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	04/08/2026

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Interdisciplinary Team (IDT- team members from different departments working together with a common purpose to set goals and make decisions that ensure residents receive the best care) initiated a care conference meeting for one of two sampled residents (Resident 1) after Resident 1 experienced an alleged manhandling from Certified Nursing Assistant (CNA)1.This failure had the potential to delay addressing Resident 1's care needs which could result in a delay in necessary interventions.Findings:During a review of Resident 1's admission Record, the admission record indicated Resident 1 was initially admitted on [DATE] and was readmitted on [DATE] with diagnoses including hemiplegia and hemiparesis(total paralysis of the arm, leg, and trunk on the same side of the body) following cerebral infarction (lack of adequate blood supply to the brain) affecting right dominant side, diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), anxiety disorder(mental health condition characterized by excessive and persistent fear or worry), and major depressive disorder(mental health condition characterized by persistent, intense feelings of sadness, worthlessness).During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 3/3/2026, the MDS indicated Resident 1 had a moderate cognitive impairment(a person has significant trouble with remembering, learning new information or making sound decisions) and required partial / moderate assistance (helper does less than half the effort) with rolling left and right on the bed, transferring to and from a bed to a chair or wheelchair, toileting hygiene, dressing and personal hygiene.During a review of Resident 1's Progress Notes titled, SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents) dated 3/24/2026 at 6:17 p.m., the SBAR indicated Resident 1 reported to the police CNA 1 mishandled her during patient care. The SBAR indicated Resident 1 stated she was turned from side to side that her hand swung.During a review of Resident 1's Care Plan titled, Risk for Decline in Psychosocial Well Being related to Resident Made Allegation that Staff Mishandled her During Care, initiated 3/24/2026, the Care Plan's goal indicated Resident 1 would be safe and free from harm through review date with a target date of 6/1/2026. The Care Plan's interventions included monitoring for any change in mood or behavior after the allegation, encouraging the resident to express feelings and no male staff to care for the resident.During an interview on 4/8/2026 at 2:19 p.m. with the Social Services Director (SSD), the SSD stated the facility did not conduct an IDT Meeting for the alleged incident of abuse on Resident 1. The SSD stated an IDT Meeting should have been done because it was a change in condition(COC- a sudden, clinically important deviation from a patient's baseline in physical, cognitive (ability to think, understand, learn, and remember) behavioral, or functional status which without immediate intervention),so the facility will find ways in preventing occurrence or incidence of the alleged abuse to Resident 1.During a concurrent interview and record review on 4/8/2026 at 2:51 p.m. with the Director of Nursing (DON), Resident 1's electronic chart was reviewed. The DON stated there was no IDT Meeting conducted addressing the manhandling of Resident 1 during personal care by CNA 1. The DON stated an IDT (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Meeting should have been held so the facility could discuss the incident and plan of care for Resident 1. The DON stated Resident 1's plan of care addressing the incident of the alleged abuse would not be followed if IDT Meeting was not conductedDuring a review of facility's policy and procedure (P&P) titled, Change in Condition, dated 4/2025, the P&P indicated Interdisciplinary Team (IDT) will collaborate with the attending physician, resident, and/or resident representative to review risk indicators and the plan of care.