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	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgewater Skilled Nursing Center	2625 East Fourth Street Long Beach, CA 90814

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50144 Based on interview, and record review, the facility failed to ensure the assessment entries on the Minimum Data Set (MDS - a resident assessment tool) related to discharge status was accurately documented to reflect that the resident was discharged home for one of three residents (Resident 78). This deficient practice had the potential to negatively affect Resident 78's plan of care and delivery of necessary care and services. Findings: During a review of Resident 78's Admission Record, dated 12/12/2024, the Admission Record indicated Resident 78 was admitted to the facility on [DATE] with diagnoses including respiratory failure and chronic kidney disease (gradual failing of the kidneys). The face sheet indicated Resident 78 was discharged on [DATE] to a board and care/assisted living/group home. During a review of Resident 78's MDS, the MDS indicated Resident 78 had moderate cognitive (ability to think and reason) impairment and required maximal assistance (helper does more than half the effort) for eating, hygiene, and position changes. During a review of Resident 78's Discharge Summary and Post-Discharge Plan of Care, dated 9/13/2024, the Discharge Summary and Post-Discharge Plan of Care indicated Resident 78 was discharge to Assisted Living/Board and Care on 9/13/2024 with arranged hospice (compassionate care for people who are near the end of life provided at the person's home or within a health care facility) services. During a concurrent interview and record review on 12/10/2024 at 2:45 p.m. with the Minimum Data Set (MDS - a resident assessment tool) Nurse (MDSN), Resident 78's MDS dated [DATE] was reviewed. The MDS indicated Resident 78 had a planned discharge to a Short-Term General Hospital on 9/13/2024. The MDSN stated the MDS was incorrect, and the MDS should have reflected that Resident 78 was discharged to an assisted living facility with hospice care. The MDSN stated the facility would correct that entry. During an interview on 12/12/2024 at 4:29 p.m., with the Director of Nursing (DON), the DON stated it was important for the MDS to be accurate in order to provide care according to the resident status and current needs. (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P), titled Resident Assessment Instrument, last revised 10/1/2019, the P&P indicated the assessment must accurately reflect the resident's status and needs.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46415 Based on interview and record review, the facility failed to ensure two of three sampled residents (Residents 5 and Resident 37) preadmission screening and resident review (PASRR) screening was reassessed to determine the facility's ability to provide care for the special needs of the residents. This deficient practice placed the residents at risk of not receiving necessary care and services. a. During a review of Resident 5's Admission Record, the Admission Record indicated the facility initially admitted Resident 4 to the facility on [DATE] and readmitted on [DATE] with diagnoses including unspecified dementia (progressive state of decline in mental abilities), mood disturbance (mental health condition that affects your emotional state), anxiety, and psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality). During a review of Resident 5's History and Physical (H&P) dated 10/12/2024, the H&P indicated Resident 5 did not have the capacity to understand and make decisions. During a review of Resident 5's Minimum Data Set (MDS a resident screening tool), dated 11/8/2024, the MDS indicated Resident 5's cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills were moderately impaired. The MDS indicated Resident 5 was dependent for toilet and personal hygiene, upper and lower body dressing, required maximal (assisting more than half the effort) assistance for sit to stand, chair/bed to chair transfer, and oral hygiene. The MDS indicated Resident 5 utilized a wheelchair and walker for mobility and had impairments on both arms, shoulders. During a review of the PASRR Level I screening dated 10/24/2024, the PASRR Level I screening indicated Resident 5 required a Level II screening due to having serious mental illness (SMI). The PASRR Level 1 screening indicated on 10/24/2024, there was a notice of attempted evaluation to complete a Level II evaluation for SM for Resident 5, however due to the facility staff being unresponsive to two or more separate attempts of communication within 48 hours of the Level I screening, the Level II screening was not completed. During a concurrent interview and record review on 12/11/2024 at 4:02 p.m., with the Director of Nursing (DON), Resident 5's PASRR was reviewed. The DON stated PASRR was a part of the admission documents, reviewed by licensed staff. The DON stated the notice regarding Resident 5's uncompleted Level II PASRR indicated Resident 5 did need a Level II screening The DON stated the facility should have resubmitted the Level I screening to ensure Resident 5 would receive the appropriate care based on her condition. The DON stated without a proper assessment, the facility will not know whether they are providing the proper service for the resident. b. During a review of Resident 37's Admission Record, the Admission Record indicated Resident 37 was admitted to the facility on [DATE] with diagnoses including major depressive disorder (MDD: serious mood disorder that causes persistent feeling of sadness and loss of interest), Type II Diabetes (disorder characterized by difficulty in blood sugar control), and hypertension (high blood pressure). (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 37's H&P dated 10/31/2024, the H&P indicated Resident 37 had a history of bipolar disorder and was capable of making decisions for himself. During a review of Resident 37's MDS, dated [DATE], the MDS indicated Resident 37's cognitive skills were intact. The MDS indicated Resident 37 was dependent for lower body dressing, required maximal assistance for bathing, toileting hygiene, sit to lying, rolling left to right, and required moderate assistance for personal and oral hygiene. The MDS indicated Resident 37 utilized a wheelchair for mobility and had an impairment on one side of the lower extremities (hip, legs). During a review of Resident 37's PASRR Level I screening dated 11/8/2024, the PASRR Level I screening the section indicated Resident 37 did not have a SMI. During a concurrent interview and record review on 12/12/2024 at 4:40 p.m., with the DON, Resident 37's PASRR Level 1 document was reviewed. The DON stated the PASRR indicated a Resident 37 did not have an SMI and a Level II screening was not indicated. The DON stated Resident 37 had a diagnosis of depression and the PASRR did not reflect his diagnosis. The DON stated Resident 37's PASRR should have been corrected and resubmitted. During a review of the facility's policy and procedure (P&P), titled PASRR, dated 12/2021, the P&P indicated it is the policy of this facility to ensure that each resident is properly screened using the PASRR specified by the State. Based upon the assessment, the facility will ensure proper referral to appropriate state agencies for the provision of specialized services to residents with ID/RC (Intellectual Disability or Related Condition) or SMI (Serious Mental Illness).

