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	12/16/2025

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. (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 0908 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 an oxygen nut and stem adaptor (a tapered, barbed connector shaped like a Christmas tree, used to securely attach suction connector tubing [a flexible medical tube that creates a secure, leak-proof link between the suction source (the machine's vacuum port) and the collection canister (which holds aspirated material)]) was readily available and connected to the portable suction machine (a medical device used during an emergency situation that creates suction to remove obstructions such as blood, saliva, vomit or other secretions from the mouth, throat or nasal passages, helping to clear the airway and make breathing easier) on the south station crash cart (a cart stocked with emergency medical equipment, supplies, and drugs for use by medical personnel especially during cardiac arrest or respiratory distress (difficulty breathing) for one of two facility crash carts.This failure resulted in the facility's staff's inability to provide suctioning to Resident 1 and had the potential for all other residents located in the south station who are experiencing breathing difficulties or required removal of secretions to have airway obstruction (blockage of airway), causing severe oxygen deprivation, respiratory distress, and potentially respiratory arrest (where breathing completely stops), brain injury (when the brain is deprived of oxygen for a prolonged period, leading to damage or death of the brain cells) and sudden death. Findings: 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 heart failure (when the heart isn't pumping blood as well as it should), and type 2 Diabetes Mellitus ([DM] a disorder characterized by difficulty in blood sugar control and poor wound healing).During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 12/16/2025, the MDS indicated Resident 1's cognition (mental action or process of acquiring knowledge and understanding ability) was intact. During a review of Resident 1's Change of Condition (COC), dated 11/25/2025 and timed at 3 p.m., the COC indicated Resident 1 was found sitting on the toilet, nonresponsive (not reacting or answering), no pulse (heart rate) and was not breathing. The COC indicated cardiopulmonary resuscitation ([CPR] an emergency technique used to restore the heartbeat and breathing) was started.During an interview on 12/10/2025 at 12:45 p.m. with Respiratory Therapist (RT) 1 stated on 11/25/2025 at 3 p.m., upon entering Resident 1's room, she saw Certified Nursing Assistants (CNAs 1 and 2) administering CPR to Resident 1. RT 1 stated upon assessing Resident 1, she saw Resident 1 had food in his mouth. RT 1 stated she put her gloves on and proceeded to remove the food from Resident 1's mouth and called for someone to retrieve the suction machine to clean the secretions from Resident 1's mouth. RT 1 stated when the facility staff (staff unknown) brought the suction machine in, they were unable to get the suction machine to work because the plastic piece was missing from the suction machine, and nobody knew where to find one. During an interview on 12/11/2025 at 10:30 a.m., CNA 1 stated on 11/25/2025, she and CNA 2 saw Resident 1 sitting on the toilet, pale, his lips were blue and was not responding. CNA 1 stated CNA 2 helped her assist Resident 1 to the floor on the floor and saw he had white secretions and something that looked like a sandwich hanging out of his mouth. CNA 1 stated the food was removed from the mouth and chest compressions were started. CNA 1 stated RT 1 arrived and continued to pull food out of Resident 1's mouth. CNA 1 stated she heard RT yell for someone to get the suction machine and an unknown staff member brought in the suction machine; however, they could not get it to work. CNA 1 stated she recalled someone saying a piece was missing.During an interview on 12/11/2025 at 11:30 a.m., the Director of Staff Development (DSD) stated it is 11 p.m. to 7 a.m. shifts responsibility to check the crash cart to make sure all emergency supplies were there and the suction machine is working. During an interview on 12/11/2025 at 3:30 p.m., Registered Nurse (RN) 1 stated on 11/25/2025, she assisted in providing CPR to Resident 1 and stated the suction machine was not working as the plastic connector piece was missing. During an interview on 12/16/2025 at 10:30 a.m., RT 2 stated on 11/25/2025, the plastic that allows you to connect the suction tubing to the suction machine was missing. RT 1 stated it is important to have a working suction machine on the crash cart is critical for removing secretions and other fluids, preventing choking, and reducing the risk of aspiration. During an interview on 12/16/2025 at 10:46 a.m. the Director of Nursing (DON) stated it is night shift who is responsible to make sure the crash cart supplies are complete, replenished, and working. DON stated she was informed on 11/25/2025 that the suction machine was not working because there was a plastic piece which is also called a Christmas tree was missing from the suction machine. The DON stated she saw the Christmas tree was missing and replaced it. it. The DON