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	03/26/2026

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide services to improve or maintain range of motion (ROM, full movement potential of a joint) for one of six sampled residents (Residents 61) with ROM concerns by failing to: 1. Ensure Resident 61's Restorative Nursing Aide (RNA, nursing aide program that help residents maintain any progress made after therapy intervention to maintain their function) program was appropriately modified to maintain and improve Resident 61's right arm ROM. 2. Ensure RNA 1 provided active assistive ROM (AAROM, movement at a given joint with a person's own effort and assistance from an external force or another person) exercises to Resident 61's both legs during an RNA session in accordance with physician's orders. These failures had the potential for Resident 61 to experience a further decline in ROM resulting in contracture (condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) development and have a decline in physical functioning, mobility (ability to move), and activities of daily living (ADL, basic activities such as eating, dressing, toileting). Findings: 1. During a review of Resident 61's admission Record, the admission Record indicated Resident 61 was initially admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses including cerebral infarction (stroke, blockage of the flow of blood brain, causing or resulting in brain tissue death), muscle weakness, and contractures (loss of motion of a joint associated with stiffness and joint deformity) of the right shoulder, both hips, both knees, and both ankles.2. During a review of Resident 61's Minimum Data Set (MDS, a resident assessment tool), dated 1/15/2026, the MDS indicated Resident 61 had severely impaired cognition (mental action or process of acquiring knowledge and understanding). The MDS indicated Resident 61 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying assistance) for eating, substantial/maximal assistance (helper does more than half the effort) for oral hygiene, personal hygiene, upper body dressing, and rolling to both sides, and was dependent (helper does all the effort) in toileting hygiene, bathing, upper body dressing, and transfers. The MDS indicated Resident 61 had functional limitations in range of motion (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 and one leg. During a review of Resident 61's Occupational Therapy (OT, profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities) Evaluation and Plan of Treatment note (OT Eval), dated 2/16/2024, the OT Eval indicated Resident 61 had impaired ROM and 0/5 strength (paralysis or no detectable muscle contraction) in the right arm.During a review of Resident 61's RNA Referral form, dated 2/16/2024, the RNA referral form indicated Physical Therapy (PT, profession aimed in the restoration, maintenance, and promotion of optimal physical function) and OT referred Resident 61 to RNA services for passive range of motion (PROM, movement at a given joint with full assistance from another person) exercises to Resident 61's right arm, five times a week or as tolerated. During a review of Resident 61's RNA Referral form, dated 9/22/2025, the RNA referral form indicated for Resident 61's RNA program to be updated to AROM exercises to Resident 61's right arm, five times a week or as tolerated. During a review of (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 61's Order Summary Report, the Order Summary Report indicated a physician's order, dated 9/22/2025, for RNA to provide active ROM (AROM, performance of ROM of a joint without any assistance or effort of another person) exercises to Resident 61's right arm, five times a week. During an observation on 3/24/2026 at 1:44 p.m. of Resident 61's RNA session, Resident 61 was lying in bed. RNA 1 demonstrated exercises and asked Resident 61 to raise the right arm up and down and out to the side away from the body, 15 times each direction. Resident 61 raised the right arm minimally to less than shoulder height and minimally away from the body and could not move through the full ROM in all directions. RNA did not assist Resident 61 in moving the right shoulder through the full ROM. RNA 1 held and supported Resident 61's upper portion of the right arm and asked Resident 61 to bend and straighten the right elbow. Resident 61 was able to partially bend and straighten the right elbow with a lot of effort, but could not move through the full ROM. RNA 1 did not assist Resident 61 in moving the right elbow through the full ROM. RNA 1 supported Resident 61's right arm by holding the right arm at the forearm and asked Resident 61 to bend the right wrist up and down and open and close the fingers of the hand. Resident 61 partially bent and straightened the right wrist and tried to bend and straighten the fingers of the right hand but could not obtain full ROM. RNA 1 did not assist Resident 61 in moving the right wrist and fingers of the right hand through the full ROM. During an interview on 3/24/2026 at 2:15 p.m. with RNA 1, RNA 1 stated Resident 61's right arm strength had improved significantly since she began working with Resident 61 for RNA about eight months ago. RNA 1 stated Resident 61's right arm was paralyzed and had no active movement. RNA 1 stated Resident 61 was now able to move the right arm minimally on his own but needed assistance moving through the full ROM. RNA 1 stated she did not assist Resident 61 in moving through the full ROM of all the joints of the right arm because the RNA order was changed from PROM exercises to AROM exercises which meant Resident 61 was to move the right arm independently and without physical assistance from RNA. During a concurrent interview and record review on 3/25/2026 at 1:27 p.m. with the Director of Rehabilitation (DOR) and Occupational Therapist 1 (OT 1), the DOR stated Rehab created the RNA programs based on a resident's needs. The DOR stated RNAs were to carry out RNA exercises as ordered. The DOR stated if an RNA program required modification due to a change in a resident's condition, PT and/or OT would re-assess the resident and modify the RNA program based on the resident's needs. The DOR reviewed Resident 61's OT Eval, dated 2/16/2024, and RNA Referral form, dated 2/16/2024, confirmed OT recommended an RNA program for PROM exercises to the right arm due to 0/5 strength in the right arm which meant Resident 61 had no active movement in the arm. The DOR reviewed Resident 61's RNA Referral form, dated 9/22/2025, and confirmed Resident 61's RNA order was modified from PROM to AROM to the right arm but did not know why. OT 1 reviewed Resident 61's Rehab Referral form, dated 9/22/2025, and confirmed OT 1 modified Resident 61's RNA program from PROM exercises to AROM but did not know why. OT 1 stated AROM exercises meant the resident moved the arm or leg through the full available ROM independently and without assistance. OT 1 stated if Resident 61 could not move the right arm fully and independently, AROM exercises as ordered would not be an appropriate modification to the RNA program because Resident 61 would need assistance to move to his end ROM to prevent joint stiffness. During a concurrent observation, interview, and record review on 3/26/2026 at 12:15 p.m. with Occupational Therapist 2 (OT 2), OT 2 reviewed Resident 61's therapy notes and confirmed OT 2 evaluated Resident 61 on 2/16/2024 and recommended RNA for PROM to the right arm because the right arm was paralyzed and had no movement. OT 2 reviewed Resident 61's RNA Referral form, dated 9/22/2025, and confirmed Resident 61's RNA order was changed from PROM exercises to AROM of the right arm but did not know why. OT 2 stated Resident 61's right arm must have improved in strength significantly in order to change Resident 61's RNA program so drastically. OT 2 entered Resident 61's room to assess Resident 61's right arm. Resident 61 wiggled the fingers of the right hand, partially bent and straightened the right elbow, was unable to straighten the right wrist, and minimally lifted the right arm. OT 2 stated Resident 61's right arm strength improved significantly (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	from the last OT evaluation in 2/16/2024 but still had significant weakness on the right arm and could not move through the full ROM on his own. OT 2 reviewed Resident 61's RNA order, dated 9/22/2025, and confirmed Resident 61 had an RNA order for AROM to the right arm. OT 2 stated the RNA program was not modified appropriately and should have been for AAROM, not AROM exercises as Resident 61 needed assistance to move through the full ROM to prevent joint stiffness and maintain and improve right arm ROM. OT 2 stated AROM exercises would not be sufficient to maintain and improve Resident 61's right arm ROM based on his current level of function. OT 2 stated it was important that RNA programs were modified appropriately to ensure the residents received the care and services needed to maintain function and prevent functional decline and contractures. During an interview on 3/26/2026 at 3:23 p.m. with the Director of Nursing (DON), the DON stated Rehab created and modified RNA programs. The DON stated if RNA programs were not created and modified appropriately based on the residents' presentation and current level of function, it could result in ROM and functional decline. 2. During a review of Resident 61's admission Record, the admission Record indicated Resident 61 was initially admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses including cerebral infarction, muscle weakness, and contractures of the right shoulder, both hips, both knees, and both ankles.During a review of Resident 61's MDS, dated [DATE], the MDS indicated Resident 61 had severely impaired cognition. The MDS indicated Resident 61 required supervision or touching assistance for eating, substantial/maximal assistance for oral hygiene, personal hygiene, upper body dressing, and rolling to both sides, and was dependent in toileting hygiene, bathing, upper body dressing, and transfers. The MDS indicated Resident 61 had functional limitations in range of motion in one arm and one leg.During a review of Resident 61's Order Summary Report, the Order Summary Report indicated a physician's order, dated 3/16/2026, for RNA to provide AAROM exercises to Resident 61's both legs, five times a week.During an observation on 3/24/2026 at 1:44 p.m. of Resident 61's RNA session, in Resident 61's room, Resident 61 was lying in bed. After assisting Resident 61 with right arm ROM exercises, RNA 1 demonstrated the exercises and asked Resident 61 to lift the left leg up and down and inwards and outwards away from the body, 15 times each direction. Resident 61 partially moved the left leg up and down and inwards and outwards towards the body but could not move through the full ROM in all directions. RNA did not assist Resident 61 in moving the left hip through the full ROM. RNA 1 held and supported Resident 61's upper portion of the leg and asked Resident 61 to bend and straighten the left knee, 15 times. Resident 61 was able to partially bend the knee downwards and upwards, but could not move through the full ROM. RNA 1 did not assist Resident 61 in moving the left leg through the full ROM. RNA 1 asked Resident 61 to move the left ankle and all toes of the left foot up and down. Resident 61 tried but was unable. RNA 1 did not assist Resident 61 with left ankle and left toe ROM exercises. RNA 1 moved to the right side of the bed and verbally asked Resident 61 to move the right leg up and down and inwards and outwards away from the body, 15 times in each direction. Resident 61 partially moved the left leg up and down and inwards and outwards towards the body, but could not move through the full ROM. RNA 1 did not assist Resident 61 in moving the right leg through the full ROM. RNA 1 held and supported Resident 61's upper portion of the leg and asked Resident 61 to bend and straighten the right knee and all the toes on the right foot, 15 times in each direction. Resident 61 was able to partially bend the knee downwards and upwards, but could not move through the full ROM. RNA 1 did not assist Resident 61 in moving the right knee through the full ROM. During a concurrent interview and record review on 3/24/2026 at 2:15 p.m. with RNA 1, RNA 1 reviewed Resident 61's physician's order, dated 3/16/2026, and confirmed Resident 61 had an RNA order for RNA to provide AAROM exercises to Resident 61's both legs. RNA 1 stated she did not know what AAROM exercises were and thought the order said AROM exercises which meant Resident 61 performed the ROM exercises on his own with only cueing or demonstration of the exercises and without physical assistance from RNA. RNA 1 stated Resident 61 was unable to fully move both legs independently but did not physically assist with ROM because she thought the order was for AROM and did not know what AAROM (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	exercises were. RNA 1 stated if a resident could not move the arm or leg through the full ROM on his or her own and did not have the proper ROM assistance, it could result in joint stiffness. During a concurrent interview and record review on 3/25/2026 at 1:27 p.m. with the DOR, the DOR stated PT and OT created the RNA programs based on a resident's needs. The DOR stated RNAs were to carry out RNA exercises as ordered. The DOR reviewed Resident 61's physician's orders, dated 3/16/2026, and confirmed Resident 61 had an RNA order for AAROM exercises to Resident 61's both legs. The DOR stated AAROM exercises were typically prescribed to residents who were unable to obtain full ROM on their own and needed the physical assistance of RNA or equipment to help move through the rest of the motion. The DOR stated if an RNA order was written for AAROM exercises to both legs, it was expected that RNA would physically assist Resident 61 through his full available ROM in all joints of both legs because Resident 61 did not have the strength or ability to obtain full range independently. The DOR stated if RNA did not provide Resident 61 with AAROM as ordered, it could result in ROM decline and contracture development. During an interview on 3/26/2026 at 3:23 p.m. with the DON, the DON stated RNAs assisted residents in the facility with activities such as ROM exercises to ensure the residents maintained their current level of function and did not experience a functional decline after discharge from skilled therapy services (services that require specialized training and experience of a licensed therapist or therapy assistant). The DON stated it was important for RNA to provide exercises as ordered to prevent potential declines in ROM function, and to avoid delaying a resident's progress towards goals. During a review of the facility's Policy and Procedure (P/P) titled, Specialized Rehabilitative Services, revised 12/2009, the P/P indicated once a resident met his or her care plan goals, a licensed professional can either discontinue treatment or initiate a maintenance program which either Nursing or Restorative Aides would implement to assure that the resident maintains his or her functional and physical status. During a review of the facility's P/P titled, Resident Mobility and Range of Motion, revised 7/2017, the P&P indicated residents would not experience an avoidable reduction in ROM and residents with limited ROM would receive the treatment and services to increase and/or prevent a further decrease in ROM. The P/P indicated the care plan would be developed by the interdisciplinary team based on comprehensive assessment and include specific interventions, exercises, and therapies to maintain, prevent avoidable decline in, and/or improve mobility and ROM. CROSS-REFERENCE TO F726

