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	01/24/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45891 Based on observation, interview, and record review the facility failed to ensure one out of nine sampled residents (Resident 73) had access to her call light (a device that allows patients to request assistance from nursing staff). This deficient practice had the potential to not meet the needs for Resident 73 and placed her at risk for accidents. Findings: During a review of Resident 73's Admission Record, the Admission Record indicated Resident 73 was admitted to the facility on [DATE] with diagnoses of muscle weakness, dementia (a general term encompassing a group of conditions that cause a gradual decline in cognitive abilities, affecting a person's memory, thinking, reasoning, and behavior), and major depressive disorder (a common mental health condition characterized by persistent feelings of sadness, loss of interest, and other symptoms that significantly interfere with daily life). During a review of Resident 73's care plans, a care plan was initiated on 5/31/2024 indicating Resident 73 was a high risk for falls related to general weakness and was totally dependent (facility staff does all the work) on transfers with goals to have no falls with interventions that included keeping Resident 73's call light within reach and answer the call light promptly. During a review of Resident 73's Minimum Data Set (MDS, a resident assessment tool) dated 12/4/2024, the MDS indicated Resident 73 had moderate cognitive impairment (a condition where a person experiences noticeable declines in cognitive functions, such as memory, attention, and reasoning). During an observation on 1/22/2025 at 8:43 a.m., Resident 73 was laying in her bed and the call light was laying on the floor on the right side of the bed out of her reach. During an observation on 1/22/2025 at 8:51 a.m., Certified Nursing Assistant (CNA 2) entered Resident 73's room and removed her breakfast tray from the bedside table, the call light was still laying on the floor. During an observation on 1/22/2025 at 8:55 a.m., CNA 2 went back into Resident 73's room and picked the call light up off the floor. Resident 73 asked CNA 2 to call her nurse (licensed vocational nurse [LVN 4] because she was nauseous and did not feel well. (continued on next page)

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	01/24/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/22/2025 at 9:11 a.m., CNA 2 stated when she entered Resident 73's room the call light was on the floor and out of Resident 73's reach. CNA 2 stated call lights always needed to be within resident's reach. During an observation and concurrent interview on 1/23/2025 at 9:36 a.m., Resident 73's call light was behind her bed wrapped around the bed frame. Resident 73 stated she was unable to reach her call light. During an observation and concurrent interview on 1/23/2025 at 10 a.m., the Director of Staff Development (DSD) entered Resident 73's room and unwrapped the call light from behind Resident 73's bed frame and clipped the call light to Resident 73's bedding within her reach. The DSD stated when she entered Resident 73's room, the call light was tangled behind her bed, and she had to fix it so Resident 73 could reach it. The DSD stated it was very important for Residents to have access to their call lights because that was their way to call for assistance when needed. The DSD stated there was no way to communicate with staff if the call light was not accessible. During an interview on 1/24/2025 at 1:23 p.m., the Director of Nursing (DON) stated Resident 73 required a lot of help from facility staff to carry out activities of daily living (ADLs, basic self-care tasks) and it was important she had her call light within reach. The DON stated it was important residents had their call lights easily accessible and not on the floor or wrapped on the bed frame so they could call for help when needed. The DON stated there was a potential for safety issues and accidents if the resident was unable to call for help when needed. During a review of the facility's policy and procedure (P/P) titled Answering the Call Lights dated 10/2010, the P/P indicated the call light was to be within easy reach when the resident was in bed.

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	01/24/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45382 Based on observation, interview, and record review, the facility failed to report changes of condition (COC, major decline or improvement in a resident's status that will not resolve itself without intervention) for two of nine sampled residents (Resident 32 and Resident 58) with limited range of motion (ROM, full movement potential of a joint) concerns by failing to: 1.Report to Medical Doctor (MD) Resident 32's multiple, consecutive Restorative Nursing Aide (nursing aide program that help residents maintain any progress made after therapy intervention to maintain their function) refusals from February 2024 to August 2024 and from August 2024 to January 2025 in accordance with the facility's Policy and Procedure (P/P) tilted, Change in a Resident's Condition or Status. 2.Notify the Resident 58 's physician during three instances when Resident 58's blood sugar exceeded 400 milligrams (mg- a unit of measurement)/(per) deciliter (dL- a unit of measurement), reference blood sugar range for a diabetic (a condition that occurs when the body doesn't use insulin properly, leading to high blood sugar levels) patient is 80-130 mg/dL before meals and less than 180 mg/dL two hours after eating) and one instance when resident 58's blood work result was critical. These failures resulted in Resident 32 not receiving services and interventions to improve ROM, prevent contractures (condition of shortening and hardening of muscles, tendons, or other tissue, often leading to joint stiffness), and improve overall mobility and physical functioning and put Resident at risk for serious health consequences for including coma, and hospitalization . Findings: 1.During a review of Resident 32's Admission Record, the Admission Record indicated the facility initially admitted Resident 32 on 8/4/2019 and readmitted Resident 32 on 1/30/2023 with diagnoses including left hemiplegia (weakness to one side of the body) and traumatic brain injury (damage to the brain from an external force that can cause temporary or permanent changes in brain function). During a review of Resident 32's Order Summary Report, the Order Summary Report indicated a physician's order, dated 8/11/2023, for RNA to assist Resident 32 with left leg passive range of motion (PROM, movement at a given joint with full assistance from another person) exercises to the left hip and left ankle, five times a week. During a review of Resident 32's RNA Documentation Survey Report flowsheet (RNA Flowsheet, daily record of RNA services provided for each month) for February 2024, the RNA Flowsheets indicated for RNA to provide PROM exercises to Resident 32's left hip and left ankle, five times a week. The squares on the RNA flowsheet indicated the letters RR on the following days: 2/1/2024 to 2/3/2024, 2/5/2024 to 2/10/2024, 2/12/2024 to 2/16/2024, 2/19/2024 to 2/23/2024, and 2/25/2024 to 2/29/2024. The key at the bottom of the RNA flowsheet indicated letters RR meant Resident Refused RNA treatment. (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 B. Wing	01/24/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 32's RNA Flowsheet for March 2024, the RNA Flowsheets indicated for RNA to provide PROM exercises to Resident 32's left hip and left ankle, five times a week. The squares on the RNA flowsheet indicated the letters RR on the following days: 3/1/2024 to 3/15/2024, 3/18/2024 to 3/23/2024, and 3/25/2024 to 3/29/2024. The key at the bottom of the RNA flowsheet indicated letters RR meant Resident Refused RNA treatment. During a review of Resident 32's RNA Flowsheet for April 2024, the RNA Flowsheets indicated for RNA to provide PROM exercises to Resident 32's left hip and left ankle, five times a week. The squares on the RNA flowsheet indicated the letters RR on the following days: 4/1/024 to 4/5/2024, 4/7/2024 to 4/12/2024, 4/15/2024 to 4/19/2024, 4/22/2024 to 4/26/2024, 4/29/2024, and 4/30/2024. The key at the bottom of the RNA flowsheet indicated letters RR meant Resident Refused RNA treatment. During a review of Resident 32's RNA Flowsheet for May 2024, the RNA Flowsheets indicated for RNA to provide PROM exercises to Resident 32's left hip and left ankle, five times a week. The squares on the RNA flowsheet indicated the letters RR on the following days: 5/1/2024 to 5/3/2024, 5/6/2024 to 5/10/2024, 5/13/2024 to 5/17/2024, 5/21/2024 to 5/24/2024, and 5/27/2024 to 5/30/2024. The key at the bottom of the RNA flowsheet indicated letters RR meant Resident Refused RNA treatment. During a review of Resident 32's RNA Flowsheet for June 2024, the RNA Flowsheets indicated for RNA to provide PROM exercises to Resident 32's left hip and left ankle, five times a week. The squares on the RNA flowsheet indicated the letters RR on the following days: 6/3/2024 to 6/5/2024, 6/10/2024 to 6/14/2024, 6/17/2024 to 6/20/2024, 6/24/2024, and 6/26/2024 to 6/28/2024. The key at the bottom of the RNA flowsheet indicated letters RR meant Resident Refused RNA treatment. During a review of Resident 32's RNA Flowsheet for July 2024, the RNA Flowsheets indicated for RNA to provide PROM exercises to Resident 32's left hip and left ankle, five times a week. The squares on the RNA flowsheet indicated the letters RR on the following days: 7/1/2024 to 7/5/2024, 7/8/2024 to 7/13/2024, 7/15/2024 to 7/19/2024, 7/22/2024 to 7/26/2024, and 7/29/2024. The key at the bottom of the RNA flowsheet indicated letters RR meant Resident Refused RNA treatment. During a review of Resident 32's RNA Flowsheet for August 2024, the RNA flowsheets indicated for RNA to provide PROM exercises to Resident 32's left hip and left ankle, five times a week. The squares on the RNA flowsheet indicated the letters RR on the following days: 8/1/2024, 8/2/2024, 8/5/2024 to 8/9/2024, 8/12/204 to 8/16/2024, 8/19/2024 to 8/23/2024, 8/26/2024 to 8/31/2024. The key at the bottom of the RNA flowsheet indicated letters RR meant Resident Refused RNA treatment. During a review of Resident 32's COC Evaluation, dated 8/1/2024, the COC Evaluation indicated the COC Evaluation was initiated due to Resident 32's multiple refusal of RNA services. The COC indicated Resident 32 was at risk for a mobility decline with recommendations for a Psychiatry consultation. During a review of Resident 32's Joint Mobility Screen (JMS, a brief assessment of a resident's range of motion of both arms and both legs), dated 8/6/2024, the JMS indicated Resident 32 had severe ROM limitations in the left hip and left knee and moderate ROM limitations in the left ankle. (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 B. Wing	01/24/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 32's RNA Flowsheet for September 2024, the RNA Flowsheets indicated for RNA to provide PROM exercises to Resident 32's left hip and left ankle, five times a week. The squares on the RNA flowsheet indicated the letters RR on the following days: 9/1/2024, 9/4/2024 to 9/6/2024, 9/9/2024 to 9/13/2024, 9/16/2024 to 9/20/2024, 9/23/2024 to 9/30/2024. The key at the bottom of the RNA flowsheet indicated letters RR meant Resident Refused RNA treatment. During a review of Resident 32's RNA Flowsheets for October 2024, the RNA flowsheets indicated for RNA to provide PROM exercises to Resident 32's left hip and left ankle, five times a week. The squares on the RNA flowsheet indicated the letters RR on the following days: 10/1/2024 to 10/5/2024, 10/7/2024 to 10/11/2024, 10/14/2024 to 10/19/2024, 10/21/2024 to 10/25/2024, and 10/28/2024 to 10/31/2024. The key at the bottom of the RNA flowsheet indicated letters RR meant Resident Refused RNA treatment. During a review of Resident 32's RNA Flowsheets for November 2024, the RNA flowsheets indicated for RNA to provide PROM exercises to Resident 32's left hip and left ankle, five times a week. The squares on the RNA flowsheet indicated the letters RR on the following days: 11/1/2024 to 11/16/2024, 11/18/2024 to 11/20/2024, and 11/25/2024 to 11/29/2024. key at the bottom of the RNA flowsheet indicated letters RR meant Resident Refused RNA treatment. During a review of Resident 32's Minimum Data Set (MDS, a federally mandated assessment tool), dated 11/5/2024, the MDS indicated Resident 32 had severely impaired cognition (ability to think, understand, learn, and remember) and vision. The MDS indicated Resident 32 required substantial/maximal assistance for eating, hygiene, upper body dressing, and rolling to both sides and was dependent in bathing, lower body dressing, and transfers. The MDS indicated Resident 32 had functional ROM limitations (limited ability to move a joint that interferes with daily functioning, including activities of daily living, or places the resident at risk of injury) in one arm (shoulder, elbow, wrist, hand) and both legs (hips, knees, ankles, and feet). During a review of Resident 32's RNA Flowsheets for December 2024, the RNA flowsheets indicated for RNA to provide PROM exercises to Resident 32's left hip and left ankle, five times a week. The squares on the RNA flowsheet indicated the letters RR on the following days: 12/2/2024, 12/5/2024, 12/9/2024 to 12/13/2024, 12/17/2024 to 12/23/2024, 12/25/2024 to 12/27/2024, and 12/30/224. The key at the bottom of the RNA flowsheet indicated letters RR meant Resident Refused RNA treatment. The squares on the RNA Flowsheet were blank on the following days: 12/3/2024, 12/4/2024, 12/15/2024, 12/16/2024, and 12/24/2024. During a review of Resident 32's RNA Flowsheets for January 2025, the RNA flowsheets indicated for RNA to provide PROM exercises to Resident 32's left hip and left ankle, five times a week. The squares on the RNA flowsheet indicated the letters RR on the following days: 1/1/2025 to 1/3/2025, 1/6/2025, 1/9/2025, 1/10/2025, 1/13/2025 to 1/17/2025, and 1/21/2025. The key at the bottom of the RNA flowsheet indicated letters RR meant Resident Refused RNA treatment. The squares on the RNA Flowsheet were blank on the following days: 1/7/2025 and 1/20/2025. (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 B. Wing	01/24/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation of Resident 32's RNA session and interview on 1/22/2025 at 10:59 am, Resident 32 was lying in bed with both legs straight with the right leg crossed over the left leg. Restorative Nursing Aide 1 (RNA 1) assisted with left arm ROM exercises. RNA 1 attempted to assist Resident 32 with PROM exercises to the left leg, but Resident 32 refused. RNA 1 stated Resident 32 always refused PROM exercises to the left leg. RNA 1 stated he did not recall the last time Resident 32 participated in left leg PROM exercises. RNA 1 stated the Nursing department and the Rehabilitation department (Rehab) were aware of Resident 32's constant refusals. During a concurrent observation and interview on 1/22/2025 at 9:12 am, Resident 32 was lying in bed with both legs straight, right leg crossed over the left leg. Resident 32 stated staff did not assist with exercises to the left leg. Resident 32 stated his left leg was painful and broken. Resident 32 stated he was unable to move the left leg on his own. During an interview on 1/23/2025 at 10:23 pm, Licensed Vocational Nurse 4 (LVN 4) stated a COC was considered anything residents experience that was different from his or her baseline. LVN 4 stated all RNA refusals were reported immediately to the charge nurse. LVN 4 stated if a resident refused RNA services two to three times consecutively, any licensed nurse must initiate a COC, re-assess the resident, notify the physician, notify the resident's responsible party, and implement any recommended interventions. LVN 4 stated it was important to notify the physician of any resident's change of condition because the physician may need to re-assess the resident, order the appropriate tests, and implement specific interventions to address the issue. LVN 4 stated if a resident had a long-standing pattern of consecutive refusals, it was important to notify and follow up with the physician to ensure the resident's needs were being met and the implemented interventions were effective. During an interview on 1/23/2025 at 10:41 am, Restorative Nursing Aide 1 (RNA 1) stated RNA attempted RNA sessions at least three times daily if a resident refused RNA services. RNA 1 stated if a resident continued to refuse RNA, RNA must notify the charge nurse immediately and discuss the resident's multiple refusals in the regular RNA meetings with nursing and the Rehabilitation Department (Rehab) to ensure all departments were aware. (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 B. Wing	01/24/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 1/23/2025 at 10:47 am, the Director of Staff Development (DSD) stated she supervised the RNAs. The DSD stated all RNA refusals must immediately be reported to the charge nurse and discussed in the regular RNA meetings with nursing and Rehab. The DSD stated if a resident consistently refused RNA, the licensed nurse must initiate a COC, notify the physician, and notify Rehab for re-assessment to possibly put the resident back on skilled therapy or modify the RNA program. The DSD stated it was important the physician, Rehab, and nursing staff were all notified of consecutive and recurring RNA refusals to ensure all departments were aware of the issue to collaboratively investigate the reason for refusals to ensure the appropriate interventions were implemented. The DSD reviewed Resident 32's RNA Flowsheets from February 2024 to January 2025. The DSD stated RR on the RNA Flowsheets indicated Resident 32 refused RNA services that day. The DSD confirmed Resident 32 refused RNA for left leg ROM exercises almost every day, five times a week, from February 2024 to January 2025. The DSD reviewed Resident 32's clinical record from February 2024 to January 2025 and confirmed one COC regarding Resident 32's multiple RNA refusals was initiated on 8/1/2024 (6 months later). The DSD stated she was unable to locate any other evidence of notification to the physician and COCs regarding Resident 32's RNA refusals after 8/1/2024 despite Resident 32's continued refusals. The DSD confirmed Resident 32 continued to refuse RNA services for left leg ROM exercises almost every day, five times a week from August 2024 to January 2025 and no additional COC was initiated. The DSD stated the first COC should have been initiated in 2/2024 when Resident 32 began a pattern of multiple and consecutive refusals of RNA services and continued initiating COCs if the interventions were ineffective. The DSD stated the facility should have followed up and initiated an additional COC after 8/1/2024 to ensure the implemented interventions were effective and the physician was notified and aware of Resident 32's continued refusals. The DSD stated RNA informed her and Rehab of Resident 32's continuous and consecutive RNA refusals in the routine RNA meetings but did not notify the physician and did not follow up to ensure any interventions were implemented or effective. The DSD stated the physician should have been notified and Rehab should have been reconsulted to provide skilled therapy services or modify the RNA program to prevent a decline in Resident 32's ROM, ADLs, and mobility. During a concurrent interview and record review on 1/24/2025 at 10:21 am, Registered Nurse 2 (RN 2) who was also the Assistant Director of Nursing stated a COC was supposed to be initiated when any change from a resident's baseline was observed. RN 2 stated RNA immediately reported any RNA refusals to the charge nurse who in turn initiated a COC and notified the physician. RN 2 stated multiple, consecutive refusals of RNA was considered a COC and the physician must be notified to ensure the resident was assessed appropriately and the proper interventions were implemented. RN 2 reviewed Resident 32's clinical record, RNA Flowsheets from February 2024 to January 2025, and COC Evaluations. RN 2 confirmed Resident 32 refused RNA multiple, consecutive times from February 2024 to January 2025 with evidence of only one COC completed regarding multiple RNA refusals on 8/1/2024. RN 2 stated a COC should have been initiated in February 2024 when multiple, consecutive RNA refusals began to occur with continued COCs thereafter until the implemented interventions were shown to be effective. RN 2 stated the physician should have been notified immediately, the reason for refusal should have been investigated, and Rehab should have been consulted for re-assessment but was not. RN 2 stated if Resident 32 was identified as having left leg ROM limitations, was at high risk for contracture development, and was in facility with no ROM exercises or interventions to maintain or prevent a decline, Resident 32 could potentially have a functional decline and develop contractures. (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 B. Wing	01/24/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 1/24/2025 at 2:06 pm, the Director of Nursing (DON) stated once staff identified a resident had a COC, a licensed nurse created a COC Evaluation, notified the physician, notified the resident's family or responsible party, implemented interventions, updated the comprehensive care plan, and monitored the resident to ensure effectiveness. The DON reviewed Resident 32's electronic medical record, RNA Flowsheets from February 2024 to January 2025, and COC Evaluation dated 8/1/2024. The DON confirmed Resident 32 refused RNA multiple, consecutive times from February 2024 to January 2025 with evidence of only one COC completed regarding multiple RNA refusals on 8/1/2024. The DON stated a COC should have been initiated in February 2024 when multiple, consecutive RNA refusals began to occur with continued COCs thereafter until the implemented interventions were shown to be effective. The DON stated an additional COC should have been initiated after 8/1/2024 when the initial COC was completed to ensure implemented interventions were effective. The DON stated the physician should have been notified immediately, the reason for refusal should have been investigated, action should have been implemented once RNA discussed the multiple refusals during the routine RNA meetings, and Rehab should have been consulted for re-assessment but was not. The DON stated the physician should have been notified earlier and throughout the process to assist in identifying the root cause of RNA refusals and suggest or provide alternative interventions to address the issue. The DON stated Resident 32 could potentially have a functional decline and develop contractures if the physician was not notified and interventions to maintain or improve ROM were not implemented. 2.During a review of Resident 58's Admission Record, the Admission Record indicated the facility admitted Resident 58 on 1/18/2024 and readmitted on [DATE] with diagnoses including diabetes mellitus (DM). During a review of Resident 58's Minimum Date Set, dated 10/18/2024, the MDS indicated Resident 58 had moderately impaired cognitive (related to thinking, reasoning, and other mental processes) skills. During a review of Resident 58's History and Physical (H&P), dated 7/15/2024, the H&P indicated, Resident 58's physician set specific goals for Resident 58, including maintaining Hemoglobin A1C (HbA1c-a blood test that measures your average blood sugar level over the past two to three months) between 7.5% (percent) to 8.0% and blood glucose (BS-blood sugar) levels between 100-200mg/dL. During a review of Resident 58's care plan for hyperglycemia (a condition where the level of glucose in your blood is higher than normal) related to DM, initiated on 5/1/2024, indicated interventions to monitor, document, and report signs or symptoms of hyperglycemia to the physician as needed. a. During a review of Resident 58's medication Administration Record (MAR), dated November 2024 and December 2024, the MAR indicated Resident 58's BS level exceeded 400 mg/dL as follows: 550 mg/dL on 11/4/2024 at 9 p.m. 410 mg/dL on 11/22/2024 at 9 p.m. 400 mg/dL on 12/24/2024 at 9 p.m. (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 B. Wing	01/24/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 58's Nursing progress notes for November 2024 and December 2024, the Nursing progress notes indicated that staff failed to notify the physician when the BS levels exceeded 400mg/dL on 11/4/2024, 11/22/2024, and 12/24/2024. During a concurrent interview and record review on 1/24/2025 at 10:00 a.m. with Registered Nurse (RN)1, Resident 58's MAR and Nursing progress notes for November 2024 and December 2024 were reviewed. RN 1 stated that staff should notify the physician immediately when Resident 58's BS levels exceeded 400mg/dL on 11/4/2024, 11/22/2024, and 12/24/2024. RN 1 stated that there was no documentation related to these incidents. b. During a review of Resident 58's blood test results, drawn on 12/11/2024, the blood test results indicated Resident 58's HgA1c was 9.7, which was higher than the physician's goal for Resident 58. During a review of Resident 58's nursing progress notes, dated 12/19/2024, the nursing progress notes indicated that staff notified the physician of the 9.7% of HbA1c eight days later on 12/19/2024. During a concurrent interview and record review on 1/24/2025 at 10:00 a.m., with Registered Nurse (RN)1, Resident 58's MAR and Nursing progress notes for November 2024 and December 2024 were reviewed. RN 1 stated that blood test results typically become available within a day after being drawn and that an HbA1c level of 9.7% was considered critically high, requiring same day physician notification to ensure timely intervention to prevent adverse reactions. RN 1 stated, the results were reported eight days later and such delays in notification could lead to complications resulting in hospitalization . During a concurrent interview and record review on 1/24/2025 at 10:44 a.m. with the Director of Nursing (DON), Resident 58's Nursing progress notes, change of condition (COC), Interdisciplinary Team (IDT-residents' health care team consisting of various specialties) meeting records for November 2024 and December 2024 were reviewed. The DON stated that there was no documentation related to these incidents. The DON also stated that failure to follow proper protocols could lead to complications, including hyperglycemia and hospitalization During a concurrent interview and review of the facility's policy and procedure (P&P) titled, Change in a resident's condition or status, dated 2001, the P&P indicated, the nurse will notify the resident's attending physician or physician on call when there had been a significant change in the resident's physical, emotional, or mental condition. The DON stated that hyperglycemic which BS levels exceeds 400mg/dL is considered as a change in condition. During a review of the facility's Policy and Procedure (P&P) titled, Change in a Resident's Condition or Status, dated 2001, the P&P indicated the facility would promptly notify the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status. The P/P indicated the nurse would notify the resident's attending physician or physician on call when there had been refusal or treatment or medications two or more consecutive times.

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	01/24/2025

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 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** 45891 50144 Based on interview and record review, the facility failed to accurately reflect two of three sampled resident's (Resident 21 and Resident 79) 1.Resident 21's medical diagnosis on the minimum data set (MDS, resident assessment tool). 2. For Resident 79 ensure pain frequency was accurately documented in the MDS. This deficient practice had the potential for Resident 21 to not receive person centered care related to her diagnosis of bipolar disorder (a mental health condition characterized by significant and persistent shifts in mood, energy, and activity levels) and Resident 79 to experience a delay of pain management care planning including obtaining the appropriate consults and providing a suitable pain management regimen and relief. Findings: 1.During a review of Resident 21's Admission Record, the Admission Record indicated Resident 21 was admitted to the facility 3/25/2024 with diagnosis of Parkinson's disease (a chronic brain disorder that causes movement problems, stiffness, and tremors), and anxiety disorder (a group of mental health conditions characterized by excessive and persistent worry, fear, and nervousness that can significantly interfere with daily life). During a review of Resident 21's Order Summary Report, the Order Summary report indicated an order was placed 6/4/2024 for Depakote (an antiseizure medication that can help treat mania [a state of abnormally elevated mood, energy, and activity levels that can last for several days or weeks] and mixed episodes of bipolar disorder) 125 milligrams (mg, a unit of measurement) twice a day (BID) for bipolar affective disorder. During a review of Resident 21's Patient Consult Psychiatry Consult dated 12/3/2024, the Psychiatry Consult indicated Resident 21 was assessed to have bipolar affective disorder and was receiving Depakote 125 mg BID for bipolar affective disorder manifested by labile (a state of rapid and unpredictable changes in mood, where emotions fluctuate intensely and frequently) moods. During a review of Resident 21's MDS dated [DATE], the MDS indicated Resident 21 had severe cognitive impairment (a deterioration or loss in intellectual capacity). The MDS did not include bipolar disorder as an active diagnosis in section I and Bipolar Disorder was not check marked for section I5900. (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 B. Wing	01/24/2025

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/24/2025 at 1:46 p.m., the Director Of Nursing (DON) reviewed Resident 21's MDS assessment dated [DATE] and stated there was no diagnosis of bipolar disorder. The DON reviewed Resident 21's Psychiatry Consult from 1/7/2025 and stated the Psychiatry Consult notes indicated Resident 21 was assessed as having bipolar disorder and receiving medication (Depakote) for bipolar disorder and stated the MDS assessment did not accurately reflect Resident 21's diagnoses. The DON stated it was important to have the MDS coded correctly to ensure the residents were receiving the correct care and treatment based on their needs. 2. During a review of Resident 79's Admission record (face sheet), dated 1/24/2025, the face sheet indicated Resident 79 was admitted to the facility on [DATE]. During a review of Resident 79's History and Physical (H&P), dated 8/20/2024, the H&P indicated Resident 79 had diagnoses including nontraumatic subdural hemorrhage (brain bleed that occurs without trauma), type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and history of a left hip replacement with chronic pain. The H&P indicated Resident 79 had capacity to make decisions. During a review of Resident 79's MDS, dated [DATE], the MDS indicated Resident 79 was able to understand and be understood by others, required supervision or touching assistance (helper provides verbal cures or steadying assistance throughout or intermittently) for hygiene, bathing, and dressing. The MDS indicated Resident 79 experienced pain occasionally. During a review of Resident 79's Physician Order Summary dated 1/24/2025, the Order Summary indicated a.Acetaminophen (over the counter medication for mild pain) tablet 325 milligrams (MG-unit of measurement) give 2 tablets by mouth every 4 hours as needed for mild pain (1-3) b.Tramadol HCL (medication to treat mild to moderate pain) oral tablet 50 MG give 1 tablet by mouth every 8 hours as needed for moderate pain (4-6) During an interview on 1/21/2024 at 12:06 p.m., with Resident 79, Resident 79 stated their pain is not being relieved with tramadol. Resident 79 stated they requested stronger pain medication, but did not receive it. During a concurrent interview and record review on 1/24/2025 at 2:48 p.m., with the MDS Coordinator (MDSC), Resident 79's records were reviewed. The MDS dated [DATE] indicated Resident 79 experiences pain occasionally. The MDSC stated the assessment reference date (ARD - date range that the MDSC references when documenting assessment) was 11/16/2024-11/22/2024. The Medication Administration Record (MAR) for November 2024 indicated Resident 79 complained of pain and received an as needed (PRN) Tramadol tablet 50 MG every day between 11/18/2204-11/22/2024. The MDSC stated the MDS should reflect that Resident 79 experiences pain almost constantly. The MDSC stated it is important for the MDS to accurately reflect the resident, to ensure the resident receives proper care and treatment. During an interview on 1/24/2024 at 3:59 p.m., with the DON, the DON stated if the MDS does not accurately reflect the resident's pain frequency, the resident may not receive a properly developed care plan and treatment to manage his pain. During a review of the facility's MDS Nurse Job Description, dated 07/2018, the job description indicated the MDS Nurse conducts observation and interviews as well as evaluations required for MDS and/or care plan preparations and assess resident care needs. (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 B. Wing	01/24/2025

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 21's policy and procedure (P/P) titled Charting and Documentation dated 2001, the P/P indicated documentation in the medical record was to be objective (not opinionated or speculative), complete, and accurate.

