STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055123	A. Building B. Wing	05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beachside Post Acute	3294 Santa Fe Avenue Long Beach, CA 90810

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure seven out of 10 sampled residents, (Resident 1, 10, 45, 52, 54, 55 and 67), who were not able to carry out Activities of Daily Living (ADLs- activities such as bathing, dressing and toileting a person performs daily) to maintain good grooming by:Failing to ensure Residents 1,10,45,52 and 54 fingernails were not long with jagged (sharp, uneven) edges.Failing to ensure Residents 55 and 67 who had long, jagged mycotic (fungus) toenails were seen by a podiatrist (foot doctor).These failures had the potential to cause pain, inflict injury and spread infection by not ensuring the fingernails for Resident's 1, 10, 45, 52 and 54 were kept short and free from jagged edges and by not ensuring Resident's 55 and 67 were seen by a podiatrist for their long, jagged mycotic toenails. Findings: 1a.During a review of Resident 1's admission Record, the admission Record indicated, Resident 1 was admitted to the facility on [DATE], and readmitted on [DATE]. Resident 1 had a diagnosis including diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), muscle weakness, and dementia (a progressive state of decline in mental abilities) . During a review of Resident 1's Care Plan titled ADL Self-Care Deficit dated 2/23/2026, the Care Plan indicated Resident 1 was totally dependent on staff for personal hygiene. The Care Plan indicated Resident 1 was to receive a qualityˆofˆlife program that included hygiene and grooming. During a review of Resident 1's History & Physical (H&P) dated 2/24/26, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS- resident assessment tool) dated 3/2/26, the MDS indicated, Resident 1 had moderate cognitive (ability to think, understand, learn, and remember) impairment. The MDS indicated Resident 1 needed substantial/maximal assistance (helper does more than half the work) with activities of daily living (ADL's). During a concurrent observation and interview with Resident 1 on 5/26/26 at 9:26 a.m. in Resident 1's room, Resident 1 was observed to have long, jagged fingernails. Resident 1 stated he would really like to have his fingernails trimmed. 1b.During a review of Resident 10's admission Record, the admission Record indicated Resident 10 was admitted to the facility on [DATE] and readmitted on [DATE]. Resident 10 had diagnosis including diabetes mellitus, muscle weakness and dementia. During a review of Resident 10's H&P, dated 1/27/26, the H&P indicated, Resident 10 did not have the (continued on next page)

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	capacity to understand and make decisions. During a review of Resident 10's MDS dated [DATE], the MDS indicated, Resident 10 had severe cognitive impairment. The MDS indicated, Resident 10 was totally dependent (helper does all the work), with ADL'S. During a review of Resident 10's Care Plan titled ADL Self-Care Deficit dated 1/22/26 the Care Plan indicated, Resident 10 was totally dependent with personal hygiene. The Care Plan indicated, Resident 10 was to be provided with a quality-of-life program which included hygiene and grooming. During an observation on 5/26/26 at 10:32 a.m., in Resident 10's room, Resident 10 was observed to have long, jagged fingernails. 1c.During a review of Resident 45's admission Record, the admission Record indicated, Resident 45 was admitted to the facility on [DATE] with the diagnosis including schizoaffective disorder(a mental illness that can affect thoughts, mood, and behavior), muscle weakness and anxiety (emotion characterized by feelings of tension, worried thoughts). During a review of Resident 45's Care Plan titled ADL Self-Care Deficit dated 9/04/25 the Care Plan indicated, Resident 45 needed moderate assistance (helper does less than half the work) with personal hygiene. The Care Plan indicated, Resident 45 was to be provided with a quality-of-life program which included hygiene and grooming. During a review of Resident 45's H&P dated 1/27/26, the H&P indicated, Resident 10 did not have the capacity to understand and make decisions. During a review of Resident 45's MDS dated [DATE], the MDS indicated, Resident 45 cognition was intact. The MDS indicated Resident 45 needed set up assistance, with ADL'S. During a concurrent observation and interview on 5/26/2026 at 11:54 a.m. with Resident 45, in Resident 45's room, Resident 45 was observed to have long, jagged fingernails. Resident 45 stated he would like to have his fingernails trimmed. 1d.During a review of Resident 52's admission Record, the admission Record indicated Resident 52 was admitted on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities) and bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs). During a review of Resident 52's MDS dated [DATE], the MDS indicated Resident 52's cognition was severely impaired. The MDS indicated Resident 52 required maximal assistance with ADLs. During a concurrent observation and interview on 5/26/2026 at 11:32 a.m. with Certified Nurse Assistant (CNA) 1 in Resident 52's room, Resident 52's fingernails were long and dirty and required trimming and cleaning. CNA 1 stated it was important for Resident 52's nails to be clean and trimmed because bacteria could collect under the nails and the resident could scratch herself. 1e.During a review of Resident 54's admission Record, the admission Record indicated, Resident 54 was admitted to the facility on [DATE] and readmitted on [DATE]. Resident 54 with diagnoses including Parkinson's disease (a progressive disease of the nervous system marked by tremor, (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	muscular rigidity, and slow, imprecise movements), muscle weakness and lack of coordination. During a review of Resident 54's Care Plan titled ADL Self-Care Deficit dated 10/24/25 the Care Plan indicated, Resident 54 needed moderate assistance with personal hygiene. The care plan indicated, Resident 54 was to be provided with a quality-of-life program which included hygiene and grooming. During a review of Resident 54's H&P dated 10/26/25, the H&P indicated, Resident 54 did not have the capacity to understand and make decisions. During a review of Resident 54's MDS dated [DATE], the MDS indicated, Resident 54 had moderate cognitive impairment. The MDS indicated, Resident 54 needed substantial/maximal assistance with ADL'S. During a concurrent observation and interview on 5/26/2026 at 2:37 p.m. with Resident 54, in Resident 54's room, Resident 54 was observed to have long, jagged fingernails. Resident 54 stated he needed to have his fingernails trimmed because they were way too long. 2. During a review of Resident 55's admission Record, the admission Record indicated, Resident 55 was admitted to the facility on [DATE] with the diagnosis including Parkinson's disease, muscle weakness and diabetes mellitus. During a review of Resident 55's Care Plan titled ADL Self-Care Deficit dated 2/24/26 the Care Plan indicated, Resident 55 was totally dependent with personal hygiene. The Care Plan indicated, Resident 55 was to be provided with a quality-of-life program which included hygiene and grooming. During a review of Resident 55's H&P dated 2/25/26, the H&P indicated, Resident 55 had the capacity to understand and make decisions. During a review of Resident 55's MDS dated [DATE], the MDS indicated, Resident 55's cognition was intact. The MDS indicated, Resident 55 was totally dependent with ADL'S. During a review of Resident 55's Order Summary Report dated 5/01/26, the order summary report indicated, Resident 55 had a standing (permanent) order to see the podiatrist every two months and as needed for mycotic and /or other foot problems. During a concurrent observation and interview on 5/26/2026 at 2:37 p.m. with Resident 55, in Resident 55's room, Resident 55 was observed to have long, jagged mycotic toenails. Resident 55 stated he needed to have his toenails trimmed because they were too long. During a review of Resident 67's admission Record, the admission Record indicated, Resident 67 was admitted to the facility on [DATE] and readmitted [DATE]. Resident 67 had a diagnosis including spinal stenosis (narrowing of the spaces in the spine [back] causing stiffness), muscle weakness and chronic kidney disease (kidneys are damaged and gradually lose their ability to filter waste and excess fluid from the blood). During a review of Resident 67's Care Plan titled ADL Self-Care Deficit dated 9/26/25 the Care Plan indicated, Resident 67 needed moderate assistance with personal hygiene. The care plan indicated, Resident 67 was to be provided with a quality-of-life program which included hygiene and grooming. