STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055387	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgewater Skilled Nursing Center	2625 East Fourth Street Long Beach, CA 90814

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45743 Based on interview and record review, the facility failed to implement a care plan to place floor mats next to Resident 1 ' s bed and to have Resident 1 ' s bed in the lowest position, for one of three sampled residents (Resident 1) who was assessed as high risk for falls. This deficient practice resulted in Resident 1 falling from her bed, which was in a high position and landing on the floor without floor mats in place. Resident 1 was transferred to a General Acute Care Hospital (GACH) where she was assessed with a non-displaced (broken bone that remains in the proper alignment) left intertrochanteric fracture (fracture of the thigh bone that connects to the hip bone). 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] with a diagnosis of generalized muscle weakness. During a review of Resident 1 ' s Minimum Data Set ([MDS]) a standardized assessment and care screening), dated 12/14/2023, the MDS indicated Resident 1 ' s cognitive skills (thinking process) for daily decision-making were severely impaired. The MDS indicated Resident 1 was totally dependent on staff for toileting, bathing, upper and lower body dressing, and personal hygiene. The MDS indicated Resident 1 had functional limitations in range of motion ([ROM] the distance and direction a joint can move to its full potential) to both sides of her lower extremities (legs). During a review of Resident 1 ' s Fall Risk Evaluation, dated 3/22/2024, the Fall Risk Evaluation indicated Resident 1 ' s fall risk score was 13. A score of 13 and above indicated a high risk for falls. During a review of Resident 1 ' s Care Plan, dated 12/14/2023, the Care Plan indicated Resident 1 was at risk for falls and fall related injuries related to the use of antidepressant medication, impaired cognition, and impaired activities of daily living ([ADL] task such as bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet and eating). The Care Plan ' s goal indicated Resident 1 would be free from falls through the review date of 7/19/2024 and the Care Plan ' s interventions indicated to have floor mats at Resident 1 ' s at bedside and to have Resident 1 ' s bed in the lowest position. (continued on next page)

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

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s Change of Condition (COC) dated 4/11/2024 and timed at 11:15 p.m., the COC indicated Certified Nurse Assistant 1 (CNA 1) heard a thud and found Resident 1 on the floor in a prone (lying on the stomach) position. Resident 1 was noted with a bump on her forehead and an abrasion on her left arm. During a review of Resident 1 ' s Physician ' s Order dated 4/11/2024, the Physician ' s Order indicated to transfer Resident 1 to a GACH for further evaluation and treatment as indicated, status post (a treatment, diagnosis, or event that a patient has experience before) an unwitnessed fall. During a review of the GACH ' s emergency room (ER) documentation dated 4/12/2024 and timed at 12:03 a. m., the ER documentation indicated Resident 1 had a hematoma (a bruise) above her left eyebrow and pain to her left hip. During a review of Resident 1 ' s X-ray of her pelvis (the area of the body below the abdomen, between the hip bones that contains the hip bones, bladder, and rectum) dated 4/12/2024 and timed at 1:03 a.m., the X-ray indicated Resident 1 had a probable nondisplaced left intertrochanteric fracture. During an interview on 4/29/2024 at 4:41 p.m., and a subsequent interview on 5/1/2024 at 4:49 p.m., CNA 1 stated, on 4/11/2024 at approximately 10:30 p.m., she was called to Resident 1 ' s room. CNA 1 stated she observed Resident 1 on the floor in a prone position and there was no floor mat on the ground. During an interview on 4/29/2024 at 5:18 p.m., CNA 2 stated, she heard Resident 1 crying in her room, she went to check on her, and found Resident 1 lying on a low air loss mattress on her right side, soiled. CNA 2 stated she went to the bathroom to get supplies to clean and change Resident 1, when she heard a loud thud. CNA 2 stated, she went to check Resident 1 and found her on the floor next to her bed on her stomach. CNA 2 stated Resident 1 ' s mattress and bed were at bedside table height, and she did not recall if a floor mat was in place on the floor. During an interview on 4/30/2024 at 3:57 p.m., Licensed Vocational Nurse 1 (LVN 1) stated on 4/11/2024 at approximately 8:45 p.m., she was called to Resident 1 ' s room and when she entered Resident 1 ' s room, she saw Resident 1 on the floor and Registered Nurse 1 (RN 1) assessing her. LVN 1 stated Resident 1 ' s bed had to be placed in the lowest position in order to transfer Resident 1 back to her bed. During an interview on 4/30/2024 at 4:19 p.m., RN 1 stated she was called to Resident 1 ' s room by CNA 1 and CNA 2, when she went to the room, she found Resident 1 on the floor with a bump to her forehead and Resident 1 complaining of discomfort. and she (RN 1) observed a bump to Resident 1 ' s forehead and complaining of discomfort. During an interview on 5/2/2024 at 1:53 p.m., the MDS Nurse stated care plans are individualized for each resident and are created to ensure residents get proper care and necessary interventions are implemented. The MDS Nurses stated when interventions are not implemented residents may not receive quality care. (continued on next page)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/2/2024 at 4:26 p.m., the Director of Nurse (DON) stated Resident 1 ' s bed should have been in the lowest position along with having floor mats in place on the floor next to Resident 1 ' s bed as indicated in Resident 1 ' s care plan. The DON stated fall mats are used and the bed is put in the lowest position to lessen the chance of injury if a resident falls out of bed. During a review of the facility ' s policy and procedure (P/P) titled, Care Planning revised 1/2021 the P/P indicated the interdisciplinary team ([IDT] a group of health care professionals with various areas of expertise who work together toward the goals of the resident) shall develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that it includes measurable objective and timeframes to meet a resident ' s medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. During a review of the facility ' s P/P titled Fall Management System, revised 1/2024, the P/P indicated the facility is provide each resident with appropriate assessment and interventions to prevent falls and to minimize complications if a fall occurs.