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	01/24/2025

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 45891 49573 Based on interview and record review, the facility failed to ensure five out of nine sampled residents (Residents 6, 24, 17, 28 and 79) had their level 1 Preadmission Screening and Resident Review (PASRR, is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care) completed accurately. This deficient practice had the potential to delay care for Resident 6, Resident 24, Resident 17, Resident 28 and Resident 79 and had the potential they would not receive the proper level of care or services they required. Findings: a. During a review of Resident 24's Admission Record, the Admission Record indicated Resident 24 was admitted to the facility 4/23/2024 with diagnoses of schizophrenia (a chronic mental illness characterized by disruptions in thought processes, perceptions, emotions, and behaviors) anxiety (a group of mental health conditions characterized by excessive and persistent worry, fear, and nervousness that can significantly interfere with daily life). During a review of Resident 24's PASRR level 1 (involves completion of an evaluation to determine if an individual has, or is suspected of having, a PASRR condition, i.e., serious mental illness (SMI), intellectual disability (ID), developmental disability (DD), or related condition (RC)) screening done on 4/23/2024 for admission to the facility, the level 1 screening was negative and per the record, Resident 24 did not require a level 2 screening (a person-centered evaluation that is completed for anyone identified by the Level 1 Screening as having, or suspected of having, a PASRR condition). The level 1 PASRR was marked no for Resident 24 being diagnosed with a serious mental illness such as schizophrenia and/ or mood disturbances. During a review of Resident 24's minimum data set (MDS, a resident assessment tool) dated 10/30/2024, the MDS indicated Resident 24 had severe cognitive impairment (a significant decline in cognitive abilities that interferes with daily life and independence). b. During a review of Resident 6's PASRR level 1 screening done on 1/3/2025 for admission to the facility, the level 1 screening was negative and per the record, Resident 6 did not require a level 2 screening. The level 1 PASRR was marked no for Resident 6 being diagnosed with a serious mental illness such as schizophrenia and/ or mood disturbances. During a review of Resident 6's Admission Record, the Admission Record indicated Resident 6 was admitted to the facility 1/5/2025 with diagnoses of bipolar disorder (a mental health condition characterized by significant and persistent shifts in mood, energy, and activity levels) and schizophrenia. (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 B. Wing	01/24/2025

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 6's minimum data set (MDS, a resident assessment tool) dated 1/12/2025, the MDS indicated Resident 6 had moderate cognitive impairment (a condition where a person experiences noticeable declines in cognitive functions, such as memory, attention, and reasoning, but not severe enough to meet the criteria for dementia). During an interview on 1/24/2025 at 1:12 p.m., the director of nursing (DON) stated the Level 1 PASRR was reviewed by admissions staff (unknown) to ensure it was done prior to admission to the facility. The DON stated the admissions staff were not nurses so they were not checking for accuracy, just that it was completed. The DON stated nursing staff reviewed the level 1 PASRRs to see if a level 2 screening was needed. The DON reviewed Resident 6 and Resident 24's, admission record, medications, and PASRR level 1's (Resident 6's completed 1/3/2025 and Resident 24's completed 4/23/2024), the DON stated the level 1 PASRRs for both Resident 6 and Resident 24 were not completed accurately because they both had a diagnosis of serious mental illness. The DON stated the accuracy of the level 1 PASRRs for Resident 6 and Resident 24 was missed upon admission. The DON stated it was important to capture an accurate level 1 PASRR because it triggers a level 2 PASRR which ensures residents with psychiatric diagnoses are being treated properly and receive the correct treatments while staying in skilled nursing facilities. b. During a review of Resident 17's Admission Record, the Admission Record indicated Resident 17 was admitted to the facility on [DATE] with diagnoses including bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety disorder (a group of mental health conditions that cause fear, dread and other symptoms that are out of proportion to the situation), and hemiplegia (paralysis on one side of body) and hemiparesis (muscle weakness on one side of the body) following cerebral infarction ([a stroke] damage to brain tissue due to loss of oxygen). During a review of Resident 17's history and physical (H/P) dated 10/24/24, the H/P indicated Resident 17 has the capacity to understand and make decisions. During a review of Resident 17's MDS, dated [DATE], the MDS indicated Resident 17 was moderately impaired in cognitive (thinking process) skills and needed supervision (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with self-care abilities such as eating, required moderate assistance (helper does less than half the effort, helper lifts, holds, or supports trunk or limbs but provides less than half the effort) for oral hygiene, required maximal assistance (helper does more than half the effort) for upper body dressing, and personal hygiene and was dependent (helper does all of the effort, resident does none of the effort to complete the activity, or the assistance or 2 or more helpers is required for the resident to complete the activity) for toileting hygiene, shower/bathe, lower body dressing, and putting on/taking off footwear. The MDS also indicated Resident 17 required moderate assistance with mobility abilities such as rolling left and right, and needed maximal assistance with sit to lying position, lying to sitting position, sit to stand and chair/bed to chair transfers. During a review of Resident 17's PASRR Level 1 Screening dated 9/30/24, the PASRR indicated Resident 17 was positive for serious mental illness (SMI) and SMI Level 2 Mental Health Evaluation was required. (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 B. Wing	01/24/2025

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 17's Notice of Attempted Evaluation for SMI Level 2 Mental Health Evaluation letter, the notice of attempted evaluation letter indicated after reviewing the positive SMI Level 1 screening and speaking with facility staff, a SMI Level 2 Mental Health Evaluation was not scheduled for the following reason that the individual currently has a duplicate PASRR on file. To reopen, the facility must resubmit a new level 1 screening. Facilities discharging to a skilled nursing facility (SNF) must submit another screening as a preadmission screening. SNFs must submit another screening as a resident review. During a concurrent observation and interview on 1/21/25 at 12:23 p.m. with Resident 17 in his room, Resident 17 was lying in bed with eyes closed. Resident 17 opened eyes when greeted. Resident 17 stated he was not sure if he was taking any medication for his mood such as a mood stabilizer. During a telephone interview on 1/23/25 at 11:45 a.m., with a representative from the California Department of Health Care Services PASRR and Utilization Management Branch, the representative stated the resident was transferred from another facility to this facility and this facility should have reached out to the other facility for the documents. The representative stated this facility should have done another screening for level 1 PASRR. During a concurrent interview and record review on 1/23/25 at 11:55 a.m. with MDS Coordinator (MDSC), the Notice of Attempted Evaluation for SMI Level 2 Mental Health Evaluation letter was reviewed. The MDSC stated the facility was supposed to submit another Level 1 PASRR screening according to what the document indicated. The MDSC stated the facility did not submit another Level 1 PASRR screening and that Resident 17 could have been improperly placed. The MDSC stated there was no plan of care in place for Resident 17 with a possible serious mental illness. c.During a review of Resident 28's Admission Record, the Admission Record indicated Resident 28 was admitted to the facility on [DATE] with diagnoses including schizophrenia (a mental illness that is characterized by disturbances in thought), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 28's H/P dated 12/21/24, the H/P indicated Resident 28 has fluctuating capacity to understand and make decisions. During a review of Resident 28's MDS dated [DATE], the MDS indicated Resident 28 was moderately impaired in cognitive skills and required supervision for self-care abilities such as eating, required maximal assistance with oral hygiene, upper body dressing, lower body dressing, putting on/taking of footwear, and personal hygiene, and was dependent on staff with toileting hygiene and shower/bathe. The MDS also indicated Resident 28 required maximal assistance with mobility such as rolling left and right, sit to lying position, lying to sitting on side of bed, sit to stand and chair/bed to chair transfers. (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 B. Wing	01/24/2025

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 28's PASRR level 1 screening dated 8/8/2022, the PASRR level 1 screening was negative, and a level II screening was not required. The reason noted for Resident 28's negative PASRR level 1 screening was no serious mental illness. The PASRR indicated NO was checked on question number 10, does the individual have a serious diagnosed mental disorder such as Depressive Disorder, Anxiety Disorder, Panic Disorder, Schizophrenia/Schizoaffective Disorder, or symptoms of Psychosis, Delusions, and/or Mood Disturbance? During a concurrent observation and interview on 1/21/2025 at 11:43 a.m., with Resident 28 in her room, Resident 28 was resting in bed with eyes closed and opened eyes when greeted. Resident 28 stated she does not know if she was taking anything for her mood like a mood stabilizer. During a concurrent interview and record review on 1/23/2025 at 11:37 a.m., with MDSC, the Level 1 PASRR Screening was reviewed. MDSC stated the level 1 PASRR screening was done incorrectly for this resident. Resident 28 has a diagnosis of schizophrenia, and the question should have been answered yes to trigger Level 2 PASRR screening to be done and Resident 28 to be evaluated for Level 2 Mental Health Evaluation. The MDSC stated Resident 28 may not be properly placed in the facility and that Level 2 PASRR services would not be offered to this resident because Level 1 was done incorrectly. The MDSC stated Resident 28 was already taking medication for schizophrenia since 8/8/22 and the facility would not be able to develop an individualized care plan for this resident because the resident was never evaluated for Level 2 PASRR. D.During a review of Resident 79's Admission Record, the Admission Record indicated Resident 79 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), 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), and muscle weakness. During a review of Resident 79's H/P dated 8/20/2024, the H/P indicated the patient has capacity for medical decision making. During a review of Resident 79's MDS dated [DATE], the MDS indicated Resident 79 had intact cognitive skills and required set up or clean up assistance (helper sets up or cleans up, resident completes activity, helper assists only prior to or following the activity) with self-care abilities such as eating, supervision with oral hygiene, toileting hygiene, shower/bathe, upper body dressing, lower body dressing, putting on/taking off footwear and personal hygiene. The MDS also indicated Resident 79 required supervision with mobility such as rolling left and right, sit to lying position, lying to sitting on side of bed, sit to stand, chair/bed to chair transfer, toilet transfer, and tub/shower transfer. During a review of Resident 79's PASRR level 1 screening dated 8/16/2024, the PASRR level 1 screening was negative, and a Level 2 screening was not required. The reason noted for Resident 79's negative PASRR Level 1 screening was no serious mental illness. The PASRR indicated NO was checked on question number 10, does the individual have a serious diagnosed mental disorder such as Depressive Disorder, Anxiety Disorder, Panic Disorder, Schizophrenia/Schizoaffective Disorder, or symptoms of Psychosis, Delusions, and/or Mood Disturbance? (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 B. Wing	01/24/2025

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 1/21/2025 at 3:09 p.m. with Resident 79 in his room, Resident 79 had just come back from smoking break. Resident 79 stated he was taking a medication for his mood but does not remember what he was taking. During a concurrent interview and record review on 1/23/2025 at 11:37 a.m., with MDSC, the Level 1 PASRR Screening was reviewed. MDSC stated the Level 1 PASRR screening was done incorrectly for this resident. Resident 79 has a diagnosis of bipolar disorder, and the question should have been answered yes to trigger Level 2 PASRR screening to be done and Resident 79 to be evaluated for Level 2 Mental Health Evaluation. During a concurrent interview and record review on 1/24/2025 at 3:36 p.m., with Director of Nursing (DON), the Notice of Attempted Evaluation for SMI Level 2 Mental Health Evaluation letter was reviewed for Resident 17 and PASRR Level 1 screening for Resident 28 and Resident 79 was reviewed. DON stated Resident 17 should have had another PASRR Level 1 screening done, and Resident 28 and Resident 79 should have been assessed for PASRR Level 1 correctly. DON stated it was important for residents to get the PASRR assessed correctly so that residents can receive the services needed for them for their mental illness such as residents with certain diagnosis, making sure the correct psychotropic medications are ordered, the psychiatrist and psychology consultations are on board to help the residents. During a review of the facility's policy and procedure (P/P) titled PASRR (Preadmission Screening and Resident Review), dated 6/2018, indicated, to ensure each patient in the facility is screened for a mental disorder (MD) or intellectual disability (ID) prior to admission and that individuals identified with MD or ID are evaluated and receive care and services in the most integrated setting appropriate to their needs .a negative Level I screen permits admission to proceed and ends the pre-screening process unless possible serious mental disorder or intellectual disability arises later . a positive PAS RR Level I screen necessitates an in-depth evaluation of the individual, by the state designated authority, known as a Level II PASRR, which must be conducted prior to admission to the facility .it is the facilities responsibility to ensure the level I PASRR is completed and accurate prior to admission.

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	01/24/2025

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 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** 45891 49573 Based on interview and record review, the facility failed to create and implement a person-centered care plan for three of three sampled residents (Residents 73, 17 and 28). The facility failed to: a.Create a care plan for Resident 73 who experienced nausea and had an order for Zofran (medication used to prevent nausea and vomiting). b.Create a care plan for Resident 17 for taking controlled medication (temazepam, a sleeping aid to help with difficulty falling asleep or staying asleep) at night. c.Create a care plan for Resident 28 for self-care deficit and grooming pertaining to fingernails. These deficient practices had the potential not to provide resident specific care and monitoring. Findings: a.During a review of Resident 73's Admission Record, the Admission Record indicated Resident 73 was admitted to the facility 11/29/2022 with diagnoses of muscle weakness, dementia (a general term encompassing a group of conditions that cause a gradual decline in cognitive abilities, affecting a person's memory, thinking, reasoning, and behavior), and major depressive disorder (a common mental health condition characterized by persistent feelings of sadness, loss of interest, and other symptoms that significantly interfere with daily life). During a review of Resident 73's order summary report, the order summary report indicated Resident 73 had an order placed 11/5/2024 for Zofran 4 milligrams (mg, a unit of measurement), give one tablet by mouth every six hours as needed for nausea and vomiting. During a review of Resident 73's Minimum Data Set (MDS, a resident assessment tool) dated 12/4/2024, the MDS indicated Resident 73 had moderate cognitive impairment (a condition where a person experiences noticeable declines in cognitive functions, such as memory, attention, and reasoning). During a review of Resident 73's care plans, there was no care plan addressing the use of as needed nausea medication (Zofran) for nausea. During an interview on 1/21/2025 at 12:19 p.m., Resident 73 stated she was feeling nauseous and feels nauseous often. During an observation on 1/22/2025 at 8:55 a.m., Resident 73 was observed telling Certified Nursing Assistant (CNA 2), I feel bad and she was feeling nauseous. (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 B. Wing	01/24/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/24/2025 at 1:29 p.m., the Director of Nursing (DON) stated she reviewed Resident 73's electronic medical record and Resident 73 had an order for as needed nausea medication (Zofran). The DON stated residents that experienced nausea or had as needed nausea medication should have a care plan addressing the nausea but Resident 73 did not have one. The DON stated it was important to have a care plan that was individualized and addressed the nausea because it would outline the interventions specific to Resident 73 and managing her nausea, it would provide continuity of care for the nursing team. b.During a review of Resident 17's Admission Record, the Admission Record indicated Resident 17 was admitted to the facility on [DATE] with diagnoses including bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety disorder (a group of mental health conditions that cause fear, dread and other symptoms that are out of proportion to the situation), and hemiplegia (paralysis on one side of body) and hemiparesis (muscle weakness on one side of the body) following cerebral infarction ([a stroke] damage to brain tissue due to loss of oxygen). During a review of Resident 17's history and physical (H/P) dated 10/24/24, the H/P indicated Resident 17 has the capacity to understand and make decisions. During a review of Resident 17's MDS, dated [DATE], the MDS indicated Resident 17 was moderately impaired in cognitive (thinking process) skills and needed supervision (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with self-care abilities such as eating, required moderate assistance (helper does less than half the effort, helper lifts, holds, or supports trunk or limbs but provides less than half the effort) for oral hygiene, required maximal assistance (helper does more than half the effort) for upper body dressing, and personal hygiene and was dependent (helper does all of the effort, resident does none of the effort to complete the activity, or the assistance or 2 or more helpers is required for the resident to complete the activity) for toileting, shower/bathe, lower body dressing, and putting on/taking off footwear. The MDS also indicated Resident 17 required moderate assistance with mobility abilities such as rolling left and right, and needed maximal assistance with sit to lying position, lying to sitting position, sit to stand and chair/bed to chair transfers. During a review of Resident 17's Order Summary Report, the Order Summary Report indicated temazepam oral capsule 15 milligram ([mg], a unit of measurement) give one capsule by mouth at bedtime for insomnia (difficulty falling asleep or staying asleep) manifested by inability to sleep ordered on 1/10/25. During a review of Resident 17's electronic medication administration record (MAR) for January 2025, the MAR indicated Resident 17 was receiving temazepam oral capsule 15 mg give one capsule by mouth at bedtime for insomnia manifested by inability to sleep from 1/10/25 to 1/23/25 with no missing gaps. During a review of Resident 17's comprehensive care plan, date unknown, the comprehensive care plan did not indicate a care plan addressing Resident 17's medication of the sleeping aid used for inability to sleep. (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 B. Wing	01/24/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 1/23/25 at 3:56 p.m. with MDS Coordinator (MDSC), the comprehensive care plan, date unknown, was reviewed. The MDSC stated there was no care plan for Resident 17 taking the sleeping aid. The MDSC stated there should have been a care plan so the facility can monitor if the medication was effective. The MDSC stated there are goals for the resident and interventions in place if the medication was not working for him but since there was no care plan, there was no monitoring. b.During a review of Resident 28's Admission Record, the Admission Record indicated Resident 28 was admitted to the facility on [DATE] with diagnoses including schizophrenia (a mental illness that is characterized by disturbances in thought), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 28's H/P dated 12/21/2024, the H/P indicated Resident 28 has fluctuating capacity to understand and make decisions. During a review of Resident 28's MDS dated [DATE], the MDS indicated Resident 28 was moderately impaired in cognitive skills and required supervision for self-care abilities such as eating, required maximal assistance with oral hygiene, upper body dressing, lower body dressing, putting on/taking of footwear, and personal hygiene, and was dependent on staff with toileting and shower/bathe. The MDS also indicated Resident 28 required maximal assistance with mobility such as rolling left and right, sit to lying position, lying to sitting on side of bed, sit to stand and chair/bed to chair transfers. During a review of Resident 28's comprehensive care plan, date unknown, the comprehensive care plan did not have a care plan for self-care and grooming pertaining to fingernails. During a concurrent observation and interview on 1/21/2025 at 11:43 a.m. with Resident 28 in her room, Resident 28 had long fingernails with black material underneath her fingernails. Resident 28 stated the last time her fingernails was trimmed, the staff cut into her skin on the side, and she does not want that to happen again. Resident 28 stated staff have not offered to clean or cut her fingernails but would want staff to try and cut them again but not touch the skin on the side. During a concurrent interview and record review on 1/24/2025 at 10:09 a.m. with Licensed Vocational Nurse (LVN) 2, the comprehensive care plan was reviewed. LVN 2 stated there should have been a care plan for this resident for her fingernails, even if the resident refused the grooming for her fingernails, there should have been a care plan for the refusal so the facility knows the services were offered but if resident refused, what other interventions can the facility do to help care for this resident. (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 B. Wing	01/24/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/24/2025 at 3:36 p.m., with Director of Nursing (DON), the DON stated the importance of having a care plan for Resident 17 taking the sleep aid and Resident 28 self-care and grooming was the care plan acts as a guidance to make sure resident centered care was provided to the residents. The DON stated each medication and/or diagnosis a resident has, should have a comprehensive care plan based on the plan of care for the resident. The DON stated there are goals and interventions for the residents and if the interventions does not work or was not effective, then the facility will let the doctors know so the facility can make changes to the care plan and find something else that may work. During a review of the facility's policy and procedure (P/P) titled Care Plans, Comprehensive Person-Centered dated 2001, the P/P indicated the care plan was to describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psycho-social well-being.

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	01/24/2025

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 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** 45382 Based on observation, interview, and record review, the facility failed to review and revise the comprehensive care plan for: 1.one of nine sampled residents (Resident 32) to address multiple, consecutive Restorative Nursing Aide (RNA, nursing program that uses restorative nursing aides to help residents maintain their function and joint mobility) refusals for Resident 32 who was identified as having left leg ROM limitations (ROM, full movement potential of a joint) and was at high risk for contracture development. 2.one of two sampled residents (Resident 79) to address severe pain that required increased use of as needed (PRN) pain medications from August 2024 to January 2025. The deficient practice for Resident 32 had the potential to negatively affect the delivery of necessary care and services and can lead to contracture (loss of motion of a joint associated with stiffness and joint deformity) development and a decline in overall physical functioning and activities of daily living (ADL, basic activities such as eating, dressing, toileting). The deficient practice for Resident 79 has the potential to result in a delay of providing pain relief and appropriate pain medication management. Findings: During a review of Resident 32's Admission Record, the Admission Record indicated the facility initially admitted Resident 32 on 8/4/2019 and readmitted Resident 32 on 1/30/2023 with diagnoses including left hemiplegia (weakness to one side of the body) and traumatic brain injury (damage to the brain from an external force that can cause temporary or permanent changes in brain function). During a review of Resident 32's Order Summary Report, the Order Summary Report indicated a physician's order, dated 8/11/2023, for RNA to assist Resident 32 with left leg passive range of motion (PROM, movement at a given joint with full assistance from another person) exercises to the left hip and left ankle, five times a week. During review of Resident 32's care plan, revised on 8/1/2024, the care plan indicated Resident 32 was at risk for a decline in ADLs and mobility (ability to move) due to Resident 32's refusal to participate in the RNA program. The care plan indicated goals for Resident 32 to have needs anticipated and met by staff and have no complications related to mobility with a revision date of 8/28/2024. The care plan indicated the interventions to meet the goals were to encourage Resident 32 to participate in ADLs to promote independence, encourage use of the call light, notify the physician of ADL declines, and consult psych (unspecified) due to RNA refusals. During a review of Resident 32's Joint Mobility Screen (JMS, a brief assessment of a resident's range of motion of both arms and both legs), dated 8/6/2024, the JMS indicated Resident 32 had severe ROM limitations in the left hip and left knee and moderate ROM limitations in the left ankle. (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 B. Wing	01/24/2025

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 32's RNA Documentation Survey Report flowsheet (RNA Flowsheet, daily record of RNA services provided for each month) for August 2024, the RNA flowsheets indicated for RNA to provide PROM exercises to Resident 32's left hip and left ankle, five times a week. The squares on the RNA flowsheet indicated the letters RR on the following days: 8/1/2024, 8/2/2024, 8/5/2024 to 8/9/2024, 8/12/204 to 8/16/2024, 8/19/2024 to 8/23/2024, 8/26/2024 to 8/31/2024. The key at the bottom of the RNA flowsheet indicated letters RR meant Resident Refused RNA treatment. During a review of Resident 32's RNA Flowsheet for September 2024, the RNA Flowsheets indicated for RNA to provide PROM exercises to Resident 32's left hip and left ankle, five times a week. The squares on the RNA flowsheet indicated the letters RR on the following days: 9/1/2024, 9/4/2024 to 9/6/2024, 9/9/2024 to 9/13/2024, 9/16/2024 to 9/20/2024, 9/23/2024 to 9/30/2024. The key at the bottom of the RNA flowsheet indicated letters RR meant Resident Refused RNA treatment. During a review of Resident 32's RNA Flowsheets for October 2024, the RNA Flowsheets indicated for RNA to provide PROM exercises to Resident 32's left hip and left ankle, five times a week. The squares on the RNA flowsheet indicated the letters RR on the following days: 10/1/2024 to 10/5/2024, 10/7/2024 to 10/11/2024, 10/14/2024 to 10/19/2024, 10/21/2024 to 10/25/2024, and 10/28/2024 to 10/31/2024. The key at the bottom of the RNA flowsheet indicated letters RR meant Resident Refused RNA treatment. During a review of Resident 32's RNA Flowsheets for November 2024, the RNA Flowsheets indicated for RNA to provide PROM exercises to Resident 32's left hip and left ankle, five times a week. The squares on the RNA flowsheet indicated the letters RR on the following days: 11/1/2024 to 11/16/2024, 11/18/2024 to 11/20/2024, and 11/25/2024 to 11/29/2024. key at the bottom of the RNA flowsheet indicated letters RR meant Resident Refused RNA treatment. During a review of Resident 32's Minimum Data Set (MDS, a federally mandated assessment tool), dated 11/5/2024, the MDS indicated Resident 32 had severely impaired cognition (ability to think, understand, learn, and remember) and vision. The MDS indicated Resident 32 required substantial/maximal assistance for eating, hygiene, upper body dressing, and rolling to both sides and was dependent in bathing, lower body dressing, and transfers. The MDS indicated Resident 32 had functional ROM limitations (limited ability to move a joint that interferes with daily functioning, including activities of daily living, or places the resident at risk of injury) in one arm (shoulder, elbow, wrist, hand) and both legs (hips, knees, ankles, and feet). During a review of Resident 32's RNA Flowsheets for December 2024, the RNA Flowsheets indicated for RNA to provide PROM exercises to Resident 32's left hip and left ankle, five times a week. The squares on the RNA flowsheet indicated the letters RR on the following days: 12/2/2024, 12/5/2024, 12/9/2024 to 12/13/2024, 12/17/2024 to 12/23/2024, 12/25/2024 to 12/27/2024, and 12/30/224. The key at the bottom of the RNA flowsheet indicated letters RR meant Resident Refused RNA treatment. During a review of Resident 32's RNA Flowsheets for January 2025, the RNA Flowsheets indicated for RNA to provide PROM exercises to Resident 32's left hip and left ankle, five times a week. The squares on the RNA flowsheet indicated the letters RR on the following days: 1/1/2025 to 1/3/2025, 1/6/2025, 1/9/2025, 1/10/2025, 1/13/2025 to 1/17/2025, and 1/21/2025. The key at the bottom of the RNA flowsheet indicated letters RR meant Resident Refused RNA treatment. (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 B. Wing	01/24/2025

