| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056378 | A. Building<br>B. Wing | 12/19/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Ocean Ridge Post Acute | 3850 E. Esther St.<br>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) |
|---|---|
| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45657<br><br>Based on observation, interview and record review, the facility failed to ensure one of 92 residents (Resident 1), did not have a gun in his possession, in the facility.<br><br>This failure had placed the other residents, staff and visitors ' safety in jeopardy and lives in danger, and could have resulted in severe injuries, hospitalization or death.<br><br>Findings:<br><br>During a review of Resident 1 ' s Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE], with diagnoses including major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), opioid dependence (a chronic disease that occurs when someone regularly uses opioids [strong pain killers] and develops a strong drive to continue using them, even when it causes harm), and suicidal ideations (thinking about or planning suicidal.)<br><br>During a review of Resident 1 ' s History and Physical (H&P) dated [DATE], the H&P indicated Resident 1 had the mental capacity to understand and make medical decisions.<br><br>During a review of Resident 1 ' s Minimum Data Set ([MDS] a standardized care assessment and care screening tool), dated [DATE], the MDS indicated Resident 1 had the ability to make self understood and the ability to understand others. The MDS indicated Resident 1 required supervision or touching assistance with activities of daily living (ADLs) such as dressing, toilet use, personal hygiene, transfer (moving between surfaces to and from bed, chair, and wheelchair) and bed mobility (how resident moves from lying to turning side to side).<br><br>During a review of Resident 1 ' s progress notes on admitted d [DATE] at 1:01 p.m., the progress notes indicated Resident 1 had episodes of confusion.<br><br>During a review of Resident 1 ' s inventory of personal items (list of belongings) dated [DATE], Resident 1 ' s inventory of personal items (list of personal belongins) did not indicate a firearm.<br><br>During a review of Resident 1 ' s progress notes dated [DATE], at 2:58 p.m., the progress notes indicated after the postmortem care was done at 7:57 a.m., the facility staff found a gun inside Resident 1 ' s bag covered with clothes, that was on the floor, beside the nightstand.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|
| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a review of Resident 1 ' s Quality Assurance Action Plan (QA) dated [DATE], the QA indicated during postmortem care and the collection of Resident 1 ' s belongings, a firearm was discovered. The QA indicated Long Beach Police Department was notified and arrived at the facility at 12:08 p.m. and confiscated the firearm.<br><br>During an interview on [DATE] at 12:10 p.m., Certified Nurse Assistant (CNA) 2 stated while doing Resident 1 ' s a postmortem care, Resident 1 ' s belongings were gathered and found a gun inside a bag, that was on the floor beside the nightstand. CNA 2 stated the Licensed Vocational Nurses (LVN) 2 LVN 2 was informed and took Resident 1 ' s belongings.<br><br>During an interview on [DATE] at 12:15 p.m., the Director of Nursing (DON) stated the charge nurse called and notified her (DON) that Resident 1 died . The DON stated, the Charge Nurse reported, when CNA 2 gathered all of Resident 1 ' s belongings, a gun was found inside a bag, that was placed on the floor beside the nightstand. The DON stated residents were not allowed to have any guns or knives in their belongings for residents ' safety. The DON stated the possession of a gun caused a safety issue and could cause harm to everybody in the facility. The DON stated it was the facility ' s responsibility to keep residents safe.<br><br>During an observation on [DATE] at 9:00 a.m. at the facility entrance, the facility hallways, activity room and residents ' rooms, there were no signs posted indicating the facility prohibit the possession of firearms, knives, or weapons in the facility.<br><br>During an interview on [DATE] at 11:30 a.m., LVN 2 stated CNA 2 found a gun inside Resident 1 ' s bag covered with clothes, that was on the floor beside the nightstand. LVN 2 stated the gun was removed and was locked in Station 1 medication room. LVN 2 stated the Administrator (ADM) came and took the gun to his office in a locked cabinet. LVN 2 stated the police officer verbalized that the gun was unloaded, and the bullets were corroded (destroyed or damaged). LVN 2 stated it was dangerous for Resident 1 to have a gun in the facility. LVN 2 stated Resident 1 could have used the gun to harm himself, other residents and staff inside the facility. LVN 2 stated it was the facility ' s responsibility to provide a safe environment for all the resident and staff inside the facility.