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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 0689 Level of Harm - 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** 45743 Based on interview and record review, the facility failed to ensure, the resident who was assessed as a high risk for falls and was totally dependent on staff for activities of daily living (ADL), did not fall out of bed and sustained injuries for one of three sampled residents (Resident 1). The facility failed to: 1. Ensure Resident 1 had more than one staff present to provide incontinence care when the resident was found being soiled while in bed. 2. Ensure Resident 1's bed was maintained in a lowest position as care planned to prevent the resident from fall. 3. To have floor mats (high-impact foam pads which are placed adjacent to the bed on the floor to help reduce the impact from falls and help prevent injuries) at the bed side to lessened possible injury during fall as care planned. These deficient practices resulted in Resident 1 falling from a bed on 4/11/2024, which was in a high position and landing on the floor without a floor mats in place and sustaining a non-displaced (broken bone that remains in the proper alignment) left intertrochanteric fracture (fracture of the thigh bone that connects to the hip bone), bump on her forehead and an abrasion on her left arm. On 4/12/2024 Resident 1 was transferred to a General Acute Care Hospital (GACH) for evaluation and treatment. 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] with a diagnoses including generalized muscle weakness. During a review of Resident 1's Minimum Data Set ([MDS]) a standardized assessment and care screening tool), dated 12/14/2023, the MDS indicated Resident 1's cognitive skills (thinking process) for daily decision-making were severely impaired. The MDS indicated Resident 1 was totally dependent on staff for activities of daily living (ADL) including toileting, bathing, upper and lower body dressing, and personal hygiene. The MDS indicated a total dependence was when a helper does all of the effort for the resident. Resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete the activity. The MDS indicated Resident 1 had functional limitations in range of motion ([ROM] the distance and direction a joint can move to its full potential) to both sides of her lower extremities (legs). During a review of Resident 1's Fall Risk Evaluation, dated 3/22/2024, the Fall Risk Evaluation indicated Resident 1's fall risk score was 13. A score of 13 and above indicated a high risk for falls. (continued on next page)