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation of Resident 32's RNA session and interview on 1/22/2025 at 10:59 am, Resident 32 was lying in bed with both legs straight with the right leg crossed over the left leg. Restorative Nursing Aide 1 (RNA 1) assisted with left arm ROM exercises. RNA 1 attempted to assist Resident 32 with PROM exercises to the left leg, but Resident 32 refused. RNA 1 stated Resident 32 always refused PROM exercises to the left leg. RNA 1 stated he did not recall the last time Resident 32 participated in left leg PROM exercises. RNA 1 stated the Nursing department and the Rehabilitation department (Rehab) were aware of Resident 32's constant refusals. During a concurrent observation and interview on 1/22/2025 at 9:12 am, Resident 32 was lying in bed with both legs straight, right leg crossed over the left leg. Resident 32 stated staff did not assist with exercises to the left leg. Resident 32 stated his left leg was painful and broken. Resident 32 stated he was unable to move the left leg on his own. During a concurrent interview and record review on 1/24/2025 and 1:43 pm, the Minimum Data Set Nurse Coordinator (MDSC) reviewed Resident 32's care plan and RNA flowsheets from August 2024 to January 2025. The MDSC stated comprehensive care plans were developed for every resident and used as a guideline to ensure proper care was provided for each resident. The MDSC stated care plans were supposed to be updated quarterly and as needed. The MDSC confirmed Resident 32's care plan was not updated and revised since 8/2024. The MDSC stated the care plan should have been revised 11/2024 for the quarterly assessment or earlier because the interventions listed on the care plan were ineffective since Resident 32 continued to repeatedly refuse RNA services after 8/2024 when the care plan was last revised. The MDSC stated the care plan should have been revised and updated to ensure Resident 32 maintained his mobility, ADLs, and ROM by offering interventions such as referral to the Rehabilitation Department (Rehab) for assessment and recommendations, notification to the doctor to discuss alternative interventions such as medications, ROM exercises during ADLs, and encouragement to participate in other types of activities through the Activities Program. The MDSC stated it was important the facility updated Resident 32's care plan to ensure he was receiving the appropriate care and services since he was identified as having ROM limitations and was at high risk for contracture development. During an interview on 1/24/2025 at 2:06 pm, the Director of Nursing (DON) stated comprehensive care plans were developed for every resident and were used as a guide for staff to identify the type of care to provide the residents in the facility. The DON stated care plans should be updated quarterly and as needed. The DON confirmed Resident 32 continued to repeatedly refuse RNA services from August 2024 to January 2025 - after the care plan was last updated. The DON stated the care plan should have been revised and updated at least quarterly in 11/2024 since the listed interventions were ineffective since Resident 32 continued to repeatedly refuse RNA services. The DON stated if a resident was continuously refusing RNA services, had ROM limitation, and was at high risk for contracture development, it was important care plans were updated to include effective interventions to maintain the resident's ROM, mobility, and ADLs such as encouragement to participate in ADLs and the Activities Program, different positioning strategies, referral to the Rehab for assessment and recommendations, and referral to the doctor for any necessary interventions. The DON stated it was important care plans were revised and updated to ensure the residents were receiving the appropriate care and services needed. 2. During a review of Resident 79's Admission record (face sheet), dated 1/24/2025, the face sheet indicated Resident 79 was admitted to the facility on [DATE]. (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 B. Wing	01/24/2025

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 79's History and Physical (H&P), dated 8/20/2024, the H&P indicated Resident 79 had diagnoses including nontraumatic subdural hemorrhage (brain bleed that occurs without trauma), type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and history of a left hip replacement with chronic pain. The H&P indicated Resident 79 had capacity to make decisions. During a review of Resident 79's MDS dated [DATE], the MDS indicated Resident 79 was able to understand and be understood by others, required supervision or touching assistance (helper provides verbal cures or steadying assistance throughout or intermittently) for hygiene, bathing, and dressing. The MDS indicated Resident 79 experienced pain occasionally. During a review of Resident 79's Physician Order Summary dated 1/24/2025, the Order Summary indicated: a. Acetaminophen tablet 325 milligrams (MG-unit of measurement) give 2 tablets by mouth every 4 hours as needed for mild pain (1-3) b. Tramadol HCL oral tablet 50 MG give 1 tablet by mouth every 8 hours as needed for moderate pain (4-6) During an interview on 1/21/2024 at 12:06 p.m. with Resident 79, Resident 79 stated their pain is not being relieved with tramadol. Resident 79 stated they requested stronger pain medication, but did not receive it. During a concurrent interview and record review on 1/24/2025 2:12 p.m. with Licensed Vocational Nurse (LVN) 3, Resident 79's Medication Administration Record (MAR) from August 2024 to January 2025 indicated the following: 1. Resident 79 complained of 7/10 pain and received Tramadol 50 MG for moderate pain (4-6): 2. Resident 79 complained of 8/10 pain and received Tramadol 50 MG for moderate pain (4-6): 3. Resident 79 complained of 5/10 pain and received Acetaminophen 325 MG for mild pain (1-3) on 1/15/2025. LVN 3 stated as needed (PRN) pain medications have parameters and should be administered to the resident as ordered. LVN 3 stated there is no PRN medication ordered for severe pain (7-10). LVN 3 stated if a resident's pain is outside the ordered parameters, the nurse needs to contact the doctor to clarify and order an appropriate medication. LVN 3 stated there is no documentation indicating that nursing contacted the physician about severe pain levels of 7 or 8 out of 10 or administering pain medications outside of the ordered parameters. During a concurrent interview and record review on 1/24/2025 at 2:48 p.m. with the MDS Coordinator (MDSC).The MDSC stated there is one care plan regarding pain that was initiated on 8/17/2024. The MDS nurse stated the pain care plan was not revised between 8/17/2024-1/24/2025. (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 B. Wing	01/24/2025

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/24/2025 at 3:59 p.m. with the Director of Nursing (DON), the DON stated comprehensive care plans were used as a guide for staff to identify the type of care to provide the residents in the facility. The DON stated care plans should be updated quarterly and as needed. The DON stated it was important care plans were revised and updated to ensure the residents were receiving the appropriate care and services needed. During a review of the facility's policy and procedure (P&P), titled Care Plans, Comprehensive Person-Centered, dated 2001, the P&P indicated Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. During a review of the facility's policy and procedure (P&P), titled Pain Assessment and Management, dated 2001, The P&P indicated the pain management interventions are consistent with the resident's goals for treatment which are defined and documented in the care plan. Pain management interventions reflect the sources, type, and severity of pain. The P&P indicated pain management is a multidisciplinary process that includes developing and implementing approaches to pain management .monitoring for the effectiveness of interventions and modifying approaches as necessary. The P&P indicated if pain has not been adequately controlled, the multidisciplinary team, including the physician, shall reconsider approaches and make adjustments. During a review of the facility's policy and procedure (P/P) titled, Care Plans, Comprehensive Person-Centered, dated 2021, the P/P indicated a comprehensive, person-centered care plan should include measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs. The P/P indicated the care plan should describe the services that are to be furnished to assist the resident attain or maintain that level of physical, mental, and psychosocial well-being. The P/P indicated the interdisciplinary team reviewed and updated the care plan when there was a significant change in the resident's condition, when the desired outcome was not met, and at least quarterly in conjunction with the required quarterly MDS assessment. 50144

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	01/24/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49573 Based on observation, interview, and record review, the facility failed to maintain good grooming, and personal hygiene for one of two sample residents (Residents 28). The resident was observed to have long fingernails with black material underneath. This deficient practice resulted in Resident 28's care needs not being met and had the potential to result in psychological harm and infection. Findings: During a review of Resident 28's Admission Record, the Admission Record indicated Resident 28 was admitted to the facility on [DATE] with diagnoses including schizophrenia (a mental illness that is characterized by disturbances in thought), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 28's H/P dated 12/21/24, the H/P indicated Resident 28 has fluctuating capacity to understand and make decisions. During a review of Resident 28's Minimum Data Set ([MDS], a resident assessment tool) dated 12/26/24, the MDS indicated Resident 28 was moderately impaired in cognitive (thinking process) skills and required supervision (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) for self-care abilities such as eating, required maximal assistance (helper does more than half the effort) with oral hygiene, upper body dressing, lower body dressing, putting on/taking of footwear, and personal hygiene, and was dependent (helper does all of the effort, resident does none of the effort to complete the activity, or the assistance or 2 or more helpers is required for the resident to complete the activity) on staff with toileting and shower/bathe. The MDS also indicated Resident 28 required maximal assistance with mobility such as rolling left and right, sit to lying position, lying to sitting on side of bed, sit to stand and chair/bed to chair transfers. During a concurrent observation and interview on 1/21/25 at 11:43 a.m. with Resident 28 in her room, Resident 28 had long fingernails with black material underneath. Resident 28 stated the last time her fingernails got cut, it cut into her skin on the side, and she does not want that to happen again. Resident 28 stated staff have not offered to clean or cut her fingernails but would want staff to try and cut them again. During an interview on 1/24/25 at 10:09 a.m. with Licensed Vocational Nurse (LVN) 2, the LVN 2 stated residents are getting their activities of daily living (ADL) and grooming done daily by Certified Nursing Assistants (CNA). LVN 2 stated CNAs does nail cutting for hands and staff should be doing the grooming for residents every shift and as needed. LVN 2 stated if residents want their nails long, that it was their wish, but staff should still offer to keep the fingernails clean. (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 B. Wing	01/24/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/24/25 at 3:36 p.m. with Director of Nursing (DON), DON stated the CNA's does the ADL's and grooming for all residents. DON stated if any resident refused any services, it should be documented and the LVN Charge Nurse should be informed. DON stated there should also be a care plan for Resident 28's preferences but it was still the facility's responsible to offer the nail cutting and cleaning to Resident 28. DON stated since there was no documentation of the services provided or the resident refusal of the services, the services were not offered to Resident 28. During a review of the facility's policy and procedure (P/P) titled, Fingernails/Toenails, Care of, dated 2001, indicated to clean the nail bed, to keep nails trimmed, and to prevent infections .nail care includes daily cleaning and regular trimming .trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin .the following information should be recorded in the resident's medical record such as any difficulties in cutting the resident's nails, any problems or complaints made by the resident with his/her hands or feet or any complaints related to the procedure, if the resident refused the treatment, the reason(s) why and the intervention taken .notify the supervisor if the resident refuses the care, report other information in accordance with facility policy and professional standards of practice.

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	01/24/2025

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 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. 45891 Based on interview and record review, the facility failed to follow the dietician's recommendations and obtain a physician's order for one of three sampled residents (Resident 32) to receive mid arm circumference measurements (a measurement of the muscle and fat in the upper arm. It's a simple and quick way to assess nutritional status and body composition) This deficient practice had the potential to delay care and delay identification of potential malnourishment (lack of proper nutrition, caused by not having enough to eat, not eating enough of the right things, or being unable to use the food that one does eat) for Resident 32. Findings: During a review of Resident 32's Admission Record, the Admission Record indicated Resident 32 was admitted to the facility 8/4/2019 with diagnoses of blindness of bilateral (both) eyes, traumatic brain injury (an injury to the brain caused by an external physical force, such as a bump, blow, jolt, or penetration), and hemiplegia (a medical condition that causes paralysis or weakness on one side of the body) of the left side. During a review of Resident 32's Weight and Vital Signs (measurements of the bodies basic functions) report, there were no weights documented in the year 2024. During a review of Resident 32's Nutritional Risk Assessment (Admission/ Annual) dated 8/7/2024, the assessment indicated Resident 32 refused to be weighed and had poor oral (PO) intake (not eating very much) and the registered dietician (RD) recommended obtaining a middle arm muscle circumference measurement. During a review of Resident 32's minimum data set (MDS, a resident assessment tool) dated 11/5/2024, the MDS indicated Resident 32 had severe cognitive impairment (a significant decline in cognitive abilities that interferes with daily life and independence). During a review of Resident 32's Order Summary Report, the report indicated an order for mid arm circumference monthly, every day shift on the first of the month for refusal of weights was not ordered until 1/22/2025. During a review of Resident 32's Interdisciplinary (IDT, a group of health care professionals with various areas of expertise who work together toward the goals of their clients) Note dated 1/21/2025, the RD indicated Resident 32 was refusing weights but agreed to allow a mid-arm muscle circumference measurement). During an interview on 1/23/2025 at 10:20 a.m., Licensed Vocational Nurse (LVN 4) stated they were not sure what a mid-arm circumference was and would need to consult the Director of Nursing (DON) or a registered nurse to find out what it was. LVN 4 stated Resident 32 never had an order for a mid-arm circumference in the past. (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 B. Wing	01/24/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/23/2025 at 11:06 a.m., the RD stated the only option to get a measurement of a resident's nutrition status if a resident was refusing weights was a mid-arm circumference measurement. The RD stated tracking of the mid arm circumference could inform you if a resident was losing weight or gaining weight. The RD stated she made the recommendation in August 2024 to measure the mid arm circumference but was not entirely sure why the order was just placed January 2025. Per the RD there was no mid arm circumference measurement in Resident 32's chart. The RD stated when she makes recommendations, she hopes the doctor is informed and the orders are obtained within 72 hours, and it is important that the nursing team follows up on her recommendations because it affects the resident's treatment, and she places the recommendations for a reason. During an interview on 1/24/2025 at 12:55 p.m., the DON stated there was no indication in Resident 32's chart that the physician was made aware of the recommendation by the RD for a mid-arm circumference for Resident 32 in August 2024 until an order was placed January 2025 to obtain a mid-arm circumference. The DON stated the mid arm circumference measurement was important because it could determine if Resident 32 was malnourished. During a review of the facility's policy and procedure (P/P) titled Nutritional assessment dated 2001, the P/P indicated the nutritional assessment was a multidisciplinary process that included gathering and interpreting data and using the data to help define meaningful interventions for the residents at risk for or with impaired nutrition.

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	01/24/2025

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 45382 Based on observation, interview, and record review, the facility failed to provide treatment and services to improve and prevent a decline in range of motion (ROM, full movement potential of a joint) for one of nine sampled residents (Resident 32) who was identified as having left leg ROM limitations, was at high risk for contracture (loss of motion of a joint associated with stiffness and joint deformity) development, and repeatedly refused Restorative Nursing Aide (nursing aide program that help residents maintain any progress made after therapy intervention to maintain their function) services for left leg ROM exercises from February 2024 to January 2025. This deficient practice had the potential to cause Resident 32 to develop contractures and have a decline in ROM, physical functioning, and activities of daily living (ADL, basic activities such as eating, dressing, toileting). Findings: During a review of Resident 32's Admission Record, the Admission Record indicated the facility initially admitted Resident 32 on 8/4/2019 and readmitted Resident 32 on 1/30/2023 with diagnoses including left hemiplegia (weakness to one side of the body) and traumatic brain injury (damage to the brain from an external force that can cause temporary or permanent changes in brain function). During a review of Resident 32's Order Summary Report, the Order Summary Report indicated a physician's order, dated 8/11/2023, for RNA to assist Resident 32 with left leg passive range of motion (PROM, movement at a given joint with full assistance from another person) exercises to the left hip and left ankle, five times a week. During a review of Resident 32's RNA Documentation Survey Report flowsheet (RNA Flowsheet, daily record of RNA services provided for each month) for February 2024, the RNA Flowsheets indicated for RNA to provide PROM exercises to Resident 32's left hip and left ankle, five times a week. The squares on the RNA flowsheet indicated the letters RR on the following days: 2/1/2024 to 2/3/2024, 2/5/2024 to 2/10/2024, 2/12/2024 to 2/16/2024, 2/19/2024 to 2/23/2024, and 2/25/2024 to 2/29/2024. The key at the bottom of the RNA flowsheet indicated letters RR meant Resident Refused RNA treatment. During a review of Resident 32's RNA Flowsheet for March 2024, the RNA Flowsheets indicated for RNA to provide PROM exercises to Resident 32's left hip and left ankle, five times a week. The squares on the RNA flowsheet indicated the letters RR on the following days: 3/1/2024 to 3/15/2024, 3/18/2024 to 3/23/2024, and 3/25/2024 to 3/29/2024. The key at the bottom of the RNA flowsheet indicated letters RR meant Resident Refused RNA treatment. During a review of Resident 32's RNA Flowsheet for April 2024, the RNA Flowsheets indicated for RNA to provide PROM exercises to Resident 32's left hip and left ankle, five times a week. The squares on the RNA flowsheet indicated the letters RR on the following days: 4/1/024 to 4/5/2024, 4/7/2024 to 4/12/2024, 4/15/2024 to 4/19/2024, 4/22/2024 to 4/26/2024, 4/29/2024, and 4/30/2024. The key at the bottom of the RNA flowsheet indicated letters RR meant Resident Refused RNA treatment. The square on the RNA Flowsheet was blank on 4/14/2024. (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 B. Wing	01/24/2025

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 32's RNA Flowsheet for May 2024, the RNA Flowsheets indicated for RNA to provide PROM exercises to Resident 32's left hip and left ankle, five times a week. The squares on the RNA flowsheet indicated the letters RR on the following days: 5/1/2024 to 5/3/2024, 5/6/2024 to 5/10/2024, 5/13/2024 to 5/17/2024, 5/21/2024 to 5/24/2024, and 5/27/2024 to 5/30/2024. The key at the bottom of the RNA flowsheet indicated letters RR meant Resident Refused RNA treatment. The squares on the RNA Flowsheet were blank on 5/20/2024, 5/25/2024, and 5/31/2024. During a review of Resident 32's RNA Flowsheet for June 2024, the RNA Flowsheets indicated for RNA to provide PROM exercises to Resident 32's left hip and left ankle, five times a week. The squares on the RNA flowsheet indicated the letters RR on the following days: 6/3/2024 to 6/5/2024, 6/10/2024 to 6/14/2024, 6/17/2024 to 6/20/2024, 6/24/2024, and 6/26/2024 to 6/28/2024. The key at the bottom of the RNA flowsheet indicated letters RR meant Resident Refused RNA treatment. The squares on the RNA Flowsheet were blank on 6/6/2024, 6/7/2024, 6/21/2024, 6/22/2024, and 6/25/2024. During a review of Resident 32's RNA Flowsheet for July 2024, the RNA Flowsheets indicated for RNA to provide PROM exercises to Resident 32's left hip and left ankle, five times a week. The squares on the RNA flowsheet indicated the letters RR on the following days: 7/1/2024 to 7/5/2024, 7/8/2024 to 7/13/2024, 7/15/2024 to 7/19/2024, 7/22/2024 to 7/26/2024, and 7/29/2024. The key at the bottom of the RNA flowsheet indicated letters RR meant Resident Refused RNA treatment. The square on the RNA Flowsheet were blank on the following days: 7/6/2024, 7/20/2024, 7/30/2024, and 7/31/2024. During a review of Resident 32's RNA Flowsheet for August 2024, the RNA flowsheets indicated for RNA to provide PROM exercises to Resident 32's left hip and left ankle, five times a week. The squares on the RNA flowsheet indicated the letters RR on the following days: 8/1/2024, 8/2/2024, 8/5/2024 to 8/9/2024, 8/12/204 to 8/16/2024, 8/19/2024 to 8/23/2024, 8/26/2024 to 8/31/2024. The key at the bottom of the RNA flowsheet indicated letters RR meant Resident Refused RNA treatment. The square on the RNA Flowsheet was blank on 8/17/2024. During a review of Resident 32's Change of Condition (COC, major decline or improvement in a resident's status that will not resolve itself without intervention) Evaluation, dated 8/1/2024, the COC Evaluation indicated the COC Evaluation was initiated due to Resident 32's multiple refusal of RNA services. The COC Evaluation indicated Resident 32 was at risk for a mobility decline with recommendations for a Psychiatry consultation. During a review of Resident 32's Joint Mobility Screen (JMS, a brief assessment of a resident's range of motion of both arms and both legs), dated 8/6/2024, the JMS indicated Resident 32 had severe ROM limitations in the left hip and left knee and moderate ROM limitations in the left ankle. During a review of Resident 32's RNA Flowsheet for September 2024, the RNA Flowsheets indicated for RNA to provide PROM exercises to Resident 32's left hip and left ankle, five times a week. The squares on the RNA flowsheet indicated the letters RR on the following days: 9/1/2024, 9/4/2024 to 9/6/2024, 9/9/2024 to 9/13/2024, 9/16/2024 to 9/20/2024, 9/23/2024 to 9/30/2024. The key at the bottom of the RNA flowsheet indicated letters RR meant Resident Refused RNA treatment. The squares on the RNA Flowsheet were blank on 9/2/2024 and 9/3/2024. (continued on next page)

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 01/24/2025

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 32's RNA Flowsheets for October 2024, the RNA flowsheets indicated for RNA to provide PROM exercises to Resident 32's left hip and left ankle, five times a week. The squares on the RNA flowsheet indicated the letters RR on the following days: 10/1/2024 to 10/5/2024, 10/7/2024 to 10/11/2024, 10/14/2024 to 10/19/2024, 10/21/2024 to 10/25/2024, and 10/28/2024 to 10/31/2024. The key at the bottom of the RNA flowsheet indicated letters RR meant Resident Refused RNA treatment. During a review of Resident 32's RNA Flowsheets for November 2024, the RNA flowsheets indicated for RNA to provide PROM exercises to Resident 32's left hip and left ankle, five times a week. The squares on the RNA flowsheet indicated the letters RR on the following days: 11/1/2024 to 11/16/2024, 11/18/2024 to 11/20/2024, and 11/25/2024 to 11/29/2024. key at the bottom of the RNA flowsheet indicated letters RR meant Resident Refused RNA treatment. During a review of Resident 32's Minimum Data Set (MDS, a federally mandated assessment tool), dated 11/5/2024, the MDS indicated Resident 32 had severely impaired cognition (ability to think, understand, learn, and remember) and vision. The MDS indicated Resident 32 required substantial/maximal assistance for eating, hygiene, upper body dressing, and rolling to both sides and was dependent in bathing, lower body dressing, and transfers. The MDS indicated Resident 32 had functional ROM limitations (limited ability to move a joint that interferes with daily functioning, including activities of daily living, or places the resident at risk of injury) in one arm (shoulder, elbow, wrist, hand) and both legs (hips, knees, ankles, and feet). During a review of Resident 32's RNA Flowsheets for December 2024, the RNA flowsheets indicated for RNA to provide PROM exercises to Resident 32's left hip and left ankle, five times a week. The squares on the RNA flowsheet indicated the letters RR on the following days: 12/2/2024, 12/5/2024, 12/9/2024 to 12/13/2024, 12/17/2024 to 12/23/2024, 12/25/2024 to 12/27/2024, and 12/30/224. The key at the bottom of the RNA flowsheet indicated letters RR meant Resident Refused RNA treatment. The squares on the RNA Flowsheet were blank on the following days: 12/3/2024, 12/4/2024, 12/15/2024, 12/16/2024, and 12/24/2024. During a review of Resident 32's RNA Flowsheets for January 2025, the RNA flowsheets indicated for RNA to provide PROM exercises to Resident 32's left hip and left ankle, five times a week. The squares on the RNA flowsheet indicated the letters RR on the following days: 1/1/2025 to 1/3/2025, 1/6/2025, 1/9/2025, 1/10/2025, 1/13/2025 to 1/17/2025, and 1/21/2025. The key at the bottom of the RNA flowsheet indicated letters RR meant Resident Refused RNA treatment. The squares on the RNA Flowsheet were blank on the following days: 1/7/2025 and 1/20/2025. During an observation of Resident 32's RNA session and interview on 1/22/2025 at 10:59 am, Resident 32 was lying in bed with both legs straight with the right leg crossed over the left leg. Restorative Nursing Aide 1 (RNA 1) assisted with left arm ROM exercises. RNA 1 attempted to assist Resident 32 with PROM exercises to the left leg, but Resident 32 refused. RNA 1 stated Resident 32 always refused PROM exercises to the left leg. RNA 1 stated he did not recall the last time Resident 32 participated in left leg PROM exercises. RNA 1 stated the Nursing department and the Rehabilitation department (Rehab) were aware of Resident 32's constant refusals. (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 B. Wing	01/24/2025