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 67's H&P dated 9/28/25, the H&P indicated, Resident 67 had the capacity to understand and make decisions. During a review of Resident 67's MDS dated [DATE], the MDS indicated, Resident 67's cognition was intact. The MDS indicated, Resident 67 needed substantial/maximal assistance with ADL'S. During a review of Resident 67's Order Summary Report dated 5/01/26, the Order Summary Report indicated, Resident 67 had a standing order to see the podiatrist every two months and as needed for mycotic toenails and /or other foot problems. During a concurrent interview and record review on 5/28/2026 at 11:28 a.m. with the Social Services Director (SSD), a list of residents seen by podiatry dated 4/28/2026 was reviewed. The list indicated Residents 55 and 67 were not seen by the podiatrist due to their insurance. The SSD stated it was her responsibility to ensure the residents were seen by the podiatrist. She stated the facility was responsible for the residents' care and should have paid for the residents to have their toenails trimmed on 4/28/2026 when the podiatrist last visited the facility. The SSD stated she had forgotten to schedule another podiatry appointment for Residents 55 and 67 to have their toenails trimmed. She stated when residents' toenails become too long, it can be very uncomfortable for them to wear shoes and socks. During a concurrent observation and interview on 5/29/26 at 7:14 a.m. with Resident 67, in Resident 67's room, Resident 67 was observed to have long, jagged mycotic toenails. Resident 67 stated he needed to have his toenails trimmed, they were too long and very uncomfortable when he wears socks. During an interview on 5/29/2026 at 9:53 a.m. with the Director of Staff Development (DSD), the DSD stated the CNAs and treatment nurses were responsible for trimming and cleaning the residents' nails. The DSD stated it was important for residents' nails to be kept clean and trimmed because long or dirty nails could cause pain and discomfort, could break the skin if the residents scratched themselves, and could curl into the skin. During an interview on 5/29/2026 at 10:56 a.m. with the Infection Prevention Nurse (IPN), the IPN stated long, unclean nails could lead to an infection if bacteria were present under the nails and the resident put their hands in their mouth, or if the resident scratched themselves and broke the skin, which could also result in an infection During an interview on 5/29/2026 at 11:03 a.m. with the Director of Nursing (DON), the DON stated dirty and long nails placed residents at risk for infection if they ate with their hands or scratched themselves, causing skin breakdown. During an interview on 5/29/2026 at 11:14 a.m. with the Administrator (ADM), the ADM stated the SSD was responsible for ensuring the residents were seen by the podiatrist. The ADM stated the facility was responsible for the residents' care and Residents 55 and 67 should have been seen by the podiatrist, and the facility should have paid the bill During a review of the facilities policy and procedure (P&P) titled, Activities of Daily Living, and Scope of Services, dated 6/2022, the P&P indicated, It is the policy of the facility that each resident receive, and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being consistent with the resident's (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	comprehensive assessment and plan of care.Staff will ensure that Activities of Daily Living are monitored, assisted with, and provided for those residents who are unable to perform Activities of Daily Living. The P&P indicated, ensure that the following ADL functions are monitored, supervised, assisted with and or provided to the Resident population that the facility is servicing to included but not limited to: a. Bathing/ Showering and or personal hygiene b. Eating/Feeding c. Mouth Care d. Dressing e. Grooming f. Toileting g. Transferring bed/Chair h. Repositioning i. Walking/Ambulation

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review the facility failed to store food in a safe and sanitary manner. The facility had 69 residents receiving oral diet. The facility failed to:1. Ensure open bags of frozen pizza dough, corn, potato puffs and hotdogs were stored in an airtight container or bags.This failure had the potential to place residents at risk for developing food borne illnesses (any illness resulting from eating contaminated/spoiled foods) and could reduce the quality of food served in the facility.Findings:During a concurrent initial kitchen observation and interview on 5/26/2026 at 8:20 a.m. with the Dietary Supervisor (DS), an open plastic bag containing frozen pizza dough, an open blue bag containing frozen corn inside a brown box, an open bag of frozen potato puffs, and an open bag of frozen hotdogs were stored in the reachˆin freezer. Crystalized ice was observed on the potato puffs and hotdogs. The DS stated the kitchen staff should have tied open plastic bags of frozen food items or stored them in sealed plastic bags or containers. The DS stated freezer burn (food drying out and losing flavor due to exposure to cold, dry air) was present on the frozen hotdogs because staff left the bag open, and the food should have been stored in a sealed bag.During an interview on 5/28/2026 at 8:29 a.m. with Dietary Aide (DA) 2, DA 2 stated open frozen items should be stored in a Ziplock bag or the plastic bag should be tied with a knot so ice crystals would not form on the frozen food. DA 2 stated the formed ice crystals could contaminate frozen food and could lead to foodˆborne illness.During an interview on 5/28/2026 at 1:23 p.m. with the Dietary Supervisor (DS), the DS stated open frozen items not stored in airtight, sealed container could cause food-borne illness and decrease the quality of food served to the residents.During an interview on 5/27/2026 at 1:54 p.m. with the Registered Dietitian (RD), the RD stated improper storage of frozen food items could decrease the flavor and quality of food.During a review of facility's policy and procedure(P&P) titled, Procedure for Freezer Storage, dated 2023, the P&P indicated frozen foods will be stored in airtight moisture -resistant wrapper such as a plastic bag or freezer paper to prevent freezer burn.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 maintain and observe infection control practices. The facility failed to:1. Ensure staff performed hand hygiene in between residents when passing lunch trays.2. Ensure Licensed Vocational Nurse (LVN) 1 performed hand hygiene before, and after medication administration on Resident 20.3.Observe Enhanced Barrier Precautions (EBP- infection control rules used in nursing homes to stop the spread of dangerous, hard-to-treat germs) before administering Resident 20's medication through gastrostomy tube (GT- a soft tube surgically inserted directly into the stomach to administer medication, fluids and nutrition).These failures had the potential to result in cross contamination (the physical movement or transfer of harmful bacteria from one person, object, or place to another) and place the residents at risk for the spread of infection. Findings: 1. During a concurrent observation and interview on 5/26/2026 at 12:11 p.m. in the hallway with Certified Nurse Assistant (CNA) 2, CNA 2 was observed going room to room passing lunch trays without performing hand hygiene between residents. CNA 2 stated he was supposed to perform hand hygiene between each resident's tray because not doing so could spread bacteria between residents and could cause them to get sick. During an interview on 5/29/2026 at 10:56 a.m. with the Infection Control Nurse (IPN), the IPN stated staff should perform hand hygiene between residents when passing trays to prevent the spread of infection that could cause residents to become sick. During an interview on 5/29/2026 at 11:03 a.m. with the Director of Nursing (DON), the DON stated staff should perform hand hygiene before and after entering residents' rooms when passing meal trays. The DON stated when staff did not perform hand hygiene between residents, it could potentially cause crossˆcontamination and lead to residents becoming sick with an infection. During a review of the facility's policy and procedure (P&P) titled, Hand Hygiene, revised 7/2019, the P&P indicated, It is the policy of the facility that all staff members perform hand hygiene before and after direct resident care and after contact with potentially contaminated substances to prevent, to the extent possible, the spread of infection. The P&P indicated, Alcohol-based hand rub should be available inside and outside of all resident rooms in order to improve access and compliance with hand hygiene. 