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	03/19/2026

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of five sampled residents (Resident 32) had a completed informed consent (a document ensuring the resident was educated of the risks and benefits of the treatment and agreed or disagreed to continue with the treatment) for Trazodone (medication prescribed to treat depressive disorder [a mental health condition marked by a prolonged low mood and a loss of interest or pleasure in everyday activities]) and Lorazepam [medication prescribed to treat anxiety disorders (persistent and excessive worry that interferes with daily activities)].This failure had the potential to result in violating the resident's right to be informed of the benefits and risks of the treatment and the right to refuse the treatment.Findings:During a review of Resident 32's admission Record, the admission Record indicated Resident 32 was admitted to the facility on [DATE] with diagnoses including depression disorder, anxiety disorder, and osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage).During a review of Resident 32's Minimum Data Set (MDS - a resident assessment tool), dated 2/6/2026, the MDS indicated Resident 32 had severe cognitive (ability to learn, reason, remember, understand, and make decisions) impairment, required setup assistance when eating, and oral hygiene, required maximal assistance (helper does more than half the effort) for upper body dressing, and was dependent for toileting hygiene, bathing, and lower body dressing. During a review of Resident 32's Physician Order Summary dated 3/19/2026, the Order Summary indicated the following:Trazodone tablet 50 milligrams (MG- a unit of measure). Give 50 MG by mouth at bedtime for Depression manifested by (M/B) inability to sleep with Start date 2/4/2026.Lorazepam tablet 1 MG. Give 1 MG by mouth every 6 hours as needed for Anxiety M/B restlessness for 14 days with start date of 3/13/2026.During a review of Resident 32's Medication Administration Record for February 2026, Resident 32 received: Trazadone tablet 50 MG as ordered from 2/7/2026 - 2/28/2026.During a review of Resident 32's Medication Administration Record for March 2026, Resident 32 received:Trazadone tablet 50 MG as ordered from 3/1/2026 - 3/19/2026.Lorazepam tablet 1 MG on 3/18/2026.During a concurrent interview and record review on 3/18/2026 at 11:03 a.m., with Registered Nurse (RN) 1, Resident 32's Informed Consent for Trazodone, dated 2/3/2026, and Informed Consent for Lorazepam, dated 2/3/2026, were reviewed. RN 1 stated the Informed Consent for Trazodone did not indicate a physician had educated the resident of risks and benefits of the treatment, therefore was incomplete. RN 1 stated the facility did not obtain consent from Resident 32 or Resident 32's representative when the Lorazepam was reordered on 3/13/2026.During an interview on 3/19/2026 at 3:40 p.m., with the Director of Nursing (DON), the DON stated it was important for informed consents to be obtained and complete to ensure the resident or responsible party is giving permission to treat them (resident), before the treatment is initiated. The DON stated if the consent is missing a physician signature, there is a risk that the physician did not explain the indication, risk, and benefits to the resident or responsible party. The DON stated informed consents should be obtained when a medication is renewed or reordered.During a review of the facility's policy and procedure (P&P), titled Informed Consent - CA, revised May 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.

