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	05/05/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the property for one of four sampled residents (Resident 1) was documented correctly on 3/12/2026 during admission to include the contents of her wallet and on 4/5/2026 during discharge, verify a ring documented on admission as left with the resident was still with the resident, and missing property were reported to law enforcement. This deficient practice resulted in Resident 1's Family Member (FM) claiming Resident 1's cash and ring were missing and the facility's inability to determine if Resident 1 had cash in her wallet and if a ring left with Resident 1, per the Inventory List documentation on 3/12/2026, was accounted for on 4/5/2026 during discharge. 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]. Resident 1 had diagnosis including cognitive communication deficit (difficulty in using thinking skills for communication, such as problems with attention, memory, understanding information, organizing thoughts, or expressing ideas clearly) and delirium (a serious disturbance in a person's mental abilities that results in a decreased awareness of one's environment and confused thinking) due to know physiological condition. During a review of Resident 1's History and Physical (H&P) dated 3/12/2026, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 3/16/2026, the MDS indicated Resident 1's cognition was moderately impaired and was dependent on staff to complete her activities of daily living ([ADLs] activities such as bathing, dressing and toileting a person performs daily).During a review of Resident 1's Inventory List dated 3/12/2026, the Inventory List indicated on admission [DATE]) a wallet and jewelry (ring) was documented. During a review of Resident 1's Physician's Orders dated 4/5/2026, the Physician's Orders indicated Resident 1 was to be transferred to a General Acute Care Hospital (GACH) via 911. During a review of Resident 1's Transfer Form dated 4/5/2026, the Transfer Form indicated Resident 1's belongings were not sent with her when she was transferred to the GACH.During a review of Resident 1's Inventory List, dated 4/5/2026 (discharge), the Inventory List indicated one wallet was documented. During an interview on 5/4/2026, at 1 p.m., Certified Nursing Assistant (CNA) 1 stated she documented Resident 1's property when she was admitted to the facility (3/12/2026). Resident 1 had a wallet and a ring; she did not look in the wallet to see the if there was any money or other items. There was a ring that Resident 1 kept with her. CNA 1 did not offer the resident if she can store her ring for her.During an interview on 5/4/2026, at 1:48 p.m., the Social Service Director (SSD) stated. The SSD stated they did not complete a theft/loss report because she assumed Resident 1 had the ring, per the Inventory List documentation on 3/12/2026.During an interview on 5/4/2026, at 2:15 p.m., the Director of Nursing (DON) stated staff should have checked the contents of Resident 1's wallet and they should have checked Resident 1 to see if she had the ring when she was discharged (4/5/2026). During an interview on 5/4/2026, at 2:20 p.m., the Administrator (ADM) stated they had no way of knowing if there was money in Resident 1's wallet because the nurse who documented Resident 1's property on the Inventory List did not look in her wallet. The ADM stated staff should have looked for (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 1's ring when she was discharged (4/5/2026).During a telephone interview on 5/4/2026, at 2:30 p.m., Resident 1's Family Member (FM) 1 stated Resident 1's ring was given to her by her relative. During a follow up interview on 5/4/2026 at 2:45 p.m., the SSD stated she should have looked for the missing ring and when she was not able to find it and should have notified law enforcement. The SSD stated she failed to notify law enforcement about the missing ring because she assumed it was with Resident 1.During a review of the facility's policy and procedure (P&P) titled, Theft and Loss of Personal Property, dated 7/14/2017, the P&P indicated any reported lost or stolen resident property will be investigated, and reported to local law enforcement under section of valuables and cash, indicated residents are advised to not bring any valuable possession in the facility, resident should not keep more than $5.00 in their room, resident can set up a trust fund with business office.