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	09/03/2024

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44958 Based on observation, interview and record review, the facility failed to ensure one of three sampled residents (Resident 3) was offered and provided a shower and was dressed in her personal clothing and not in a hospital gown. These deficient practices resulted in Resident 3 not receiving a shower for 28 days and her family's preference of her being dressed in her personal clothing and not a hospital gown, not being followed. This deficient practice had the potential to lower Resident 1's self-esteem. Findings: During a review of Resident 3's Admission Record (Face Sheet), the Face Sheet indicated Resident 3 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including dementia (a disease affecting how one thinks and understands), hemiplegia (inability to move one side of the body), hemiparesis (weakness on one side of the body) of the left side of her body, and generalized muscle weakness. During a review of Resident 3's Minimum Data Set ([MDS] a standardized assessment and care-screening tool), dated 8/7/2024, the MDS indicated Resident 3 had severe cognitive impairment and was rarely or never understood by others. The MDS indicated Resident 3 was dependent (helper does all the effort) on staff for hygiene, toileting, showering, bathing and dressing. During an observation on 9/3/2024, at 9:44 a.m., and 1:10 p.m., Resident 3 was observed in her room, in bed, wearing a hospital gown. During a telephone interview on 9/3/2024, at 1:15 p.m., Resident 3's responsible party (RP 3) stated she did not know when Resident 3 last received a shower. RP 3 stated when she asked the nursing staff about Resident 3's shower schedule, no one could tell her when Resident 3's assigned shower days were or when Resident 3 last received a shower. RP 3 stated it was sad to see Resident 3 with dirty hair. RP 3 stated the facility had not called to inform her of any refusals made by Resident 3 to take a shower. RP 3 stated it was the preference of the family for Resident 3 to be dressed in her personal clothes and not in a hospital gown. (continued on next page)

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

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

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 09/03/2024

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Edgewater Skilled Nursing Center	2625 East Fourth Street Long Beach, CA 90814

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/3/2024, at 1:35 p.m., Certified Nursing Assistant 2 (CNA 2) stated she was not sure but thinks Resident 3's assigned shower days were every Wednesday during the 3 p.m., - 11 p.m., shift. CNA 2 stated she did not know the last time Resident 3 was offered or provided a shower. CNA 2 stated she did not offer or provide Resident 3 with a shower or bed bath during her shift (7 a.m., - 3 p.m., shift) and did not dress Resident 3 in her personal clothing because Resident 3 was not receiving visitors today (9/3/2024). During a concurrent interview and record review on 9/3/2024 at 3:30 p.m., and a subsequent interview at 3:34 p.m., with the Director of Nursing (DON), Resident 3's Bathing Point of Care Flow Sheet dated 8/5/2024 through 9/2/2024 was reviewed. The Bathing Point of Care Flow Sheet indicated Resident 3 had not received a shower for 28 days and there was no documentation indicating Resident 3 refused to take a shower. The DON stated the Bathing Point of Care Flow Sheet was a record that showed documentation of resident's showers and/or their refusal to take a shower. The DON stated the Bathing Point of Care Flow Sheet indicated Resident 3 had not been showered for 28 days. The DON stated nursing staff should be aware of their resident's shower days and the last time a resident received a shower and should offer residents' the choice to dress in their personal clothing and to receive a shower. During a review of facility's Policy and Procedure (P/P), titled Activities of Daily Living, revised 11/2007, the P&P indicated residents are given treatment and services to maintain or improve her abilities, residents who are unable to carry out ADLs will receive assistance as needed.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44958 Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 2), who had poor safety awareness and was at risk for injury, had a call light button (device used to call nursing staff) within reach. This deficient practice resulted in a delay in Resident 1's care and services and had the potential for Resident 1 to act without assistance and sustain a fall/injury. Findings: During a review of Resident 2's Admission Record (Face Sheet), the Face Sheet indicated Resident 2 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills), muscle weakness and rheumatoid arthritis (a disease that causes pain, swelling, stiffness, and loss of function in the joints). During a review of Resident 2's Minimum Data Set ([MDS] a standardized assessment and care-screening tool), dated 6/28/2024, the MDS indicated Resident 2 had severe cognitive impairment . The MDS indicated Resident 2 was dependent (helper does all the effort) on staff for hygiene, toileting, showering, and bathing. During a review of Resident 2's Care Plan, dated 4/17/2023, the Care Plan indicated Resident 2 was at risk for fall's related to confusion, gait (the way a person walks)/balance problems, hypotension (low blood pressure), incontinence (inability to control urination and bowel movements) and she was unaware of her safety needs. The care plan indicated Resident 2 would be free from falls and minor injuries. The care plan interventions indicated for the call light to be within Resident 2's reach and to encourage Resident 2 to use the call light to call for assistance as needed. During a concurrent observation and interview on 9/3/2024, at 9:40 a.m., with Resident 2, Resident 2 was observed lying in bed on her right side with the call light button on the top left side of her bed. Resident 2 stated, she needed to call someone to get her coffee, but she could not find her call light button. During a concurrent observation and interview on 9/3/2024, at 9:45 a.m., with Registered Nurse (RN) 1, RN 1 observed Resident 2's call light located on the top of the head of Resident 2's bed and stated Resident 2's call light was not within Resident 2's reach. RN 1 stated staff should have ensured Resident 2 could see and touch the call light button prior to leaving Resident 2's room. During an interview on 9/3/2024, at 3:45 p.m., the Director of Nursing (DON) stated the nursing staff must ensure residents' call lights were in reach prior to leaving the residents' room. The DON stated interventions to ensure Resident 2's call light was in reach should be implemented as indicated in Resident 2's care plan. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Call light/Bell, revised 5/2007, the P&P indicated it is the policy of this facility to provide the resident a means of communication with nursing staff. The P&P indicated staff to leave the resident comfortable, place call device within resident's reach before leaving room.