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents/responsible party had the opportunity to formulate an advance directive (document indicating the Resident's healthcare wishes in emergency cases where they are not able to make a decision) for one of four sampled residents (Resident 11).This deficient practice had the potential to violate the resident's right to be fully informed of the option to formulate their advance directives and cause conflict with the residents' wishes regarding health care.Findings:During a review of Resident 11's admission record, the admission record indicated Resident 11 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness or paralysis on one side of the body) following cerebral infarction (stroke - loss of blood flow to a part of the brain), chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing), and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 11's Minimum Data Set (MDS - a resident assessment tool), dated 1/19/2026, the MDS indicated Resident 11's cognition (ability to learn, reason, remember, understand, and make decisions) was intact and was dependent (helper does all of the effort) for toileting, bathing, oral hygiene, and dressing.During a concurrent interview and record review on 3/18/2026 at 4:12 p.m., with the Social Services Director (SSD), Resident 11's Social Services Assessment/Evaluation - V3, dated 12/19/2025, was reviewed. The SSD stated Resident 11's Social Services Assessment/Evaluation-V3 did not indicate that Resident 11 had an advance directive or was informed about their (Resident 11's) right to formulate an advance directive. The SSD stated Resident 11 should have been screened for an advance directive and informed of the right to formulate an advance directive when Resident 11 was readmitted on [DATE]. The SSD stated it was important to screen resident's for an advance directive to ensure that residents' wishes and preferences are carried out.During an interview on 3//19/2026 at 3:40 p.m., with the Director of Nursing (DON), the DON stated advance directives are assessed upon admission. The DON stated it was important to screen for advance directives on admission because it is the resident's right to formulate an advance directive.During a review of the facility's policy and procedure (P&P), titled Advance Directives, revised May 2017, the P&P indicated Information about advance directives will be given to each resident as part of the admission paperwork. Resident and/or responsible parties will complete the Advance Directive checklist that will be maintained in the resident's chart. The checklist will indicate whether an Advance Directive has been executed and, if so, a copy will be provided to the facility. If an Advance Directive has not been executed, the checklist will indicate such, however if the resident executes one in the future, a copy shall be provided to the facility.

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure staff were monitoring behaviors for a medication being administered for one of three sampled residents (Resident 88) when resident was taking quetiapine (a medication used to treat behavioral disorders). This deficient practice had the potential to place Resident 88 at risk for significant adverse consequences (unwanted, uncomfortable, or dangerous effects that a drug may have) from the use of unnecessary psychotropic medication (medications that alter the chemical makeup of the brain and nervous system to treat mental health disorders, affecting mood, cognition, and behavior) for an extended period, which could result in impairment or decline in the resident's mental, physical condition, functional, and psychosocial status.Findings:During a review of Resident 88's admission Record, the admission Record indicated Resident 88 was admitted to the facility on [DATE] with diagnoses including diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), schizophrenia (a mental illness that is characterized by disturbances in thought), and osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage) of the hips. During a review of Resident 88's Minimum Data Set ([MDS], a resident assessment tool) dated 3/11/2026, the MDS indicated Resident 88 had intact cognitive (thought process) functioning for daily decision making. The MDS indicated Resident 88 was maximal assistance (helper does more than half the effort to complete the task) with self-care abilities such as eating, hygiene and dressing. The MDS indicated Resident 88 was moderate assistance (helper does less than half the effort to complete the task) for mobility such as rolling, sitting, standing and transfers. During a review of Resident 88's Order Summary Report, the Order Summary Report, dated 3/9/2026, indicated quetiapine oral tablet 25 milligram ([mg], a unit of measurement for medication use) give 25 mg by mouth at bedtime for schizophrenia manifested by restlessness.During a review of Resident 88's Medication Administration Record ([MAR] a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 3/1/2026 to 3/31/2026, the MAR indicated quetiapine oral tablet 25 mg was documented give 25 mg by mouth at bedtime for schizophrenia manifested by restlessness was administered nine times from 3/1/2026 to 3/31/2026 at 9:00 p.m.During a review of Resident 88's comprehensive care plan, dated 3/13/2026, the comprehensive care plan indicated a focus of anti-psychotic medication use related to quetiapine oral tablet 25 mg, give 25 mg by mouth at bedtime for schizophrenia manifested restlessness with goals that resident will show a decrease in episodes of signs and symptoms of the diagnosis through the review date with interventions to document episodes of behavior and document non-pharmacological interventions: back rub, speak to /approach in a calm