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	01/24/2025

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49889 Based on interview, and record review the facility failed to protect the residents right to be free from physical abuse for one of two sampled residents (Resident 1). The facility failed to: 1. Ensure Certified Nursing Assistant (CNA) 1 did not leave the room when on [DATE] Resident 1 and Resident 2 had verbal argument to prevent physical altercation (punched Resident 1 in the head 10 times) between both residents. 2. Ensure facility investigated CNA 2's grievance dated [DATE] about witnessing Resident 1 being upset towards Resident 2 and had an argument. The facility to develop preventative measure to safeguard both residents from possible physical altercation. 3. Develop a comprehensive care plan for Resident 1's aggressive behavior and Resident 2's room dominating behavior (wants the room to himself and tries to impose his own rules) with intervention to prevent physical altercation between the residents. 4. Ensure Social Service staff and/or Social Service Director (SSD) conducted three-day follow up visits after Resident 2 was cohorted with Resident 1 in one room on [DATE] to evaluate their compatibility as roommates. These failures resulted in Resident 1 being assaulted by Resident 2 on [DATE]. Resident 2 punched Resident 1 in the head 10 times with his fists. As a result, Resident 1 sustained 4.0 centimeter ([cm] unit of measurement) by 2.0 cm elevated blue and green discoloration to the left side of the forehead. On [DATE] Resident 1 was transferred to a General Acute Care Hospital (GACH) for evaluation of seizure (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness) like activity where the resident was diagnosed to have a subdural hematoma (brain bleed), and herniation of the brain (medical emergency where part of the brain tissue moves or protrudes through a rigid structure in the skull) and Resident 1 expired on [DATE] at 08:06 a.m. Findings: (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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1 ' s Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE] and readmitted [DATE] with diagnoses including seizures, presence of a ventriculoperitoneal (connection between the brain's ventricles and the peritoneal [space in the abdomen] cavity [space]) shunt ([VP]) a device that allows drainage of excess cerebrospinal fluid ([CSF](relating to the brain and spine), history of other mental and behavioral disorders, peripheral neuropathy (disease causing numbness or weakness in the hands and feet) and essential hypertension (high blood pressure). During a review of Resident 1's History and Physical (H&P), dated [DATE], the H&P indicated Resident 1 did have the capacity to understand and make decisions. During a review of Resident 1 ' s Minimum Data Set ([MDS]- resident assessment tool) dated [DATE], the MDS indicated Resident 1 was cognitively (ability to think, understand, learn, and remember) intact and needed substantial assistance (helper does more than half the work) with activities of daily living ([ADL's] - activities such as bathing, dressing, and toileting a person performs daily). The MDS also indicated Resident 1 was not able to walk. During a review of Resident 1's Change of Condition (COC), dated [DATE], and timed at 6:53 p.m., the COC form indicated Resident 1 was involved in a resident-to-resident altercation. The COC indicated Resident 1 reported being struck by Resident 2. The COC indicated Resident 1 was observed with a bump (an elevated area on the skin) measured 4.0 cm by 2.0 cm with blue and green discoloration to the left side of Resident 1's forehead. During a review of Resident 1's Psychosocial/Social Services Note dated [DATE] and timed at 11:48 a.m., the Psychosocial/Social Services Note indicated that Resident 1 stated that Resident 1 and Resident 2 did not like each other. The Psychosocial/Social Services Note indicated Resident 1 could not remember the reason for Resident 1 and Resident 2's argument, and by the time Resident 1 realized there was Resident 2 in front of him, Resident 2 started hitting Resident 1 in the face 10 times. The Psychosocial/Social Services Note indicated Resident 1 used his hand to protect his face. During a review of Resident 1's Psychosocial/Social Service Note dated [DATE] and timed at 12:19 p.m., the Psychosocial/Social Service Note indicated Resident 1 complained of a headache. During a review of Resident 1's Nurses Progress Notes dated [DATE] and timed at 7:57 p.m., the Nurses