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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 - Few	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** 44958 Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents'(Resident 3) who was dependent on staff for care was returned and repositioned every two hours This deficient practice put Resident 3 at risk for skin breakdown leading to pressure injuries/ulcers wounds created by extended pressure on the skin). Findings: During a review of Resident 3's Admission Record (Face Sheet), the Face Sheet indicated Resident 3 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including dementia (disease affecting how one thinks and understand), hemiplegia (inability to move one side of the body), hemiparesis (weakness on one side of the body) to her left side, and generalized muscle weakness. During a review of Resident 3's Minimum Data Set ([MDS] a standardized assessment and care-screening tool), dated 8/7/2024, the MDS indicated Resident 3 had severe cognitive impairment and was rarely or never understood by others. The MDS indicated Resident 3 was dependent (helper does all the effort) on staff for hygiene, toileting, showering, bathing, and dressing. The MDS indicated Resident 3 was frequently incontinent (inability to control urination and bowel movements) of urine and was always incontinent of bowel. The MDS indicated Resident 3 was at risk for developing pressure ulcer/injuries. During a review of Resident 3's Care Plan, dated 3/13/2023, the Care Plan indicated Resident 3 had pressure ulcers or a potential for pressure ulcer development related to mobility, incontinence, end stage renal disease and diabetes mellitus ([DM] a chronic disease that causes high blood sugar levels). The Care Plan's goals indicated Resident 3's skin would be intact, would be free of redness, blisters, or discoloration. The Care Plan's interventions indicated to educate Resident 1, Resident 1's family, and caregivers regarding the causes of skin breakdown including frequent repositioning. During a review of Resident 3's Care Plan, dated 2/21/2023, the Care Plan indicated restorative nursing assistants were to perform exercises on Resident 3's bilateral (both) lower extremities (legs) in all joints and planes seven times per week as tolerated to maintain range of motion ([ROM] the degree to which a joint or muscle can move, or the distance a moving object can travel) and to prevent contractures (fixed tightening of muscle, tendons, ligaments, or skin, prevents normal movement of the associated body part). The care plan interventions indicated to turn and reposition Resident 3 every two hours or as needed. On 9/3/2024, at 9:44 a.m., 11:11 a.m., and 1:10 p.m., Resident 3 was observed lying in bed on her back. During a telephone interview on 9/3/2024, at 1:15 p.m., Resident 3's Responsible Party (RP 3) stated she visited Resident 3 weekly and had often observed Resident 3 not being turned every two hours. RP 3 stated she was concerned Resident 3 would develop a pressure injury. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/3/2024, at 1:35 p.m., Certified Nursing Assistant 2 (CNA 2) stated Resident 3 was dependent on staff for grooming and toilet use. CNA 2 stated she last repositioned and changed Resident 3's incontinent brief at approximately 8:30 a.m., (9/3/2024). CNA 2 stated it was important that Resident 3 be turned at least every two hours to prevent pressure injuries from forming. During an interview on 9/3/2024, at 3:45 p.m., the Director of Nursing (DON) stated residents who are dependent on staff should be turned at least every two hours and as needed. The DON stated failing to turn and reposition a dependent resident places the resident at risk for skin breakdown. During a review of the facility's policy and procedure (P&P), titled, Skin Management System, revised 5/2020, the P&P indicated any resident who enters the facility without a pressure ulcer will have appropriate preventative measures taken to ensure that the resident does not develop pressures ulcers unless the resident's clinical condition makes the development unavoidable. The P&P indicated the preventative plan of care to prevent the development of skin breakdown or prevent existing pressure injuries from worsening, nursing staff shall implement preventative measures as appropriate and consistent with the resident 's condition and preferences, stabilize, reduce and remove any existing any underlying risks, reposition the individual in such a way that pressure is relieved or redistributed.