

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  01/21/2026
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	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview, and record review, the facility failed to ensure when they were made aware of a missing wallet for one of three sampled residents (Resident 1) and a subsequent allegation of an unauthorized charge of \$800.00 made against Resident 1's credit card, that the allegation of suspected theft was reported to the California Department of Public Health (CDPH). This deficient practice resulted in the CDPH's inability to investigate the allegation of misappropriation of Resident 1's wallet and money in a timely manner. This deficient practice had the potential for information to be lost/forgotten and for the property of residents residing at the facility to go missing. Findings: During a review of Resident 1's admission Record (Face Sheet), the Face Sheet indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including metabolic encephalopathy (a disease in which the functioning of the brain is affected by some agent or condition such as viral infection or toxins in the blood), pneumonia (an infection/inflammation in the lungs), acute chronic respiratory failure (a condition in which the lungs have a hard time loading blood with oxygen or removing carbon dioxide [a colorless, odorless waste gas produced by cellular metabolism that the body transports via blood and exhales through the lungs], with hypoxia (diminished availability of oxygen to the body tissues), and diabetes mellitus ([DM]a disorder characterized by difficulty in blood sugar [b/s] control and poor wound healing). During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool), dated 11/26/2025, the MDS indicated Resident 1's cognition (the ability to think and reason) was intact. During a review of Resident 1's SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents), dated 11/19/2025, the SBAR indicated Resident 1 was transferred to the emergency department for drowsiness and refusal to eat breakfast. During a review of Resident 1's Physician Order, dated 11/22/2025, the Physician Order indicated to readmit Resident 1 to the facility. During a review of Resident 1's Inventory of Personal Effects, dated 11/19/2025, the Inventory of Personal Effects indicated Resident 1 had one billfold/wallet, two credit cards, and four check booklets. During a review of the facility's Theft and Loss Log, dated 11/2025, the Theft and Loss Log indicated on 11/22/2025 (the day Resident 1 was readmitted to the facility), Resident 1 reported his wallet was missing. The Theft and Loss Log indicated on 11/27/2025 the wallet was replaced. During a review of Resident 1's Theft/Loss Report, dated 11/27/2025, the Theft/Loss Report indicated Resident 1 reported his brown leather billfold/wallet was missing on 11/22/2025 at 2:30 p.m. The Theft/Loss Report indicated the area on the form designated to estimate the value of the lost items and the area designated to indicate if the lost item was listed on the resident's inventory form were left blank. During an interview on 1/21/2026 at 10 a.m., Resident 1 stated he was transferred to the GACH (11/19/2025) and he was too sick to remember to take his wallet with him. Resident 1 stated he always left his wallet in the same spot, in the drawer next to his bed and while still in</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  Facility ID: 055364	If continuation sheet Page 1 of 4

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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>the GACH he asked Family Member (FM) 2 to look for it but FM 2 could not find the wallet in its usual spot, which made him realize the wallet had been stolen. Resident 1 stated someone charged \$800 to his credit card, but the bank caught it and reimbursed the money back to his account. Resident 1 stated he informed SSS 1 of the theft of his wallet and the unauthorized \$800.00 withdrawal. Resident 1 stated they replaced his wallet but not the contents inside of it. Resident 1 stated FM 1 called (date unknown) SSS 2 to report that his wallet had been stolen along with the contents inside including his credit card, his Medicare card, Medi-Cal card, social security card, family pictures, and an unauthorized charge to his account for \$800.00, but they refused to help. During an interview on 1/21/2026 at 11:18 a.m., The Social Services Director (SSD) stated when Resident 1 returned from the GACH (11/22/2025) he reported to SSS 1 (exact date unknown) that someone had taken \$800.00 out of his bank account, but the bank had reimbursed the money to Resident 1. The SSD stated the theft of Resident 1's wallet and the missing money should have been reported to the police since the amount of money that was missing was greater than \$100. The SSD stated due to Resident 1's cognitive state he (SSD) was not sure if Resident 1 could report what happened accurately. The SSD stated Resident 1's allegation that \$800.00 was missing from his bank account after the report that his wallet was missing does suggest someone could have taken his credit card and used it. During an interview on 1/21/2026 at 11:40 a.m., SSS 1 stated when Resident 1 returned from the GACH (11/22/2025), he reported (exact date unknown) to him that \$800.00 was missing from his bank account. SSS 1 stated Resident 1 reported his bank was going to return the money to him so he (SSS 1) did not think to report the missing money to the CDPH because he was told by Resident 1 that the bank would handle it but acknowledged that the allegation that \$800.00 was missing could imply that someone from the facility took his wallet. During an interview on 1/21/2026 at 2:17 p.m., the Administrator (ADM) stated he was not aware that Resident 1 reported to SSS 1 that \$800.00 was missing from his bank account. The ADM stated if Resident 1 reported \$800.00 had been taken from his bank account, following the report that his wallet was lost, the missing money should have been reported to the CDPH per regulations. During a review of facility's policy and procedure (P&amp;P) titled Investigating Incidents of Theft and/or Misappropriation of Resident Property dated 4/2017, the P&amp;P indicated should an alleged or suspected case of staff misappropriation of resident property be reported, the facility Administrator, or his/her designee, will notify the following agencies within 24-hours of such incident, as appropriate: a. State Licensing and Certification Agency b. Ombudsman c. Resident Representative d. Adult Protective Services e. Law Enforcement Officials The P&amp;P indicated the results of the investigation will be reported to the administrator within five (5) working days of the reported incident, and the administrator or his/her designee will notify the resident and/or the resident's representative of the results of their investigation and the corrective action taken within five (5) working days of the completion of the investigation. The P&amp;P indicated the administrator will report the investigation to the local police department, the ombudsman, and to the state survey and certification agency within five (5) working days of the incident. During a review of facility's P&amp;P titled Identify Exploitation, Theft and Misappropriation of Resident Property, dated 4/2021, the P&amp;P indicated, staff and providers were expected to report suspected exploitation, theft or misappropriation of resident property.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview, and record review, the facility failed to ensure an allegation made by one of three sampled residents (Resident 1) that his wallet was missing and a subsequent allegation of an unauthorized charge of \$800.00 was made against Resident 1's credit card, was investigated. This deficient practice resulted in the inability of the facility to determine who at the facility might have been responsible for the theft of Resident 1's wallet and the misappropriation of \$800.00 from Resident 1's bank account. This deficient practice placed other residents at risk of their property being stolen due to non-investigation of the allegation. Findings: During a review of Resident 1's admission Record (Face Sheet), the Face Sheet indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including metabolic encephalopathy (a disease in which the functioning of the brain is affected by some agent or condition such as viral infection or toxins in the blood), pneumonia (an infection/inflammation in the lungs), acute chronic respiratory failure (a condition in which the lungs have a hard time loading blood with oxygen or removing carbon dioxide [a colorless, odorless waste gas produced by cellular metabolism that the body transports via blood and exhales through the lungs], with hypoxia (diminished availability of oxygen to the body tissues), and diabetes mellitus ([DM] a disorder characterized by difficulty in blood sugar [b/s] control and poor wound healing). During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool), dated 11/26/2025, the MDS indicated Resident 1's cognition (the ability to think and reason) was intact. During a review of Resident 1's SBAR ([situation, background, assessment, recommendation] a communication tool used by healthcare workers when there is a change of condition among the residents), dated 11/19/2025, the SBAR indicated Resident 1 was transferred to the emergency department for drowsiness and refusal to eat breakfast. During a review of Resident 1's Physician Order, dated 11/22/2025, the Physician Order indicated to readmit Resident 1 to the facility. During a review of Resident 1's Inventory of Personal Effects, dated 11/19/2025, the Inventory of Personal Effects indicated Resident 1 had one billfold/wallet, two credit cards, and four check booklets. During a review of the facility's Theft and Loss Log, dated 11/2025, the Theft and Loss Log indicated on 11/22/2025 (the day Resident 1 was readmitted to the facility) Resident 1 reported his wallet was missing. The Theft and Loss Log indicated on 11/27/2025 the wallet was replaced. During a review of Resident 