manner, reposition, offer snacks/fluids, assess for pain, provide a quiet environment.During a concurrent interview and record review on 3/19/2026 at 9:20 a.m. with the Assistant Director of Nursing (ADON), the Order Summary Report and the MAR for March 2026 were reviewed. The ADON stated the monitoring of behaviors for the quetiapine oral tablet medication should have been done on the same day the medication was ordered. The ADON stated the staff could be giving the residents medication for behaviors that may not exist if the staff are not monitoring for the behaviors the medication was ordered for. The ADON stated the medication given to the residents can make the residents' behaviors worse if the resident was given a medication for a behavior they are not displaying.During a concurrent interview and record review on 3/19/2026 at 10:36 a.m. with Licensed Vocational Nurse (LVN) 2, the Order Summary Report and the MAR for March 2026 were reviewed. LVN 2 stated the quetiapine medication was ordered for Resident 88's restlessness behaviors such as not being able to calm down and having episodes of restless and not being able to sleep. LVN 2 stated there should have been an order for (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	monitoring behaviors that Resident 88 was having because if staff may be giving the medication for no reason. LVN 2 stated the medication can affect Resident 88's mental status and it can be considered a chemical restraint (the use of medication to control behavior or restrict freedom of movement, rather than to treat a specific medical or psychiatric condition) for the residents. During an interview on 3/19/2025 at 4:14 p.m. with the Director of Nursing (DON), the DON stated there should have been monitoring of behaviors for the medication residents are taking for behaviors. The DON stated the staff should be monitoring the behaviors that was related to the medication residents are taking. The DON stated the behavior monitoring of restlessness should be more specific as well as behavior monitoring should not be vague. The DON stated the staff should be monitoring the target behaviors of the medication it was ordered for so the staff can know if the medication was effective at targeting the behaviors residents was manifesting. The DON stated if staff are not monitoring behaviors for the medication it was ordered for, the medication ordered can be considered a chemical restraint and the resident can get unwanted side effects. During a review of the facility's policy and procedures (P&P) titled Psychotropic Medications, revised 12/2023, indicated, it is the policy of this facility to ensure that residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record.psychotropic medications shall not be administered for the purpose of discipline or convenience.psychotropic medications shall not be administered for the purpose of discipline or convenience. They are to be administered only when required to treat the resident's medical symptoms and will be considered only after nonpharmacological interventions have been attempted and failed. psychotropic medication was prescribed to treat a specific diagnosed condition, as documented in the clinical record and monitoring for adverse consequences and effectiveness of medications are in place.

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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** Based on observation, interview, and record review, the facility failed to ensure a comprehensive care plan was implemented for one of three sampled residents (Resident 88), who received narcotic pain medication (strong prescription medications used to treat moderate-to-severe acute or chronic pain).This deficient practice had the potential to negatively affect the quality of life and wellbeing for Resident 88 to prevent them from achieving their highest practical well-being.Findings:During a review of Resident 88's admission Record, the admission Record indicated Resident 88 was admitted to the facility on [DATE] with diagnoses including diabetes mellitus ([DM], a disorder characterized by difficulty in blood sugar control and poor wound healing), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), schizophrenia (a mental illness that is characterized by disturbances in thought), and osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage) of the hips.During a review of Resident 88's Minimum Data Set([MDS], a resident assessment tool) dated 3/11/2026, the MDS indicated Resident 88 had intact cognitive (thought process) functioning for daily decision making. The MDS indicated Resident 88 was maximal assistance (helper does more than half the effort to complete the task) with self-care abilities such as eating, hygiene and dressing. The MDS indicated Resident 88 was moderate assistance (helper does less than half the effort to complete the task) for mobility such as rolling, sitting, standing and transfers.During a review of Resident 88's Order Summary Report, the Order Summary Report indicated tramadol tablet 100 milligram (mg, a unit of measurement) by mouth every 12 hours as needed for pain, for moderate pain 4 - 6 to severe pain 7 - 10 in pain scale (a tool used to measure pain intensity and guide treatment, 1 to 3 being mild pain, 4 to 6 being moderate pain, and 7 to 10 being severe pain).During a review of Resident 88's comprehensive care plan, dated 3/13/2026, the comprehensive care plan did not indicate a focus for tramadol medication as needed for pain with goals and interventions in place for the narcotic pain medication use.During a concurrent observation and interview on 3/16/2026 at 10:33 a.m. in Resident 88's room, Resident 88 was lying in bed. Resident 88 stated he has pain in both of his legs and that he gets