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	08/05/2025

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 - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure for four of four sampled residents, who had orders for an electrocardiogram ([EKG/ ECG] a test that measures the electrical activity of the heart), and/or who had a change of condition (COC), that the EKG results and the COC were reported to the physician(s) in a timely manner. The facility failed to: 1. Notify the physician when Resident 2 reported lightheadedness, weakness and feeling dizzy when ambulating to the bathroom on 6/20/2025. 2. Notify the physician(s) of the results of EKGs conducted for Resident 1, Resident 3 and Resident 4. These deficient practices resulted in: 1. Resident 2 being assessed with an altered level of consciousness ([ALOC] a change in a person's awareness and responsiveness to their environment, compared to their normal state), bradycardia (a slow HR , reference range 60-100 bpm), hypotension (low blood pressure, below 90/60 mmHg), bradypnea (slow breathing, below 12 breaths per minute) and a critically high Potassium (a metallic element that is important in body functions such as regulation of blood pressure [B/P] and of water content in the cells, transmission of nerve impulses, digestion, muscle contraction, and heartbeat) level of 7.3 milliequivalents ([mEq] a unit of measurement)/per liter ([L] a unit of measurement) (reference range 3.5 to 5.2 mEq/L) on 6/22/2025. Resident 2 was transferred to a General Acute Care Hospital (GACH) on 6/22/2025 where he was admitted to the Intensive Care Unit ([ICU] a specialized section of a hospital that provides critical care to patients with life-threatening illnesses or injuries) and STAT (immediately or without delay) dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) was conducted. 2. Resident 1's physician was not aware of Resident 1's EKG results for two days after the EKG was conducted and Resident 3 and Resident 4's physician were not aware of Resident 3 and Resident 4's EKG results for over two months after their EKGs were conducted. Cardiology consultations for follow up related to Resident 3 and Resident 4's EKG results were ordered on 7/13/2025. These deficient practices had the potential for Resident 1, 2, 3 and 4 to suffer detrimental consequences related to their heart including death. 1. 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 diagnoses including type 2 diabetes mellitus ([DM] a disorder characterized by difficulty in blood sugar control and poor wound healing) and diabetic chronic kidney disease ([CKD] a serious complication of diabetes that occurs when high blood sugar (b/s) levels damage the kidneys' filtering system). During a review of Resident 2's Minimum Date Set ([MDS] a resident assessment tool) dated 7/15/2025, the MDS indicated Resident 2's cognition (the mental processes involved in acquiring knowledge and understanding) was intact. During a review of Resident 2's untitled Care Plan dated 5/26/2025, the Care Plan indicated Resident 2 had anemia (a condition where the body does not have enough healthy red blood cells) and was at risk for weakness, fatigue (a feeling of tiredness, exhaustion, or lack of energy that can make it difficult to perform daily activities) and dizziness. The goal of this care plan was to minimize the signs and symptoms (s/s) of complications related to anemia. The Care Plan's interventions included monitoring Resident 2 for s/s of anemia including dizziness, syncope (a temporary loss of consciousness and muscle control, commonly known as fainting), and weakness, and to report to the physician as needed. During a review of Resident 2's untitled Care Plan dated 5/26/2025, the Care Plan indicated Resident 2 was on diuretic therapy (a treatment that helps the body eliminate excess fluid through the urine often involving water pills) related to hypertension ([HTN] high blood pressure). The goal of this Care Plan was for Resident 2 to be free from discomfort or adverse reactions related to diuretic use for three months. The Care Plan's interventions included monitoring Resident 2 and observing for possible side effects such as dizziness, fatigue, and an increased risk for falls, and reporting to physician. During a review of Resident 2's Untitled Care Plan dated 2/11/2025, the Care Plan indicated Resident 2 had DM. The goal of the Care Plan was to minimize Resident 2's risk for complications related to DM. The Care Plan's interventions included monitoring/documenting/reporting as needed s/s of hyperglycemia (increased b/s) including increase in thirst, headaches, trouble concentrating, blurred vision, frequent urination, fatigue, and weight loss and s/s of hypoglycemia (low b/s) including sweating, tremors (shaking), increased heart rate (HR), pallor (pale skin), nervousness, confusion, slurred speech, lack of coordination, and a staggering gait During a review of Resident 2's Nursing Progress Note dated 6/20/2025 and timed at 3:49 p.m., the Nursing Progress Note indicated Resident 2 experienced an episode of lightheadedness and weakness while using the restroom, verbalizing, I feel dizzy and weak while refusing prescribed medication offered to him because