<br><br>During an interview on [DATE] at 1:34 p.m., the Medical Doctor (MD) stated, Residents 1 ' s possession of the gun inside the facility placed Resident 1 and other residents ' safety in danger. The MD stated the facility should have an efficient system in searching residents ' belongings.<br><br>During a review of the facility ' s policy and procedures (P&P) titled Firearms and Other Weapons, dated 2001, the P&P indicated the facility prohibits any employee, resident, visitor, vendor, or any individual from possessing firearms or other weapons designed to do bodily harm (e.g. knives, explosives) while in/on our facility ' s premises. Signage is posted throughout the building relative to our facility ' s policies governing the possession of firearms or other weapons while on or on our facility ' s premises. |

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| | 056378 | A. Building<br>B. Wing | 12/19/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Ocean Ridge Post Acute | 3850 E. Esther St.<br>Long Beach, CA 90804 |

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|---|---|
| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45657<br><br>Based on interview, and record review, the facility failed to develop an individualized care plan for one of four sampled residents (Resident 1), who had an Out on Pass ([OOP] a temporary permission of a patient to leave the facility in a specified time) order and diagnosis of suicidal ideations (thinking about or feel preoccupied with the idea of death and suicide [ending own life]).<br><br>This deficient practice resulted in staff not knowing what interventions should have been followed and implemented when Resident 1 returned to the facility from OOP.<br><br>This deficient practice had potentially affected in maintaining Resident 1 ' s highest practicable physical, medical, and psychosocial well-being, that might have contributed to Resident 1 ' s death.<br><br>Findings:<br><br>During a review of Resident 1 ' s Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE], with diagnoses including major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), opioid dependence (a chronic disease that occurs when someone regularly uses opioids [strong pain killers] and develops a strong drive to continue using them, even when it causes harm), and suicidal ideations (thinking about or planning suicidal).<br><br>During a review of Resident 1 ' s History and Physical (H&P) dated 10/7/2024, the H&P indicated Resident 1 had the mental capacity to understand and make medical decisions.<br><br>During a review of Resident 1 ' s Minimum Data Set ([MDS] a standardized care assessment and care screening tool), dated 10/11/2024, the MDS indicated Resident 1 had the ability to make self understood and the ability to understand others. The MDS indicated Resident 1 required supervision or touching assistance with activities of daily living (ADLs) such as dressing, toilet use, personal hygiene, transfer (moving between surfaces to and from bed, chair, and wheelchair) and bed mobility (how resident moves from lying to turning side to side).<br><br>During a review of Resident 1 ' s physician ' s order dated 10/6/2024, the physician ' s order indicated Resident 1 may go OOP for 4 hours.<br><br>During a review of Resident 1 ' s OOP sign in and out sheet, the OOP sign in and out sheet indicated Resident 1 went OOP by himself on 10/6/2024, 10/7/2024, 10/15/2024 and on 11/12/2024.<br><br>During a review of Resident 1 ' s care plan, there was no plan of care plan formulated for Resident 1 ' s going OOP.<br><br>(continued on next page) |

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| | 056378 | A. Building<br>B. Wing | 12/19/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Ocean Ridge Post Acute | 3850 E. Esther St.<br>Long Beach, CA 90804 |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a review of Resident 1 ' s Substance Abuse care plan dated 10/7/2024, the substance abuse care plan indicated Resident 1 had opioid dependency and was at risk for becoming a missing person, for death, elopement (leaving the facility without supervision), self-harm, suicidal ideations, worsening mental health. The intervention indicated to increase monitoring (unspecified) and supervision. Resident 1 ' s care plan did not indicate plan of care for Resident 1 ' s suicidal ideations.