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide medically related social services (professional interventions provided by social workers to help residents manage the emotional, social, and financial impacts of illness) for two of six sampled residents (Resident 19 and Resident 45) failing to:A. Ensure Resident 19 was seen by podiatrist (a medical specialist focused on diagnosing, treating, and rehabilitating conditions related to the foot, ankle, and lower leg) as requested.B. Ensure Resident 45 was seen by ophthalmologists (a medical specializing in comprehensive eye and vision care, including medical and surgical treatment) in three months as recommended. These failures had the potential to result in delay in the delivery of care and services.Findings:A. During a review of Resident 19's admission record, the admission record indicated Resident 19 was admitted to the facility on [DATE] with diagnoses including cerebral infarction (the blood supply to part of the brain is blocked or reduced), dementia (a progressive state of decline in mental abilities), muscle weakness, and chronic pain syndrome (pain that persists or recurs for longer than 3 months).During a review of Resident 19's History and Physical (H&P), dated 11/11/2025, the H&P indicated, Resident 19 had no capacity (ability) to understand and make decisions.During a review of Resident 19's MDS, dated [DATE], the MDS indicated Resident 19 required maximal assistance (Helper does more than half the effort) from one staff for toileting hygiene, shower, dressing, personal hygiene, transfer, moderate assistance (Helper does less than half the effort) from one staff for bed mobility, and supervision or touching assistance (Helper provide verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) from one staff for oral hygiene and eating.During a review of Resident 19's Order Summary Report (OSR), dated 3/25/2026, the OSR indicated, consult podiatry as needed for mycotic/hypertrophic nails and or keratotic lesions was ordered on 11/10/2025.During a concurrent observation and interview on 3/23/2026, at 10:59 a.m., with Resident 19 in his room, Resident 19's right toenails were observed. Resident 19's right toenails were thick, long, and dark yellow with some parts turned black. Resident 19's toenails were growing in unnatural position toward right side. Resident 19's top of the big toe had callus (an area of thickened and sometimes hardened skin that forms as a response to repeated friction, pressure, or other irritation). Resident 19 stated, right toenails were long and hurt whenever he stood up to transfer from bed to wheelchair or do therapy. Resident 19 stated, it had been long time since he was seen by podiatrist. Resident 19 stated, he and his Responsible Party (RP) asked multiple times to see podiatrist, but no one helped him yet.During a concurrent interview and record review on 3/25/2026, at 1:04 p.m., with the Social Service Director (SSD), Resident 19's Convalescent Podiatry Care Evaluation and Treatment, dated 12/4/2025 was reviewed. The Convalescent Podiatry Care Evaluation and Treatment indicated, Resident 19 had tinea unguium (a common fungal infection of the fingernails or toenails), toe pains on both, corns (a small, localized area of thickened, hardened skin that develops on the feet, typically on the toes, due to chronic friction or pressure) and callosities (thickened, hardened, or elevated patches of skin resulting from chronic friction, pressure, or irritation). The Convalescent Podiatry Care Evaluation and Treatment indicated, debridement (the medical removal of dead, damaged, or infected tissue) and trimming of nails, corns, and callosities were done. The SSD stated, she should have followed up with podiatrist office for Resident 19 to be seen by a podiatrist more often. The SSD stated she was not aware of Resident 19's right toenails being long and painful when he stood up.B. During a review of Resident 45's admission record, the admission record indicated Resident 45 was admitted to the facility on [DATE] with diagnoses including right eye blindness, muscle weakness, and Acute Kidney Injury (AKI-a sudden and often reversible reduction in kidney function).During a review of Resident 45's H&P, dated 6/24/2025, the H&P indicated, Resident 45 had fluctuating capacity (ability) to (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	understand and make decisions.During a review of Resident 45's MDS dated [DATE], the MDS indicated Resident 45 required moderate assistance from one staff for transfer, dressing, and supervision or touching assistance (Helper provide verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) from one staff for oral hygiene, shower, personal hygiene, toilet hygiene, eating.During a review of Resident 45's Care Plan (CP) titled, Resident 45 has impaired visual function related to blindness on right eye, revised 7/14/2025, the CP Goal indicated, Resident 45 will maintain optimal quality of life within limitation imposed by visual function through by 4/23/2026. The CP Interventions indicated arrange consultation with eye care practitioner as required.During a concurrent observation and interview on 3/23/2026, at 10:37 a.m., with Resident 45 in his room, Resident 45's right eye cornea (the transparent, dome-shaped outer layer at the very front of the eye) was cloudy and opaque (unclear). Resident 45 stated he lost vision in his right eye due to possible glaucoma (a group of eye diseases that damage the optic nerve often due to high fluid pressure inside the eye). Resident 45 stated, he became blind because he missed the optimal time to get treatment. Resident 45 stated he was not seen by his ophthalmologist as frequently as he wanted. Resident 45 stated, he was supposed to see ophthalmologist on 1/2026, but he was not seen by ophthalmologist until 2/2026. Resident 45 stated, he was worried about his left eye, and he asked the staff to arrange an appointment with ophthalmologist multiple times.During a concurrent interview and record review on 3/25/2026, at 1:37 p.m., with the SSD, Resident 45's Ophthalmology Exam/Consult and Report, dated 10/14/2025 was reviewed. The Ophthalmology Exam/Consult and Report indicated, the ophthalmologist recommended follow up in three months. The SSD stated that the follow up visit did not occur in three months and last visit was on 2/12/2026 that was over three months. The SSD stated the staff should have followed through with the follow-up appointment in three months to ensure Resident 45 received the care and treatment as ophthalmologist recommended.During an interview on 3/26/2026, at 2:53 p.m., with the Director of Nursing (DON), the DON stated, the SSD should be proactive with assisting the residents. The DON stated it was SSD's responsibility to assist the residents with all aspects of their lives. The DON stated that it was important to ensure specialty consultancy appointments were made in timely manner and follow through. The DON stated the staff should have identified the residents' needs and arranged necessary services.During a review of the facility's Policy and Procedure (P&P) titled, Job Description: Social Service Director, revised 12/2025, the P&P indicated, The Social Services Director leads and oversees the delivery of social services to residents and their families, ensuring that each individual achieves the highest practicable level of physical, emotional, and psychosocial well-being .Essential Duties: Provide medically related social services so that the highest practicable physical, mental and psychosocial wellbeing of each resident is attained or maintained. Assist in making outpatient appointments as ordered and schedule on-site ancillary patient services to include optometry, podiatry, dentistry and psychiatric services.During a review of the facility's Policy and Procedure (P&P) titled, Social Service, revised 1/2026, the P&P indicated, Policy Interpretation and Implementation: e. Compiling and maintaining up-to-date information about community health and service agencies avail?able for resident referrals; f. Making referrals to social service agencies as necessary or appropriate; g. Maintaining appropriate documentation of referrals and providing social service data summaries to such agencies.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to:Ensure clean linen carts were accessed only by facility staff.Implement the facility's Policy and Procedure (P&P) titled Departmental (Environmental Services) - Laundry and Linen, which indicated all soiled linens and medical devices must be placed in the laundry area, in a covered laundry hamper which can contain the moisture.These failure had the potential to increase the risk of infection and cross-contamination (the transfer of bacteria, viruses, microorganisms, or other harmful substances from one surface to another through improper or unsanitary equipment, procedures, or products) among facility staff and residents. Findings: A. During an observation on 3/23/2026 at 10:09 a.m., a resident was observed accessing the clean linen cart located in front of room [ROOM NUMBER] without staff assistance. During an interview on 3/24/2026 at 1:13 p.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated clean linen carts should only be accessed by facility staff to prevent the spread of bacteria. LVN 1 stated if clean linen carts were accessed by residents without assistance from the facility staff, there would be an increased risk for the spread of infection to other residents. During an interview on 3/25/2026 at 2:14 p.m. with the Director of Nursing (DON), the DON stated the importance of making sure clean linen carts were only accessed by facility staff was to ensure the linens were not contaminated. The DON stated if clean linen carts were accessed by residents without assistance from facility staff, there would be potential for an increased risk for cross contamination. During a review of the facility's P&P titled Laundry and Bedding, Soiled dated 2001, the P&P did not indicate procedures for individuals who were designated to access clean linen carts. b. During a concurrent observation and interview on 3/26/2026 at 3:07 p.m., with Laundry Aid (LA) 1, in the laundry area, multiple items were observed leaning against a wall above the hamper next to the washing machine, rather than being placed in a designated hamper or laundry chute. LA 1 stated the items included a resident's hat, soiled clothing, a shower blanket, medical devices; a wedge (essential positioning aids used to prevent pressure ulcers, facilitate turning, and improving comfort for immobile residents), a heel protector (a proactive medical devices designed to prevent pressure injuries in non-ambulatory residents by elevating the heel off the mattress), Intermittent pneumatic compression devices (leg squeezers-inflatable sleeves used in nursing homes to prevent blood blots and improve circulation in immobile residents), and used linens. LA 1 stated the observed items were used (soiled) it is not acceptable to store medical devices in the laundry area or to leave soiled linens outside a designated covered container. During an interview on 03/26/2026 at 4:06 p.m. with the Director of Nursing (DON), the DON stated soiled linens and soiled medical devices must be kept in a designated container. The DON stated these practices are necessary to prevent contamination and infection. During a review of the facility's P&P titled Departmental (Environmental Services) – Laundry and Linen, dated January 2026, the P&P indicated to consider all soiled linen to be potentially infectious, all soiled linen must be placed directly into a covered laundry hamper which can contain the moisture. If laundry chutes are used, only closed and leak-resistant bags will be put into the chute. Loose items will not be placed in the laundry chute.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interview and record review, the facility failed to maintain staff documentation of screening, education, offering, and current Coronavirus Disease 2019 ([COVID-19] a new infectious viral disease that could cause respiratory illness) vaccination status for all licensed practitioners.These failures had the potential to increase the risk of transmission of COVID-19 and other respiratory infections to all residents.Findings:During a concurrent interview and record review on 3/26/2026 at 9:59 a.m. with the Infection Preventionist (IP), the facility updated 2025-2026 COVID-19 vaccine acceptance/declination forms, undated, were reviewed. The IP stated all individuals who provide care or have contact with residents, including the licensed practitioners, are considered staff, and the facility should encourage staff to receive COVID-19 immunization, including providing screening, education, offering vaccination, and maintaining documentation of vaccination status. The IPN stated she did not document or maintain COVID-19 vaccination status for licensed practitioners including screening, education, offering. The IP stated this is essential to prevent the spread of COVID-19 and other respiratory infections, and without tracking vaccination status, resident may be at risk of illness. During an interview on 3/26/2026 at 4:06 p.m. with the Director of Nursing (DON), the DON stated the facility should maintain COVID-19 vaccination records for all staff, including licensed practitioners, to monitor vaccination status and reduce the risk of illness for residents.During a review of the facility's Procedure and Policy (PP) titled Coronavirus Disease (COVID-19)-Vaccination of Staff, dated January 2026, the P&P indicated staff are educated about benefits, risks, and potential side effects of the COVID-19 vaccine. The P&P indicated Staff' means individuals who provide any care, treatment, or other services for the facility and/or its residents, regardless of clinical responsibility or resident contact, including employees, licensed practitioners, students, trainees, and volunteers.

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Ocean Ridge Post Acute	3850 E. Esther St. Long Beach, CA 90804

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to formulate Advance Directives ([AD]-written statement of a person's wishes regarding medical treatment made to ensure those wishes are carried out should the person be unable to communicate them to a doctor) and Physician Orders for Life-Sustaining Treatment ([POLST]- a medical order that helps give people with serious illness more control over their care during a medical emergency) correctly in the medical records of two of 14 sampled residents (Resident 1 and Resident 13) by not:A. Ensuring the AD and the POLST were signed by a designated Responsible Party (RP) for Resident 1.B. Identifying a designated Resident Representative for Resident 13. These failures had the potential to result in delays of care and treatment and/ or inadvertently missed health care wishes/ decisions of the residents during emergencies, end of life, and changes in condition. Findings: A. During a review of Resident 1's admission Record, the admission Record indicated, Resident 1 was initially admitted to the facility on [DATE] and last re-admission was on [DATE] with diagnoses including dysarthria (the muscles used for speech are weak or are hard to control), alcoholic cirrhosis of liver (the final, often irreversible stage of alcohol-related liver disease, characterized by severe scarring and chronic inflammation from long-term, heavy alcohol use) with ascites (a buildup of fluid in your abdomen causing a swollen belly), and generalized anxiety disorder (a group of mental health conditions that cause fear, dread and other symptoms that are out of proportion to the situation). During a review of Resident 1's Advance Healthcare Directive Acknowledgement Form, dated [DATE], the Advance Healthcare Directive Acknowledgement Form indicated, it was signed by Resident 1. During a review of Resident 1's History and Physical (H&P), dated [DATE], the H&P indicated, Resident 1 was capable of making medical decisions. During a review of Resident 1's H&P, dated [DATE], the H&P indicated, Resident was capable of making medical decisions. During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool), dated [DATE], the MDS indicated Resident 1 required dependent assistance (Helper does all of the effort) from two or more staff for hygiene, shower/bath, dressing, bed mobility, transfer, and supervision or touching assistance (Helper provides verbal cues and /or touching/steadying and contact guard assistance as resident competes activity) from one staff for eating. During a concurrent interview and record review on [DATE], at 10:07 a.m., with Registered Nurse Supervisor (RNS) 1, Resident 1's Physician Orders for Life-Sustaining Treatment (POLST), dated [DATE] was reviewed. The POLST indicated, Resident 1 had an order for Do Not Attempt Resuscitation (DNR- a medical order written by a doctor to instruct health care providers NOT to do cardiopulmonary resuscitation [CPR] if breathing stops or the heart stops beating). The POLST indicated, the AD was discussed with a legally recognized Decisionmaker for Resident 1 and the POLST was signed by Resident 1's Family Member (FM) 2 as a legally recognized decisionmaker. RNS 1 stated, she could not provide any documentation to prove FM 2 was the legally recognized (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	decisionmaker or Responsible Party (RP) in Resident 1's chart. RNS 1 stated, the POLST was not completed because it was signed by an unauthorized person (FM 2). RNS 1 stated, if the POLST was not complete and accurate, the resident would be treated as a full code and all life sustaining measures would be done during the emergency per policy. RNS 1 stated, the resident would be treated against his/her wish. During a concurrent interview and record review on [DATE], at 10:54 a.m., with the Social Service Director (SSD), Resident1's admission Record, dated [DATE] was reviewed. The admission Record indicated, Resident 1 and FM 1 were documented as Resident 1's RPs. The admission Record indicated, FM 2 was an Emergency Contact, but not the RP. The SSD stated, the RP and legally recognized decisionmaker were different because the legally recognized decision maker should provide documents such as Power of Attorney (POA-a legal document that identifies and empowers a person to speak for someone who wants assistance with financial or healthcare matters) or court appointed Conservatorship (when a judge appoints another person to act or make decisions for the person who needs help). The SSD stated, Both FM 1 and FM 2 did not have any legal documents to prove that they were Resident 1's RP or decisionmaker. The SSD stated, the staff including herself should have ensured and clarified the RP or legal decisionmaker for Resident 1 to honor the resident's wishes regarding care and treatment. During a concurrent interview and record review on [DATE], at 2:36 p.m., with the Director of Nursing (DON), Resident 1's The Subjective, Objective, Assessment and Plan (SOAP-a standardized method for documenting patient encounters by healthcare providers) Note, dated [DATE] was reviewed. The SOAP Note indicated, Resident was capable of making medical decisions. The DON stated, the staff should have reviewed and clarified all clinical and legal documents to decide who would be RP or legal decisionmaker. The DON stated, all recent H&P and SOAP notes indicated, Resident 1 had the capacity (ability) to make his own medical decisions and did not require an RP or a legal decision maker. The DON stated, if the resident had the capacity to make decisions, there was no need for an RP to make the decisions for Resident 1. The DON stated, important medical decisions such as AD and POLST should be discussed and signed by an RP or legal decisionmaker to honor residents' wishes. The DON stated, identifying an RP and legal decisionmaker was important to ensure right person to make right decision for the residents, especially during the emergency. During a review of the facility's Policy and Procedure (P&P) titled, Advance Directives, revised 1/2026, the P&P indicated, Decision-Making Capacity:1. Upon admission the interdisciplinary team assesses the resident's decision-making capacity and identifies the primary decision-maker if the resident is determined not to have decision-making capacity. 2. The interdisciplinary team conducts ongoing review of the resident's decision-making capacity and invokes the resident representative or health care agent if the resident is determined not to have decision-making capacity. Changes are documented in the care plan and medical record. During a review of the facility's Policy and Procedure (P&P) titled, Physician Orders for Life-Sustaining Treatment (POLST) Policy, revised 1/2026, the P&P indicated, Guidelines for completing POLST: 5. A legally recognized decisionmaker may execute the POLST form only if the patient lacks capacity or has designated that the decisionmaker's authority is effective immediately. 6. To be valid a POLST form must be signed by (1) a physician, or by a nurse practitioner or a physician assistant acting under the supervision of a physician and within the scope of practice authorized by law and (2) the patient or decisionmaker. During a review of the facility's Policy and Procedure (P&P) titled, Responsible Party, undated, the (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	P&P indicated, Definition: Responsible Party (RP): An individual identified by the resident (or legal representative) to assist with care coordination, communication, and administrative matters. Legal Representative: A court-appointed or legally authorized decision-maker (e.g., conservator, power of attorney for healthcare) . Procedure: 2. Documentation must include name and contact information, relationship with resident, and scope of involvement . 5. Responsible party shall not: Make medical decisions unless legally authorized. Override resident decisions (if resident has capacity). During a review of the facility's Policy and Procedure (P&P) titled, Capacity to Make Decisions, undated, the P&P indicated, Procedure: 5. If a resident has a capacity, resident makes decisions independently and staff must respect refusal of care, provide education on risks/benefits, and document informed refusal. 6. Family input does not override resident decisions. B. During a review of Resident 13's admission Record, the admission Record indicated Resident 3 was admitted to the facility on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities), metabolic encephalopathy, and palliative care. The admission Record indicated Resident 13 was self responsible. During a review of Resident 13's H&P regarding a hospice hospice [end of life care focused on comfort and pain control] physician face to face encounter dated [DATE], the H&P indicated Resident 13 did not have full medical capacity to make decisions. The H&P indicated the next of kin information was not specifically identified during this visit, though the hospice care decisions suggest appropriate surrogate decision-maker involvement. During a review of Resident 13's MDS, dated [DATE], the MDS indicated Resident 13 had moderate cognitive impairment. The MDS indicated Resident 13 was dependent on bathing, lower body (waist below) dressing, rolling left to right, sit to lying, lying to sitting on side of bed, chair/bed-to-chair transfer, required substantial assistance (helper does more than half the effort) for upper body (waist above), toileting hygiene, personal hygiene, required partial assistance (helper does less than half the effort) for oral hygiene, and required supervision for eating. The MDS indicated Resident 13 had impairments on both sides of the upper (arms/shoulder) and lower (hips/legs) extremities. During a concurrent interview and record review on [DATE] at 3:18 p.m., with the Social Service Director (SSD), the SSD indicated she did the initial visits, checks the residents Brief Interview for Mental Status (BIMS, tool that help facilities monitor cognitive function), checks the H&P, and would ask the resident if they would like to add a family as a responsible party. The SSD stated if the resident did not have the capacity to designate a responsible party, they would ask the son/daughter. If there is a power of attorney (POA, legal document that allows someone to manage financial and legal affairs when you become incapacitated) the SSD stated requested documents to determine the responsible party and next of kin. The SSD stated Family Member 13 (FM 13) was involved in Resident 13's care as Resident 13 had periods of confusion. The SSD stated Resident 13 did not have the capacity to be self-responsible and there were no notes specifying who Resident 13's decision maker was. The SSD stated the Interdisciplinary Team (IDT health care professionals who work together with the resident to plan the residents plan of care) put the resident as self-responsible. The SSD stated they would want to know who the decision maker was for Resident 12. The SSD stated responsible parties are also designated in emergencies to make medical decisions and indicated she would refer the resident to a conservator but did not since Resident 13 had FM 13. The SSD stated on Resident 13's admission Record, Resident 13 was designated as self and FM 13 was not specified. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 2:49 p.m., with the DON, the DON stated it was important to have a representative for Resident 13 who does not have the capacity to make decisions, as it was legally binding and necessary in emergency situations to implement the residents wishes. During a review of the facility's P&P titled, Capacity To Make Decisions, undated, the P&P indicated the facility shall assess, respect, and support each resident's decision-making capacity and right to make informed choices regarding care, treatment, and services in accordance with state and federal regulations. When a resident lacks capacity, decisions shall be made by a legally authorized representative in accordance with applicable laws. Informed Consent—a process in which a resident or a legally authorized representative voluntarily agrees to care after being informed of diagnosis, proposed treatment, risks/benefits, and alternatives (including no treatment). Legally authorized representative – includes a Health Care Agent (via Advance Directive/Durable Power of Attorney (DPOA), Court-appointed Conservator or a Surrogate decision-maker per California law. If a resident lacks capacity, facility may identify appropriate legally authorized representative, verify legal authority (e.g., DPOA, conservatorship documents), obtain informed consent, and continue to involve resident to the maximum extent possible. During a review of the facility's P&P titled, Responsible Party, undated, the P&P indicated the facility recognizes the role of a Responsible Party (RP) as an individual designated by the resident to assist with communication, care coordination, and administrative matters. The Responsible Party does not assume financial liability unless they have independently agreed to such responsibility. The facility shall ensure that the Responsible Party's role is clearly defined, compliant with federal and California regulations, and does not infringe upon the residents' rights. Responsible Party (RP): An individual identified by the resident (or legal representative) to assist with care coordination, communication, and administrative matters. Legal Representative: A court-appointed or legally authorized decision-maker (e.g., conservator, power of attorney for healthcare). The resident may voluntarily designate a Responsible Party upon admission or at any time. Documentation must include name and contact information, relationship with resident, and scope of involvement. The designation must be signed by the resident or legal representative included in the medical record and admission agreement.