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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. 50387 Based on observation, interview, and record review, the facility failed to develop a trauma (a deeply distressing or disturbing event that overwhelms a person's ability to cope, causing significant and lasting negative consequences) informed care plan for one of one residents (Resident 52), who reported difficulty sleeping related to previous trauma. This failure had the potential to compromise Resident 52's emotional well-being and increas the risk of re-traumatization. Findings: During a review of Resident 52's Admission Record, the Admission Record indicated the facility admitted Resident 52 on 10/10/2023 with diagnoses including major depressive disorder (a mental health condition that can cause severe feelings of sadness, hopelessness, and a loss of interest in activities), and anxiety disorder (a condition that causes excessive and persistent feelings of fear, worry, dread, and uneasiness.) During a review of Resident 52's Minimum Data Set (MDS-a resident assessment tool), dated 10/11/2024, the MDS indicated Resident 52 was cognitively (the ability to think and process information) intact. The MDS indicated Resident 52 had symptoms of feeling down, depressed, or hopeless, up to once a day. During a review of Resident 52's History and physical (H&P), dated 11/3/2024, the H&P indicated Resident 52 had a history of alcohol abuse (excessive consumption of alcohol that may lead to negative consequences). During a review of Resident 52's Social Services Assessment/Evaluations dated 1/17/2024 and 9/20/2024, the Social Services Assessment/Evaluations indicated Resident 52 had verbalized being raped at 9 years old, and later on being in the a war. The Social Services Assessment/Evaluations indicated Resident 52 verbalized his wife had committed suicide. During an interview on 12/11/2024 at 1:28 p.m., Resident 52, stated that he couldn't sleep well related to the previous trauma and the facility provided the resident with medications, which help him a little to sleep at night but not significantly. The resident stated, he experienced triggers (something that causes a person to involuntarily recall a previous traumatic experience), although not specific ones. Resident 52 stated that these triggers tend to occur around certain people. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review Resident 52's care plan on 12/11/2024 at 3:20 p.m. with Registered Nurse (RN) 1,. RN 1 stated that she was not aware of Resident 52's trauma, and that there was no care plan or documentation addressing his trauma. RN 1 stated that if a resident was identified or screened as having experienced trauma, the goal is to minimize triggers or discomfort related to the resident's trauma, and residents with trauma could be triggered by various factors, depending on the nature of the trauma. RN 1 stated that when a traumatized resident is identified, the process involves notifying Social Services and the interdisciplinary team (IDT the resident's healthcare team consisting of various specialties) to initiate a trauma informed care plan. RN 1 stated the care plan interventions and goals are discussed during the huddle (short stand-up staff meeting) the staff is made aware to ensure appropriate care measures are in place. During an interview on 12/11/2024 at 4:57 p.m., with the Social Service Director (SSD), the SSD stated that he mentioned Resident 52's trauma assessment during the IDT meetings. During a concurrent interview and record review on 12/12/2024 at 10:10 a.m. with the DON, Resident 52's Social Services Assessment/Evaluations dated 1/17/2024 and 9/20/2024 were reviewed. The DON stated that Resident 52's trauma was screened on 1/17/2024 and 9/20/2024 by Social Services. The DON stated that the facility should have developed an individualized care plan for Resident 52's history of trauma. The DON emphasized the importance of creating an individualized care plan, stating that it addresses the resident's specific issues and helps prevent potential triggers that could retraumatize the resident. During a review of the facility's policy and procedure (P&P) titled, Comprehensive Person-Centered Care Planning, revised 12/2023, Indicated the IDT will develop and implement a comprehensive person-centered, and trauma-informed care plan for each resident and will include resident's needs identified in the comprehensive assessment, any specialized services. During a review of the facility's P&P title, Behavioral Health Services, revised 4/2019 indicated the plan of care will include non-pharmacological interventions and individualized, person-centered care approaches as well as trauma-informed approaches in accordance with resident's customary routines, with input from the resident.

