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	05/15/2025

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 0580 Level of Harm - Actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to notify the physician of a change of condition (COC) for one of three sampled residents (Resident 2). The facility failed to: 1. Notify Resident 2's physician when Resident 2, who was receiving Aspirin [ASA] used as a blood thinner to prevent a stroke) and Clopidogrel Bisulfate ([Plavix] a medication used to prevent blood clots [blood cells that clump together and could obstruct the flow of blood]), sustained a head injury on 5/4/2025, that resulted in an abrasion, (a scrape of the top layer of the skin), a laceration (a cut with a jagged or torn wound that is caused by a sharp object), a small bump with substantial (large in size, number, or amount) bleeding to his head. 2. Notify Resident 2's physician, following Resident 2's head injury, to obtain an order for the discontinuance of Aspirin and Clopidogrel Bisulfate to prevent bleeding in the resident's brain. Resident 2 continued to receive blood thinners from 5/4/2024 through 5/9/2025 daily. 3. Notify Resident 2's physician following Resident 2's head injury (5/4/2025), when Resident 2 exhibited noticeable changes in behavior that included decrease in appetite, drowsiness, and being less talkative that were not his typical behaviors. 4. Follow Resident 2's untitled Care Plan dated 4/25/2025, that indicated to monitor, document and report adverse reactions of anticoagulant therapy to include lethargy, loss of appetite, and sudden changes in mental status. These deficient practices resulted in a delay in evaluation and treatment for Resident 2 following an injury and bleeding to his head on 5/4/2025. Resident 2 was transferred to a General Acute Care Hospital (GACH) on 5/9/2025 (four days after the injury to his head) via 911 when he was found lethargic and unarousable by Resident 2's Family Member (FM) 1. Resident 2 was diagnosed with a subarachnoid hemorrhage (a life threatening condition where bleeding occurs in the space between the brain and the tissue covering the brain) and was transfused (a procedure where blood or blood components are administered through an intravenous line ([IV] a flexible plastic tube inserted into the vein to administer medications, blood products and fluids) with one unit (refers to a single bag of blood) of platelets (small, colorless, cell fragments found in the blood that play a crucial role in blood clotting). (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 05/15/2025

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

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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 0580 Level of Harm - Actual harm Residents Affected - Few	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] with a diagnosis including Alzheimer's disease (a progressive disorder that affects memory, thinking, and behavior), and a history of falling. During a review of Resident 2's Minimum Data Set ([MDS] a resident assessment tool) dated 5/2/2025, the MDS indicated Resident 2 had moderate cognitive impairment (noticeable but mild memory and thinking problems). The MDS indicated Resident 2 required maximum assistance (helper does more than half the effort) with toileting hygiene, and substantial assistance (helper does more than half the effort) with dressing, and personal hygiene. During a review of Resident 2's Physician's Order, dated 4/25/2025, the Physician's Orders indicated to administer the following medications and to monitor for signs and symptoms (s/s) of bleeding such as hematoma (a collection of blood outside of a blood vessel caused by a broken blood vessel) every shift, and notify the physician if s/s occur: 1. Aspirin 81 milligrams ([mg] a metric unit of measurement, used for medication dosage and/or amount) once a day to prevent a cerebral vascular accident ([CVA - stroke] loss of blood flow to a part of the brain) 2. Clopidogrel Bisulfate 75 mg once a day for CVA prevention. During a review of Resident 2's Medication Administration Record ([MAR] a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 4/2025 and 5/2025, the MAR indicated Resident 2 received Aspirin 81 mg and Clopidogrel 75 mg once a day from 4/26/2025 through 5/9/2025. During a review of Resident 2's untitled Care plan, dated 4/25/2025, the Care Plan indicated Resident 2 was on antiplatelets ([Aspirin and Clopidogrel] medications that prevent blood form sticking together). The Care Plan's goal indicated Resident 2's risk for adverse reactions (an unintended and harmful effect that occurs as a result of taking a medication) related to the medications use would be minimized. The Care Plan's interventions indicated to monitor, document and report adverse reactions of anticoagulant therapy to include lethargy, loss of appetite, and sudden changes in mental status. During a review of Resident 2's SBAR ([situation, background, assessment, recommendation] a communication tool used by healthcare workers when there is a change of condition among the residents), dated 5/4/2025 and timed at 7 p.m., the SBAR indicated Resident 2 hit his head on a shelf. The SBAR indicated Resident 2 was sitting at the edge of the bed, something hit him, but he (Resident 2) did not remember what it was. The SBAR indicated Resident 2 sustained a small cut and a small bump on the front of his head. During a review of Resident 2's Nursing Progress Note, dated 5/9/2025 and timed at 1:50 p.m., the Nursing Progress Note indicated Resident 2's Family Member (FM) 1 was observed in Resident 2's room at 12:55 p. m., screaming and trying to wake up Resident 2. The Nursing Progress Note indicated Resident 2 was lethargic. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 2's SBAR, dated 5/9/2025, the SBAR indicated Resident 2 was lethargic and unarousable at 12:55 p.m., and was transferred to the GACH via 911. During a review of Resident 2's Emergency Medical Services (EMS) form, dated 5/9/2025, the EMS form indicated Resident 2's blood pressure (BP) upon arrival was 86/42 millimeters of mercury ([mmHg] a unit of pressure commonly used to measure BP, normal BP is typically between 90/60 mmHG and 120/80 mmHG) During a review of the GACH's admission record, dated 5/9/2025, the GACH's admission record indicated Resident 2 arrived at the GACH at 2:38 p.m., due to bleeding in the brain, altered mental status, low BP, and monitoring for long-term blood thinner use. During a review of the GACH's Emergency Department's (ED) Provider Notes, dated 5/9/2025 and timed at 7:10 p.m., the ED Provider Notes indicated Resident 2 had an abrasion to the front scalp (the skin covering the head, excluding the face) with strips of surgical tape and a band aid in place. During a review of the GACH's Assessment/Plan Note dated 5/9/2025, the Assessment/Plan Note indicated Resident 2 received one unit of platelets for transfusion in the ED. During a review of the GACH's Imaging Note, dated 5/10/2025 and timed at 5:26 a.m., the GACH's Imaging Note indicated Resident 2 had a possible subarachnoid hemorrhage. During a review of the GACH's Consult note, dated 5/10/2025 and timed at 7:47 a.m., the GACH's Consult note indicated Resident 2 had a left parietal (on top of the head) traumatic subarachnoid hemorrhage. During an interview on 5/14/2025 at 9:27 a.m., and a subsequent interview at 9:40 a.m., FM 1 stated on 5/4/2025 (time unknown), she received a call from Registered Nurse (RN) 1 saying that Resident 2 scraped his head when bending over looking pictures, there was some bleeding, but he did not have to go to the GACH. FM 1 stated on 5/9/2025 around 1 p.m., she came to pick up Resident 2, he was sitting on his walker in the hallway and was having difficulty speaking. FM 1 stated Resident 2 pointed to his groin, letting her know he need to go to the bathroom, she took him to the bathroom and while walking he became very unstable, he began to slump over, and she had to brace him using her knee to prevent him from falling. FM 1 stated, Resident 2's eyes rolled back, and he stopped breathing, so she called for help and asked RN 1 to call 911. During an observation on 5/14/2025 at 12:48 p.m., in Resident 2's room, Resident 3's (Resident 2's Roommate) shelf was observed on the floor at the foot of Resident 3's bed. The shelf was made of a flimsy (light and easily moved/not stable) plastic material and was approximately three feet high with four individual shelves. The edges of the shelf was ridged (marked or formed with narrow raised bands) and corroded (metals or other material slowly destroyed or weakened by chemical action). (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	During an interview on 5/14/2025 at 10:29 p.m., RN 1 stated on 5/4/2025 after dinner, he was informed by a staff member (unknown who this was) that Resident 2 had an accident. RN 1 stated he went to Resident 2's room and saw blood on the floor and observed Resident 2 sitting on his bed bleeding from his forehead. RN 1 stated Resident 2 told him something hit his face, but he (Resident 2) was not able to fully explain what it was. RN 1 stated he spoke to Resident 3, who witnessed some of the incident. RN 1 stated Resident 3 told him that Resident 2 bent down to look at pictures that were on his (Resident 3's) shelf when he (Resident 2) stood up he was bleeding. RN 1 stated he called Resident 2's physician on 5/4/2025 (time unknown), left a voicemail and sent the physician a text message but he (RN 1) received no response from the physician. RN 1 stated he did not work the next day and was unsure if anyone followed up with Resident 2's physician. RN 1 stated he should have followed up with the physician or medical director when he received no response from Resident 2's physician. During an interview on 5/14/2025 at 12:13 p.m., Certified Nursing Assistant (CNA) 5 stated on 5/8/2025 she noticed Resident 2 was acting differently from