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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** Based on observation, interview, and record review, the facility failed to ensure the Case Manager (CM) reported one of six sampled resident's (Resident 51) multiple refusals for Orthopedic (specialty area in medicine referring to the management of the muscles, bones, and their connective structures) follow up appointments to the physician. This deficient practice resulted in a delay of Resident 51's care and had the potential for worsening of Resident 51's left shoulder and left ankle fractures, delayed healing, and a decline in mobility (ability to motion, range of motion (ROM, full movement potential of a joint), activities of daily living (ADL, basic activities such as eating, dressing, toileting), physical comfort and psychosocial well-being. Findings:During a review of Resident 51's admission Record, the admission Record indicated Resident 51 was admitted to the facility on [DATE] with diagnoses including systemic involvement of connective tissue (group of disorders where the immune system attacks its own healthy tissues causing widespread inflammation and damage to skin, blood vessels, joints [where two bones meet], and organs), muscle weakness, and polyneuropathy (damage of the nerves that can cause weakness, numbness, and burning pain).During a review of Resident 51's History and Physical (H&P), dated 11/11/2025, the H&P indicated Resident 51 was transferred to the facility from a hospital on [DATE] for rehabilitation after being hit on the left side of the body while crossing the street on 11/3/2025. The H&P indicated Resident 51 sustained multiple fractures, which included a left humerus fracture, a left distal fibula fracture (break in the smaller of the two lower leg bones between the knee and the ankle), a left tibia dislocation (knee injury where the shin bone loses contact with the lower part of the thigh bone), and a left medial malleolus fracture (break in the bony bump on the inner side of the ankle). The H&P indicated Resident 51 had surgery to re-align Resident 51's left ankle dislocation on 11/3/2025 and had additional surgeries to repair the bone fractures of the left ankle and left humerus on 11/5/2025.During a review of Resident 51's Minimum Data Set (MDS, a resident assessment tool), dated 2/16/2026, the MDS indicated Resident 51 had severe cognitive (mental action or process of acquiring knowledge and understanding) impairment. The MDS indicated Resident 51 required set up/clean up assistance (helper sets up or cleans up) for eating, oral hygiene, and rolling to both sides, supervision or touching assistance (helper provides verbal cues and/or touching and/or contact guard assistance as resident completes the activity) for toileting hygiene, bathing, dressing, and personal hygiene and partial/moderate assistance (helper does less than half the effort) for putting on and taking off footwear. The MDS indicated Resident 51 had functional limitations in range of motion (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 and one leg.During a review of Resident 51's Orthopedic Consultation note (Ortho Note), dated 12/17/2025, the Ortho Note indicated Resident 51's left arm was to be non-weightbearing (NWB, restriction in which a person is not allowed to put any weight through the operated body part) and Resident 51's left leg was weightbearing as tolerated (WBAT, a person is medically cleared to place as much weight through the affected arm or leg to the point of comfort or tolerance) while wearing a Controlled Ankle Motion boot (CAM boot, orthopedic device used to immobilize the foot, ankle, or lower leg in a fixed position and removing some of the weight off the foot and ankle while walking) boot. The Ortho Note indicated Resident 51 to follow up with orthopedics on 1/28/2026 at 11 a.m.During a review of Resident 51's Order Summary Report, the Order Summary Report indicated a physician's order, dated 12/17/2025, to follow up with orthopedics on 1/28/2026 at 11 a.m.During a review of Resident 51's Order Summary Report, the Order Summary Report indicated a physician's order, dated 12/23/2025, for Resident 15 to continue with NWB precautions to the left arm.During a review of Resident 51's Order Summary Report, the Order Summary Report indicated a physician's order, dated 12/23/2025, for Resident 51's left leg to be WBAT while wearing a CAM boot.During a (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	review of Resident 51's Interdisciplinary Team (IDT, team of health care professionals that work together with the resident and/or resident's representative to prioritize the resident 's needs and goals) Progress Note, dated 1/22/2026, the IDT Progress Note indicated an IDT meeting was held at Resident 51's bedside due to Resident 51's refusal to wear the left leg CAM boot when walking. The IDT Progress Note indicated Occupational Therapist 1 (OT 1) educated Resident 51 that a front wheeled walker (FWW, mobility device with two wheels in the front used for support when standing or walking) would not be provided if Resident 51 did not wear the left leg CAM boot due to increased risk of re-injury to the left leg. The IDT Progress Note indicated an orthopedic follow up appointment was scheduled for 1/28/2026 at which time Resident 51 would discuss possibly discontinuing the left leg CAM boot with the physician. The IDT Progress Note indicated therapy services would work on transfers only, not walking, until further clarification from the orthopedics physician. During a concurrent observation and interview on 3/23/2026 at 1:26 p.m. with Resident 51 in Resident 51's room, Resident 51 was sitting at the edge of the bed wearing slippers on both feet. Resident 51 stated she broke her left shoulder and left ankle in November 2025 when she was hit by a car while crossing the street. Resident 51 minimally raised the left arm and stated she was unable to move the left arm well because it felt very heavy and her left hand felt numb. Resident 51 removed both slippers, moved both ankles up and down, and stated she needed a massage to the left leg because she had cramps (sudden, involuntary tightening of the muscle) and tightness in the calf muscle (lower part of the leg). Resident 51 stated she walked with a FWW in the room without the CAM boot and puts weight through her left arm. Resident 51 stated she refused the scheduled orthopedics appointment in January 2026 because she did not want to leave her husband (who was also a resident at the facility) unattended. Resident 51 stated was unsure what happened because staff never followed up with scheduling another orthopedics appointment and she had not heard anything regarding the status of her left arm and ankle for over two months. During a concurrent interview and record review on 3/25/2026 at 9:49 a.m. with the Case Manager (CM), the CM stated she was responsible for scheduling follow up consultation appointments for the residents in the facility. The CM stated if a resident missed or refused a follow up consultation appointment, the CM must attempt to re-schedule the appointment, document the reason for missed appointments or refusals in the clinical record, notify the physician, create a care plan, conduct an IDT meeting, and continue to follow up with the resident to investigate the reason for refusal, offer accommodations, and re-schedule the appointment. The CM reviewed Resident 51's clinical record and confirmed Resident 51 was supposed to follow up with orthopedics on 1/28/2026 but did not. The CM stated she scheduled a follow up orthopedic appointment for Resident 51 on 1/28/2026 but Resident 51 refused to attend and the CM did not document the refusal in the clinical record. The CM stated she tried to schedule additional follow up orthopedic appointment's multiple times with Resident 51, but Resident 51 refused each time and the CM did not document the re-scheduling attempts and did not notify nursing or the physician of Resident 15's repeated refusals. The CM stated she should have followed up and rescheduled Resident 51's orthopedic appointment, investigated the reasons for Resident 51's refusals and offered possible accommodation, notified the physician, developed a care plan, and held an interdisciplinary team meeting, but did not. The CM stated it was important for staff to notify the physician of Resident 51's refusals to follow up with orthopedics because the physician could have reassessed the situation and directed the team in the proper management of Resident 51's care. During a concurrent interview and record review on 3/25/2026 at 2:59 p.m. with the Director of Rehabilitation (DOR), the DOR reviewed Resident 51's IDT Progress Note, dated 1/22/2026, and confirmed PT and OT could not issue Resident 51 a FWW and safely work on walking exercises with Resident 51 until Resident 51 followed up with orthopedics on 1/28/2026. The DOR stated Resident 51 reached her highest practical level in therapy, mobility, and ADLs with the NWB restrictions to the left arm and Resident 51's refusal to wear a CAM boot when walking per physician's orders and needed guidance from the orthopedic physician to safely progress Resident 51 in therapy. The DOR reviewed Resident 51's clinical record (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure two of five sampled residents (Resident 10 and Resident 12) were free from unnecessary psychotropic (any drug that affects brain activity related to mental processes and behavior) medications by failing to:1.Ensure Resident 10 had an appropriate diagnosis before starting treatment with Xanax [(generic name - alprazolam) a prescription medication that slows down brain activity which helps reduce anxiety (constantly feeling worried and nervous)]. 2.Ensure Resident 12 had an appropriate diagnosis before starting treatment with Depakote [(generic name - valproic acid or divalproex sodium) a prescription medication that helps calm overactive brain activity which helps control seizures (sudden bursts of abnormal electrical activity in the brain), stabilizes mood, and sometimes prevents migraines (a severe, strong, and throbbing headache that affects an individual's ability to function)].These failures had the potential to place Resident 10 and Resident 12 at risk for unnecessary exposure to psychotropic medications and adverse drug reactions (a harmful or unwanted effect caused by a medication when taken normally and correctly), which could result in impairment or decline in the residents' physical and functional condition, and mental and psychosocial status.Findings:A. During a review of Resident 10's admission Record, the admission Record indicated the facility admitted Resident 10 on 9/4/2024 and was readmitted 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), schizophrenia (a mental illness that is characterized by disturbances in thought) and depression (a mental health condition where someone feels very sad, empty, or loses interest in things for a long time).During a review of Resident 10's History and Physical (H&P) dated 2/26/2025, the H&P indicated Resident 10 had the capacity for making decisions.During a review of Resident 10's Minimum Data Set (MDS - a resident assessment tool) dated 3/4/2026, the MDS indicated Resident 10 had moderate cognitive (ability to think or make decisions) impairment. The MDS indicated Resident 10 needed setup or clean-up assistance (helper assists only prior to or following the activity) with eating, supervision with oral hygiene, maximum assistance (helper does more than half the effort to complete the activity) with showering, and moderate assistance (helper does less than half the effort to complete the activity) with upper body and lower body dressing, putting on and taking off footwear, and toileting and personal hygiene. The MDS indicated Resident 10 had active diagnoses of depression, bipolar disorder, and schizophrenia. The MDS did not indicate Resident 10 had an active diagnosis of anxiety. The MDS indicated Resident 10 was taking antipsychotic [a drug that helps reduce symptoms of hallucinations (seeing, hearing, or feeling something that is not actually there), delusions (strong beliefs that are not true) or severe confusion], antianxiety (a drug that help with feeling calmer and less worried), and antidepressant (a drug that helps with the feeling of sadness and improves an individual's mood) medications.During a review of Resident 10's Order Summary Report (a document containing a summary of all active physician orders) dated 3/25/2026, the order summary report included the following physician orders:-Monitor side effects (S/E) Anti-Anxiety Drug: Xanax - Sedation, Drowsiness, Lethargy (feeling abnormally sleepy, sluggish, or unresponsive, beyond ordinary tiredness), Confusion, Memory, Impairment, Fatigue, Dizziness, Depression, Nausea and/or Vomiting, Change in Appetite, Headaches, Blurred Vision, Impaired Coordination, Possible Falls, Subdued Behavior, Withdrawal Compared to Baseline, or a Limitation in Functional Capacity. every shift Side effects observed. + yes, - no, order date 11/4/2025, start date 11/4/2025.-Xanax Oral Tablet 0.25 MG [milligrams - metric unit of measurement, used for medication dosage and/or amount] Give 1 tablet by mouth two times a day for Anxiety manifested by (M/B) inability to relax, order date 11/6/2025, start date 11/6/2025.During a concurrent interview and record review on 3/25/2026 at 8:58 a.m. with Registered Nurse Supervisor (RNS) 1, Resident 10's (continued on next page)

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Ocean Ridge Post Acute	3850 E. Esther St. Long Beach, CA 90804

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	diagnosis information in the admission record, order summary report, history and physical dated 2/26/2026, and psychiatrist note dated 3/4/2026 were reviewed. RNS 1 stated the diagnosis list did not indicate Resident 10 had a diagnosis of anxiety. RNS 1 stated the physician order indicated Xanax oral tablet 0.25 mg give 1 tablet by mouth two times a day for anxiety manifested by inability to relax was ordered 11/6/2025 and was started on 11/6/2025. RNS 1 stated the history and physical dated 2/26/2026 did not indicate Resident 10 had a diagnosis of anxiety. RNS 1 stated the psychiatrist note dated 3/4/2026 did not indicate a diagnosis of anxiety but indicated that Resident 10 was prescribed Xanax for anxiety. RNS 1 stated the importance of having a diagnosis prior to starting any medication was to ensure the resident needed the medication to control or treat the diagnosis. RNS 1 stated if the resident did not have a diagnosis of anxiety prior to starting an antianxiety medication there was potential that the resident would experience adverse effects from the medication.During an interview on 3/26/2026 at 10:52 a.m., with the Assistant Director of Nursing (ADON), the ADON stated the importance of ensuring the resident was prescribed a medication for existing diagnoses prior to starting any medication was to ensure the resident was assessed for any signs and symptoms or behaviors that may be treated or controlled by prescription medications. The ADON stated if the resident did not have a diagnosis of anxiety and was prescribed antianxiety medication there was potential for the resident to experience negative effects or the opposite effect of the medication.B. During a review of Resident 12's admission Record, the admission Record indicated the facility admitted Resident 12 on 3/20/2025 and was readmitted on [DATE] with diagnoses including anxiety disorder (constantly feeling worried and nervous), depression (a mental health condition where someone feels very sad, empty, or loses interest in things for a long time), and schizophrenia (a mental illness that is characterized by disturbances in thought).During a review of Resident 12's History and Physical (H&P) dated 1/8/2026, the H&P indicated Resident 10 had the capacity to make decisions.During a review of Resident 12's MDS dated [DATE], the MDS indicated Resident 12 had moderate cognitive impairment. The MDS indicated Resident 12 needed moderate assistance (helper does less than half the effort to complete the activity) with lower body dressing and putting on or taking off footwear and supervision with eating, showering, upper body dressing, toileting, and oral and personal hygiene. The MDS indicated Resident 12 had active diagnoses of anxiety, depression, and schizophrenia. The MDS did not indicate an active diagnosis of bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs). The MDS indicated Resident 12 was taking antipsychotic medications.During a review of Resident 12's Order Summary Report dated 3/25/2026, the order summary report included the following:-Monitor behavior episodes of Anticonvulsant/mood stabilizer use DEPAKOTE m/b bipolar disorder as evidenced by sudden angry outbursts Attempt Non-Pharmacological interventions: 0= No Non-Pharmacological interventions needed 1 = Re-positioning/limb elevation 2=Reassurance/Emotional Support 3 = Provide Distraction/Diversionary Activities 4 = Exercise/ROM/Ambulation/Stretching 5= Rest Period/Quiet Environment 6 = Deep Breathing/Relaxations Exercise every shift, order date 1/7/2026 and start date 1/7/2026-Depakote Oral Tablet Delayed Release 250 MG [milligrams - metric unit of measurement, used for medication dosage and/or amount] (Divalproex Sodium) Give 2 tablet by mouth two times a day for bipolar disorder manifested by mood changes as evidenced by sudden angry outbursts give 2 tabs = 500 mg) order date 1/6/2026 and start date 1/6/2026During a concurrent interview and record review on 3/25/2026 at 8:16 a.m., with Registered Nurse Supervisor (RNS) 1, Resident 12's diagnosis list, order summary report, history and physical dated 1/8/2026, and psychiatrist notes dated 2/3/2026 and 3/4/2026 were reviewed. RNS 1 stated Resident 12's diagnosis list did not indicate bipolar disorder as one of the diagnoses. RNS 1 stated Resident 12's order summary report indicated Resident 12 was prescribed Depakote oral tablet delayed release 250 mg give to tablet by mouth two times a day for bipolar disorder manifested by mood changes as evidenced by sudden angry outbursts give 2 tabs. RNS 1 stated Resident 12's history and physical dated 1/8/2026 did not indicate a diagnosis of (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bipolar disorder. RNS 1 stated Resident 12's psychiatrist notes dated 2/3/2026 and 3/4/2026 did not indicate a diagnosis of bipolar disorder but indicated Resident 12 was prescribed Depakote for Bipolar disorder. RNS 1 stated it was important to ensure the resident had a diagnosis and needed the medication to control or treat the specific diagnosis. RNS 1 stated if the resident did not have a diagnosis of Bipolar disorder prior to starting an antianxiety medication there would be potential that the resident will experience adverse effects.During a concurrent interview and record review on 3/26/2026 at 10:59 a.m., with the ADON, Resident 12's diagnosis information in the admission record and order summary report were reviewed. The ADON stated Resident 12's diagnosis information in the admission record indicated bipolar disorder, the bipolar disorder diagnosis was added on 3/25/2026 and the order summary report indicated Resident 12 was prescribed Depakote for bipolar disorder on 1/6/2026 (78 days before Resident 12 was diagnosed with Bipolar). The ADON stated the importance of having a diagnosis prior to starting any medication was to ensure the resident was assessed for any signs and symptoms or behaviors that may be treated or controlled by prescription medications. The ADON stated if the resident did not have a diagnosis of Bipolar and was prescribed antianxiety medication there would be potential for the resident to experience negative side effects or the opposite effect the medication was intended to produce.During a review of the facility's policy and procedure (P&P) titled Psychotropic Medication Use dated 2001, the P&P indicated .Adequate Indications for Psychotropic Medication Use.5. Diagnosis alone does not necessarily warrant the use of psychotropic medication a. If a psychiatric diagnosis is part of the rationale for the use of psychotropic medication, there will be sufficient supporting documentation that the resident meets the criteria for that diagnosis (based on the current Diagnostic and Statistical Manual of Mental Disorders).