2. During a review of Resident 20's admission Record, the admission Record indicated Resident 20 was originally admitted on [DATE] and was readmitted on [DATE]. Resident 20's diagnoses including hemiplegia affecting the right dominant side (total paralysis of the arm, leg, and trunk on the right side of the body), dysphagia (difficulty in swallowing), and gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). During a review of Resident 20's Minimum Data Set (MDS- a resident assessment tool) dated 3/18/2026, the MDS indicated Resident 20 had severely impaired cognitive (ability to think, understand, learn, and remember) skills. The MDS indicated Resident 20 required substantial/maximal assistance (helper does more than half the effort) with toileting hygiene, dressing, oral hygiene, and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dressing. The MDS indicated Resident 20 had a feeding tube (flexible plastic tube used to safely liquid food, fluids, and medications directly into the stomach or small intestines). During a review of Resident 20's History and Physical (H&P) dated 4/21/2026, the H&P indicated Resident 20 did not have the capacity to understand and make decisions. During a medication pass observation on 5/26/2026 at 4:00 p.m. with LVN 1, LVN 1 did not perform hand hygiene before taking Resident 20's vital signs (VS-measure the basic functions of the body which include temperature, blood pressure, pulse and respiratory [breathing] rate), before preparing and crushing medications, or before administering Resident 20's medications via the gastrostomy tube. LVN 1 did not wear gloves or a protective gown before taking Resident 20's vital signs or administering medications through the GT. After administering the medications, LVN 1 wiped his hands with Clorox wipes (preˆmoistened disposable wipes used to clean and kill germs on surfaces). During an interview on 5/26/2026 at 4:50 p.m. with LVN 1, LVN 1 stated he had forgotten to perform hand hygiene. He stated he had not practiced hand hygiene at the start of the medication pass, so he decided to continue not performing hand hygiene while administering medications to Resident 20. LVN 1 stated that not practicing hand hygiene could place residents at risk for contracting an infection due to contaminated staff hands. 3. During an interview on 5/28/2026 at 1:10 p.m. with LVN 3, LVN 3 stated licensed nurses should wear gloves, a mask, and a protective gown when a resident was on EBP. LVN 3 stated staff should not use Clorox wipes for hand hygiene because they could cause chemical burns and were intended only for use on surfaces. LVN 3 stated staff practiced hand hygiene by using alcohol based hand rub (ABHR-liquid, gel used to quickly kill microorganism on hands) or by washing their hands with soap and water. During an interview on 5/28/2026 at 11:27 a.m. with the Infection Preventionist Nurse (IPN), the IPN stated licensed nurses were expected to perform hand hygiene before administering medications and when switching from one task to another during the medication pass. The IPN stated Resident 20 was on EBP because of the gastrostomy tube, and LVN 1 should have practiced hand hygiene and worn personal protective equipment (PPE) before administering medications to Resident 20. The IPN stated staff used ABHR or soap and water for hand hygiene. The IPN stated LVN 1 could spread infection among staff and residents by not practicing hand hygiene. During an interview on 5/28/2026 at 4:59 p.m. with the DON, the DON stated LVN 1's failure to perform hand hygiene and wear Personal Protective Equipment (PPE- equipment used to prevent or minimize exposure to hazards) during the medication pass could spread infection among residents and staff due to contamination from his hands. During a review of facility's P&P titled, Medication Administration via Enteral Tube, revised 4/2017, the P&P indicated the licensed nurse should wash hands and wear gloves, then check placement of GT and administer medications via GT. During a review of facility's P&P titled, Enhanced Standard Precautions, revised 5/2024, the P&P indicated, EBP is an approach of targeted gown and glove use during high contact resident care activities(hands-on task that involve close proximity to a resident) to reduce transmission of multidrug-resistant organism (MDRO- type of germ that can cause an infection that is hard to treat and had developed resistance to a lot of infection).

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure two of three sampled residents (Resident 33 and Resident 88) were appropriately notified regarding the changes in their Medicare coverage through provision of Notice of Medicare Non-Coverage (NOMNC-given by the facility to residents at least two days before the end of a Medicare covered Part A stay or when all of Part B therapies are ending) form.This deficient practice had the potential to result in the responsible parties not being able to exercise their right to file and appeal.Findings:During a review of Resident 33's admission Record, the admission Record indicated Resident 33 was admitted to the facility on [DATE] with diagnoses including hypertension (HTN- high blood pressure) and diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing).During a review of Resident 33's Minimum Data Set (MDS- a resident assessment tool) dated 3/12/2026, the MDS indicated Resident 33's cognition (ability to think, understand, learn, and remember) was intact. The MDS indicated Resident 33 required maximal (helper does more than half the effort) with activities of daily living (ADLs- activities such as bathing, dressing, and toileting a person performs daily).During a review of Resident 33's History and Physical (H&P) dated 2/10/2026, the H&P indicated Resident 33 has the capacity to understand and make decisions. During a review of Resident 88's admission Record, the admission Record indicated Resident 88 was admitted to the facility on [DATE] with diagnoses including depression (a serious mood disorder that causes a persistent feeling of sadness and a loss of interest in activities) and severe chronic kidney disease (progressive damage and loss of kidney function in the kidneys).During a review of Resident 88's MDS dated [DATE], the MDS indicated Resident 88's cognition was intact. The MDS indicated Resident 88 required supervision (helper provides verbal cues or touching assistance) with ADLs.During a review of Resident 88's H&P dated 2/21/2026, the H&P indicated Resident 88 has the capacity to understand and make decisions.During an interview on 5/28/2026 at 7:27 a.m., with Resident 33, the NOMNC form was provided, and Resident 33 denied that the signature on the form was his and denied having seen or ever being presented with the NOMNC form.During a concurrent interview and record review on 5/28/2026 at 7:41 a.m. with the Business Office Manager (BOM), the NOMNC forms for Residents 33 and 88 were reviewed. The BOM stated she had signed the NOMNC forms for Residents 33 and 88, but she acknowledged she should not have signed them because she was not the resident or the resident representative. The BOM stated signing the forms without the residents' consent or knowledge could cause the residents to feel a loss of trust and would affect their rights.During an interview on 5/29/2026 at 11:03 a.m. with the Director of Nursing (DON), the DON stated the NOMNC forms should only be signed by the resident or the resident representative, not the BOM, because having the BOM sign them could result in a lack of trust in the staff.During a review of the facility's policy and procedure (P&P) titled, Medicare Beneficiary Notice, revised 8/2018, the P&P indicated, It is the facility's policy to adhere to Medicare guidelines and to provide proper and timely notices to Medicare Beneficiaries when skilled services will end. The P&P also indicated, It is the facility's responsibility to ensure forms are completed as per Medicare guidelines and given to the resident and/or representative timely.