<br><br>During an interview on 12/19/2024 at 1:17 p.m., Licensed Vocational Nurse (LVN) 3 stated the licensed nurse should have created a personalized care plan based on the resident ' s diagnoses. LVN 3 stated Resident 1 ' s care plan should have contained the problems identified, the goal, and ensure the interventions were appropriate for Resident 1 ' s needs. LVN 3 stated, the importance of creating Resident 1 ' s OOP care plan, was for the nurses to be aware of the interventions to follow when Resident 1 returned to the facility after the OOP. LVN 3 stated, the care plan will guide the nurses, what and how to assess Resident 1 properly, when he returned to the facility.<br><br>During a concurrent interview and record review on 12/19/2024 at 1:55 p.m. with Registered Nurses (RN) 1, Resident 1 ' s care plans were reviewed. RN 1 stated Resident 1 did not have a personalized care plan according to his diagnosis or needs. RN 1 stated Resident 1 had a history of suicidal ideation, the licensed nurses should have developed a care plan based on his diagnosis. RN 1 reviewed substance abuse care plan and stated the suicidal ideation diagnosis should have been care planned separate from the substance abuse care plan. RN 1 stated the interventions should have included monitoring Resident 1 for verbalization of suicidal ideation and mood changes. RN 1 stated Resident 1 should had been supervised visually and room visits conducted, to observe his belongings for anything unusual. RN 1 stated when residents have an OOP order, a care plan specific for OOP should be developed. RN 1 stated Resident 1 had no care plan for OOP. RN 1 stated the importance of having an OOP care plan was to ensure nurses were guided to monitor and inspect Resident 1 on his return.<br><br>During an interview on 12/19/2024 at 2:47 p.m., the Director of Nursing (DON) stated care plans should be individualized basing on residents ' needs and diagnosis. The DON stated care plans should include interventions specific to each resident for staff to identify the problems and address in a timely manner. The DON stated Resident 1 ' s care plan for OOP should have been developed to guide the nurses on what procedures to follow when Resident 1 returned from OOP. The DON stated Resident 1 ' s care plan should have been to increase monitoring Resident 1 ' s drug seeking behavior and verbalization of symptoms of depression.<br><br>During a review of the facility ' s policy and procedures (P&P) titled, Care Plan, Comprehensive Person-Centered, dated 2001, the P&P indicated comprehensive, person-centered care plan that included measurable objectives and timetables to meet the resident ' s physical, psychological and functional needs must be developed and implemented for each resident. |

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| | 056378 | A. Building<br>B. Wing | 12/19/2024 |

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| Ocean Ridge Post Acute | 3850 E. Esther St.<br>Long Beach, CA 90804 |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45657<br><br>Based on interview and record review, the facility failed to provide supervision and an environment free of accident hazards, to one of four sampled residents (Resident 1), when:<br><br>1). Resident 1 who was admitted to the facility on [DATE], and with diagnoses of opioid dependence (a chronic disease that occur when someone regularly use opioids [strong pain killers] and develops a strong drive to continue using them, even when it causes harm), and suicidal ideations (thinking about or planning suicidal), with Out On Pass ([OOP] a temporary permission of a patient to leave the facility) order on [DATE] without supervision, was not assessed when returning to the facility.<br><br>2). Total of four bottles containing 18 Ibuprofen (anti-inflammatory drug) 800 milligrams (mg- metric unit of measurement) tablets and quetiapine (medication for schizophrenia, bipolar disorder, and depression) tablets were found in Resident 1 ' s bedside drawer.<br><br>3). A facility staff found a gun inside Resident 1 ' s bag covered with clothing, that was placed on the floor beside the nightstand.<br><br>These failures had potentially caused Resident 1 to ingest overdose amounts of medications (Ibuprofen and quetiapine), contributing to Resident 1 ' s death.<br><br>These failures placed all the residents, staffs and visitors who were in the facility, lives and safety in danger, which could result to severe injuries, hospitalization , and death.<br><br>Findings:<br><br>During a review of Resident 1 ' s Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE], with diagnoses including major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), opioid dependence, and suicidal ideations.