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 1/22/2025 at 9:12 am, Resident 32 was lying in bed with both legs straight, right leg crossed over the left leg. Resident 32 stated staff did not assist with exercises to the left leg. Resident 32 stated his left leg was painful and broken. Resident 32 stated he was unable to move the left leg on his own. During an interview on 1/21/2025 at 2:45 pm, the Director of Rehabilitation (DOR) stated the Rehabilitation Department (Rehab) created and modified the RNA programs based on the resident's needs. The DOR stated RNA meetings with the DOR, nursing administration, and all RNAs were held one to two times a month to discuss any concerns, resident refusals, improvements, and declines. The DOR stated if any concerns, repeated refusals, and declines were discussed in the meetings, a licensed therapist would re-evaluate the resident, put the resident on skilled therapy services if indicated, or modified the RNA program. During an interview on 1/23/2025 at 10:41 am, Restorative Nursing Aide 1 (RNA 1) stated RNA attempted RNA sessions at least three times daily if a resident refused RNA services. RNA 1 stated if a resident continued to refuse RNA, RNA must notify the charge nurse immediately and discuss the resident's multiple refusals in the regular RNA meetings with nursing and Rehab to ensure all departments were aware. RNA 1 stated Rehab typically re-assessed the resident and notified the RNAs of any modifications to the program. During a concurrent interview and record review on 1/23/2025 at 10:47 am, the Director of Staff Development (DSD) stated she supervised the RNAs. The DSD stated the purpose of the RNA program was to maintain a resident's level of function and prevent a decline in ROM and mobility. The DSD stated all RNA refusals must immediately be reported to the charge nurse and discussed in the regular RNA meetings with nursing and Rehab. The DSD stated if a resident consistently refused RNA, the licensed nurse must initiate a COC, notify the physician, and notify Rehab for re-assessment to evaluate for skilled therapy needs or modify the RNA program. The DSD stated it was important the physician, Rehab, and nursing staff were all notified of consecutive and recurring RNA refusals to ensure all departments were aware of the issue to collaboratively investigate the reason for refusals to ensure the appropriate interventions were implemented. The DSD reviewed Resident 32's RNA Flowsheets from February 2024 to January 2025. The DSD stated RR on the RNA Flowsheets indicated Resident 32 refused RNA services that day. The DSD stated a blank square on the RNA Flowsheets indicated RNA did not provide Resident 32 with RNA services that day. The DSD confirmed Resident 32 refused and/or did not receive RNA for left leg ROM exercises almost every day, five times a week, from February 2024 to January 2025. The DSD reviewed Resident 32's clinical record and confirmed no other treatment and services to maintain or improve Resident 32's left leg ROM were implemented between February 2024 and January 2025. The DSD stated the facility should have implemented multiple COCs between February 2024 and January 2025, investigated the reason for RNA refusals, implemented interventions, and continuously re-assessed the resident to ensure interventions were effective or offered alternatives but did not. The DSD stated RNA informed her and Rehab of Resident 32's continuous and consecutive RNA refusals in the routine RNA meetings but was unsure why Rehab was not reconsulted for re-assessment. The DSD stated Rehab should have been reconsulted to provide skilled therapy services or modify the RNA program to prevent a decline in Resident 32's ROM, ADLs, and mobility since Resident 32 had left leg ROM limitations, was unable to move the left leg on his own and was at high risk for contracture development. (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 B. Wing	01/24/2025

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 1/24/2025 at 3:59 pm, the DOR stated the facility provided RNA and skilled therapy services to maintain, improve and prevent declines in the resident's ROM and mobility. The DOR reviewed Resident 32's clinical record and confirmed Resident 32 refused and/or did not receive RNA services almost every day, five times a week, from February 2024 to January 2025. The DOR stated Rehab was unaware of Resident 32's multiple, consecutive RNA refusals prior to August 2024 since there was only one COC Evaluation, dated 8/1/2024, regarding Resident 32's RNA refusals and assumed Resident 32 was receiving RNA services as ordered. The DOR stated Rehab would not know to intervene unless they were notified by RNA or if a COC was initiated either before 8/1/2024 since the refusals began in February 2024 and after 8/1/2024 since Resident 32 continued to refuse RNA services despite implemented interventions. The DOR stated residents if who required skilled therapy and/or RNA services did not receive it, it could result in a possible functional decline. During a concurrent interview and record review on 1/24/2025 at 2:06 pm, the Director of Nursing (DON) stated the facility maintained, improved, and prevented declines in a resident's level of function and ROM by skilled therapy services and the RNA program. The DON stated it was important residents received the appropriate care and services to improve, maintain, and prevent a decline in ROM, mobility, and overall function. The DON stated all residents who were identified as having ROM limitations and were continuously refusing RNA should be evaluated by Rehab to assess for skilled therapy needs, provide modifications to the RNA program, and/or provide recommendations for alternative interventions if RNA refusals persisted. The DON reviewed Resident 32's RNA Flowsheets from February 2024 to January 2025 and confirmed Resident 32 refused and/or did not receive RNA services for left leg ROM exercises almost every day, five days a week, from February 2024 to January 2025. The DON stated RNA was ordered with the intention of maintaining left leg ROM but was not provided as ordered since Rehab did not assess the resident after multiple consecutive refusals, the RNA program was never re-assessed or modified, the care plan was not updated with alternative interventions, the COCs were not initiated timely, and no follow up assessments occurred to check for effectiveness of implemented interventions. The DON stated it was important residents received treatment and services to maintain and improve ROM and mobility to prevent functional declines and contractures. During a review of the facility's Policy and Procedure titled, Resident Mobility and Range of Motion, dated 2001, indicated residents would not experience an avoidable reduction in ROM and residents with limited ROM would receive treatment and services to increase and/or prevent a further decrease in ROM. The policy further indicated nursing would identify the resident's current ROM of his or her joints and limitations in movement as part of the comprehensive assessment and develop a plan of care to include specific interventions, exercises, and therapies to maintain, prevent avoidable decline in, and/or improve ROM.

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	01/24/2025

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50387 Based on observation, interview, and record review, the facility failed to assess one of one sampled resident (Resident 22) for indwelling urinary catheter (Foley-a thin, flexible tube inserted into the bladder to drain urine) removal when there was no documentation indicating that the resident's clinical condition required continued catheterization (inserting a thin, flexible tube called a catheter into a body cavity to drain fluid or examine an internal area). This failure had the potential to increase the risk of Foley catheter induced infections due to unnecessarily prolonged Foley Catheter use. Findings: During a review of Resident 22's Admission Record, the Admission Record indicated the facility admitted Resident 22 on 12/20/2024 with diagnoses including periprosthetic fracture (a broken bone that happens around or very close to an artificial joint implant) around internal prosthetic (a device that replaces a missing body part or function) left hip joint, multiple fractures of ribs. During a review of Resident 22's History and Physical Examination (H&P), dated 12/31/2024, the H&P indicated that Resident 22 had the capacity to understand and make decisions. During a review of Resident 22's Minimum Data Set (MDS- a resident assessment tool), dated 1/6/2025, the MDS indicated that Resident 22 was cognitively (related to thinking) intact. MDS also indicated that Resident 22 needed assistance of two or more helpers to complete activity of toileting hygiene. During a review of Resident 22's Order Summary Report, as of 1/21/2025, the Order Summary Report indicated an order to place a 16 French (a measurement of its diameter) indwelling urinary catheter on 12/31/2024 for urinary retention (a condition that makes it difficult or impossible to empty the bladder). During an observation on 1/21/2025 at 2:51 p.m., in Resident 22's room, Resident 22 had a Foley catheter and a Foley catheter drainage bag. During an interview on 1/22/2025 at 4:14 p.m., LVN 1 stated that Resident 22 still had the Foley catheter due his to limited ability to turn without assistance. (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 B. Wing	01/24/2025

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 1/22/2025 at 4:23 p.m., with the Director of Nursing (DON), MDS dated [DATE] and physician's progress note for December 2024 and January 2025, were reviewed. The DON stated that Resident 22 kept the foley catheter for urinary retention, but this was not an approved diagnosis for long term catheter use in a nursing home setting. The DON stated that the MDS indicated the resident required assistance with turning, bathing, and toileting, which were not valid reasons to justify continued Foley catheter use. The DON stated that there was no documentation indicating staff or the Interdisciplinary Team (IDT- the resident's healthcare team consisting of various specialties) assessed Resident 22 for keeping the Foley catheter since admission. The DON stated that the resident has multiple comorbidities, increasing risks of infection when a Foley catheter is used without a proper medical indication. During a review of the facility's policy and procedure (P&P) titled, Catheter Care, Urinary dated 2001, indicated the facility to review and document the clinical indications for catheter use prior to inserting. Nursing and the IDT should assess and document the ongoing need for a catheter that in in place and remove the catheter as soon as it is no longer needed

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	01/24/2025

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45891 Based on observation, interview, and record review the facility failed to follow physician's orders for enteral (a method of providing nutrition through a tube inserted into the gastrointestinal tract (GI tract) feeding for one of five sampled residents (Resident 42). This deficient practice had the potential for Resident 42 to experience continued weight loss. Findings: During a review of Resident 42's Admission Assessment, the Admission Assessment indicated Resident 42 was admitted to the facility on [DATE] with diagnoses of traumatic brain injury (TBI, an injury to the brain caused by an external physical force, such as a bump, blow, jolt, or penetration), aphasia (a language disorder that affects a person's ability to understand, produce, or use language due to damage to the brain areas responsible for language processing), and encounter for attention to gastrostomy (a surgical procedure that creates an opening in the stomach through the abdominal wall. This opening allows a tube (G-tube, gastrostomy tube) to be inserted into the stomach for feeding). During a review of Resident 42's Weights and Vitals (measurement of the body's basic functions) Summary, the following weights were recorded: 8/6/2024- 158 pounds (lbs., a unit of measurement) 11/1/2024- 155.6 lbs. 12/12/2024- 153.2 lbs. 1/9/2025- 148 lbs. (6.3 percent (%) weight loss in 6 months, 4.8% weight loss in 3 months, and 3.3% weight loss in 1 month) During a review of Resident 42's Minimum Data Set (MDS, a resident assessment tool) dated 12/17/2024, the MDS indicated Resident 42 was rarely or never understood others and was receiving nutrition through a feeding tube. During a review of Resident 42's Nutrition Narrative Note dated 1/14/2025, the note indicated Resident 42 was experiencing slow progressive weight loss and had lost 10 lbs. between 8/6/2024 and 1/9/2025 (6 months). The note indicated Resident 42 was currently receiving Glucerna 1.5 (a type of feeding formula) at 65 milliliters (ml, a unit of measurement) an hour (hr., a unit of measurement) and the registered dietician (RD) recommended the tube feeding be increased to 70 ml/hr. due to weight loss. During a review of Resident 42's Order Summary Report, the order for Glucerna 1.5 at 65 ml/ hr. was discontinued on 1/16/2025 and an order was placed on 1/16/2025 for Glucerna 1.5 at 70 ml/hr. for 20 hours. Start feeding at 2 p.m. and turn off at 10 a.m. or until total volume is met. (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 B. Wing	01/24/2025

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 1/21/2025 at 3:47 p.m., Resident 42's Glucerna 1.5 tube feeding was running at 65 ml/hr. During an observation on 1/23/2025 at 9:25 a.m., Resident 42's Glucerna 1.5 tube feeding was running at 65 ml/hr. During an observation and concurrent interview on 1/23/2025 at 4:02 p.m., Licensed Vocational Nurse (LVN 3) entered Resident 42's room to check Resident 42's tube feeding rate, the tube feeding rate was set to 65 ml/ hr. LVN 3 stated it was their job to ensure the tube feeding rate matched the physicians orders and Resident 42 had an order change on 1/16/2024 (8 days earlier) to increase the tube feeding rate to 70 ml/hr. but they still had it set to 65 ml/ hr. LVN 3 stated there was a potential for weight loss if the feeding rate was set below what it was ordered for. During an interview on 1/23/2025 at 4:27 p.m., the registered dietician (RD) stated Resident 42 has been progressively losing weight over the past 6 months. On 1/14/2025 the RD made a recommendation to increase the Glucerna 1.5 tube feeding rate to 70 ml/ hr. The RD stated she gives the recommendation; nursing team then gets the order from the physician and implements the order. The RD stated when she gives recommendations they should be followed through within 72 hours. The RD stated if the physician input the order for tube feeding to run at 70 ml/ hr., the tube feeding rate should have been changed to 70 ml/ hr. The RD stated the potential outcome of not providing the correct tube feeding rate to the resident was continued weight loss. During an interview on 1/24/2025 at 1:02 p.m., the Director of Nursing (DON) stated she reviewed Resident 42's physicians orders, nurses progress notes and Resident 42's weekly summary and Glucerna 1.5 at 70 ml/hr. was ordered on 1/16/2025 but the chart was still reflecting that the nurses were running the tube feeding at 65 ml/hr. The DON stated if the feeding rate was not set to the correct rate, the resident was not meeting their nutritional goal. During a review of the facility's policy and procedure (P/P) titled Enteral Tube Feeding via Continuous Pump dated 2001, the P/P indicated to check the enteral nutrition label against the order before administration and check the rate of administration (ml/hr.). The P/P indicated when initiating the feeding the nurse was to connect the infusion pump, set the rate, and press start. During a review of the facility's P/P titled Weight Assessment and Intervention dated 2001, the P/P indicated interventions for undesirable weight loss are based on careful consideration of the following, including nutrition and hydration needs of the resident and the use of feeding tubes.

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	01/24/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49573 Based on observation, interview, and record review, the facility failed to provide proper respiratory care for four of six residents (Residents 69, 496, 492 and 53) by failing to: 1.Administer oxygen 2 liters (L- a unit of measure)/minutes(min) as ordered by the physician for Resident 69, 496 and 492. 2. Ensure adequate monitoring of oxygen saturation (amount of oxygen the body is processing) for one of three sampled residents (Resident 53) who was on oxygen for diagnosis of chronic respiratory failure (a long-term condition that makes it hard to breathe because the lungs can't exchange enough oxygen and carbon dioxide) and chronic obstructive pulmonary disease ([COPD], a chronic lung disease causing difficulty in breathing). These failures has the potential to result in inadequate oxygenation, oxygen toxicity (lung damage that happens from breathing in too much extra oxygen), and dependency on oxygen, placing the resident at risk for serious heath complications, negative respiratory outcome and increased risk for injury or death. Findings: 1a.During a review of Resident 69's Admission Record, the Admission Record indicated the facility admitted Resident 69 on 3/21/2024 with diagnoses including respiratory failure (a serious condition that occurs when your lungs can't move enough oxygen into your blood or remove enough carbon dioxide), chronic respiratory obstructive pulmonary diseases (COPD-a lung disease that makes it hard to breath), and shortness of breath. During a review of Resident 69's Minimum Data Set (MDS-a resident assessment tool), dated 12.27.2024, indicated Resident 69 was cognitively (related to thinking) intact and did not have functional limitation in range of motion. During a review of Resident 69's Order Summary Report, orders as of 1/21/2024, the Order Summary Report indicated that there was an order dated 10/24/2024 to give oxygen at 2 L/m via (through) nasal cannula (NC-a device that gives you additional oxygen through your nose). During a review of Resident 69's care plan for oxygen therapy, initiated on 3/22/2024, the care plan interventions included to administer oxygen at 2L/min via NC as ordered. During an observation on 1//21/2024 at 10:44 a.m., in Resident 69's room, Resident 69 was sitting on the right-side edge of the bed, receiving oxygen at 4L/min via NC. During an observation on 1//21/2024 at 4:04 p.m., in Resident 69's room, Resident 69 was sitting in a chair next to the bed, receiving oxygen at 4.25 L/min via NC. (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 B. Wing	01/24/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 1/24/2025 at 8:47 a.m. with the DON, Resident 69's Order Summary, active as of 1/22/2025, was reviewed. The DON stated that Resident 69 had received oxygen at 4 L/min on 1/21/2024 at 10:44 a.m., and 4.25 L/min on 1/21/2024 at 4:04 p.m., via NC instead of Resident 69 receiving oxygen at 2L/min as ordered by the physician and staff failed to provide proper respiratory care to Resident 69. 1b.During a review of Resident 496's Admission Record, the Admission Record indicated the facility admitted Resident 496 on 1/21/2025 with diagnoses including COPD and shortness of breath. During a review of Resident 496's Nursing- Admission/Readmission Evaluation/Assessment, dated 1/21/2025, the Nursing- Admission/Readmission Evaluation/Assessment indicated, Resident 496 was alert. During a review of Resident 496's Order Summary Report, orders as of 1/21/2025, the Order Summary Report indicated an order to give oxygen level at 2L/min via NC on 1/21/2025. During a review of Resident 496's care plan for oxygen, initiated on 1/21/2025, the care plan indicated Resident 496 requires continuous oxygen related to acute (sudden onset) respiratory failure, with interventions including administering oxygen at 2L/min via NC. During an observation on 1/22/2025 at 10:10 a.m., in Resident 496's room, Resident 496's oxygen level was set at 3.25L/min for Resident 496. During a concurrent interview and record review on 1/22/2025 at 3:46 p.m., with the Director of Nursing (DON), the Order Summary, active as of 1/22/2025, was reviewed. The DON stated that Resident 496 had received oxygen at between 3L/min and 4L/min via NC on 1/22/2025 at 10:10 a.m., instead of 2L/min as ordered by the physician and staff failed to provide proper respiratory care to Resident 496. 1c.During a review of Resident 492's Admission Record, the Admission Record indicated the facility admitted Resident 492 on 1/10/2025 with diagnoses including leukemia (a cancer that affects the blood and bone marrow, causing the body to produce too many abnormal white blood cells). During a review of Resident 492's History and Physical (H&P) Examination, dated 1/21/2025, the H&P indicated Resident 492 could make needs known but could not make medical decisions. During a review of Resident 492's Order Summary Report, active orders as of 1/21/2024, the Order Summary Report indicated an order to give oxygen level at 2L/min via NC on 1/19/2025. During a review of Resident 492's care plan for oxygen, initiated on 1/19/2025, the care plan indicated Resident 492 requires continuous oxygen related to shortness of breath, with interventions including administering oxygen at 2L/min via NC. During an observation on 1/21/2025 at 10:59 a.m., in Resident 492's room, Resident 492 was lying in bed, receiving oxygen at 3.5L/min via NC. (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 B. Wing	01/24/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 1/24/2025 at 8:47a.m., with the DON, Resident 492's Order Summary Report, active as of 1/21/2024, was reviewed. The DON stated that Resident 492 had received oxygen at 3.5L/min via NC on 1/21/2025 at 10:59 a.m., instead of 2L/min as physician-ordered and staff failed to provide proper respiratory care to Resident 492. The DON stated that both the Registered Nurse (RN) and Respiratory Therapist (RT) are responsible for providing appropriate respiratory care. The DON also stated that excessive oxygen administration can lead to oxygen toxicity, dependency, in particular, COPD residents who receive more oxygen than required are at risk of respiratory arrest, as they rely on low oxygen levels to trigger breathing, overuse of oxygen can also make it difficult to wean off, leading to hypercapnia (having too much carbon dioxide built up in your blood) and other adverse effects. 2. During a review of Resident 53's Admission Record, the Admission Record indicated Resident 53 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including chronic respiratory failure with hypoxia (a condition where the body is unable to effectively exchange oxygen and carbon dioxide over a prolonged period, resulting in persistently low levels of oxygen in the blood (hypoxia) due to impaired lung function), COPD, hypertension (HTN, high blood pressure), and hyperlipidemia (a condition where there are high levels of lipids, or fats, in the blood). During a review of Resident 53's MDS, dated [DATE], the MDS indicated Resident 53 had moderate cognitive impairment (limitation in mental functioning and in skills such as communication, self-help, and social skills). According to the MDS, Resident 53 required supervision assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) for functional abilities such as eating, maximal assistance (helper does more than half the effort, helper lifts, holds, or supports trunk or limbs, but provides more than half the effort) with oral hygiene, and upper body dressing, and personal hygiene and was dependent (helper does all of the effort, resident does none of the effort to complete the activity) on toileting, shower/bathe and lower body dressing. The MDS also indicated Resident 53 required supervision with mobility such as rolling left and right, sit to lying position, and needed moderate assistance (helper does less than half the effort) with lying to sitting on side of the bed, and dependent on chair/bed to chair transfers. During a review of Resident 53's Order Summary Report, dated 12/19/2024, the Order Summary Report indicated to check oxygen saturation every shift as needed. During a review of Resident 53's comprehensive care plan dated 1/10/25, the comprehensive care plan indicated Resident 53 requires the use of oxygen continuous high concentration related to COPD and will not exhibit signs of respiratory distress, shortness of breath, chest tightness or pain, trouble sleeping caused by shortness of breath, coughing or wheezing. The interventions/tasks administer oxygen as medical doctor ordered and monitor oxygen saturation via pulse oximetry as indicated. During a review of Resident 53's medication administration records (MAR) for December 2024, the MAR indicated check oxygen saturation each shift for diagnosis of chronic respiratory failure. The MAR also indicated check oxygen saturation every shift as needed with start date of 12/19/2024 and no oxygen saturation was documented for this order from 12/12/2024 to 12/31/2024. During a review of Resident 53's MAR for January 2025, the MAR indicated to check oxygen saturation every shift as needed ordered on 12/19/24 and discontinued on 1/24/25 and no oxygen saturation was documented for this order from 1/1/2025 to 1/24/2025. (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 B. Wing	01/24/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 53's oxygen saturation task summary report, the task summary report indicated the oxygen saturation was not checked on 12/20/2024, 12/22/2024, 12/23/2024, 12/25/2024, 12/26/2024, 12/27/2024, 12/29/2024, 12/31/2024, 1/2/2024, 1/3/2025, 1/4/2025, 1/5/2025, 1/7/2025, 1/8/2025, 1/9/2025, 1/10/2025, 1/11/2025, 1/12/2025, 1/14/2025 until 1/24/2025. During an observation and interview on 1/21/2025 at 12:04 p.m., in Resident 53's room, Resident 53 was sitting on his bed watching a movie on his laptop. Resident 53 had a tracheostomy (a surgical procedure that creates an opening in the neck into the windpipe, allowing air to pass into the lungs) in his neck. Resident 53 was receiving 4.5 liters of oxygen through his tracheostomy in his neck with the tubing dated 1/21/2025. During an interview and record review on 1/24/2025 at 10:02 a.m., with Licensed Vocational Nurse (LVN) 2, the MAR for December 2024 and January 2025 was reviewed. LVN 2 stated Resident 53's oxygen saturation should have been checked every shift and as needed instead because Resident 53 was on oxygen and had a diagnosis of chronic respiratory distress with hypoxia and COPD. LVN 2 stated Resident 53's oxygen saturation should be checked with every vital sign task every shift. LVN 2 stated if Resident 53's oxygen saturation was not checked every shift, Resident 53 can have a change in condition such as going into respiratory distress because not enough oxygen is in the body and not enough oxygen will go to the brain. During an interview and record review on 1/24/2025 at 3:36 p.m., with the Director of Nursing (DON), the MAR for December 2024 and January 2025 was reviewed. The DON stated Resident 53's oxygen saturation should have been checked every shift. The DON stated staff should be checking the oxygen saturation every shift so staff can identify a change in condition before the resident becomes symptomatic when his oxygen saturation starts to desaturate (the condition of a low blood oxygen concentration During a review of the facility's policy and procedure (P/P), titled Oxygen Administration, dated 2001, indicated while the resident is receiving oxygen therapy, assess for the following: signs or symptoms of cyanosis (i.e., blue tone to the skin and mucous membranes), signs or symptoms of hypoxia (i.e., rapid breathing, rapid pulse rate, restlessness, confusion), signs or symptoms of oxygen toxicity (i.e., tracheal irritation, difficulty breathing, or slow, shallow rate of breathing), vital signs, lung sounds, arterial blood gases and oxygen saturation, if applicable; and, other laboratory results (hemoglobin, hematocrit, and complete blood count), if applicable. During a review of the facility's P/P titled Charting and Documentation, dated 2001, indicated all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record the following information is to be documented in the resident medical record such as treatments or services performed, changes in the resident's condition, events, incidents or accidents involving the resident. 50387

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	01/24/2025

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45891 50144 Based on observation, interview and record review, the facility failed to: 1. Manage residents' severe pain (7-10/10) appropriately for one of two sampled residents (Resident 79) by: a.Not notifying the physician of severe pain levels from 8/21/2024 to 1/23/2025 b.Not following the physician's ordered pain medication parameters c.Not accurately documenting pain in the minimum data set (MDS - a resident assessment tool) d.Not updating care plans to address continued pain e.Not consistently documenting pain location 2. Accurately assess one of nine sampled residents (Resident 32)'s pain per the physician's order. These failures resulted in a delay of obtaining the appropriate consults and providing a suitable pain management regimen and pain relief for Resident 79, and a potential for Resident 32 to exerience unnecessary pain. Findings: During a review of Resident 79's Admission Record dated 1/24/2025, the Admission Record indicated Resident 79 was admitted to the facility on [DATE]. During a review of Resident 79's History and Physical (H&P), dated 8/20/2024, the H&P indicated Resident 79 had diagnoses including nontraumatic subdural hemorrhage (brain bleed that occurs without trauma), type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and history of a left hip replacement with chronic pain. The H&P indicated Resident 79 had capacity to make decisions. During a review of Resident 79's Minimum Data Set (MDS - a resident assessment tool), dated 11/22/2024, the MDS indicated Resident 79 was able to understand and be understood by others, required supervision or touching assistance (helper provides verbal cures or steadying assistance throughout or intermittently) for hygiene, bathing, and dressing. The MDS indicated Resident 79 experienced pain occasionally. During a review of Resident 79's Physician Order Summary dated 1/24/2025, the Order Summary indicated: (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 B. Wing	01/24/2025

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a.Acetaminophen (over the counter medication to treat mild pain) tablet 325 milligrams (MG-unit of measurement) give 2 tablets by mouth every 4 hours as needed for mild pain (1-3) b.Tramadol HCL (medication to treat mild to moderate pain) oral tablet 50 MG give 1 tablet by mouth every 8 hours as needed for moderate pain (4-6) During an interview on 1/21/2024 at 12:06 p.m., with Resident 79, Resident 79 stated their pain is not being relieved with tramadol. Resident 79 stated they requested stronger pain medication, but did not receive it. During a concurrent interview and record review on 1/24/2025 at 2:12 p.m., with Licensed Vocational Nurse (LVN) 3, Resident 79's records were reviewed. The Medication Administration Record (MAR) from August 2024 to January 2025 indicated the following: 1. Resident 79 complained of 7/10 pain and received Tramadol 50 MG for moderate pain (4-6): a. 1 day in August 2024: 8/20/2024 b. 4 days in September 2024: 9/4/2024, 9/8/2024, 9/14/2024, 9/16/2024 c. 8 days in October 2024: 10/2/2024, 10/5/2024, 10/9/2024, 10/22/2024, 10/23/2024, 10/28/2024, 10/30/2024, 10/31/2024 d. 10 days in November 2024: 11/5/2024, 11/6/2024, 11/9/2024, 11/11/2024, 11/12/2024, 11/14/2024, 11/21/2024, 11/24/2024, 11/ 29/2024, 11/30/2024, e. 11 days in December 2024: 12/1/2024, 12/2/2024, 12/5/2024, 12/6/2024, 12/7/2024, 12/8/2024, 12/11/2024, 12/14/2024, 12/14/2024, 12/25/2024, 12/26/2024, f. 11 days in January 2025: 1/2/2025, 1/5/2025, 1/6/2025, 1/8/2025, 1/9/2025, 1/11/2025, 1/16/2025, 1/17/2025, 1/20/2025, 1/22/2025, 1/23/2025. 2. Resident 79 complained of 8/10 pain and received Tramadol 50 MG for moderate pain (4-6): a. 2 days in August 2024: 8/21/2024, 8/27/2024 b. 1 day in October 2024: 10/27/2024 c. 1 day in November 2024: 11/24/2024 d. 1 day in December 2024: 12/27/2024 e. 4 days in January 2025: 1/3/2025, 1/18/2025, 1/19/2025, 1/24/2025. 3. Resident 79 complained of 5/10 pain and received Acetaminophen 325 MG for mild pain (1-3) on 1/15/2025. (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 B. Wing	01/24/2025