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure the Ombudsman (an advocate for residents of nursing homes, board and care centers, and assisted living facilities) was notified for one of three sampled residents (Resident10) who was hospitalized on [DATE].This failure violated the rights of Resident 10 by not notifying the ombudsman to ensure Resident 10's discharge was safe and appropriate.Findings:During a review of Resident 10's admission Record, the admission Record indicated Resident 10 was admitted to the facility on [DATE] and readmitted on [DATE]. Resident 10 had a diagnoses including diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), muscle weakness and dementia.During a review of Resident 10's H&P, dated 1/27/26, the H&P indicated, Resident 10 did not have the capacity to understand and make decisions.During a review of Resident 10's Minimum Data Set (MDS-resident assessment tool) dated 5/4/26, the MDS indicated, Resident 10 had severe cognitive (ability to think, understand, learn, and remember) impairment. The MDS indicated, Resident 10 was totally dependent (helper does all the work), with activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily)During a review of Resident 10's Physicians Discharge summary dated [DATE], the Physicians Discharge Summary indicated, Resident 10 was discharged to the general acute care hospital (GACH) on 3/9/26 for a low hemoglobin (when the body lacks healthy red blood cells).During a concurrent interview and record review on 5/28/2026 at 10:03 a.m. with the Assistant Director of Nursing (ADON), Resident 10's Notice of Transfer/discharge date d 3/9/2026 was reviewed. The Notice of Transfer/Discharge indicated the Ombudsman was notified of Resident 10's discharge on [DATE]. The ADON stated that when residents were transferred to the GACH, the Ombudsman should be notified the same day. The ADON stated the Ombudsman was informed so they were aware the resident was no longer in the care of the facility and to ensure the discharge was appropriate. The ADON stated the Ombudsman served as the residents' advocate.During an interview on 5/29/2026 at 1:03 p.m. with the Director of Nursing (DON), the DON stated the Ombudsman should be notified immediately after a resident was transferred to the GACH to inform the Ombudsman that the resident was no longer in the facility and to ensure the discharge was appropriate to meet the resident's needsDuring a review of the facility's policy and procedure (P&P) titled Discharge Process dated 10/2017, the P&P indicated, The facility will send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman and record the reasons for the transfer or discharge in the resident's medical record will include the following, the reason for transfer or discharge, the effective date of transfer or discharge and the location to which the resident is to be transferred or discharged as soon as practicable when an immediate transfer or discharge is required by the resident's urgent medical needs.

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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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **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 6) with a positive Preadmission Screening and Resident Review Level 1 screening ([PASRR] a federal requirement to identify individuals with serious mental illness ([SMI] a mental, behavioral, or emotional condition that interferes with or limits a person's ability to function in daily life), and intellectual disability ([ID] when a person has significant limitations in their mental abilities), prior to admission to the facility received a required PASARR Level II evaluation to determine the need for specialized services and appropriate placement.This failure had the potential to result in the resident's serious mental illness not being comprehensively evaluated, the resident not receiving specialized services as needed, and placement decisions being made without a complete assessment of the resident's mental health needs.Findings:During a review of Resident 6's admission Record, the admission Record indicated Resident 61 was initially admitted to the facility on [DATE], with a diagnoses of Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), depression (persistent feelings of sadness, emptiness, and a loss of interest in activities), anxiety disorder (emotion characterized by feelings of tension, worried thoughts) and bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs).During a review of Resident 6's Medical Administration Record (MAR) dated 2/3/2025, the MAR indicated, Latuda (a prescription medication considered a antipsychotic (medications used to treat residents with mental disorder) oral tablet 20 milligram (mg-unit of measurement) give one tablet by mouth in the evening for bipolar disorder manifested by (m/b) mood swings from being sociable to keeping to self.During a review of Resident 6's Preadmission Screening and Resident Review (PASRR) Level 1 Screening, dated 3/13/2025, the PASRR indicated, Result of Level I Screening: Level 1- Positive for SMI. During a review of Resident 6's Care Plan, dated 7/13/2025, the Care Plan indicated, Level II PASRR Recommendation; Related to Manifested by: Resident with positive Level I PASRR screening and followed by Level II PASRR evaluation on: 7/13/2026.The Care Plan indicated a goal to help resident/ responsible party to identify mental health conditions or developmental disability and to ensure proper placement, whether in the community or in a nursing facility based on a personalized recommended specialized services by PASRR Level II.During a review of Resident 6's Progress Notes, dated 1/29/2026, the Progress Notes indicated, the resident describes his mood as steady, with persistent but manageable depressive features such as low motivation and occasional feelings of emotional heaviness.During a review of Resident 6's History and Physical (H&P), dated 2/18/2026, the H&P indicated, Resident 6 had the capacity to understand and make decisions.During a review of Resident 6's Progress Notes, dated 5/5/2026, the Progress Notes indicated, the patient was medically fragile individual with severe cognitive impairment consistent with advanced neurocognitive decline, currently resident in a highly supervised care setting.During a concurrent interview and record review on 5/28/2026 at 1:23 p.m. with the Medical Data Set Nurse (MDSN), Resident 6's PASRR Level I dated 3/13/2025 was reviewed. The PASRR Level I indicated that Resident 6 had a serious mental illness and was receiving psychotropic medication. The MDSN stated that she was responsible for screening residents. She stated Resident 6's diagnoses were considered mental illnesses for PASRR purposes including anxiety disorder, bipolar disorder, depression, and schizophrenia. She stated Resident 6 had a diagnosis of anxiety disorder and had been prescribed Latuda 20 mg daily. She stated based on the positive PASRR Level I screening, a PASRR Level II evaluation should have been completed. The MDSN stated she did not know why a PASRR Level II evaluation had not been obtained. She further stated the purpose of a PASRR Level II evaluation was to assess a resident's mental health needs and determine whether specialized services were required. MDSN stated if a resident who screened positive on the PASRR Level I did not receive a Level II evaluation, the resident's mental health needs (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	might not be fully assessed and recommendations for specialized services could be missed.During a review of the facility's policy and procedure (P&P) titled, PASRR (Preadmission Screening Resident Review), dated 2019, the P&P indicated, If the result of the Level I screening is positive due to a diagnosed or suspected mental illness identified, the Level I Screening will automatically be sent to the DHCS Contractor for a Level II prescreening call.