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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** Based on interview and record, the facility failed to ensure a Minimum Data Set ([MDS] - a resident assessment tool) assessment was completed accurately for three of 23 sampled residents (Resident 10, 12, and 19) by failing to:1. Ensure Resident 10 and Resident 12's mental health diagnoses was reflected in the resident assessment.2. Ensure Resident 19's dental health status was reflected in the resident assessment.This deficient practice resulted in incorrect data being transmitted to the Centers for Medicare and Medicaid Services (CMS) and had the potential to negatively affect the plan of care and delivery of care and services for Resident 10, 12, and 19.Findings: A. During a review of Resident 10's admission Record, the admission Record indicated the facility admitted Resident 10 on 9/4/2024 and was readmitted 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), schizophrenia (a mental illness that is characterized by disturbances in thought) and depression (a mental health condition where someone feels very sad, empty, or loses interest in things for a long time). During a review of Resident 10's History and Physical (H&P) dated 2/26/2025, the H&P indicated Resident 10 had the capacity for making decisions. During a review of Resident 10's Minimum Data Set (MDS – a resident assessment tool) dated 3/4/2026, the MDS indicated Resident 10 had moderate cognitive (ability to think or make decisions) impairment. The MDS indicated Resident 10 needed setup or clean-up assistance (helper assists only prior to or following the activity) with eating, supervision with oral hygiene, maximum assistance (helper does more than half the effort to complete the activity) with showering, and moderate assistance (helper does less than half the effort to complete the activity) with upper body and lower body dressing, putting on and taking off footwear, and toileting and personal hygiene. The MDS indicated Resident 10 had a active diagnoses of depression, bipolar disorder, and schizophrenia. The MDS did not indicate Resident 10 had an active diagnosis of anxiety. The MDS indicated Resident 10 was taking antipsychotic [a drug that helps reduce symptoms of hallucinations (seeing, hearing, or feeling something that is not actually there), delusions (strong beliefs that are not true) or severe confusion], antianxiety (a drug that help with feeling calmer and less worried), and antidepressant (a drug that helps with the feeling of sadness and improves an individual's mood) medications. During a review of Resident 10's Order Summary Report (a document containing a summary of all active physician orders) dated 3/25/2026, the order summary report included the following physician orders: -Xanax Oral Tablet 0.25 MG [milligrams - metric unit of measurement, used for medication dosage and/or amount] (Alprazolam) Give 1 tablet by mouth two times a day for Anxiety (constantly feeling worried and nervous) manifested by (M/B) inability to relax, order date 11/6/2025, start date 11/6/2025. During a concurrent interview and record review on 3/26/2026 at 10:05 a.m., with the Minimum Data Set Nurse (MDSN), Resident 10's MDS dated [DATE] was reviewed. The MDSN stated Resident 10's MDS dated [DATE] did not indicate a diagnosis of anxiety. The MDSN stated she should have conducted another assessment upon the start of the new medication for anxiety. The MDSN stated the importance of conducting another assessment was to ensure that the resident's new diagnosis (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was reflected accurately. The MDSN stated if the assessment was not conducted accurately there would be a potential the resident's plan of care would be inadequate and inaccurate. B. During a review of Resident 12's admission Record, the admission Record indicated the facility admitted Resident 12 on 3/20/2025 and was readmitted on [DATE] with diagnoses including anxiety disorder constantly feeling worried and nervous), depression (a mental health condition where someone feels very sad, empty, or loses interest in things for a long time), and schizophrenia. During a review of Resident 12's History and Physical (H&P) dated 1/8/2026, the H&P indicated Resident 10 had the capacity to make decisions. During a review of Resident 12's Minimum Data Set (MDS – a resident assessment tool) dated 1/13/2026, the MDS indicated had moderate cognitive (ability to think or make decisions) impairment. The MDS indicated Resident 12 needed moderate assistance (helper does less than half the effort to complete the activity) with lower body dressing and putting on or taking off footwear and supervision with eating, showering, upper body dressing, toileting, and oral and personal hygiene. The MDS indicated Resident 12 had active diagnoses of anxiety, depression, schizophrenia. The MDS did not indicate an active diagnosis of bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs). The MDS indicated Resident 12 was taking antipsychotic [a drug that helps reduce symptoms of hallucinations (seeing, hearing, or feeling something that is not actually there), delusions (strong beliefs that are not true) or severe confusion] and antianxiety (a drug that helps with feeling calmer and less worried) medications. During a review of Resident 12's Order Summary Report (a document containing a summary of all active physician orders) dated 3/25/2026, the order summary report indicated the following: -Depakote Oral Tablet Delayed Release 250 MG [milligrams - metric unit of measurement, used for medication dosage and/or amount] (Divalproex Sodium) Give 2 tablet by mouth two times a day for bipolar disorder manifested by mood changes as evidenced by sudden angry outbursts give 2 tabs = 500 mg) order date 1/6/2026 and start date 1/6/2026 During a concurrent interview and record review on 3/26/2026 at 10:02 a.m., with the Minimum Data Set Nurse (MDSN) Resident 12's MDS assessment dated [DATE] was reviewed. The MDSN stated Resident 12's MDS assessment dated [DATE] did not indicate a diagnosis of bipolar disorder and should have been included in the assessment. The MDSN stated if the diagnosis of bipolar was not included in the assessment there would be potential for inappropriate or lack of treatment and services which could contribute to the delay in progress of the resident's medical condition. During an interview on 3/26/2026 at 11:20 a.m. with the Director of Nursing (DON), the DON stated the importance of an accurate MDS assessment was to ensure the facility submitted accurate data to CMS and to develop a plan of care that includes the residents' new mental health diagnosis. The DON stated if the MDS assessment did not have accurate resident data, there would be potential for the residents' to not receive the proper plan of care and lack the treatment, monitoring, and follow-up regarding the new mental health diagnosis. C. During a review of Resident 19's admission record, the admission record indicated Resident 19 was admitted to the facility on [DATE] with diagnoses including cerebral infarction (the blood supply to part of the brain is blocked or reduced), dementia (a progressive state of decline in mental abilities), (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and dysphagia (difficulty swallowing). During a review of Resident 19's History and Physical (H&P), dated 11/11/2025, the H&P indicated, Resident 19 had no capacity (ability) to understand and make decisions. During a review of Resident 19's MDS, dated [DATE], the MDS indicated Resident 19 required maximal assistance (Helper does more than half the effort) from one staff for toileting hygiene, shower, dressing, personal hygiene, transfer, moderate assistance (Helper does less than half the effort) from one staff for bed mobility, and supervision or touching assistance (Helper provide verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) from one staff for oral hygiene and eating. During a concurrent observation and interview on 3/23/2026, at 10:59 a.m., with Resident 19 in his room, Resident 19 was watching television in bed and missing upper front teeth were observed during the interview. Resident 19 stated, he lost his partial dentures while he was in General Acute Care Hospital (GACH) prior to admission to this facility. Resident 19 stated, his wife and he told the nursing staff that he had lost his partial dentures, but no one helped him. Resident 19 stated, it was painful to chew hard food items like chopped chicken or diced unripe melon. During a concurrent interview and record review on 3/25/2026, 3:17 p.m., with the Minimum Data Set Nurse (MDSN), Resident 19's MDS section L-Oral/Dental Status, dated 11/17/2025 and 12/16/2026 was reviewed. The MDS section L-Oral/Dental Status indicated, Resident 19 did not have any broken or loosely fitting full or partial dentures. The MDS section L-Oral/Dental Status indicated, Resident 19 did not have any mouth or facial pain, discomfort or difficulty with chewing. The MDSN stated, she was not aware of Resident 19's missing upper front teeth and she should have assessed the resident thoroughly before documenting in MDS. The MDSN stated, the staff did not document Resident 19's dental status, and she thought there was no problem. MDSN stated, MDS coding should be done accurately because it affects the resident's plan of care and treatment. During a concurrent interview and record review on 3/26/2026, at 2:46 p.m., with the Director of Nursing (DON), Resident 19's Dental Progress Note (DPN), dated 1/9/2026 was reviewed. The DPN indicated, Resident 19 had broken teeth. The DON stated, MDSN should have reviewed the DPN and should have assessed Resident 19's dental status thoroughly before documenting MDS. The DON stated, all assessment in MDS should be coded correctly because this would affect resident's overall care and treatment negatively. The DON stated, assessments should be accurate to get a clear representation of the residents. During a review of the facility's Policy and Procedure (P&P) titled, Certifying Accuracy of the Resident Assessment, revised 11/2019, the P&P indicated, Policy Interpretation and Implementation: 2. Any person who completes any portion of the MDS assessment, tracking form, or correction request form is required to sign the assessment certifying the accuracy of that portion of that assessment . 4. The Resident Assessment Coordinator is responsible for ensuring that an MDS assessment has been completed for each resident. During a review of the facility's Policy and Procedure (P&P) titled, Resident Assessments, revised 1/2026, the P&P indicated, Policy Interpretation and Implementation: 12. Information in the MDS assessments will consistently reflect information in the progress notes, plans of care, and resident observations/interviews. 13. All resident assessments completed within the previous 15 months are maintained in the resident's active clinical record. The results of the assessments are used to develop, review, and revise the resident's comprehensive care plan.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on interview and record review, the facility failed to ensure four of 23 sampled residents (Residents 3, 10, 11, and 12) Preadmission Screening and Resident Review (PASARR) were reassessed appropriately by:Failing to ensure Resident 3 was reassessed for PASARR Level II upon readmissionFailing to ensure PASARR Level I was resubmitted when Resident 10 and Resident 12 had a new medication and diagnosis.Failing to ensure PASARR Level I was followed through with and reassess Resident 11's PASARR Level II upon admission. This deficient practice placed Residents 3, 10, 12 and 11 at risk of not receiving necessary care and services they need. Findings: a) During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities) schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 3's Minimum Data Set (MDS, a resident assessment tool), dated 2/19/2026, the MDS indicated Resident 3 had mild cognitive (judgement, planning, organization to manage average demands in one's environment) impairment. The MDS indicated Resident 3 was dependent on facility staff for personal hygiene, lower body (waist below) dressing, toileting hygiene, bathing, lying to sitting on side of bed, required substantial assistance (helper does more than half the effort) for upper body (waist above), roll left to right, sit to lying, required partial assistance (helper does less than half the effort) for oral hygiene and required supervision for eating. The MDS indicated Resident 3 had impairments on both sides of the upper (arms/shoulder) and lower (hips/legs) extremities and utilized a wheelchair. During a review of Resident 3's Notice of Attempted Evaluation dated 5/5/2025, the Notice of Attempted Evaluation indicated the Level II evaluation for serious mental illness (SMI) was not completed due to Resident 3 being temporarily transferred to the hospital for treatment. During a concurrent interview and record review on 3/25/2026 at 12:39 p.m., with Registered Nurse Supervisor 1 (RNS 1), RNS 1 stated when a resident is admitted to the facility, facility staff review the PASARR and continue with ensuring an assessment for Level II if indicated. RNS 1 stated Resident 3 was not assessed for Level II on 5/5/2025 due to being sent out to the hospital. RNS 1 stated after Resident 3 was readmitted to the facility, there should have been a follow up to do the second evaluation and indicated the attempt to reassess Resident 3 was missed. During an interview on 3/26/2026 at 3:50 p.m., with the Director of Nursing (DON), the DON stated PASARR is done to ensure the facility would be able to care for the residents appropriately and meet their mental health needs. The DON stated if the residents are not reassessed, the residents will not get the follow up they need and will not be able to address or care for the residents appropriately. (b) During a review of Resident 10's admission Record, the admission Record indicated the facility admitted Resident 10 on 9/4/2024 and was readmitted 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), schizophrenia (a mental illness that is characterized by disturbances in thought) and depression (a mental health condition where someone (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	feels very sad, empty, or loses interest in things for a long time). During a review of Resident 10's History and Physical (H&P) dated 2/26/2025, the H&P indicated Resident 10 had the capacity for making decisions. During a review of Resident 10's MDS dated [DATE], the MDS indicated Resident 10 had moderate cognitive (ability to think or make decisions) impairment. The MDS indicated Resident 10 needed setup or clean-up assistance (helper assists only prior to or following the activity) with eating, supervision with oral hygiene, maximum assistance (helper does more than half the effort to complete the activity) with showering, and moderate assistance (helper does less than half the effort to complete the activity) with upper body and lower body dressing, putting on and taking off footwear, and toileting and personal hygiene. The MDS indicated Resident 10 had active diagnoses of depression, bipolar disorder, and schizophrenia. The MDS did not indicate Resident 10 had an active diagnosis of anxiety. The MDS indicated Resident 10 was taking antipsychotic [a drug that helps reduce symptoms of hallucinations (seeing, hearing, or feeling something that is not actually there), delusions (strong beliefs that are not true) or severe confusion], antianxiety (a drug that help with feeling calmer and less worried), and antidepressant (a drug that helps with the feeling of sadness and improves an individual's mood) medications. During a review of Resident 10's Order Summary Report (a document containing a summary of all active physician orders) dated 3/25/2026, the order summary report included the following physician orders: -Xanax Oral Tablet 0.25 MG [milligrams - metric unit of measurement, used for medication dosage and/or amount] (Alprazolam) Give 1 tablet by mouth two times a day for Anxiety M/B (manifested by) inability to relax, order date 11/6/2025, start date 11/6/2025. During a concurrent interview and record review on 3/25/2026 at 9:17 a.m., with Registered Nurse Supervisor (RNS) 1, Resident 10's PASARR dated 9/2/2025 was reviewed. RNS 1 stated Resident 10's PASARR Level I screening dated 9/2/2025 did not indicate a diagnosis of anxiety. RNS 1 stated Resident 10 did not have another PASARR Level I screening submitted with the new diagnosis of anxiety. RNS 1 stated the importance of conducting a resident review of the PASARR Level I screening was to ensure the resident was assessed for any new diagnoses to ensure the resident's needs could be met. RNS 1 stated if a review of the PASARR Level I screening was not conducted, the resident might not receive services and treatment that the resident needed. During a concurrent interview and record review on 3/26/2026 at 10:52 a.m., with the Assistant Director of Nursing (ADON) Resident 10's PASARR dated 9/2/2025 was reviewed. The ADON stated Resident 10's PASARR Level I screening dated 9/2/2025 did not indicate a diagnosis of anxiety. The ADON there was no new resident review PASARR Level I screening that was submitted for the Resident 10's diagnosis of anxiety. The ADON stated if a resident review PASARR Level I was not submitted for a new diagnosis, there would be potential that the resident may not receive the treatment and services that he or she needed. (c) During a review of Resident 12's admission Record, the admission Record indicated the facility admitted Resident 12 on 3/20/2025 and was readmitted on [DATE] with diagnoses including anxiety disorder (constantly feeling worried and nervous), depression (a mental health condition where someone feels very sad, empty, or loses interest in things for a long time), and schizophrenia (a mental illness that is characterized by disturbances in thought). (continued on next page)