Tramadol for the leg pain.During a concurrent interview and record review on 03/19/2026 at 11:00 a.m. with Licensed Vocational Nurse (LVN) 2, the comprehensive care plan dated 3/13/2026 was reviewed. LVN 2 stated there should have been a care plan for the narcotic pain medication tramadol. LVN 2 stated some of the interventions for any type of pain medication would be to try non pharmacologic interventions first and if that does not work, then give the pain medication tramadol as ordered. LVN 2 stated for interventions with pain medication, the staff should be monitoring the adverse effects like respiratory depression, any side effects the resident may experience while on the pain medications and if the pain medication was effective at relieving the pain. LVN 2 stated the care plan was a plan of care for the residents and how the staff will care for the residents. LVN 2 stated the care plan was important, so the staff can meet the goal of the residents.During an interview on 3/19/2026 at 3:57 p.m. with the Director of Nursing (DON), the DON stated a care plan was interventions of what the facility staff will do for the residents and that it was a structure of how the residents will be cared for. The DON stated there should have been a care plan for the narcotic pain medication tramadol. The DON stated the goal of the care plan was to see if the interventions being done for the residents are effective and if not, the care plan would need to be revised and updated. The DON stated if a care plan was not implemented for the pain medication, the staff wouldn't know if the medication was effective, if the pain was relieved, or if the residents needed additional interventions to manage the pain.During a review of the facility's policy and procedure (P&P) titled Comprehensive Person Centered Care Planning, revised 12/2023, indicated, the facility shall develop a comprehensive person-centered care plan for each resident that includes (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment.to properly care for each resident and instructions needed to provide effective and person-centered care that meet professional standards of quality care.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 40) who received hemodialysis (a medical procedure to remove fluid and waste products from the body) had a dialysis emergency kit (a prepared, accessible collection of essential medical supplies, medications, and documents designed for dialysis patients to use during emergencies) at the bedside.This failure had the potential for delayed intervention during accidental bleeding including death for Resident 40.Findings:During a record review of Resident 40's admission Record, the admission Record indicated Resident 40 was originally admitted to the facility on [DATE] and readmitted on [DATE] with a diagnosis including end stage renal disease ([ESRD], irreversible kidney failure) on dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidneys have failed), diabetes mellitus ([DM]-a disorder characterized by difficulty in blood sugar control and poor wound healing) and anemia (a condition where the body does not have enough healthy red blood cells).During a record review of Resident 40's Minimum Data Set ([MDS], a resident assessment tool) dated 3/6/2026, the MDS indicated the Resident 40 has an intact cognitive (thought process) functioning. The MDS indicated Resident 40 needed clean up assistance (helper cleans up while resident completes the task) to moderate assistance (helper does less than half the effort to complete the task) with self-care abilities such as eating, hygiene, and dressing. The MDS indicated Resident 40 was dependent (helper does all of effort to complete the task) for mobility such as rolling and sitting up at edge of bed.During a record review of Resident 40's Order Summary Report dated 3/6/2026, the Order Summary Report indicated an order for hemodialysis on Monday and Friday related to ESRD dependence on renal dialysis. During a record review of Resident 40's Order Summary Report dated 3/6/2026, the Order Summary Report indicated a physician order of dressing on dialysis access site (a surgically created lifeline on the body that allows blood to be removed, cleaned by a machine, and returned to the body during dialysis) to be changed at dialysis center and as needed at facility. The Order Summary Report also indicated monitor dialysis access site for signs or symptoms of infection, swelling, bleeding every shift.During a concurrent observation and interview on 3/19/2026 at 12:09 p.m. in Resident 40's room, there was no emergency dialysis kit visible at bedside or anywhere in the room. Resident 40 stated he has dialysis on Monday and Friday. Resident 40 stated an emergency kit usually hangs up on the board near the side of his bed, but it was not there anymore and stated staff keep moving it so now he does not know where it was.During a concurrent observation and interview on 3/19/2026 at 12:13 p.m. with Certified Nursing Assistant (CNA) 1 in Resident 40's room, CNA 1 checked Resident 40's bedside dresser with Resident 40's permission and around the resident's room but could not find the dialysis emergency kit at the bedside. CNA 1 stated that the dialysis emergency kit was kept at the bedside hanging from the wall, but it was not there. CNA 1 stated Resident 40 was supposed to have dialysis emergency kit at bedside in case of emergencies like bleeding out of the dialysis access site.During a concurrent observation and interview on 3/19/2026 at 12:18 p.m. with the Assistant Director of Nursing (ADON) in Resident 40's room, the ADON stated the dialysis emergency kit should be hanging on the wall. The ADON stated the importance to have the dialysis emergency kit readily available at the bedside