STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055744	A. Building B. Wing	06/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Atlantic Memorial Healthcare Center	2750 Atlantic Avenue Long Beach, CA 90806

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **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) received effective pain management by failing to ensure Licensed Vocational Nurse (LVN) 1 addressed Resident 1's pain when the resident developed dysuria (painful urination) on 6/10/2026.This failure put Resident 1 at risk of unrelieved pain and for delay of care.During a review of Resident 1's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 1 was admitted on [DATE] to the facility with diagnoses including Parkinson's Disease(a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), myasthenia gravis(chronic autoimmune[body gets confused and produces proteins that attack normal cells]disorder that causes muscles to feel weak and tire out easily), hypertension(HTN- high blood pressure), and chronic kidney disease(kidneys are damaged and lose their ability to filter waste and extra water from the blood).During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 5/26/2026, the MDS indicated Resident 1 had moderately impaired cognitive skills (noticeable problems with thinking and required increased assistance with activities of daily living [ADL- activities such as bathing, dressing and toileting a person performs daily]) and was dependent on staff with bathing.During a review of Resident 1's History and Physical (H&P-physician's comprehensive and initial assessment of a patient) dated 5/23/2026, the H&P indicated Resident 1 had the capacity to understand and make decisions.During a review of Resident 1's Change in Condition Evaluation (COC-a sudden, clinically 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 6/10/2026 at 7:22 p.m , the COC indicated Resident 1 was complaining of dysuria with a pain scale(tool using numbers to measure and describe pain) of 5 out of 10 (0- no pain, 1 to 3 mild pain, 4 to 6 moderate pain and 7 to 10 severe pain).During a review of Resident 1's Care Plan titled, Resident is having dysuria, initiated on 6/10/2026, the Care Plan indicated interventions including monitoring of pain levels, providing medication, treatment as ordered and notifying the physician if the pain did not improve.During a review of Resident 1's Order Summary Report dated 5/21/2026, the Order Summary Report indicated an order for Acetaminophen (medicine used to relieve pain) 325 milligrams (mgs.- unit of measurement) 2 tablets by mouth every 4 hours as needed for mild pain (1-3) not to exceed 3 grams(GM- unit of measurement) in 24 hours.During a concurrent interview and record review on 6/16/2026 at 10:56 a.m., with Licensed Vocational Nurse (LVN) 2, Resident 1's COC dated 6/10/2026, Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) dated 6/10/2026 and Order Summary Report were reviewed. LVN 2 stated Resident 1 complained of dysuria 5/10 pain scale on 6/10/2026 and there was no pain medicine administered to Resident 1 when the resident complained of dysuria on 6/10/2026 at 7:22 p.m. LVN 2 stated there was no new order addressing Resident 1's pain level of 5. LVN 2 stated LVN 1 should have notified the physician of Resident 1's level of pain, for appropriate pain medication intended for pain level of 5. LVN 2 stated Resident had a physician order for (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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Acetaminophen 325 mgs. 2 tablets for mild pain (pain level of 1 to 3). LVN 2 stated Resident 1's pain level could increase and resident's pain would likely linger affecting her quality of life.During a telephone interview on 6/16/2026 at 4:05 p.m., with LVN 2, LVN 2 stated Resident 1 was complaining of pain during urination on 6/10/2026. LVN 1 stated she did not administer any pain medicine when Resident complained of dysuria 5/10 pain level on 6/10/2026 at 7:22 p.m. LVN 2 stated she could not remember why she did not give pain medicine to Resident 1. LVN 1 stated she should have called the physician for appropriate medication when Resident 1 was complaining of pain 5/10. LVN 1 stated Resident 1's pain level could continue to increase if her pain was not addressed properly.During a concurrent interview and record review on 6/16/2026 at 1:41 p.m., with RN Supervisor (RNS)1, Resident 1 COC dated 6/10/2026 at 7:26 p.m. and MAR dated 6/10/2026 were reviewed. RNS 1 stated LVN 1 should have notified the physician of Resident 1's pain scale of 5/10 because Acetaminophen was intended for mild pain (pain scale 1 to 3) and there was no other pain medicine ordered for Resident 1.RNS 1 stated the licensed nurse should have notified the physician to obtain medication appropriate for pain scale of 5/10. RNS 1 stated Resident 1's pain could get worse and could put Resident 1 at risk for hospitalization.During an interview on 6/16/2026 at 4:36 p.m., with the Director of Nursing (DON), the DON stated LVN 1 should have notified the physician because the pain level was 5/10 and asked for an appropriate medication for pain. DON stated Acetaminophen was only for pain scale of 1-3. DON stated Resident 1 could suffer more pain because pain should be addressed to ensure the resident will be free of pain.During a review of facility's policy and procedure (P&P) titled, Pain Recognition and Management, revised 12/2023, the P&P indicated t consulting the physician if pain management is ineffective or for additional interventions if pain is not relieved by current orders.