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	05/21/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure an allegation of missing/stolen money was reported to the California Department of Public Health (CDPH) for one of five sampled resident's (Resident 1). This deficient practice resulted in the inability of the CDPH to investigate the allegation of stolen money in a timely manner and had the potential for information pertinent to the investigation to be lost and/or forgotten.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 neuritis (a condition where the nerve or the nerve that surrounds the nerve is inflamed), neuralgia (a sharp, severe and burning pain that results from nerve irritation or damage) and osteomyelitis (infection of the bone) of the right ankle and foot. During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 3/3/2026, the MDS indicated Resident 1 was able to make decisions that were reasonable and consistent and he required a one -person assist to complete his activities of daily living ([ADLs]routine tasks/activities such as bathing, dressing, toileting hygiene, repositioning in bed and transferring from sitting to standing position. During a review of Resident 1's Order Summary (Physician's Order) dated 5/18/2026, the Physician's Order indicated to transfer Resident 1 the GACH for further evaluation because of back pain and per family request. During a telephone interview on 5/20/2026 at 10:32 a.m., Resident 1's Emergency Contact (EC) stated Resident 1 told her he had $300 at the facility but when she picked up Resident 1's belongings from the facility there was only $48.The EC stated Resident 1 told her he reported to a staff person (unknown) at the facility that he was missing money before he was transferred to the General Acute Care Hospital (GACH) because he was worried his money was stolen at the facility. During an interview on 5/20/2026 at 1:37 p.m., Licensed Vocational Nurse (LVN) 1 stated a week before Resident 1 was transferred to the GACH (date unknown) he overheard Resident 1 telling a rehabilitation staff person (unknown) that he (Resident 1) lost $300 at the facility heard the rehabilitation staff person report what Resident 1 said to Registered Nurse Supervisor (RNS) 1. LVN 1 stated he did not report Resident 1's concern to the Administrator (ADM) because the rehabilitation staff person had already reported it to RNS 1. During a telephone interview on 5/20/2026 at 2:24 p.m., RNS 1 stated she was unaware that Resident 1 was missing money and no one reported it to her. During an interview on 5/21/2026 at 11:43 a.m., the ADM stated LVN 1 should have immediately reported Resident 1's allegation of missing and/or stolen money to him so he could file a report with the local government agencies including the CDPH and so he could conduct an investigation The ADM stated reporting to the CDPH was necessary to ensure they were implementing the facility's policies and procedures on abuse prevention and resident rights and they were compliant with the state and federal regulations. During a review of the facility's Policy and Procedure (P/P) titled, Abuse: Prevention and Prohibition Against revised 12/2023, the P/P indicated the facility shall ensure the residents of the facility are free from abuse, neglect, misappropriation of resident property, exploitation and mistreatment. The facility staff with knowledge of an actual or potential violation of this policy must report the violation to his/her supervisor and/or the facility administrator (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	immediately and such allegations of abuse, neglect and misappropriation of property be reported to the appropriate State and Federal Agencies in the applicable timeframe.

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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 - Few	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** The facility failed to ensure a care plan was created for one of five sampled residents (Resident 1), who was at risk for constipation (a common condition where bowel movements become difficult, infrequent) due to opioid use (a drug used to reduce moderate to severe pain). This deficient practice resulted in Resident 1's transfer to a General Acute Care Hospital (GACH) for evaluation and treatment due to back pain where he was assessed with constipation. This deficient practice had the potential for Resident 1 to become impacted (a mass of dry, hard stool that cannot be eliminated by a normal bowel movement).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 neuritis (a condition where the nerve or the nerve that surrounds the nerve is inflamed), neuralgia (a sharp, severe and burning pain that results from nerve irritation or damage) and osteomyelitis (infection of the bone) of the right ankle and foot. During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 3/3/2026, the MDS indicated Resident 1 was able to make decisions that were reasonable and consistent and he required a one -person assist to complete his activities of daily living ([ADLs]routine tasks/activities such as bathing, dressing, toileting hygiene, repositioning in bed and transferring from sitting to standing position. During a review of Resident 1's Physician's Order dated 4/27/2026, the Physician's Order indicated Resident 1 was prescribed Tramadol (an opioid medicine used to treat moderate to severe pain) 50 milligrams ([mg] metric unit of measurement, used for medication dosage and/or amount) every six hours as needed for a severe pain level of 7 out of 10 (an 11 eleven point scale where pain is rated from zero to 10; 0=no pain, 1-3=mild pain, 4-6=moderate pain, and 7-10=severe pain, and 10=worst imaginable pain). During a review of Resident 1's Care Plan on use of opioids dated 4/27/2026, the Care Plan indicated Resident 1 would be free from adverse reactions, pain and discomfort related to opioid use with interventions to monitor Resident 1 for adverse reactions associated with the use of opioids such as drowsiness, dizziness, nausea and vomiting, respiratory depression (a potentially life-threatening condition where breathing becomes abnormally show. shallow, or ineffective) and constipation. During a review of Resident 1's clinical record, there was no indication that a Care Plan was developed to address the potential for Resident 1 to become constipated as a result of his opioid use until Resident 1 was transferred to a GACH (5/18/2026). During a telephone interview on 5/20/2026 and timed at 10:32 a.m., Resident 1's Emergency Contact (EC) stated she decided to take Resident 1 to a General Acute Care Hospital (GACH) to be evaluated due to back pain. The GACH found he had a Urinary Tract Infection ([UTI] an infection in any part of the urinary tract system) and was constipated. During an interview on 5/21/2026 and timed at 1:41 p.m., the Director of Nursing (DON) stated Resident 1's Care Plan should have been created in a timely manner to address Resident 1's risk of constipation. During a review of the facility's Policy and Procedures (P/P) titled, Comprehensive Person-Centered Care Planning revised 12/2023, the P/P indicated the facility shall develop a comprehensive person-centered plan of care for each resident necessary to properly care for each resident and instructions needed to provide effective and person-centered care that meet professional standards of quality care.