Progress Notes indicated Resident 1 left side forehead had a purplish skin discoloration measured 3.0 cm by 2.0 cm with slight swelling. On [DATE] Resident 1 was transferred to a General Acute Care Hospital (GACH) for evaluation of seizure like activity where the resident was diagnosed to have a subdural hematoma, and herniation of the brain. During a review of GACH's Computed Tomography Scan (CT scan- imaging test used to detect internal injuries) dated [DATE], indicated Resident 1 had a large right hemispheric (half of the brain) hyperacute (unusually severe) /acute (sudden) subdural hematoma with brain herniation. During a review of GACH's Admission Record dated [DATE] the GACH's Admission Record indicated Resident 1 expired on [DATE] at 08:06 a.m. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 2 ' s Admission Record, the Admission Record indicated Resident 2 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including chronic obstructive pulmonary disease ([COPD]-a chronic lung disease causing difficulty in breathing), type 2 diabetes mellitus ([DM]-a disorder characterized by difficulty in blood sugar control and poor wound healing), and heart failure (heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen). During a review of Resident 2's H&P, dated [DATE], the H&P indicated, Resident 2 had the capacity to understand and make decisions. During a review of Resident 2's Psychosocial/Social Services Note dated [DATE], the Psychosocial/Social Services Note indicated that Resident 2 room was changed due to roommate (Resident 4) incompatibility. During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2 had moderate cognitive impairment. The MDS also indicated, Resident 2 needed set up or clean up assistance (helper sets up and cleans up) with ADL's. During a review of Resident 2's COC form, dated [DATE] and timed at 7:07 p.m., the COC indicated Resident 2 was involved in a resident-to-resident altercation resulting in Resident 1 being struck by Resident 2. The COC indicated Resident 2's physician was informed with recommendations including to monitor Resident 2 for aggressive behavior, emotional distress and psychiatric (mental and behavior) evaluation. During a review of CNA 1's Statement dated [DATE], The CNA 1's Statement indicated CNA 1 was present in the room during the incident (verbal altercation) involving Resident 1 and Resident 2. The CNA 1's Statement indicated Resident 2 verbalized I am done Mamas. Resident 1 began saying inappropriate words (unknown). CNA 1 left Resident 1 and Resident 2's room. During a review of Resident 2's Psychosocial/Social Services Note dated [DATE], the Psychosocial/Social Services Note indicated that Resident 2 stated that Resident 1 was talking bad about him and laughing. The Psychosocial/Social Services Note indicated Resident 2 did not remember what was said, he just felt like he needed to do something to Resident 1, so he went to his bed side and thinks he hit Resident 1 on his face three times. The Psychosocial/Social Services Note indicated Resident 2 stated he does not get along with Resident 1. During an interview with Resident 1 on [DATE] at 4:00 p.m., Resident 1 stated that he and Resident 2 have not been getting along well, and the staff was aware of the situation. Resident 1 stated that Resident 2 insists he turns off his television and lights by 8 p.m. Resident 1 stated Resident 2 wants the room to himself and tries to impose his own rules. Resident 1 stated, he refrained from speaking up his concerns (Resident 2's behavior towards Resident 1) to facility staff because he felt this was his room and space and does not want to move to another room. Resident 1 stated that he did not remember what triggered the argument between Resident 1 and Resident 2 on [DATE]. Resident 1 stated he remembered was when Resident 2 approached the side of his bed and began hitting him on the head and face with his fist. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on [DATE] at 12:20 p.m., with Resident 3 (roommate of Resident's 1 and Resident 2), Resident 3 stated he witnessed the altercation between Resident 1 and Resident 2. Resident 3 stated Resident 2 called CNA 1 mama, mama, mama then Resident 1 said she was not your mama. Resident 3 stated, when CNA 1 left the room, Resident 2 got out of bed went over to Resident 1's bed and started hitting him on the head multiple times. Resident 3 stated, Resident 1 does not like when Resident 2 calls the CNA's mama. During an interview on [DATE] at 12:49 p.m. with CNA 2, CNA 2 stated that she had taken care of Resident 1 and Resident 2 multiple times. CNA 2 stated Residents 1 and 2 argued a lot. CNA 2 stated Resident 1 was the aggressor as he gets upset and jealous if CNA 2 spend more time with Resident 2. CNA 2 stated last month (December) Resident 1 got into an argument with Resident 2 when CNA 2 gave Resident 2 two cups of coffee. CNA 2 stated Resident 1 does not like when Resident 2 calls CNA 1 mama. Resident 1 thinks it was unprofessional for Resident 2 to call the CNA's mama. CNA 2 stated she told the Registered Nurse Supervisor (RNS) about the argument on [DATE] and was advised to do a grievance report and give it to Social Services Director ([SSD]- promotes the welfare of others). CNA 2 stated she filled out the grievance and gave it to the Registered Nurse Supervisor (RNS) but could not remember exactly what she wrote on the grievance report. CNA 2 stated she had not heard anything from SSD regarding her grievance report. During an interview on [DATE] at 3:42 p.m. with CNA 1, CNA 1 stated that she had taken care of Resident 1 and 2 multiple times. CNA 1 stated on [DATE] she went to Residents 1 and 2 room to see if the residents were done with dinner. CNA 1 stated Resident 2 said yes mama, Resident 1 responded stop calling her mama. CNA 1 stated she took Resident 2 dinner tray out of Resident 2's room, when I heard a noise coming from Resident 1 and 2's room. CNA 1 stated when she got back to the room Resident 2 was standing over Resident 1's bed. CNA 1 stated she immediately separated the residents and called the Assistant Director of Nurses (ADON) to come to the room. CNA 1 stated she should have reported to the charge nurse about Resident 1 telling Resident 2 to stop calling her mama, she just did not get a chance as it happened so fast. CNA 1 stated staff should inform licensed staff right way when a resident has an issue with another resident because the residents could end up having a physical altercation. During a concurrent interview and record review on [DATE] at 1:59 p.m., Grievance Record dated [DATE], was reviewed with RNS. RNS stated, CNA 2 told him about the verbal argument regarding coffee between Resident 1 and 2. RNS stated he directed CNA 2 to write it down on a grievance form and that he would turn it to SSD. RNS stated he talked to Resident 1 and 2 about the verbal argument and neither resident was mad. RNS confirmed there was no documentation in Resident 1 and 2's clinical record regarding the incident on [DATE]. During a phone interview on [DATE] at 10:40 a.m. with Resident 1's Family Member (FM) 1, FM 1 stated that Resident 1 had an issue with Resident 2 wanting Resident 1 to turn the television and lights off early (8 p.m.) and Resident 1 would not do it. FM 1 stated she was looking for another facility for Resident 1. During a phone interview on [DATE] at 11:05 a.m. with Resident 2's FM 2, FM 2 stated Resident 2 would complain that Resident 1 would talk too loud to Resident 2. FM 2 stated Resident 2 was hardheaded and have a lot of health concern. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review on [DATE] at 8:30 a.m. with SSD Resident 2's Psychosocial/Social Services Note dated [DATE] was reviewed. The Psychosocial/Social Services Note dated [DATE], indicated Resident 2 was moved to a new room because of roommate incompatibility. The SSD stated Resident 2's room change was due to previous roommate said that Resident 2 was too loud and made too much noise and wanted him to be moved. SSD stated that was the reason why Resident 2's room was changed and cohorted with Resident 1. SSD stated that there was no documentation of SSD's conversation with Resident 2 and did not follow up with Resident 2 regarding his behavior (too loud and made too much noise). SSD stated there was no care plan initiated to address Resident 2's behavior. During a concurrent interview and record review on [DATE] at 8:37 a.m. with SSD, the Grievance Record dated [DATE] was reviewed. The Grievance Record was completed by CNA 2 and indicated that Resident 2 was upset with Resident 1 because Resident 1 told Resident 2 Why did you get two coffees. The Grievance Record indicated Resident 2 responded You need to mind your own business. The grievance report investigation indicated the SSD spoke with both residents but did not discuss the concern and both residents stated everything was okay. The recommendation/resolution was to make sure if in the future any concerns presented, to address it with the residents (Resident 1 and Resident 2). The SSD stated that she went to Resident 1 and Resident 2's room and neither resident had concerns