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	03/16/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **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 1), who required a two-person assist with transfers from a sitting to standing position and from a chair to bed, was assisted by Certified Nursing Assistant (CNA 1) and another staff member conducting a full body lift to transfer Resident 1 from a chair to her bed. This deficient practice resulted in Resident 1 standing up and attempting to transfer from a chair to her bed without assistance and falling to the floor. Resident 1 was transferred to a General Acute Care Hospital (GACH) where she was diagnosed with bilateral (both sides) acute distal fibular fractures (a sudden traumatic break in the lower end of the calf bone) of both ankles. 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]. Resident 1's diagnoses included diabetes mellitus ([DM] a disorder characterized by difficulty in blood sugar control and poor wound healing), morbid obesity (overweight), and extrapyramidal movement disorder ([EPS] drug induced movement disorders' primarily side effects of antipsychotics [medications that help people who have severe mental health issues] and other mental and emotional conditions], causing involuntary spasms, tremors, rigidity, and restlessness). During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool), dated 3/1/2026, the MDS indicated Resident 1's cognition (the ability to think and reason) was intact. The MDS indicated Resident 1 required maximal assistance (helper does more than half the effort by lifting or holding trunk or limbs) when going from sitting to standing.During a review of Resident 1's Fall Risk Evaluation, dated 11/16/2025, the Fall Risk Evaluation indicated Resident 1 was at moderate risk for falls.During a review of Resident 1' s Weight Summary report, dated 3/4/2026, the Weight Summary report indicated Resident 1 weighed 219 pounds ([lbs] a unit of measurement) and was four feet 10 inches tall. The Weight Summary report indicated Resident 1's body mass index ([BMI] a quick calculation using a person's weight and height to estimate their total body fat) was 45.8. 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 3/4/2026, and timed at 2:28 p.m., the SBAR indicated at 9:38 a.m., after Resident 1 was transferred from a chair to her bed both of her legs became weak, and she was eased to the floor. The SBAR indicated at approximately 3 p.m., Resident 1 complained of pain in both her legs and had swelling to her right ankle along with a bluish discoloration.During a review of Resident 1's Physician's Orders, dated 3/4/2026, and timed at 4:24 p.m., the Physician's Order indicated Resident 1 may be transferred to a GACH.During a review of Resident 1's Transfer Form, dated 3/4/2026, and timed at 5:34 p.m., the Transfer Form indicated Resident 1 was transferred to a GACH.During a review of the GACH's admission Record, dated 3/4/2026, the admission Record indicated Resident 1 was admitted to the GACH on 3/4/2026 at 5:37 p.m.During a review of the GACH's ED (Emergency Department) Note, Physician (ED Note), dated 3/4/2026, the ED Note indicated Resident 1 presented with bilateral ankle pain and stated she fell when getting out of her shower chair that morning (3/4/2026). The ED Note indicated Resident 1 had significant diffuse (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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NAME OF PROVIDER OR SUPPLIER Long Beach Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3401 Cedar Avenue Long Beach, CA 90807	

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F 0689 Level of Harm - Actual harm Residents Affected - Few	swelling (a generalized accumulation of fluid in body tissues that causes widespread puffiness, tight skin, and reduced movement) and ecchymosis (bruising resulting from bleeding underneath the skin) to her right ankle and her left ankle was assessed likely swelling. The ED Note indicated the X-ray (a procedure that takes pictures of the inside of the body to diagnose broken bones and other injuries) showed an acute distal fibular fracture of both ankles.During a review of the GACH's Radiology (a medical specialty that uses imaging to diagnose and treat diseases) report, dated 3/4/2026, and timed at 6:08 p.m., the Radiology report indicated Resident 1 had displaced fractures (a broken bone where the pieces have moved out of their normal alignment) of the left and right distal fibula.During a review of the GACH's Orthopedic Consultation note, dated 3/7/2026, and timed at 2:05 p.m., the Orthopedic Consultation note indicated Resident 1 had bilateral bimalleolar fractures (a severe, unstable ankle injury involving fractures of both the inner and outer parts of the ankle). The Orthopedic Consultation note indicated the plan was for Resident 1 to undergo an Open Reduction and Interna Fixation ([ORIF] a surgery to fix a broken bone where the surgeon makes an incision to realign the broken bone pieces into the correct position by using hardware such as screws, plates, or rods to hold the bone in place while it heals) of both ankles.During a review of the GACH's Physician's Progress Note, dated 3/11/2026, and timed at 10:04 p.m., the Physician's Progress Note indicated the Pulmonologist (a medical doctor specialized in diagnosing and treating diseases of the respiratory system) recommended a closed reduction (a non-surgical orthopedic procedure used to realign a fractured or dislocated bone to its natural position without making an incision) for Resident 1's ankle fractures instead of surgery because it was safer. The Physician's Progress Note indicated on 3/5/2026 Resident 1 had two doses of morphine (a medication primarily used to treat moderate to severe pain) 3 milligrams ([mg] a metric unit of measurement, used for medication dosage and/or