

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 12/16/2024
NAME OF PROVIDER OR SUPPLIER Long Beach Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44958</p> <p>Based on interview and record review the facility failed to ensure one of three sampled residents (Resident 1's) was treated with respect and in a dignified manner, when the Social Services Director (SSD) tugged at and eventually took Resident 1's sweater and a bottle of medication ([Norco] medication used to treat moderate to severe pain) from her without her permission and after Resident 1 refused to give the SSD the bottle of medication.</p> <p>This deficient practice resulted in Resident 1's complaint of pain to her left and right shoulders, Resident 1 being afraid of the SSD and not wanting to interact with her anymore. This deficient practice had the potential for long term injury and pain and for care and services to be unprovided to Resident 1 due to fear of interacting with the SSD.</p> <p>Findings:</p> <p>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 diagnoses including bipolar disorder (a serious mental illness that affects how a person thinks, feels, and behaves), atrioventricular block ([AV block] a heart rhythm disorder that causes the heart to beat slower than it should) and type 2 diabetes ([DM] a disease that occurs when blood glucose, also called blood sugar [b/s], is too high).</p> <p>During a review of Resident 1's History and Physical (H/P), dated 10/18/2024, the H/P indicated, Resident 1 had the capacity to understand and make decisions.</p> <p>During a review of Resident 1's Minimum Data Set [(MDS), a resident assessment tool] dated 10/24/2024, the MDS indicated Resident 1 was able to understand and be understood by others. The MDS indicated Resident 1 's cognition (ability to register and recall information) was intact.</p> <p>During a review of Resident 1's Situation, Background, Assessment and Recommendation ([SBAR] a form of communication between members of a health care team, dated 10/18/2024 the SBAR indicated Resident 1 was hiding narcotics (strong medication used to treat pain) in her sweater, the narcotics were taken away by the SSD.</p> <p>(continued on next page)</p>

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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1's Nurse Progress Notes dated 10/18/2024 and timed at 2:08 p.m., the Nurse Progress Notes indicated Resident 1 retrieved a bottle out of her sweater and self-administered one pill from the bottle and returned the bottle to the pocket of her sweater. The Nurse Progress Notes indicated Resident 1 refused to give the medication bottle to the Licensed Vocational Nurse (LVN) 1, LVN 1 called the Social Services Director (SSD) for assistance and the SSD took the medication bottle away from Resident 1.</p> <p>During a review of Resident 1's Nurse Progress Note dated 10/25/2024 and timed at 6:35 p.m., the Nurse Progress Notes indicated the Interdisciplinary Team ([IDT] a group of medical professionals from different disciplines who work together to help a resident achieve their goals) met at Resident 1's bedside to address the resident's concern regarding her right and left shoulder pain, which she reported occurred following an incident on Friday (10/18/2024) when her jacket was tugged by another staff member (SSD).</p> <p>During a telephone interview on 12/16/2024 at 11:10 a.m., Resident 1's Responsible Party (RP) 1 stated Resident 1 informed her that on 10/18/2024, she (Resident 1) was holding onto her (Resident 1's) sweater when the SSD pulled the sweater away from her (Resident 1's) grasp with the intent to take Resident 1's Norco medication bottle from her (Resident 1). RP 1 stated Resident 1 did give permission for the SSD to take her sweater or medication and trying to take the medication by tugging on Resident 1's sweater caused Resident 1 pain in both of her shoulders. RP 1 stated she reported the incident to the Director of Nurses (DON) on approximately 10/21/2024 but stated she did not receive a follow up to her report. RP 1 stated Resident 1 did not feel safe with the SSD and did not want to interact with her anymore.</p> <p>During an interview on 12/16/2024 at 12:18 p.m., LVN 1 stated on 10/18/2024 she saw Resident 1 take a bottle labeled Norco from her sweater pocket, take a pill and put it back in her sweater pocket. LVN 1 stated she asked Resident 1 to give her the medication bottle but Resident 1 refused to give it to her. LVN 1 stated she asked the SSD for assistance, and we (LVN 1 and the SSD) informed Resident 1 that she could not self-administer the Norco. LVN 1 stated Resident 1 was holding onto her sweater and refused to relinquish the bottle of medication, that was when the SSD took the sweater from Resident 1. LVN 1 stated she did not report the incident because she did not think it was abuse but stated taking Resident 1's sweater from her without her permission was a violation of Resident 1's rights.</p> <p>During an interview on 12/16/2024 at 1:15 p.m., the SSD stated she was called into Resident 1's room on 10/18/2024 by LVN 1 because LVN 1 found Resident 1 had medication (Norco) in a medication bottle in her (Resident 1's) sweater pocket. The SSD stated she asked Resident 1 to give her the medication bottle, but she (Resident 1) refused. The SSD stated we (the SSD and LVN 1) educated Resident 1 on the risks of self-administering Norco and informed Resident 1 it was against the facility's policy to keep narcotics on her person, but Resident 1 still refused to give them the medication so she took the sweater from Resident 1 in order to get the medication bottle from inside Resident 1's sweater pocket.