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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** 50144 Based on interview and record review, the facility failed to review and revise care plans when medication regimens were updated for one of three sampled residents (Resident 15). This failure had the potential to result in not accurately addressing Resident 15's psychosocial care. Findings: During a review of Resident 15's Admission Record, the Admission Record indicated the facility initially admited Resident 8 on 2/22/2020 and readmitted on [DATE] with diagnoses including anxiety disorder (persistent and excessive worry that interferes with daily activities) and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 15's History and Physical (H&P) dated 6/4/2023, the H&P indicated Resident 15 had the capacity to understand and make decisions. During a review of Resident 15's order summary report as of 12/12/2024, the order summary report indicated: a. Mirtazapine tablet 7.5 MG, give 1 tablet by mouth at bedtime for poor meal intake, starting on 5/14/2024. b. Trazadone HCl oral tablet 100 MG, give 100 MG by mouth at bedtime for inability to sleep, starting on 9/17/2024. During a concurrent interview and record review on 12/12/2024 at 1:18 p.m., with Licensed Vocational Nurse (LVN) 1, Resident 15's order summary dated 12/12/2024 and care plans were reviewed. The order summary indicated to monitor side effects of Lexapro (medication used to treat anxiety and depression), starting 10/3/2023. Resident 15's care plans did not include monitoring for Mirtazapine and Trazadone. LVN 1 stated this care plan should have been updated. During a concurrent interview and record review on 12/12/2024 at 4:29 p.m., with the Director of Nursing, Resident 78's order summary and care plans were reviewed. The DON stated orders and care plans should be reviewed and revised so that it accurately reflects the resident's status and what the resident has ordered. During a review of the facility's policy and procedure (P&P), titled Psychotropic Medications, last revised February 2024, The P&P indicated new physician's orders for psychotropic medications will be communicated to the Social Services department for review with the Interdisciplinary Team (IDT) and appropriate are planning will be done to ensure updated information in the resident's psychosocial care plan.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46415 Based on interview and record review, the facility failed to ensure one of five sampled residents (Resident 2) received her last dose of antibiotic per physican's order. This deficient practice could have potentially prolonged Resident 2's infection. Findings: During a review of Resident 2's Admission record, the Admission Record indicated the facility initially admitted Resident 2 on 9/3/2024 and readmitted on [DATE] with diagnoses including atherosclerosis (chronic inflammatory disease of the arteries) of right leg with ulceration (a small open sore or wound generally found in the stomach or on the skin) of thigh, peripheral venous (damaged or blocked veins that affect blood flow) insufficiency, and heart failure (a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling). During a review of Resident 2's Minimum Data Set [(MDS- a resident assessment tool], dated 9/14/2024, the MDS indicated Resident 2's cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills were intact. The MDS indicated Resident 2 required maximal (assisting more than half the effort) assistance for shower transfer, rolling left and right, and required supervision for chair/bed to chair transfer, personal, toilet, and oral hygiene, and dressing the upper (arms, shoulders) and lower (hip, legs) body. During a review of the Order Summary Report (Physician Orders) for 11/2024, the Order Summary Report indicated Resident 2 had an order for Clindamycin (medication to treat a wide range of bacterial infections) Hydrochloride (HCL: salt used in medication) oral capsule 300miligram (mg: unit of measure of mass): give 300 mg by mouth four times a day for cellulitis (a skin infection that causes swelling and redness) of right leg for seven days that started 11/9/2024 with an end date of 11/16/2024. During a review of the Medication Administration Record (MAR) for 12/2024, the MAR indicated Resident 2 did not receive her 5:00 p.m. and 9:00 p.m. doeses for 11/25/2024. The MAR indicated the order was discontinued on 11/15/2024 at 10:03p.m. During a concurrent interview and record review on 12/12/2024 at 5:18 p.m., with the Director of Nursing (DON), Resident 2's MAR dated 11/15/2024 and Progress Notes dated 11/15/2024 were reviewed. The DON stated according to the progress note Resident 2 came back on 11/15/2024 at 6:00p.m. and the MAR indicated Resident 2 did not receive any antibiotics for the 5:00p.m. and the 9:00p.m. doses. DON stated Resident 2 should have taken the last antibiotic at 9:00p.m. as the medication was discontinued at 10:03p.m. The DON stated Resident 2 not receiving her last dose of antibiotic indicated she did not complete her antibiotics and if the antibiotics were not completed, the infection may not be resolved. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P), titled Medication Administration: Administration of Drugs, revised 5/2007, the P&P indicated it is the policy of this facility that medications shall be administered as prescribed by the attention physician. Medications must be administered in accordance with the written orders of the attending physician. Unless otherwise specified by the resident's attending physician, routine medications should be administered as scheduled. During a review of the facility's policy and procedure (P&P), titled Resident Assessment: Physician Orders-CA, revised 5/2007, the P&P indicated drugs and biologicals that are required to be refilled must be reordered from the issuing pharmacy not less than three (3) days prior to the last dosage being administered to assure that refills are on hand.

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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. 