<br><br>During a review of Resident 1 ' s History and Physical (H&P) dated [DATE], the H&P indicated Resident 1 had the mental capacity to understand and make medical decisions.<br><br>During a review of Resident 1 ' s Minimum Data Set ([MDS] a standardized care assessment and care screening tool), dated [DATE], the MDS indicated Resident 1 had the ability to make self-understood and the ability to understand others. The MDS indicated Resident 1 required supervision or touching assistance with activities of daily living (ADLs) such as dressing, toilet use, personal hygiene, transfer (moving between surfaces to and from bed, chair, and wheelchair) and bed mobility (how resident moves from lying to turning side to side).<br><br>During a review of Resident 1 ' s progress notes on admitted d [DATE] at 1:01 p.m., the progress notes indicated Resident 1 had episodes of confusion.<br><br>(continued on next page) |

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| | 056378 | A. Building<br>B. Wing | 12/19/2024 |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | a). During a review of Resident 1 ' s physician ' s order dated [DATE], the physician ' s order indicated Resident 1 may go OOP for four (4) hours.<br><br>During a review of Resident 1 ' s OOP (sign in and out) sheet, the OOP sign in and out sheet indicated Resident 1 went OOP by himself on [DATE] at 11:00 a.m. to a store and returned at 2:45 p.m. On [DATE] at 12:30 p.m., Resident 1 went to the store and returned at 3:05 p.m. On [DATE] at 2:00 p.m., Resident 1 went to the store and returned at 5:00 p.m. On [DATE] at 12:37 p.m., Resident 1 went to the store and returned to the facility at 2:00 p.m. The OOP sign in and out sheet for [DATE], [DATE], [DATE] and [DATE] did not indicate Resident 1 was checked for items brought back to the facility upon return.<br><br>During a review of Resident 1 ' s progress notes dated [DATE], [DATE], [DATE], and [DATE], the progress notes did not indicate Resident 1 was assessed upon return to the facility.<br><br>During an interview on [DATE] at 12:07 p.m. with Receptionist (Recep) 2, Recep 2 stated when Resident 1 went OOP, Recep 2 made sure the nurses were made aware of Resident 1 leaving the facility. Recep 2 stated she have not checked the facility policy about OOP and was not sure what the OOP policy was. Recep 2 stated, it was important to assess residents when they leave and return to the facility to know what items they bring back with them.<br><br>During an interview on [DATE] at 1:17 p.m., Licensed Vocational Nurse (LVN) 3 stated when residents are newly admitted to the facility, residents were evaluated physically and psychologically. LVN 3 stated we do not let newly admitted residents go OOP within 3 days of admission. LVN 3 stated residents with psychiatric issues would need go out with supervision unless the primary doctor and psychiatrist ordered for a resident to go OOP independently. LVN 3 stated Resident 1 had a history of substance abuse and was dangerous for him to go OOP alone because he could be looking for drugs outside the facility and relapse. LVN 3 stated when Resident 1 came back from OOP, Resident 1 should have been assessed physically by Licensed Nurses and documented the results of assessment in the progress notes.<br><br>During a concurrent interview and record review on [DATE] at 1:55 p.m. with Registered Nurse (RN) 1, RN 1 stated newly admitted residents were monitored for 72 hours. RN 1 stated Resident 1 had history of substance abuse and suicidal ideation and had the potential to have gotten drugs from outside and overdosed, and caused his death. RN 1 stated Resident 1 should have been assessed when he returned from OOP.<br><br>During an interview on [DATE] at 2:47 p.m., the Director of Nurses (DON) stated it was too early for Resident 1 to go OOP (after one day of admission), much more by himself. The DON stated one day was not enough time, to have a clear assessment in Resident 1 ' s behavior.<br><br>During an interview on [DATE] at 3:37 p.m., the Medical Doctor (MD) stated, I am not sure if Resident 1 needed supervision when going OOP. MD stated the decision of OOP order was based on nurses ' assessment. The MD stated when residents are newly admitted to the facility, the MD should first assess the resident and determine if safe for any residents to go OOP independently.<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Ocean Ridge Post Acute | 3850 E. Esther St. Long Beach, CA 90804 |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | b) During a review of Resident 1 ' s progress notes dated [DATE] at 2:58 p.m., the progress notes indicated, after Resident 1 ' s postmortem care was done on [DATE] at 7:57 a.m., the Certified Nurse Assistance (CNA) 2 gathered Residents 1 ' s belonging and observed multiple bottles with (unidentified) medications inside Resident 1 ' s bedside drawer.