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

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 12's H&P dated 1/8/2026, the H&P indicated Resident 10 had the capacity to make decisions. During a review of Resident 12's MDS dated [DATE], the MDS indicated Resident 12 had moderate cognitive impairment. The MDS indicated Resident 12 needed moderate assistance (helper does less than half the effort to complete the activity) with lower body dressing and putting on or taking off footwear and supervision with eating, showering, upper body dressing, toileting, and oral and personal hygiene. The MDS indicated Resident 12 had active diagnoses of anxiety, depression, and schizophrenia. The MDS did not indicate Resident 12 had an active diagnosis of bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs). The MDS indicated Resident 12 was taking antipsychotic [a drug that helps reduce symptoms of hallucinations (seeing, hearing, or feeling something that is not actually there), delusions (strong beliefs that are not true) or severe confusion] and antianxiety (a drug that helps with feeling calmer and less worried) medications. During a review of Resident 12's Order Summary Report (a document containing a summary of all active physician orders) dated 3/25/2026, the order summary report included the following: -Depakote Oral Tablet Delayed Release 250 MG [milligrams - metric unit of measurement, used for medication dosage and/or amount] (Divalproex Sodium) Give 2 tablet by mouth two times a day for bipolar disorder manifested by mood changes as evidenced by sudden angry outbursts give 2 tabs = 500 mg) order date 1/6/2026 and start date 1/6/2026. During a concurrent interview and record review on 3/25/2025 at 8:36 a.m., with Registered Nurse Supervisor (RNS) 1 Resident 12's PASARR Level 1 screening dated 8/6/2025 was reviewed. RNS 1 stated PASARR Level I screening dated 8/6/2025 did not indicate a diagnosis of bipolar disorder. RNS 1 stated if a resident review of the PASARR Level I screening was not submitted, the resident might not receive the appropriate treatment or services for the resident's mental illness. During a concurrent interview and record review on 3/26/2026 at 10:59 a.m., with the Assistant Director of Nursing (ADON) Resident 12's PASARR Level I screening dated 8/6/2025 was reviewed. The ADON stated if a resident review PASARR Level I was not submitted for a new diagnosis, there would be potential that the resident may not receive the treatment and services that he or she needed. (d). During a review of Resident 11's admission Record, the admission Record indicated, Resident 11 was initially admitted to the facility on [DATE] and last admission was 3/20/2026 with diagnosis including dementia (a progressive state of decline in mental abilities), anxiety disorder (constantly feeling worried and nervous), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and psychotic disorder (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality). During a review of Resident 11's H&P, dated 1/22/2026, the H&P indicated, Resident 11 could not make medical decisions, but she could make needs known. During a review of Resident 11's MDS, dated [DATE], the MDS indicated Resident 11 required dependent assistance (Helper does all of the effort) from two or more staff for transfer, shower, dressing, personal hygiene, toilet hygiene, and maximal assistance (Helper does more than half the effort) from one staff for personal hygiene, oral hygiene, bed mobility. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 3/25/2026, at 10:15 a.m., with Registered Nurse Supervisor (RNS) 1, Resident 11's PASARR Level I Screening, dated 1/19/2026 was reviewed. The PASARR Level I Screening indicated, Level I was positive for Serious Mental Illness (SMI) which indicates a follow up with a PASARR Level II assessment. RNS 1 stated, PASARR Level II should have been evaluated, but she could not find any document regarding PASARR Level II. RNS 1 stated, if PASARR was not done accurately and followed through for level II, Resident 11 would not receive the mental health related treatment and care he needed. During a concurrent interview and record review on 3/25/2026, at 2:40 p.m., with the Director of Nursing (DON), Resident 11's Notice of Exempted Hospital Discharge, dated 1/19/2026 was reviewed. The Notice of Exempted Hospital Discharge indicated, negative level I screening indicates a level II mental health evaluation is not required. The Notice of Exempted Hospital Discharge indicated, if the individual remains in the nursing facility longer than 30 days, the facility must resubmit a new level I screening as a resident review on the 31st day. The DON stated, new PASARR level I should have submitted on 2/19/2026 (31st day since admission of 1/19/2026) since Resident 11 was planned to stay longer than 30 days. The DON stated, Resident 11 was admitted from General Acute Care Hospital (GACH) Psychiatric unite (provide 24/7 care for acute mental health disorders, focusing on safety, crisis stabilization, and medication management) due to SMI. The DON stated, Resident 11 definitely needed mental health treatment and care. The DON stated, the staff should have followed up with Level II evaluation to provide proper care and treatment. During a review of Resident 11's Care Plan (CP) titled, Resident 11 has behavior problems, revised on 1/22/2026, the CP Goal indicated, Resident 11 would not have evidence of behavior problems by target date of 5/8/2026. The CP Interventions indicated, administer medications as ordered, and monitor/document side effects and effectiveness. During a review of the facility's Policy and Procedure (P&P) titled, PASARR, revised 1/2026, the P&P indicated, 1. b. If the level I screen indicates that the individual may meet the criteria for a MD, ID, or RD, he or she is referred to the state PASARR representative for the Level II (evaluation and determination) screening process. c. Upon completion of the Level II evaluation, the State PASARR representative determines if the individual has a physical or mental condition, what specialized or rehabilitative services he or she needs, and whether placement in the facility is appropriate.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement an individualized care plan with measurable objectives, timeframes, and interventions for 2 of 3 Residents (Residents 51 and 19) by failing to:Develop a comprehensive care plan and conduct an Interdisciplinary Team (IDT, team of health care professionals that work together with the resident and or resident's representative to prioritize the resident 's needs and goals) meeting for Resident 51 who had a left shoulder and left ankle fracture (broken bone) and refused multiple times to follow up with orthopedic (branch of surgery concerned with conditions involving the muscles and bones) appointments per physicians recommendations.Develop and implement a comprehensive person-centered care plan for Resident 19's dental health status.These failures had the potential to negatively affect the delivery of necessary care and services. For Resident 51, this failure had the potential to lead to contracture (loss of motion of a joint associated with stiffness and joint deformity) development, delayed healing, and a decline in overall physical functioning and activities of daily living (ADL, basic activities such as eating, dressing, toileting).This failure had the potential to result in Resident 19, and Resident 51's needs not being met, affecting the residents' well-being, and poor patient outcomes.Findings: 1. During a review of Resident 51's admission Record, the admission Record indicated Resident 51 was admitted to the facility on [DATE] with diagnoses including systemic involvement of connective tissue (group of disorders where the immune system attacks its own healthy tissues causing widespread inflammation and damage to skin, blood vessels, joints [where two bones meet], and organs), muscle weakness, and polyneuropathy (damage of the nerves that can cause weakness, numbness, and burning pain). During a review of Resident 51's History and Physical (H&P), dated 11/11/2025, the H&P indicated Resident 51 was transferred to the facility from a hospital on [DATE] for rehabilitation after being hit on the left side of the body while crossing the street on 11/3/2025. The H&P indicated Resident 51 sustained multiple fractures, which included a left humerus (upper arm bone) fracture, a left distal fibula fracture (break in the smaller of the two lower leg bones between the knee and the ankle), a left tibia dislocation (knee injury where the shin bone loses contact with the lower part of the thigh bone), and a left medial malleolus fracture (break in the bony bump on the inner side of the ankle). The H&P indicated Resident 51 had surgery to re-align Resident 51's left ankle dislocation on 11/3/2025 and had additional surgeries to repair the bone fractures of the left ankle and left humerus on 11/5/2025. During a review of Resident 51's Orthopedic Consultation note (Ortho Note), dated 12/17/2025, the Ortho Note indicated Resident 51's left arm was to be non-weightbearing (NWB, restriction in which a person is not allowed to put any weight through the operated body part) and Resident 51's left leg was weightbearing as tolerated (WBAT, a person is medically cleared to place as much weight through the affected arm or leg to the point of comfort or tolerance) while wearing a Controlled Ankle Motion boot (CAM boot, orthopedic device used to immobilize the foot, ankle, or lower leg in a fixed position and removing some of the weight off the foot and ankle while walking) boot. The Ortho Note indicated for Resident 51 to follow up with orthopedics on 1/28/2026 at 11 a.m. During a review of Resident 51's Order Summary Report, the Order Summary Report indicated a physician's order, dated 12/17/2025, to follow up with orthopedics on 1/28/2026 at 11 a.m. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 51's Order Summary Report, the Order Summary Report indicated a physician's order, dated 12/23/2025, for Resident 15 to continue with NWB precautions to the left arm. During a review of Resident 51's Order Summary Report, the Order Summary Report indicated a physician's order, dated 12/23/2025, for Resident 51's left leg to be WBAT while wearing a CAM boot. During a review of Resident 51's Interdisciplinary Team (IDT, team of health care professionals that work together with the resident and/or resident's representative to prioritize the resident 's needs and goals) Progress Note, dated 1/22/2026, the IDT Progress Note indicated an IDT meeting was held at Resident 51's bedside due to Resident 51's refusal to wear the left leg CAM boot when walking. The IDT Progress Note indicated Occupational Therapist 1 (OT 1) educated Resident 51 that a front wheeled walker (FWW, mobility device with two wheels in the front used for support when standing or walking) would not be provided if Resident 51 did not wear the left leg CAM boot due to increased risk of re-injury to the left leg. The IDT Progress Note indicated an orthopedic follow up appointment was scheduled for 1/28/2026 at which time Resident 51 would discuss possibly discontinuing the left leg CAM boot with the physician. The IDT Progress Note indicated therapy services would work on transfers only, not walking, until further clarification from the orthopedics physician. During a review of Resident 51's Minimum Data Set (MDS, a resident assessment tool), dated 2/16/2026, the MDS indicated Resident 51 had severe cognitive (mental action or process of acquiring knowledge and understanding) impairment. The MDS indicated Resident 51 required set up/clean up assistance (helper sets up or cleans up) for eating, oral hygiene, and rolling to both sides, supervision or touching assistance (helper provides verbal cues and/or touching and/or contact guard assistance as resident completes the activity) for toileting hygiene, bathing, dressing, and personal hygiene and partial/moderate assistance (helper does less than half the effort) for putting on and taking off footwear. The MDS indicated Resident 51 had functional limitations in range of motion (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 and one leg. During a concurrent observation and interview on 3/23/2026 at 1:26 p.m. with Resident 51 in Resident 51's room, Resident 51 was sitting at the edge of the bed wearing slippers on both feet. Resident 51 stated she broke her left shoulder and left ankle in November 2025 when she was hit by a car while crossing the street. Resident 51 minimally raised the left arm and stated she was unable to move the left arm well because it felt very heavy and her left hand felt numb. Resident 51 removed both slippers, moved both ankles up and down, and stated she needed a massage to the left leg because she had cramps (sudden, involuntary tightening of the muscle) and tightness in the calf muscle (lower part of the leg). Resident 51 stated she walked with a FWW in the room without the CAM boot and puts weight through her left arm. Resident 51 stated she refused the scheduled orthopedics appointment in January 2026 because she did not want to leave her husband (who was also a resident at the facility) unattended. Resident 51 stated was unsure what happened because staff never followed up with scheduling another orthopedics appointment and she had not heard anything regarding the status of her left arm and ankle for over two months. During a concurrent interview and record review on 3/25/2026 at 9:49 a.m. with the Case Manager (CM), the CM stated she was responsible for scheduling follow up consultation appointments for the residents in the facility. The CM stated if a resident missed or refused a follow up consultation appointment, the CM must attempt to re-schedule the appointment, document the reason for missed appointments or refusals in the clinical record, notify the physician, create a care plan, conduct an (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	IDT meeting, and continue to follow up with the resident to investigate the reason for refusal, offer accommodations, and re-schedule the appointment. The CM reviewed Resident 51's clinical record and confirmed Resident 51 was supposed to follow up with orthopedics on 1/28/2026 but did not. The CM stated she scheduled a follow up orthopedic appointment for Resident 51 on 1/28/2026 but Resident 51 refused to attend and the CM did not document the refusal in the clinical record. The CM stated she tried to schedule additional follow up orthopedic appointments multiple times with Resident 51, but Resident 51 refused each time and the CM did not document the re-scheduling attempts. The CM stated she should have followed up and rescheduled Resident 51's orthopedic appointment, investigated the reasons for Resident 51's refusals and offered possible accommodations, notified the physician, developed a care plan, and held an interdisciplinary team meeting, but did not. The CM reviewed Resident 51's clinical record and confirmed the facility did not create a care plan or conduct an IDT for Resident 51's multiple refusals to follow up with orthopedics but should have. The CM stated if the facility developed a care plan and held an IDT meeting as indicated, the physician would have been notified, interventions would have been created to address the issue, and the entire team would have been aware of Resident 51's refusals and lack of follow up with orthopedics. During a concurrent interview and record review on 3/26/2026 at 10:11 a.m. with the Minimum Data Set Nurse (MDSN), the MDSN stated a care plan was developed and used as a guideline to ensure proper care was provided for each resident. The MDSN stated IDTs were conducted upon admission, quarterly, and as needed if any area of concern requiring a formal, interdisciplinary discussion was warranted. The MDSN reviewed Resident 51's clinical record and confirmed the facility did not develop a comprehensive care plan or conduct an IDT meeting to address Resident 51's refusals to follow up with orthopedics as recommended and ordered but should have. The MDSN stated care plan development and IDT conferences were important to ensure the root cause of the issue was properly investigated and appropriate interventions were implemented to address the areas of concern. During an interview on 3/26/2026 at 3:23 p.m., the Director of Nursing (DON) stated comprehensive care plans were used as a guide to ensure the appropriate care and services were provided for each resident. The DON stated care plans were used to ensure problem areas were accurately identified, goals were created, and interventions were implemented to address a resident's areas of concerns. The DON stated it was important care plans were accurate to ensure the staff was aware of the resident's status and the appropriate care and services were provided. The DON stated any resident refusals for follow up appointments should be documented in the clinical record, care planned, reported to the physician, nursing, and the resident's family, and addressed in an IDT meeting to ensure all staff were aware of the resident's refusal and interventions were in place to address the areas of concern. The DON stated if a resident's refusal to follow up with orthopedics as recommended and ordered was not care planned and discussed in an IDT meeting, it could potentially result in missed interventions, delays in necessary care and services, and placement of unnecessary restrictions on a resident which could negatively impact a resident's progress and function. During a review of the facility's Policy and Procedure (P/P) titled, Care Plans, Comprehensive Person-Centered, revised 12/2016, the P/P indicated the IDT, in conjunction with the resident and his/her family or legal representative developed and implemented a comprehensive, person-centered care plan for each resident. The P/P indicated the comprehensive care plan would include measurable objectives and timeframes, describe the services that were to be furnished to attain or maintain the resident's highest practicable, physical, mental, and psychosocial well-being, describe services that would otherwise be provided for the above but were not provided due to the resident exercising his or her rights, including the right to refuse treatment, reflect on the resident's expressed wishes (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	regarding care and treatment goals, and aid in preventing or reducing a decline in the resident's functional status and/or functional levels. The P/P indicated identifying problem areas and their causes and developing interventions that were targeted and meaningful to the resident were the end point of an interdisciplinary process. 2. During a review of Resident 19's admission record, the admission record indicated Resident 19 was admitted to the facility on [DATE] with diagnoses including cerebral infarction (the blood supply to part of the brain is blocked or reduced), dementia (a progressive state of decline in mental abilities), and dysphagia (difficulty swallowing). During a review of Resident 19's H&P, dated 11/11/2025, the H&P indicated, Resident 19 had no capacity (ability) to understand and make decisions. During a review of Resident 19's MDS, dated [DATE], the MDS indicated Resident 19 required maximal assistance (Helper does more than half the effort) from one staff for toileting hygiene, shower, dressing, personal hygiene, transfer, moderate assistance (Helper does less than half the effort) from one staff for bed mobility, and supervision or touching assistance (Helper provide verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) from one staff for oral hygiene and eating. During a concurrent observation and interview on 3/23/2026, at 10:59 a.m., with Resident 19 in his room, Resident 19 was watching television in bed. Resident 19 missing upper front teeth. Resident 19 stated, he lost his partial dentures while he was in a General Acute Care Hospital (GACH) prior to admission. Resident 19 stated, he told the nursing staff, but no one helped him retrieve or replace his dentures. Resident 19 stated, it was painful to chew hard food items like chopped chicken or diced unripe melon. During a concurrent interview and record review on 3/25/2026, at 3:25 p.m., with the Minimum Data Set Nurse (MDSN), Resident 19's Care Plan (CP), dated from 11/10/2025 to 3/25/2026 was reviewed. Resident 19's Care Plans did not address Resident 19's dental health status. The MDSN stated, Resident 19's dental health status such as missing partial denture and broken upper front teeth should have been reflected in CP. The MDSC stated, this would delay the treatment and care to prevent complications such as social isolation, unintended weight loss, and low self-esteem. The MDSC stated, the staff failed to address and develop CP for Resident 19's dental health issues. During an interview on 3/26/2026, at 2:46 p.m., with the Director of Nursing (DON), the DON stated, the resident's care plan is the specific resident's plan of care, and it should be initiated as soon as the staff identified the concerns. The DON stated, if the CP for Resident 19's dental health issues were not developed and implemented, Resident 19 might suffer from unintended weight loss, dental pain related to chewing food, and loss of dignity due to missing denture and broken teeth. During a review of the facility's Policy and Procedure (P&P) titled, Care plans, Comprehensive Person-Centered, revised 1/2026, the P&P indicated, Policy Statement: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation: 8. The comprehensive, person-centered care plan will: a. Include measurable objectives and timeframes; b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . g. Incorporate identified problem areas; Incorporate risk factors associated with identified problems . 10. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Identifying problem areas and their causes, and developing interventions that are targeted and meaningful to the resident, are the endpoint of an interdisciplinary process.

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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** Based on interview and record review, the facility failed to ensure the comprehensive person-centered care plan was revised, updated, and reflected ophthalmologist (a medical professional specializing in comprehensive eye and vision care, including medical and surgical treatment) recommendations for one of seven sampled residents (Resident 45).This failure had the potential to result in Resident 45's vision worsening due to dry eyes and increased Intra Ocular Pressure (IOP- a measurement of the fluid pressure inside the eye). Findings:During a review of Resident 45's admission record, the admission record indicated Resident 45 was admitted to the facility on [DATE] with diagnoses including right eye blindness, muscle weakness, and dysphagia (difficulty swallowing).During a review of Resident 45's History and Physical (H&P), dated 6/24/2025, the H&P indicated, Resident 45 had fluctuating capacity (ability) to understand and make decisions.During a review of Resident 45's Minimum Data Set (MDS-a resident assessment tool), dated 1/23/2026, the MDS indicated Resident 45 required moderate assistance (Helper does less than half the effort) from one staff for transfer, dressing, and supervision or touching assistance (Helper provide verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) from one staff for oral hygiene, shower, personal hygiene, toilet hygiene, eating.During a review of Resident 45's Order Summary Report (OSR), dated 3/25/2026, the OSR indicated, instill one drop of artificial tears in both eyes every four hours as needed for dry eyes was ordered on 3/25/2026. During a concurrent interview and record review on 3/25/2026, at 10:10 a.m., with Registered Nurse Supervisor (RNS) 1, Resident 1's Ophthalmology Exam/Consult and Report, dated 10/14/2025 and 2/12/2026 were reviewed. The Ophthalmology Exam/Consult and Report indicated, artificial tears regimen for dry eye treatment and Monocular Precautions such as control IOP, avoiding eye rubbing, and monitor for medications were recommended. RNS 1 stated, all the recommendations from the ophthalmologist should be carried out and reflected in Resident 45's care plan as interventions.During a concurrent interview and record review on 3/25/2026, at 3:35 p.m., with the Minimum Data Set Nurse (MDSN), Resident 45's Care Plan (CP) titled, Resident 45 has impaired visual function related to blindness on right eye, revised 7/14/2025 was reviewed. The CP goal indicated, Resident 45 will maintain optimal quality of life within limitation imposed by visual function through 4/23/2026. The CP Interventions indicated, identify factors affecting visual function and monitor signs and symptoms of acute eye problems. The CP interventions indicated, there were no interventions for dry eyes and IOP control. The MDSN stated, the staff failed to reflect ophthalmologist's recommendations to CP. The MDSN stated, CP interventions should be revised and updated when there were recommendations from specialists including ophthalmologist to prevent further vision loss.During an interview on 3/26/2026, at 2:53 p.m., with the Director of Nursing (DON), the DON stated, ophthalmologist's recommendations should be carried out as ordered after notifying the Primary Care Physician (PCP) and reflected to care plan as interventions to prevent further vision loss. The DON stated, preserving vision loss was important to maintain Resident 45's quality of life. The DON stated, the staff should have revised and updated care plan on 10/14/2025 and 2/12/2026 after ophthalmologist visits because ophthalmologists emphasized same recommendations twice in a row.During a review of the facility's Policy and Procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, dated 1/2026, the P&P indicated, Policy Interpretation and Implementation: 8. The comprehensive, person-centered care plan will: b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . 13. Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change. 14. The Interdisciplinary Team must review and update the care plan: a. When there has been a significant change in the resident's condition.

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Ocean Ridge Post Acute	3850 E. Esther St. Long Beach, CA 90804