50387 Based on observation, interview, and record review, the facility failed to implement infection control practices during indwelling urethral catheter (Foley catheter-a thin tube that is inserted into your bladder through the urethra-the tube you pee through and left there to continuously drain your urine into a collection bag) care for one of one sampled resident (Resident 1) by: a. Failing to perform hand hygiene before and after Foley catheter care. b. Failing to ensure and the resident's urine bag was kept off the floor. This deficient practice had the potential for urinary tract infection (UTI- condition that affect the urinary tract and can cause urine to flow abnormally) recurrence. Findings. During a review of Resident 1's Admission Record, the Admission Record indicated the facility admitted Resident 1 on 8/15/2016, and readmitted him on 2/14/2024 with diagnoses including infection and inflammatory reaction (the body reacting negativly to an inserted foreign object) due to indwelling urethral catheter, calculus of kidney (a solid mass of minerals and salts that forms in the kidney), neuromuscular dysfunction of bladder (a condition that occurs when the nerves and muscles that control the bladder do not work together properly), and encounter for fitting and adjustment of urinary device. During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool), dated 11/29/2024, the MDS indicated Resident 1's cognitive (the ability to think and process information) skills for daily decision making were severely impaired. During a review of Resident 1's History and physical(H&P) from a General Acute Care Hospital (GACH), dated 1/30/2024, the H&P indicated Resident 1 had penile (relating to the penis) edema (swelling, or fluid buildup in the body's tissues) with scrotal (a part of external male genitalia located at the base of the penis) erythema (reddening of the skin, or a skin rash, caused by inflammation). Resident 1 was diagnosed with sepsis (a life-threatening medical emergency that occurs when the body had an extreme response to an infection) and Acute kidney injury (AKI-sudden decline in kidney function that can occur within a few hours or days). During a review of Resident 1's Order Summary Report, active orders as of 12/12/2024, the Order Summary Report indicated an order on 12/9/2024 to provide enhanced barrier precautions (EBP a set of infection control measures used to reduce the spread of multidrug-resistant organisms [infectious organisms that are resistant to antibiotics]) including the use of personal protective equipment (PPE equipment worn to minimize exposure to hazards that cause injuries and illnesses) for high resident contact care activities related to indwelling (remaining within) catheter, to be implemented every shift. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's Care Plan for atitled Risk for infection, revised on 8/18/2024, the Care Plan indicated Resident 1 was at risk for infection related to an Indwelling device. The care plan goal indicated to reduce the risk of transmission of a pathogen (any organism that causes disease). The care plan interventions included educating caregivers regarding the importance of handwashing, EBP: PPE required for high resident contact care activities related to indwelling catheter. During a review of Facility Census, dated December 11/24/2024 indicated that Resident 1 shared the room with 2 other residents. During a concurrent observation and interview on 12/9/2024 at 1:08 p.m., with Certified Nursing Assistant (CNA) 2 in Resident 1's room. Resident 1's urine bag was observed touching floor, the urine bag was covered by a dignity bag. CNA 2 stated, that covering the urine bag with a dignity bag that touched the floor. During a concurrent and observation interview on 12/11/2024 at 8:09 a.m., with CNA 1 in Resident 1's room, an EBP sign was observed on Resident 1's door and on the wall near the head of Resident 1's bed. Observation details: a. Initial Entry: CNA 1 entered the room, touched Resident 1's blanket, and adjusted the bed without performing hand hygiene and wearing gloves. b. Supplies Handling: CNA 1 brought care supplies into the room placed them on the bedside table, touched bed, moved it to create space between the wall and the bed, and left the room without performing hand hygiene before and after. c. Foley Catheter Care: CNA 1 returned with a basin and towels, wore gloves and a gown without performing hand hygiene, cleansed the Foley insertion site and scrotal area with a wet towel, and changed the bottom sheet. CNA 1 then covered Resident 1 with a new blanket, and lowered the bed. d. Restroom Activities: CNA 1 discarded water from the basin in the restroom sink while wearing the same gloves used during Foley catheter care. CNA 1 then grabbed two discarded plastic bags used for linen, tied knots in the bags, opened the door with the same gloves on, and left the room carrying the plastic bags. CNA 1 stated that he did not perform hand hygiene, and put on PPE before and after providing care to Resident 1. CNA 1 stated that these actions could lead to the spread of infection. During a concurrent observation and interview on 12/12/2024 at 10:10 a.m., with the Director of Nursing (DON), the DON stated that the urine bag should not touch the floor, even when placed in a dignity bag. The DON stated it as imprtant to practice p hand hygiene as a standard practice before and after providing care and wearing a gown and mask as part of EBP protocols. The DON acknowledged that failure to follow these practices could result in infection or contamination to the Resident 1. During a review of the facility's policy and procedure (P&P) titled, Infection Control Policy/ Procedure, revised 2013, indicated that staff to wash hands put on gloves on before catheter care and remove gloves and wash hands after the care. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Hand Hygiene, revised 12/2023, indicated that it is the facility's responsibility to oversee and ensure healthcare workers perform hand hygiene, one of the most effective measures to prevent the spread of infection, based on accepted standards. The P&P indicated that Hand hygiene is a general term that applies to hands washing, antiseptic hand wash, and alcohol-based hand rub. The P/P indicated that healthcare workers to perform hand hygiene before and after direct contact with residents, after contact with a resident's intact skin, after contact with objects (e.g., medical equipment), after removing gloves, before and after assisting a resident, and after removing and disposing of personal protective equipment. During a review of the P&P titled, IPCP Standard and Transmission-Based Precautions, revised 3/2024, the P&P indicated that Standard Precautions are infection prevention practices applied to the care of all residents. These include Hand hygiene, EBP: used alongside standard precautions and EBP expands the use of PPE including gowns and gloves, during high-contact resident care activities. The P&P indicated that these practices reduce the risk of indirect transfer of multidrug-resistant organisms (MDROs) to staff hands and clothing, and subsequently to other residents, and also indicated that use of gowns and gloves for high-contact resident care activities is required for residents with indwelling medical devices, such as urinary catheters, to prevent the acquisition and colonization of MDROs.