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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 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's Care Plan, dated 12/14/2023, the Care Plan indicated Resident 1 was at risk for falls and fall related injuries due to the use of antidepressant medication (medication used to treat depression), impaired cognition, and impaired ADLs. The Care Plan's goal indicated Resident 1 would be free from falls through the review date of 7/19/2024 and the Care Plan's interventions included to have floor mats at Resident 1's bedside and to keep Resident 1's bed in the lowest position. During a review of Resident 1's Change of Condition (COC) dated 4/11/2024 and timed at 11:15 p.m., the COC indicated a Certified Nurse Assistant (CNA 2) heard a thud and found Resident 1 on the floor in a prone (lying on the stomach) position. Resident 1 was noted with a bump on her forehead and an abrasion on her left arm. During a review of Resident 1's physician's order dated 4/11/2024, the physician's order indicated to transfer Resident 1 to a GACH for further evaluation and treatment as indicated, status post (after) an unwitnessed fall. During a review of the GACH's emergency room (ER) documentation dated 4/12/2024 and timed at 12:03 a.m., the ER documentation indicated Resident 1 had a hematoma (a bruise) above her left eyebrow and pain to her left hip. During a review of Resident 1's X-ray (an imaging test to view the body internal structure) report of the resident's pelvis (the area of the body below the abdomen, between the hip bones that contains the hip bones, bladder, and rectum) area, dated 4/12/2024 and timed at 1:03 a.m., the X-ray report indicated Resident 1 had a probable nondisplaced left intertrochanteric fracture. During an interview on 4/29/2024 at 4:41 p.m., and a subsequent interview on 5/1/2024 at 4:49 p.m., CNA 1 stated, on 4/11/2024 at approximately 10:30 p.m., she was called to Resident 1's room. CNA 1 stated she observed Resident 1 on the floor in a prone position and there was no floor mat on the ground. During an interview on 4/29/2024 at 5:18 p.m., CNA 2 stated, that on 4/11/2024, between 10:15 p.m. and 10:30 p.m., she heard Resident 1 crying in her room. CNA 2 stated she went to check on Resident 1 and found the resident lying on a low air loss mattress (a type of medical mattress designed to reduce pressure on the skin, which helps prevent pressure ulcers or bed sores) on her right side, soiled. CNA 2 stated she went to the bathroom to get supplies to clean and change Resident 1, when she heard a loud thud. CNA 2 stated, she went to check Resident 1 and found her on the floor next to her bed on her stomach. CNA 2 stated Resident 1's mattress and bed were at bedside table height, and she did not recall if a floor mat was in place on the floor. CNA 2 stated the best way to prevent a fall was to have a two persons assistance with Resident 1 care. During an interview on 4/30/2024 at 3:57 p.m., the Licensed Vocational Nurse (LVN 1) stated on 4/11/2024 at approximately 10:40 p.m., she was called to Resident 1's room and when she entered Resident 1's room, she saw Resident 1 on the floor and the Registered Nurse (RN 1) was assessing the resident. LVN 1 stated Resident 1's bed had to be placed in the lowest position in order to transfer Resident 1 back to the bed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 4/30/2024 at 4:19 p.m., RN 1 stated she was called to Resident 1's room by CNA 1 and CNA 2 at approximately 10:50 p.m. RN 1 stated when she went to the room, she found Resident 1 on the floor with a bump to her forehead and Resident 1 complained of discomfort. During an interview on 5/2/2024 at 4:26 p.m., the Director of Nursing (DON) stated Resident 1's bed should have been in the lowest position along with floor mats in place on the floor next to Resident 1's at bed along with having two staff members present while providing care. The DON stated floor mats and two staff members are used to lessen the chance of injury if a resident falls out of bed. During a review of the facility's policy and procedure (P/P) title Fall Management System, revised 1/2024, the P/P indicated the facility is to provide an environment that remains as free of accident hazards as possible. The P/P indicated to provide each resident with appropriate assessment and interventions to prevent falls and to minimize complications if a fall occurs.