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide treatment and care in accordance with professional standards of practice for one of six sampled residents (Residents 51) by failing to follow up with an orthopedic (specialty area in medicine referring to the management of the muscles, bones, and their connective structures) consultation appointment for Resident 51's left humerus (upper arm bone) and left ankle fractures (broken bone) per consulting physician's recommendations.This deficient practice resulted in Resident 51 not receiving necessary treatment and services to improve mobility (ability to move) and activities of daily living (ADL, basic activities such as eating, dressing, toileting) and had the potential to result in a further decline in Resident 51's left arm and left ankle range of motion (ROM, full movement potential of a joint), unnecessary weightbearing (guidance from a physician limiting the amount of weight a person can put through a specific arm and/or leg after surgery) and orthotic device (medical device such as a brace or boot designed to support, realign, protect, prevent and correct deformities and improve function) restrictions, delayed healing, and a decline in overall physical functioning.Findings: During a review of Resident 51's admission Record, the admission Record indicated Resident 51 was admitted to the facility on [DATE] with diagnoses including systemic involvement of connective tissue (group of disorders where the immune system attacks its own healthy tissues causing widespread inflammation and damage to skin, blood vessels, joints [where two bones meet], and organs), muscle weakness, and polyneuropathy (damage of the nerves that can cause weakness, numbness, and burning pain). During a review of Resident 51's History and Physical (H&P), dated 11/11/2025, the H&P indicated Resident 51 was transferred to the facility from a hospital on [DATE] for rehabilitation after being hit on the left side of the body while crossing the street on 11/3/2025. The H&P indicated Resident 51 sustained multiple fractures, which included a left humerus fracture, a left distal fibula fracture (break in the smaller of the two lower leg bones between the knee and the ankle), a left tibia dislocation (knee injury where the shin bone loses contact with the lower part of the thigh bone), and a left medial malleolus fracture (break in the bony bump on the inner side of the ankle). The H&P indicated Resident 51 had surgery to re-align Resident 51's left ankle dislocation on 11/3/2025 and had additional surgeries to repair the bone fractures of the left ankle and left humerus on 11/5/2025.During a review of Resident 51's Minimum Data Set (MDS, a resident assessment tool), dated 2/16/2026, the MDS indicated Resident 51 had severe cognitive (mental action or process of acquiring knowledge and understanding) impairment. The MDS indicated Resident 51 required set up/clean up assistance (helper sets up or cleans up) for eating, oral hygiene, and rolling to both sides, supervision or touching assistance (helper provides verbal cues and/or touching and/or contact guard assistance as resident completes the activity) for toileting hygiene, bathing, dressing, and personal hygiene and partial/moderate assistance (helper does less than half the effort) for putting on and taking off footwear. The MDS indicated Resident 51 had functional limitations in range of motion (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 and one leg.During a review of Resident 51's Physical Therapy (PT, profession aimed in the restoration, maintenance, and promotion of optimal physical function) Evaluation and Plan of Treatment (PT Eval), dated 11/11/2025, the PT Eval indicated Resident 51's medical precautions included for Resident 51's left leg to be toe-touch weightbearing (TTWB, safety measure after surgery or fractures prescribed by the physician which allows a person to touch the toes of the injured leg on the ground for balance while walking) while wearing a Controlled Ankle Motion boot (CAM boot, orthopedic device used to immobilize the foot, ankle, or lower leg in a fixed position and removing some of the weight off the foot and ankle while walking) for four weeks. During a review of Resident 51's Occupational Therapy (OT, profession that provides services to increase and/or maintain a person's capability to participate in everyday life (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	activities) Evaluation and Plan of Treatment (OT Eval), dated 11/11/2025, the OT Eval indicated Resident 51's medical precautions included for Resident 51's left leg to be TTWB while wearing a CAM boot for four weeks and for Resident 51's left arm to be non-weightbearing (NWB, restriction in which a person is not allowed to put any weight through the operated body part) and positioned in a sling (flexible material used to support a person during a mechanical lift transfer) when Resident 51 was out of bed. During a review of Resident 51's Orthopedic Consultation note (Ortho Note), dated 12/17/2025, the Ortho Note indicated Resident 51's left arm was to be NWB and Resident 51's left leg was weightbearing as tolerated (WBAT, a person is medically cleared to place as much weight through the affected arm or leg to the point of comfort or tolerance) while wearing a CAM boot. The Ortho Note indicated Resident 51 to follow up with orthopedics on 1/28/2026 at 11 a.m. During a review of Resident 51's Order Summary Report, the Order Summary Report indicated a physician's order, dated 12/17/2025, to follow up with orthopedics on 1/28/2026 at 11 a.m. During a review of Resident 51's Order Summary Report, the Order Summary Report indicated a physician's order, dated 12/23/2025, for Resident 51 to continue with NWB precautions to the left arm. During a review of Resident 51's Order Summary Report, the Order Summary Report indicated a physician's order, dated 12/23/2025, for Resident 51's left leg to be WBAT while wearing a CAM boot.During a review of Resident 51's Interdisciplinary Team (IDT, team of health care professionals that work together with the resident and/or resident's representative to prioritize the resident 's needs and goals) Progress Note, dated 1/22/2026, the IDT Progress Note indicated an IDT meeting was held at Resident 51's bedside due to Resident 51's refusal to wear the left leg CAM boot when walking. The IDT Progress Note indicated Occupational Therapist 1 (OT 1) educated Resident 51 that a front wheeled walker (FWW, mobility device with two wheels in the front used for support when standing or walking) would not be provided if Resident 51 did not wear the left leg CAM boot due to increased risk of re-injury to the left leg. The IDT Progress Note indicated an orthopedic follow up appointment was scheduled for 1/28/2026 at which time Resident 51 would discuss possibly discontinuing the left leg CAM boot with the physician. The IDT Progress Note indicated therapy services would work on transfers only, not walking, until further clarification from the orthopedics physician. During a review of Resident 51's OT Discharge summary, dated [DATE], the OT Discharge Summary indicated Resident 51 was discharged from OT services due to highest practical level achieved.During a review of Resident 51's PT Discharge summary, dated [DATE], the PT Discharge Summary indicated Resident 51 was discharged from OT services due to highest practical level achieved. During a concurrent observation and interview on 3/23/2026 at 1:26 p.m. with Resident 51 in Resident 51's room, Resident 51 was sitting at the edge of the bed wearing slippers on both feet. Resident 51 stated she broke her left shoulder and left ankle in November 2025 when she was hit by a car while crossing the street. Resident 51 minimally raised the left arm and stated she was unable to move the left arm well because it felt very heavy and her left hand felt numb. Resident 51 removed both slippers, moved both ankles up and down, and stated she needed a massage to the left leg because she had cramps (sudden, involuntary tightening of the muscle) and tightness in the calf muscle (lower part of the leg). Resident 51 stated she walked with a FWW in the room without the CAM boot and puts weight through her left arm. Resident 51 stated she refused the scheduled orthopedics appointment in January 2026 because she did not want to leave her husband (who was also a resident at the facility) unattended. Resident 51 stated was unsure what happened because staff never followed up with scheduling another orthopedics appointment and she had not heard anything regarding the status of her left arm and ankle for over two months. During a concurrent interview and record review on 3/25/2026 at 9:27 a.m. with Registered Nurse Supervisor 1 (RNS 1), RNS 1 stated a licensed nurse was responsible for accepting a resident's paperwork and implementing new physician orders and recommendations when a resident returned to the facility from a consultation appointment. RNS 1 stated if follow up appointments were recommended by the consulting physician; the licensed nurse entered the recommended date and time of the follow up appointment in the physician's orders and informed the (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	case manager who then scheduled the follow up appointment based on the physician's instructions. RNS 1 reviewed Resident 51's physician's orders, dated 12/17/2025, and confirmed Resident 51 was supposed to follow up with Orthopedics on 1/28/2026 per physician's orders, but was unable to verify if Resident 51 attended the scheduled appointment because there were no ortho notes or progress notes confirming the visit. RNS 1 stated the lack of orthopedic follow-up as recommended could potentially result in injury due to lack of updated instructions and precautions in how to properly care for the residents and a decline in function. During a concurrent interview and record review on 3/25/2026 at 9:49 a.m. with the Case Manager (CM), the CM stated she was responsible for scheduling follow up consultation appointments for the residents in the facility. The CM stated if a resident missed or refused a follow up consultation appointment, the CM must attempt to re-schedule the appointment, document the reason for missed appointments or refusals in the clinical record, notify the physician, create a care plan, conduct an IDT meeting, and continue to follow up with the resident to investigate the reason for refusal, offer accommodations, and re-schedule the appointment. The CM reviewed Resident 51's clinical record and confirmed Resident 51 was supposed to follow up with orthopedics on 1/28/2026 but did not. The CM stated she scheduled a follow up orthopedic appointment for Resident 51 on 1/28/2026 but Resident 51 refused to attend and the CM did not document the refusal in the clinical record. The CM stated she tried to schedule additional follow up orthopedic appointment's multiple times with Resident 51, but Resident 51 refused each time and the CM did not document the re-scheduling attempts and did not notify nursing or the physician of Resident 51's repeated refusals. The CM stated she should have followed up and rescheduled Resident 51's orthopedic appointment, investigated the reasons for Resident 51's refusals and offered possible accommodation, notified the physician, developed a care plan, and held an interdisciplinary team meeting, but did not. The CM stated it was important for residents to attend follow-up appointments as recommended or ordered to ensure staff provided the appropriate care and services based on the resident's current medical needs. During a concurrent interview and record review on 3/25/2026 at 2:59 p.m. with the Director of Rehabilitation (DOR), the DOR reviewed Resident 51's clinical record. The DOR stated Resident 51 was evaluated by OT services on 11/11/2025 and discharged from OT services on 1/30/2025 due to a functional plateau (state of little of no change). The DOR stated Resident 51 was evaluated by PT on 11/11/2025 and discharged from PT on 2/5/2025 due to a functional plateau. The DOR reviewed Resident 51's IDT Progress Note, dated 1/22/2026, and confirmed PT and OT could not issue Resident 51 a FWW and safely work on walking exercises with Resident 51 until Resident 51 followed up with orthopedics on 1/28/2026. The DOR stated Resident 51 reached her highest practical level in therapy, mobility, and ADLs with the NWB restrictions to the left arm and Resident 51's refusal to wear a CAM boot when walking per physician's orders and needed guidance from the orthopedic physician to safely progress Resident 51 in therapy. The DOR reviewed Resident 51's clinical record and stated he was unsure if Resident 51 attended her scheduled ortho appointment on 1/28/2026 because there were no ortho notes or progress notes in the chart. The DOR stated lack of orthopedic follow up could result in a lack of progress or decline in a resident's function. During an interview on 3/26/2026 at 3:23 p.m. with the Director of Nursing (DON), the DON stated the licensed nurse was responsible for accepting a resident's paperwork and implementing new physician orders and recommendations when a resident returned to the facility from a consultation appointment. The DON stated if follow up appointments were recommended by the physician, the charge nurse contacted the case manager or social worker to schedule the follow up appointment based on the physician recommendations. The DON stated any resident refusals for follow up appointments should be documented in the clinical record, care planned, discussed in an IDT meeting, and reported to the physician, nursing, and the resident's family. The DON stated if residents did not attend follow up appointments as recommended or ordered, it could result in missed interventions, delays in necessary care and services, and placement of unnecessary restrictions on a resident which could negatively impact a resident's progress and (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	function. During a review of the facility's Policy and Procedure (P/P) titled, Referrals, Appointments, Follow-up, Social Services/Case Manager, revised 12/2008, the P/P indicated Social Services or Case Management personnel shall coordinate most resident referrals with outside agencies. The P/P indicated Social Services or Case Management would collaborate with the nursing staff or other pertinent disciplines to arrange for services that have been ordered by the physician such as clinic appointments. The P/P indicated Social Services or Case Management would document the referral in the resident's medical record and collaborate follow up appointments/referrals with the nursing staff or other pertinent disciplines to ensure appropriate follow-up was carried out.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of six sampled residents (Resident 51) who had a left shoulder and a left ankle fracture (broken bone) was:1. Wearing a Controlled Ankle Motion boot (orthopedic device used to immobilize or protect the foot and ankle after an injury or surgery) during transfers (moving from one place to another) and walking and not weightbearing (putting pressure or force through an arm or leg) through the left arm per physician's orders2. Not walking with a front-wheeled walker (FWW, mobility device with two wheels in the front used for support when standing or walking) per Physical Therapy (PT, profession aimed in the restoration, maintenance, and promotion of optimal physical function) and Occupational Therapy (OT, profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities) recommendations. This deficient practice placed Resident 51 at risk for fall and injury, worsening fractures, delayed healing, pain, and a decline in overall physical functioning. Findings: During a review of Resident 51's admission Record, the admission Record indicated Resident 51 was admitted to the facility on [DATE] with diagnoses including systemic involvement of connective tissue (group of disorders where the immune system attacks its own healthy tissues causing widespread inflammation and damage to skin, blood vessels, joints [where two bones meet], and organs), muscle weakness, and polyneuropathy (damage of the nerves that can cause weakness, numbness, and burning pain). During a review of Resident 51's History and Physical (H&P), dated 11/11/2025, the H&P indicated Resident 51 was transferred to the facility from a hospital on [DATE] for rehabilitation after being hit on the left side of the body while crossing the street on 11/3/2025. The H&P indicated Resident 51 sustained multiple fractures, which included a left humerus fracture, a left distal fibula fracture (break in the smaller of the two lower leg bones between the knee and the ankle), a left tibia dislocation (knee injury where the shin bone loses contact with the lower part of the thigh bone), and a left medial malleolus fracture (break in the bony bump on the inner side of the ankle). The H&P indicated Resident 51 had surgery to re-align Resident 51's left ankle dislocation on 11/3/2025 and had additional surgeries to repair the bone fractures of the left ankle and left humerus on 11/5/2025.During a review of Resident 51's Minimum Data Set (MDS, a resident assessment tool), dated 2/16/2026, the MDS indicated Resident 51 had severe cognitive (mental action or process of acquiring knowledge and understanding) impairment. The MDS indicated Resident 51 required set up/clean up assistance (helper sets up or cleans up) for eating, oral hygiene, and rolling to both sides, supervision or touching assistance (helper provides verbal cues and/or touching and/or contact guard assistance as resident completes the activity) for toileting hygiene, bathing, dressing, and personal hygiene and partial/moderate assistance (helper does less than half the effort) for putting on and taking off footwear. The MDS indicated Resident 51 had functional limitations in range of motion (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 and one leg.During a review of Resident 51's PT Evaluation and Plan of Treatment (PT Eval), dated 11/11/2025, the PT Eval indicated Resident 51's medical precautions included for Resident 51's left leg to be toe-touch weightbearing (TTWB, safety measure after surgery or fractures prescribed by the physician which allows a person to touch the toes of the injured leg on the ground for balance while walking) while wearing a CAM boot for four weeks. During a review of Resident 51's OT Evaluation and Plan of Treatment (OT Eval), dated 11/11/2025, the OT Eval indicated Resident 51's medical precautions included for Resident 51's left leg to be TTWB while wearing a CAM boot for four weeks and for Resident 51's left arm to be non-weightbearing (NWB, restriction in which a person is not allowed to put any weight through the operated body part) and positioned in a sling (flexible material used to support a person during a mechanical lift transfer) when Resident 51 was out of bed.During a review of Resident 51's (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Orthopedic Consultation note (Ortho Note), dated 12/17/2025, the Ortho Note indicated Resident 51's left arm was to be NWB and Resident 51's left leg was weightbearing as tolerated (WBAT, a person is medically cleared to place as much weight through the affected arm or leg to the point of comfort or tolerance) while wearing a CAM boot. The Ortho Note indicated Resident 51 to follow up with orthopedics on 1/28/2026 at 11 a.m. During a review of Resident 51's Order Summary Report, the Order Summary Report indicated a physician's order, dated 12/17/2025, to follow up with orthopedics on 1/28/2026 at 11 a.m.During a review of Resident 51's Order Summary Report, the Order Summary Report indicated a physician's order, dated 12/23/2025, for Resident 51 to continue with NWB precautions to the left arm.During a review of Resident 51's Order Summary Report, the Order Summary Report indicated a physician's order, dated 12/23/2025, for Resident 51's left leg to be WBAT while wearing a CAM boot.During a review of Resident 51's Progress Note, dated 1/21/2026, written and signed by Occupational Therapist 2 (OT 2), the Progress Note indicated staff informed OT 2 that Resident 51 was seen walking to the restroom without assistance and without wearing a CAM boot to the left leg. The Progress Note indicated OT 2 informed Resident 51 that he was unable to issue a FWW as she requested because Resident 51 refused to wear the physician ordered CAM boot during transfers and for walking to reduce the risk of re-injury to the left leg. The Progress Not indicated OT 2 instructed Resident 51 to use a bedside commode with assistance as safe alternative due to Resident 51's non-compliance with the CAM boot but Resident 51 refused. During a review of Resident 51's IDT Progress Note, dated 1/22/2026, the IDT Progress Note indicated an IDT meeting was held at Resident 51's bedside due to Resident 51's refusal to wear the left leg CAM boot when walking. The IDT Progress Note indicated Occupational Therapist 1 (OT 1) educated Resident 51 that a FWW would not be provided if Resident 51 did not wear the left leg CAM boot due to increased risk of re-injury to the left leg. The IDT Progress Note indicated an orthopedic follow up appointment was scheduled for 1/28/2026 at which time Resident 51 would discuss possibly discontinuing the left leg CAM boot with the physician. The IDT Progress Note indicated therapy services would work on transfers only, not walking, until further clarification from the orthopedics physician. During a review of Resident 51's OT Discharge summary, dated [DATE], the OT Discharge Summary indicated Resident 51 was discharged from OT services due to highest practical level achieved.During a review of Resident 51's PT Discharge summary, dated [DATE], the PT Discharge Summary indicated Resident 51 was discharged from OT services due to highest practical level achieved. During a concurrent observation and interview on 3/23/2026 at 1:26 p.m. with Resident 51 in Resident 51's room, Resident 51 was sitting at the edge of the bed wearing slippers on both feet. Resident 51 stated she broke her left shoulder and left ankle in November 2025 when she was hit by a car while crossing the street. Resident 51 minimally raised the left arm and stated she was unable to move the left arm well because it felt very heavy and her left hand felt numb. Resident 51 removed both slippers, moved both ankles up and down, and stated she needed a massage to the left leg because she had cramps (sudden, involuntary tightening of the muscle) and tightness in the calf muscle (lower part of the leg). Resident 51 stated she walked with a FWW in the room without the CAM boot and puts weight through her left arm. Resident 51 stated she refused the scheduled orthopedics appointment in January 2026 because she did not want to leave her husband (who was also a resident at the facility) unattended. Resident 51 stated was unsure what happened because staff never followed up with scheduling another orthopedics appointment and she had not heard anything regarding the status of her left arm and ankle for over two months. During a concurrent observation and interview on 3/25/2026 at 4:20 pm with Resident 51 in Resident 51's room, Resident 51 was wearing slippers on both feet and walking in the room using an FWW. Resident 51 was not wearing a CAM boot and was observed pushing through the left arm while walking with an FWW. Resident 51 stated she did not like to wear the CAM boot on her left leg while walking because it was too heavy and the material rubbed against her skin. Resident 51 stated she put weight through her left arm when walking with a FWW and when standing up because her injury was over four months ago and had not heard anything from staff (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	regarding any changes to her weightbearing restrictions. Resident 51 stated a staff member provided her with a FWW a long time ago to help her get to the bathroom, but she did not remember when or which staff member it was. During a concurrent interview and record review on 3/26/2026 at 10:35 a.m. with OT 2, OT 2 reviewed Resident 51's therapy notes and confirmed Resident 51 was evaluated by OT services on 11/11/2025 and discharged from OT services on 1/30/2026. OT 2 stated OT discharged Resident 51 from OT services because she reached her maximal functional level in mobility and activities of daily living (ADL, basic activities such as eating, dressing, and toileting) because of her orthopedic restrictions and refusal to wear the left leg CAM boot per physician's orders. OT 2 stated Resident 51 never used a walker during therapy because she was unsafe to do so due to Resident 51's refusal to wear the left leg CAM boot and inability or refusal to maintain the left arm NWB precautions per physician's orders. OT 2 reviewed Resident 51's Progress Note, dated 1/21/2026, and confirmed staff informed Resident 51 was observed walking unassisted with a FWW and without wearing the left leg CAM boot. OT 2 stated he did not recommend and/or issue Resident 51 a FWW due to safety concerns and risk of injury and recommended Resident 51 perform transfers only, no walking. OT 2 stated Resident 51 was unsafe to walk with a FWW and did not know how Resident 51 obtained an FWW. OT 2 stated if Resident 51 was walking with a FWW without a left leg CAM boot and weightbearing through the left arm, it could result in harm and injury. During a concurrent interview and record review on 3/26/2026 at 11:28 a.m. with Physical Therapist 1 (PT 1), PT 1 reviewed Resident 51's therapy notes and confirmed Resident 51 was evaluated by PT services on 11/11/2025 and discharged from OT services on 2/5/2026. PT 1 stated Resident 51 was discharged from PT services because she reached her maximal functional level in mobility because of her orthopedic restrictions and refusal to wear the left leg CAM boot per physician's orders. PT 1 stated the purpose of a CAM boot was to protect the operated leg by removing pressure or force off the joint when transferring or walking. PT 1 stated PT 1 did not issue Resident 51 a FWW because it was unsafe. PT 1 stated Resident 51 tried walking one to two times during therapy but stopped and could not continue due to safety concerns and Resident 51's continued non-compliance with physician's orders. PT 1 stated Resident 51 was unsafe walking with a FWW without a left leg CAM boot and weightbearing through the left arm because it was against physician's orders and had the potential to disrupt Resident 51's healing process. During a concurrent interview on 3/26/2026 at 3:23 p.m. with the Director of Nursing (DON), the DON stated PT and OT determined the level of assistance and type of device a resident needed to safely transfer and walk in the facility. The DOR stated it was important for residents to follow physician's orders and therapy recommendations to prevent injury and accidents. The DOR stated if Resident 51 was walking with a FWW that was not recommended by therapy without wearing a left leg CAM boot and weightbearing through the left arm against physician's orders, it could result in worsening of the fractures, harm, injury, and accidents. During a review of the facility's Policy and Procedures (P/P) titled, Safety of Residents, revised 1/2026, the P/P indicated resident safety and supervision and assistance to prevent accidents were facility-wide priorities. The P/P indicated the care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices.

