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	01/17/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44443 Based on interview and record review, the facility failed to notify one of three sampled resident ' s (Resident 1) resident representative (RR) 1 immediately after Resident 1 sustained a fall and was transferred to a General Acute Care Hospital (GACH) for evaluation. This failure resulted Resident 1 ' s RR 1 not being notified of Resident 1 ' s fall and transfer to the GACH until five hours and 25 minutes later. The deficient practice resulted in violation of the RR 1 ' s right to be informed of Resident 1 ' s care and services provided. 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 cerebrovascular insufficiency (a temporary lack of blood flow to the brain), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) affecting left dominant side, abnormalities of gait (a manner of walking on foot) and mobility. During a review of Resident 1 ' s History & Physical (H&P), dated 4/6/2024, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1 ' s Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 10/9/2024, the MDS indicated Resident 1 had severe cognitive impairment and was usually able to understand and be understood by others. The MDS indicated Resident 1 required maximal assistance from staff for sit to lying, lying to sitting on side of bed, sit to stand position, and required partial/ moderate assistance from staff for chair to bed and bed to chair transfers. During a review of Resident 1 ' s Progress Notes, dated 1/9/2025, the Progress Notes indicated, on 1/9/2025 at 3:20 p.m., Resident 1 fell and hit the left side of her head on the floor. The Progress Notes indicated Resident 1 was transferred to a GACH for evaluation. (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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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 1/15/2025 at 2:12 p.m., with RR 1, RR stated RR 2 called the facility on 1/9/2025 around 8 p.m. and was told Resident 1 was not at the facility and was transferred to the GACH. RR 1 stated she and RR 2 were concerned that they were not aware of Resident 1 ' s status and surprised to hear that Resident 1 was not at the facility. RR 1 stated she was upset and frustrated because the facility should have called her immediately after Resident 1 had the fall and was transferred to the GACH on 1/9/2025. During an interview on 1/16/2025, at 4:49 p.m., with Registered Nurse Supervisor (RNS) 1, RNS 1stated, Resident 1 fell on [DATE] around 3:20 p.m., and endorsed to the Charge Nurse (CN) 1 around 3:30 p.m., for CN 1 to notify Resident 1 ' s family of the fall and transfer to the GACH. RNS 1 stated she endorsed to CN 1 to call Resident 1 ' s RRs because she had a lot of charting and tasks to carry out. RNS 1 stated she later found out on 1/9/2025 that Resident 1 ' s RRs were not notified of Resident 1 ' s fall and transfer to the GACH until around 8 p.m. RNS 1 stated Resident 1 ' s RRs should have been notified immediately so they were aware of Resident 1 ' s fall and here whereabouts. During a concurrent interview and record review on 1/17/2025 at 3 p.m., with the Director of Nursing (DON), Resident 1 ' s Progress Notes dated 1/9/2025 and timed at 3:20 p.m. was reviewed. The Progress Notes indicated Resident 1 sustained a witnessed fall and Licensed Vocational Nurse (LVN) 2 notified RR 1 of the fall and transfer to the GACH at 8:45 p.m. (five hours and 25 minutes after the incident occurred). The DON stated, the family/RRs should have been notified immediately so the family was aware, knows what happened, doesn ' t worry, and doesn ' t get upset. The DON stated if the nurse was busy, and CN 1 got too busy to call Resident 1 ' s RRs, then another nurse or the DON should have notified the family immediately of what happened and where the resident was transferred to. During a review of the facility ' s policy and procedure (P&P) titled Change in Condition, Response, dated 1/2022, the P&P indicated, the resident/resident representative will be notified of the change of condition and any changes in the resident ' s medical or nursing care.

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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** 44443 Based on observation, interview and record review, the facility failed to implement its Infection Prevention and Control Program by failing to: 1. Ensure Certified Nurse Assistant (CNA) 4 ' s N95 (a disposable face mask that cover ' s the user ' s nose and mouth which offers protection from small solid or liquid droplets found in the air) was covering her nose. 2. Ensure CNA 4 washed her hands upon exiting Resident 10 ' s room after providing care to Resident 10. These failures placed residents, staff, and the community at higher risk for cross contamination, transmitting infectious microorganisms, and an increased spread of Influenza A (a contagious an infection of the nose, throat and lungs, which are part of the respiratory system) in the facility and community. Findings: During a review of Resident 10 ' s Admission Record (Face Sheet), the Face Sheet indicated Resident 10 was initially admitted on [DATE] and readmitted on [DATE] with diagnoses including type 2 diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing), acute respiratory failure (a serious medical condition that occurs when the lungs are unable to absorb enough oxygen into the blood), and chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing). During a review of Resident 10 ' s Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 10/15/2024, the MDS indicated Resident 10's cognition was intact and was able to understand and be understood by others. During an observation on 1/17/2025, at 5:10 p.m., in Resident 10 ' s room, Certified Nurse Assistant (CNA 4) was observed wearing an N95 mask below her nose while talking to Resident 10 and adjusting his clothing. CNA 4 was then observed walking out of Resident 10 ' s room, did not use hand sanitizer, nor wash her hands after providing care to Resident 10. During an interview on 1/17/2025 at 5:12 p.m. with CNA 4, CNA 4 stated, she had the mask below her nose because it was hard to breathe. CNA 4 stated she should have had the N95 covering both her mouth and nose. CNA 4 stated it is important to wear the N95 face mask appropriately, so germs are not spread to other residents making them sick. CNA 4 stated she forgot to use hand sanitizer and wash her hands upon exiting Resident 10 ' s room. CNA 4 stated hand washing should be done to prevent the spread of germs to other residents which could potentially make them sick. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/17/2025 at 5:15 p.m., with the Infection Preventionist (IP), the IP stated, all staff are supposed to wear the N95 face mask snugly above their nose and covering the mouth. The IP stated the importance of wearing the N95 mask correctly is because it protects staff from contracting and spreading Influenza A throughout the facility, especially during an outbreak. The IP stated all staff must wash their hands with soap and water before and after direct contact with the residents. During a review of the Center for Disease Control (CDC), Sequence for Donning Personal Protective Equipment (PPE), undated, indicated, for the mask or respirator secure ties or elastic bands at middle of head and neck, fit flexible band to nose bridge, fit snug to face and below chin. During a review of the facility ' s policy and procedure (P&P), titled Hand Hygiene, dated 12/2023, the P&P indicated to use an alcohol-based hand rub containing at least 62% alcohol or alternatively soap and water for before and after direct contact with residents .