Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055364	A. Building B. Wing	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Long Beach Healthcare Center	3401 Cedar Avenue Long Beach, CA 90807

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45425 Based on interview, and record review, the facility failed to create a care plan for one of three sampled residents (Resident 1) when Resident 1 refused care and treatment to his left buttock stage 2 (outer layer of skin (epidermis) or the deeper layer of skin (dermis) is damaged) pressure injury (injury to the skin and soft tissue that occur when an area of skin is under prolonged pressure), right hip stage 2 pressure injury and bilateral foot diabetic ulcers (open wound caused by poor circulation, nerve damage or infection). This deficient practice had the potential for Resident 1's left buttock stage 2 pressure injury, right hip stage 2 pressure injury and bilateral foot diabetic ulcers to increase in size and delay healing. Findings: During a review of Resident 1's Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with type two diabetes ([DM] high blood sugar) with skin ulcers (open wound) and unstageable pressure ulcers of the sacral region (portion of the spine between your lower back and tailbone), right hip, and left buttock. During a review of Resident 1's Minimum Data Set ([MDS] a standardized assessment and care screening tool) dated 7/17/2024, the MDS indicated Resident 1's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was moderately impaired. During a review of Resident 1's Physician's Order dated 8/2/2024, the Physician's Orders indicated the following: 1. Cleanse Resident 1's left buttock stage 2 pressure injury with normal saline ([n/s] a mixture of sodium chloride [salt] and water, often used to clean wounds) pat dry, apply barrier cream and cover with waterproof adhesive foam dressing every three days or as needed. 2. Cleanse Resident 1's left foot multiple areas of diabetic ulcers with n/s, pat dry, apply gauze soaked with betadine (solution used to prevent skin infections) and cover with bordered gauze and change daily. (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: 055364	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/13/2024
NAME OF PROVIDER OR SUPPLIER Long Beach Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3401 Cedar Avenue Long Beach, CA 90807	

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Cleanse Resident 1's left heel diabetic ulcer with n/s, pat dry, apply gauze soaked with betadine and cover with bordered gauze and change daily. 4. Cleanse Resident 1's right foot diabetic ulcers with n/s, pat dry, apply gauze soaked with betadine and cover with bordered gauze and change daily. 5. Cleanse Resident 1's right hip stage 2 pressure injury with n/s, pat dry, apply barrier cream and cover with waterproof adhesive foam dressing every three days or as needed. During a review of Resident 1's Weekly Wound Note dated 7/16/2024, the Wound Note indicated Resident 1 had a behavior of refusing wound treatments despite explanation of risk and benefits. During an interview on 8/13/2024 at 12:07 p.m., and a subsequent interview at 3:32 p.m., Licensed Vocational Nurse 1 (LVN 1) stated Resident 1 was non-complaint with his wound treatments. LVN 1 stated she could not find a care plan that addressed Resident 1's non-compliance with his wound treatments and a care should have been created with interventions that might encourage Resident 1 to allow staff to treat his left buttock stage 2 pressure injury and left foot diabetic ulcers. During an interview on 8/13/2024 at 3:41 p.m., the Director of Nursing (DON) stated when a resident refuses care, a care plan should be created, and the physician should be notified. The DON stated the care plan provides communication to the rest of the interdisciplinary ([IDT] a group of dedicated healthcare professionals who work together to provide care) team so they can devise interventions that address residents' care needs. During a review of the facility's policy and procedure (P/P), titled, Care Plans, Comprehensive Person Centered dated 3/2022, the P/P indicated the IDT should review and update the care plan when there has been a significant change in the resident's condition.

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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 0684

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide appropriate treatment and care according to orders, resident’s preferences and goals.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 45425

Based on observation, interview, and record review, the facility failed to ensure one of two sampled residents (Resident 2) physician's orders to change Resident 2's nasal cannula and to clean Resident 2's right ischium (lower and back region of the hip bone) pressure injury (an area of skin is under pressure for a long time, causing the skin and underlying tissue to break down) and Stage IV (deep wound that may impact muscle, tendons, ligaments, and bone) sacral coccyx (tail bone) pressure injury with normal saline ([n/s] a mixture of sodium chloride [salt] and water, often used to clean wounds) was followed.