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LVN 3 stated as needed (PRN) pain medications have parameters (administration restrictions set by the physician) and should be administered to the resident as ordered. LVN 3 stated there is no PRN medication ordered for severe pain (7-10). LVN 3 stated if a resident's pain is outside the ordered parameters, the nurse needs to contact the doctor to clarify and order an appropriate medication. LVN 3 stated there is no documentation indicating that nursing contacted the physician about severe pain levels of 7 or 8 out of 10 or administering pain medications outside of the ordered parameters. The electronic MAR (eMAR) Notes were reviewed from 1/1/2025-1/24/2025 and indicated the following: 1. Resident 79's pain location was not documented for 21/27 pain assessments associated with Tramadol administration: 1/1/2025, 1/2/2025, 1/2/2025, 1/3/2025, 1/4/2025, 1/5/2025, 1/6/2025, 1,7/2025, 1/8/2025, 1/9/2025, 1/10/2025, 1/11/2025, 1/15/2025, 1/16/2025, 1/17/2025, 1/18/2025, 1/19/2025, 1/20/2025, 1/21/2025, 1/21/2025, 1/23/2025, 1/23/2025 2. Resident 79's pain location was not documented for 4/4 pain assessments associated with Acetaminophen administration: 1/12/2025, 1/14/2025, 1/15/2025, 1/19/2025 LVN 3 stated location of pain should be assessed when assessing pain. LVN 3 stated location of pain is inconsistently documented in Resident 79's eMAR progress notes. During a concurrent interview and record review on 1/24/2025 at 2:48 p.m., with the MDS Coordinator (MDSC), Resident 79's records were reviewed. The MDS dated [DATE] indicated Resident 79 experiences pain occasionally. The MDSC stated the MDS should reflect that Resident 79 experiences pain almost constantly. The MDSC stated there is one care plan regarding pain that was initiated on 8/17/2024. The MDS nurse stated the pain care plan was not revised between 8/17/2024-1/24/2025. During an interview on 1/24/2024 at 3:59 p.m., with the Director of Nursing (DON), the DON stated medications should be administered within the ordered pain scale parameters, and if they resident complains of pain outside the parameters, the physician should have been contacted. The DON stated it is important for location of pain to be documented when assessing pain to know if the pain is acute (new) or chronic. The DON stated the MDS pain assessments need to accurately reflect the resident to ensure the resident's care plan is properly developed and revised to manage their pain. 2. During a review of Resident 32's Admission Record, the Admission Record indicated Resident 32 was admitted to the facility 8/4/2019 with diagnoses of blindness of bilateral eyes, traumatic brain injury (an injury to the brain caused by an external physical force, such as a bump, blow, jolt, or penetration), and hemiplegia (a medical condition that causes paralysis or weakness on one side of the body) of the left side. During a review of Resident 32's minimum data set (MDS, a resident assessment tool) dated 11/5/2024, the MDS indicated Resident 32 had severe cognitive impairment (a significant decline in cognitive abilities that interferes with daily life and independence). During a review of Resident 32's order summary report, Resident 32 had an order placed 1/30/2024 to monitor pain level using the following scale: 0= no pain, 1-4= mild pain, 5-6= moderate pain, 7-10= severe pain, every shift. (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 B. Wing	01/24/2025

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 32's history and physical (H&P) report dated 12/31/2024, the H&P indicated Resident 32 had history of a gun shot wound (GSW) to the right skull in 2019 and had neuropathic pain (a chronic pain condition that arises from damage or dysfunction in the nervous system). During a review of Resident 32's medication administration report (MAR) for the month of January 2025, Resident 32 was to be monitored for pain, using the following scale: 0= no pain, 1-4= mild pain, 5-6= moderate pain, 7-10= severe pain, every shift. A review of the MAR indicated an X was being documented instead of a number, every day and every shift for the pain level until evening (3p.m. to 11 p.m.) shift on 1/22/2025 evening shift where a 0, no pain was documented. During an interview on 1/24/2025 at 12:55 p.m., the director of nursing (DON) stated Resident 32 was verbal and able to use the pain scale and the numeric pain scale was appropriate for Resident 32. The DON stated it was important to monitor pain to ensure the residents received proper management of their pain. The DON stated she reviewed Resident 32's MAR for January 2025 and the nurses were documenting X instead of an actual numeric number for level of pain. The DON stated the nurses were not following the physician's order because the order indicated to use a numeric number (1-10) and indicate the number on the MAR. The DON stated there was a potential that pain could be missed if the resident was not assessed for pain as ordered. During a review of the facility's policy and procedure (P/P) titled Pain Assessment and Management dated 2001, the P/P indicated nursing staff were to assess the resident's pain by using a consistent approach and a standardized pain assessment appropriate to the resident's

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	01/24/2025

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 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** 49130 Based on observation, interview, and record review, the facility failed to: 1. Ensure ClearLax ([generic name - polyethylene glycol] a medication used to treat constipation), Advair Diskus ([generic name: fluticasone-salmeterol] a medication delivered through a device in the form of inhalation powder, used to treat breathing problems due to asthma [a chronic lung disease causing inflammation and muscle tightness around airways] and chronic obstructive pulmonary disease [COPD - a chronic lung disease causing difficulty in breathing]) and Aspirin [a medication used to prevent heart attack (flow of blood and oxygen is blocked) and stroke (loss of blood flow to a part of the brain)] were administered in accordance with physician orders and manufacturer formulation specifications affecting three of four sampled residents during medication administration (Residents 35, 70 and 342). 2. Administer Resident 36's Hydralazine (a medication used to treat high blood pressure) within 60 minutes of its scheduled time as per facility's policy and procedure (P&P) titled, Medication Administration - General Guidelines, dated 05/2022, affecting one of four sampled residents during medication administration (Resident 36). 3. Maintain accurate documentation of Hydrocodone-Acetaminophen (a controlled medication [medications that the use and possession of are controlled by the federal government] used to treat pain), Clonazepam (a controlled medication used to treat panic disorder and seizure [a medical term used to describe sudden, uncontrolled burst of electrical activity in the brain]), Pregabalin (a controlled medication used to treat fibromyalgia [pain in muscles and soft tissues] related pain, neuropathic (nerve related) pain and a subset of seizures [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness]) and Oxycodone (a controlled medication used to treat moderate to severe pain) on accountability record or controlled medication count sheet/controlled drug record ([CDR] - a document indicating perpetual inventory and administration of controlled substances, affecting three residents (Residents 84, 57 and 22) in one of two inspected medication carts (Station 1 Medication Cart 1). 4. Ensure scheduled Methadone was available for one of one sampled resident (Resident 90). These deficient practices failed to provide medications in accordance with the physician's orders or professional standards of practice, maintain accurate documentation of controlled medications, and had the potential to result in medical complications due to hypertension, stroke, choking, constipation, oral thrush (a fungal infection that can grow in mouth or throat), and controlled medications loss and/or drug diversion for Residents 22, 35, 36, 57, 70, 84 ,342 and 90. Findings: (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 B. Wing	01/24/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1a. During a review of Resident 35's Admission Record (a document containing demographic and diagnostic information), dated 1/22/2025, the admission record indicated, Resident 35 was originally admitted to facility on 12/5/2024 and readmitted on [DATE] with diagnoses including but not limited to chronic obstructive pulmonary disease, shortness of breath, atherosclerotic (a condition with buildup of fat and calcium) in arteries of extremities with intermittent claudication [a medical term used to describe pain caused by reduced blood flow to the legs or arms]) heart disease of native coronary artery (artery supplying blood to the heart muscle) without angina pectoris (chest pain) and systolic congestive heart failure ([CHF] a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling). During a review of Resident 35's History and Physical (H&P), dated 1/3/2025, the document indicated, Resident 35 had the capacity to make own medical decisions. During a review of Resident 35's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 1/10/2025, the MDS indicated, Resident 35's cognition (mental action or process of acquiring knowledge and understanding through thought and the senses) was moderately impaired. The MDS indicated Resident 35 needed moderate assistance to supervision level assistance from the facility staff in performing activities of daily living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) such as eating, oral hygiene, toileting, showering, upper and lower body dressing and wearing/taking off footwear. During a concurrent observation and interview of medication administration on 1/22/2025 at 8:57 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 prepared and administered five medications to Resident 35. LVN 1 stated she used eight-ounce (oz - a unit of measurement for volume) water to dissolve one capful (17 grams [gm - a unit of measurement for mass]) of ClearLax. LVN 1 dissolved one capful of ClearLax in a cup measuring four oz water and poured four oz water in another water cup. LVN 1 then mixed contents from both water cups indicating she used eight oz to dissolve one capful of ClearLax. During an observation on 1/22/2025 at 9:10 a.m. in Resident 35's room, LVN 1 instructed Resident 35 to rinse mouth after administering Advair Diskus. Resident 35 was not observed rinsing his mouth. LVN 1 did not ensure that Resident 35 finished full dose of ClearLax solution before exiting Resident 35's room. Per manufacturer's labeling, patients should be advised to rinse his/her mouth with water without swallowing after inhalation of Advair Diskus to help reduce the risk of fungal infection of the mouth and pharynx may occur. During a medication reconciliation review on 1/22/2025 at 11:18 a.m. Resident 35's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for January 2025 was reviewed. The MAR indicated Miralax (generic name - polyethylene glycol) oral powder documented as administered. During a review of Resident 35's Order Summary Report (a document containing a summary of all active physician orders), dated 1/22/2025, the order summary report indicated, but not limited to the following physician orders: (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 B. Wing	01/24/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Advair Diskus inhalation aerosol powder breath activated 500-50 microgram (mcg - a unit of measurement for mass) / actuation (act - spray) 1 puff inhale orally two times a day for COPD, order date 1/7/2025, start date 1/8/2025 Miralax (generic name - polyethylene glycol 3350) oral powder 17 gm/scoop give 1 scoop by mouth one time a day for bowel management hold for loose stools, mix with 5 ounces of water, order date 1/3/2025, start date 1/4/2025 1b. During a review of Resident 70's admission record, dated 1/22/2025, the admission record indicated, Resident 70 was admitted to the facility on [DATE] with diagnoses including but not limited to acute myocardial infarction (MI - heart attack) and atherosclerotic heart disease of native coronary artery without angina pectoris. During a review of Resident 70's MDS, dated [DATE], the MDS indicated, Resident 70's cognition was intact. The MDS indicated Resident 70 needed moderate assistance from facility staff for showering and supervision level assistance in performing ADLs such as eating, oral hygiene, toileting, upper and lower body dressing and wearing/taking off footwear. During an observation on 1/22/2025 between 9:11 a.m. and 9:22 a.m., LVN 1 prepared and administered eight medications to Resident 70 that included one tablet of aspirin 81 mg chewable tablet. LVN 1 failed to instruct Resident 70 to chew the aspirin tablet. Resident 70 was observed swallowing all medications including aspirin 81 mg chewable tablet. During a review of Resident 70's order summary report, dated 1/22/2025, the order summary report indicated but not limited to the following physician order: Aspirin oral capsule 81 mg, give 1 tablet by mouth one time a day for deep venous thrombosis ([DVT] a condition where blood clot (thrombus) forms in one or more of the deep veins in the body, usually in the legs) prophylaxis (PPX - prevention) do not crush, order date 11/18/2024, start date 11/19/2024 1c. During a review of Resident 342's admission record, dated 1/22/2025, the admission record indicated Resident 342 was admitted to the facility on [DATE] with diagnosis including but not limited to systolic congestive heart failure. During a review of Resident 342's history and physical, dated 1/9/2025, the document indicated Resident 342 had the capacity to understand and make decisions. During a review of Resident 342's MDS, dated [DATE], Resident 342's cognition was moderately impaired. The MDS indicated Resident 342 needed supervision level assistance from facility staff for eating and oral hygiene, maximal assistance for personal hygiene and upper body dressing, and Resident 342 was dependent for toileting, showering, lower body dressing and putting on/taking off footwear. During an observation on 1/22/2025 at 9:43 a.m., LVN 1 prepared and administered eight medications to Resident 342 that included one capful of polyethylene glycol. LVN 1 stated she dissolved one capful of polyethylene glycol in four oz water. (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 B. Wing	01/24/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 342's order summary report, dated 1/22/2025, the order summary report indicated, but not limited to the following physician order: Polyethylene Glycol 3350 oral packet 17 gm, give 1 packet by mouth one time a day for bowel management hold for loose stool, mix with 5 ounces of liquids (juice/water), order date 1/8/2025, start date 1/9/2025. During a concurrent interview and record review on 1/22/2025 at 1:41 p.m. with LVN 1, the order details of Resident 35's polyethylene glycol, Resident 70's aspirin 81 mg and Resident 342's polyethylene glycol were reviewed. LVN 1 stated Resident 35's physician order for polyethylene glycol indicated to dissolve one scoop with five oz water. LVN 1 stated the order should have been clarified. LVN 1 then used one oz medicine cup to show water cup could only measure up to four oz volume. LVN 1 stated she did not have a graduated cup with measurements. LVN 1 stated Residents 35 and 342 were at risk for cramping and gastrointestinal issues if they did not receive appropriate dose of polyethylene glycol dissolved in sufficient amount of water as prescribed by physician. LVN 1 stated Resident 70 was supposed to chew the aspirin 81 mg instead of swallowing it because it was a chewable formulation. LVN 1 stated the physician's order for Resident 70's aspirin 81 mg should also be clarified because it indicated aspirin 81 mg oral capsule instead of chewable. LVN 1 stated aspirin 81 mg chewable would be the most effective if it was taken according to manufacturer requirements. LVN 1 stated Resident 70 would be at a risk for blood clots, pulmonary embolism (a blood clot in an artery in the lungs blocking the blood flow) or even hospitalization if aspirin 81 mg was not given as prescribed. 2. During a review of Resident 36's admission record, dated 1/22/2025, the admission record indicated, Resident 36 was admitted to the facility on [DATE] with diagnosis including but not limited to essential (primary) hypertension (high blood pressure). During a review of Resident 36's history and physical, dated 1/10//2025, the document indicated it was unclear if Resident 36 was able to make his or her own medical decisions. During a review of Resident 36's MDS, dated [DATE], the MDS indicated Resident 36's cognition was moderately impaired. The MDS indicated Resident 36 needed supervision assistance from facility staff to perform ADLs such as eating, moderate assistance for oral hygiene, maximal assistance for upper body dressing, and dependent for toileting, showering, lower body dressing, putting on/taking off footwear and personal hygiene. During a concurrent observation and interview on 1/22/2025 between 9:51 a.m. and 10:02 a.m. with LVN 2, LVN 2 prepared and administered seven medications to Resident 36 that included Hydralazine 50 mg with the pharmacy label that indicated, Give 1 tablet by mouth at 8 a.m., 1 p.m., 5 p.m. after meals for HTN, hold if SBP less than (<) 110. LVN 2 stated Resident 36's blood pressure (BP) was 118/67 millimeters mercury (mmHg - a unit of measurement for BP) and heart rate (HR) was 60 beats per minute (bpm). During a medication reconciliation review on 1/22/2025 at 12:37 p.m. Resident 36's MAR for January 2025 was reviewed. The MAR indicated the scheduled time of medication administration for Hydralazine 50 mg was 8:00 a.m., 10:00 a.m. and 1:00 p.m. with directions to give 1 tablet by mouth after meals for hypertension hold for systolic blood pressure (SBP) below 110 and start date as 7/8/2024. (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 B. Wing	01/24/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 36's order summary report, dated 1/22/2025, the order summary report indicated, but not limited to the following physician orders: Hydralazine hydrochloride (HCl) oral tablet 50 mg, give 1 tablet by mouth after meals for hypertension hold for SBP below 110, order date 7/8/2024, start date 7/8/2024 During a concurrent interview and record review on 1/22/2025 at 3:52 p.m. with LVN 2, Resident 36's administration details and order details for hydralazine 50 mg were reviewed. LVN 2 stated Resident 36's physician order for hydralazine 50 mg indicated to give one tablet after a meal at 8 a.m. LVN 2 stated hydralazine 50 mg for Resident 36 was documented as administered on 1/22/2025 at 10:03 a.m. which was late by almost two hours from the scheduled time of 8:00 a.m. LVN 2 stated she knew that she was running late on giving medications, so she requested the nurse supervisor to call physician to receive an approval from physician for late administration. LVN 2 stated hydralazine was to treat Resident 36's high blood pressure and if it was given late, then there was a risk for high blood pressure and stroke. During an interview on 1/24/2025 at 11:03 a.m. with Director of Nursing (DON), DON stated according to facility policy, a medication could be given as early as one hour before and as late as one hour after the scheduled time of administration. DON stated the nurses should check administration instructions on the pharmacy label and the electronic medication administration record (eMAR) and if they did not match, the order should have been clarified to prevent medication errors. DON stated hydralazine 50 mg for Resident 36 was administered to resident at 10:00 a.m. which was beyond one hour late. DON stated Resident 36 was at increased risk of having a headache, neck pain, high blood pressure, stroke and hospitalization . DON stated Resident 70's aspirin chewable tablet should have been separated from other medications and nurse should have instructed resident to chew the tablet. DON stated the nurse should have clarified physician's which indicated aspirin capsule, but chewable aspirin was administered. DON stated resident on fluticasone-salmeterol was supposed to rinse mouth after use to prevent oral thrush. DON stated the medicine cup used to measure water to dissolve medications measured at five oz if filled up completely to the brim. DON stated pharmacy allowed polyethylene glycol to be dissolved in four oz to eight oz water and physician order indicated to use five oz water to dissolve polyethylene glycol. DON stated it would be better to use graduated water cups to be able to measure volume instead of guessing. DON stated residents were at the risk of adverse effects such as constipation, bloating and even choking if not able to safely swallow the medication. 3a. During a review of Resident 84's admission record, dated 1/23/2025, the admission record indicated Resident 84 was admitted to the facility on [DATE] with diagnoses including but not limited to generalized muscle weakness, pain in right hip and pain in left hip. During a review of Resident 84's MDS, dated [DATE], the MDS indicated, Resident 84's cognition was moderately impaired. The MDS indicated Resident 84 needed maximal assistance from the facility staff to perform ADLs such as toileting, showering, upper and lower body dressing, putting on/taking off footwear, personal hygiene, moderate assistance for oral hygiene, and supervision assistance for eating. During a review of Resident 84's order summary report, dated 1/23/2025, the order summary report indicated, but not limited to the following active physician order: (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 B. Wing	01/24/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Norco (generic name - hydrocodone with acetaminophen) oral tablet 5-325 mg, give 1 tablet by mouth every 4 hours as needed for moderate to severe pain (4-10) not to exceed (NTE) 3 grams (gm - a unit of measurement for mass) acetaminophen (APAP) in 24 hours, order date 1/22/2025, start date 1/22/2025. During a review of Resident 84's telephone/verbal order signature details, dated 1/24/2025, the document indicated, but not limited to the following discontinued and active physician orders: Discontinue order: Effective date 1/22/2025 3:19 p.m. Norco oral tablet 5-325 mg (hydrocodone-APAP) give 1 tablet by mouth every 6 hours as needed for moderate to severe pain (4-10) NTE 3 grams APAP in 24 hours, order date/created date 1/22/2025 3:19 p.m. New order: Start date 1/22/2025 3:30 p.m. Norco oral tablet 5-325 mg (hydrocodone-APAP) give 1 tablet by mouth every 4 hours as needed for moderate to severe pain (4-10) NTE 3 grams APAP in 24 hours, order date/created date 1/22/2025 3:18 p.m. During a concurrent inspection, interview and record review on 1/23/2025 at 2:45 p.m. with LVN 1 of Station 1 Medication Cart 1, Resident 84's medication card / bubble pack, facility's controlled medication count sheet (CDR) and the medication administration details in eMAR for hydrocodone-APAP 5-325 mg were reviewed. Resident 84's medication card / bubble pack for hydrocodone-APAP 5-325 mg contained a quantity of four tablets remaining. The facility's CDR indicated a quantity of five tablets remaining with the last dose administered on 1/23/2025 at 3:00 a.m. The administration details in eMAR indicated the last dose of one tablet of hydrocodone-APAP 5-325 mg for Resident 84 was documented as administered on 1/23/2025 at 10:09 a.m. LVN 1 stated she forgot to document in CDR after administering hydrocodone-APAP to Resident 84. LVN 1 stated she should have documented in CDR immediately after administering the medication to Resident 84 to prevent medication errors, controlled medication misuse, overdose and diversion. 3b. During a review of Resident 57's admission record, dated 1/23/2025, the admission record indicated Resident 57 was originally admitted to the facility on [DATE] and then readmitted on [DATE] with diagnoses including but not limited to generalized muscle weakness, anxiety disorder, unspecified dorsalgia (back pain) and unspecified osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage). During a review of Resident 57's history and physical, dated 12/26/2024, the document indicated Resident 57 had the capacity to understand and make decisions. During a review of Resident 57's MDS, dated [DATE], the MDS indicated Resident 57's cognition was moderately impaired. The MDS indicated Resident 57 needed supervision assistance from facility staff to perform ADLs such as eating, oral hygiene, upper and lower body dressing, putting on/taking off footwear, personal hygiene, and needed moderate assistance for toileting and showering. During a review of Resident 57's order summary report, dated 1/23/2025, the order summary report indicated, but not limited to the following active physician orders: Klonopin (generic name - clonazepam) oral tablet 1 mg, give 1 tablet by mouth three times a day for anxiety manifested by (m/b) restlessness, order date 12/24/2024, start date 12/24/2024. (continued on next page)

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 01/24/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Norco oral tablet 5-325 mg (hydrocodone-acetaminophen), give 1 tablet by mouth every 6 hours as needed for moderate pain (4-6) and give 2 tablets by mouth every 6 hours as needed for severe pain (7-10) NTE 3 gm APAP/24 hours, order date 12/24/2024, start date 12/24/2024. Norco oral tablet 5-325 mg (hydrocodone-acetaminophen), give 2 tablets by mouth every 6 hours as needed for severe pain (7-10) NTE 3 gm APAP/24 hours, order date 12/24/2024, start date 12/24/2024. Pregabalin oral capsule 50 mg, give 1 capsule by mouth two times a day for right thigh pain, order date 12/24/2024, start date 12/24/2024. During a concurrent inspection, interview and record review on 1/23/2025 between 2:45 p.m. and 4:19 with LVN 1 of Station 1 Medication Cart 1, Resident 57's medication card / bubble pack, facility's-controlled medication count sheet (CDR) and the medication administration details in eMAR for clonazepam 1 mg, hydrocodone-APAP 5-325 mg and pregabalin 50 mg were reviewed. The details are indicated below: a. Resident 57's medication card / bubble pack for hydrocodone-APAP 5-325 mg contained a quantity of 11 tablets remaining. The facility's CDR indicated a quantity of 13 tablets remaining with the last dose administered on 1/23/2025 at 6:06 a.m. The administration details in eMAR indicated the last dose of two tablets of hydrocodone-APAP 5-325 mg for Resident 57 were documented as administered on 1/23/2025 at 12:19 p.m. b. Resident 57's medication card / bubble pack for clonazepam 1 mg contained a quantity of two tablets remaining. The facility's CDR indicated a quantity of three tablets remaining with the last dose administered on 1/23/2025 at 9:51 a.m. The administration details in eMAR indicated effective date and time for the doses of one tablet of clonazepam 1 mg for Resident 57 were 9:51 a.m. and 12:37 p.m. on 1/23/2025 and documented as administered on 1/23/2025 at 11:56 a.m. and 12:38 p.m. respectively. c. Resident 57's medication card / bubble pack for pregabalin 50 mg contained a quantity of 13 capsules remaining. The facility's CDR indicated a quantity of 14 capsules remaining with the last dose administered on 1/22/2025 at 9:00 p.m. The administration details in eMAR indicated the last dose of one capsule of pregabalin 50 mg for Resident 57 was on 1/23/2025 at 11:56 a.m. LVN 1 stated it was not an excuse that she was distracted with some behavioral concerns with Resident 57 and forgot to document hydrocodone-APAP, clonazepam and pregabalin in CDR after administering them to Resident 57. LVN 1 stated she should have documented in CDR immediately after administering the medication to Resident 57 to prevent medication errors, behavioral disturbances, adverse events due to untreated pain and anxiety, overdose and diversion. 3c. During a review of Resident 22's admission record, dated 1/23/2025, the admission record indicated Resident 22 was admitted to the facility on [DATE] with diagnoses including but not limited to, generalized muscle weakness, periprosthetic fracture around internal prosthetic (artificial) left hip joint, person injured in unspecified motor vehicle accident, multiple fractures of ribs and presence of artificial hip joint. During a review of Resident 22's history and physical, dated 12/31/2024, the document indicated Resident 22 had the capacity to understand and make decisions. (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 B. Wing	01/24/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 22's MDS, dated [DATE], the MDS indicated Resident 22's cognition was intact. The MDS indicated Resident 22 needed moderate assistance from the facility staff for eating, maximal assistance for oral hygiene, upper and lower body dressing and personal hygiene, and dependent on facility staff for toileting, showering and putting on/taking off footwear. During a review of Resident 22's order summary report, dated 1/23/2025, the order summary report indicated, but not limited to the following but not limited to active physician order: Roxicodone (generic name - oxycodone HCl) oral tablet 5 mg, give 1 tablet by mouth every 4 hours as needed for severe pain (7-10), order date 12/30/2024, start date 12/30/2024. During a concurrent inspection, interview and record review on 1/23/2025 between 2:45 p.m. and 4:19 p.m. with LVN 1 of Station 1 Medication Cart 1, Resident 22's medication card / bubble pack, facility's-controlled medication count sheet (CDR) and the medication administration details in eMAR for oxycodone immediate release (IR) 5 mg were reviewed. Resident 22's medication card / bubble pack for oxycodone IR 5 mg contained a quantity of 16 tablets remaining. The facility's CDR indicated a quantity of 17 tablets remaining with the last dose administered on 1/22/2025 at 4:58 p.m. The administration details in eMAR indicated the last dose of one tablet of oxycodone IR 5 mg for Resident 22 was documented as administered on 1/23/2025 at 10:36 a.m. LVN 1 stated it was her mistake to forget to document on CDR immediately after oxycodone IR 5 mg was administered to Resident 22. LVN 1 stated oxycodone is a highly addictive controlled medication and should be accurately recorded to prevent medication errors, overdose, death and drug diversion. During an interview on 1/24/2025 at 11:40 a.m. with the DON, DON stated it was very important that the facility nurse documented controlled substance administration in eMAR, controlled medication count sheet (CDR) immediately after administering controlled medications to residents. DON stated it was important that controlled medications were administered as ordered and prevent duplicate administration to prevent addiction and dependency. DON stated the residents were at risk of adverse effects such as inadequate pain relief, worsening of anxiety and behavioral episodes because of missing documentation in CDR for hydrocodone-APAP, pregabalin, oxycodone and clonazepam. DON stated the inaccurate documentation of controlled medications increased the risk for overdose, drug diversion and misuse. 4. During a review of Resident 90's Admission record dated 1/24/2025, the Admission record indicated Resident 79 was admitted to the facility on [DATE] with diagnoses including facture of right femur (thigh bone), dorsalgia (pain in the back or spine), wedge compression fracture of lumbar vertebrae [fracture that occurs when the front of a vertebra (bone in spine) collapses in the lower back forming a wedge shape], and chronic pain syndrome. During a review of Resident 90's History and Physical (H&P), dated 3/4/2024, the H&P indicated Resident 90 was capable of making medical decisions. During a review of Resident 90's MDS dated [DATE], the MDS indicated Resident 90 was able to understand and be understood by others, required supervision or touching assistance (helper provides verbal cures or steadying assistance throughout or intermittently) for eating, hygiene, and bathing. (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 B. Wing	01/24/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 90's Physician Order Summary dated 1/24/2025, the Order Summary indicated: 1. Methadone HCL Oral Tablet 10 MG, give 8 tablet by mouth one time a day for chronic back pain/compression Fracture of spine give 8 tabs = to 80 MG, start date 3/3/2024 2. Transfer to hospital due to uncontrol pain via 911, order date 12/13/2024 During a review of Resident 90's Medication Administration Record (MAR) for December 2024, the MAR indicated Resident 90 did not receive the scheduled Methadone on 12/13/2024. During a review of Resident 90's GACH records, undated, the records indicated Resident 90 was admitted to the GACH on 12/13/2025 at 11:03 p.m. with the admitting diagnosis of back pain. During a concurrent interview and record review on 1/24/2025 2:17 p.m. with Licensed Vocational Nurse (LVN) 3, Resident 90's records were reviewed. 1. The nursing progress note dated 12/13/2024 at 9:32 a.m. indicated Resident 90's routine methadone dose was unavailable for administration, physician was notified and instructed to monitor for symptoms of withdrawal, and the pharmacy stated the methadone was out for delivery. 2. The nursing progress note dated 12/13/2024 at 10:56 p.m. indicated Resident 90 complained of 10/10 lower back pain on 12/13/2024 at around 8:30 p.m. and resident would like to go to the hospital. Resident 90 was transferred on 12/13/2024 around 9 p.m. 3. The nursing progress note dated 12/13/2024 at 11:03 p.m. indicated the outgoing charge nurse stated Resident 90 was out of medication and that the RN supervisor said the medication was on the way. LVN 3 stated there is no documentation prior to 12/13/2024 stating that the methadone was requested from pharmacy to be restocked. LVN 3 stated the facility's process is to order when there is a 3-day supply remaining so that the medication will not run out. During a concurrent interview and record review on 1/24/2024 at 3:52 p.m. with the Director of Nursing (DON), Resident 90's records were reviewed. The DON stated Resident 90 did not receive his scheduled methadone and was transferred the same day for uncontrolled pain. The DON stated the methadone should be administered as scheduled. The DON stated it is important to not miss methadone doses because missed doses place the resident at risk for withdrawals. The DON stated the methadone should have been ordered before running out of the methadone supply. During a review of the facility's policy and procedure (P&P), Administering Medications, dated 2001, the P&P stated medications are administered in a safe and timely manner, and as prescribed. During a review of the facility's P&P titled, Medication Administration - General Guidelines, dated 05/2022, the P&P indicated, Medications are administered within [60 minutes] of scheduled time, except before, with or after meal orders, which are administered [based on mealtimes]. Unless otherwise specified by the prescriber, routine medications are administered according to the established medication administration schedule for the facility. The P&P indicated, Medications are administered as prescribed in accordance with good nursing principles and practices .do so. (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 B. Wing	01/24/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Administering Medications, dated 2001, the P&P indicated, Medications are administered in a safe and timely manner, and as prescribed. Medications are administered in accordance with prescriber orders, including any time frame. During a review of the facility's P&P titled, Controlled Substances, dated 05/2022, the P&P indicated, Accurate accountability of the inventory of all controlled drugs is maintained at all times. When a controlled substance is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record and the medication administration record (MAR): 1) Date and time of administration (MAR, Accountability Record), 2) Amount administered (Accountability Record), 3) Remaining quantity (Accountability Record), 4) Initials of the nurse administering the dose, completed after the medication is actually administered (MAR, Accountability Record). 50144