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide appropriate care for one of ten sampled residents (Resident 20). The facility failed to:1.Ensure Licensed Vocational Nurse (LVN) 1 verified the placement of the gastrostomy tube (GT-a soft tube surgically inserted directly into the stomach to administer medications, fluids, and nutrition) and checked or assessed the gastric residual volume (GRV-the amount of fluid or tubeˆfeeding formula [liquid nutrition] remaining in the stomach at a specific point in time) of Resident 20's GT prior to administering medications.This failure had the potential to place Resident 20 at risk for aspiration pneumonia (a lung infection caused by stomach or oral contents entering the lungs), vomiting, and the possibility of medications entering the wrong tract if the feeding tube was not positioned correctly, which could lead to peritonitis (inflammation or infection of the lining of the abdomen).Findings:During a review of Resident 20's admission Record, the admission Record indicated Resident 20 was originally admitted on [DATE] and was readmitted on [DATE]. Resident 20's diagnoses including hemiplegia affecting the right dominant side (total paralysis of the arm, leg, and trunk on the right side of the body), dysphagia (difficulty in swallowing), and gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems).During a review of Resident 20's Order Summary Report dated 11/9/2020, the Order Summary Report indicated checking GT placement and patency every shift.During a review of Resident 20's Order Summary Report dated 10/6/2023, the Order Summary Report indicated checking residuals of GT every shift.During a review of Resident 20's Minimum Data Set (MDS- a resident assessment tool) dated 3/18/2026, the MDS indicated Resident 20 had severely impaired cognitive (ability to think, understand, learn, and remember) skills. The MDS indicated Resident 20 required substantial/maximal assistance (helper does more than half the effort) with toileting hygiene, dressing, oral hygiene, and dressing. The MDS indicated Resident 20 had a feeding tube (flexible plastic tube used to safely liquid food, fluids, and medications directly into the stomach or small intestines).During a review of Resident 20's History and Physical (H&P) dated 4/21/2026, the H&P indicated Resident 20 did not have the capacity to understand and make decisions.During an observation of medication administration on 5/26/2026 at 4:00 p.m. in Resident 20's room with LVN 1, LVN 1 did not verify or assess the placement of the GT. LVN 1 did not check the GRV of Resident 20's GT prior to administering medications.During an interview on 5/26/2026 at 4:50 p.m., with LVN 1, LVN 1 stated he forgot to check the placement of the GT and the gastric residual before administering Resident 20's medications. He stated he would check the GT placement and gastric residual in the future to ensure the GT was correctly positioned before giving medications. LVN 1 stated he should have verified Resident 20's GT placement and gastric residual. He stated failing to verify the GT placement could put Resident 20 at risk for aspiration pneumonia. He stated checking the gastric residual would help ensure the resident was not at risk for vomiting, and a high residual could put Resident 20 at risk for vomiting.During an interview on 5/28/2026 at 11:27 a.m., with the Infection Preventionist Nurse (IPN), IPN stated licensed nurses must verify GT placement and check the gastric residual before administering medications through the GT. The IPN stated if the GT was not in place, Resident 20 could aspirate, would not receive his medication, and could be at risk for infection due to possible GT dislodgement (medical device has accidentally moved or been forced out of its original, correct position).During an interview on 5/28/2026 at 4:59 p.m., with the Director of Nursing (DON), the DON stated licensed nurses should check and verify GT placement to ensure it is correct before administering medications. The DON explained that if the GT placement was not verified, the nurse would not know whether the medications administered through the GT entered the correct route, and Resident 20 could experience significant pain.During a review of facility's policy and procedure (P&P) (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	titled, Medication Administration via Enteral tube, revised 4/2017, the P&P indicated the nurse will verify tube placement by forcefully injecting air into tube while listening with stethoscope to the abdomen for a loud bubbling sound. The P&P indicated to check the residual amounts of feeding once placement is verified, then administer the medications.

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure staff were informed of and individualized, traumaˆinformed care (an approach to delivering care that involves understanding, recognizing and responding to the effects of all types of trauma for residents with Post-Traumatic Stress Disorder (PTSD a mental health condition that can develop after experiencing or witnessing a traumatic event) for two of three residents reviewed for PTSD (Residents 28 and 66).This failure resulted in staff not being aware of each resident's PTSD triggers and increased the risk of unnecessary stress or escalation for the residents.Findings:During a review of Resident 28's admission Record, the admission Record indicated Resident 28 was admitted to the facility on [DATE] and readmitted on [DATE]. The admission Record indicated Resident 28 with diagnoses including PTSD and dementia (a progressive state of decline in mental abilities).During a review of Resident 28's Care Plan titled, PTSD, dated 12/22/2025, the Care Plan interventions indicated to beware of the triggers that cause the resident to escalate and the triggers included being touched by male personnel.During a review of Resident 28's Minimum Data Set (MDS- a resident assessment tool) dated 3/23/2026, the MDS indicated Resident 28's cognition (ability to think, understand, learn, and remember) was intact. The MDS indicated Resident 28 required maximal (helper does more than half the effort) assistance with activities of daily living (ADLs- activities such as bathing, dressing, and toileting a person performs daily).During a review of Resident 66's admission Record, the admission Record indicated Resident 66 was admitted to the facility on [DATE] with diagnoses including PTSD and rheumatoid arthritis (a chronic progressive disease-causing inflammation in the joints and resulting in painful deformity and immobility).During a review of Resident 66's Care Plan titled, PTSD, dated 1/29/2026, the Care Plan interventions indicated to beware of the triggers that cause the resident to escalate and the triggers included loud noises and yelling.During a review of Resident 66's MDS dated [DATE], the MDS indicated Resident 66's cognition was intact. The MDS indicated Resident 66 required maximal (helper does more than half the effort) assistance with ADLs.During an interview on 5/28/2026 at 9:09 a.m., with Resident 66, Resident 66 stated he has been diagnosed with PTSD, and his triggers include loud noises and fighting people.During an interview on 5/28/2026 at 9:35 a.m. with Certified Nurse Assistant (CNA) 4, CNA 4 stated she had not been made aware of which residents had PTSD or what their triggers were unless the residents told her themselves. CNA 4 stated she knew about Resident 66's PTSD and triggers because he informed her when she cared for him. CNA 4 stated it was important for staff to be informed about residents with PTSD and their triggers so they could provide proper care.During an interview on 5/28/2026 at 10:18 a.m. with CNA 3, CNA 3 stated she had not been aware that Resident 28 had PTSD or what his triggers were. CNA 3 stated she should have been informed of Resident 28's PTSD and triggers so she could better care for him and know what to watch for in case something happened.During an interview on 5/28/2026 at 11:12 a.m. with Registered Nurse Supervisor (RNS) 1, RNS 1 stated it was important for CNAs to be aware of residents with PTSD and their triggers so they would not trigger the residents and so the residents would feel safe and comfortable in the facility.During an interview on 5/29/2026 at 11:03 a.m., with the Director of Nursing (DON), the DON stated all staff needed to know which residents had PTSD and what their triggers were so they could avoid triggering the residents and causing them additional stressDuring a review of the facility's policy and procedure (P&P) titled, Treatment and Services for Mental Disorders, Psychosocial Adjustment Difficulty, Trauma, and/or Post-Traumatic Stress Disorder, revised 10/2017, the P&P indicated, Residents admitted with a mental or psychosocial adjustment difficulty, or who have a history of trauma and/or PTSD, will receive appropriate person-centered and individualized treatment and services to meet their assessed needs.