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	05/06/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of two sampled residents (Resident 1) was free from physical abuse. The facility failed to:1. Ensure Resident 1 did not swung his hands backward and struck Resident 2 on the nose when Resident 2 asked Resident 1 to pick up tissue paper on the floor.2. Follow Resident 1's Care Plan titled Resident 1 has behavioral problem: physical aggression manifested by striking out initiated on 03/01/2026 with interventions of one to one (1:1) supervision by staff.3. Follow the facility's policy and procedures (P&P) titled Resident to Resident Altercation which indicated facility staff will monitor residents for aggressive/inappropriate behaviors towards other residents, facility members, victors, or to the staff.These failures resulted in Resident 1 striking Resident 2 on the face, causing a nosebleed, and placed Resident 2 at risk for further physical harm, unnecessary anxiety, and fear related to Resident 1's behavior.Findings:During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE]. The admission Record indicated Resident 1 with diagnoses of paranoid (a pattern of behavior where a person feels distrustful and suspicious of other people) schizophrenia (a mental illness that is characterized by disturbances in thought), violent behavior (actions that threaten, harm, or injure people or property, such as physical assault, verbal threats, and property damage , type 2 diabetes (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing).During a review of Resident 1 Care Plan titled Resident 1 has behavioral problem: physical aggression manifested by striking out initiated on 03/01/2026, the Care Plan indicated a goal resident will be maintain manageable level daily for three months. The Care Plan interventions indicated a one to one (1:1) supervision by staff, psychiatry consult as ordered, administer medication per physician order and monitor side effects of medication.During a review of Resident 1's Minimum Data Set (MDS-resident assessment tool) dated 3/18/2026, the MDS indicated Resident 1 had moderate impairment with cognitive skills (ability to think, understand, learn, and remember) for daily decision-making. The MDS indicated Resident 1 required partial/moderate assistance (helper does less than half the effort, helper lifts, holds, or supports trunk or limbs) from staff for activities of daily living (ADL- routine tasks/activities such as bathing, dressing and toileting) and with transfers between surfaces.During a review of Resident 1 's COC dated 4/29/2026 timed at 3:53 p.m., the COC indicated Resident 1 with aggression, unprovoked aggression toward others.During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was originally admitted to the facility on [DATE] and readmitted on [DATE]. The admission Record indicated Resident 2 with diagnoses of but not limited to, unspecified anxiety disorder (emotion characterized by feelings of tension, worried thoughts), post-traumatic stress disorder unspecified (PTSD - a disorder in which a person has difficulty recovering after experiencing or witnessing a traumatic event), type 2 diabetes with foot ulcer (open wound on the foot). During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2 had intact cognitive skills for daily decision-making. The MDS indicated Resident 2 required partial/moderate assistance from staff for ADLs. During a review of Resident 2's Change of Condition ([COC] a sudden, clinically (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	important deviation from a patient's baseline in physical, cognitive (ability to think, understand, learn, and remember) behavioral, or functional status which without immediate intervention, may result in complications or death) dated 04/29/2026 timed at 3:14 p.m., the COC , indicate Resident 2 was found in a common area following an altercation with another resident. The COC indicated Resident 2 was punched in the nose and had active bleeding from the right naris (nose).During a concurrent observation and interview on 05/06/2026 at 09:27 a.m., with Resident 1, Resident 1 was observed in the hallway accompanied by a staff member. Resident 1 was unable to recall the incident on 4/29/2026 of him hitting another resident or altercation with anyone involving another resident. Resident 1 repeatedly asked what the surveyor wanted, appeared avoidant did not make eye contact, and refused to answer additional questions.During an interview on 05/06/2026 at 10:55 a.m., with Resident 2, and family member (FM) 1, Resident 2 stated she and Resident 1 were in the hallway when Resident 1 threw a paper tissue on the floor after blowing his nose. Resident 2 stated she asked Resident 1 to pick up the tissue. Resident 2 stated Resident 1 became upset, swung his hands backward, and struck her on the nose, causing her nose to bleed. Resident 2 stated she was feeling better but did not want to be around Resident 1 anymore because she believed he (Resident 1) needed assistance and supervision. Resident 2's FM 1 was present at the bedside during the interview and stated he had been notified of the incident between Resident 1 and Resident 2 and verbalized the facility need to ensure resident safety.During a concurrent interview and record review on 05/06/2026 at 2:50 p.m., with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated Resident 1 was very unpredictable and did not like women. LVN 1 stated the day before (5/5/2026), Resident 1 struck two CNAs and said, I hate nurses. LVN 1 stated Resident 1 liked to get his own way and became very aggressive when he did not. LVN 1 stated staff were closely monitoring Resident 1's behaviors until placement could be arranged at another facility better equipped to address his behaviors and diagnosis. LVN 