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50387 Based on observation, interview, and record review, the facility failed to develop a trauma informed care plan for one of one resident (Resident 52), who reported difficulty sleeping related to previous trauma. This failure has the potential to compromise Resident 52's emotional well-being and increased the risk of re-traumatization. Findings: During a review of Resident 52's Admission Record, the Admission Record indicated the facility admitted Resident 52 on 10/10/2023 with diagnoses including major depressive disorder (a mental health condition that can cause severe feelings of sadness, hopelessness, and a loss of interest in activities), and anxiety disorder (a condition that causes excessive and persistent feelings of fear, worry, dread, and uneasiness.) During a review of Resident 52's Minimum Data Set (MDS-a resident assessment tool), dated 10/11/2024, the MDS indicated Resident 52 was cognitively (the ability to think and process information) intact, had symptom of feeling down, depressed, or hopeless, never, or once a day. During a review of Resident 52's History and physical (H&P), dated 11/3/2024, the H&P indicated Resident 52 had ethyl alcohol (EtOH) abuse (The excessive consumption of alcohol that led to negative consequences). During a review of Resident 52's Social Services Assessment/Evaluation dated 1/17/2024 and 9/20/2024 indicated Resident 52 had trauma and verbalized that the resident was raped at 9 years old, being in the [NAME] war, and having his wife commit suicide. During an interview on 12/11/2024 at 1:28 p.m. with Resident 52, the resident stated that he couldn't sleep well related to the previous trauma and the facility provided the resident with medications, which help him a little to sleep at night but not significantly. The resident stated, he experienced triggers, although not specific ones, and noted that these triggers tend to occur around certain people related to the previous trauma. During an interview on 12/11/2024 at 1:45 p.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated that she was not specifically aware of any trauma residents including Resident 52. LVN 2 stated that she monitored the resident's behavior because it populated as a task on her job assignments in the computer system and the behavior monitoring is the only aspect of care she checked for the resident and that there were no specific trauma-related tasks assigned. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review Resident 52's care plan on 12/11/2024 at 3:20 p.m. with Registered Nurse (RN) 1,. RN 1 stated that she was not aware of Resident 52's trauma, and that there was no care plan or documentation addressing his trauma. RN 1 stated that if a resident was identified or screened as having experienced trauma, the goal is to minimize triggers or discomfort related to the resident's trauma, and the residents with trauma could be triggered by various factors, depending on the nature of trauma. RN 1 stated that when a traumatized resident is identified, the process involves notifying Social Services and the interdisciplinary team (IDT). The supervisor is informed, and during the huddle, the staff is communicated with to ensure appropriate care measures are in place. During an interview on 12/11/2024 at 4:57 p.m. with Social Service Director (SSD), the SSD stated that he mentioned Resident 52's trauma assessment during the IDT meetings. During a concurrent interview and record review on 12/12/2024 at 10:10 a.m. with the DON, of Resident 52's Social Services Assessment/Evaluation dated 1/17/2024 and 9/20/2024. The DON acknowledged that Resident 52's trauma was screened on 1/17/2024 and 9/20/2024 by Social Services. The DON stated that an individualized care plan should have developed for the resident following the screening. The DON emphasized the importance of creating an individualized care plan, stating that it addresses the resident's specific issues and helps prevent potential triggers that could retraumatize the resident. During a review of the facility's policy and procedure (P&P) titled, Comprehensive Person-Centered Care Planning, revised 12/2023, Indicated the IDT will develop and implement a comprehensive person-centered, and trauma-informed care plan for each resident and will include resident's needs identified in the comprehensive assessment, any specialized services. During a review of the facility's P&P title, Behavioral Health Services, revised 4/2019 indicated the plan of care will include non-pharmacological interventions and individualized, person-centered care approaches as well as trauma-informed approaches in accordance with resident's customary routines, with input from the resident.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46415 Based on observation and interview, the facility failed to ensure one of three sampled residents (Resident 36) had the required Insulin Glargine Solution (medication that controls the amount of sugar in the blood) on hand to be administered. This deficient practice resulted in Resident 37 not getting the insulin on time. During a review of Resident 36's Admission record, the Admission Record indicated Resident 36 was admitted to the facility on [DATE] with diagnoses including Type II Diabetes Mellitus (DM: a disorder characterized by difficulty in blood sugar control and poor wound healing), hypertension (high blood pressure), and long-term use of insulin (hormone that regulates blood sugar levels). During a review of Resident 36's History and Physical (H&P) dated 1/14/2024, the H&P indicated Resident 36 has the capacity to understand and make decisions. During a review of Resident 36's Minimum Data Set [(MDS) a resident screening tool], dated 10/14/2024, the MDS indicated Resident 36's cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills were mildly impaired. The MDS indicated Resident 36 was dependent for chair/bed to chair transfer, personal hygiene, required maximal (assisting more than half the effort) assistance for bathing, and toileting hygiene, and required set up for oral hygiene and eating. During a review of the Order Summary Report (Physician Order), the order indicated Resident 36 had an active order for Insulin Glargine Solution 100 unit (amount of substance)/milliliter (mL: unit of fluid volume) inject 34 units subcutaneously (layer of tissue under the skin) one time a day for diabetes dated 1/11/2024. During an observation and interview on 12/11/2024 at 10:27 a.m., with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated Resident 36's Insulin glargine was not available. LVN 1 stated she would follow up with the pharmacy. LVN 1 stated the medication needs to be readily available as the resident could be in distress if the medication is not available. During a review of the facility's policy and procedure (P&P), titled Medication Administration: Administration of Drugs, revised 5/2007, the P&P indicated it is the policy of this facility that medications shall be administered as prescribed by the attention physician. Medications must be administered in accordance with the written orders of the attending physician. Unless otherwise specified by the resident's attending physician, routine medications should be administered as scheduled. During a review of the facility's policy and procedure (P&P), titled Resident Assessment: Physician Orders-CA, revised 5/2007, the P&P indicated drugs and biologicals that are required to be refilled must be reordered from the issuing pharmacy not less than three (3) days prior to the last dosage being administered to assure that refills are on hand.