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility's Social Services Director (SSD) failed to ensure two out of 10 sampled residents (Resident's 55 and 67) were seen by a podiatrist (foot doctor) for treatment of their long, jagged (sharp, uneven) mycotic (fungal) toenails.This deficient practice resulted in a delay in necessary care and services for Resident 55 and Resident 67.Findings:During a review of Resident 55's admission Record, the admission Record indicated, Resident 55 was admitted to the facility on [DATE] with a diagnoses including Parkinson's disease(a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), muscle weakness and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing).During a review of Resident 55's Care Plan titled ADL Self-Care Deficit dated 2/24/26 the Care Plan indicated, Resident 55 was totally dependent with personal hygiene. The Care Plan indicated, Resident 55 was to be provided with a quality-of-life program which included hygiene and grooming.During a review of Resident 55's History and Physical (H&P) dated 2/25/26, the H&P indicated, Resident 55 had the capacity to understand and make decisions.During a review of Resident 55's Minimum Data Set (MDS-resident assessment tool) dated 3/03/26, the MDS indicated Resident 55's cognition (ability to think, understand, learn, and remember) was intact. The MDS indicated Resident 55 was totally dependent (helper does all the work) with Activities of Daily Living During a review of Resident 55's Order Summary Report dated 5/01/26, the order summary report indicated, Resident 55 had a standing (permanent) order to see the podiatrist every two months and as needed for mycotic and /or other foot problems.During a concurrent observation and interview on 5/26/2026 at 2:37 p.m. with Resident 55, in Resident 55's room, Resident 55 was observed to have long, jagged mycotic toenails. Resident 55 stated he needed to have his toenails trimmed because they were too long.During a review of Resident 67's admission Record, the admission Record indicated, Resident 67 was admitted to the facility on [DATE] and readmitted [DATE]. Resident 67 had a diagnosis including spinal stenosis (narrowing of the spaces in the spine [back] causing stiffness), muscle weakness and chronic kidney disease (kidneys are damaged and gradually lose their ability to filter waste and excess fluid from the blood).During a review of Resident 67's Care Plan titled ADL Self-Care Deficit dated 9/26/25 the Care Plan indicated, Resident 67 needed moderate assistance with personal hygiene. The care plan indicated, Resident 67 was to be provided with a quality-of-life program which included hygiene and grooming.During a review of Resident 67's H&P dated 9/28/25, the H&P indicated, Resident 67 had the capacity to understand and make decisions.During a review of Resident 67's MDS dated [DATE], the MDS indicated, Resident 67's cognition was intact. The MDS indicated Resident 67 needed substantial/maximal (helper does more than half the work) assistance with ADL'S.During a review of Resident 67's Order Summary Report dated 5/01/26, the Order Summary Report indicated, Resident 67 had a standing order to see the podiatrist every two months and as needed for mycotic toenails and /or other foot problems.During a concurrent interview and record review on 5/28/2026 at 11:28 a.m. with the Social Services Director (SSD), a list of residents seen by podiatry dated 4/28/2026 was reviewed. The list indicated Residents 55 and 67 were not seen by the podiatrist due to their insurance. The SSD stated it was her responsibility to ensure the residents were seen by the podiatrist. She stated the facility was responsible for the residents' care and should have paid for the residents to have their toenails trimmed on 4/28/2026 when the podiatrist last visited the facility. The SSD stated she had forgotten to schedule another podiatry appointment for Residents 55 and 67 to have their toenails trimmed. She stated when residents' toenails become too long, it can be very uncomfortable for them to wear shoes and socks.During a concurrent observation and interview on 5/29/26 at 7:14 a.m. with Resident 67, in Resident 67's room, Resident 67 was observed to have long, jagged mycotic toenails. Resident 67 stated he needed to (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	have his toenails trimmed, they were too long and very uncomfortable when he wears socks.During an interview on 5/29/2026 at 9:53 a.m. with the Director of Staff Development (DSD), the DSD stated the CNAs and treatment nurses were responsible for trimming and cleaning the residents' nails. The DSD stated it was important for residents' nails to be kept clean and trimmed because long or dirty nails could cause pain and discomfort, could break the skin if the residents scratched themselves, and could curl into the skin.During an interview on 5/29/2026 at 11:03 a.m. with the Director of Nursing (DON), the DON stated regardless of the payor source, the facility was responsible for providing care to the residents. The DON stated it was the SSD's responsibility to inform administration that the facility needed to pay for Residents 55 and 67 to have their toenails trimmed. The DON stated there was a possibility that Residents 55 and 67 could scratch themselves and develop a skin tear that could lead to an infection.During an interview on 5/29/2026 at 11:14 a.m. with the Administrator (ADM), the ADM stated the SSD was responsible for ensuring residents were seen by podiatry. The ADM stated the facility was responsible for providing the care and services Residents 55 and 67 needed. The ADM stated Residents 55 and 67 should have been seen by podiatry on 4/28/2026.During a review of the facilities policy and procedure (P&P) titled, Social Services Program dated 1/2027, the P&P indicated, Social services is responsible for making referrals to community resources as necessary and appropriate and maintaining appropriate documentation of referrals, when needed.During a review of the facilities policy and procedure (P&P) titled, Activities of Daily Living, and Scope of Services, dated 6/2022, the P&P indicated, It is the policy of the facility that each resident receive, and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being consistent with the resident's comprehensive assessment and plan of care.Staff will ensure that Activities of Daily Living are monitored, assisted with, and provided for those residents who are unable to perform Activities of Daily Living.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure medications are administered safely and in accordance with accepted standards of practice on two of nine sampled residents (Resident 20 and Resident 50). The facility failed to:1.Ensure Licensed Vocational Nurse (LVN) 1 verified the placement of the gastrostomy tube (GT-a soft tube surgically inserted directly into the stomach to administer medications, fluids, and nutrition) and checked or assessed the gastric residual volume (GRV-the amount of fluid or tubeˆfeeding formula [liquid nutrition] remaining in the stomach at a specific point in time) of Resident 20's GT prior to administering medications. 