1 stated she was not present when Resident 1 had the altercation with Resident 2.During a concurrent interview and record review on 05/06/2026 at 3:12 p.m. with the Registered Nurse Supervisor (RNS), the RNS stated he did not witness the incident between Resident 1 and Resident 2, but staff heard a noise and responded to the scene. The RNS stated he assisted and assessed Resident 2 after Resident 1 struck Resident 2 on the nose, causing a nosebleed. The RNS stated Resident 2 refused to go to the hospital. The RNS stated the bleeding stopped and staff offered pain medication to Resident 2. He stated that staff continued to monitor Resident 2, and at the time of the interview, no swelling or bruising was observed.During an interview on 05/06/2026 at 3:44 p.m. with the Director of Nursing (DON), the DON stated Resident 1 had previously been on 1:1 supervision due to safety and behavioral concerns. The DON stated staff discontinued the 1:1 supervision because Resident 1 had remained calm and had not exhibited behavioral issues unless provoked. The DON stated staff continued to monitor Resident 1 hourly; however, no staff witnessed the incident and only heard a loud noise in the hallway. The DON stated social services was actively seeking an alternative placement for Resident 1 and anticipated a possible discharge soon. The DON stated Resident 1 was placed back on 1:1 supervision on 05/06/2026 because he had become increasingly unpredictable.During a review of the facility's P&P revised 09/2022, titled Resident to Resident Altercation the P&P indicated Facility staff monitor residents for aggressive/inappropriate behaviors towards other residents, facility members, victors, or to the staff.During a review of the facility's P&P revised 12/2021 titled Resident Rights the P&P indicated Federal and state laws guarantee certain basic rights to all residents of this facility, these rights include the residents right to: be free from abuse, neglect, misappropriation of property, and exploitation.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to enforce its own policy related to maintaining a safe and sanitary environment and effective infection control practices by not ensuring staff followed required infection control procedures for residents on enhanced barrier precautions (EBP- infection control measure used to prevent the spread of multidrug -resistant organisms (MDRO- refers to bacteria and other germs that have developed resistance to multiple classes of antimicrobial drugs)This deficient practice had the potential for transmission of infectious microorganisms and crossˆcontamination (the transfer of bacteria, viruses, microorganisms, or other harmful substances from one surface to another through improper or unsanitary equipment, procedures, or products), placing both residents and staff at risk for the spread of infection.Findings:During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was originally admitted to the facility on [DATE] and readmitted on [DATE]. The admission Record indicated Resident 2 with diagnoses of but not limited to, unspecified anxiety disorder (emotion characterized by feelings of tension, worried thoughts), post-traumatic stress disorder unspecified (PTSD - a disorder in which a person has difficulty recovering after experiencing or witnessing a traumatic event), type 2 diabetes with foot ulcer (open wound on the foot).During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2 had intact cognitive (ability to think, understand, learn, and remember) skills for daily decision-making. The MDS indicated Resident 2 required partial/moderate assistance (helper does less than half the effort, helper lifts, holds, or supports trunk or limbs) from staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting).During an observation on 05/06/2026 at 10:29 a.m., Certified Nursing Assistants (CNA) 1 and CNA 2 were observed providing postˆshower care to Resident 2, who was on EBP for left foot ulcers (wound), without donning the required personal protective equipment (PPE-equipment used to prevent or minimize exposure to hazards) while in Resident 2's room.During an interview on 05/06/2026 at 11:13 a.m. with CNA 1, CNA 1 stated she had been in a rush to change Resident 2 after showering her, which is why she did not put on PPE. CNA 1 stated PPE was required to protect staff and other residents from contamination and stated she should have donned PPE before providing care to Resident 2.During an interview on 05/06/2026 at 2:12 p.m. with CNA 2, CNA 2 stated that it was important to sanitize hands and don PPE before entering any room with isolation precautions. CNA 2 stated she came to assist with Resident 2's care but acknowledged she should have put on her PPE before assisting with the resident's care.During a concurrent interview on 05/06/2026 at 3:44 p.m. with the Director of Nursing (DON) and the Infection Preventionist (IP), the DON stated signage was posted throughout the facility and at resident room entrances to remind staff of isolation requirements. The DON stated an inˆservice training on enhanced barrier precautions (EBP) had been conducted, but she did not understand why staff sometimes failed to follow proper procedures. The IP stated she had recently started working at the facility and would provide more infectionˆcontrol training to help ensure these issues did not occur again.During a review of the facility's policy and procedure (P&P) revised 12/2024, titled Enhanced Barrier Precautions the P&P indicated Enhanced Barrier precautions (EBPs) are utilized to prevent the spread of multi drug resistant organism (MDROs) to residents. Section 8. Stated example of high contact resident care actives requiring the use of gown and gloves for EBPs includeb. bathing/showering.c. providing hygiene or grooming.