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46415 50144 Based on observation, interview, and record review, the facility failed to ensure three of four residents (Resident 8, 15, and 37) were free of unnecessary medications by failing to: 1.Ensure informed consents for the use of psychotropic medication were obtained for Resident 8 and Resident 15. 2. Ensure informed consents were obtained prior to the use of Trazadone Hydrochloride (HCL: salt used in medication) medication used to treat depression and or anxiety)150 milligram (mg: unit of meaure of mass) and Quetiapine Fumarate (brand name Seroquel) medication used to treat schizophrenia (a mental illness that is characterized by disturbances in thought), depression, and bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs) 100mg for Resident 37. 3. Ensure the indication for Quetiapine Fumarate 100mg was clarified prior to administration for Resident 37. Findings: a. During a review of Resident 8's Admission Record, the Admission Record indicated Resident 8 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Dementia (a progressive state of decline in mental abilities), Anxiety Disorder (persistent and excessive worry that interferes with daily activities), and Major Depressive Disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 8's History and Physical (H&P), dated 5/26/2023, the H&P indicated Resident 8 did not have the capacity to understand and make decisions. During a review of Resident 8's Order Summary Report as of 12/12/2024, the Order Summary Report indicated: i. Ativan oral tablet 0.5 milligrams (mg), give 1 tablet by mouth every 24 hours as needed for anxiety manifested by (m/b) expressing excessive worries about certain situations, starting on 7/16/2024. ii. Duloxetine HCl capsule delayed release particles 20 mg, give 1 capsule by mouth one time a day for depression m/b verbalization of feeling sad, starting on 7/17/2024. iii. Risperidone oral tablet 0.5 mg, give 0.5 mg by mouth at bedtime for visual hallucinations m/b verbalization of seeing things not present, starting on 5/21/2024. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 8's Medication Administration Record (MAR) for November 2024 and December 2024, MAR indicated: i. Ativan 0.5 MG tablet was administered one time from 11/1/2024 to 12/12/2024. ii. Duloxetine HCl 20 MG capsule was administered every day from 11/1/2024 to 12/12/2024. iii. Risperidone 0.5 MG tablet was administered every night from 11/1/2024 to 12/12/2024. b. During a review of Resident 15's Admission Record, the Admission Record indicated Resident 8 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Anxiety Disorder (persistent and excessive worry that interferes with daily activities) and Major Depressive Disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 15's H&P, dated 6/4/2023, the H&P indicated Resident 15 had the capacity to understand and make decisions. During a review of Resident 15's Order Summary Report as of 12/12/2024, the Order Summary Report indicated Mirtazapine tablet 7.5 mg, give 1 tablet by mouth at bedtime for poor meal intake, starting on 5/14/2024. During a review of Resident 15's MAR for December 2024, the MAR indicated Mirtazapine 7.5 mg tablet was administered every night 12/1/2024-12/12/2024. During a concurrent interview and record on 12/12/2024 at 4:29 p.m. with the Director of Nursing (DON)Resident 8 and Resident 15's Informed Consents were reviewed. The informed consents indicated the following: i. Resident 8's Informed Consent for Ativan 0.5 mg, 1 tablet every 24 hours as needed m/b sudden angry outburst with no valid reason. Consent obtained from Resident 8's representative on 5/13/2022. ii. Resident 8's Informed Consent for Duloxetine HCl 30 MG m/b verbalization of being sad. Consent obtained from Resident 8's representative on 3/21/2022. iii. Resident 8's Informed Consent for Risperidone 0.5 mg, give 0.5 mg by mouth at bedtime for visual hallucinations m/b verbalization of seeing things not present. Consent obtained from Resident 8's representative on 5/21/2024. iv. Resident 15's Informed Consent for Remeron (Brand name for Mirtazapine) 7.5 mg nightly for depression m/b poor sleep. Consent obtained from Resident 15 on 12/20/2023. The DON stated psychotropic (medications affecting how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior) medication cannot be administered without a consent. The DON stated informed consents for psychotropic medication are valid for six months, and Resident 8 and Resident 15's consents should have been reobtained from the resident and/or resident's responsible party every 6 months. The DON stated informed consents are important so the resident and/or responsible party is aware of the indication, risk, and right to refuse the medication. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. During a review of Resident 37's Admission Record, the Admission Record indicated Resident 37 was admitted to the facility on [DATE] with diagnoses including major depressive disorder (MDD: serious mood disorder that causes persistent feeling of sadness and loss of interest), Type II Diabetes (disorder characterized by difficulty in blood sugar control), and hypertension (high blood pressure). During a review of Resident 37's H&P dated 10/31/2024, the H&P indicated Resident 37 had a history of bipolar disorder and was capable of making decisions for himself. During a review of Resident 37's MDS, dated [DATE], the MDS indicated Resident 37's cognitive skills were intact. The MDS indicated Resident 37 was dependent for lower body dressing, required maximal assistance for bathing, toileting hygiene, sit to lying, rolling left to right, and required moderate assistance for personal and oral hygiene. The MDS indicated Resident 37 utilized a wheelchair and for mobility and had an impairment on one side of the lower extremities (hip, legs). During a review of the Order Summary Report (Physician Order) dated 11/2024, the Order Summary Report indicated Resident 37 had an order for Quetiapine Fumarate oral (mouth) tablet100 mg: give one tablet by mouth every 12 hours (hrs) for depression manifested by (m/b) verbalization of feelings of sadness on 11/8/2024 start date 11/9/2024 but was discontinued. Quetiapine Fumarate100mg: give one table by mouth every 12 hours for schizophrenia m/b sudden angry outburst was ordered on 11/12/2024 and started on 11/12/2024. During a review of the Medication Administration Record (MAR: electronic record of when the medications are given) for November and December 2024, the MAR indicated Resident 37 did not have any episodes of sudden angry outbursts. During a concurrent interview and record review on 12/12/2024 with . with Licensed Vocational Nurse 1 (LVN 1), the order and H&P from a General Acute Care Hospital (GACH) were reviewed. LVN 1 stated Trazadone HCL 150 mg was for depression m/b verbalization of feeling of sadness and Quetiapine Fumarate 100 mg was for schizophrenia m/b sudden angry outbursts. LVN 1 stated a diagnosis for schizophrenia is not on the admission record. LVN 1 stated on the GACH record, it indicated a diagnosis of schizophrenia with a