2. Ensure LVN 3 assessed Resident 50's pulse rate before administering Metoprolol, (a medication used to treat high blood pressure by relaxing blood vessels and slowing the pulse rate) with a pulseˆbased hold parameter (a physicianˆordered instruction that guides when the medication should or should not be given).These failures placed Resident 20 and Resident 50 at risk for ineffective medication administration, aspiration (accidental inhalation of foreign material into the lungs), adverse drug reactions (harmful or unintended effects caused by a medication), and avoidable decline in health status. Findings:During a review of Resident 20's admission Record, the admission Record indicated Resident 20 was originally admitted on [DATE] and was readmitted on [DATE]. Resident 20's had diagnoses including hemiplegia affecting the right dominant side (total paralysis of the arm, leg, and trunk on the right side of the body), dysphagia (difficulty in swallowing), and gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems).During a review of Resident 20's Order Summary Report dated 11/9/2020, the Order Summary Report indicated checking GT placement and patency every shift.During a review of Resident 20's Order Summary Report dated 10/6/2023, the Order Summary Report indicated checking residuals of GT every shift.During a review of Resident 20's Minimum Data Set (MDS- a resident assessment tool) dated 3/18/2026, the MDS indicated Resident 20 had severely impaired cognitive (ability to think, understand, learn, and remember) skills. The MDS indicated Resident 20 required substantial/maximal assistance (helper does more than half the effort) with toileting hygiene, dressing, oral hygiene, and dressing. The MDS indicated Resident 20 had a feeding tube (flexible plastic tube used to safely liquid food, fluids, and medications directly into the stomach or small intestines).During a review of Resident 20's History and Physical (H&P) dated 4/21/2026, the H&P indicated Resident 20 did not have the capacity to understand and make decisions.1. During an observation of medication administration on 5/26/2026 at 4:00 p.m. in Resident 20's room with LVN 1, LVN 1 did not verify or assess the placement of the GT. LVN 1 did not check the GRV of Resident 20's GT prior to administering medications.During an interview on 5/26/2026 at 4:50 p.m., with LVN 1, LVN 1 stated he forgot to check the placement of the GT and the gastric residual before administering Resident 20's medications. He stated he would check the GT placement and gastric residual in the future to ensure the GT was correctly positioned before giving medications. LVN 1 stated he should have verified Resident 20's GT placement and gastric residual. He stated failing to verify the GT placement could put Resident 20 at risk for aspiration pneumonia. He stated checking the gastric residual would help ensure the resident was not at risk for vomiting, and a high residual could put Resident 20 at risk for vomiting.During an interview on 5/28/2026 at 11:27 a.m., with the Infection Preventionist Nurse (IPN), IPN stated licensed nurses must verify GT placement and check the gastric residual before administering medications through the GT. The IPN stated if the GT was not in place, Resident 20 could aspirate, would not receive his medication, and could be at risk for infection due to possible GT dislodgement (medical device has accidentally moved or been forced out of its original, correct position).During an interview on 5/28/2026 at 4:59 p.m., with the Director of Nursing (DON), the DON stated licensed nurses should check and verify GT placement to ensure it is correct before (continued on next page)

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	055123	A. Building B. Wing	05/29/2026

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Beachside Post Acute	3294 Santa Fe Avenue Long Beach, CA 90810

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administering medications. The DON explained that if the GT placement was not verified, the nurse would not know whether the medications administered through the GT entered the correct route, and Resident 20 could experience significant pain.During a review of facility's policy and procedure (P&P) titled, Medication Administration via Enteral tube, revised 4/2017, the P&P indicated the nurse will verify tube placement by forcefully injecting air into tube while listening with stethoscope to the abdomen for a loud bubbling sound. The P&P indicated to check the residual amounts of feeding once placement is verified, then administer the medications.2.During a review of Resident 50's admission Record, the admission Record indicated Resident 50 was admitted to the facility on [DATE] with diagnoses including hypertension (HTN- high blood pressure), cardiac murmur (a whooshing sounds made by rapid, choppy blood flow through the heart), and muscle weakness.During a review of Resident 50's Order Summary Report dated 2/21/2025, the Order Summary Report indicated an order of metoprolol tartrate oral tablet , give one tablet by mouth two times a day for HTN , hold for systolic blood pressure (SBP- measures the pressure of the blood as it pushes against the artery walls when the heart beats) less than 110 millimeters of mercury (mmHg-unit of measurement used to record blood pressure) and pulse rate less than 60 beats per minute (bpm).During a review of Resident 50's MDS dated [DATE], the MDS indicated Resident 50 had an intact cognition and required set up or clean-up assistance (helper sets up or cleans up as resident completes the activity) with bathing, dressing, toileting hygiene and personal hygiene.During a concurrent medication pass observation and interview on 5/27/2026 at 9:20 a.m. with LVN 3 in Resident 50's room, LVN 3 obtained Resident 50's blood pressure. LVN 3 stated she only takes a resident's blood pressure. LVN 3 stated she will take the pulse rate only when required by the physician's medication parameters. LVN 3 then administered one tablet of metoprolol tartrate 50ˆmilligram (mg unit of measurement) to Resident 50 without assessing Resident 50's pulse rate.During a concurrent interview and record review on 5/27/2026 at 9:28 a.m., with LVN 3, Resident 50's physician order for Metoprolol was reviewed. LVN 3 stated the order included a parameter to hold Metoprolol if the pulse rate was less than 60 beats per minute, and she acknowledged she did not check Resident 50's pulse rate. LVN 3 stated if Resident 50's pulse rate was already low, administering Metoprolol could slow it further and cause dizziness or fainting. She stated a low pulse rate meant a heart rate or pulse rate below 60 beats per minute.During an interview on 5/28/2026 at 1:10 p.m., with LVN 3, LVN 3 stated she should have taken the complete set of vital signs, which include body temperature, pulse rate, blood pressure, and respiratory rate (breaths per minute). She stated Metoprolol lowers the pulse rate and decreases the heart's pumping action. LVN 3 stated not assessing Resident 50's pulse rate before administering Metoprolol could cause Resident 50 to become dizzy, tired, faint, and possibly increase her risk of hospitalization.During an interview on 5/28/2026 at 4:59 p.m., with the Director of Nursing (DON), the DON stated the licensed nurse should check the medication instructions, including any hold parameters. The DON stated if Resident 50's pulse rate was not checked before administering Metoprolol, the resident's pulse could drop very low, which could cause dizziness, bradycardia (a heart rate below 60 beats per minute), and syncope (fainting due to a sudden drop in blood pressure or heart rate that temporarily reduces blood flow).During a review of facility's P&P titled, Medication Administration, revised 4/2025, the P&P indicated Medications must be administered in accordance with the physician orders and the licensed nurse should check vital signs if necessary.Cross reference F693