</p> <p>During an interview on 12/16/2024 at 3 p.m., the DON stated she was notified of the incident that occurred between the SSD and Resident 1 on approximately 10/25/2024. The DON stated the facility did not report the incident because neither she nor the Administrator (ADM) thought the incident was abuse. The DON stated the facility should have reported the incident because Resident 1 complained of shoulder pain following the incident and because Resident 1 did not feel safe around the SSD.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's Policy and Procedure (P/P), titled, Self-Administration of Medications revised 12/2016, the P/P indicated residents have the right to self-administer medications if the IDT team has determined that it is clinically appropriate and safe for the resident to do so. As part of their overall evaluation, the staff and practitioner will assess each residents' mental and physical abilities to determine whether self-administering medications is clinically appropriate for the resident.</p> <p>During a review of the facility's P&P titled Resident Rights, dated 12/2021, the P&P indicated the facility employees will treat all residents with kindness, respect, and dignity.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44958</p> <p>Based on interview and record review, the facility failed to report an alleged physical altercation between the Social Services Director (SSD) and one of three sampled residents (Resident 1) to the California Department of Public Health (CDPH) within two hours of them being made aware of the allegation. On 10/18/2024 at approximately 8:30 a.m., Licensed Vocational Nurse (LVN) 1 witnessed the SSD tug Resident 1's sweater, eventually taking it from her (Resident 1) without Resident 1's permission. On 10/18/2024 Resident 1's Responsible Party (RP) 1, reported that LVN 1 had taken Resident 1's sweater from her by tugging on it, causing Resident 1 pain to both of her shoulders and Resident 1 being afraid of the SSD. On 10/25/2024, Resident 1 complained of left and right shoulder on alleging the pain resulted from the SSD pulling/tugging and taking the sweater from her (Resident 1).</p> <p>This deficient practice resulted in the CDPH being unaware of the allegation of abuse and potential injury to Resident 1, causing a delay in the CDPH's investigation. This deficient practice had the potential for other abuse allegations to go unreported.</p> <p>Findings:</p> <p>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 diagnoses including bipolar disorder (a serious mental illness that affects how a person thinks, feels, and behaves), Atrioventricular Block ([AV block] a heart rhythm disorder that causes the heart to beat slower than it should) and diabetes type 2 ([DM] a disease that occurs when blood glucose, also called blood sugar [b/s], is too high).</p> <p>During a review of Resident 1's History and Physical (H/P), dated 10/18/2024, the H/P indicated, Resident 1 had the capacity to understand and make decisions.</p> <p>During a review of Resident 1's Minimum Data Set [(MDS), a resident assessment tool, dated 10/24/2024, the MDS indicated Resident 1 was able to understand and be understood by others. The MDS indicated Resident 1's cognition (ability to register and recall information) was intact. The MDS indicated Resident 1 had functional limitations in range of motion ([ROM] the direction a joint can move to its full potential on one side of her lower extremities ([LE] legs).</p> <p>During a review of Resident 1's Situation, Background, Assessment and Recommendation ([SBAR] a form of communication between members of a health care team) dated 10/18/2024 the SBAR indicated Resident 1 was hiding narcotics (strong medication used to treat pain) in her sweater, the narcotics were taken away from Resident 1 by the SSD.</p> <p>During a review of Resident 1's Nurse Progress Notes dated 10/18/2024 and timed at 2:08 p.m., the Nurse Progress Notes indicated Resident 1 retrieved a bottle out of her sweater and self-administered one pill from the bottle then returned the bottle to the pocket of her sweater. The Nurse Progress Notes indicated Resident 1 refused to give the medication bottle to the Licensed Vocational Nurse (LVN) 1, LVN 1 called the Social Services Director (SSD) for assistance and the SSD took the medication bottle away from Resident 1.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1's Nurse Progress Note dated 10/25/2024 and timed at 6:35 p.m., the Nurse Progress Notes indicated the Interdisciplinary Team ([IDT] a group of medical professionals from different disciplines who work together to help a resident achieve their goals) met at Resident 1's bedside to address the resident's concern regarding her right and left shoulder pain, which she (Resident 1) reported occurred following an incident on Friday (10/18/2024) when her jacket was tugged by another staff member (SSD).</p> <p>During a telephone interview on 12/16/2024 at 11:10 a.m., Resident 1's Responsible Party (RP) 1 stated Resident 1 informed her that on 10/18/2024, she (Resident 1) was holding onto her sweater when the SSD pulled the sweater away from her (Resident 1's) with the intent to take Resident 1's Norco medication bottle from her (Resident 1). RP 1 stated Resident 1 did not give permission for the SSD to take away her medication and trying to take the medication by tugging on Resident 1's sweater caused Resident 1 pain in both of her shoulders. RP 1 stated she reported the incident to the Director of Nurses (DON) on approximately 10/21/2024 but stated she did not receive a follow up to her report. RP 1 stated Resident 1 does feel safe with the SSD and does not want to interact with her anymore.