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	01/08/2025

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 - Some	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** 47092 Based on interview and record review, the facility failed to ensure a resident, who was initially assessed and determined to be at high risk for falls and had a history of falling at the facility did not fall and continue to fall for one out of four sampled residents (Resident 1). The facility failed to: 1. Ensure the licensed nurses developed a care plan that addressed Resident 1 ' s inability to communicate his needs or use the call light when needing assistance which led to Resident 1 falling on 11/14/2024, 11/28/2024, and on 12/13/2024. 2. Ensure the nursing staff implemented interventions timely when Resident 1 fell on [DATE]. Resident ' s 1 ' s Post Fall Care Plan interventions dated initiated 11/14/2024 included a room change closer to the nursing station which was not initiated until 11/19/2024 (five days after the first fall on 11/14/2024), and also included an order for a Perimeter Low Air Loss Mattress (an air inflated mattress with raised borders on the sides designed to protect the skin and prevent falling) which was not ordered until 11/21/2024 (one week after the first fall on11/14/2024). These deficient practices resulted in Resident 1 ' s continued falls and had the potential for Resident 1 to sustain serious injuries and/or death as a result of the falls. 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 acute respiratory failure with hypoxia (a serious medical condition that occurs when the body doesn ' t have enough oxygen in its tissues), stage 4 pressure ulcer (Full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) of sacral region (lower back), aphasia (a disorder that makes it difficult to speak), and cognitive communication deficit (difficulty communicating due to an underlying issue with cognition). (continued on next page)