amount) and a rapid response team (specialized healthcare professionals called to a hospital patient's bedside when they show early signs of decline to provide immediate critical care to prevent heart attack or respiratory failure) was called to place Resident 1 on a Bilevel Positive Airway Pressure ([BiPAP] a noninvasive ventilator used to assist breathing by delivering pressurized air through a mask) machine due to her labored breathing (abnormal, effortful breathing that requires more energy than usual, often indicating serious respiratory distress) and was administered one ampule (a small sealed glass vial containing a single dose of medication) of Narcan (a medication used to reverse opioid (a class of drugs used for severe or chronic pain management) overdoses by blocking opioid receptors in the brain to restore breathing within minutes). The Physician's Progress Note indicated Resident 1 would likely run into problems postoperatively (after surgery) such as difficult extubating (removing a breathing tube from a patient's airway, signaling the end of mechanical ventilation) and respiratory acidosis (a condition occurring when the lungs cannot remove enough carbon dioxide [a colorless odorless, non-flammable gas) due to the use of narcotics. During a review of the GACH's Progress Note Physician (Physician's Note), dated 3/10/2026, the Physician's Note indicated the Pulmonologist ordered Boniva (a prescription bisphosphonate medication used to treat or prevent osteoporosis in women after menopause by strengthening bones and reducing fracture risk), vitamin d2 (a supplement essential for calcium absorption, bone health, and treating deficiencies), Calcium (a supplement for bone health, muscle function, and nerve transmission) to treat osteopenia (a condition where bones have low bone density, a measurement of the amount of calcium and other minerals packed into a segment of bone, indicating its strength and durability) and bilateral casts on her ankles.During a concurrent interview on 3/12/2026 at 4:11 p.m., with the MDS Specialist and a review of Resident 1's at risk for falls Care Plan, dated 6/2/2023, the at risk for falls Care Plan indicated Resident 1 was at risk for falls related to (r/t) her diagnosis of hypotension (abnormally low blood pressure, typically below 90/60 mmHg), neuropathy (damage to the nerves outside the brain and spinal cord, often causing weakness, numbness, and pain, typically in the hands and feet), generalized weakness, obesity, a history of falls requiring a one person assist for transfers, and an EPS movement disorder. The at risk for falls Care Plan's goal indicated Resident 1would have a reduction (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	in the risk for falls. The at risk for falls Care Plan's intervention included safe resident handling, transfer resident with a full body lift using a two person assist. The MDS Specialist stated despite the Care Plan's initiation date of 6/2/2023 the at risk for falls Care Plan was current and accurately indicated Resident 1 required two-person assistance when transferring from a chair due to her obesity and having poor strength in her lower extremities. During an interview on 3/13/2026, at 10:19 a.m., Licensed Vocational Nurse (LVN) 1 stated on 3/4/2026 at approximately 9:30 a.m., she was informed by CNA 1 that Resident 1 fell when transferred from a shower chair to her bed. LVN 1 stated she assessed Resident 1 and at the time of her fall she was without pain or swelling, but at approximately 2 p.m., CNA 1 reported to her that Resident 1 had pain and swelling to her right leg. LVN 1 stated she was not aware of Resident 1's Care Plan but Resident 1 likely required two-person assistance with transfers due to her obesity and muscle weakness. During an interview on 3/13/2026, at 11:27 a.m., CNA 1 stated on 3/4/2026 in the morning (exact time unknown) after showering Resident 1, she brought her back to her room on a shower chair. Resident 1 stood up using a walker, she was next to her bed where she held onto the bed's side rail. CNA 1 stated Resident 1 would normally pivot (a technique used to move a patient with limited mobility between two surfaces by having them stand or partially stand, rotate on one or both feet, and sit down) in order to get onto her bed, but instead Resident 1 screamed for help and stated her legs felt weak. CNA 1 stated she got behind Resident 1, yelled for help, and eased Resident 1 onto the floor where she landed on her bottom with her knees and feet bent. CNA 1 stated she worked with Resident 1 for four years and usually assisted Resident 1 during transfers alone without assistance because Resident 1 was able to help by walking on most days. CNA 1 stated prior to Resident 1 transferring she would ask her how she felt to determine if she was able to stand or not. If Resident 1 felt tired, she (CNA 1) would ask for assistance transferring Resident 1. CNA 1 stated she was not aware Resident 1's Care Plan indicated she required two-person assistance with transfers. During an interview on 3/13/2026, at 3 p.m., the Director of Nursing (DON) stated CNA 1 should have asked for assistance when she transferred Resident 1 from the shower chair to her bed on 3/4/2026. The DON stated the licensed nurses should have communicated Resident 1's need for a two person assist during transfers to prevent Resident 1 from falling. During a review of facility's P/P titled Falls and Fall Risk, Managing, revised 3/2018, the P&P indicated based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks to try to prevent the resident from falling and try to minimize complications from falling. Risk factors include conditions such as lower extremity weakness and functional impairments, and medical conditions such as neurological disorders, and balance/gait disorders. The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls.