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	06/10/2026

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 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 interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services to one of three sampled residents (Resident 2). * The facility failed to ensure appropriate notifications were made, an assessment was completed, a care plan was developed, and the resident's unusual behavior was monitored and documented in response to Resident 2's involvement in an allegation of abuse. This failure had the potential to result in ineffective provision of care and negative outcomes for the resident. Findings: Review of the facility's P&P titled Acute Condition Changes - Clinical Protocol dated October 2010 showed the nursing staff will contact the physician based on the urgency of the situations. The nursing staff will make pertinent observations and collect appropriate information to report to the physician. The nursing staff and physician will discuss possible causes based on the resident history, current symptoms, medication regimes, and existing test results. The staff will monitor and document the resident progress and responses to the treatment with a recent acute change in condition until the problem or condition has resolved. Review of the Intake Information Report for the facility reported incident dated 6/2/26, showed the potential victim, Resident 1, reported she was poked with a walking stick by Resident 2. Resident 2 stated she thought it was someone else and was doing it playfully. On 6/10/26 at 0930 hours, an interview was conducted with Resident 2. When Resident 2 was asked about the incident, Resident 2 stated she did not want to talk about this small incident and did not want to keep hearing about it repeatedly. Medical record review for Resident 2 was initiated on 6/10/26. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's MDS dated [DATE], showed Resident 2 had a BIMS score of 10, indicating moderately impaired decision-making skills. Review of Resident 2's medical record failed to show documented evidence a change of condition assessment was initiated, the appropriate notifications were made, a care plan was developed, or if monitoring and documentation of Resident 2's behavior were completed in response to the allegation of abuse. On 6/10/26 at 1520 hours, an interview and concurrent medical record review for Resident 2 was conducted with RN 1. RN 1 stated when an allegation of abuse was received, the staff would ensure the resident was safe, notify the facility's abuse coordinator immediately, and initiate an investigation. RN 1 stated the staff would initiate a change of condition process, including completing an assessment of the resident and notifying the physician and resident's representative. RN 1 stated a care plan should be developed and ongoing monitoring performed. When RN 1 was asked about the alleged resident perpetrator (Resident 2), RN 1 stated for the alleged perpetrator, the staff would also assess the resident, notify the physician and resident representative. After reviewing Resident 2's medical record, RN 1 verified and acknowledged there was no documented change of condition, no care plan was developed and no monitoring of Resident 2's behavior related to the allegation of abuse. On 6/10/26 at 1630 hours, an interview and concurrent medical record review for Resident 2 was conducted with the DON. The DON was informed and verified the above findings.

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