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	01/24/2025

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49130 Based on interview and record review, the facility failed to act on two recommendations from the consultant pharmacist (a professional responsible for reviewing each resident's medication profile monthly to identify and report changes) from 12/11/2024 regarding lowering of the dose of Seroquel (generic name - quetiapine, a medication used to treat schizophrenia (a mental illness that is characterized by disturbances in thought) 150 milligram (mg - a unit of measurement for mass) once daily at bedtime and sertraline (a medication used to treat depression [sadness, low mood]) 50 mg once daily in one of five residents sampled for unnecessary medications (Resident 41). This deficient practice of failing to respond to recommendations from the consultant pharmacist could have resulted in Resident 41 receiving a higher than necessary dose of quetiapine and sertraline possibly resulting in medication side effects (a secondary, typically undesirable effect of a drug or medical treatment) leading to a decrease in physical, mental, or psychosocial well-being. Findings: During a review of Resident 41's Admission Record (a document containing demographic and diagnostic information), dated 1/23/2025, Resident 41 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including but not limited to schizoaffective (a mental illness that can affect thoughts, mood, and behavior) disorder - depressive type and major depressive disorder. During a review of Resident 41's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 1/16/2025, the MDS indicated Resident 41's cognition was intact. The MDS indicated, Resident 41 needed supervision assistance from facility for Activities of Daily Living (ADLs) such as eating, moderate assistance for oral and personal hygiene, maximal assistance for upper and lower body dressing, and dependent on facility staff for toileting, showering and putting on/taking off footwear. During a review of Medication Regimen Review (MRR - a monthly evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences associated with medication), dated 12/11/2024, the review indicated the consultant pharmacist recommended reducing Resident 41's quetiapine 150 mg daily at bedtime and sertraline 50 mg once daily. The MRR document indicated, NP indicated she disagreed with consultant pharmacist's recommendation without providing clinical rationale. During a review of Resident 41's Order Summary Report (a document containing a summary of all active physician orders), dated 1/23/2025, the order summary report indicated but not limited to the following physician orders: Seroquel oral tablet (quetiapine fumarate), give 150 mg by mouth at bedtime for schizoaffective disorder m/b delusions. Informed consent obtained by medical doctor (MD) from responsible party, order date 5/18/2023, start date 5/18/2023. (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 B. Wing	01/24/2025

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Sertraline hydrochloride (HCl) tablet 50 mg, give 1 tablet by mouth one time a day for depression m/b verbalization of sadness. Informed consent obtained by MD from responsible party, order date 5/18/2023, start date 5/18/2023. During a review of Resident 41's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 1/1/2025 to 1/23/2025, 12/1/2024 to 12/31/2024, 11/1/2024 to 11/30/2024, the MAR indicated both sertraline 50 mg and quetiapine 150 mg were administered. The MAR indicated, there were zero episodes documented for physician order, monitor episodes of delusions of someone is out to get her tally with hashmarks, every shift for the use of Seroquel. The MAR indicated, there were zero episodes documented for physician order, monitor episodes of depression manifested by (m/b) verbalization of sadness, tally with hashmarks, drug: sertraline every shift for depression. During a review of Resident 41's progress notes, dated 12/10/2024, the document indicated, Today the patient reports feeling psychologically stable, therefore, will defer any medication adjustments. Med trials: gradual dose reduction (GDR): not applicable (N/A). During a review of Resident 41's patient consult follow-up visit note, dated 1/14/2025, the document indicated, Med trials: gradual dose reduction (GDR): not applicable (N/A). During an interview on 1/24/2025 at 3:12 p.m. with the Director of Nursing (DON), DON stated there should be gradual dose reduction attempted and pharmacist would send recommendation to physician to be agreed or disagreed with. DON stated physician should provide a clinical rationale if he/she disagreed with the pharmacist recommendation for Resident 41. DON stated the clinical rationale was important because the psychotropic medications have a lot of side effects, so there should have been a reason that would outweigh the risks of the medication. DON stated without the clinical reason, Resident 41 could experience side effects from psychotropic medications. During an interview on 1/24/2025 at 4:50 a.m. with the Psychiatry Nurse Practitioner (NP), NP stated she had not reduced the dose for Resident 41's quetiapine and sertraline because Resident 41 stated that she was feeling better with the medications. NP stated Resident 41 was stable with the medication regimen, had not got better or worse so she did not have a reason to reduce the medication. NP stated there had not been episodes reported for delusions and hallucinations for Resident 41 and Resident 41 had not expressed anything except depression and labile (changes in mood) mood. During a review of the facility's policy and procedure (P&P) titled, Medication Regimen Review, dated 05/2022, the P&P indicated, The consultant pharmacist identifies irregularities through a variety of sources including the resident's clinical record .documents. Resident-specific irregularities and/or clinically significant risks resulting from medications are documented in resident's [active record] and reported to the Director of Nursing, .as appropriate. The P&P indicated, Recommendations are acted upon and documented by the facility staff and/or the prescriber. Prescriber accepts and acts upon suggestion or rejects and provides an explanation for disagreeing. If there is potential for serious harm and the attending physician or prescriber does not concur, or refuses to document an explanation for disagreeing, the director of nursing and the consultant pharmacist will contact the medical director .this process must be completed in a manner to ensure no actual harm occurs.

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	01/24/2025

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49573 Based on observation, interview, and record review, the facility failed to ensure adequate monitoring of side effect for one of two sample residents (Resident 53) who was receiving an anticoagulant (a medication used to prevent and treat blood clots [that can cause severe health issues] in the blood vessels and the heart) medication and were at high risk for bleeding from12/19/2024. This deficient practice had the potential to cause a delay in necessary care and services resulting in injury or death. Findings: During a review of Resident 53's Admission Record, the Admission Record indicated Resident 53 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including chronic respiratory failure with hypoxia (a condition where the body is unable to effectively exchange oxygen and carbon dioxide over a prolonged period, resulting in persistently low levels of oxygen in the blood (hypoxia) due to impaired lung function), chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing), hypertension (HTN, high blood pressure), and hyperlipidemia (a condition where there are high levels of lipids, or fats, in the blood). During a review of Resident 53's Minimum Data Set ([MDS a resident assessment tool) dated 12/27/24, the MDS indicated Resident 53 had moderate cognitive impairment (limitation in mental functioning and in skills such as communication, self-help, and social skills) and required supervision assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) for functional abilities such as eating, maximal assistance (helper does more than half the effort, helper lifts, holds, or supports trunk or limbs, but provides more than half the effort) with oral hygiene, and upper body dressing, and personal hygiene and was dependent (helper does all of the effort, resident does none of the effort to complete the activity) on toileting, shower/bathe and lower body dressing. The MDS indicated Resident 53 required supervision with mobility such as rolling left and right, sit to lying position, and needed moderate assistance (helper does less than half the effort) with lying to sitting on side of the bed, and dependent on chair/bed to chair transfers. During a review of Resident 53's Order Summary Report, the Order Summary Report indicated apixaban(anticoagulant) oral tablet five milligram ([mg], unit of measurement) give one tablet by mouth two times a day for DVT PPX ([Deep Vein Thrombosis prophylaxis] is a set of measures to prevent deep vein thrombosis (DVT), a blood clot in a deep vein) ordered on 12/19/24. No monitoring for side effects. During an observation and interview on 1/21/2025 at 12:04 p.m., in Resident 53's room, Resident 53 was sitting on his bed watching a movie on his laptop. Resident 53 had a tracheostomy (a surgical procedure that creates an opening in the neck into the windpipe, allowing air to pass into the lungs) in his neck and was not able to verbalize his words but was able to move his lips to mouth his words. Resident 53 was able to answer questions when asked by mouthing his words. Resident 53 mouthed that he thought he was taking a blood thinner but was not sure if he was taking it or not. (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 B. Wing	01/24/2025

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 1/24/25 at 9:46 a.m. with Licensed Vocational Nurse (LVN) 2, the MAR for December 2024 and January 2025. LVN 2 stated residents who are on anticoagulant should be monitored for bleeding from the start date. LVN 2 stated the staff should monitor for bleeding like discoloration of skin, bleeding in gums, dark stools, any source of bleeding, bleeding that doesn't stop. LVN 2 stated staff should be monitoring residents who are on anticoagulant every shift and if residents are not monitored, residents can bleed out. LVN 2 stated Resident 53's anticoagulant monitoring was missed from 12/20/25 to 1/13/25 and Resident 53 should have been monitored during that time. During a concurrent interview and record review on 1/24/25 at 3:36 p.m. with Director of Nursing (DON), the MAR for December 2024 and January 2025 was reviewed. DON stated residents who are on anticoagulant medication should be monitored every shift. DON stated the importance of monitoring residents who are taking anticoagulant medication was to make sure staff address the side effects if there are internal bleeding, bleeding in the gums, dark tarry stools and to inform the medical doctor right away. During a review of the facility's policy and procedure (P/P) titled Medication Administration-General Guidelines dated May 2022, indicated, monitoring of side effects or medication-related problems occurs continually, but particularly after medication administration and especially after the first few doses of a new medication. During a review of the facility's P/P titled Charting and Documentation, dated 2001, indicated all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record .the following information is to be documented in the resident medical record such as treatments or services performed, changes in the resident's condition, events, incidents or accidents involving the resident.

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	01/24/2025

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 49573 Based on interview and record review, the facility failed to obtain informed consent prior to administering a controlled medication (a drug or chemical that are regulated by the government for their manufacture, possession, and use) for one of three sampled residents (Resident 17) who was on temazepam (a medication used to treat certain types of sleep problem) for insomnia (a sleep disorder in which you have trouble falling asleep, staying asleep, or waking up too early). This deficient practice had the potential for Resident 17 to experience adverse (unwanted or dangerous medication side effects) effect of temazepam when receiving the medication without knowledge. Findings: During a review of Resident 17's Admission Record, the Admission Record indicated Resident 17 was admitted to the facility on [DATE] with diagnoses including bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety disorder (a group of mental health conditions that cause fear, dread and other symptoms that are out of proportion to the situation), and hemiplegia (paralysis on one side of body) and hemiparesis (muscle weakness on one side of the body) following cerebral infarction ([a stroke] damage to brain tissue due to loss of oxygen). During a review of Resident 17's history and physical (H/P) dated 10/24/24, the H/P indicated Resident 17 has the capacity to understand and make decisions. During a review of Resident 17's Minimum Data Set ([MDS- a resident assessment tool) dated 10/30/24, the MDS indicated Resident 17 was moderately impaired in cognitive (thinking process) skills and needed supervision (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with self-care abilities such as eating, required moderate assistance (helper does less than half the effort, helper lifts, holds, or supports trunk or limbs but provides less than half the effort) for oral hygiene, required maximal assistance (helper does more than half the effort) for upper body dressing, and personal hygiene and was dependent (helper does all of the effort, resident does none of the effort to complete the activity, or the assistance or 2 or more helpers is required for the resident to complete the activity) for toileting, shower/bathe, lower body dressing, and putting on/taking off footwear. The MDS also indicated Resident 17 required moderate assistance with mobility abilities such as rolling left and right, and needed maximal assistance with sit to lying position, lying to sitting position, sit to stand and chair/bed to chair transfers. During a review of Resident 17's Order Summary Report, the Order Summary Report indicated temazepam oral capsule 15 milligram ([mg], a unit of measurement) give one capsule by mouth at bedtime for insomnia manifested by inability to sleep ordered on 1/10/25. (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 B. Wing	01/24/2025

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 17's electronic medication administration record (MAR) for January 2025, the MAR indicated Resident 17 was receiving temazepam oral capsule 15 mg give one capsule by mouth at bedtime for insomnia manifested by inability to sleep from 1/10/25 to 1/23/25 with no missing gaps. During a review of Resident 17's informed consent, there was no informed consent for the medication temazepam at the dosage, frequency and reasoning for the medication order temazepam oral capsule 15 mg give one capsule by mouth at bedtime for insomnia manifested by inability to sleep. During a concurrent observation and interview on 1/21/25 at 12:23 p.m. with Resident 17 in his room, Resident 17 was lying in bed with eyes closed. Resident 17 opened eyes when greeted. Resident 17 stated he was taking a sleeping pill at night to help him sleep but does not know the name of it. During a concurrent interview and record review of the informed consent on 1/23/25 at 3:56 p.m. with MDS Coordinator (MDSC). There was no informed consent for the medication temazepam at this dosage, frequency and reasoning for the medication order temazepam oral capsule 15 mg give one capsule by mouth at bedtime for insomnia manifested by inability to sleep. The MDSC stated the facility should have an informed consent for psychotropic medication for Resident 17. The MDSC stated the need to have a new informed consent with the new order of temazepam because the frequency and dosage changed with this order. The MDSC stated Resident 17 was no longer receiving this medication on an as needed basis but now daily. The MDSC stated if there was no informed consent for psychotropic medication, residents would not be aware of the side effect of the medication. During an interview on 1/24/25 at 3:36 p.m. with Director of Nursing (DON), the DON stated there should have been a new informed consent for the temazepam medication because there was a change in frequency and dosage. DON stated since this medication was a controlled medication, the facility had to make sure the risk and side effects were discussed with the resident so that the resident was informed, and made sure the resident was agreeable to take the medication. During a review of the facility's policy and procedure (P/P) titled, Psychoactive/Psychotropic Medication Use, dated 7/2024, indicated the prescribing clinician will obtain informed consent from the resident (or, as appropriate, the resident representative) for use of a Psychotropic medication . a psychotropic medication is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: Antipsychotic, Antidepressant, Antianxiety, Mood Stabilizer, and Sedative-Hypnotic . prior to administration of a Psychotropic medication, the prescribing clinician will obtain informed consent from the resident (or as appropriate, the resident representative), and document the consent in the medical record.

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	01/24/2025

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49130 Based on observation, interview, and record review, the facility failed to maintain a medication error rate of less than 5% (percent) during medication pass for four of four sampled residents (Residents 35, 70, 342 and 36) by failing to administer ClearLax ([generic name - polyethylene glycol] a medication used to treat constipation), Advair Diskus ([generic name: fluticasone-salmeterol] a medication delivered through a device in the form of inhalation powder, used to treat breathing problems due to asthma [a chronic lung disease causing inflammation and muscle tightness around airways] and chronic obstructive pulmonary disease [COPD - a chronic lung disease causing difficulty in breathing]) and Aspirin [a medication used to prevent heart attack (flow of blood and oxygen is blocked) and stroke (loss of blood flow to a part of the brain)] in accordance with physician orders and manufacturer formulation specifications, and Hydralazine (a medication used to treat high blood pressure) within 60 minutes of its scheduled time as per facility's policy and procedure (P&P) titled, Medication Administration - General Guidelines, dated 05/2022. These deficient practices of medication administration error rate of 17.86% exceeded the five (5) percent threshold. Findings: a. During a review of Resident 35's Admission Record (a document containing demographic and diagnostic information), dated 1/22/2025, the admission record indicated, Resident 35 was originally admitted to facility on 12/5/2024 and readmitted on [DATE] with diagnoses including but not limited to chronic obstructive pulmonary disease, shortness of breath, atherosclerotic (a condition with buildup of fat and calcium) in arteries of extremities with intermittent claudication [a medical term used to describe pain caused by reduced blood flow to the legs or arms]) heart disease of native coronary artery (artery supplying blood to the heart muscle) without angina pectoris (chest pain) and systolic congestive heart failure ([CHF] a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling). During a review of Resident 35's History and Physical (H&P), dated 1/3/2025, the document indicated, Resident 35 had the capacity to make own medical decisions. During a review of Resident 35's Minimum Data Set (MDS - a resident assessment), dated 1/10/2025, the MDS indicated, Resident 35's cognition (mental action or process of acquiring knowledge and understanding through thought and the senses) was moderately impaired. The MDS indicated Resident 35 needed moderate assistance to supervision level assistance from the facility staff in performing activities of daily living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) such as eating, oral hygiene, toileting, showering, upper and lower body dressing and wearing/taking off footwear. During a concurrent observation and interview of medication administration on 1/22/2025 at 8:57 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 prepared and administered the following five medications to Resident 35. (continued on next page)

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 01/24/2025

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. One puff of fluticasone-salmeterol diskus 500-50 microgram (mcg - a unit of measurement for mass) 2. One capful (17 gram [gm] - a unit of measurement for mass) of ClearLax with eight-ounce (oz - a unit of measurement for volume) water 3. One tablet of ferrous sulfate (a medication to treat low level of iron) 325 milligrams (mg - a unit of measurement for mass) 4. One tablet of clopidogrel (a medication used to prevent blood clots) 75 mg 5. One vial of albuterol-ipratropium (a combination medication used to treat difficulty breathing) via nebulizer to be inhaled LVN 1 stated she used eight oz water to dissolve one capful (17 gm) of ClearLax. LVN 1 dissolved one capful of ClearLax in a cup measuring four oz water and poured four oz water in another water cup. LVN 1 then mixed contents from both water cups indicating she used eight oz to dissolve one capful of ClearLax. During an observation on 1/22/2025 at 9:10 a.m. in Resident 35's room, LVN 1 did not ensure that Resident 35 finished full dose of ClearLax solution before exiting Resident 35's room. Resident 35 did not follow LVN 1's instructions to rinse mouth after using Advair Diskus. Per manufacturer's labeling, patients should be advised to rinse his/her mouth with water without swallowing after inhalation of Advair Diskus to help reduce the risk of fungal infection of the mouth and pharynx. During a review of Resident 35's Order Summary Report (a document containing a summary of all active physician orders), dated 1/22/2025, the order summary report indicated, but not limited to the following physician orders: Advair Diskus inhalation aerosol powder breath activated 500-50 mcg / actuation (act - spray) 1 puff inhale orally two times a day for COPD, order date 1/7/2025, start date 1/8/2025 Miralax (generic name - polyethylene glycol 3350) oral powder 17 gm/scoop give 1 scoop by mouth one time a day for bowel management hold for loose stools, mix with 5 ounces of water, order date 1/3/2025, start date 1/4/2025 b. During a review of Resident 70's admission record, dated 1/22/2025, the admission record indicated, Resident 70 was admitted to the facility on [DATE] with diagnoses including but not limited to acute myocardial infarction (MI - heart attack) and atherosclerotic heart disease of native coronary artery without angina pectoris. During a review of Resident 70's MDS, dated [DATE], the MDS indicated, Resident 70's cognition was intact. The MDS indicated Resident 70 needed moderate assistance from facility staff for showering and supervision level assistance in performing ADLs such as eating, oral hygiene, toileting, upper and lower body dressing and wearing/taking off footwear. (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 B. Wing	01/24/2025

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 1/22/2025 between 9:11 a.m. and 9:22 a.m., LVN 1 prepared and administered the following eight medications to Resident 70. 1. One tablet of aspirin 81 mg chewable 2. One tablet of bupropion hydrochloride (a medication used to treat low mood) (HCl) extended release (XL) 150 mg 3. One tablet of carvedilol (a medication used to treat high blood pressure and heart conditions) 6.25 mg 4. Three tablets (750 mg) of divalproex (a medication used to treat seizure [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness]) delayed release (DR) 250 mg 5. One tablet of furosemide (a medication used to treat fluid retention and high blood pressure) 40 mg 6. One tablet of isosorbide mononitrate (a medication used to improve blood flow) extended release (ER) 30 mg 7. One tablet of potassium chloride (a medication used to treat low level of potassium) extended release (ER) 10 milliequivalent (mEq - a unit of measurement for mass) 8. One capsule of tamsulosin (a medication used in men to help urine flow easily) 0.4 mg LVN 1 failed to instruct Resident 70 to chew the aspirin tablet. Resident 70 was observed swallowing all medications including aspirin 81 mg chewable tablet. During a review of Resident 70's order summary report, dated 1/22/2025, the order summary report indicated but not limited to the following physician order: Aspirin oral capsule 81 mg, give 1 tablet by mouth one time a day for deep venous thrombosis ([DVT] a condition where blood clot (thrombus) forms in one or more of the deep veins in the body, usually in the legs) prophylaxis (PPX - prevention) do not crush, order date 11/18/2024, start date 11/19/2024 c. During a review of Resident 342's admission record, dated 1/22/2025, the admission record indicated Resident 342 was admitted to the facility on [DATE] with diagnosis including but not limited to systolic congestive heart failure. During a review of Resident 342's history and physical, dated 1/9/2025, the document indicated Resident 342 had the capacity to understand and make decisions. During a review of Resident 342's MDS, dated [DATE], Resident 342's cognition was moderately impaired. The MDS indicated Resident 342 needed supervision level assistance from facility staff for eating and oral hygiene, maximal assistance for personal hygiene and upper body dressing, and Resident 342 was dependent for toileting, showering, lower body dressing and putting on/taking off footwear. (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 B. Wing	01/24/2025

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 1/22/2025 at 9:43 a.m., LVN 1 prepared and administered the following eight medications to Resident 342. 1. One tablet of clopidogrel 75 mg 2. One capsule of gabapentin (a medication used to treat seizure and nerve pain) 300 mg 3. One tablet of methocarbamol (a medication used to treat muscle spasms) 500 mg 4. One-half tablet of metoprolol tartrate (a medication used to treat high blood pressure and heart conditions) 25 mg 5. One tablet of pioglitazone (a medication used to treat diabetes [DM] - a disorder characterized by difficulty in blood sugar control and poor wound healing) 45 mg 6. One capful (17 gm) of ClearLax dissolved with four oz water 7. One tablet of sodium chloride 1 gm 8. Two tablets of sennosides 8.6 mg plus docusate sodium (a combination medication used to treat constipation) 50 mg LVN 1 stated she dissolved one capful of polyethylene glycol in four oz water. During a review of Resident 342's order summary report, dated 1/22/2025, the order summary report indicated, but not limited to the following physician order: Polyethylene Glycol 3350 oral packet 17 gm, give 1 packet by mouth one time a day for bowel management hold for loose stool, mix with 5 ounces of liquids (juice/water), order date 1/8/2025, start date 1/9/2025. During a concurrent interview and record review on 1/22/2025 at 1:41 p.m. with LVN 1, the order details of Resident 35's polyethylene glycol, Resident 70's aspirin 81 mg and Resident 342's polyethylene glycol were reviewed. LVN 1 stated the residents' orders should have been clarified. Resident 35's physician order for polyethylene glycol indicated to dissolve one scoop with five oz water. LVN 1 then used one oz medicine cup to show water cup could only measure up to four oz volume. LVN 1 stated she did not have a graduated cup with measurements. LVN 1 stated Residents 35 and 342 were at risk for cramping and gastrointestinal issues because they did not receive polyethylene glycol dissolved in the amount of water as prescribed by physician. LVN 1 stated Resident 70 was supposed to chew the aspirin 81 mg instead of swallowing it because it was a chewable formulation. LVN 1 stated the physician's order for Resident 70's aspirin 81 mg should also be clarified because it indicated aspirin 81 mg oral capsule instead of chewable tablet. LVN 1 stated aspirin 81 mg chewable would be the most effective if it was taken according to manufacturer requirements. LVN 1 stated Resident 70 would be at a risk for blood clots, pulmonary embolism (a blood clot in an artery in the lungs blocking the blood flow) or even hospitalization if aspirin 81 mg was not given as prescribed. (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 B. Wing	01/24/2025