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Ocean Ridge Post Acute	3850 E. Esther St. Long Beach, CA 90804

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure Restorative Nursing Aide 1 (RNA 1) was competent to provide active assistive range of motion (AAROM, use of muscles surrounding the joint to perform the exercise but required some help from a person or equipment) exercises to one of six sampled resident's (Resident 61) both legs in accordance with physician orders.This deficient practice resulted in an inefficient delivery of range of motion (ROM, full movement potential of a joint) services for Resident 61 and had the potential to result in ROM decline, contracture (loss of motion of a joint associated with stiffness and joint deformity) development, and an overall decline in physical functioning for residents receiving Restorative Nursing Aide (RNA, trained nursing staff who help residents gain an improved quality of life by increasing their level of strength and mobility) services. Findings:During a review of Resident 61's admission Record, the admission Record indicated Resident 61 was initially admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses including cerebral infarction (stroke, blockage of the flow of blood brain, causing or resulting in brain tissue death), muscle weakness, and contractures (loss of motion of a joint associated with stiffness and joint deformity) of the right shoulder, both hips, both knees, and both ankles.During a review of Resident 61's Minimum Data Set (MDS, a resident assessment tool), dated 1/15/2026, the MDS indicated Resident 61 had severely impaired cognition (mental action or process of acquiring knowledge and understanding). The MDS indicated Resident 61 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying assistance) for eating, substantial/maximal assistance (helper does more than half the effort) for oral hygiene, personal hygiene, upper body dressing, and rolling to both sides, and was dependent (helper does all the effort) in toileting hygiene, bathing, upper body dressing, and transfers. The MDS indicated Resident 61 had functional limitations in range of motion (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 and one leg.During a review of Resident 61's Order Summary Report, the Order Summary Report indicated a physician's order, dated 3/16/2026, for RNA to provide AAROM exercises to Resident 61's both legs, five times a week.During an observation on 3/24/2026 at 1:44 p.m. of Resident 61's RNA session, in Resident 61's room, Resident 61 was lying in bed. After assisting Resident 61 with right arm ROM exercises, RNA 1 demonstrated the exercises and asked Resident 61 to lift the left leg up and down and inwards and outwards away from the body, 15 times each direction. Resident 61 partially moved the left leg up and down and inwards and outwards towards the body but could not move through the full ROM in all directions. RNA did not assist Resident 61 in moving the left hip through the full ROM. RNA 1 held and supported Resident 61's upper portion of the leg and asked Resident 61 to bend and straighten the left knee, 15 times. Resident 61 was able to partially bend the knee downwards and upwards, but could not move through the full ROM. RNA 1 did not assist Resident 61 in moving the left leg through the full ROM. RNA 1 asked Resident 61 to move the left ankle and all toes of the left foot up and down. Resident 61 tried but was unable. RNA 1 did not assist Resident 61 with left ankle and left toe ROM exercises. RNA 1 moved to the right side of the bed and verbally asked Resident 61 to move the right leg up and down and inwards and outwards away from the body, 15 times in each direction. Resident 61 partially moved the left leg up and down and inwards and outwards towards the body, but could not move through the full ROM. RNA 1 did not assist Resident 61 in moving the right leg through the full ROM. RNA 1 held and supported Resident 61's upper portion of the leg and asked Resident 61 to bend and straighten the right knee and all the toes on the right foot, 15 times in each direction. Resident 61 was able to partially bend the knee downwards and upwards, but could not move through the full ROM. RNA 1 did not assist Resident 61 in moving the right knee through the full ROM. During a concurrent interview and record review on (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/24/2026 at 2:15 p.m. with RNA 1, RNA 1 reviewed Resident 61's physician's order, dated 3/16/2026, and confirmed Resident 61 had an RNA order for RNA to provide AAROM exercises to Resident 61's both legs. RNA 1 stated she did not know what AAROM exercises were and thought the order said AROM exercises which meant Resident 61 performed the ROM exercises on his own with only cueing or demonstration of the exercises and without physical assistance from RNA. RNA 1 stated Resident 61 was unable to fully move both legs independently but did not physically assist with ROM because she thought the order was for AROM and did not know what AAROM exercises were. RNA 1 stated if a resident could not move the arm or leg through the full ROM on his or her own and did not have the proper ROM assistance, it could result in joint stiffness. During a concurrent interview and record review on 3/24/2026 at 2:35 p.m. with the Director of Staff Development (DSD), the DSD stated the RNAs in the facility were Certified Nursing Assistants (CNA) with specialized training in RNA services. The DSD reviewed Resident 61's physician's order, dated 3/16/2026, and confirmed Resident 61 had an RNA order for RNA to provide AAROM exercises to Resident 61's both legs. The DSD stated AAROM meant the resident performed as much ROM as possible on his or her own and the RNA physically assisted the resident through the rest of the ROM. The DSD stated if RNA did not know what AAROM exercises were and did not assist the residents with the appropriate ROM exercises as ordered, it could result in joint stiffness, ROM decline, and contractures. During a concurrent interview and record review on 3/25/2026 at 1:27 p.m. with the Director of Rehabilitation (DOR), the DOR stated Rehab created the RNA programs based on a resident's needs. The DOR stated RNAs were to carry out RNA exercises as ordered. The DOR reviewed Resident 61's physician's orders, dated 3/16/2026, and confirmed Resident 61 had an RNA order for AAROM exercises to Resident 61's both legs. The DOR stated AAROM exercises were typically prescribed to residents who were unable to obtain full ROM on their own and needed the physical assistance of RNA or equipment to help move through the rest of the motion. The DOR stated it was important that RNAs were competent in the different types of ROM exercises as ordered to ensure they were appropriately addressing the resident's needs to prevent ROM decline and contracture development. During an interview on 3/26/2026 at 3:23 p.m. with the Director of Nursing (DON), the DON stated RNAs assisted residents in the facility with activities such as ROM exercises to ensure the residents maintained their current level of function and did not experience a functional decline after discharge from skilled therapy services (services that require specialized training and experience of a licensed therapist or therapy assistant). The DON stated RNAs must understand and demonstrate competency in the different types of range of motion exercises when providing RNA services to help prevent injuries, contracture development, and functional declines.During a review of the facility's Policy and Procedures (P/P), titled, Staffing, Sufficient and Competent Nursing, revised 1/2026, the P/P indicated the facility provided sufficient numbers of nursing staff with the appropriate skills and competency to provide nursing and related care and services for all residents in accordance with resident care plans and the facility assessment.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on interview and record review, the facility failed to complete the performance evaluations (a way to measure how well you are doing a specific job or assignment) at least once every 12 months for Certified Nurse Assistants (CNA) 1, 2 and Restorative Nursing Aide (RNA - nursing aide program that help residents maintain any progress made after therapy intervention to maintain their function) 1.This failure had the potential to result in the inability to identify staff-specific clinical weaknesses, creating potential for nurse aids to perform tasks incorrectly and not meeting residents' needs Findings:During a concurrent interview and record review on 3/25/2026 at 3:06 p.m., with the Director of Staff Development (DSD), CNA 1, 2, and RNA 1's Anniversary Performance Review (APR), for years of 2024 and 2025 were reviewed. The DSD stated performance evaluations were essential to assess staff performance, identify training needs, and communicate facility expectations to meet residents' care needs. The DSD stated the facility did not complete APR's for the following staff and years:a. CNA 1's date of hire (DOH) was 7/18/2023, and missing APR for 2024 and 2025.b. CNA 2's DOH was 1/8/2024, and missing APR for 2025.c. RNA 1's DOH was 3/13/2023, and missing APR for 2024 and 2025. During an interview on 3/26/2026 at 4:06 p.m., with the Director of Nursing (DON), the DON stated performance evaluations should be completed at least annually and as needed to ensure nurse aids are providing appropriate care, meeting expected performance, and identify strengths and areas for improvement.During a review of the facility's Policy and Procedure (P&P) titled, Performance Evaluation, revised January 2026, the P&P indicated a performance evaluation will be completed on each employee at the conclusion of his/her 90-day probationary period, and at least annually thereafter.

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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** Based on observation, interview, and record review, the facility failed to clarify physician orders for two of six sampled residents (Residents 15's and 32's) by failing to:1. Clarify frequency (number of times) for administration of Resident 15's artificial tears eye drops.2. Clarify frequency and ensure that there was no risk of duplicate therapy for Resident 32's multiple acetaminophen (a medication used to treat fever and pain) orders.These deficient practices had the potential to cause medication errors, inadequate treatment or excess dosage for Residents 15 and 32, and placed Resident 32 at risk for acetaminophen toxicity and liver damage. Findings:1. During a review of Resident 15's admission Record (a document containing demographic and diagnostic information), dated 3/23/2026, the admission record indicated the facility admitted Resident 15 on 3/5/2024 with diagnoses including Type 2 Diabetes Mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing) without complications and disorder involving the immune mechanism.During a review of Resident 15's Internal Medicine Note, dated 3/10/2026, the note indicated Resident 15 had capacity for medical decision making.During a review of Resident 15's Minimum Data Set (MDS - a resident assessment tool), dated 3/11/2026, the MDS indicated Resident 15's cognition (mental action or process of acquiring knowledge and understanding through thought and the senses) was moderately impaired. The MDS indicated Resident 15 needed supervision assistance from the facility staff for 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, moderate assistance for oral hygiene, upper body dressing and personal hygiene, and maximal assistance for toileting hygiene, showering, lower body dressing and putting on or taking off footwear. During a review of Resident 15's Care Plan, dated 1/13/2025, the care plan indicated, Focus: vision/eyes: resident is at risk for altered peripheral vision, altered experiences, seeing halos, flashes of lights, curtains over eyes, pain, and localized infection, diabetic retinopathy (serious, often asymptomatic, complication of diabetes caused by high blood sugar damaging blood vessels in the retina) due to diabetes, disease process. Goal: will be free from eye discomfort/pain. Interventions/Tasks: monitor eyes for irritation, redness or increased dryness and notify physician.During a review of Resident 15's medication reconciliation on 3/23/2026, Resident 15's Order Summary Report (a document containing a summary of all active physician orders), dated 3/23/2026, the order summary report indicated the following physician orders:Artificial Tears Ophthalmic Solution 0.2-0.2-1% (glycerin [viscous liquid used to provide moisture] - Hypromellose [a product used as a lubricant to treat dry eyes] - polyethylene glycol 400 [a product used as a lubricant to treat dry eyes]), instill 1 drop in both eyes as needed for dry eyes, order date 1/13/2026, start date 1/13/2026.During a review of Resident 15's Medication Administration Record (MAR, a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) dated 3/1/2026 to 3/23/2026, the MAR indicated artificial tears ophthalmic solution was administered one time on 3/16/2026.During a review of Resident 15's Order Summary Report, dated 3/23/2026, the order summary report indicated the artificial tears' physician order was modified to indicate a frequency as follows: Artificial Tears Ophthalmic Solution 0.2-0.2-1% (glycerin [viscous liquid used to provide moisture] - Hypromellose [a product used as a lubricant to treat dry eyes] - polyethylene glycol 400 [a product used as a lubricant to treat dry eyes]), instill 1 drop in both eyes every 4 hours as needed for dry eyes, order date 3/23/2026, start date 3/23/2026. During a concurrent interview and record review on 3/23/2026 at 3:07 p.m. with Licensed Vocational Nurse (LVN) 2, Resident 15's active physician orders were reviewed. The physician order for Resident 15's artificial tears eye drops did not indicate a frequency for as needed dosing for dry eyes. LVN 2 stated it was important to have the frequency of as needed dosing for Resident 15's artificial tears eye drops because while one nurse could interpret the order to (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	give the artificial tears eye drops two times a day, another nurse could interpret the same order to give it three times a day as needed. LVN 2 stated there was a risk that medication might not be administered properly. During an interview on 3/24/2026 at 1:52 p.m. with the Director of Nursing (DON), the DON stated the physician orders should include medication name, dosage, strength, frequency, time and any special instructions. The DON stated artificial tears eye drops should have had a frequency and not just as needed. DON stated if the instructions did not include how many times the artificial tears eye drops should be administered, there would be no guidance for the facility staff as to when to give the medication and patient could get it as many times as they requested. DON stated there was a risk for resident to be overmedicated with artificial tears.2. During a review of Resident 32's admission Record, dated 3/23/2026, the admission record indicated the facility admitted Resident 32 on 3/5/2026 with diagnoses including hepatomegaly (abnormal enlargement of the liver [an important organ in human body located in the upper right abdomen that performs over 500 essential functions, including filtering blood, detoxifying chemicals, metabolizing drugs, and producing bile for digestion], not elsewhere classified, uncomplicated alcohol dependence, fatty (change of) liver (a condition that occurs when excess fat [5%-10% or more of liver weight] builds up in liver cells, often linked to obesity, type 2 diabetes, and high cholesterol]) not elsewhere classified and muscle weakness.During a review of Resident 32's History and Physical (H&P) dated 3/8/2026, the H&P indicated Resident 32 did not have capacity for medical decision making due to chronic encephalopathy (a medical term for a disease or dysfunction altering brain function, often causing altered mental state, confusion, personality changes, and seizures [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness].During a review of Resident 32's MDS, dated [DATE], the MDS indicated Resident 32's cognition was moderately impaired. The MDS indicated Resident 32 needed setup or clean-up assistance from the facility staff for performing ADLs such as eating, oral hygiene and personal hygiene, and supervision or touching assistance for toileting hygiene, showering, upper body dressing, lower body dressing and putting on or taking off footwear.During a concurrent observation and interview on 3/23/2026 at 12:20 p.m. with LVN 3, LVN 3 prepared and administered the following three medications to Resident 32. LVN 3 stated Resident 32 requested Tylenol, generic name - acetaminophen (medication used for pain) for right side pain.a. Two tablets of acetaminophen 325 milligrams ([mg] a metric unit of measurement, used for medication dosage and/or amount)b. One capsule of gabapentin (a medication used to treat nerve pain and seizures) 300 mgc. One capsule of Zenpep (a medication used to treat exocrine pancreatic insufficiency [EPI - a condition where the pancreas does not produce enough enzymes to digest food]) 10000 unitsDuring a review of Resident 32's Order Summary Report, dated 3/23/2026, the order summary report indicated but not limited to the following physician orders:Acetaminophen Oral Tablet 500 mg, give 2 tablets by mouth as needed for moderate to severe pain 4-10, Non-Pharmacological Interventions (NPI) as follows: 1. Relaxation 2. Adjust room temp/lighting 3. Reposition 4. Toileting 5. Music/TV 6. Snacks 7. Warm/cold compress 8. Breathing exercise. Not to exceed 3-gram ([gm] a metric unit of measurement, used for medication dosage and/or amount) per 24 hours, to include all acetaminophen (APAP) products, give 2 tablets = 1000 mg, QD (daily), order date 3/5/2026, start date 3/5/2026. 2. Acetaminophen tablet 325 mg, give 2 tablets by mouth every 4 hours as needed for temperature greater than or equal to 100.3 F, *NTE 3 gm/24 hours *to include all APAP products, order date 3/6/2026, start date 3/6/2026. 3. Acetaminophen tablet 325 mg, give 2 tablets by mouth every 6 hours as needed for mild pain 1-3, NPI as follows: 1. Relaxation 2. Adjust room temp/lighting 3. Reposition 4. Toileting 5. Music/TV 6. Snacks 7. Warm/cold compress 8. Breathing exercise. *NTE 3 gm/24 hours, to include all APAP products, give 2 tablets = 650 mg, order date 3/6/2026, start date 3/6/2026. 4. Gabapentin oral capsule 300 mg, give 1 capsule by mouth three times a day for neuropathy, order date 3/5/2026, start date 3/5/2026. 5. Zenpep 10000-32000 unit capsule delayed release particles, give 1 capsule by mouth with meals for EPI, take with food, order date 3/5/2026, start date 3/6/2026.During a (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	concurrent interview and record review on 3/23/2026 at 2:53 p.m. with LVN 3, Resident 32's Order Details for acetaminophen 500 mg was reviewed. The order details dated 3/23/2026 indicated, Order Date: 3/5/2026 7:27 p.m., order summary: Acetaminophen Oral Tablet 500 mg, give 2 tablets by mouth as needed for moderate to severe pain 4-10, NPI as follows: 1. Relaxation 2. Adjust room temp/lighting 3. Reposition 4. Toileting 5. Music/TV 6. Snacks 7.Warm/cold compress 8. Breathing exercise. Not to exceed 3-gram ([gm] a metric unit of measurement, used for medication dosage and/or amount) per 24 hours, to include all acetaminophen (APAP) products, give 2 tablets = 1000 mg, QD (daily). LVN 3 stated Resident 32 complained of mild pain, so she (LVN 3) administered two tablets of acetaminophen 325 mg. LVN 3 stated the order for acetaminophen 500 mg did not clearly indicate a frequency which could increase the risk for acetaminophen overdose. LVN 3 stated the order indicated 2 tabs = 1000 mg, QD at the end of the order, but it was not clear if it was QD (daily) as needed or QD scheduled and first part of the order did not indicate a frequency for as needed dosing.During a review of Resident 32's MAR, dated 3/1/2026 to 3/23/2026, the MAR indicated two tablets each of separate orders of acetaminophen 325 mg and 500 mg which were documented as administered to Resident 32 on the following dates and times:1a. Acetaminophen 500 mg, 2 tablets by mouth as needed for moderate to severe pain 4-10, administered on 3/12/2026 at 5:12 p.m.1b. Acetaminophen 325 mg, 2 tablets by mouth every 6 hours as needed for mild pain 1-3, administered on 3/12/2026 at 8:30 p.m.2a. Acetaminophen 500 mg, 2 tablets by mouth as needed for moderate to severe pain 4-10, administered on 3/13/2026 at 3:08 p.m.2b. Acetaminophen 325 mg, 2 tablets by mouth every 6 hours as needed for mild pain 1-3, administered on 3/13/2026 at 8:30 p.m.3a. Acetaminophen 325 mg, 2 tablets by mouth every 6 hours as needed for mild pain 1-3, administered on 3/23/2026 at 12:24 p.m. 3b. Acetaminophen 500 mg, 2 tablets by mouth every 24 hours as needed for moderate to severe pain 4-10, administered on 3/23/2026 at 4:39 p.m.During an interview on 3/24/2026 at 1:44 p.m. with the DON, the DON stated she (DON) corrected the order for Resident 32's acetaminophen 500 mg on 3/23/2026 so that it indicated instructions with frequency of every 24 hours as needed. DON stated she saw Resident 32's medical diagnoses and medical history of fatty liver disease and alcohol dependance. DON stated Resident 32 would be at risk for liver toxicity if acetaminophen was not administered appropriately.During a review of the facility's policy and procedure (P&P) titled, Medication Orders, dated 2001, the P&P indicated, The purpose of this procedure is to establish uniform guidelines in the receiving and recording of medication orders. The P&P indicated, 1. Medication Orders - When recording orders for medication, specify the type, route, dosage, frequency and strength of the medication ordered. A placebo. orders. The P&P indicated, PRN (as needed) Medication Orders - When recording PRN medication orders, specify the type, route, dosage, frequency, strength and the reason for administration. Example: Tylenol 500 mg by mouth 4 hours as needed for mild pain or temp greater than 101-degree Fahrenheit [(F) is a unit of temperature].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. The P&P indicated, Medications are administered in accordance with prescriber orders, including any required time frame.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure proper labeling of medications in one of two inspected medication carts (Station 2 Medication Cart 2) according to manufacturer's specifications and ensure clean medication storage in one of one inspected medication room (Station 1 Medication Room) by failing to: 1. Ensure Resident 52's Lantus Solostar ([generic name - insulin glargine] a type of insulin [a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) pen in Station 2 Medication Cart 2 was labeled with an open date in accordance with manufacturer's specifications.2. Ensure Resident 42's Lantus Solostar pen was labeled with an open date and expired Humalog Kwikpen ([generic name - insulin lispro] a type of insulin [a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) labeled with an open date of [DATE] was removed from Station 2 Medication Cart 2 in accordance with manufacturer's specifications. 3. Remove three contaminated vitamin C liquid bottles from medication storage in Station 1 Medication Room.These deficient practices placed Residents 42, 52 and other facility residents at risk of receiving medications that had become expired, ineffective or toxic due to improper labeling and/or storage and had the potential to cause adverse health effects such as hypoglycemia (low blood glucose level), hyperglycemia (high blood glucose level) and hospitalization.Findings:1. During a review of Resident 52's admission Record (a document containing demographic and diagnostic information), dated [DATE], the admission record indicated the facility admitted Resident 52 on [DATE] with diagnosis that included but not limited to cerebral infarction (a type of ischemic stroke caused by a blockage in brain blood vessels, resulting in a lack of oxygen and brain cell death) due to unspecified occlusion (blockage of blood vessels) or stenosis of unspecified cerebral artery (narrowing of artery inside the brain).During a review of Resident 52's History and Physical (H&P) dated [DATE], the H&P indicated Resident 52 could make medical decisions. The H&P indicated Resident 52 had diagnosis of Type 2 Diabetes Mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing).During a concurrent inspection and interview on [DATE] at 3:17 p.m. with Licensed Vocational Nurse (LVN) 1 of Station 2 Medication Cart 2, the following medication was not labeled with an open date as required by manufacturer's specifications:a. One Lantus Solostar 100 units (a unit of measurement for dose) per milliliters ([mL] a unit of measurement for volume) prefilled pen for Resident 52 with no open date.According to the manufacturer's product labeling, unopened / not in-use Lantus Solostar pen if stored at room temperature below 86-degree Fahrenheit [(F) is a unit of temperature]) [30-degree Celsius [(C) is a unit of temperature]) and opened / in-use Lantus Solostar pen must be used within 28 days. During a review of Resident 52's Order Summary Report (a document containing a summary of all active physician orders), dated [DATE], the order summary report indicated but not limited to the following physician orders: Lantus Solostar 100 units/mL solution pen-injector, inject 16 units subcutaneously (under the skin) one time a day for DM 2, order date [DATE], start date [DATE].2. During a review of Resident 42's admission Record, dated [DATE], the admission record indicated the facility admitted Resident 42 on [DATE] with diagnosis that included but not limited to Type 2 Diabetes Mellitus with hyperglycemia.During a review of Resident 42's H&P, dated [DATE], the H&P indicated Resident 42 could make own medical decisions.During a concurrent inspection and interview on [DATE] at 3:17 p.m. with LVN 1 of Station 2 Medication Cart 2, the following medications for Resident 42 were not labeled with an open date and/or not removed from storage after being expired, as required by manufacturer's specifications:a. One Lantus Solostar 100 units/mL prefilled pen for Resident 42 with no open date.According to the manufacturer's product labeling, unopened / not in-use Lantus Solostar pen if stored at room (continued on next page)