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F 0600 Level of Harm - Minimal harm or potential for 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. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 5) was not verbally abused by Certified Nursing Assistant (CNA) 1, when CNA 1 and Resident 5 got into an argument and CNA 1 used profanity. This deficient practice resulted in Resident 5 being frustrated and upset when during an argument between him and CNA 1, CNA 1 said fuck you.During a review of Resident 5's admission Record (Face Sheet), the Face Sheet indicated Resident 5 was admitted to the facility on [DATE] with diagnoses including post laminectomy syndrome (a condition where persistent or recurrent pain develops after a laminectomy or other spinal surgery) and depression (a common mental health condition characterized by persistent feelings of sadness, hopelessness, and loss of interest in previously enjoyable activities). During a review of Resident 5's Minimum Data Set ([MDS] a resident assessment tool) dated 7/17/2025, the MDS indicated Resident 5's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was intact, and he required substantial/maximal assistance (helper does more than half the effort) to complete his activities of daily living ([ADLS] activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 5's Change of Condition (COC) Evaluation note dated 7/28/2025, the COC note indicated Resident 5 was agitated, did not want the CNAs to touch items on his bedside table, and was shouting and cursing at the CNAs. During a review of Resident 5's Interdisciplinary Team ([IDT] a group of professionals from different fields who work together to achieve a common goal) note dated 7/29/2025, the IDT note indicated Resident 5 had a verbal altercation with CNA 1 resulting in Resident 5 raising his voice and CNA 1 responding in a loud manner. The IDT note indicated Resident 5 had poor impulse control which led to Resident 5's verbal outburst towards staff. During an interview on 7/30/2025 at 9:43 a.m., Resident 5 stated on 7/28/2025 he put on his call light and CNA 3 came to his room to tell him that CNA 1 would come to assist him when he (CNA 1) was available and that upset him (Resident 5). Resident 5 stated, when CNA 1 finally came to his room, they got into an argument, CNA 1 was upset, walked out of the room and said, fuck you. Resident 5 stated the experience of CNA 1 saying fuck you to him (Resident 5) was frustrating and upsetting because he usually got along with CNA 1 and he believed CNA 1 was a good worker until this happened. During a telephone interview on 7/30/2025 at 12:52 p.m., Licensed Vocational Nurse (LVN) 4 stated on 7/28/2025 she was at the middle nursing station (down the hall from Resident 5's room) and heard Resident 5 and CNA 1 yelling at each other using profanity and she heard LVN 5 tell CNA 1 that he should not speak to Resident 5 that way. LVN 4 stated after the argument, CNA 1 was very angry and walked toward the front of the building, he was pacing, and he might have kicked the door before he left the building. During a telephone interview on 7/30/2025 at 1:07 p.m., CNA 2 stated she spoke to CNA 1 after the incident and CNA 1 was upset and said Resident 5 was ungrateful and took advantage of his kindness and he (CNA 1) was feeling abused and angry. During a telephone interview on 7/30/2025 at 1:14 p.m., CNA 1 stated when he went to Resident 5's room on 7/28/2025, Resident 5 was upset and was cursing at him about not coming to his room himself and sending CNA 3 instead. CNA 1 stated that he told Resident 5 to calm down, but he (Resident 5) would not calm down. CNA 1 stated he walked out of Resident 5's room and said, fuck this CNA 1 stated Resident 5 heard him curse and responded, fuck you too. CNA 1 stated he did not react appropriately to Resident 5, he should have walked away. CNA 1 stated the way he responded to Resident 5 was considered a form of verbal abuse. During an interview on 8/1/2025 at 2:04 p.m., the Director of Staff Development (DSD) stated as part of the employee's orientation, they are trained how to act professionally and treat the residents with respect and dignity. The DSD stated CNA 1 should have walked away when Resident 5 began yelling at him and politely told him (Resident 5) that he (CNA 1) would come back. During an interview on 8/1/2025 at 2:40 p.m., the Administrator (ADM) stated RN 2 reported to him that Resident 5 and CNA 1 were cursing at each other. The ADM stated CNA 1 should have remembered while he was at work to be professional when interacting with residents. During a review of the facility's Job Description for Certified Nursing Assistants (CNA) dated 9/2020, the Job Description indicated CNAs should ensure all residents are treated fairly, with kindness, dignity, and respect, and their rights are protected at all times. The Job Description indicated skills and abilities a CNA should have include the ability to interact tactfully, effectively, and professionally with other employees, residents, family members, and visitors. During a review of the facility's Policy and Procedure (P/P) titled Abuse, Neglect, Exploitation and Misappropriation

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to assess one of four sampled residents (Resident 1) after Resident 1 complained of chest pain and a electrocardiogram ([EKG/ECG] a test that measures the electrical activity of the heart) was ordered due to chest discomfort. This deficient practice resulted no documentation or knowledge of Resident 1's medical stats and had the potential for a delay in care and treatment.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 the diagnoses including CKD and DM. During a review of Resident 1's MDS dated [DATE], the MDS indicated Resident 1's cognition was intact. During a review of Resident 1's Physician Progress Note dated 6/10/2025, the Physician Progress Note indicated Resident 1 reported that she was experiencing chest pain on her left side which started a few weeks prior, but she could not remember the exact date that it began. The Physician Progress Note indicated a 12-lead EKG (a non-invasive test that measures the heart's electrical activity using 10 electrodes placed on the body) would be conducted due t Resident 1's chest discomfort. During a review of Resident 1's Physician's Order dated 6/10/2025, the Physician's Order indicated to conduct a 12-lead EKG for Resident 1 due to intermittent chest discomfort. During an interview on 7/30/2025 at 3:34 p.m., Registered Nurse (RN) 1 stated she received and carried out the order from Resident 1's physician for the 12-lead EKG but stated she did assess Resident 1 for chest pain/discomfort, and she should have assessed her because the indication for ordering the EKG was chest discomfort. RN 1 stated chest pain/discomfort could have been related to conditions including a heart attack. During an interview on 7/31/2025 at 2:35 p.m., the Clinical Mentor (CM) stated after a change of condition (COC) is reported, residents' should be assessed and a care plan created to have a treatment plan for the residents'. During a phone interview on 8/8/2025 at 12:39 p.m., Resident 1's physician stated Resident 1 complained of chest discomfort and as a result of her complaint he ordered that a EKG be conducted. Resident 1's physician stated nursing should follow the protocol when a resident experiences a COC if that includes monitoring and assessment. During a review of the facility's Job Description titled Registered Nurse (RN) Supervisor dated 9/2020, the Job Description indicated the duties and responsibilities of the RN supervisor included performing assessment functions including identification of changes in resident's physical or psychological condition. During a review of the facility's Policy and Procedure (P/P), titled Change in a Resident's Condition or Status dated 2/2021, the P/P indicated prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider. The P/P indicated the nurse will record in the resident's medical record relative to the changes in the resident's medical/mental conditions or status.