question mark, however it is not clear whether the resident actually had schizophrenia and would be followed up with the doctor to confirm the manifestation. LVN 1 stated Resident 37 is on monitoring for angry outbursts. LVN 1 stated she had not seen the resident angry or have angry outbursts. LVN 1 stated medications should be discontinued if the resident does not present the behavior the medication is prescribed for. LVN 1 stated informed consents are obtained prior to administering medications as it was the residents rights to take the medication or not. During a concurrent interview and record review on 12/12/2024 at 4:59 p.m., with the DON, the order and informed consent was reviewd. The DON stated informed consents for psychotropic medications are completed upon admission and the medication cannot be administered without the consent form. The DON stated the order for Trazadone 150 mg was ordered on 11/8/2024 and started on 11/9/2024, and the informed consent should have been obtained on 11/8/2024 or 11/9/2024. The DON stated the informed consent for Trazadone 150 mg was dated 11/11/2024. The DON stated if the resident did not consent for the medication and was administered on 11/9/2024 the resident took the medications without being informed of the risks and benefits, and the right to refuse the medication. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policies and Procedures (P&P), titled Care and Treatment: Psychotropic Drug Use, revised 8/2017, the P&P indicated the licensed nurses shall review the classification of the drug, the appropriateness of the diagnosis, its indication/behavior monitors and related adverse side effects prior to verification of admission orders with the Attending Physician. These residents will be referred to the facility's Psychotropic Drug Review Committee and/or the Psychiatrist to ensure psychotropic medications are prescribed to treat a specific diagnosed condition as documented in the clinical record, informed consent was obtained prior to medication use. During a review of the facility's policies and Procedures (P&P), titled Care and Treatment: Informed Consent-CA, revised 5/2019, the P&P indicated physician's orders related to the use of psychotherapeutic drug and physical restrains should not be initiated until an informed consent is obtained. -

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 50387 Based on observation, interview, and record review, the facility failed to ensure dietary staff knew the proper techinize of thawing frozen food and testing the concentration of the sanitizer. These deficient practices had the potential to cause food-borne illnesses due to improperly thawed for being served to the residdnts of the facility, and the sanitizer not being at an effective strength. Findings: a.During a concurrent observation and interview on 12/9/2024 at 9:35 a.m., with the Dietary Aid (DA) 2, in the Kitchen, DA 2 checked the sanitizer concentration in a sanitizer bucket using the the wrong testing strip. DA 2 acknowledged that there was no color change on the test strip to indicate the concentration level of the sanitizer solution. b.During a concurrent observation and interview on 12/9/2024 at 9:35 a.m. with the Dietary Supervisor (DS), in the Kitchen, a sealed frozen item was observed running under hot water in a stainer in the sink. The DS acknowledged that the water was hot and stated DA 2 had accidently turned on the hot water, but the proper method required using cold water. During an interview on 12/10/2024 at 8:15 a.m., with the DS, the DS stated that DA 2 had used the wrong test strip to test sanitizer concentration. During an interview on 12/10/2024 at 11:29 a.m., with [NAME] 1, [NAME] 1 stated that the frozen item should be placed in a basin and cold water run over it to ensure proper thawing. During a review of the facility's Policy and procedure (P&P) titled, Quaternary Ammonium Log Policy dated 2023, the P&P indicated: the Food and Nutrition Service worker will place the sanitation solution in the appropriately labeled bucket and test its concentration. The concentration will be tested at least once per shift or whenever the solution becomes cloudy. If the reading is below 200 ppm, the solution will be replaced, and the replacement solution will be tested before use. During a review of the facility's P&P titled, Thawing of meats dated 2023, the P&P indicated, Thawing meat properly can be done in these four ways: 3. Submerge under running water at a temperature of 70 Fahrenheit (a way of measuring temperature) or lower .4. This works well for frozen vegetables and ground meat.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50387 Based on observation, interview, and record review, the facility failed to: 1. Store staff personal belongings outside the food storage area. 2. Ensure proper labeling of potatoes and green produce. These deficient practices had the potential to cause food-borne illnesses. Findings: a.During a concurrent observation and interview on 12/9/2024 at 8:22 a.m., with Dietary Aid (DA)1, in the dry food storage area, staff personal belongings were observed, one black jacket and one white tote bag were hanging on the first shelf to the left side of the door. Additionally, one black jacket and one black backpack were observed on the second self from the bottom on the right side of door. DA 1 stated that these items belong to kitchen staff and acknowledged they should not be in the food storage area as they can lead to cross-contamination, potentially causing food borne illness. b.During a concurrent observation and interview on 12/9/2024 at 8:22 a.m., with DA 3, in the dry food storage area, there was a container of potatoes on the bottom shelf without labeling. DA 3 stated proper labeling is required for the potatoes to ensure the correct use of the items. c.During a concurrent observation and interview on 12/9/2024 at 8:25 a.m., with DA 1, in the refrigerator, a container of green produce was labeled as strawberry and did not include a delivery date. During an interview on 12/9/2024 at 9:05 a.m. with the Dietary Supervisor (DS), the DS stated that produce items should have delivery dates marked on containers to ensure proper tracking and use before expiration. The DS stated that without proper labeling and dates, could lead to food born illness. During a review of the facility's Policy and Procedure (P&P) titled, Employee Personal Items dated 2023, the P&P indicated, employees bringing in personal items from outside (i.e., jackets, cell phones, keys, pursed, etc.) will not be kept in the kitchen area. During a review of the facility's P&P titled, Storage of food and supplies dated 2023, the P&P indicated, food storage area should be used only for food, label should be visible, and all food will be dated-month, day, year. During a review of the facility's P&P titled, Labeling and Dating of Foods dated 2023, the P&P indicated: Food delivered to facility needs to be marked with a delivery or received date, whole unprocessed or purchased pre-processed Produce is dated with a delivery date (DD).