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44958 Based on observation, interview, and record review, the facility failed to implement Enhanced Barrier Precautions ([EBP] precautions utilized to prevent the spread of multidrug resistant organisms [MDROS - bacteria that resist treatment with more than one antibiotic [medication that treat bacterial infections] for one of three sampled residents (Resident 1) who had a pressure injury wound (wound caused by pressure on the skin) on her sacrum (buttocks), when Certified Nursing Assistant 1 (CNA 1) did not use an isolation gown when performing high contact activities such as repositioning and removing Resident 1's incontinent brief (a disposable undergarment designed to absorb urine and feces). These deficient practices resulted in Resident 1's care needs being provided without the use of EBP and placed Resident 1 at increased risk of acquiring an infection. Findings: During a review of Resident 1's Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including hemiplegia (a condition that causes a loss of strength on side of the body), hemiparesis (inability to move one side of the body), type 2 diabetes ([DM] a disease that occurs when blood sugar, is too high) and blindness. During a review of Resident 1's Minimum Data Set ([MDS] a standardized assessment and care-screening tool), dated 7/26/2024, the MDS indicated Resident 1's cognitive skills for daily decision-making were moderately impaired. The MDS indicated Resident 1 required substantial/maximum assistance (the helper does more than half the effort) from staff for hygiene, toileting, bathing/showering, and dressing. The MDS indicated Resident 1 had two wounds categorized as stage 2 pressure injuries (shallow open wound with a red or pink base that can appear as a blister or an open sore cause by pressure to the skin). During a review of Resident 1's Care Plan, dated 8/18/2024, the Care Plan indicated Resident 1 was at risk for infection related to the presence of a pressure injury. The Care Plan's goal indicated Resident 1 would be free from signs and symptoms of infection related to her pressure injury. The Care Plan's interventions included to use Personal Protective Equipment ([PPE] gowns, gloves, mask, shields as needed, for high resident contact care activities), and to use EBP for Resident 1's Sacro coccyx pressure injury. During an observation on 9/3/2024, at 9:55 a.m., outside of Resident 1's room, a EBP sign was observed to be posted on the door. During a concurrent observation on 9/3/2024, at 10 a.m., Licensed Vocational Nurse (LVN 1) was observed gathering ointments from a wound treatment cart and was overheard giving directions to CNA 1 to reposition Resident 1 in preparation for her wound treatment to her sacrum. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 9/3/2024, at 10:05 a.m., in Resident 1's room, CNA 1 was observed standing at Resident 1's bedside, without a gown on, with Resident 1 turned away from her. Resident 1 was observed without an incontinent brief on leaving her sacrum area exposed. CNA 1 stated she repositioned Resident 1 and removed Resident 1's incontinent brief in preparation for LVN 1 to complete Resident 1's wound treatment. CNA 1 stated Resident 1 was on EBP, and she (CNA 1) should have worn a gown prior to repositioning Resident 1 and removing Resident 1's the incontinent brief. During an interview on 9/3/2024, at 10:07 a.m., LVN 1 stated Resident 1 required EBP and was not sure why CNA 1 did not wear a gown prior to providing high-contact care to Resident 1. LVN 1 stated CNA 1 put Resident 1 at risk for infections by not donning (to put on) a gown prior to providing care. During an interview on 9/3/2024, at 3:30 p.m., the Director of Nursing (DON) stated all residents with wounds must have an EBP sign in front of their door and an isolation cart for staff's use. The DON stated staff should be properly educated on understanding the rationale for EBP. The DON stated staff must wear the proper PPE when providing care to the residents with wounds to prevent the spread of any disease-causing microorganism. The DON stated failure to ensure staff understood and implemented EBP put the Resident 1 at risk for infections that could lead to death. During a review of the facility's policy and procedure (P&P) titled, Enhanced Barrier Precautions (EBP), dated 3/2024, the P&P are used in conjunction with standard precautions (infection prevention practices that apply to the care of all residents) and expand the use of PPEs, through the use of gowns and gloves during high contact resident care activities that provide opportunities for indirect transfer of MDROs to the staff hands and clothing when indirectly transferred to residents or from resident to resident. The P/P indicated the use of gown and gloves for high contact resident care activities is indicated when contact precautions do not otherwise apply for nursing home residents with wounds or indwelling medical devices regardless of known MDRO infection or colonization. The P/P indicated examples of high contact resident care activities requiring gown and glove use for EBP include dressing, showering /bathing, transferring, providing hygiene, changing linens , changing briefs, or assisting with toileting, device care or use, wound care.