

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056378	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2024
NAME OF PROVIDER OR SUPPLIER Ocean Ridge Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 3850 E. Esther St. Long Beach, CA 90804	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36292</p> <p>Based on interview, and record review, the facility failed to ensure one of three sampled resident's (Resident 2) medical record was complete and accurate when</p> <p>a. the facility failed to document an assessment after an allegation of suspected drug use was made regarding Resident 2.</p> <p>b. the facility failed to enter the correct date and time of a weekly assessment completed for Resident 2.</p> <p>This deficient practice resulted in an inaccurate depiction of Resident 2's care and health status.</p> <p>Findings:</p> <p>During a review of Resident 2's Admission Record, the admission record indicated Resident 2 was originally admitted to the facility on [DATE] with diagnoses including Opioid dependence (physical and psychological reliance on opioids, a substance found in certain prescription pain), blood clots (mass of blood that forms to stop bleeding) in the arms and legs, substance abuse (Excessive use of psychoactive drugs, such as alcohol, pain medications, or illegal drugs), paraplegia (unable to move legs and lower body), and one sided weakness.</p> <p>During a review of Resident 2's Minimum Data Set (MDS), a standardized assessment and care-screening tool, dated 2/21/2024, the MDS indicated Resident 2 had moderately impaired cognition, and needed supervision with eating, oral hygiene, and toilet hygiene, and upper body dressing. Resident 2 needed partial assistance with showering, and lower body dressing.</p> <p>During a review of Resident 2's progress notes, the notes indicated on 4/15/2024 at 3:11 p.m., kitchen staff saw Resident 2 allegedly injecting himself with the syringe but quickly hid what he was doing when noticed the kitchen staff was around.</p> <p>During a review of Resident 2's medical records, no documented evidence of a completed assessment was made on 4/15/2024 after the incident was reported.</p> <p>During a review of Resident 2's progress notes, the notes indicated:</p> <p>(continued on next page)</p>

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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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>a. On 4/16/2024 at 7:54 p.m., Resident 2 left the facility at 7:45 p.m. via easy transport in stable condition.</p> <p>b. Late entry on 4/19/2024 at 5:16 p.m. Weekly summary notes indicated Resident 2 was assessed. The entry did not indicate when the assessment date and time.</p> <p>During a phone interview on 4/25/2024 at 3:10 p.m., with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated the assessment for Resident 2 was not documented after the incident of alleged drug use was reported but it was completed.</p> <p>During a phone interview with the Director of Nursing (DON) on 4/25/2024 at 4:30 p.m. the DON stated staff should have documented an assessment after the alleged drug use was reported. The DON stated the late entry on 4/19/2024 should have indicated the date and time the assessment was completed, because the resident was already discharged .</p> <p>During a review of the facility's policy and procedure titled Charting Documentation undated, the policy indicated any notable changes in the resident's medical, physical, functional, or psychosocial condition observed by staff, should be documented in the resident's medical record. Documentation of procedures and treatments should include care-specific details, including items such as: the date and time the procedure/treatment was provided; the name and title of the individual(s) who provided the care, the assessment data and/or any unusual findings obtained during the procedure/treatment, if applicable.</p>		