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	10/04/2024

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** 44958 Based on observation, interview and record review, the facility failed to develop and implement a care plan addressing specific interventions for one of three sampled residents (Resident 3) who frequently removes her nasal cannula (small plastic tube, which fits into the person ' s nostrils for providing supplemental oxygen). These deficient practices resulted in Resident 3 not receiving oxygen as ordered and staff not being aware of specific interventions to provide to Resident 3. Findings: During a review of Resident 3's Admission Record (Face Sheet) the Face Sheet indicated Resident 2 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including sepsis (a life-threatening blood infection), heart failure (serious condition that occurs when the heart can't pump enough blood to meet the body's needs) and dementia (a progressive state of decline in mental abilities). During a review of Resident 3's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 7/9/2024, the MDS indicated Resident 3 did not have the ability to think, learn, remember, use judgement, and make decisions. During a review of Resident 3's Order Summary Report (physician ' s orders), dated 7/1/2024, the physician orders indicated administer continuous oxygen at two liters per minute via nasal cannula to keep oxygen saturations (O2 sat- a measurement of how much oxygen the blood is carrying as a percentage) above 93%. During a review of Resident 3's Clinical Record (Care Plan section), initiated 6/3/2024, the Care Plan indicated Resident 3 required oxygen therapy related to desaturation (low oxygen level in the blood). The Care Plan goal indicated Resident 3 will have no signs and symptoms of poor oxygen absorption for three months with a target date of 10/1/2024. The Care Plan interventions included: monitor Resident 3 for signs and symptoms of respiratory distress and report the following to the medical doctor as needed: respirations (breathing), pulse oximetry (measurement of oxygen in blood), increased heart rate, restlessness, diaphoresis, headaches, lethargy , confusion, atelectasis (collapse of lung), hemoptysis (blood in mucus) , cough, pleuritic (pain when breathing) pain, increased work of breathing , and skin color. (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
	055364	A. Building B. Wing	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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	During a concurrent observation and interview on 10/4/2024 at 10:57 a.m., with Certified Nurse Assistant 1 (CNA 1) in Resident 3 ' s room, Resident 3 was observed lying in bed with the nasal cannula laying on top the blanket and not in Resident 3 ' s nares. The nasal cannula was observed connected to the oxygen machine which was delivering 2 liters of oxygen through the nasal cannula. CNA 1 stated Resident 3 must have removed her oxygen tube from her nose because it was observed laying on her stomach and not in her nose where it should be. CNA 1 was observed placing the nasal cannula in Resident 3 ' s nostrils, Resident 3 was observed pulling off the nasal cannula from out of her nostrils. CNA 1 stated, Resident 3 always pulls of her cannula. I can tell the Licensed Vocational Nurse (LVN)1 but she already knows, this always happens. During an interview on 10/4/2024, at 11:10 a.m., LVN 1 stated Resident 3 consistently removes her nasal cannula from her nose. LVN 1 stated Resident 3 should have a care plan to address interventions staff should take ensure Resident 3 is monitored and unlicensed staff know what to do when they find Resident 3 without her nasal cannula. LVN 1 stated CNA 1 should not have placed the nasal cannula in Resident 3 ' s nares but instead should have alerted a licensed nurse for Resident 3 to be properly assessed for a decreased oxygen level. During an interview on 10/4/2024, at 3:30 p.m., the Director of Nursing (DON) stated Resident 3 did not have a care plan addressing her frequent behavior of removing her nasal cannula. The DON stated a care plan would direct staff to know what roles and interventions they can provide to the resident when it happens. The DON stated, CNA 1 should have immediately notified a licensed nurse that Resident 3 removed her nasal cannula. The DON stated a CNA must notified a licensed nurse once Resident 3 was found without a nasal cannula so a nurse could assess the resident and ensure no other interventions were needed. The DON stated, a care plan addressing Resident 3 ' s behavior would ensure Resident 3 received the appropriate care and services. The DON stated failure to develop a specific and comprehensive resident centered care plan placed Resident 3 at risk for desaturation and delay in services. During a review of the facility ' s policy and procedure, (P&P) titled, Care Plans, Comprehensive Person-Centered revised 3/2022, the P&P indicated 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. The P&P indicated a comprehensive, person-centered care plan describes the services that are to be furnished to attain or maintain the resident ' s highest practicable physical, mental, and psychosocial wellbeing including which professional services are responsible for each element of care. The P&P indicated, when possible, interventions address the underlying source of the problem areas not just symptoms or triggers are addressed, and assessments of residents are ongoing and care plans are revised as information about the residents and residents ' condition change.