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46415 Based on observation, interview, and record review, the facility failed to implement their infection control policy for two of three sampled residents (Resident 130 and 53) by: 1.Ensuring staff performed hand hygiene after providing care for a resident and before going to Resident 130's room. 2. Ensuring staff doffed (systematic removal of personal protective equipment [PPE: equipment worn to minimize exposure to injury or infection] to prevent infection and contamination after administering medication to Resident 53. These deficient practices had the potential to transmit infectious microorganisms and increase the risk of infection for the residents. a. During a review of Resident 130's Admission record, the Admission Record indicated Resident 130 was admitted to the facility on [DATE] with diagnoses including generalized weakness, cerebrovascular accident (CVA: stroke, loss of blood flow to a part of the brain), and Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements). During a review of Resident 130's History and Physical (H&P) dated 12/5/2024, the H&P indicated Resident 130 had the capacity to understand and make decisions. During a review of Resident 130's Minimum Data Set [(MDS) a resident assessment tool], dated 12/10/2024, the MDS indicated Resident 130's cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills were intact. The MDS indicated Resident 130 was dependent for sit to lying, required maximal (assisting more than half the effort) assistance for bathing, toileting hygiene, and required moderate (assisting less than half the effort) for personal hygiene and oral hygiene. During an observation on 12/9/2024 at 3:29 p.m., of Certified Nursing Assistant 3 (CNA 3), CNA 3 exited a resident's room. CNA 3 went to Resident 130's room to answer the call light. CNA 3 did not without perform hand hygined before going into and before leaving the residents' room. During an interview on 12/9/2024 at 3:29p.m. with CNA 3, CNA 3 stated when entering a room, she would sanitize her hand before diaper change or when providing direct patient care, but if she enters a room to check in on the resident as was the case for Resident 130 as she asked who her Certified Nursing Assistant (CNA) was, since she does not have direct contact with the resident, she does not have to do hand hygiene. CNA 3 stated hand hygiene is done to prevent cross contamination. b. During a review of Resident 53's Admission Record, the Admission Record indicated Resident 53 was admitted to the facility on [DATE] with diagnoses including cerebral infarction (blood flow to the brain is blocked) due to embolism (blood clot), hypertension (high blood pressure), and dementia (a progressive state of decline in mental abilities). (continued on next page)

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	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgewater Skilled Nursing Center	2625 East Fourth Street Long Beach, CA 90814

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 53s MDS dated [DATE], the MDS indicated Resident 53's cognitive skills were mildly impaired. The MDS indicated Resident 53 required moderate assistance for shower transfer, supervision for bathing, toileting hygiene, personal hygiene, chair/bed to chair transfer, and required set up for oral hygiene and eating. During a concurrent observation and interview on 12/11/2024 at 9:08 a.m. with Licensed Vocational Nurse 3 (LVN 3), LVN 3 removed her gloves and removed her gown by grabbing the front of the gown with her bare hands. LVN 3 stated when wearing PPE, you would put your gown, mask, goggles, and then gloves and would remove it by taking the gloves, gown, goggles and mask. LVN 3 stated it is important to wear proper PPE to protect yourself and the resident as improper use of PPE can cause sicknesses, spread infections, and the resident can become ill. During an interview on 12/12/2024 at 10:46 a.m. with the Infection Preventionist Nurse (IPN), the IPN stated hand washing or hand sanitization is done before and after direct contact with the resident or before performing an invasive procedure to prevent anything from spreading. The IPN stated hand hygiene should be done prior to entering and exiting a residents room whether they are on standard precaution (infection prevention practice to avoid transmission of infectious agents) or on enhanced barrier precaution (EBP: reduce transmission of multi-drug resistant organisms) as it is the first protection against infection control. The IPN stated it is not known what the staff was doing prior to entering the room, and even if the staff does not touch anything, they may come in contact with a doorknob or curtain and want to ensure their hands are clean prior to coming in contact with such items or objects. The IPN stated not doing proper hand hygiene can get yourself sick and transmit different bacteria one place to another. IPN stated when removing a gown, after the gloves are removed, hand hygiene can be performed and untie the gown from the back, but the gown should not be removed from the front without gloves on due to cross contamination. During a review of the facility's policy and procedure (P&P), titled Hand Hygiene, revised 12/2023, the P&P indicated it is the policy of this facility to provide the necessary supplies, education, and oversight to ensure healthcare workers perform hand hygiene, which is one of the most effective measures to prevent the spread of infection, based on accepted standards. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively soap (antimicrobial or non-antimicrobial) and water for the following situations: before and after coming on duty. During a review of the facility's policy and procedure (P&P), titled IPCP Standard and Transmission-Based Precautions, revised 3/2024, the P&P indicated standard precautions are infection prevention practices that apply to the care of all residents regardless of suspected or confirmed infection or colonization status . standard precaution includes hand hygiene. Personal protective equipment (PPE): [NAME] PPE upon room entry, then doff and properly discard PPE and perform hand hygiene before exiting the patient room to contain pathogens. 50387

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	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgewater Skilled Nursing Center	2625 East Fourth Street Long Beach, CA 90814

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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 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50144 Based on observation, interview and record review, the facility failed to ensure 15 of 35 residents rooms met the 80 square feet ([sq. ft.] unit of area equal to a square one foot long on each side) per residents in multiple resident rooms. Rooms 25, 26, 27, 28, 29, 30, 31, 32, 33, and 34 housed two residents per room, and Rooms 18, 20, 21, 35 and 36 housed four residents per room. This deficient practice had the potential to result in inadequate nursing care to the residents. Findings: During an observation on 12/12/2024 at 11:59 a.m., the following rooms were observed room [ROOM NUMBER], 20, 21, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, and room [ROOM NUMBER] did not meet the requirement of 80 square feet per residents. During a review of the Client Accommodations Analysis Form, dated 12/12/224, provided by the Administrator (ADM) on 12/12/2024, the Client Accommodations Analysis Form indicated Rooms 25, 26, 27, 28, 29, 30, 31, 32, 33, and 34 were occupied by two residents per room and had a total square feet measurement of 153.33 square feet. The Client Accommodations Analysis Form indicated Rooms 18, 20, 21, 35 and 36 were occupied with four residents per room and had a total square feet measurement ranging from 283.5 square feet to 296.66 square feet. During an interview on 12/12/2024 at 12:30 p.m. with Resident 15, Resident 15 stated there was no issues with the room space, Resident 15 stated having adequate space for all the belongings in the multiple resident room. During an observation of rooms 18, 20, 21, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, and room [ROOM NUMBER] from 12/9/2024-12/12/2024 by the survey team, the residents care needs, and health were not affected by room size. The residents or the facility staff, who were providing care to the residents in these resident rooms, did not complain about not having enough space to provide adequate care. The facility provided a request to continue the room waivers on 12/12/2024.