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

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

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(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 - Some	During a review of Resident 1 ' s Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 12/13/2024, the MDS indicated Resident 1 ' s cognition (a problem with a person ' s ability to think, learn, remember, use judgment, and make decisions) was severely impaired. The MDS indicated Resident 1 was bed bound and dependent (helper does all the effort) for all activities of daily living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 1 ' s Fall Risk assessment dated [DATE], the Fall Risk Assessment indicated Resident 1 was a high fall risk. During a review of Resident 1 ' s Physician Order dated 11/11/2024, the order indicated a Speech-Language Pathologist ([SLP] an expert who assesses, diagnoses, and treats speech, language, and swallowing disorders) to evaluate and treat Resident 1 three times a week for four weeks for cognitive-communicative deficit, aphasia, dysarthria (a speech disorder that makes it difficult to speak clearly), and dysphagia (difficulty swallowing). During a review of Resident 1 ' s Care Plan dated 11/6/2024, dated 11/6/2024, the Care Plan indicated Resident 1 was at risk for falls due to limited mobility, impaired ADL skills, and impaired cognitive skills. The Care Plan ' s goal was for Resident 1 was to be free from falls with interventions that included to be sure the call light is within reach and encourage Resident 1 to use the call light for assistance as needed. The Care Plan did not address Resident 1 ' s inability to communicate his needs or use the call light when needing assistance. During a review of Resident 1 ' s Interdisciplinary Team (IDT - a group of medical professionals from different disciplines who work together to help a resident achieve their goals) Care Plan Review dated 11/22/2024, the IDT-Care Plan Review indicated Resident 1 was not able to use his call light or make his needs known when needing assistance due to being non-verbal. 1. During a review of Resident 1 ' s Nursing Progress Note dated 11/14/2024 at 12:40 p.m., the Nursing Progress Note indicated Resident 1 was found on the floor next to his bed and reported having head and nose pain. During a review of Resident 1 ' s Nursing Home to Hospital Transfer Form (Transfer Form) dated 11/14/2024, the Transfer Form indicated Resident 1 was sent to a General Acute Care Hospital (GACH) for evaluation because of the fall on 11/14/2024 at 12:45 p.m. via 911. Resident 1 was evaluated at the GACH and returned to the facility on [DATE]. During a review of Resident 1 ' s Rehabilitation Services Screening Tool (Rehab Screening Tool) dated 11/14/2024, the Rehab Screening Tool indicated a recommendation to move Resident 1 closer to the nursing station for close monitoring, and recommended roll-control side bed bolsters (a long, narrow, triangular firm pillow used as a safety device to prevent residents from falling out of bed). During a review of Resident 1 ' s post fall Care Plan dated 11/14/1024, the Care Plan indicated Resident 1 had a fall on 11/14/2024 with a goal to resume usual activities without further incident with a target date of 2/4/2025. The Care Plan ' s interventions included for Resident 1 to have a perimeter LALM mattress and to assign Resident 1 closer to the nursing station. The Care Plan did not address Resident 1 ' s inability to communicate his needs or use the call light when needing assistance. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 1 ' s Physician Order dated 11/21/2024 at 9:50 a.m., the order indicated standard treatment of a low air loss mattress with bolsters for wound management. 2. During a review of Resident 1 ' s Rehab Screening Tool dated 11/28/2024 and timed at 1:30 p.m., the Rehab Screening Tool indicated Resident 1 was found lying in the floor and reported left head pain. The Rehab Screening Tool indicated Resident 1 ' s fall was unwitnessed. During a review of Resident 1 ' s Nursing Progress Note dated 11/28/2024, the Nursing Progress Note indicated 911 was called and Resident 1 was transferred to the GACH for evaluation on 11/28/2024 at 4:40 p. m. Resident 1 retuned to the facility on [DATE]. 3. During a review of Resident 1 ' s SBAR Communication Form (SBAR - situation, background, assessment, recommendation- a communication tool used by healthcare workers when there is a change of condition among the residents) dated 12/13/2024 at 3:40 a.m., the SBAR Communication Form indicated Resident 1 had an unwitnessed fall, complained of head pain, and was transferred to a GACH via 911. As of 1/8/2025, Resident 1 has not returned to the facility. During a review of Resident 1 ' s Post Fall Care Plan dated revised 12/2/2024, the Care Plan indicated the goal was to resume usual activities without further incident through the review date of 2/4/2025. The Care Plan ' s interventions included to transfer Resident 1 to the hospital per physician and family request. The Care Plan did not address Resident 1 ' s inability to communicate his needs or use the call light when needing assistance. During an interview on 1/6/2024 at 1:24 p.m., Certified Nursing Assistant (CNA) 1 stated when she was caring for residents who try to get out of bed, she would check on them at least once an hour and inform the supervisor in case the resident needs someone to be with them all the time. CNA 1 stated residents who try to get out of bed usually have a bed alarm. During an interview on 1/6/2024 at 1:32 p.m., CNA 2 stated on 11/28/2024 nurses were asking for help with Resident 1 who had a fall. CNA 2 stated she saw Resident 1 ' s legs on the bed but his body and head was on the floor mat next to his bed. CNA 2 stated she never directly worked with Resident 1 but during report the nurses discussed him shaking a lot. During an interview on 1/6/2024 at 1:55 p.m., CNA 3 stated Resident 1 was not able to use the call light at all and was confused most of the time. CNA 3 stated he was there on 11/28/2024 when Resident 1 fell and believed it was because he slid off the bed since the air mattress was slippery there was no side rails. CNA 3 stated Resident 1 had bed bolsters on both sides but sometimes the bed bolsters would fall on the floor. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/6/2024 at 2:46 p.m., Licensed Vocational Nurse (LVN) 1 stated she had worked with Resident 1 would move a lot to the point where he would be on the edge of the bed so she would have to reposition him. LVN 1 stated Resident 1 was not able to talk. LVN 1 was not working when Resident 1 fell but if he had an unwitnessed fall, she would assess him and call 911 right away because it could be serious such as head or spinal cord injury. LVN 1 stated it is even more serious for Resident 1 if he had fallen because he is on blood thinners which could cause internal bleeding. LVN 1 stated for high risk for falls residents there is no protocol beyond monitoring a resident every two hours, but she would check on the Resident 1 once an hour since he is high risk for falls. LVN 1 stated in report there was a discussion about a nurse trying to reach out to the son to see if he could be more involved by coming to the facility to sit with his dad to prevent him from falling again. During an interview on 1/6/2024 at 3:22 p.m., Registered Nurse (RN) 1 stated for an unwitnessed fall, with suspected head injury and complaints of head pain, she would call 911 right away, especially if the resident was on blood thinners because they could die from a brain bleed. RN 1 stated on 11/28/2024 when Resident 1 fell a second time she walked by Resident 1 ' s room and heard CNA 4 ask for help. RN 1 stated when she went in the room, she saw Resident 1 dangling from the bed with his head in the air not touching the floor. RN 1 stated she and CNA 4 assisted him to the floor and it was an assisted fall without injuries, so they did not call 911 right away. RN 1 stated instead she called the physician after her assessment who later suggested to send Resident 1 to the hospital. RN 1 stated Resident 1 did not have a history of seizures (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness) but he moved in bed a lot, and she thinks he fell from moving in bed. RN 1 stated he had a low air loss mattress which can contribute to falling because it is slippery, and he was not able to push the call light, so they constantly monitored him. RN 1 stated they normally monitor residents every 2 hours but Resident 1 required more frequent monitoring. RN 1 was unable to state a specific time fame of the increased monitoring or how this is ensured. During an interview on 1/7/2024 at 9:35 a.m., CNA 4 stated she recalled the incident on 11/28/2024 when Resident 1 was falling out of bed. CNA 4 stated Resident 1 never actually fell but was hanging off the bed one foot from the floor. CNA 4 stated she called for help and RN 1 and other staff members of unknown name came to assist Resident 1 to the floor. During an interview on 1/7/2025 at 7:45am, CNA 5 stated he was on the night shift when Resident 1 fell (12/13/2024) but was not directly assigned to Resident 1. CNA 5 stated another CNA he did not recall called for help, so he went in the room and saw Resident 1 on the floor with a surprised look on his face. CNA 5 stated they received in report on 12/12/2024 that Resident 1 had fallen before and to keep a closer eye on him. CNA 5 stated when the CNAs were told in report to keep an eye on him that was not accompanied by a specific time frame, but he interpreted that as checking in on your Resident every two hours if they are high risk for falls. CNA 5 stated if a resident requires more monitoring than once every 2 hours, they usually assign a one-to-one sitter, meaning a person stays with the resident the whole shift. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/7/2025 at 10:14 a.m., RN 1 stated since Resident 1 was a high fall risk and fell twice already frequent monitoring would be needed which would mean more than once every 2 hours especially since Resident 1 could not use the call light or ask for help. RN 1 was not able to give me a specific time frame for monitoring. RN 1 stated a bed alarm was never implemented for Resident 1 because it would not be appropriate for an air mattress since the purpose of an air mattress is to protect the skin by reducing pressure. During an interview on 1/8/2025 at 8:30 a.m., the Director of Nursing stated Resident 1 was moved closer to the nursing station on 11/19/2024 after he fell on [DATE] and the order for the Perimeter LALM was not ordered until 11/21/2024 because the IDT had to discuss the plan first. The DON stated there should have been other interventions in the care plan such as monitoring with specific time frames to prevent falls since Resident 1 could not use the call light or ask for help. The DON was not able to give me a specific time frame. During a review of facility ' s policy and procedure (P&P) titled Comprehensive Person-Centered Care Planning dated revised 1/2022, the P&P indicated the interdisciplinary team (IDT) shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet the resident ' s medical, nursing, mental, and psychosocial needs. During a review of facility ' s P&P titled Change in Condition, Response dated revised 1/2022, the P&P indicated if at any time, it is recognized by any one of the team members that the condition or care needs of the resident have changed, the Licensed Nurse or Nurse Supervisor should be made aware (such as a fall) and the IDT shall collaborate with the attending physician, resident and/or resident representative to review risk indicators and plan of care. The P&P further indicated each department notified will perform their own evaluation and assessment to determine if the change requires further interventions and implement actions accordingly, and the nurse will transcribe the treatment and plan of care relative to the change of condition on the resident Electronic Medical Record (EMR).