</p> <p>During an interview on 12/16/2024 at 12:18 p.m., LVN 1 stated on 10/18/2024 she saw Resident 1 take a bottle labeled Norco from her sweater pocket, take a pill and put it back in her sweater pocket. LVN 1 stated she asked Resident 1 to give her the medication bottle but Resident 1 refused to give it to her. LVN 1 stated she asked the SSD for assistance, and we (LVN 1 and the SSD) informed Resident 1 that she could not self-administer the Norco. LVN 1 stated Resident 1 was holding onto her sweater and refused to relinquish the bottle of medication, that was when the SSD took the sweater from Resident 1. LVN 1 stated she did not report the incident because she did not think it was abuse but stated taking Resident 1's sweater from her without her permission was a violation of Resident 1's rights.</p> <p>During an interview on 12/16/2024 at 1:15 p.m., the SSD stated she was called into Resident 1's room on 10/18/2024 by LVN 1 because LVN 1 found Resident 1 had medication (Norco) in a medication bottle in her (Resident 1's) sweater pocket. The SSD stated she asked Resident 1 to give her the medication bottle, but Resident 1 refused. The SSD stated we (the SSD and LVN 1) educated Resident 1 on the risks of self-administering Norco and informed Resident 1 it was against the facility's policy to keep narcotics on her person, but Resident 1 still refused to give them the medication so she (SSD) took the sweater from Resident 1 in order to get the medication bottle from inside her sweater pocket.</p> <p>During an interview on 12/16/2024 at 3 p.m., the DON stated she was notified of the incident that occurred between the SSD and Resident 1 on approximately 10/25/2024. The DON stated the facility did not report the incident because neither she nor the Administrator (ADM) thought the incident was abuse. The DON stated the facility should have reported the incident because Resident 1 complained of shoulder pain following the incident and because Resident 1 did not feel safe around the SSD.</p> <p>During a review of the facility's Job Description titled, Director of Nursing dated 9/2020 , the Job Description indicated the DON reports the following in accordance with established facility procedures and regulatory standards, accidents and incidents, resident grievances, complaints, and allegations of resident abuse or misappropriation of resident property.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's policy and procedure (P/P), titled, Abuse, Neglect, Exploitation and Misappropriation Prevention dated 12/2007, the P/P indicated the facility will implement measures to address factors that may lead to abusive situations such as investigate and report any allegations within timeframes required by federal requirements.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44958</p> <p>Based on interview and record review, the facility failed to conduct a timely and thorough investigation for one of three sampled residents (Resident 1) when the Social Services Director (SSD) removed Resident 1's sweater from Resident 1's grasp against Resident 1's consent on 10/18/2024. Resident 1 complained of left and right shoulder on 10/25/2024 alleging the pain resulted from the SSD removing the sweater from her grasp.</p> <p>This deficient practice had the potential to result in unidentified abuse affecting Resident 1.</p> <p>Findings:</p> <p>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 diagnoses including bipolar disorder (a serious mental illness that affects how a person thinks, feels, and behaves), Atrioventricular Block ([AV block] a heart rhythm disorder that causes the heart to beat slower than it should) and diabetes type 2 ([DM] a disease that occurs when blood glucose, also called blood sugar [b/s], is too high).</p> <p>During a review of Resident 1's History and Physical (H/P), dated 10/18/2024, the H/P indicated, Resident had the capacity to understand and make decisions.</p> <p>During a review of Resident 1's Minimum Data Set [(MDS), a resident assessment tool) dated 10/24/2024, the MDS indicated Resident 1 was able to understand and be understood by others. The MDS indicated Resident 1's cognition (ability to register and recall information) was intact.</p> <p>During a review of Resident 1's Situation, Background, Assessment and Recommendation ([SBAR] a form of communication between members of a health care team dated 10/18/2024 the SBAR indicated Resident 1 was hiding narcotics (strong medication used to treat pain) in her sweater, the narcotics were taken away by the SSD.</p> <p>During a review of Resident 1's Nurse Progress Notes dated 10/18/2024 and timed at 2:08 p.m., the Nurse Progress Notes indicated Resident 1 retrieved a bottle out of her sweater pocket and self-administered one pill from the bottle and returned the bottle to the pocket of her sweater. The Nurse Progress Notes indicated Resident 1 refused to give the medication bottle to the Licensed Vocational Nurse (LVN) 1, LVN 1 called the SSD for assistance and the SSD took the medication bottle away from Resident 1.</p> <p>During a review of Resident 1's Nurse Progress Notes dated 10/25/2024 and timed at 6:35 p.m., the Nurse Progress Notes indicated the Interdisciplinary Team ([IDT] a group of medical professionals from different disciplines who work together to help a resident achieve their goals) met at Resident 1's bedside to address Resident 1's concern regarding her right and left shoulder pain, which she (Resident 1) reported occurred following an incident on Friday (10/18/2024) when her (Resident 1's) jacket was tugged by another staff member (SSD).</p> <p>(continued on next page)</p>		

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