was in case the resident bleeds out at the bedside, the dialysis emergency kit was readily available to use right away.During an interview on 3/20/2026 at 4:37 p.m. with the Director of Nursing (DON), the DON stated it was important to have the dialysis emergency kit at the bedside for emergency purposes such as if the residents bleed out, the staff can put a dressing and apply pressure to stop the bleeding. The DON stated if the dialysis emergency kit is not readily available at the bedside, the staff would be scrambling to find supplies to stop the bleeding, and the resident could bleed out.During the facility's policy and procedure (P&P) titled Dialysis (Renal), Pre- and Post-Care, revised on 12/2023, indicated, it is the policy of this facility to assess and maintain patency of renal (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dialysis access. dialysis access should be assessed upon return to the facility for patency and any unusual redness or swelling.post dialysis access care as ordered.any problems with a resident's access should be addressed immediately.excessive bleeding from graft sites, redness, swelling, pain, or a non-functioning graft requires medical attention.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on interview and record review, the facility failed to ensure staff were in-serviced (specialized training or education provided to staff while on the job) to care for residents that was diagnosed for trauma-informed care and post-traumatic stress disorder ([PTSD], a disorder in which a person has difficulty recovering after experiencing or witnessing a traumatic event).This failure had the potential to result in residents being re-traumatized by staff who were not educated on PTSD and could be harmful for resident's psychosocial status.Findings:During a concurrent interview and record review on 03/19/2026 at 12:37 p.m. with the Director of Staff Development (DSD), the Inservice Binder for Staff Training of 2025 was reviewed. The DSD stated there was no in-services or training for staff on residents with PTSD, or trauma informed care. The DSD stated there should be in-service for staff on PTSD and trauma informed care, so staff are aware of residents' potential triggers and changes of behavior. The DSD stated staff should have been educated on understanding the types of behaviors to keep themselves and the residents safe. The DSD stated there should be in-service for staff on residents with PTSD and trauma informed care every year. During an interview on 3/19/2026 at 4:28 p.m. with the Director of Nursing (DON), the DON stated the staff should have been in-service for PTSD and trauma informed care due to some of the residents having the diagnosis of PTSD in the facility. The DON stated the importance of staff being in-serviced for PTSD and trauma informed care so the staff can approach and know how to talk to the residents, have specific interventions for residents and know what to avoid when providing care for the residents. The DON stated if staff are not educated on trauma informed care for PTSD residents, the residents may feel the fear that happened before, which can be very traumatic on the resident and create more trauma for the residents. During a review of the facility's policy and procedures (P&P) titled, Behavioral Health Services, revised 12/2023, indicated it is the policy of this facility to provide residents with necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being.trauma survivors will receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident.the interdisciplinary team ([IDT], a collaborative group of healthcare professionals who work together to create and implement a comprehensive care plan for a patient) will ensure that residents who display or have a history of trauma, or PTSD receives the appropriate treatment and services to attain the highest practicable mental or psychosocial well-being.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow manufacturer's storage specifications for one of six sampled resident's (Resident 11) levalbuterol inhalation solution, USP (an inhaled prescription medicine used for the treatment or prevention of breathing difficulties).This failure had the potential to reduce the medication's effectiveness and placing the resident at risk for shortness of breath and difficulty.Findings:During a concurrent interview and record review on [DATE] at 1:38 p.m. with Licensed Vocational Nurse (LVN) 1, at nurses' station 1, medication cart 1 contained an open levalbuterol inhalation solution, USP 0.63 milligram (mg)/3 milliliters (ml) labelled for Resident 11. The medication packaging indicated an open date of [DATE]. LVN 1 stated the label indicated Once the foil pouch is opened, the vials should be used within two weeks. During an interview on [DATE] at 3:40 p.m., with the Director of Nursing (DON), the DON stated, ensuring medications were not expired was important to maintain medication potency and effectiveness. The DON stated, staff should follow the manufacturer's guidelines for discard and expiration dates. The DON stated, residents who receive expired levalbuterol inhalation solution are at risk for shortness of breath and wheezing. During a review of the manufacturer's information insert for levalbuterol inhalation solution, dated 02/2020, the insert indicated when a Levalbuterol Inhalation Solution, USP foil pouch is opened, use the vials within 2 weeks. During a review of the facility's policy and procedure (P&P) titled, Medication Storage and Labeling, undated, the P&P indicated, All drugs will be labeled and stored in a manner consistent with manufacturers' published specifications, federal and state regulations, and to enhance accurate and safe medication administration by the facility staff.

