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	06/08/2026

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 0774 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Help the resident with transportation to and from laboratory services outside of the facility. **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 2) did not wait over three hours for transportation back to the facility following her 2:45 p.m., appointment on 4/21/2026. This deficient practice resulted in Resident 2 without a means of transportation back to the facility following the completion of her appointment on 4/21/2026 at 3:45 p.m. Resident 2 remained in the lobby of the medical provider for approximately 4 hours without food, water or the use of a restroom until a transportation company arrived at 7 p.m., to take her back to the facility. This deficient practice had the potential for Resident 1 to be hungry, dehydrated, cold and frightened.Findings: During a review of Resident 2's admission Record (Face Sheet), the Face Sheet indicated Resident 2 was admitted to the facility on [DATE]. Resident 2 had diagnoses including acquired absence of left leg above knee (above the knee amputation [AKA] surgical removal of the portion of the leg above the knee), difficulty walking, hypertension ([HTN] high blood pressure), and type 2 diabetes ([DM] a disorder characterized by difficulty in blood sugar control and wound healing) with other circulatory complications. During a review of Resident 2's Minimum Data Set ([MDS] a resident assessment tool) dated 3/10/2026, the MDS indicated Resident 2 was cognitively intact (when an individual has normal, unimpaired mental capabilities) and required partial/moderate assistance (helper does less than half the effort) with toilet hygiene, shower/bath, lower body dressing and she used a wheelchair as a mobility device. During a review of Resident 2's Transportation Request dated 4/17/2026 the Transportation Request indicated Resident 2 would be taken to her outside medical appointment by a transportation company on 4/21/2026 at 1 p.m. and she would be picked up from the medical appointment at 3:30 p.m., for transfer back to the facility. During a review of Resident 2's clinical record, there was no documentation to indicate when Resident arrived to the facility. During an interview on 6/3/2026 at 9:45 a.m., Resident 2 stated on 4/21/2026 she had a scheduled doctor's appointment at 2:45 p.m., at an outside medical facility, transportation was scheduled to pick her up from the facility at 1:50 p.m., and Certified Nurse Assistant (CNA) 3 was assigned to escort her to the appointment. Resident 2 stated when her appointment was completed at 3:45 p.m., she and CNA 3 waited in the lobby of the medical facility for transportation to arrive. After sitting there for approximately 15 minutes, she called the transportation company and was told she was a no show. She then called the facility 16 times between 3:57 p.m., and 6:05 p.m., she was transferred several times to the nursing station, but no one ever picked up the phone to speak with her. At approximately 6 p.m., a security guard at the medical facility asked her and CNA 3 to leave because they were closing. The security guard agreed to let them stay in the medical facility's lobby but told them if they left the lobby the doors would automatically lock and they would not be able to reenter the lobby. She was scared, hungry and needed to use the restroom. Resident 2 stated she ordered pizza for herself and CNA 3 and never went to the restroom until she returned to the facility after 7 p.m. During an interview on 6/4/2026 at 9:35 p.m., the Supervisor of the Transportation Company stated their transportation (a van) attempted to pick up Resident 2 on 4/21/2026 at 3:41p.m., but Resident 2 was not there and when they called her phone, no one answered. Resident 2 was considered a no show, and their driver left. The facility's Social Service (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0774 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Specialist (SSS) called them at 4 p.m., to reschedule Resident 2's ride, we told the SSS we had no one available at that time to pick Resident 2 up, but we would continue looking. At 4:40 p.m., we found transportation to pick up Resident 2, but the transportation was not available until 7 p.m. Resident 2 was picked up at 7:15 p.m., and arrived at the facility at 8 p.m. During an interview on 6/4/2026 at 1:45 p.m., the Social Services Director (SSD) stated transportation was scheduled to pick up Resident 2 from her medical appointment on 4/21/2026 at 3:30 p.m., if Resident 2 missed her pick up time, it was the responsibility of the escort (CNA 3) to notify them. SSS stated CNA 3 called him (time unknown) to report that the Transportation Company left without picking up Resident 2. He told CNA 3 to just wait he would call the transportation company to find out when a ride would be available. SSS stated he called the Transportation company at approximately around 4 p.m. and was told it was after hours but they would try to find transportation for