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47092 Based on interview and record review, the facility failed to document a resident ' s change of condition in the medical record for one of four sampled resident ' s (Resident 1). This deficient practice resulted in inaccurate documentation of the care provided to Resident 1 after he sustained a fall with injury on 11/28/2024. This deficient practice had the potential for non-continuity of Resident 1 ' s care by other health care providers. 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 acute respiratory failure with hypoxia (a serious medical condition that occurs when the body doesn ' t have enough oxygen in its tissues), stage 4 pressure ulcer (Full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) of sacral region (low back), aphasia (a disorder that makes it difficult to speak), and cognitive communication deficit (difficulty communicating due to an underlying issue with cognition). During a review of Resident 1 ' s Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 12/13/2024, the MDS indicated Resident 1 ' s cognition (a problem with a person ' s ability to think, learn, remember, use judgement, and make decisions) was severely impaired. The MDS indicated Resident 1 was bed bound and dependent (helper does all the effort) for all activities of daily living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 1 ' s Rehab Screening Tool dated 11/28/2024 at 1:30 p.m., the Rehab Screening Tool indicated Resident 1 had an unwitnessed fall, found lying in the floor, and reported left head pain. During a review of Resident 1 ' s Nursing Progress Note dated 11/28/2024, the Nursing Progress note indicated 911 was called and Resident 1 was transferred to a General Acute Care Hospital (GACH) for evaluation on 11/28/2024 at 4:40 p.m. During an interview on 1/6/2024 at 3:22 p.m., Registered Nurse (RN) 1 stated on 11/28/2024 when Resident 1 fell a second time she walked by Resident 1 ' s room and heard CNA 4 ask for help. RN 1 stated when she went in the room, she saw Resident 1 dangling from the bed with his head in the air not touching the floor. RN 1 stated she and CNA 4 assisted him to the floor and it was an assisted fall without injuries, so they did not call 911 right away. RN 1 stated instead she called the physician after her assessment who later suggested to send Resident 1 to the hospital. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/7/2024 at 10:28 a.m., RN 1 stated normally after a fall she would document a change of condition note, fall assessment, pain assessment, and if applicable a transfer assessment, which would give in detail the account of the fall but on 11/28/2024 she must have forgotten. RN 1 stated inaccurate documentation could cause confusion between the health care providers and a delay or error in care. During an interview on 1/8/2024 at 8:35 a.m., the Director of Nursing (DON) stated documentation of events such as falls should be an accurate reflection of how they found the resident including what type of fall it was, the nurses ' assessment interventions done, and notification to the physician and physician recommendations to communicate to health care providers for future planning of care. During a review of facility ' s policy and procedure (P&P) titled Change in Condition, Response, dated revised 1/2022, the P&P indicated if at any time, it is recognized by any one of the team members that the condition or care needs of the resident have changed, the nurse will perform and document an assessment, and the nurse will transcribe the treatment and plan of care relative to the change of condition on the resident Electronic Medical Record (EMR).