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	055387	A. Building B. Wing	03/19/2026

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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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure documented food preferences was followed for one of three sampled residents (Resident 75), when Resident 75 was served food items documented as resident's dislikes. This failure had the potential to contribute to reduced nutritional intake, affecting the resident's overall health and wellˆbeing.Findings:During a review of Resident 75's admission Record (Face sheet), the admission Record indicated the facility admitted the resident on 9/14/2023 and re-admitted on [DATE], with diagnoses including diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing) and essential hypertension (HTN- high blood pressure).During a review of Resident 75's Minimum Data Set (MDS- a resident assessment tool), the MDS indicated the resident had intact cognitive function (ability to process information, learn, and reason without impairment).During a review of Resident 75's physician's order dated 3/15/2025, the physician's order indicated a consistent carbohydrate (CCHO- an eating plan designed to keep blood sugar levels stable) diet.During a review of Resident 75's care plan (personalized health care plan) dated 9/26/2023 and revised 6/22/2025, the care plan indicated the resident was at risk for hypoglycemia (low blood sugar). The care plan indicated interventions including monitoring compliance with diet and offering substitutes for foods not eaten.During a review of Resident 75's lunch meal ticket, the lunch meal ticket indicated chicken and turkey only, and no dessert. The lunch meal ticket indicated 1/2 cup ice cream or sherbet and listed green beans as a dislike.During a concurrent observation and interview on 3/16/2026 at 12:43 p.m. with Resident 75 in the resident's room, Resident 75 stated she did not eat lunch because she was served green beans despite disliking them. Resident 75 pointed to the lunch meal ticket on her tray, which listed green beans under the dislikes section. [NAME] beans were observed on the resident's lunch plate.During a concurrent observation and interview on 3/18/2026 at 12:39 p.m. with Resident 75 in the resident's room, a covered food tray was observed on the bedside table. Resident 75 uncovered the tray, and stated she was served a chocolate dessert, and sherbet. The resident stated she was not supposed to receive any dessert other than sherbet as per her meal ticket. The resident stated she felt the staff were not reading her ticket and trays should have been prepared with food preferences and dislikes first, so they could be done correctly.During a review of the facility's CCHO Diets weekly menu, dated 3/16-3/22, the menu indicated green beans were served for lunch on March 16, 2026. The menu indicated 1/2 portion of chocolate peanut butter bar was served for lunch on March 18, 2026. During a concurrent interview and record review on 3/18/2026 at 1:03 p.m. with the kitchen aid (KA), a photograph of Resident 75's 3/16/2026 lunch tray was reviewed. The KA stated green beans were present on the plate and the meal ticket listed green beans as a dislike. The KA stated she verified residents' food preferences and dislikes by comparing the meal tickets with the food items during tray line. The KA stated residents would not want to eat when their food preferences were not honored.During an interview on 3/18/2026 at 1:13 p.m. with Dietary Manager (DM), the DM stated she kept track of residents' food preferences and dislikes by assessing residents upon admission and updating meal tickets weekly and as needed. The DM stated residents become unhappy when preferences were not honored. The DM stated residents could remain hungry and upset if meals were not consumed due to their preferences not being followed.During an interview on 3/19/2026 at 4:03 p.m. with Director of Nursing (DON), the DON stated residents' food preferences and dislikes were reviewed upon admission, quarterly, and as needed through meal tickets. The DON stated honoring food preferences was important to encourage residents to eat. The DON stated residents felt unheard when preferences were not honored, which could lead to poor food intake and weight loss. The DON stated residents should have been offered food alternatives when they did not eat their meal.During a review of the facility's policy and procedure (P&P) titled, Food Preferences, undated, the P&P (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated Resident's food preferences will be adhered to within reason. Substitutes for all foods disliked will be given from the appropriate food group.Updating of food preferences will be done as the resident's needs change and/or during the quarterly review.