the previous day (5/7/2025), he was sleepy all day, less talkative, only got up to eat meals then wanted to go back to bed. CNA 5 stated on 5/9/2025 Resident 2 did not want to eat breakfast or lunch, he was arousable but sleepy, he yelled and wanted to hit her when she tried to assist him back to bed. CNA 5 stated she notified licensed Vocational Nurse (LVN) 5 of Resident 2's sleepiness on 5/8/2025 and she notified RN 1 that Resident 2 did not want to eat on 5/9/2025 in the morning after breakfast. During an interview on 5/14/2025 at 12:31 p.m., LVN 4 stated on 5/4/2025 at approximately 7 p.m., she heard Resident 2 yelling for help, when she went to his room she observed him bleeding from his scalp. LVN 4 stated Resident 2 had an abrasion, a laceration and a small bump on his scalp. LVN 4 stated she did not call Resident 2's physician because RN 1 told her he would call the physician. LVN 4 stated she remembered receiving a report that Resident 2 had a fall on 5/4/2025. LVN 4 stated she was not told to withhold Resident 2's Aspirin and Clopidogrel so she continued to administer both medications to Resident 2, as ordered, until 5/9/2025 when he was transferred to the GACH. LVN 5 stated, typically when a resident falls, has a suspected head injury and was receiving blood thinners, an order for labs (a medical procedure where a sample of blood, urine, or other fluids or tissues are analyzed to help diagnose or monitor a health condition) and/or imaging diagnostics (use of various technologies to create visual pictures inside the body to help diagnose, treat, or monitor a health condition) is obtained to rule out possible bleeding to the brain. During an interview on 5/14/2025 at 2:34 p.m., the Director of Nursing (DON) stated the licensed nurses continued to administer blood thinners, Aspirin and Clopidogrel, to Resident 2 after the injury to his head on 5/4/2025. The DON stated the licensed nurses should have called Resident 2's physician to notify him of Resident 2's head injury and to obtain an order to hold the Aspirin and Clopidogrel. The DON stated blood thinners could cause excessive bleeding and a possible brain bleed. During an interview on 5/14/2025 at 4:44 p.m., LVN 3 stated on 5/4/2025 she worked 11p.m. to 7a.m., and was informed about Resident 2's accident by RN 1 and LVN 4. LVN 3 stated she did not call Resident 2's physician because she was told RN 1 already called him. During an interview on 5/14/2025 at 4:45 p.m., Nurse Practitioner (NP) 1 stated he did not remember any report about Resident 2. NP 1 stated if a Resident was on blood thinners, had an accident/head injury, he would have recommended sending Resident 2 out to the GACH for a CT scan (computed tomography, a diagnostic imaging procedure that uses a combination of x-rays to produce images inside of the body) to make sure there is no intracranial (inside the skull) bleeding. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	During an interview on 5/15/2025 at 9:32 a.m., the Physician Assistant (PA) 1 stated on 5/4/2025 he was on call covering for Resident 2's physician but did not receive any calls about Resident 2. PA 1 stated Resident 2 was receiving blood thinners and was 90% more likely to sustain a brain bleed than those who were not receiving blood thinners following a head injury. PA 1 stated had he been informed that Resident 2 had a head injury he (Resident 2) would have been sent him to the hospital right away to get a CT scan to make sure he did not have a brain bleed. During an interview on 5/15/2025 at 2:50 p.m., Housekeeping (HK) 1 stated on 5/4/2025 he was asked by Certified Nursing Assistant (CNA) 6 to clean Resident 2's room. HK 1 stated he went to Resident 2's room and observed a shelf (at the foot of Resident 3/s bed), and approximately six inches in front of the shelf was a puddle of blood with a towel placed over it. HK 1 stated the blood on the floor was approximately the size of a baseball with little drops of blood scattered around the it. HK 1 stated he did not see blood on the shelf but stated he was not sure if anyone had already cleaned it from the shelf. During a review of the facility's undated Policy and Procedure (P/P), titled Change in Resident's Condition of Status the P/P indicated the nurse will notify the attending physician or physician on call within 24 hours (except in medical emergencies) when there has been an accident, a significant change in the resident's physical/emotional/mental condition, and the need to transfer to the hospital. The P/P indicated prior to notifying the physician the nurse will make detailed observations and gather pertinent relevant information. During a review of the facility's P/P titled Accidents and Incidents-Investigating and Reporting dated 3/2018, the P/P indicated the nurse supervisor, charge nurse, or department director shall document the time of the injured person's attending physician being notified, as well as the time the physician responded and his or her instructions.