<br><br>During a review of Resident 1 ' s Quality Assurance Action Plan (QA) dated [DATE], the QA indicated the following medications were identified inside the bottles:<br><br>1). [NAME] oval tablets, marked 18 Ibuprofen (anti-inflammatory drug) 800 milligrams (mg- metric unit of measurement)<br><br>2). [NAME] oval tablets, marked 56 quetiapine (medication for schizophrenia, bipolar disorder, and depression) 300 mg.<br><br>3). [NAME] oval tablets marked 300 quetiapine 300 mg.<br><br>4). [NAME] oval tablets, marked 259 quetiapine 300 mg.<br><br>During an interview on [DATE] at 12:10 p.m., the Certified Nurse Assistance (CNA) 2 stated, during the postmortem care process for Resident 1, the belongings were accounted for, and some bottles of pills (unidentified) were found on the nightstand table.<br><br>During an interview on [DATE] at 12:15 p.m., the Director of Nursing (DON) stated, on [DATE], a call was received from the Charge Nurse, notified her (DON) that Resident 1 had died and that medications bottles were found on Resident 1 ' s bedside table. The DON stated some of the bottles were empty and some had ibuprofen and quetiapine tablets. The DON stated Resident 1 used to go out on pass (OOP). The DON stated we believed he got the medications maybe from the pharmacy or he got it from his previous home.<br><br>During an interview on [DATE] at 2:47 p.m., the DON stated the risk of having medications at the bedside without proper self-administration assessment, can place the residents at risk for drug overdose and other drug reactions, resulting to hospitalization or death.<br><br>c). During a review of Resident 1 ' s progress notes dated [DATE], at 2:58 p.m., the progress notes indicated after the postmortem care was done at 7:57 a.m. for Resident 1, the CNA 2 found a gun inside Resident 1 ' s bag covered with clothes, that was on the floor, beside the nightstand.<br><br>During an interview on [DATE] at 11:30 a.m., LVN 2 stated CNA 2 the gun found inside Resident 1 ' s bag was taken by the Administrator (ADM) and the ADM turned the gun over to the police officer when they arrived at the facility. LVN2 stated it was dangerous for Resident 1 to have a gun in the facility. Resident 1 could have used it to harm himself and other residents and staff inside the facility. LVN 2 stated it was the facility ' s responsibility to provide a safe environment for all the resident and staff inside the facility.<br><br>During an interview on [DATE] at 12:00 p.m., the Social Services Designee (SSD) stated the facility was not aware how the gun got inside the facility. The SSD stated when Resident 1 goes OOP and comes back with bags, it was the nurse ' s responsibility to check all items any resident would bring back to the facility.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on [DATE] at 2:31 p.m., the DON stated the facility prohibit (forbid) to have a gun in the facility. The DON stated residents ' safety are the facility ' s priority.<br><br>During a review of the facility ' s policy and procedures (P&P) titled, Safety and Supervision of Residents, dated 2001, the P&P indicated resident safety and supervision to prevent accidents are facility wide priorities. The P&P indicated safety risk and environmental hazard should be identified on an ongoing basis through a combination of employee training, monitoring, reporting processes. The P&P indicated employee should be trained on potential accident hazards, how to identify and report accident hazards. The P&P indicated the care team shall target interventions to reduce individual risk related to hazards in the environment, including adequate supervision. The P&P indicated resident supervision was a core component of the systems approach to safety. The P&P indicated the type and frequency of resident supervision should be determined by the individual resident ' s assessed needs and identified hazards in the environment. |