These deficient practices resulted in the physician's orders to change Resident 2's nasal cannula and Resident 2's wound treatment not being followed, placing Resident 2 at risk of acquiring an infection from exposure to bacteria and germs, and delay healing for Resident 2's right ischium and sacral coccyx wounds.

Findings:

During a review of Resident 2's Admission Record (Face Sheet), the Face Sheet indicated Resident 2 was admitted to the facility on [DATE]. Resident 2 had diagnoses including a right ischium pressure injury, and a Stage IV sacral coccyx pressure injury.

During a review of Resident 2's Minimum Data Set ([MDS] a standardized assessment and screening tool) dated 7/23/2024, the MDS indicated Resident 2's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was severely impaired.

a. During a review of Resident 2's Physician's Order dated 8/9/2024, the Physician's Order indicated to change Resident 2's oxygen tubing on Sunday during the night shift every week and as needed.

During an observation on 8/13/2024 at 12:17 p.m. in Resident 2's room, Resident 2's nasal cannula was observed without a date.

During an interview on 8/13/2024 at 12:17 p.m., Licensed Vocational Nurse 1 (LVN 1) stated Resident 2's nasal cannula tubing should have a date when it was last changed and if there was no date, there was no way to know when the nasal cannula was last changed. LVN 1 stated Resident 2 could be exposed to bacteria growth in the cannula if it was not changed.

During a review of the facility's policy and procedure (P/P) titled Oxygen dated 2/29/2024, the (P/P) indicated oxygen tubing and mask/cannula should be changed weekly.

b. During a review of Resident 2's Physician's Order dated 8/10/2024, the Physician's Order indicated to:

1. Clean Resident 2's right ischium pressure injury with n/s solution during the day shift, daily.

2. Clean Resident 2's Stage IV sacral coccyx pressure injury with n/s solution during the day shift, daily.

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F 0684

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

During an observation of Resident 2's wound treatment on 8/13/2024 at 12:17 p.m., with LVN 1, LVN 1 used wound cleanser spray (a rinsing solution used to remove foreign materials on a wound surface and its surrounding skin) to cleanse Resident 2's right ischium and sacral coccyx pressure injuries.

During an interview on 8/13/2024 at 12:17 p.m., LVN 1 stated the physician's orders indicated to cleanse Resident 2's wounds with n/s but n/s solution was not available, and the wound cleanser spray was be used instead.

During an interview on 8/13/2024 at 1:49 p.m., the Director of Nursing (DON stated n/s should be used if ordered by the physician because it could affect the wound due to the components of the wound cleanser. The DON stated the nasal cannula should be dated when a new cannula is opened and if the nasal cannula was not changed as ordered, residents could be at risk of inhaling germs which could travel to their respiratory system.

During a review of the facility's P/P titled Wound Care dated 10/2010, the P/P indicated the physician's order should be verified as part of the preparation set in wound care.

During an observation of Resident 2's wound treatment on 8/13/2024 at 12:17 p.m., with LVN 1, LVN 1 used wound cleanser spray (a rinsing solution used to remove foreign materials on a wound surface and its surrounding skin) to cleanse Resident 2's right ischium and sacral coccyx pressure injuries.

During an interview on 8/13/2024 at 12:17 p.m., LVN 1 stated the physician's orders indicated to cleanse Resident 2's wounds with n/s but n/s solution was not available, and the wound cleanser spray was be used instead.

During an interview on 8/13/2024 at 1:49 p.m., the Director of Nursing (DON stated n/s should be used if ordered by the physician because it could affect the wound due to the components of the wound cleanser. The DON stated the nasal cannula should be dated when a new cannula is opened and if the nasal cannula was not changed as ordered, residents could be at risk of inhaling germs which could travel to their respiratory system.

During a review of the facility's P/P titled Wound Care dated 10/2010, the P/P indicated the physician's order should be verified as part of the preparation set in wound care.