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure medications were stored properly on one of two medication storage rooms. The facility failed to:1. Ensure Resident 40's discontinued Risperidone (antipsychotic -[a type of medication prescribed to treat mental health problem]) was disposed of and not kept in a box labeled extra medicines in the Medication Storage room.2. Ensure expired hemorrhoidal ointment (medicated jelly or paste used to soothe swollen, inflamed veins in the rectal area) was not stored in the medication storage room.These failures resulted in expired and discontinued medications being available in the medication storage area, increasing the risk of medication administration error and having the potential to unintentional dispensing of expired or discontinued medications to residents.Findings:1. During a review of Resident 40's admission Record, the admission Record indicated Resident 40 was admitted to the facility on [DATE] with diagnoses including schizoaffective disorder(a mental illness that can affect thoughts, mood, and behavior), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), post-traumatic stress disorder (PTSD- a disorder in which a person has difficulty recovering after experiencing or witnessing a traumatic event) and depression (serious mood disorder that causes persistent feelings of sadness, emptiness, or a loss of interest in activities once enjoyed).During a review of Resident 40's History and Physical (H&P) dated 12/23/2025, the H&P indicated Resident 40 had the capacity to understand and make decisions.During a review of Resident 40's Physician Order dated 5/7/2026, the Physician Order indicated an order of Risperdal (Risperidone) 2 milligrams (mgs-unit of measurement) give one tablet by mouth two times a day for schizoaffective disorder manifested by physical aggression was discontinued on 5/7/2026 at 12:59 p.m.During a review of Resident 40's Physician Order dated 5/7/2026, the Physician Order indicated Risperdal (Risperidone) one mg. give two tablets by mouth at bedtime for schizoaffective disorder manifested by physical aggression that may lead to altercation, total of 2 mgs. was discontinued on 5/7/2026 at 12:41 p.m.During a concurrent observation and interview on 5/26/2026 at 10:37 a.m. with Licensed Vocational Nurse (LVN) 2 in the medication storage room, clear plastic box labeled extra medicines filled with residents' medicines and an empty clear plastic box labeled discontinued medicines were on a shelf. Observed an unopen medication bubble pack (blister pack or multi-dose card) labeled as Risperidone one milligram (mg.-unit of measurement) one time a day and give two tablets (20 mg) at bedtime for schizoaffective disorder for Resident 40 was inside the clear plastic box labeled extra medicines. LVN 2 stated the dose of Risperidone 1 mg for Resident 40 was discontinued and was increased to 2 mgs LVN 2 stated the bubble pack of Risperidone 1 mg should have been discarded and not kept inside the box labeled extra medicines.During a subsequent interview on 5/26/2026 at 2:48 p.m., with LVN 2, LVN 2 stated licensed nurses placed discontinued residents' medications in the box labeled for discontinued medications in the medication storage area. She stated she had placed Resident 40's Risperidone in the box intended for extra medications and should have placed it in the discontinued medications box so the Registered Nurse (RN) Supervisor could dispose of it. LVN 2 stated Resident 40's Risperidone could have been used for other residents by licensed nurses.During an interview on 5/26/2026 at 2:25 p.m., with the Director of Nursing (DON), the DON stated the facility stored medications received from the general acute care hospital (GACH) and then gave them to family members. The DON stated Risperidone came from the facility's own pharmacy. She stated Resident 40's Risperidone should have been destroyed because the dose had been changed and the medication was no longer being used by the resident. She stated Resident 40's Risperidone dose had been changed on 5/7/2026. The DON stated the discontinued dose of Risperidone should have been placed in the box labeled for (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	discontinued medications. She stated the RN Supervisor and LVN performed destruction of residents' nonˆcontrolled prescription (medications that requires a doctor's prescription) medications on 5/26/2026. The DON stated there was a risk the discontinued Risperidone from Resident 40 could have been given to another resident.2. During an observation on 5/26/2026 at 10:37 a.m. in the medication storage room with LVN 2, an expired hemorrhoidal ointment with an expiration date of 8/2025 was stored on the shelf.During an interview on 5/26/2026 at 11:09 a.m., with LVN 2, LVN 2 stated the expired hemorrhoidal ointment would not be effective because its potency decreased when used on residents.During an interview on 5/29/2026 at 11:09 a.m., with the DON, the DON stated storing an expired hemorrhoidal ointment created a risk it could be used on residents and would not be effective. The DON stated that using an expired hemorrhoidal ointment on a resident could cause side effects (any effect of medication or treatment that happens in addition to its main and intended goal), such as diarrhea (loose stool) or constipation (hard stool).During a review of facility's policy and procedure (P&P) titled, Disposal of Medications and Medication-Related Supplies, revised 1/2025, the P&P indicated discontinued medications not returned to the pharmacy are destroyed in accordance with Medication Destruction policy. The P&P indicated expired medications, and medications discontinued by a prescriber are marked as discontinued or stored in a separate location and later destroyed.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on observation, interview and record review, the facility failed to ensure food service staff were competent in reading test strips (a small, treated piece of paper or plastic designed to interact with a sample and reveal the presence, absence, or concentration of specific chemical substances) used for testing chlorine (deep cleaning and sanitizing agent) in the dishwashing machine.This failure had the potential to put residents at risk for food borne illness (any illness resulting from eating contaminated/spoiled foods) due to inability to read and interpret the test strips used for testing the correct range of sanitizer solutions for the dishwashing machine.Findings:During a concurrent observation and interview with Dietary Aide (DA)1, DA 1 demonstrated on how to check the amount of chlorine in the dishwashing machine after the final rinse by dipping a test strip in the water and comparing the test strip to the color chart of the test strip container. DA 1 stated the strip read 50 parts per million (PPM- unit of measurement) and the kitchen staff follows 50-200 PPM for chlorine test.During a review of kitchen's Dish Machine Temperature Log, (document that records the temperature of the dishwasher machine during wash and rinse cycle, and reading obtained from test strip used to check chlorine) dated 5/2026, the Dish Machine Temperature Log indicated the following readings ranging from 58, 59, 60, 68, 69 and 70 PPM on various dates taken during breakfast and lunch.During a concurrent interview and record review on 5/27/2026 at 1:43 p.m. with DA 1, the kitchen's Dish Machine Temperature Log dated 5/2026 was reviewed. DA 1 stated that readings of 58, 59, 60, 68, and 70 PPM were not correct interpretations because the chlorine color chart only indicated a range of 50-100 PPM. She stated she had estimated the readings of 58, 59, 60, and 70 PPM because someone had instructed her to read them that way. DA 1 stated the color chart did not provide readings between 50 and 100 PPM. She stated not reading the log according to the color chart could place residents at risk for food˜borne illness because chlorine was used to kill germs on dishes and pots.During a concurrent interview and record review on 5/28/2026 at 8:29 a.m. with DA 2, the kitchen's Dish Machine Temperature Log dated 5/2026 was reviewed. DA 2 stated she checked the chlorine level in the dishwashing machine before starting to wash dishes to ensure the proper amount of chlorine would sanitize and clean the dishes. She stated the kitchen did not have a device that provided a specific numerical chlorine reading. DA 2 stated she approximated the chlorine level based on how the test strip became darker or lighter when reading levels such as 70, 69, 60, and 58 ppm. She stated the normal chlorine range in the dish machine was 50-100 ppm. DA 2 stated she had not been reading the chlorine test strips correctly and that residents could get sick if the strips were not interpreted properly.During an interview on 5/28/2026 at 1:23 p.m., with the Dietary Supervisor (DS), DS stated someone had told DA 1 and DA 2 to interpret and read the test strips by estimating the readings. The DS stated reading and interpreting chlorine test strips incorrectly could pose a hazard to residents and could lead to food˜borne illness.During a review of facility's policy and procedure (P&P) titled, DishWashing, undated, the P&P indicated the chlorine should read 50-100 ppm on dish surface in final rinse.