regarding coffee and that there were no issues between them. The SSD stated she did not talk to CNA 2 about the grievance she wrote and further investigate. The SSD stated she never documented in Resident 1 and Resident 2's records about CNA 2's grievance because it was staff member who file the grievance and not a resident. The SSD stated she used the grievance record documentation as her clinical documentation and keeps the grievance records in her office. The SSD stated she never discussed the grievance with the Director of Nurses (DON) because there were no concerns between the residents. During a concurrent interview and record review on [DATE] at 10:05 a.m. with the Assistant Director of Nursing (ADON), reviewed CNA 2's Grievance Record dated [DATE]. The ADON stated that she had not seen the grievance record until today [DATE]. The ADON stated she was not aware that Resident 1 and Resident 2 had an argument on [DATE]. The ADON stated that all grievances need to be discussed with the nursing staff. The ADON stated Resident 1 and Resident 2 should have COC, care plans for behavior monitoring and a three-day room visit by social service staff. The ADON stated SSD should have done 3-days of follow up room visits with both Residents 1 and Resident 2 to ensure both residents were safe. During a concurrent interview and record review on [DATE] at 10:05 a.m. with the ADON, the SSD Progress Note dated [DATE] for Resident 2 was reviewed. The SSD Progress Note indicated Resident 2 had a room change on [DATE] due to roommate (previous roommate before Resident 1) incompatibility. There was no other documentation found in the clinical record. The ADON stated SSD should have done room visits after the room change to ensure that Resident 2 was compatible with his new roommate (Resident 1). During a concurrent interview and record review on [DATE] at 11:01 a.m. with the Director of Nursing (DON), the SSD Progress Note dated [DATE] for Resident 2 was reviewed. The SSD Progress Note indicated Resident 2 had a room change on [DATE] due to previous roommate (Resident 4) incompatibility. The DON stated the behaviors between Resident 2 and the previous roommate (Resident 4) should have been care planned. The DON stated the SSD should have done a three-day room visits to make sure Resident 2 liked his new roommate (Resident 1) and to ensure their cohorting compatibility. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review on [DATE] at 11:01 a.m. with the DON, the CNA 2 Grievance Record dated [DATE] was reviewed. The DON stated she had not been made aware of this grievance record until [DATE] and was not aware that Resident 1 and Resident 2 had any previous grievances. The DON stated the grievance should have been brought to her attention so she could have discussed it and come up with a resolution for Resident 1 and Resident 2. The DON stated this grievance should have been documented in the clinical record by the RNS and the SSD. The DON stated a COC should have been done and SSD should have a three-day follow up room visits with both residents and a care planned. The DON stated Resident 1 and Resident 2 behaviors should have been monitored. The DON stated any incident of altercation between residents should be addressed right away and manage the situations before it could be escalated, and an altercation occurs. During a review of the facility's policy and procedure (P&P) titled Abuse Prevention Program revised , d+[DATE], the P&P indicated Protect our residents from abuse by anyone including but not necessarily limited to: facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representatives, friends, visitors, or any other individual. Identify and assess all possible incidents of abuse. During a review of the facility's P&P titled Residents Rights dated ,d+[DATE] indicated Federal and State laws guarantee certain basic rights of this facility. These rights include the residents right to be free from abuse, neglect, misappropriation of property and exploitation. During a review of the SSD's job description dated ,d+[DATE] indicated the SSD reports the following in accordance with established facility procedures and regulatory standards, accidents and incidents, resident grievances, complaints, allegations of resident abuse and or misappropriation of resident property.