was an emergency, within 24 hours). Residents who seek to return to the facility after the state bed-hold period has expired (or when state law does not provide for bed-holds) are allowed to return to their previous room if available or immediately to the first available bed in a semi-private room provide that the resident: a. still requires the services provided by the facility; and is eligible for Medicare skilled nursing facility or Medicaid nursing facility services. |