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	04/30/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to maintain the infection control practices to help prevent the development and transmission of diseases and infections. * The facility failed to ensure an EBP signage and PPE cart were available by Resident 3's entrance door. * The facility failed to ensure the EBP was followed for Resident 3 when LVN 1 and CNA 1 failed to wear a gown during wound care. These failures posed the risk of not preventing the spread of infection in the facility and posed the risk of unsanitary environment.Findings: Review of the facility's P&P titled Infection Prevention - Employee Exposure (undated) showed EBP may be implemented but not limited to:- Residents with the presence of indwelling devices (e.g., urinary catheter, feeding tubes,endotracheal or tracheostomy tube, vascular catheters);- Residents with the presence of chronic wounds;- Residents with functional disability and total dependence on others for assistance with ADL is also recognized as a risk factor for MDRO transmission and may be considered for residents who do not have an indwelling device or wounds; Under the Implementation of EBP for High-Risk Residents section showed wear gowns and gloves while performing the following, high-contact tasks associated with the greatest risk for MDRO contamination of HCP hands, clothes, and the environment: any care activity where close contact with the resident is expected to occur such as bathing, peri-care, assisting with toileting, changing incontinence briefs, respiratory care. a. Medical record review for Resident 3 was initiated on 4/29/26. Resident 3 was admitted to the facility on [DATE]. Review of Resident 3's MDS assessment dated [DATE], showed the resident was cognitively intact. Review of Resident 3's Wound Assessment Report dated 4/9/26, showed Resident 3 had a Stage 3 pressure injury to the sacrococcyx, extending to the bilateral buttocks. On 4/9/26 at 1035 hours, an observation and concurrent interview was conducted with LVN 1. LVN 1 verified there was no EBP signage and PPE cart by Resident 3's entrance door. LVN 1 acknowledged Resident 3 had a Stage 3 pressure injury to the sacrococcyx. LVN 1 stated there was no EBP signage because Resident 3 had no chronic wound or catheter. LVN 1 stated the admission nurse was responsible for placing the EBP signage by the entrance door. On 4/30/26 at 1357 hours, an interview was conducted with the DSD/IP. The DSD/IP was made aware and acknowledged the above findings. The DSD/IP stated there should have been an EBP signage and PPE cart by Resident 3's entrance door. The DSD/IP stated there should be an EBP signage so the staff would know they needed to put the gown and gloves before entering the room. b. Review of Resident 3's Order Summary Report dated 4/29/26, showed a physician's order dated 4/9/26, for Venelex external ointment (promote healing of skin ulcers and wounds), apply to sacrococcyx extended to right and left buttocks topically every day for the Stage 3 pressure injury, cleanse with normal saline, pat dry cover with foam and dry dressing. On 4/29/26 at 1039 hours, an observation of Resident 3's wound care was conducted with LVN 1 and CNA 1. LVN 1 was observed not wearing a gown during Resident 3's wound care. In addition, CNA 1 was also observed not wearing a gown while assisting LVN 1 during Resident 3's wound care. On 4/29/26 at 1051 hours, an interview was conducted with LVN 1. LVN 1 acknowledged she was not wearing a gown during Resident 3's wound care. LVN 1 stated Resident 3 had no chronic wound or catheter. LVN 1 stated the gown was only needed if the resident had chronic (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wound. When LVN 1 was asked what chronic wound meant, LVN 1 stated a wound that was non healing or getting worse. On 4/29/26 at 1207 hours, an interview was conducted with CNA 1. CNA 1 stated she used a gown when there was an EBP signage and PPE cart by the resident's entrance door. CNA 1 verified she did not wear a gown during Resident 3's wound care. CNA 1 stated she did not use a gown because there was no EBP signage and PPE cart by Resident 3's entrance door. On 4/30/26 at 1418 hours, an interview was conducted with the DSD/IP. The DSD/IP was made aware and acknowledged the above findings. The DSD/IP stated the CNA and LVN should have put on the gown during Resident 3's wound care. The DSD/IP stated the facility staff needed to put on the gown for potential transmission of body fluids. On 4/30/26 at 1630 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.