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	06/25/2026

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 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure a urine sample ordered for a urine toxicology test (a test performed to detect evidence of a recent drug use or misuse in a sample of urine) was collected, per the physician's order, for one of six sampled resident (Resident 4). This deficient practice resulted in the facility being unable to determine if Resident 4 had illegal substances present in her system and the potential for mismanagement of Resident 4's care needs.Findings: During a review of Resident 4's admission Record (Face Sheet), the Face Sheet indicated Resident 4 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 4 had diagnoses including anxiety disorder (a mental health condition that involves excessive fear, worry, or nervousness that interferes with daily life), opioid (a drug used to reduce moderate to severe pain) dependence and chronic obstructive pulmonary disease ([COPD] a chronic lung disease causing difficulty in breathing). During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 4/20/2026, the MDS indicated Resident 4 was able to make decisions that were reasonable and consistent and she required a one person assist to complete her activities of daily living ([ADLs] activities such as bathing, dressing, toileting a person performs daily). During a review of Resident 4's Change of Condition (COC) Evaluation dated 6/9/2026 and timed at 6:53 p.m., the COC indicated Resident 4 was assessed with an altered level of consciousness ([ALOC] a reduced state of alertness or difficulty to arouse) pinpoint pupils (when the pupils are too small and narrow and fail to widen or enlarge in dim lighting) and was only responsive to painful stimuli (a technique used by medical personnel for assessing the consciousness level of a person who is not responding to normal interactions, voice commands or gentle physical stimuli). Paramedics were called and Resident 4 was administered Narcan (a medicine administered to reverse the effects of an opioid overdose). Upon administration of Narcan, Resident 4 became alert and responded verbally. During a review of Resident 4's Nursing Progress Notes dated 6/9/2026 and timed at 9:24 p.m., the Nursing Progress Notes indicated Resident 4 was observed lethargic (a condition when a person has a decrease in consciousness with feelings of fatigue, drowsiness and sleepiness) with visual hallucinations (seeing things that aren't real, like objects, shapes, people, animals or lights), jerking movements and loss of bowels. Resident 4 was transferred to the GACH by paramedics for further evaluation and treatment. During a review of Resident 4's COC dated 6/10/2026 and timed at 7:47 a.m., the COC indicated Resident 4 was readmitted to the facility. The COC indicated a Complete Blood Count ([CBC] a group of blood tests that measure the number and size of the different cells in the blood), a Comprehensive Metabolic Panel ([CMP] a blood test that measures different kinds of substances that provide information about metabolism and balance of certain chemicals in the body), a urinalysis ([UA] a test of the urine used to detect urinary tract infections, kidney disease and diabetes) and a urine toxicology test were ordered. During a review of the Order Summary Report (Physician's Order) dated 6/10/2026 (no time documented), the Physician's Order indicated an order for a CBC, CMP, UA, and urine toxicology test. During a review of Resident 4's Urine Toxicology Test, the Urine Toxicology Test indicated Resident 4's specimen (urine) could not be completed because (continued on next page)

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

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the specimen was collected using a wrong media (wrong collection container). The specimen needed to be recollected, and a new order obtained for the test to be done. During a telephone interview on 6/22/2026 at 2:20 p.m., Licensed Vocational Nurse (LVN) 2 stated on 6/10/2026 during the end of the 7 a.m. to 3 p.m. shift, she received a report from Registered Nurse Supervisor (RNS) 3 that Resident 4's urine sample needed to be recollected. LVN 2 stated she did not endorse that report to the oncoming 3 p.m. to 11 p.m. shift. During a telephone interview on 6/22/2026 at 3:34 p.m., RNS 3 stated on 6/10/2026 during the 7 a.m. to 3 p.m. shift, he checked Resident 4's laboratory results, which indicated Resident 4's urine toxicology screen had not been completed because the urine sample was collected using the wrong specimen container. RNS 3 stated Resident 4 refused to give a urine sample during the 7 a.m. to 3 p.m. shift and he did not endorse the information to the oncoming 3 p.m., to 11 p.m., shift because he got busy and forgot. During an interview on 6/22/2026 at 5:42 p.m., the Director of Nursing Services (DON) stated, LVN 2 and RNS 3 should have endorsed Resident 4's refusal to provide a urine sample to the 3 p.m. to 11 p.m. shift so the nurses could have followed up with Resident 4 to attempt to collect the urine specimen. During a review of the facility's Policy and Procedure (P/P) titled, Lab and Diagnostic Test Results-Clinical Protocol revised 11/ 2018, the P/P indicated the facility staff will process test requisitions and arrange for tests.

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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 the medical record one of six sampled residents (Resident 4) had documentation to indicate Resident 4 refused to provide a urine sample for a urine toxicology test (a test performed to detect evidence of a recent drug use or misuse in a sample of urine) ordered by her physician. This deficient practice resulted in documentation of Resident 4's care missing from her clinical record and had the potential for non-continuity of care.Findings: During a review of Resident 4's admission Record (Face Sheet), the Face Sheet indicated Resident 4 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 4 had diagnoses including anxiety disorder (a mental health condition that involves excessive fear, worry, or nervousness that interferes with daily life), opioid (a drug used to reduce moderate to severe pain) dependence and chronic obstructive pulmonary disease [(COPD] a chronic lung disease causing difficulty in breathing). During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 4/20/2026, the MDS indicated Resident 4 was able to make decisions that were reasonable and consistent and she required a one person assist to complete her activities of daily living ([ADLs] activities such as bathing, dressing, toileting a person performs daily). During a review of Resident 4's Change of Condition (COC) Evaluation dated 6/9/2026 and timed at 6:53 p.m., the COC indicated Resident 4 was assessed with an altered level of consciousness ([ALOC] a reduced state of alertness or difficulty to arouse) pinpoint pupils (when the pupils are too small and narrow and fail to widen or enlarge in dim lighting) and was only responsive to painful stimuli (a technique used by medical personnel for assessing the consciousness level of a person who is not responding to normal interactions, voice commands or gentle physical stimuli). Paramedics were called and Resident 4 was administered Narcan (a medicine administered to reverse the effects of an opioid overdose). Upon administration of Narcan, Resident 4 became alert and responded verbally. During a review of Resident 4's Nursing Progress Notes dated 6/9/2026 and timed at 9:24 p.m., the Nursing Progress Notes indicated Resident 4 was observed lethargic (a condition when a person has a decrease in consciousness with feelings of fatigue, drowsiness and sleepiness) with visual hallucinations (seeing things that aren't real, like objects, shapes, people, animals or lights), jerking movements and loss of bowels. Resident 4 was transferred to GACH by the paramedics for further evaluation and treatment. During a review of Resident 4's COC dated 6/10/2026 and timed at 7:47 a.m., the COC indicated Resident 4 was readmitted to the facility. The COC indicated a Complete Blood Count ([CBC] a group of blood tests that measure the number and size of the different cells in the blood), a Comprehensive Metabolic Panel ([CMP] a blood test that measures different kinds of substances that provide information about metabolism and balance of certain chemicals in the body), a urinalysis ([UA] a test of the urine used to detect urinary tract infections, kidney disease and diabetes) and a urine toxicology test were ordered. During a review of Order Summary dated 6/25/2026, the Order Summary indicated a Physician Order dated 6/10/2026, for Resident 4 a CBC, CMP, UA, and Urine Toxicology Test. During a review of Resident 4's Urine Toxicology Test, the Urine Toxicology Test indicated Resident 4's specimen (urine) could not be completed because the specimen was collected using a wrong media (wrong collection container). The specimen needed to be recollected, and a new order obtained for the test to be done. During a telephone interview on 6/22/2026 at 3:34 p.m., RNS 3 stated on 6/10/2026 during the 7 a.m. to 3 p.m. shift, he checked Resident 4's laboratory results, which indicated Resident 4's urine toxicology screen had not been completed because the urine sample was collected using the wrong specimen container. RNS 3 stated Resident 4 refused to give a urine sample during the 7 a.m. to 3 p.m. shift and he did not endorse the information to the oncoming 3 p.m., to 11 p.m., shift, he did not document in Resident 4's clinical record or on the facility's communication board because he got busy and forgot. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/22/2026 at 5:42 p.m., the Director of Nursing Services (DON) stated RNS3 should have documented in Resident 4's clinical record to indicate the need for a follow up and Resident 4's refusal to provide a urine sample. During a review of the facility's Policy and Procedure (P/P) titled, Charting and Documentation revised 7/2017, the P/P indicated all services provided to the resident, progress toward the care plan goal, or any changes in the resident's medical, physical, functional or psychosocial condition shall be documented in the resident's medical record to facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. The documentation of the procedures and treatments will include care-specific details, including but not limited to: a. the date and time the procedure/ treatment was provided,b. the name and title of the individual (s) who provide the care;c. the assessment data and/or unusual findings obtained during the procedure/ treatment,d. how the resident tolerated the procedure/ treatmente. whether the resident refused the procedure/ treatmentf. notification of the family, physician or other staff if indicated, andg. the signature and title of the individual documenting.