1's Theft/Loss Report, dated 11/27/2025, the Theft/Loss Report indicated Resident 1 reported his brown leather billfold/wallet was missing on 11/22/2025 at 2:30 p.m. The Theft/Loss Report indicated the area on the form designated to estimate the value of the lost items and the area designated to indicate if the lost item was listed on the resident's inventory form were left blank. During a review of the facility's Five Day Report, dated 1/27/2026, the Five Day Report indicated the facility did not begin an investigation into the allegation made by Resident 1 that an unauthorized \$800.00 was charged to his bank account after his wallet was reported missing on 11/22/2025 until 1/21/2026. During an interview on 1/21/2026 at 10 a.m., Resident 1 stated he was transferred to the GACH (11/19/2025) and was too sick to remember to take his wallet with him. Resident 1 stated he always left his wallet in the drawer next to his bed and while he was still in the GACH he asked Family Member (FM) 2 to look for it but FM 2 could not find the wallet in its usual spot, which made him realize the wallet had been stolen. Resident 1 stated someone charged \$800.00 to his credit card, but the bank caught it and reimbursed the money back to his account. Resident 1 stated he informed Social Services Specialist (SSS) 1 of the theft of his wallet and the unauthorized \$800.00 withdrawal. Resident 1 stated they replaced his wallet but not the contents inside of it. Resident 1 stated FM 1 called SSS 2 (1/19/2026) to report that his wallet had been stolen along with</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>the contents inside including his credit card, his Medicare card, Medi-Cal card, social security card, family pictures, and an unauthorized charge to his account for \$800.00, but they refused to help. During an interview on 1/21/2026 at 10:16 a.m., FM 1 stated when he spoke to SSS 2 on 1/19/2026 and informed him that Resident 1 was still missing items and cash from his wallet, and he (FM 1) expressed concern that no investigation had been conducted when Resident 1's wallet was stolen while Resident 1 was at the GACH. FM 1 stated he asked SSS 2 if the police had been contacted but was told by SSS 2 that Resident 1's missing wallet concern had been resolved, and SSS 2 would not discuss it further. During an interview on 1/21/2026 at 11:18 a.m., The Social Services Director (SSD) stated when Resident 1 returned from the GACH (11/22/2025) he reported to SSS 1 (exact date unknown) that someone had taken \$800.00 out of his bank account, but the bank had reimbursed the money to Resident 1. The SSD stated the theft of Resident 1's wallet and the missing money should have been reported to the police since the amount of money that was missing was greater than \$100. The SSD stated Resident 1's allegation that \$800.00 was missing from his bank account after the report that his wallet was missing does suggest someone could have taken his credit card and used it. The SSD stated if someone reports an item as stolen, the facility must investigate the allegation. During an interview on 1/21/2026 at 11:40 a.m., SSS 1 stated when Resident 1 returned from the GACH (11/22/2025), he reported (exact date unknown) to him that \$800.00 was missing from his bank account. SSS 1 stated Resident 1 reported his bank was going to return the money to him so he (SSS 1) did not think to report the missing money to the CDPH because he was told by Resident 1 that the bank would handle it. SSS 1 acknowledged the allegation that \$800.00 was missing from Resident 1's bank account could imply that someone from the facility took his wallet. SSS 1 stated he did not think to investigate Resident 1's allegation that money had been taken from his bank account because the bank, per Resident 1's report, was handling it and would reimburse the money to Resident 1's bank account. During an interview on 1/21/2026 at 2:17 p.m., the Administrator (ADM) stated he was not aware that Resident 1 reported to SSS 1 that \$800.00 was missing from his bank account. The ADM stated if Resident 1 reported \$800.00 had been taken from his bank account, following the report that his wallet was lost, the allegation should have been investigated, per regulations. During a review of facility's Policy and Procedure (P&amp;P) titled Investigating Incidents of Theft and/or Misappropriation of Resident Property dated 4/2017, the P&amp;P indicated all reports of theft or misappropriation for resident property shall be promptly and thoroughly investigated. The P&amp;P indicated the facility will exercise reasonable care to protect resident property loss or theft, including by promptly responding to and investigating complaints of theft or misappropriation of property and training staff to educate them about activities that constitute and procedures for reporting misappropriation of resident property. The P&amp;P indicated when an incident of theft and/or misappropriation of resident property is reported, the administrator will appoint a staff member to investigate the incident.</p>		