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interview and record review, the facility failed to provide documented evidence of COVID-19 (a contagious respiratory disease that spreads from person to person through coughing, sneezing, or talking) vaccine screening, education, administration, and/or declination for two of seven sampled staff members: Medical Doctor (MD) 1 and MD 2.This failure had the potential for an increased risk of COVID-19 exposure for facility residents and staff from delayed identification of vaccine status and missed opportunities to prevent the spread of COVID-19 within the facility.Findings:During a concurrent interview and record review on 3/18/2026 at 3:31 p.m., with the Infection Prevention Nurse (IPN), the facility's Employee Health Tracking Log (record that includes vaccination status of all employees) was reviewed. The IPN stated there was no documentation indicating MD 1 and MD 2 were educated and offered the COVID-19 vaccine. The IPN stated they (IPN) did not offer the COVID-19 vaccine to the physicians.During an interview on 3/19/2026 at 3:40 p.m., with the Director of Nursing (DON), the DON stated that all facility staff, including physicians, should have been screened for having received the COVID-19 vaccine. The DON stated COVID-19 vaccines and record-keeping was important to help prevent the spread of COVID-19 to the residents and staff within the facility.During a review of the facility's policy and procedure (P&P) titled, Immunizations - Staff, revised July 2023, the P&P indicated, Staff includes individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement. This includes facility employees, students, trainees, volunteers, licensed practitioners.Employees will be encouraged to remain up to date and current with COVID-19 vaccine guidance, per the CDC.2. Staff receiving a COVID-19 vaccine will provide written consent using the Consents for COVID-19 Vaccination Form. a. If an employee declines the vaccine for reasons other than medical contraindication, this shall be documented on the Consent for COVID-19 Vaccination. b. The consent and record of vaccination record shall be maintained in the employee medical record.

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F 0880 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on interview and record review, the facility failed to review Infection Prevention and Control Program Policy annually.This finding has the potential to increase the risk of infection for the residents.Findings:During a concurrent interview and record review on 3/18/2026 at 3:31 p.m., with the Infection Prevention Nurse (IPN), the facility's policy and procedure (P&P) titled, Infection Prevention and Control Program, revised December 2023 was reviewed. The IPN stated the P&P was last reviewed and updated by the facility on December 2023. The IPN stated the P&P should be reviewed annually. The P&P indicated, The facility will conduct an annual review of the Infection Prevention and Control Program and the program.During an interview on 3/19/2026 at 3:40 p.m. with the Director of Nurses (DON), the DON stated policies should be reviewed every year to ensure the policy reflects updates and changes to the regulations.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	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** 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 3/19/2026 at 2:40 p.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 3/16/2026, provided by the Administrator (ADM) on 3/16/2026, 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 3/19/2026 at 3:13 p.m. with Resident 39, Resident 39 stated there was no issues with the room space, Resident 66 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 3/16/2026 - 3/19/2026 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.During an interview on 3/19/2026 at 3:59 p.m. with the ADM, the ADM stated the facility will request to continue the room waivers as part of their plan of correction.