

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 07/28/2025
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)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement its abuse prevention policy by failing to report the alleged physical abuse between Resident 1 and Resident 2 to the State Survey Agency (California Department of Public Health-CDPH) within two hours of the occurrence for two of three sample residents (Resident 1 and Resident 2). This failure had potential to result in a delay of an onsite inspection by the CDPH to ensure alleged physical abuse was investigated and lead to a delay in prevention of potential ongoing physical abuse. Findings: A. During a review of Resident 1's admission Record, the admission Record indicated, Resident 1 was initially admitted to the facility on [DATE] and last readmission was on 6/14/2025 with diagnoses including anxiety disorder (a group of mental health conditions characterized by excessive, persistent, and unrealistic worry and fear about everyday situations), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest) and osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage). During a review of Resident 1's History and Physical (H&P), dated 6/16/2024, the H&P indicated, Resident 1 had the capacity (ability) to understand and make decision. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 6/21/2025, the MDS indicated Resident 1 required moderate assistance (Helper does less than half the effort) from one staff for bed mobility and transfer. B. During a review of Resident 2's admission Record, the admission Record indicated, Resident 1 was initially admitted to the facility on [DATE] and last readmission was on 2/10/2025 with diagnoses including dementia (a progressive state of decline in mental abilities), and malignant neoplasm of cecum (cancerous tumor development in the cecum, which is the beginning of the large intestine[colon]). During a review of Resident 2's H&P, dated 4/7/2025, the H&P indicated, Resident 1 had the fluctuating capacity to understand and make decision. During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2 required moderate assistance from one staff for bed mobility and maximal assistance (Helper does more than half the effort) from one staff for transfer. During an interview on 7/28/2025, at 10:55 a.m., with Resident 1 in the activity room, Resident 1 stated, she was talking with another resident in a hallway near the smoking area and dining room regarding her upcoming wedding on 7/12/2025 around dinner time, and Resident 2 bumped into her wheelchair. Resident 1 stated, Resident 2 did not apologize, and they ended up having a big argument and Resident 2 slapped her left side of face. Resident 1 stated, she reported to the nurse who came to separate them regarding the incident because she did not want Resident 2 to hit her again. During an interview on 7/28/2025, at 11:20 a.m., with Resident 2 in her room, Resident 2 stated, she did not recall the incident. Resident 2 stated, she did not do anything. During an interview on 7/28/2025, at 12:35 p.m., with Certified Nurse Assistant (CNA) 1, CNA 1 stated, she heard about the incident on 7/12/2025 between Resident 1 and Resident 2. CNA 1 stated, Licensed Vocation Nurse (LVN) 1 and Registered Nurse Supervisor (RNS) 1 did not report the incident in a timely manner, and they got suspended. CNA 1 stated, alleged abuse should be reported right away because all healthcare workers are mandatory reporters for abuse. During a concurrent interview and record review on 7/28/2025, at 12:55 p.m., with RNS 2, Resident 1's Change in Condition Evaluation, dated 7/12/2025 was reviewed. The Change in Condition Evaluation indicated, Resident 1 stated, another resident came by and hit on the left side of the head, and the primary physician was notified. RNS 2 stated, she recalled that LVN 1 told her that RNS 1 was fully aware of the situation and told her there was nothing else to do further. RNS 2 stated, LVN 1 told her that she should have reported to the Administrator herself. RNS 2 stated, RNS 1 told her that he did not think it was serious since Resident 1 did not have visible injuries. RNS 2 stated, LVN 1 and RNS 1 should have reported alleged physical abuse within two hours of occurrence to Abuse Coordinator (Administrator), State Agency, Ombudsman, and local police per abuse policy. During a telephone interview on 7/28/2025, at 3:10 p.m., with CNA 2, CNA 2 stated, he was at the dining room at the time of incident, and he heard someone yelling for help. CNA 2 stated, he went to hallway and witnessed Resident 1, and Resident 2 were yelling at each other and another resident was holding Resident 1. CNA 2 stated, RNS 1 came a few minutes later, and he reported to RNS 1 what he witnessed. CNA 2 stated, he reported the incident to LVN 1 as well. CNA 2 stated, he thought they would report to proper authorities because he was assisting residents in the dining room, but he found out that they did not report. CNA 2 stated, staff are mandatory reporters, and this incident should have been reported within two hours of occurrence. During an interview on 7/28/2025, at 3:45 p.m. with Administrator (ADM) ADM stated, RNS 1 and LVN 1 admitted that</p>		