STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555027	A. Building B. Wing	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beachside Nursing Center	7781 Garfield Avenue Huntington Beach, CA 92648

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure the medical record was complete and accurately maintained for two of 15 final sampled residents (Residents 1 and 33) and two of three residents (Residents 78 and 90) reviewed for closed records. * The facility failed to document in the medical record all the observations, assessments, vital signs, interventions, and change in condition, when Resident 78 expired in the facility. In addition, the facility failed to document the names and titles of the facility staff who conducted these observations and assessments and performed the interventions. * The facility failed to ensure the physician's orders for the route of medication administration for Resident 1 were accurate. The medication route was ordered for oral administration instead of via GT. * The facility failed to ensure Resident 33's wound treatment and monitoring was documented according to the facility's policy. * The facility failed to ensure resident's IDT Care Plan Review was complete and accurate according to the facility's policy. Additionally, the facility failed to ensure Resident 90's vital signs at the time of discharge were documented in the resident's medical record according to the facility's policy. These failures had the potential for the residents' care needs not being met as the medical record was incomplete.Review of the facility's P&P titled Charting and Documentation revised 4/2008 showed all services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record. All observations, medications administered, and services performed must be documented in the resident's clinical records. All incidents, accidents, or changes in the resident's condition must be recorded. Documentation of procedures and treatments shall include care-specific details and shall include at a minimum: the date and time the procedure/treatment was provided; the name and title of the individual who provided the care; the assessment data and/or any unusual findings obtained during the procedure/treatment; how the resident tolerated the procedure/treatment; whether the resident refused the procedure/treatment; notification of the family and physician; and the signature and title of the individual documenting. 1. Closed medical record review for Resident 78 was initiated on [DATE]. Resident 78 was admitted to the facility on [DATE], and expired at the facility on [DATE]. Review of Resident 78's POLST dated [DATE], showed not to attempt resuscitation (if Resident 78 found pulseless and not breathing). Review of Resident 78's progress note dated [DATE] at 0637 hours, showed Resident 78 was pronounced deceased at 0630 hours. Resident 78's death was confirmed by two licensed nurses. The resident's family and administration were notified. Review of Resident 78's progress noted dated [DATE] at 0928 hours, showed Resident 78 expired on (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

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[DATE] at 0630 hours, the resident's code status was DNR, the medical doctor pronounced the death, family was notified, and postmortem care was completed. However, further review of Resident 78's medical record failed to show documentation specific to the events surrounding Resident 78's death. Resident 78's medical record failed to show documentation specific to all observations conducted, assessments conducted, vital signs obtained, interventions performed, and changes in condition. Additionally, the medical record failed to show documentation of the names and titles of the facility staff who conducted observations and assessments and performed interventions. On [DATE] at 0930 hours, a telephone interview was conducted with LVN 6. LVN 6 verified she was assigned to care for Resident 78 at the time of her death on [DATE]. LVN 6 stated she observed Resident 78 alive and at her baseline physical and mental status, on the morning of [DATE] at approximately 0500 hours. LVN 6 stated after she completed her morning medication administration (sometime before 0700 hours), the CNA assigned to care for Resident 73 informed LVN 6 that Resident 78 was observed unresponsive and was not moving. LVN 6 stated she then entered Resident 78's room and performed an assessment of Resident 78. LVN 6 stated she checked Resident 78's carotid artery for a pulse but stated she could not feel Resident 78's carotid pulse. LVN 6 stated she did not observe Resident 78 breathing, as evidenced by a lack of chest rise and fall. LVN 6 stated she attempted to obtain Resident 78's oxygen saturation, however, she was unable to obtain a reading. LVN 6 stated Resident 78 had a DNR order, therefore, she did not perform CPR. LVN 6 verified all observations, assessments, vital signs, interventions, changes in condition, and the names and titles of the facility staff who conducted observations, conducted assessments, and performed interventions, should have been documented in Resident 78's medical record. On [DATE] at 0951 hours, an interview and concurrent closed medical record review was conducted with the DON. The DON verified the findings and stated all observations, assessments, vital signs, interventions, changes in condition, and the names and titles of the facility staff who conducted observations, conducted assessments, and performed interventions, surrounding Resident 78's death, should have been documented in Resident 78's medical record, to ensure an accurate and complete account of Resident 78's condition. 