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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 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45657<br><br>Based on interview and record review, the facility failed to ensure, one of four sampled residents (Resident 1), had no medications at the bedside.<br><br>This failure had potentially caused the resident drug overdose that resulted in in death.<br><br>Findings:<br><br>During a review of Resident 1 ' s Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE], with diagnoses including major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), opioid dependence (a chronic disease that occurs when someone regularly uses opioids [strong pain killers] and develops a strong drive to continue using them, even when it causes harm), and suicidal ideations (thinking about or planning suicidal.)<br><br>During a review of Resident 1 ' s History and Physical (H&P) dated [DATE], the H&P indicated Resident 1 had the mental capacity to understand and make medical decisions.<br><br>During a review of Resident 1 ' s Minimum Data Set ([MDS] a standardized care assessment and care screening tool), dated [DATE], the MDS indicated Resident 1 had the ability to make self understood and the ability to understand others. The MDS indicated Resident 1 required supervision or touching assistance with activities of daily living (ADLs) such as dressing, toilet use, personal hygiene, transfer (moving between surfaces to and from bed, chair, and wheelchair) and bed mobility (how resident moves from lying to turning side to side).<br><br>During a review of Resident 1 ' s progress notes on admitted d [DATE] at 1:01 p.m., the progress notes indicated Resident 1 had episodes of confusion.<br><br>During a review of Resident 1 ' s progress notes dated [DATE] at 2:58 p.m., the progress notes indicated, after Resident 1 ' s postmortem care was done on [DATE] at 7:57 a.m., the facility staff gathered Residents 1 ' s belonging and observed multiple bottles with (unidentified) medications inside Resident 1 ' s bedside drawer.<br><br>During a review of Resident 1 ' s Quality Assurance Action Plan (QA) dated [DATE], the QA indicated during postmortem care and the collection of the Resident 1 ' s belongings, a total of four empty medications bottles and nine bottles containing medication were discovered. The medications identified inside the bottle included:<br><br>1). [NAME] oval tablets, marked 18 Ibuprofen (anti-inflammatory drug) 800 milligrams (mg- metric unit of measurement)<br><br>2). [NAME] oval tablets, marked 56 quetiapine (medication for schizophrenia, bipolar disorder, and depression.) 300 mg.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056378 | A. Building<br>B. Wing | 12/19/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Ocean Ridge Post Acute | 3850 E. Esther St.<br>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.

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|---|---|
| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 3). [NAME] oval tablets marked 300 quetiapine 300 mg.<br><br>4). [NAME] oval tablets, marked 259 quetiapine 300 mg.<br><br>During an interview on [DATE] at 12:10 p.m., the Certified Nurse Assistance (CNA) 2 stated, during the postmortem care process for Resident 1, the belongings were accounted for and some bottles of pills were found on the nightstand. CNA 2 stated the bottles were closed. CNA 2 stated, the Licensed Vocational Nurses (LVN) 2 was informed of the findings.<br><br>During an interview on [DATE] at 12:15 p.m., the Director of Nursing (DON) stated, on [DATE], a call was received from the Charge Nurse and notified her (DON) that Resident 1 had died . The DON stated, the Charge Nurse reported, during the process of doing the postmortem care, medications bottles were found on Resident 1 ' s bedside table. The DON stated some of the bottles were empty and some had ibuprofen and quetiapine tablets. The DON stated Resident 1 used to go out on pass (OOP). The DON stated we believed he got the medications maybe from the pharmacy or he got it from his previous home.<br><br>During an interview on [DATE] at 11:30 a.m., LVN 2 stated the labels on the bottles could not be read. LVN 2 stated she could not identify what kind of pills were in the bottle. LVN 2 stated there were more than two bottles. LVN 2 stated some of the bottles were empty and had some pills. LVN 2 stated it was not safe for Resident 1 to keep medications at bedside. LVN 2 stated keeping medications at the bedside placed any residents at risk for drug overdose.<br><br>During an interview on [DATE] at 2:47 p.m., the DON stated all medications must be kept in the medication cart or medication room which only licensed nurses had access. The DON stated the risk of keeping medications at the bedside without a proper self-administration assessment, can place the residents at risk for drug overdose and other drug reactions, resulting to hospitalization or death.<br><br>During a review of the facility ' s policy and procedures (P&P) titled Medications Labeling and Storage, dated 2001, the P&P indicated, medications should be stored in cabinets, drawers, carts, or automatic dispensers ' system. |