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49889 Based on interview and record review the facility failed to ensure that one out of two sampled residents (Resident 2) were free from a significant medication error when Resident 2 ' s escitalopram (depression medication) was not started on 5/1/2024 as ordered by Resident 1 ' s physician. This failure had the potential for Resident 2 ' s clinical depression to worsen. Findings: During a review of Resident 2 ' s Admission Record, the Admission Record indicated Resident 2 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and heart failure (heart muscle is unable to pump enough blood to meet the body ' s needs for blood and oxygen). During a review of Resident 2 ' s History & Physical (H&P), dated 5/2/24, the H&P indicated, Resident 2 had the capacity to understand and make decisions. During a review of Resident 2 ' s Minimum Data Set (MDS - a resident assessment tool) dated 12/14/2024, the MDS indicated Resident 2 had moderate cognitive (ability to think, understand, learn, and remember) impairment. The MDS also indicated, Resident 2 needs set up or clean up assistance (helper sets up and cleans up) with Activities of Daily Living (ADL ' s). During a review of Resident 2 ' s Physician ' s Order dated 6/6/2023, indicated Resident 2 started taking escitalopram 20 milligram (mg-unit of measurement) once a day for depression manifested by verbalization of sadness. During a review of Resident 2 ' s Psychiatric Progress Note dated 3/26/2024, indicated Resident 2 has major depressive disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life) and is taking escitalopram 20 mg once a day for depression manifested by verbalization of sadness. During a review of Resident 2 ' s Informed Consent dated 4/0620/24, indicated Resident 2 signed his informed consent for escitalopram 20 mg once a day for depression manifested by verbalization of sadness. During a review of Resident 2 ' s Physician ' s Order dated 5/1/2024, indicated Resident 2 had an order for escitalopram 20 mg once a day for depression manifested by verbalization of sadness. Medication on hold for signature of informed consent. During a review of Resident 2 ' s general acute care hospital (GACH) inquiry dated 5/7/2024, the GACH inquiry indicated Resident 2 has a diagnosis of depression and is taking escitalopram 20 mg orally once a day. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 2 ' s Care Profile dated 1/22/2025, indicated Resident 2 was transferred to GACH on 4/16/2024 and readmitted back to the facility on [DATE] and then transferred back to GACH on 5/5/2024 and readmitted back to facility on 5/8/2024. During a concurrent interview and record review on 1/23/2025 at 3:12 p.m. with the Assistant Director of Nurses (ADON) Resident 2 ' s GACH inquiry dated 5/7/ 2024 was reviewed. The ADON stated the GACH inquiry indicated Resident 2 should have been started on escitalopram 20 mg once a day for depression manifested by verbalization of sadness. ADON stated Resident 2 should not be taken off his depression medications cold turkey (abrupt withdrawal). The ADON stated a gradual dose reduction needs to be done first. ADON also stated that clinical worsening and emergence of behaviors could occur. During a concurrent interview and record review on 1/23/2025 at 3:12 p.m. with the Director of Nurses (DON), Resident 2 ' s Physician Order dated 5/1/2024, was reviewed, the Physicians Order indicated that Resident 2 had order for escitalopram 20 mg once a day for depression manifested by verbalization of sadness. Medication on hold for signature of informed consent. The DON stated that Resident 2 does have the capacity to understand and make decisions for himself and that Resident 2 should have been started on escitalopram on 5/1/2024, and that there was a possibility for relapse and that Resident 2 could have mood changes. During a review of the facility ' s policy and procedure (P&P) titled Reconciliation of Medications on admitted d 2017, the P&P indicated, the purpose of this procedure is to ensure medications safety by accurately accounting for the resident's medications, routes and dosages upon admission or readmission to the facility. 1. Medication reconciliation is the process of comparing pre-discharge medications to post-discharge medications by creating an accurate list of both prescription and over the counter medications that includes the drug name. dosage, frequency, route, and indication for use for the purpose of preventing unintended changes or omissions at transition points in care. 2. Medication reconciliation reduces medication errors and enhances resident safety by ensuring that the medications the resident needs and has been taking continue to be administered without interruption, in the correct dosages and routes, during the admission/transfer process.