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d. During a review of Resident 36's admission record, dated 1/22/2025, the admission record indicated, Resident 36 was admitted to the facility on [DATE] with diagnosis including but not limited to essential (primary) hypertension (high blood pressure). During a review of Resident 36's history and physical, dated 1/10//2025, the document indicated it was unclear if Resident 36 was able to make his or her own medical decisions. During a review of Resident 36's MDS, dated [DATE], the MDS indicated Resident 36's cognition was moderately impaired. The MDS indicated Resident 36 needed supervision assistance from facility staff to perform ADLs such as eating, moderate assistance for oral hygiene, maximal assistance for upper body dressing, and dependent for toileting, showering, lower body dressing, putting on/taking off footwear and personal hygiene. During a concurrent observation and interview on 1/22/2025 between 9:51 a.m. and 10:02 a.m. with LVN 2, LVN 2 prepared and administered the following seven medications to Resident 36. The pharmacy label for Hydralazine 50 mg indicated, Give 1 tablet by mouth at 8 a.m., 1 p.m., 5 p.m. after meals for HTN, hold if SBP less than (<) 110. LVN 2 stated Resident 36's blood pressure (BP) was 118/67 millimeters mercury (mmHg - a unit of measurement for BP) and heart rate (HR) was 60 beats per minute (bpm). 1. One tablet of hydralazine 50 mg supposed to be at 8 a.m. 2. One tablet of nifedipine (a medication used to treat high blood pressure) ER 60 mg 3. One tablet of furosemide 20 mg 4. One capsule of gabapentin 300 mg 5. One tablet of levetiracetam (a medication used to treat seizure) 500 mg 6. One tablet of potassium chloride ER 10 mEq 7. One tablet of topiramate (a medication used to treat seizure and headache) 50 mg During a medication reconciliation review on 1/22/2025 at 12:37 p.m. Resident 36's MAR for January 2025 was reviewed. The MAR indicated the scheduled time of medication administration for Hydralazine 50 mg was 8:00 a.m., 10:00 a.m. and 1:00 p.m. with directions to give 1 tablet by mouth after meals for hypertension hold for systolic blood pressure (SBP) below 110 and start date as 7/8/2024. During a review of Resident 36's order summary report, dated 1/22/2025, the order summary report indicated, but not limited to the following physician orders: Hydralazine hydrochloride (HCl) oral tablet 50 mg, give 1 tablet by mouth after meals for hypertension hold for SBP below 110, order date 7/8/2024, start date 7/8/2024 (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 B. Wing	01/24/2025

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 1/22/2025 at 3:52 p.m. with LVN 2, Resident 36's administration details and order details for hydralazine 50 mg were reviewed. LVN 2 stated Resident 36's physician order for hydralazine 50 mg indicated to give one tablet after a meal at 8 a.m. LVN 2 stated hydralazine 50 mg for Resident 36 was documented as administered on 1/22/2025 at 10:03 a.m. which was late by almost two hours from the scheduled time of 8:00 a.m. LVN 2 stated hydralazine was to treat Resident 36's high blood pressure and if it was given late, then there was a risk for high blood pressure and stroke. During an interview on 1/24/2025 at 11:03 a.m. with Director of Nursing (DON), DON stated according to facility policy, a medication could be given as early as one hour before and as late as one hour after the scheduled time of administration. DON stated the nurses should check administration instructions on the pharmacy label and the electronic medication administration record (eMAR) and if they did not match, the order should have been clarified to prevent medication errors. DON stated hydralazine 50 mg for Resident 36 was administered to resident at 10:00 a.m. which was beyond one hour late. DON stated Resident 36 was at increased risk of having a headache, neck pain, high blood pressure, stroke and hospitalization . DON stated Resident 70's aspirin chewable tablet should have been separated from other medications and nurse should have instructed resident to chew the tablet. DON stated the nurse should have clarified physician's which indicated aspirin capsule, but chewable aspirin was administered. DON stated resident on fluticasone-salmeterol was supposed to rinse mouth after use to prevent oral thrush. DON stated the medicine cup used to measure water to dissolve medications measured at five oz if filled up completely to the brim. DON stated pharmacy allowed polyethylene glycol to be dissolved in four oz to eight oz water and physician order indicated to use five oz water to dissolve polyethylene glycol. DON stated it would be better to use graduated water cups to be able to measure volume instead of guessing. DON stated residents were at the risk of adverse effects such as constipation, bloating and even choking if not able to safely swallow the medication. During a review of the facility's P&P titled, Medication Administration - General Guidelines, dated 05/2022, the P&P indicated, Medications are administered within [60 minutes] of scheduled time, except before, with or after meal orders, which are administered [based on mealtimes]. Unless otherwise specified by the prescriber, routine medications are administered according to the established medication administration schedule for the facility. The P&P indicated, Medications are administered as prescribed in accordance with good nursing principles and practices .do so. During a review of the facility's P&P titled, Administering Medications, dated 2001, the P&P indicated, Medications are administered in a safe and timely manner, and as prescribed. Medications are administered in accordance with prescriber orders, including any time frame.

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	01/24/2025

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45891 49130 Based on interview and record review, the facility failed to prevent a significant medication error for 1 out of three sampled residents (Resident 6) who was receiving medication for high blood pressure. This deficient practice had the potential for Resident 6 to experience hypotension (a condition where the blood pressure falls below normal levels and could cause dizziness or fainting) leading to the possibility of falls or accidents. Findings: During a review of Resident 6's Admission Record, the Admission Record indicated Resident 6 was admitted to the facility on [DATE] with diagnoses of hypertension (high blood pressure) and dependence on renal dialysis (a type of treatment that helps your body remove extra fluid and waste products from your blood when the kidneys are not able to). During a review of Resident 6's Order Summary Report, the Order Summary Report indicated an order was placed 1/5/2025 for amlodipine Besylate (medication to treat high blood pressure) oral tablet 10 milligrams (mg, a unit of measurement), give one tablet by mouth one time a day for hypertension hold (do not give) for the following parameters (specific instructions): 1. systolic blood pressure (SBP, the top number of a blood pressure reading) below 110 and/ or heart rate (HR) less than 60. 2. hold blood pressure medications on dialysis days (Monday (M), Wednesday (W), and Friday (F)) to prevent hypotension during dialysis During a review of Resident 6's minimum data set (MDS, a resident assessment tool) dated 1/12/2025, the MDS indicated Resident 6 had moderate cognitive impairment (a condition where a person experiences noticeable declines in cognitive functions, such as memory, attention, and reasoning, but not severe enough to meet the criteria for dementia) and was receiving dialysis. (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 B. Wing	01/24/2025

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and concurrent record review of Resident 6's January 2025 Medication Administration Report (MAR) on 1/24/2025 at 1:37 p.m., the Director of Nursing (DON) stated Resident 6 was taking amlodipine 10 mg once daily for blood pressure management and there were parameters set by the physician stating to hold the amlodipine if the SBP was below 110 or HR was less than 60 BPM and he was not supposed to receive the amlodipine on dialysis days (MWF). The DON stated after reviewing Resident 6's MAR for January 2025, Resident 6 received the amlodipine 10 mg on 1/8/2025 (W), 1/13/2025 (M), and 1/17/2025 (F) which were on his dialysis days. The DON stated Resident 6 also received amlodipine on 1/16/2025 with a BP of 108/64 and HR of 58 and on 1/17/2025 with a BP of 108/72 and HR of 56. The DON stated amlodipine was not given per physician's orders on those dates. The DON stated the importance of following physician's orders for blood pressure medication parameters was to prevent hypotension and there was a potential for harm. The DON stated the potential outcome of becoming hypotensive was dizziness, accidents, and falls. The DON stated parameters were in place so nurses would know when it was okay to give or hold medications and they were to be followed. The DON stated not following physicians orders was a medication error. During a review of the facility's policy and procedure (P/P) titled Medication Administration- General Guidelines) dated 12/2019, the P/P indicated medications were to be administered in accordance with written orders of the prescriber.

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	01/24/2025

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 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. 49130 Based on observation, interview, and record review, the facility failed to: 1. Ensure Resident 81's lorazepam (a controlled substance [a medication with a high potential for abuse] used to treat anxiety [a medical condition described by feeling of fear or uneasiness]) 2 milligrams (mg - a unit of measurement for mass) per milliliters (mL - a unit of measurement for volume) concentrate was labeled with an open date in accordance with manufacturer's requirements in one of two inspected medication rooms (Station 1 Medication Room). 2. Ensure storage and/or labeling of two bottles of latanoprost ophthalmic solution (a medication in form of eye drops used to treat high pressure in the eyes), one Advair Diskus inhalation device ([generic name: fluticasone-salmeterol] a medication delivered in the form of inhalation powder through a device used to treat breathing problems) and one fluticasone-salmeterol inhalation device, per manufacturer requirements, affecting two residents (Residents 84 and 35) in one of two inspected medication carts (Station 1 Medication Cart 1). These deficient practices had the potential to result in Residents 35, 81 and 84 receiving medications that had become expired, ineffective, or toxic due to improper storage and labeling possibly leading to adverse health consequences such as breathing problems, eye irritation and hospitalization . Findings: 1. During a concurrent inspection and interview on 1/22/2025 at 4:19 p.m. with Registered Nurse (RN) 1 of the medication refrigerator in Station 1 Medication Room, the following medication was found stored in a manner contrary to its manufacturer's requirements: One bottle of lorazepam oral concentrate 2 mg/mL for Resident 81 opened bottle without an opened date label on the bottle. According to the manufacturer's product labeling, lorazepam oral concentrate 2 mg/mL should be stored in refrigerator at 2-to 8 degrees Celsius [(C) is a unit of temperature] (36 to 46-degree Fahrenheit [(F) is a unit of temperature] and an opened bottle should be discarded after 90 days. RN 1 stated lorazepam oral concentrate for Resident 81 did not have an open date and it should have had an opened date so that the facility could determine its expiration date and would know when to discard and reorder medication. RN 1 stated lorazepam oral concentrate could potentially harm the Resident 81 if given as an expired medication or would not be effective for resident's anxiety and restlessness. RN 1 stated the resident could stop breathing, potentially causing hospitalization . (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 B. Wing	01/24/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/24/2025 at 11:03 a.m. with the Director of Nursing (DON), DON stated lorazepam oral concentrate did not have a label with the open date which would be necessary to indicate medication was already in use and to determine its expiration date. DON stated if there was no opened date, and if administered to the resident beyond expiration, the medication might not have had the intended effect and would not be safe to administer to resident. 2. During a concurrent inspection and interview on 1/23/2025 at 2:45 p.m. with Licensed Vocational Nurse (LVN) 1 of the Station 1 Medication Cart 1, the following medications were either expired, stored in a manner contrary to their respective manufacturer's requirements, or not labeled with an open date as required by their respective manufacturer's specifications: a. One unopened bottle of latanoprost ophthalmic solution 0.005 percent (%) for Resident 84 with no open date. b. One opened bottle of latanoprost ophthalmic solution 0.005% for Resident 84 with opened date of 12/11/2024. According to manufacturer's requirements, Resident 84's latanoprost 0.005% expired on 1/22/2024. According to the manufacturer's product labeling, unopened bottle(s) should be stored under refrigeration at 2 C to 8 C (36 F to 46 F and open or in-use bottle may be stored at room temperature up to 25 C (77 F) for six weeks. c. One package of fluticasone-salmeterol 250 microgram (mcg - a unit of measurement for mass) - 50 mcg for Resident 84 with no open date. According to the manufacturer's product labeling, fluticasone-salmeterol should be discarded one month after removal from the moisture-protective foil overwrap pouch or after all blisters have been used (when the dose indicator reads 0), whichever comes first. d. One package of brand name Advair Diskus 250-50 mcg inhalation device for Resident 35 with no open date and no facility pharmacy label. (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 B. Wing	01/24/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a subsequent interview with LVN 1, LVN 1 stated the unopened bottle of latanoprost eye solution for Resident 84 should have had an open date because it was removed from the refrigerator and stored in the medication cart. LVN 1 stated for the opened bottle of latanoprost with the open date of 12/11/2024, latanoprost expired on 1/8/2025, 28 days after opened date and/or removal from the refrigerator and should not be in medication cart, per facility policy. LVN 1 stated latanoprost was used to treat Resident 84's glaucoma (a medical condition described as a group of eye diseases that can cause vision loss and blindness by damaging a nerve in the back of your eye called the optic nerve) so if medication was not stored properly it would not be safe or effective to treat glaucoma. LVN 1 stated Resident 84 could experience eye itching, redness and irritation. LVN 1 stated she should have placed an open date on Resident 84's fluticasone-salmeterol inhaler to be able to determine expiration date. LVN 1 stated it would not be safe or effective to administer fluticasone-salmeterol to Resident 84. LVN 1 stated Resident 35's Advair Diskus should not have been accepted or administered to resident. LVN 1 stated this was Resident 35's home medication that resident preferred so it was left in the medication cart. LVN 1 stated she was not aware of the policy for home mediations. LVN 1 stated Advair Diskus should have been discarded when resident brought it because it did not have an open date and would be difficult to ensure appropriate storage conditions before it was brought to the facility LVN 1 stated Resident 35's Advair Diskus might not be safe and effective for resident's breathing difficulty. During an interview on 1/24/2025 at 11:40 a.m. with the DON, DON stated latanoprost eye drops should have been stored in the refrigerator and should have had an open date if removed from the refrigerator. DON stated due to improper storage, latanoprost would lose its therapeutic effect and would pose a risk for resident to experience adverse events such as vision changes, dizziness, headache if medication was systemically absorbed. DON stated the fluticasone-salmeterol inhalation device should have had an open date so that facility staff could figure out when to discard the medication upon expiration. DON stated medications brought by residents from home such as Advair Diskus should have been inspected for opened date, expiration date and instructions before it was administered to the resident. DON stated due to improper storage, medication might not provide the therapeutic benefit and safety. DON stated it would increase the risk of wheezing, breathing difficulties and even hospitalization due to worsening of chronic obstructive pulmonary disease ([COPD] a chronic lung disease causing difficulty in breathing). During a review of the facility's policy and procedure (P&P) titled, Medication Storage in the Facility, dated 05/2022, the P&P indicated, Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The P&P indicated, medications requiring refrigeration are kept in a refrigerator at temperatures between 36 F (2 C) and 46 F (8 C) with a thermometer to allow temperature monitoring . When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated .the nurse shall place a date opened sticker on the medication and enter the date opened and the new date of expiration .the expiration date of the vial or container will be [30] days unless the manufacturer recommends another date or regulations/guidelines require different dating. The nurse will check the expiration date of each medication before administering it. No expired medications will be administered to a resident. All expired medications will be removed . amount remaining.

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	01/24/2025

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 45891 Based on observation, interview, and record review the facility failed to: 1. Ensure strawberries, grapes, limes, and lettuce stored in the refrigerator maintained its quality and freshness 2. Ensure fruits and vegetables were maintained in a manner to conserve flavor, palatability, and appearance This deficient practice had the potential to impact 83 of 88 resident's nutritional status, quality of life and can lead to insufficient food intake. Findings: During an observation on 1/21/2025 at 8:28 a.m., with the Dietary Supervisor (DS), the produce refrigerator in the kitchen contained fruits and vegetables including two cartons of strawberries with a delivery date of 1/16/2025 and appeared mushy and dark in color, one bag of purple grapes with a delivery date of 1/16/2025 and appeared mushy and dark in color, a bag containing five limes dated 12/20/204 that had brown spots on them, and lettuce that was delivered 1/9/2024 that appeared wilted (lost its firmness). The DS stated the facility was to check quality and freshness of the produce by feeling it to see if it felt soft and by looking at the appearance. The DS stated the items in the refrigerator needed to be thrown out. During an interview on 1/22/2025 at 11 a.m., the DS stated the produce (strawberries, limes, lettuce, and grapes) was thrown out due to not meeting the quality and freshness of fresh produce for their residents. During an interview on 1/23/2025 at 11:06 a.m., the Registered Dietician (RD) stated the appearance of fresh produce should be firm and colorful, no bruising (damage to the plant tissue of fruits and vegetables caused by external forces like impact or compression, resulting in a visible discoloration and change in texture, usually appearing as a brown or discolored spot on the surface, without necessarily breaking the skin), discoloration, and should not appear slimy or mushy. The RD stated kitchen staff were to check the produce for their appearance to ensure the fruit and vegetables were not old or spoiling (going bad). The RD stated poor appearance of fruits and vegetables could make the facility residents mad and could decrease their intake if the residents would not eat the produce. The RD Stated if the appearance of the produce was not something you would eat at home, it should not be served to the residents. During a review of the facility's policy and procedure (P/P) titled Food Palatability undated, the P/P indicated all residents were to receive food that was not only nutritious but also palatable to enhance their dining experience and over-all well-being. Food was to be stored in a manner that minimized nutrient loss and maintained food safety. Facility staff was to regularly monitor and rotate food supplies to ensure freshness.

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	01/24/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45891 Based on observation, interview, and record review, the facility failed to store food in a sanitary manner to prevent growth of microorganisms (an organism that can be seen only through a highly magnifying lense) that could cause food borne illness (food poisoning: any illness resulting from the food spoilage of contaminated food, pathogenic bacteria, viruses, or parasites that contaminate food, as well as toxins) for 83 out of 88 total residents in the facility by failing to: 1. Ensure one onion and two bell peppers that were cut in half and placed in the refrigerator were labeled and dated 2. Ensure an unopened box of donuts (unknown count) stored in the refrigerator was labeled and dated 3. Ensure three bean burritos were labeled and dated 4. Ensure bacon stored in the refrigerator was properly sealed and covered These deficient practices had the potential to result in pathogen (germ) exposure and placed residents at risk for developing foodborne illness (food poisoning) with symptoms including upset stomach, stomach cramps, nausea, vomiting and diarrhea. Findings: During an observation and concurrent interview on 1/21/2025 at 8:28 a.m., a tour of the kitchen was done with the dietary supervisor (DS). The facility refrigerator contained three bean burritos, the DS stated there was no date and no label on the bean burritos. The refrigerator contained a box of donuts that were not labeled or dated. The DS stated the donuts were delivered frozen and the donuts should have been dated with the date received, and the date they were thawed. The DS stated the donuts were good for 72 hours from being thawed but there was no date indicating when they were removed from the freezer. The refrigerator contained a package of bacon that was ripped open, not sealed, and open to air in the refrigerator. A second refrigerator containing produce in the kitchen contained one onion and two bell peppers that were cut in half and placed in the refrigerator and were not labeled and dated. The DS stated his cook (CK 1) used the other half of the onion and two bell peppers for an omelette (unknown date) and forgot to label and date the leftovers. The DS stated they serve a vulnerable population. During an interview on 1/23/2025 at 11:06 a.m., the registered dietician (RD) stated all food stored in the kitchen needed to have delivery date, date opened, and/ or a use by date (the last day recommended for consuming a food product while it's still at its best quality) so that spoiled food or food of poor quality was not served to their residents. The RD stated all food items needed to be properly sealed and covered so the food was not open to air because oxidation (a chemical reaction that occurs when food is exposed to oxygen, causing it to break down and lose its nutritional value) occurs and the food spoils faster. The RD stated it was all the kitchen staff's responsibility to ensure food was labeled, dated, and stored properly. (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 B. Wing	01/24/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the facility's policy and procedure (P/P) titled Food Receiving, labeling, and Storage dated 11/2022, the P/P indicated all foods stored in the refrigerator or freezer were to be covered, labeled, and dated (use by 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	01/24/2025

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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. 45891 Based on observation, interview, and record review the facility failed to ensure two out of two facility dumpsters were not overfilled and left with the lid open. This deficient practice had the potential to harbor and feed pest including rodents and flies. Findings: During an observation and concurrent interview on 1/21/2025 at 8:57 a.m., with the Dietary Supervisor (DS) in the facility parking lot, the facility dumpsters were noted with the following: 1. the left dumpster was overfilled, and lid was unable to shut properly 2. the right dumpster lid was left open The DS stated facility staff (unknown) must have forgot to close the lid when they threw the trash, and the dumpster lids need to be closed properly. During an interview on 1/24/2025 at 3:40 p.m., the maintenance supervisor (MS) stated the dumpster lids needed to be completely closed due to the potential for a foul smell and attracting pest such as flies. A review of the facility's policy and procedure (P/P) titled Food-Related Garbage and Rubbish Disposal dated 4/2026 indicated outside dumpsters provided by garbage pick-up services will be kept closed. Garbage and rubbish containing food waste will be stored in a manner that is inaccessible to vermin (rodents).

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	01/24/2025

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 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. 45382 Based on observation, interview, and record review, the facility failed to provide Physical Therapy (PT, profession aimed in the restoration, maintenance, and promotion of optimal physical function) services for one of nine sampled residents (Resident 32) who was identified as having left leg range of motion (ROM, full movement potential of a joint) limitations, was at high risk for contracture (loss of motion of a joint associated with stiffness and joint deformity) development, and repeatedly refused Restorative Nursing Aide (nursing aide program that help residents maintain any progress made after therapy intervention to maintain their function) services for left leg ROM exercises from February 2024 to January 2025. This deficient practice prevented Resident 32 from receiving skilled therapy services (services that require specialized training and experience of a licensed therapist or therapy assistant) to maximize joint ROM, functional abilities, and maintain or achieve the highest practicable level of function. Findings: During a review of Resident 32's Admission Record, the Admission Record indicated the facility initially admitted Resident 32 on 8/4/2019 and readmitted Resident 32 on 1/30/2023 with diagnoses including left hemiplegia (weakness to one side of the body) and traumatic brain injury (damage to the brain from an external force that can cause temporary or permanent changes in brain function). During a review of Resident 32's Order Summary Report, the Order Summary Report indicated a physician's order, dated 8/11/2023, for RNA to assist Resident 32 with left leg passive range of motion (PROM, movement at a given joint with full assistance from another person) exercises to the left hip and left ankle, five times a week. During a review of Resident 32's RNA Documentation Survey Report flowsheet (RNA Flowsheet, daily record of RNA services provided for each month) for February 2024, the RNA Flowsheets indicated for RNA to provide PROM exercises to Resident 32's left hip and left ankle, five times a week. The squares on the RNA flowsheet indicated the letters RR on the following days: 2/1/2024 to 2/3/2024, 2/5/2024 to 2/10/2024, 2/12/2024 to 2/16/2024, 2/19/2024 to 2/23/2024, and 2/25/2024 to 2/29/2024. The key at the bottom of the RNA flowsheet indicated letters RR meant Resident Refused RNA treatment. During a review of Resident 32's RNA Flowsheet for March 2024, the RNA Flowsheets indicated for RNA to provide PROM exercises to Resident 32's left hip and left ankle, five times a week. The squares on the RNA flowsheet indicated the letters RR on the following days: 3/1/2024 to 3/15/2024, 3/18/2024 to 3/23/2024, and 3/25/2024 to 3/29/2024. The key at the bottom of the RNA flowsheet indicated letters RR meant Resident Refused RNA treatment. During a review of Resident 32's RNA Flowsheet for April 2024, the RNA Flowsheets indicated for RNA to provide PROM exercises to Resident 32's left hip and left ankle, five times a week. The squares on the RNA flowsheet indicated the letters RR on the following days: 4/1/024 to 4/5/2024, 4/7/2024 to 4/12/2024, 4/15/2024 to 4/19/2024, 4/22/2024 to 4/26/2024, 4/29/2024, and 4/30/2024. The key at the bottom of the RNA flowsheet indicated letters RR meant Resident Refused RNA treatment. (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 B. Wing	01/24/2025

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 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 32's RNA Flowsheet for May 2024, the RNA Flowsheets indicated for RNA to provide PROM exercises to Resident 32's left hip and left ankle, five times a week. The squares on the RNA flowsheet indicated the letters RR on the following days: 5/1/2024 to 5/3/2024, 5/6/2024 to 5/10/2024, 5/13/2024 to 5/17/2024, 5/21/2024 to 5/24/2024, and 5/27/2024 to 5/30/2024. The key at the bottom of the RNA flowsheet indicated letters RR meant Resident Refused RNA treatment. During a review of Resident 32's RNA Flowsheet for June 2024, the RNA Flowsheets indicated for RNA to provide PROM exercises to Resident 32's left hip and left ankle, five times a week. The squares on the RNA flowsheet indicated the letters RR on the following days: 6/3/2024 to 6/5/2024, 6/10/2024 to 6/14/2024, 6/17/2024 to 6/20/2024, 6/24/2024, and 6/26/2024 to 6/28/2024. The key at the bottom of the RNA flowsheet indicated letters RR meant Resident Refused RNA treatment. During a review of Resident 32's RNA Flowsheet for July 2024, the RNA Flowsheets indicated for RNA to provide PROM exercises to Resident 32's left hip and left ankle, five times a week. The squares on the RNA flowsheet indicated the letters RR on the following days: 7/1/2024 to 7/5/2024, 7/8/2024 to 7/13/2024, 7/15/2024 to 7/19/2024, 7/22/2024 to 7/26/2024, and 7/29/2024. The key at the bottom of the RNA flowsheet indicated letters RR meant Resident Refused RNA treatment. During a review of Resident 32's RNA Flowsheet for August 2024, the RNA flowsheets indicated for RNA to provide PROM exercises to Resident 32's left hip and left ankle, five times a week. The squares on the RNA flowsheet indicated the letters RR on the following days: 8/1/2024, 8/2/2024, 8/5/2024 to 8/9/2024, 8/12/204 to 8/16/2024, 8/19/2024 to 8/23/2024, 8/26/2024 to 8/31/2024. The key at the bottom of the RNA flowsheet indicated letters RR meant Resident Refused RNA treatment. During a review of Resident 32's COC Evaluation, dated 8/1/2024, the COC Evaluation indicated the COC Evaluation was initiated due to Resident 32's multiple refusal of RNA services. The COC indicated Resident 32 was at risk for a mobility decline with recommendations for a Psychiatry consultation. During a review of Resident 32's RNA Flowsheet for September 2024, the RNA Flowsheets indicated for RNA to provide PROM exercises to Resident 32's left hip and left ankle, five times a week. The squares on the RNA flowsheet indicated the letters RR on the following days: 9/1/2024, 9/4/2024 to 9/6/2024, 9/9/2024 to 9/13/2024, 9/16/2024 to 9/20/2024, 9/23/2024 to 9/30/2024. The key at the bottom of the RNA flowsheet indicated letters RR meant Resident Refused RNA treatment. During a review of Resident 32's RNA Flowsheets for October 2024, the RNA flowsheets indicated for RNA to provide PROM exercises to Resident 32's left hip and left ankle, five times a week. The squares on the RNA flowsheet indicated the letters RR on the following days: 10/1/2024 to 10/5/2024, 10/7/2024 to 10/11/2024, 10/14/2024 to 10/19/2024, 10/21/2024 to 10/25/2024, and 10/28/2024 to 10/31/2024. The key at the bottom of the RNA flowsheet indicated letters RR meant Resident Refused RNA treatment. During a review of Resident 32's RNA Flowsheets for November 2024, the RNA flowsheets indicated for RNA to provide PROM exercises to Resident 32's left hip and left ankle, five times a week. The squares on the RNA flowsheet indicated the letters RR on the following days: 11/1/2024 to 11/16/2024, 11/18/2024 to 11/20/2024, and 11/25/2024 to 11/29/2024. key at the bottom of the RNA flowsheet indicated letters RR meant Resident Refused RNA treatment. (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 B. Wing	01/24/2025

