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	02/05/2026

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1) who had a history of urinary retention (inability to completely empty the bladder of urine), and was exhibiting signs of urinary retention (groin and abdominal pain), requiring indwelling catheter (flexible soft tube inserted in the body to drain urine) insertion was inserted timely by Licensed Vocational Nurse (LVN) 1 when she could not locate the indwelling catheter supply in the facility. This deficient practice resulted in Resident 1 experiencing further pain and discomfort and placed him at risk for bladder injury and infection. Resident 1 was subsequently transferred to a General Acute Care Hospital (GACH) via 911 for treatment. 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 myocardial infarction ([MI] heart attack), type 2 Diabetes Mellitus ([DM] a disorder characterized by difficulty in blood sugar control and poor wound healing) and muscle weakness.During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool), dated 1/10/2026, the MDS indicated Resident 1 had moderate cognitive impairment (ability to think and reason) and was always able to understand and be understood by others.During a review of Resident 1's Order Summary Report (Physician's Orders), dated 2/5/2026, the Order Summary Report indicated discontinue foley catheter (indwelling catheter) and monitor for urinary retention every shift and reinsert indwelling catheter if unable to void (urinate), every shift for three days, ordered on 1/21/2026.During a review of Resident 1's Nursing Notes, dated 1/21/2026 and timed at 9:10 p.m., the Nursing Notes indicated Resident 1's was on monitoring for urinary retention after the indwelling catheter was removed.During a review of Resident 1's Nursing Notes, dated 1/22/2026, the Nursing Notes indicated Resident 1's was unable to urinate and reported feeling pressure and later pain in the groin and abdomen after attempting to urinate several times. The Nursing Note indicated LVN 1 was unable to insert indwelling catheter resulting in Resident 1's transfer to the GACH.During a review of Resident 1's Skilled Nursing Facility (SNF) to Hospital form, dated 1/22/2025, the SNF to Hospital form indicated Resident 1's reported pain in his groin area at level of 9 out of 10 on the numeric pain scale rating of 0 to 10 (where 0 to 3 = mild pain, 4 to 7 = moderate pain, 8 to 10 = severe pain, and 10 = worst pain possible). The SNF to Hospital form indicated Resident 1 was transferred to the GACH on 1/22/2026 at 3:39 a.m. due to abdominal pain.During a telephone interview on 2/5/2026 at 8:17 a.m. with LVN 1, LVN 1 stated she received report that Resident 1's indwelling catheter was removed on 1/21/2026 before 3 p.m. LVN 1 stated that around 12:30 a.m., Resident 1 was attempting to urinate but was unable to and began experiencing increasing groin pain. LVN 1 stated the physician's order required reinsertion of the catheter if Resident 1 could not urinate. LVN 1 stated she was unable to locate catheter supplies to carry out the order, resulting in increased pain for Resident 1. LVN 1 stated she asked her coworker, another staff nurse, (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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for help to locate the catheter but they were unsuccessful in locating them. LVN 1 stated she called the Director of Nursing (DON) for assistance; however, the DON did not provide specific instructions on where to find the supplies. LVN 1 stated she was not oriented on where the facility kept its supplies. LVN 1 stated the delay in inserting the indwelling catheter caused unnecessary pain and placed Resident 1 at risk of bladder injury. LVN 1 stated since she could not find nor insert the indwelling catheter into Resident 1's bladder, she had to call emergency services for transfer to the GACH as she could not provide the necessary care at the facility.During an interview on 1/6/2025 at 8:50 a.m., with the DON, the DON stated on 1/22/2026 at approximately 12:30 a.m., she received a call from LVN 1 regarding Resident 1's severe pain requiring indwelling catheter insertion. The DON stated LVN 1 asked where the catheters were located. The DON stated she could not provide the location because she did not know where the supplies were stored. The DON stated she considered going to the facility to assist her in looking for the supplies but instructed LVN 1 to call 911 due to Resident 1's increased pain and risk of bladder injury. The DON stated the nursing staff is trained to reinsert the indwelling catheters but could not because they did not know where the supplies were. The DON stated she failed to give specific instructions because she was unaware of the supply location and stated she needed to be oriented to the location of facilities supplies. The DON stated it is her responsibility to know supply locations and provide guidance to nurses at all times. The DON stated she later learned that the catheters were stored in a locked nursing supply closet. The DON stated the lack of availability of supplies placed Resident 1 in unnecessary pain and placed Resident 1 at risk for bladder injury and even infection.During a review of the facility's undated 2025-2026 Facility Assessment (detailed evaluation that a skilled nursing facility must perform at least once a year to ensure it has the staff, equipment and resources to meet its residents' care needs), the facility assessment indicated the facility cares for many different residents with various types of care needs. The list below identifies the most common or frequently provided services including.intermittent or indwelling or other urinary catheters.