

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055387	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/15/2024
NAME OF PROVIDER OR SUPPLIER  Edgewater Skilled Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow resident to participate in the development and implementation of his or her person-centered plan of care.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44958</b></p> <p>Based on interview and record review, the facility failed to conduct an Interdisciplinary Team (IDT-team of health care professionals that work together toward and prioritize the resident 's needs) care conference involving one of three sampled residents (Resident 1) and Resident 1's Responsible Party (RP1) prior to discontinuing Resident 1's speech therapy (treatment that improves ability to talk and use other language skills).</p> <p>This deficient practice violated the Resident 1 and RP 1's rights to be informed and the right to participate in resident's plan of care.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record, the admission record indicated Resident 1 was originally admitted to the facility on [DATE] with diagnoses including human immunodeficiency virus (HIV- is a virus that attacks the body's immune system), hemiplegia (unable to move one side of body) affecting right side, and percutaneous gastrostomy tube (PEG-Tube- surgically placed tube into the stomach, used to administer medication and nutrition).</p> <p>During a review of Resident 1's Minimum Data Set (MDS), a standardized assessment and care-screening tool, dated 3/6/2024, the MDS indicated Resident 1 had severe cognitive impairment (ability to think, learn, remember, use judgement, and make decisions). The MDS indicated Resident 1 was receiving speech -language pathology and audiology services (therapy to treat disorders involving speech, language, swallowing, cognitive, communication, hearing and balance disorders) from 2/14/2024 through 3/4/2024.</p> <p>During a review of Resident 1's Speech Language Pathologist (SLP/speech therapist - work with residents who have speech, language, voice disorders and treat residents with trouble swallowing) Discharge summary, dated 3/5/2024, the record indicated Resident 1 received SLP services from 2/14/2024 through 3/4/2024.</p> <p>During a review of Resident 1's SLP Evaluation and Plan of Treatment record dated 4/30/2024, the record indicated Resident 1 restarted treatment on 4/30/2024.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/14/2024, at 3:15 p.m., RP 1 stated he was not informed Resident 1's speech therapy was discontinued in March and restarted in late April. RP 1 stated during my daily visits, I observed Resident 1 was not receiving speech therapy, I approached a speech therapist who told me the therapy ended on 3/4/2024. RP 1 stated he was frustrated about not being notified of the discontinuation of therapy not being part of the plan of care. RP 1 stated he felt distrustful of the facility and angry.</p> <p>During an interview on 5/15/2024, at 8:48 a.m. the Director of Rehabilitation (DOR) stated Resident 1 received speech therapy services on 2/14/2024 through 3/4/2024. The DOR stated during scheduled sessions, Resident 1 often refused therapy and became aggressive with the therapists. The DOR stated the therapy team (the speech therapists and DOR) decided it would be best to terminate Resident 1's speech therapy for a duration of time. The DOR stated Resident 1's speech therapy was restarted on 4/30/2024. The DOR stated RP 1 was not informed of Resident 1's speech therapy was discontinued on 3/4/2024 and restarted on 4/30/2024. The DOR stated the facility should have discussed the plan of care with RP1 and should have had an IDT meeting. The DOR stated failure to inform and involve RP1 violated his rights and Resident 1's right.</p> <p>During an interview on 5/15/2024, at 2 p.m., the Director of Nursing (DON), the DON stated it was residents and/or responsible party's rights to be informed of any treatment changes. The DON stated the speech therapy department should have discussed and involved RP1 in plans to discontinue Resident 1's speech therapy prior to the actual discontinuation. The DON stated the facility should have should have held an IDT meeting to discuss the Resident 1's condition before and after the discontinuation of the speech therapy. The DON stated failing to update RP 1 about Resident 1' s change in treatment violated Resident 1 and RP 1's rights.</p> <p>During a review of the facility's policy and procedure, (P/P) titled, Comprehensive Resident Centered Plan of Care revised January 2021, the P/P indicated to the extent possible the resident, the resident's family and or RP should participate in the development of the care plan.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44958</b></p> <p>Based on interview and record review the facility failed to ensure one of three sampled residents (Resident 1) who had a gastrostomy tube (G-tube- surgically placed tube into the stomach, used to administer medication and nutrition), had measures in place to prevent the g-tube from being inadvertently dislodged a second time on 3/31/2024. The facility failed to revise Resident 1's care plans to include interventions to prevent future unintentional dislodgements of the G tube and the facility failed to investigate to determine the cause of Resident 1's multiple G-tube dislodgements.