Resident 2. During an interview on 6/5/2026 at 9:30 a.m., CNA 3 stated she called the facility on 4/21/2026 (time unknown) and spoke to the SSD and was told by the SSD to just wait, he would call the Transportation company to reschedule a ride for Resident 2. CNA 3 stated after she spoke to the SSD the battery on her phone died and she was not able to make or receive any calls. CNA 3 stated she was scared, her eyes were burning, she was hungry and had no money for food. Resident 2 ordered a pizza for both of them During an interview on 6/8/2026 at 11 a.m., the SSS stated he called the Transportation Company at approximately 4 p.m., and again at 5 p.m. (4/21/2026). He could have called a cab to see if they were available to pick up Resident 2 but Resident 2 was unable to transfer herself from her wheelchair to a car and needed special transportation that could accommodate her wheelchair. During an interview on 6/8/2026 at 2 p.m., the DON stated they should have had a system in place to get Resident 1 back to the facility when she was not picked up from her appointment at the expected time. Licensed nurses and/or social services should have called the clinic and the Transportation Company when Resident 2 did not return from her appointment. During a review of the facility's Policy and Procedure (P/P) revised 12/2008, titled Transportation, Social Service the P/P indicated our facility shall help with transportation for residents as needed.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure an allegation of abuse was documented in the clinical record for one of three sampled residents (Resident 1). This deficient practice resulted in an incomplete depiction of Resident 1's status and had the potential for Resident 1's allegation of abuse to go unrecognized and compromise the investigation.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]. Resident 1 had diagnoses including osteomyelitis (inflammation of bone or bone marrow, usually due to infection) of the vertebra (one of the bones that make up the spinal column); cervical (neck) region, lack of coordination and alcohol use. During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 5/14/2026, the MDS indicated Resident 1?s cognition was moderately impaired. Resident 1 required supervision/touch assistance with toilet transfer, rolling left and right, sitting to lying, lying to sitting on side of the bed, and sitting to stand. During a review of Resident 1's Change of Condition (COC) Evaluation dated 5/17/2026 and timed at 3 p.m., the COC indicated on 5/16/2026 at 6:40 a.m., Resident 1 called Certified Nurse Assistant (CNA) 1 for assistance as she (Resident 1) positioned herself on the edge of the bed in an attempt to stand up unattended. CNA 1 stood in front of Resident 1 to help but she (CNA 1) handled Resident 1 roughly by striking Resident 1 on her right knee three times with her (CNA 1) right elbow. During a telephone interview on 6/2/2026 at 10:02 a.m., Resident 1 stated at approximately 1 a.m. (5/17/2026) she was in bed and needed to go to the restroom. CNA 1 came to her room and told her to hold on while she retrieved gloves. CNA 1 came back to her room and told her to hold on again. Resident 1 stated she needed to go to the bathroom, so she tried to stand up, and that was when CNA 1 stood in front of her, cursed at her, then shoved her (CNA 1) left elbow into her right knee and then shoved her aggressively on her right shoulder to make her sit on the bed. CNA 1 jabbed her right elbow to my right knee which made me cry due to the pain in my back. I reported what happened to Registered Nurse (RN) 2, and RN 2 told CNA 1 to leave immediately and do not come back. During an interview on 6/3/2026 at 7 a.m., RN 2 stated on 6/17/2026 at approximately 1 a.m., he went to Resident 1's room because RN 1 told her Resident 1 was yelling. RN 2 stated Resident 1 told him what CNA 1 did to her by demonstrating with elbow jabbing motion. RN 2 stated he told CNA 1 to leave the room. RN 2 stated he should have documented Resident 1's allegation of abuse so others who reviewed Resident 1's record would know what happened. During an interview on 6/3/2024 at 12:48 p.m., LVN 1 stated she worked on 6/17/2026 during the 7 a.m. to 3 p.m. shift and during the change of shift report RN 1 told her about the allegation made by Resident 1 against CNA 1. LVN 2 stated she created a COC regarding the allegation because it had not been done by the previous shift. During an interview on 6/8/2026 at 3 p.m., the Director of Nursing (DON) stated RN 2 called her around 2 a.m., to notify her of Resident 1's allegation of abuse. RN 2 should have created a COC per their policy. During a review of the facility's Policy and Procedure (P/P) revised July 2017, titled Charting and Documentation the P/P indicated All services provided to the resident progress towards the care plan goals or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. The following information is to be documented in the resident medical record: 1. Changes in the resident's medical condition. 2. Events incidents or accidents involving the resident's.