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 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 32's Minimum Data Set (MDS, a federally mandated assessment tool), dated 11/5/2024, the MDS indicated Resident 32 had severely impaired cognition (ability to think, understand, learn, and remember) and vision. The MDS indicated Resident 32 required substantial/maximal assistance for eating, hygiene, upper body dressing, and rolling to both sides and was dependent in bathing, lower body dressing, and transfers. The MDS indicated Resident 32 had functional ROM limitations (limited ability to move a joint that interferes with daily functioning, including activities of daily living, or places the resident at risk of injury) in one arm (shoulder, elbow, wrist, hand) and both legs (hips, knees, ankles, and feet). During a review of Resident 32's RNA Flowsheets for December 2024, the RNA flowsheets indicated for RNA to provide PROM exercises to Resident 32's left hip and left ankle, five times a week. The squares on the RNA flowsheet indicated the letters RR on the following days: 12/2/2024, 12/5/2024, 12/9/2024 to 12/13/2024, 12/17/2024 to 12/23/2024, 12/25/2024 to 12/27/2024, and 12/30/224. The key at the bottom of the RNA flowsheet indicated letters RR meant Resident Refused RNA treatment. The squares on the RNA Flowsheet were blank on the following days: 12/3/2024, 12/4/2024, 12/15/2024, 12/16/2024, and 12/24/2024. During a review of Resident 32's RNA Flowsheets for January 2025, the RNA flowsheets indicated for RNA to provide PROM exercises to Resident 32's left hip and left ankle, five times a week. The squares on the RNA flowsheet indicated the letters RR on the following days: 1/1/2025 to 1/3/2025, 1/6/2025, 1/9/2025, 1/10/2025, 1/13/2025 to 1/17/2025, and 1/21/2025. The key at the bottom of the RNA flowsheet indicated letters RR meant Resident Refused RNA treatment. The squares on the RNA Flowsheet were blank on the following days: 1/7/2025 and 1/20/2025. During a review of Resident 32's Joint Mobility Screen (JMS, a brief assessment of a resident's range of motion of both arms and both legs), dated 1/23/2024, the JMS indicated Resident 32 had severe ROM limitations in the left hip and moderate ROM limitations in the left knee and the left ankle. During an observation of Resident 32's RNA session and interview on 1/22/2025 at 10:59 am, Resident 32 was lying in bed with both legs straight with the right leg crossed over the left leg. Restorative Nursing Aide 1 (RNA 1) assisted with left arm ROM exercises. RNA 1 attempted to assist Resident 32 with PROM exercises to the left leg, but Resident 32 refused. RNA 1 stated Resident 32 always refused PROM exercises to the left leg. RNA 1 stated he did not recall the last time Resident 32 participated in left leg PROM exercises. RNA 1 stated the Nursing department and the Rehabilitation department (Rehab) were aware of Resident 32's constant refusals. During a concurrent observation and interview on 1/22/2025 at 9:12 am, Resident 32 was lying in bed with both legs straight, right leg crossed over the left leg. Resident 32 stated staff did not assist with exercises to the left leg. Resident 32 stated his left leg was painful and broken. Resident 32 stated he was unable to move the left leg on his own. During an interview on 1/21/2025 at 2:45 pm, the Director of Rehabilitation (DOR) stated the Rehabilitation Department (Rehab) created and modified the RNA programs based on the resident's needs. The DOR stated RNA meetings with the DOR, nursing administration, and all RNAs were held one to two times a month to discuss any concerns, resident refusals, improvements, and declines. The DOR stated if any concerns, repeated refusals, and declines were discussed in the meetings, a licensed therapist would re-evaluate the resident, put the resident on skilled therapy services if indicated, or modified the RNA program. (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 B. Wing	01/24/2025

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 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/23/2025 at 10:41 am, Restorative Nursing Aide 1 (RNA 1) stated RNA attempted RNA sessions at least three times daily if a resident refused RNA services. RNA 1 stated if a resident continued to refuse RNA, RNA must notify the charge nurse immediately and discuss the resident's multiple refusals in the regular RNA meetings with nursing and Rehab to ensure all departments were aware. RNA 1 stated Rehab typically re-assessed the resident and notified the RNAs of any modifications to the program. During a concurrent interview and record review on 1/23/2025 at 10:47 am, the Director of Staff Development (DSD) stated she supervised the RNAs. The DSD stated all RNA refusals must immediately be reported to the charge nurse and discussed in the regular RNA meetings with nursing and Rehab. The DSD stated if a resident consistently refused RNA, the licensed nurse must initiate a COC, notify the physician, and notify Rehab for re-assessment to evaluate for skilled therapy needs or modify the RNA program. The DSD stated it was important the physician, Rehab, and nursing staff were all notified of consecutive and recurring RNA refusals to ensure all departments were aware of the issue to collaboratively investigate the reason for refusals to ensure the appropriate interventions were implemented. The DSD reviewed Resident 32's RNA Flowsheets from February 2024 to January 2025. The DSD stated RR on the RNA Flowsheets indicated Resident 32 refused RNA services that day. The DSD confirmed Resident 32 refused RNA for left leg ROM exercises almost every day, five times a week, from February 2024 to January 2025. The DSD reviewed Resident 32's clinical record from February 2024 to January 2025 and confirmed one COC regarding Resident 32's multiple RNA refusals was initiated on 8/1/2024 (6 months later). The DSD stated a COC should have been initiated and PT should have been consulted in February 2024 due to Resident 32's multiple, consecutive RNA refusals. The DSD stated the facility should have followed up and initiated an additional COC and consulted PT after 8/1/2024 to ensure the implemented interventions were effective and the physician was notified and aware of Resident 32's continued refusals. The DSD stated RNA informed her and Rehab of Resident 32's continuous and consecutive RNA refusals in the routine RNA meetings but was unsure why Rehab was not reconsulted for re-assessment. The DSD stated Rehab should have been reconsulted to provide skilled therapy services or modify the RNA program to prevent a decline in Resident 32's ROM, ADLs, and mobility since Resident 32 had left leg ROM limitations and was at high risk for contracture development. (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 B. Wing	01/24/2025

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 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 1/23/2024 at 2:52 pm, Physical Therapist 1 (PT 1) stated Rehab created and modified RNA programs for residents in the facility to maintain their level of function and prevent declines. PT 1 confirmed Resident 32 was not seen by PT for years while in the facility and was unable to locate any PT documentation in Resident 32's medical record. PT 1 stated she performed Resident 32's JMA on 1/23/2025 and stated Resident 32 had severe ROM limitations in the left hip and moderate ROM limitations in the left knee and left ankle. PT 1 stated Resident 32 was cooperative with the assessment but required increased time, slow gradual stretching, distraction, and constant re-direction. PT 1 stated Resident 32's entire left leg had hypertonicity (abnormal increase in muscle tone), spasticity (abnormal muscle tightness due to prolonged muscle contraction), and left ankle clonus (abnormal reflex response involving involuntary and rhythmic muscle contractions). PT 1 stated Resident 32 was at high risk for contracture development due to hypertonicity, low levels of activity, and low level of participation in exercises and functional activities. PT 1 stated once a resident was transitioned to the RNA program, Rehab assumed the RNA program was being carried out unless RNA notified the DOR or nursing of any concerns such as multiple refusals. PT 1 stated she was recently notified of Resident 32's multiple, consecutive RNA refusals and was unaware Resident 32 refused RNA services for left leg ROM from February 2024 to January 2025. PT 1 stated Resident 32 should have been re-assessed by PT once the facility was notified of multiple, consecutive RNA refusals to ensure Resident 32 received the appropriate care and services. PT 1 stated Resident 32 could have benefitted from a PT assessment for skilled therapy needs or modification of the RNA program. PT 1 stated Resident 32's left leg should have been properly evaluated and managed by PT as RNA did not have the knowledge base or qualifications to identify and work with residents with hypertonicity, spasticity, and clonus. During an interview and record review on 1/24/2025 at 3:59 pm, the DOR stated he reviewed Resident 32's medical records and was unable to find documented evidence Resident 32 was seen or evaluated by PT while in the facility. The DOR stated he discussed the JMA, dated 1/23/2025, with PT 1 and stated Resident 32 had left leg ROM limitations in the knee, hip, and ankle and hypertonicity throughout the entire left leg. The DOR stated RNAs did not have the knowledge base and skills to work with residents with hypertonicity and required increased training or guidance from a skilled therapist for proper management of Resident 32's left leg during RNA sessions. The DOR stated Rehab was unaware Resident 32 had multiple, consecutive RNA refusals prior to August 2024 since there was only one Change of Condition (COC, major decline or improvement in a resident's status that will not resolve itself without intervention) Evaluation, dated 8/1/2024, regarding Resident 32's RNA refusals. The DOR stated Rehab would not know to intervene unless they were notified by RNA or if a COC was initiated either before 8/1/2024 since the refusals began in February 2024 and after 8/1/2024 since Resident 32 continued to refuse RNA services despite implemented interventions. The DOR stated Rehab was not ordered on 8/1/2024 because psychiatry was ordered as the main intervention. The DOR stated Rehab assumed the intervention was effective and Resident 32 was participating in RNA since another COC was never initiated after 8/1/2024. The DOR stated Resident 32 would have benefited from a PT evaluation if he was informed and aware of Resident 32's continued, consecutive refusals for re-assessment for skilled therapy needs or modification of the RNA program. The DOR stated residents if who required skilled therapy services did not receive it, it could result in a possible functional decline. (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 B. Wing	01/24/2025

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 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 1/24/2025 at 10:43 am, the Assistant Director of Rehabilitation (ADOR) stated she attended the regular RNA meetings along with the DSD and all the RNAs. The ADOR stated Rehab re-assessed residents who refused RNA sessions multiple, consecutive times to evaluate for skilled therapy needs or modification of the RNA program since only Rehab was qualified to make any modifications to the RNA plan of care. The ADOR stated she was unaware of Resident 32's multiple, consecutive RNA refusals from February 2024 to August 2024 until a COC was initiated on 8/1/2024. The ADOR stated the recommendation at the time was to consult Psychiatry as the refusal was thought to be related to medication and behavior. The ADOR stated Rehab never re-assessed Resident 32 after the COC was initiated on 8/1/2024. The ADOR stated Rehab assumed the implemented interventions were effective since another COC was never initiated thereafter. The ADOR stated Resident 32 should have been evaluated by PT as soon as Resident 32 refused RNA consecutively from February 2024 to August 2024 and after August 2024 when Resident 32 continued to refuse RNA services despite implemented interventions. The ADOR stated Resident 32 was at high risk for contracture development because he had left sided hypertonicity, limited mobility, and the diagnoses of traumatic brain injury and hemiplegia. The ADOR stated if a resident who required skilled therapy services did not receive it, it could result in decreased ROM, contracture development, and functional decline. During an interview on 1/24/2025 at 1:49 pm, the Director of Nursing (DON) stated the facility maintained, improved, and prevented declines in a resident's level of function and ROM by skilled therapy services and the RNA program. The DON stated it was important that residents who required skilled therapy services received them to prevent worsening of contractures, ROM, mobility, and overall function. The DON stated all residents who were identified as having ROM limitations and were continuously refusing RNA should be evaluated by Rehab to ensure the proper services and interventions were provided to address the resident's needs and prevent a decline. During a review of the facility's undated Policy and Procedure titled, Skilled Physical Therapy, the P/P indicated PT commonly treatment patients impaired by orthopedic, neurological, musculoskeletal or general medical conditions that affected their functional mobility skills. The P/P indicated those patients with good rehab potential were placed on intensive PT treatment programs which focus on restoring the patients to their prior level of function. The P/P indicated patients with limited rehab potential were seen by PT for evaluation and establishment of a functional maintenance program that can be carried out by non-licensed staff or caregivers. During a review of the facility's undated P/P titled, Philosophy of Patient Care, the P/P indicated the goal of Rehabilitation Services was to provide the highest quality of services to each individual patient who needed assistance in returning to their maximum functional abilities. The P/P indicated the Rehabilitation team was involved with the patients currently receiving therapy, but also provided input for all residents in the facility through staff education and consultation, completion of admission, annual, and referred screens, attendance at key meetings within the facility, routine therapy programs and involvement in RNA programs, fall prevention, and would care when appropriate. The P/P indicated the goal of Rehabilitation Services was to provide proper assessment of needs to functional mobility, pain management, contracture management, promotion of wound healing, activities of daily loving, seating and positioning, swallowing and communication. The P/P indicated a health plan was designed that encouraged maximal functional independence and above all promoted the well-being and quality of life of each patient.

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	01/24/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 45382 Based on observation, interview, and record review, the facility failed to ensure one of nine sampled residents (Resident 28) had complete and accurate physician's orders by failing to ensure Resident 28's splint (rigid material or apparatus used to support and immobilize a broken bone or impaired joint) orders to both knees, the left elbow, and the left hand included the designated staff member to apply the splints and the splint wear time (length of time and frequency a person can tolerate wearing the splint for safety, comfort, and maximal benefits). This failure has the potential to result in an inaccurate depiction of care and services rendered for Resident 28. Findings: During a review of Resident 28's Admission Record, the Admission Record indicated the facility admitted Resident 28 on 8/8/2022 with diagnoses including muscle wasting and atrophy (thinning or loss of muscle tissue) and chronic obstructive pulmonary disease (lung disease that causes obstruction of airflow and can limit normal breathing). During a review of Resident 28's Minimum Data Set (MDS, a federally mandated assessment tool), dated 12/26/2024, the MDS indicated Resident 28 was cognitively (ability to think, understand, learn, and remember) intact. The MDS indicated Resident 28 required supervision/touching assistance for eating, substantial/maximal assistance for hygiene, dressing, rolling to both sides, transfers, and was dependent in toilet hygiene and bathing. The MDS indicated Resident 28 had functional ROM limitations (limited ability to move a joint that interferes with daily functioning, including activities of daily living, or places the resident at risk of injury) in one arm (shoulder, elbow, wrist, hand) and both legs (hip, knee, ankle, foot). During a review of Resident 28's Order Summary Report, the Order Summary Report indicated a physician's order, dated 1/21/2025, for patient may wear bilateral (both) knee extension splints as tolerated for contracture (loss of motion of a joint associated with stiffness and joint deformity) management. During a review of Resident 28's Order Summary Report, the Order Summary Report indicated a physician's order, dated 1/21/2025, for patient may wear a left elbow extension splint as tolerated for contracture management. During a review of Resident 28's Order Summary Report, the Order Summary Report indicated a physician's order, dated 1/21/2025, for patient may wear a left resting hand splint as tolerated for contracture management. (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 B. Wing	01/24/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 1/21/2025 at 10:33 am, in the resident's room, Resident 28 was lying in bed with a pillow on the right side of the body. Resident 28's left elbow and left wrist were bent, and all fingers of the left hand were straight and bent at the knuckle joints. Resident 28 was unable to raise the left arm to shoulder level. Resident 28's both hips and both knees were bent and both ankles moved up and down minimally. Resident 28 stated she was unable to straighten both knees and usually wore splints to both knees and the left arm, but staff had not come by to put them on her yet. During an interview and record review on 1/21/2025 at 2:45 pm, the Director of Rehabilitation (DOR) stated a licensed Physical Therapist (PT, professional aimed in the restoration, maintenance, and promotion of optimal physical function) or Occupational Therapist (OT, professional that provides services to increase and/or maintain a person's capability to participate in everyday life activities) must assess a resident's needs for splints and establish the splint wear schedule before ordering any splints for a resident. The DOR stated the licensed PT or OT assessed for splints, determined the splint wear schedule, and entered the splint order into the electronic charting system. The DOR stated the Rehabilitation Department (Rehab) and RNA (once transitioned to an RNA program) were responsible for applying and removing splints because they were properly trained to do so. The DOR reviewed Resident 28's physician orders for splinting, dated 1/21/2025, and stated the physician orders for splinting were confusing and incomplete because they did not include the designated staff member responsible for applying the splints and did not include a specific splint wear time which indicated how long a resident could safely tolerate the splints. The DOR stated every splint order should include the staff member(s) responsible for applying the splint, the type of splint, and the splint wear time. The DOR stated splint orders must be specific because unclear splint orders could lead to any unqualified staff member applying splints for an unspecified amount of time which could potentially cause harm, skin breakdown, and pain. During an interview on 1/25/2025 at 1:49 pm, the Director of Nursing (DON) stated Rehab was responsible for assessing the types of splints and determining the splint wear time for all residents in the facility. The DON reviewed Resident 28's physician orders for splinting, dated 1/21/2025, and stated the splinting orders were unclear and written incorrectly because they did not include the designated staff member responsible for applying the splints and did not include a specific splint wear time. The DON stated the splinting orders as written were confusing and could potentially lead to any unqualified staff member applying splints to a resident's arms and legs for an unknown amount of time without any monitoring for adverse effects which could lead to skin breakdown, pain, and discomfort. During a review of the facility's Policy and Procedure (P/P) titled Orthotic Application, revised 7/2013, the P/P indicated an orthotic or splint was a device placed on a resident's limb to help improve or correct performance or prevent further deformity. The P/P indicated therapy assessed the resident for the appropriate splint and set up a program for application which would be monitored by the RNAs to ensure correct usage and optimal splint condition. The P/P indicated the documentation guidelines for splints indicated the therapy department should document the wearing tolerance, range of motion improvement, pain, odor, and skin integrity. The P/P indicated staff who were applying and removing the orthotic were responsible for determining if there were any changes in skin integrity from the orthotic. The P/P indicated that once the splint wearing schedule was established by therapy, a clarification of the physician's order was needed to specify the type of splint, where it was applied, and the wearing schedule. (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 B. Wing	01/24/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P/P titled Charting and Documentation, dated 2001, the P/P indicated the medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. The P/P indicated documentation in the medical record would be objective (not opinionated or speculative), complete, and accurate.

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	01/24/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 45382 Based on observation, interview and record review the facility failed to follow appropriate infection control practices for three of three sampled residents by ; 1.Allowing Resident 22's indwelling urinary catheter (Foley-a small, flexible tube that is inserted into the bladder to drain urine when someone can't urinate on their own) drainage bag touched the floor. 2.Not replacing Resident 496's nasal cannula (NC-a small, flexible tube with two prongs that go inside your nostrils, used to deliver extra oxygen to someone who needs it) with new one after fell on the ground. 3.Failing to ensure Certified Nursing Assistant 1 (CNA 1) wore an isolation gown (protective apparel used to protect the wearer from the transfer of microorganisms and body fluids) while repositioning Resident 28 who was on Enhanced Barrier Precautions (EBP, infection control intervention using gown and gloves during high contact resident care activities designed to reduce the transmission of multi-drug-resistant organisms). This failure had the potential to transmit infectious microorganisms and increase the risk of infection among the residents and staff members. Findings: a.During a review of Resident 22's Admission Record, the Admission Record indicated the facility admitted Resident 22 on 12/20/2024 with diagnoses including periprosthetic fracture (a broken bone that happens around or very close to an artificial joint implant) around internal prosthetic (a device that replaces a missing body part or function) left hip joint, multiple fractures of ribs. During a review of Resident 22's History and Physical Examination (H&P), dated 12/31/2024, the H&P indicated that Resident 22 had the capacity to understand and make decisions. During a review of Resident 22's Minimum Data Set (MDS- a resident assessment tool), dated 1/6/2025, the MDS indicated that Resident 22 was cognitively (related to thinking) intact. MDS indicated that Resident 22 needed assistance of two or more helpers to complete activity of toileting hygiene. During a review of Resident 22's Order Summary Report, as of 1/21/2025, the Order Summary Report indicated an order to place a 16 French (a measurement of its diameter) Foley catheter on 12/31/2024 for urinary retention (inability to urinate or empty the bladder). During an observation on 1/21/2025 at 2:51 p.m., in Resident 22's room, Resident 22's urinary catheter drainage bag was hung on left side of the resident's bed touching the floor. (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 B. Wing	01/24/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/22/2025 at 4:14 p.m., with Licensed Vocational Nurse (LVN)1, LVN 1 stated that Resident 22's Foley catheter drainage bag should not touch the floor to prevent the spread of infections. LVN 1 also stated that if the bag touches the floor, infections could travel back to the bladder and kidneys. During an interview on 1/22/2025 at 4:23 p.m., with the Director of Nursing (DON), the DON stated that staff should have kept Resident 22's Foley catheter drainage bag off the floor to prevent infection. The DON stated that Foley catheter's drainage bag contact with the floor increases the risk of infection, especially given Resident 22's age and multiple comorbidities (the presence of two or more diseases or conditions in a person at the same time). During a review of the facility's policy and procedure (P&P) titled, Catheter Care, Urinary dated 2001, the P&P indicated to be sure the Foley tubing and drainage bag are kept off the floor for infection control. b.During a review of Resident 496's Admission Record, the Admission Record indicated the facility admitted Resident 496 on 1/21/2025 with diagnoses including chronic obstructive pulmonary disease (COPD-a lung disease that makes it hard to breath) and shortness of breath. During a review of Resident 496's Nursing- Admission/Readmission Evaluation/Assessment, dated 1/21/2025, the Nursing- Admission/Readmission Evaluation/Assessment indicated Resident 496 was alert. During a review of Resident 496's Order Summary Report, as of 1/21/2025, the Order Summary Report indicated that there was an order to give oxygen level at 2liters(L)/(Per) minutes(min) via NC. During an observation on 1/22/2025 at 10:10 a.m., in Resident 496's room, Resident 496 was sitting in bed without wearing a NC while talking with Certified Nurse Assistant (CNA) 3. CNA 3 was standing on right side of the resident's bed with her left foot stepping on the resident's nasal cannular, which was on the floor. CNA 3 left the room after communicating with the resident. During a concurrent observation and interview on 1/22/2025 at 10:15 a.m. in Resident 496's room, observed CNA 3 returned to the room, picked up the NC from the floor, and placed it on the resident's bed. CNA 3 then went to the restroom, pulled out a paper towel, dispensed hand sanitizer on it, and wiped the NC once. CNA 3 then placed the NC's back on the resident's ears. CNA 3 stated that she could wash the nasal cannular to reuse after falling on the ground or replace with a new one. During an interview on 1/22/2025 at 10:28 a.m., with LVN 2, LVN 2 stated that a NC that falls on the ground must be replaced to prevent the spread of infection. LVN 2 also stated that cleansing a nasal cannula with hand sanitizer after it falls on the ground is not an appropriated method of sanitization. During an interview on 1/22/2025 at 3: 46 p.m. with the DON, the DON stated that a NC after it fell on the ground was potential of contamination and cleaning a NC with hand sanitizer was an inappropriate and that it should be replaced. During a review of the facility's policy and procedure (P&P) titled, Departmental (Respiratory Therapy)-Prevention of Infection not dated, indicated that staff should change the oxygen cannula and tubing every seven days, or as needed for infection control. (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 B. Wing	01/24/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on1/23/2025 at 2:39 p.m. with DON, the facility's P&P titled, Departmental (Respiratory Therapy)-Prevention of Infection not dated was reviewed. The DON stated NC, and tubing should be changed as needed, including when soiled or contaminated. The DON also stated that even if contamination is not visibly apparent, it should be replaced immediately to prevent infection. c. During a review of Resident 28's Admission Record, the Admission Record indicated the facility admitted Resident 28 on 8/8/2022 with diagnoses including muscle wasting and atrophy (thinning or loss of muscle tissue) and chronic obstructive pulmonary disease (lung disease that causes obstruction of airflow and can limit normal breathing). During a review of Resident 28's Order Summary Report, the Order Summary Report indicated a physician's order, dated 4/8/2024, for Resident 28 to be on EBP precautions due to tracheostomy stoma (surgically created opening through the neck into the windpipe) and Candida auris (fungal infection). During an observation on 1/21/2025 at 10:33 a.m. in the resident's room, Resident 28 was lying in bed with a pillow on the right side of the body. Resident 28 had a light pink bandage on the throat and was wearing a nasal cannula (plastic tube to deliver supplemental oxygen). CNA 1 entered Resident 28's room, put on gloves, and did not put on an isolation gown. CNA 1 walked to Resident 28's bed, removed Resident 28's blankets, repositioned Resident 28's pillow on the right side of the body, pulled Resident 28 up in bed, repositioned Resident 28's right leg, and replaced the blankets over Resident 28's body. CNA 1 picked up Resident 28's backpack which was on the ground, put it on Resident 28's bed, removed both gloves, performed hand hygiene, and exited the room. During an interview on 1/21/2025 at 10:41 a.m., CNA 1 stated she did not wear an isolation gown while providing direct care to Resident 28. CNA 1 stated she should have worn an isolation gown while repositioning Resident 28 in bed because she provided direct patient care to Resident 28 who was on EBP precautions. CNA 1 stated it was important to follow infection control protocols to protect the residents, herself, and staff from infection. During an interview on 1/24/2025 at 11:40 a.m., the Infection Preventionist Nurse (IPN) stated the purpose of EBP was to reduce the transmission of Multi-Drug Resistant Organisms (MRDO, bacteria resistant to many antibiotics). The IPN stated all staff providing direct patient care which included repositioning residents on EBP precautions must wear the appropriate personal protective equipment (PPE, equipment worn to minimize exposure to hazards that can cause serious injuries and illnesses) which included an isolation gown and gloves to prevent the spread of infection and reduce the transmission of MRDO. During an interview on 1/24/2025 at 2:06 pm, the Director of Nursing (DON) stated it was important all staff followed the proper infection control protocols to prevent the spread of infection. 50144 50387