STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056378	A. Building B. Wing	02/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ocean Ridge Post Acute	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)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement its abuse reporting and prevention policy and procedure (P&P) by failing to report unusual occurrences to officials which included the Long-Term Care Ombudsman, Law Enforcement, and the California Department of Public Health (CDPH) for one of five sampled residents (Resident 1), when Resident 1 sustained a displaced (bone snaps into two or more pieces and shifts out of alignment) fracture (break) through the left humeral neck (upper portion of the left arm bone just below the shoulder ball) injury of unknown origin.This failure had potential to result in a delay in an onsite inspection by the CDPH to ensure injuries from unknown origins were investigated and lead to a delay in preventing potential unknown injuries.Findings:During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including polyosteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage [firm, flexible tissue]), dementia (a progressive state of decline in mental abilities), and muscle weakness. During a review of Resident 1's history and physical (H&P) dated 8/29/2025, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 1/28/2026, the MDS indicated Resident 1 had moderate cognitive (judgement, planning, organization to manage average demands in one's environment) impairment. The MDS indicated Resident 1 was dependent on facility staff for all aspects of activities of daily living (ADL: basic activities such as eating, dressing, toileting), roll left and right and had impairments on both sides of the upper (shoulders/arms) and lower (hips/knees) extremities. During a review of Resident 1's change in condition (COC), dated 2/1/2026 at 11:17 p.m., the COC indicated Resident 1 had swelling of the left arm and had ecchymosis (discoloration of the skin resulting from bleeding underneath caused by bruising). During a review of Resident 1's X-Ray (a medical test that enables providers to get pictures of the inside of the body) Report, dated 2/2/2026, the X-Ray report indicated Resident 1 had a displaced fracture at surgical neck of humerus (left). During a review of Resident 1's COC, dated 2/3/2026 at 1:13 p.m., the COC indicated Resident 1 was transferred to a general acute care hospital (GACH) for treatment of Resident 1's left humerus fracture. During an interview on 2/23/2026 at 4:02 p.m., with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated Certified Nursing Assistant 2 (CNA 2) informed her about Resident 1's left arm discoloration. LVN 1 stated Resident 1's arm was discolored in the upper and lower part of the left arm. LVN 1 stated when there was a COC, she should have but did not notify her Director of Nursing (DON). During a concurrent interview and record review on 2/24/2026 at 10:52 a.m., with the DON, the facility's P&P titled Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, dated 2001 was reviewed. The DON stated an unusual occurrence included suspected abuse, such as an injury of unknown origin, and the facility's protocol for unusual occurrences was for LVN 1 to report to the DON, the (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056378	A. Building B. Wing	02/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ocean Ridge Post Acute	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)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administrator (ADMN), notify CDPH, the ombudsman (resident advocate) and if needed, law enforcement, and Adult Protective Services (APS: state-mandated program that investigates reports of abuse for ages 60 and above. The DON stated a serious injury such as accidents and fractures are unusual occurrences that must be reported to the appropriate officials and CDPH within two hours. The DON stated if a case of suspected abuse is not reported, the resident may not feel safe. The DON stated when LVN 1 found out about Resident 1's fracture on 2/3/2026, she should have informed her (DON) about it. The DON stated upon reviewing the Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating policy, which indicated all abuse including injuries of unknown origin now knows that this incident was reportable. During an interview on 2/24/2026 at 12:34 p.m., with the ADMN, the ADMN stated an unusual occurrence is an occurrence that cannot be explained, defined, or identify the root cause. The ADMIN stated for an unusual occurrence, and abuse allegations the facility would report the incident, notify the ombudsman, police, and CDPH within two hours of the initial incident, and follow up within 5 days with an investigation of the incident. The ADMN stated they do not know how Resident 1's left arm got broken. The ADMN stated this incident is an injury of an unknown origin and would have been reportable and indicated it would be reported since it is of an unknown origin. The ADMN stated should have investigated this incident to help them determine whether it was abuse or not. The ADMN stated if no one reported it, it could open the residents up to further harm and injury. During a review of the facility's policy and procedure (P&P) titled, Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, dated 2001, the P&P indicated all reports of resident abuse (including injuries of unknown origin), neglect.are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. If resident abuse or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. The administrator of the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: The state licensing/certification agency responsible for surveying/licensing the facility. Immediately is defined as a. within two hours of an allegation involving abuse or result in serous bodily injury; or b. within 24 hours of an allegation that does not involve abuse or result in serious bodily injury. Within five (5) business days of the incident, the administrator will provide a follow-up investigation report. During a review of the facility's P&P titled, Unusual Occurrence Reporting, dated 2001, the P&P indicated as required by federal or state regulations, our facility reports unusual occurrences or other reportable events which affect the health, safety, or welfare of our residents, employees or visitors. Unusual occurrences shall be reported via telephone to appropriate agencies as required by current law and/or regulations within twenty-four (24) hours of such incident or as otherwise required by federal and state regulations. A written report detailing the incident and actions taken by the facility after the event shall be sent or delivered to the state agency (and other appropriate agencies as required by law) within forty-weight (48) hours of reporting the event or as required by federal and state regulations.