2. Review of the facility's P&P titled Medication Administration (undated) showed medications are administered in accordance with the written orders of the attending physician. Medical record review for Resident 1 was initiated on [DATE]. Resident 1 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 1's H&P examination dated [DATE], showed Resident 1 had a GT and medical diagnosis of dysphagia (difficulty swallowing). Review of Resident 1's Order Summary Report, showed the following physician's orders: - dated [DATE], a diet order of NPO (nothing by mouth), - dated [DATE], to administer famotidine (medication that helps reduce stomach acid) 40 mg one tablet by mouth one time a day for supplement, - dated [DATE], to administer ferrous sulfate (supplement) 325 mg one tablet by mouth one time a day for supplement, and- dated [DATE], to administer acetaminophen (pain reliever) 500 mg tablet by mouth every eight hours for pain, not to exceed 3 grams in 24 hours. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 1's MAR for February 2026 showed Resident 1 was administered the following medications and signed for by the licensed nurse as administered via oral route: - on [DATE] at 0900 hours and from 2/19 to [DATE] at 0600 hours, Resident 1 was administered with the famotidine and ferrous sulfate medications; and - on [DATE] at 1400 and 2200 hours, [DATE] at 0600 and 2200 hours, and [DATE] at 0600 hours, Resident 1 was administered with the acetaminophen medication. On [DATE] at 1423 hours, an interview and concurrent medical record review for Resident 1 was conducted with LVN 5. LVN 5 stated Resident 1 was NPO and received all her medications via GT. LVN 5 verified the above findings. LVN 5 stated the ordered route for the above medications should be change to accurately reflect the care that the resident was receiving, which was to receive the medications via GT. On [DATE] at 1029 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings for Resident 1. 3. Medical record review for Resident 33 was initiated on [DATE]. Resident 33 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 33's H&P examination dated [DATE], showed the resident had no capacity to understand and make decisions. Review of Resident 33's Order Summary Report dated [DATE], showed the following physician's orders: - dated [DATE], to monitor low air loss mattress function and placement according to weight and comfort every shift; and - dated [DATE], to apply antifungal cream 2% to perineal for skin management every shift. Review of Resident 33's TAR showed the following: - a wound treatment ordered on [DATE], to apply antifungal cream 2 % to the perineal for skin management every shift was blank with no licensed nurse initial to indicate if the wound treatment was completed or any code why the wound treatment was not completed on the PM shift (1500 to 2300 hours) on the following dates: [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. - a monitoring ordered on [DATE], to monitor low air loss mattress function and placement according to weight and comfort every shift was blank with no licensed nurse initial to indicate if monitoring was completed or any code to indicate why the monitoring was not completed on the PM shift on the following dates: [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. On [DATE] at 0857 hours, an interview and concurrent medical record review for Resident 33 was conducted with LVN 8. LVN 8 verified the above findings. On [DATE] at 0952 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Resident 90's pulse was 94 beats per minute on [DATE] at 0035 hours; and - Resident 90's respiration was 17 breaths per minute on [DATE] at 0253 hours. Review of Resident 90's MAR for 1/1 – [DATE] showed the following: - Resident 90's blood pressure was 122/80 mmHg on [DATE] at 0900 hours; and - Resident 90's pulse was 94 beats per minute on [DATE] at 0900 hours. Review of Resident 90's Discharge Summary and Post-Discharge Plan of Care dated [DATE], showed the resident's pain level was zero on [DATE] at 2304 hours. Review of Resident 90's Discharge Note dated [DATE] at 1521 hours, showed the resident was discharged with a family member with stable vital signs. However, further review of Resident 90's medical record failed to show a measurement of the resident's vital signs prior discharge, to indicate resident's medical status measurement at the time of discharge. On [DATE] at 1338 hours, an interview and concurrent closed medical record review for Resident 90 was conducted with RN 1. RN 1 verified Resident 90's vital signs measurements from the Weights and Vital Signs Summary, and Resident 90's MAR for 1/1 – [DATE] as listed above. RN 1 stated Resident 90's vital signs should have been obtained at the time of the resident's discharge, to assess if the resident was stable. On [DATE] at 0919 hours, an interview was conducted with the DON. The DON stated the expectation was for the licensed nurses to obtain the resident's vital sign measurements just prior to the time of the resident's discharge. On [DATE] at 1005 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the findings as above.