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	056378	A. Building B. Wing	03/26/2026

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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	temperature below 86 F (30 C) and opened / in-use Lantus Solostar pen must be used within 28 days. b. One Humalog Kwikpen prefilled pen for Resident 42 with an open date of [DATE]. The Humalog Kwikpen expired on [DATE].According to the manufacturer's product labeling, once opened / in-use or once stored at room temperature, below 86 F (30 C), insulin lispro pen must be used within 28 days or be discarded. LVN 1 stated the expired insulin for Resident 42 should have been removed from medication cart. LVN 1 stated the insulins for Resident 42 and 52 should have had an open date to determine their (insulin's) expiration date. LVN 1 stated if the residents received an expired medication or insulin, the residents could become sick and if the insulin did not work properly, the residents could become hypo or hyper glycemic.During a review of Resident 42's Order Summary Report, dated [DATE], the order summary report indicated but not limited to the following physician orders:a. Humalog KwikPen 100 units/mL solution pen-injector, inject as per sliding scale: If 70-149 = 0, if blood sugar below 70 and able to swallow give 8 ounce ([oz] a unit of measurement for volume) of orange juice, follow hypoglycemia protocol; 150-199 = 1; 200-249 = 2; 250-299 = 3; 300-349 = 5; 350-399 = 6 if blood sugar >399 milligrams ([mg] metric unit of measurement, used for medication dosage and/or amount) per deciliter ([dL] a unit of measurement for volume) = 7 units and call Medical Doctor (MD), subcutaneously before meals and at bedtime for DM, order date [DATE], start date [DATE].b. Lantus SoloStar 100 units/mL solution pen-injector, inject 10 units subcutaneously one time a day for DM, administer after dinner, hold if blood sugar (BS) <100, order date [DATE], start date [DATE].During an interview on [DATE] at 1:57 p.m. with the Director of Nursing (DON), the DON stated facility nurses should have stored the insulin in the refrigerator when they (insulins) were not open or not in use, and once they (insulins) were opened and/or removed from the refrigerator, the facility nurses should have labeled them with an open date. The DON stated if an insulin did not have an open date and was not stored in refrigerator, then there was a risk that the insulin could have passed its beyond-use date and the facility nurses would not be able track its (insulin's) expiration date. DON stated there would be a risk that insulin could be administered beyond expiration date and pose a risk of not managing blood sugar well and could potentially place residents at risk for hyperglycemia or hypoglycemia.3. During a concurrent inspection and interview on [DATE] at 3:58 p.m. with the Assistant Director of Nursing (ADON) of Station 1 Medication Room, there were three bottles of vitamin C that were leaking, looked contaminated and/or deteriorated with brown colored spillage on and around the bottles on medicine cabinet's shelf. a. Three bottles of vitamin C labeled with sealed clear plastic around their lids.The ADON stated although the vitamin C bottles were not expired, they (vitamin C bottles) did not look good to be administered.During an interview on [DATE] at 1:57 p.m. with the DON, the DON stated the vitamin C bottles looked dirty and they could have been contaminated. The DON stated there was a risk of contamination and would not be safe to administer to facility's residents. The DON stated it was important to replace them (vitamin C bottles) with clean stock and the shelf area needed to be cleaned so that the other medications would not be contaminated.During a review of facility's policy and procedure (P&P) titled, Medication Labeling and Storage, dated 2001, the P&P indicated, The facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls. The P&P indicated, The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. If the facility has discontinued, outdated or deteriorated medications or biologicals.returning or destroying these items. The P&P indicated, Multi-dose vials that have been opened or accessed (e.g., needle punctured) are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial. The P&P indicated, Labeling of medications and biologicals. consistent with applicable federal and state requirements and currently accepted pharmaceutical practices.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to replace partial dentures and follow through with a dental visit as requested by the resident and Responsible Party (RP) for one of seven sampled residents (Resident 19).This failure had the potential to result in Resident 19 having discomfort and pain while chewing foods that could lead to unintended weight loss and lower self-esteem.Findings:During a review of Resident 19's admission record, the admission record indicated Resident 19 was admitted to the facility on [DATE] with diagnoses including cerebral infarction (the blood supply to part of the brain is blocked or reduced), dementia (a progressive state of decline in mental abilities), and dysphagia (difficulty swallowing).During a review of Resident 19's History and Physical (H&P), dated 11/11/2025, the H&P indicated, Resident 19 had no capacity (ability) to understand and make decisions.During a review of Resident 19's MDS, dated [DATE], the MDS indicated Resident 19 required maximal assistance (Helper does more than half the effort) from one staff for toileting hygiene, shower, dressing, personal hygiene, transfer, moderate assistance (Helper does less than half the effort) from one staff for bed mobility, and supervision or touching assistance (Helper provide verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) from one staff for oral hygiene and eating.During a concurrent observation and interview on 3/23/2026, at 10:59 a.m., with Resident 19 in his room, Resident 19 was watching television in bed and missing upper front teeth were observed during the interview. Resident 19 stated, he lost his partial denture while he was in a General Acute Care Hospital (GACH) prior to admission to this facility. Resident 19 stated, RP and he told the nursing staff, but no one helped him. Resident 19 stated, it was painful to chew hard food items like chopped chicken or diced unripe melon.During a concurrent interview and record review on 3/25/2026, at 10:27 a.m., with Registered Nurse Supervisor (RNS) 1, Resident 19's Inventory of Personal Items, dated on 11/10/2025 was reviewed. The Inventory of Personal Items indicated, Resident 19 had no personal belongings. RNS 1 stated, she was not aware of Resident 19's missing partial denture during hospitalization and broken upper front teeth. RNS 1 stated, the staff should have notified the Social Service Director (SSD) to get a replacement. RNS 1 stated, if the resident did not have proper fitted dentures or broken teeth, the resident might have discomfort or pain that could lead to unintended weight loss.During a concurrent interview and record review on 3/25/2026, at 1:04 p.m., with the SSD, Resident 19's Dental Progress Note (DPN), dated 1/9/2026 was reviewed. The DPN indicated, Resident 19 had broken teeth, but Resident 19 refused to extract (remove or pull out) the broken teeth. The SSD stated, she did not know that Resident 19 lost his partial upper front denture prior to admission. The SSD stated, she should have followed through with Resident 19 regarding the reason for refusal after last dental visit on 1/9/2026. The SSD stated, having proper fitting dentures and treatment of broken teeth were important because this could lead to weight loss due to discomfort and low self-esteem.During an interview on 3/25/2026, at 1:10 p.m., with Resident 19 and RP at the bedside, Resident 19 stated, he misunderstood when the dentist mentioned extractions. Resident 19 stated, he thought he would pull out all his upper teeth and that was why he refused treatment. Resident 19 stated, he just needed to have partial denture, not full denture. Resident 19's RP stated, Resident 19 and she asked the nursing staff regarding denture replacement but no response so far. Resident 19's RP stated, Resident 19 did not want to show his missing teeth and did not smile anymore among other people and complained about dental pain while eating hard food.During an interview on 3/26/2026, at 2:46 p.m., with the Director of Nursing (DON), the DON stated, the SSD should have followed up with the dental office to get a partial denture replacement immediately. The DON stated, the nursing staff should have communicated with the SSD regarding the missing denture and refusal of treatment. The DON stated, providing denture in timely manner was important because it could affect the ability to eat, and it could lead to social isolation.During a review of Resident 19's Speech Therapy (diagnoses (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and corrects communication, language, cognitive, voice, and swallowing disorders) Treatment Encounter Note, dated 1/12/2026, the Speech Therapy Treatment Encounter Note indicated, Resident 19 demonstrated stable swallow performance with mildly prolonged bolus breakdown due to his dental status and continue with soft and bite-size food diet.During a review of Resident 19's Order Summary Report (OSR), date 3/25/2026, the OSR indicated, provide fortified (foods that have extra nutrients) and no added salt diet with thin liquid and soft/bite sized texture was ordered on 11/14/2025. The OSR indicated, consult with dental for oral hygiene with follow up and treatment as indicated was ordered on 11/10/2025.During a review of Resident 19's Care Plan (CP), dated from 11/10/2025 to 3/25/2026, the CP indicated, there was no CP for dental issues such as broken teeth or missing partial denture.During a review of the facility's Policy and Procedure (P&P) titled, Dental Services, revised 1/2026, the P&P indicated, Policy Statement: Routine and emergency dental services are available to meet the resident's oral health services in accordance with the resident's assessment and plan of care. Policy Interpretation and Implementation: 1. Routine and 24-hour emergency dental services are provided to our residents through: a contract agreement with a licensed dentist that comes to the facility monthly . 6. Social services representatives will assist residents with appointments . 10. If dentures are damaged or lost, residents will be referred for dental services within 3 days. If the referral is not made within 3 days, documentation will be provided regarding what is being done to ensure that the resident is able to eat and drink adequately while awaiting the dental services; and the reason for the delay.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure two of three sampled residents (Resident 46 and 91) understood the Arbitration Agreement ([AA]-a written contract where you agree to settle disputes out of court with a private, neutral person instead of judge or jury) prior to obtaining their signature.This failure had the potential to affect residents' rights, as residents may sign legally binding agreements without fully understating the terms, including the waiver of the right to pursue claims in a court of law.Findings:a. During a review of Resident 46's admission Record, the admission Record indicated the facility admitted Resident 46 on 3/18/2026 with diagnoses including end stage renal disease (permanent state of kidney failure where kidneys work at less than 10% capacity, failing to filter waste and extra fluid from the blood), heart failure (a chronic condition where the heart is too weak or stiff to pump blood efficiently) and arterial fibrillation (an irregular heartbeat).During a review of Resident 46's History and Physical (H&P), dated 3/20/2026, the H&P indicated, Resident 46 had the ability to understand and make decisions.\During a review of Resident 46's Minimum Data Set (MDS- a resident assessment tool), dated 3/25/2026, The MDS indicated Resident 46's cognitive (functions your brain uses to think, pay attention, process information, and remember things) was moderately impaired.During a review of Resident 46's Arbitration Agreement dated 3/18/2026, the AA indicated Resident 46 signed the agreement.During an interview on 3/25/2026 at 11:54 a.m. with Resident 46, Resident 46 stated he did not know what arbitration was. b. During a review of Resident 91's admission Record, the admission Record indicated the facility admitted Resident 91 on 12/4/2025, and readmitted on [DATE] with normal pressure hydrocephalus (a brain condition where a special fluid builds up inside the brain), respiratory disorders (medical conditions that affect the lungs and airways) and immunodeficiency (a condition where the body's immune system is weakened). During a review of Resident 91's H&P dated 12/5/2025, the H&P indicated whether Resident 91 had the ability to understand and make decisions. During a review of Resident 91's MDS dated [DATE], The MDS indicated Resident 91's cognitive was moderately impaired.During a review of Resident 91's Arbitration Agreement dated 12/7/2025, the AA indicated Resident 91 signed the agreement.During an interview on 3/25/2026 at 11:52 a.m. with Resident 91, Resident 91 stated, the resident did not know what arbitration was. During a concurrent interview and record review on 3/25/2026 at 12:15 p.m. with the admission Coordinator (AC), Resident 46's AA, dated 3/18/2026 and 91's AA, dated 12/7/2025 were reviewed. The AC stated she asked Resident 46 and 91 if they understood the arbitration agreement, upon their response to yes, proceeded with signing without verifying their understanding. The AC stated arbitration affects residents' rights, including waving the right to go to court. During an interview on 3/26/2026 at 2:23 p.m. with the Director of Nursing (DON), the DON stated arbitration is a way to resolve disputes outside of court and singing the agreement gives up the right to proceed in court. The DON stated it is important to ensure the residents or family understand what arbitration means and what the agreement involves before signing, and staff should verify understanding more thoroughly than by asking yes-or no questions. During a review of the facility's Policy & Procedure (P&P) titled Binding Arbitration Agreements, dated November 2023, the P&P indicated after the terms and conditions of the agreement are explained, the resident or representative must acknowledge that he or she understands the agreement before being asked to sign the document:a. A signature alone is not sufficient acknowledgement of understanding.b. The resident (or representative) must verbally acknowledge understanding, and the verbal acknowledgement documented by the staff member who explains the agreement.