</p> <p>This deficient practice resulted in Resident 1 requiring to be admitted to the hospital for surgical intervention to replace the G-tube and had the potential for malnutrition (not enough nutrients) and underdosing of medications.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record, the admission record indicated Resident 1 was originally admitted to the facility on [DATE] with diagnoses including a percutaneous gastrostomy tube (PEG-Tube- surgically placed tube into the stomach, used to administer medication and nutrition).</p> <p>During a review of Resident 1's Minimum Data Set (MDS), a standardized assessment and care-screening tool, dated 3/6/2024, the MDS indicated Resident 1 had severe cognitive impairment (ability to think, learn, remember, use judgement, and make decisions). The MDS indicated Resident 1 received nutrition through a feeding tube.</p> <p>During an interview on 5/14/2024, at 3:15 p.m., RP 1 stated Resident 1's G Tube was removed unintentionally on 1/19/2024 and Resident 1 had to be transferred to the general acute care hospital (GACH). RP 1 stated he was very frustrated and angry at the facility because on 3/31/2024 Resident 1's Gt tube was unintentionally removed a second time and required Resident 1 to be transferred again to GACH. RP 1 stated he was fearful that Resident 1's might be dislodged again.</p> <p>During a concurrent interview and record review, on 5/15/2023 at 9:45 a.m., with the MDS Nurse, Resident 1's Change of Condition (COC) note, dated 1/19/2024 was reviewed. The COC note indicated at approximately 8:40 a.m., Licensed Vocational Nurse (LVN )1 was approached by a Certified Nurse Assistant (CNA) to assist with Resident 1. Resident 1 was observed with a G tube completely dislodged as Resident 1 was pulling his gown up and he pulled his G tube out. The MDS nurse stated the notes indicated Resident 1's G-tube was unintentionally removed on 1/19/2024 and resulted in a transfer to GACH for it to be replaced.</p> <p>During a concurrent interview and record review, on 5/15/2023 at 10 a.m., with LVN 3, Resident 1's progress notes dated 3/31/2024 was reviewed. The progress note indicated at approximately 8:30 a.m., per LVN 2, during medication administration, the G-tube slid out of the abdominal binder (a belt that encircles the abdomen) and was not intact. LVN 3 stated she was notified by LVN 2 of Resident 1's G-tube dislodgement. LVN 3 stated Resident 1 was transferred to GACH 1 for reinsertion for the G-tube.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/14/2024, at 3:15 p.m., LVN 3 stated Resident 1's G-tube unintentionally removals could have resulted in potential trauma to the g-tube site, malnutrition and underdosing of medications due to Resident 1 not being able to receive nutrition and medications through his G-tube.</p> <p>During a concurrent interview and record review, on 5/15/2023 at 10:30 a.m., with the MDS nurse, Resident 1's progress notes, IDT notes and care plans were reviewed. The MDS nurse stated the documents do not indicate Resident 1's care plans were revised after the unintentional G-tube dislodgements on 1/19/2024 and 3/31/2024 to include interventions specific to preventing future unintentional dislodgements. The MDS stated Resident 1's care plans did not reflect the use of the abdominal binder which was used to secure the G-tube. The MDS nurse stated specific care plan revisions should have been discussed in the IDT meeting following the incident and reflected on the care plans.</p> <p>During an interview on 5/15/2024, at 1:45 p.m., the Director of Nursing (DON) it was her responsibility to ensure staff was providing residents with the appropriate care and services as indicated in their plan of care. The DON stated the facility must ensure Resident 1 received the appropriate care for maintenance of his G-tube. The DON stated unintentional removal of the G-tube puts Resident 1 at risk for trauma such as bleeding to the site. The DON stated the facility put Resident 1 at risk for malnutrition and underdosing of medication due to the G-tube not being accessible. The DON stated the facility failed to revise Resident 1's care plans to include interventions to prevent future inadvertent G-tube dislodgements. The DON stated the facility has not investigated the cause of Resident 1's multiple G-tube dislodgements. The DON stated failing to investigate the reasons for Resident 1's multiple G-tube dislodgements and failure to revise care plan interventions places Resident 1 at risk for future unintentional G-tube dislodgements.</p> <p>During a review of the facility's policy and procedure, (P/P) titled, Comprehensive Resident Centered Plan of Care revised January 2021, the P/P indicated it was the policy of the facility that the IDT shall develop and implement a comprehensive person-centered care plan for each resident to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>During a review of the facility's job description Director of Nursing (DON) dated October 2021, the job description indicated the DON will assist in management and direction of the nursing department in accordance with federal, state and local standards, guidelines, and regulations that govern our facility and may be directed by the Administrator and Medical Director to ensure that the highest degree of quality of care is maintained at all times. The DON is delegated the administrative authority, responsibility, and accountability necessary for carrying out the assigned duties. The job description indicates the DON manages and directs all aspects of Nursing Services Department.</p>		