

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055995	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/10/2025
NAME OF PROVIDER OR SUPPLIER North Long Beach Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 260 E Market St Long Beach, CA 90805	

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)
<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Resident 1's responsible party's (RP) request was honored when he requested Resident 1 to be removed from the podiatrist patient list. This deficient practice resulted in Resident 1 being seen by the podiatrist on 5/6/2025. Findings: During a review of Resident 1's admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities). During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 8/26/2025, the MDS indicated Resident 1's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was severely impaired and was dependent on facility staff to complete her activities of daily living ([ADLs] activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 1's Social Services Progress Note dated 1/2/2025, the Social Services Progress note indicated Resident 1's RP requested that Resident 1 be removed from the facility's podiatry list and would arrange for any necessary podiatry services. During an interview on 9/10/2025 at 11:49 a.m., with Resident 1's RP, Resident 1's RP stated he had discussed during an Interdisciplinary Team meeting ([IDT] a group of professionals from different fields who work together to achieve a common goal), he did not want the assigned podiatrist to see Resident 1. The RP stated a few weeks ago, he came to see Resident 1 and he found the podiatrist removing her socks and he immediately told him (the podiatrist) that he would prefer Resident 1 not be seen. The RP stated he informed the Social Services Director (SSD) and the Director of Nursing (DON) to have Resident 1 removed from the list and the SSD stated she would. During an interview on 9/10/2025 at 1:37 p.m., with the SSD, the SSD stated last month (8/2025), Resident 1's RP informed her that he did not want the podiatrist to see Resident 1. The SSD stated she was not aware of any previous requests from Resident 1's RP to remove Resident 1 from the podiatrist list. During an interview on 9/10/2025 at 2:10 p.m., with the DON, the DON stated the social services department should be coordinating with the podiatrist office regarding which residents are to be seen. The DON stated that the request made by Resident 1's RP to remove the resident from the podiatry list was overlooked. The DON stated that this coordination should have occurred when the RP initially made the request in 1/2025. During a review of the facility's policy and procedure (P/P) titled Resident Rights, dated 12/2021, the P/P indicated federal and state laws guarantee certain basic rights to all residents of the facility, these rights include the resident's right to be informed of and participate in, his or her care planning and treatment.</p>

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify Resident 1's Responsible Party (RP) of a significant change in condition, when Resident 1 had a fall that occurred on 8/29/2025 at 4:39 a.m. Resident 1's RP not notified until 7 a.m. This deficient practice had the potential to delay the RP's involvement in care decisions and compromised the residents' right to informed participation in their care. This deficient practice resulted in an approximately two-and-a-half-hour delay in notifying Resident 1's RP. Findings: During a review of Resident 1's admission Record (Face Sheet), the admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities). During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 8/26/2025, the MDS indicated Resident 1's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was severely impaired was dependent on facility staff to complete her activities of daily living ([ADLs] activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 1's Change of Condition (COC) Note dated 8/29/2025 and timed at 4:39 a.m., the COC note indicated Resident 1 was found by a Certified Nurse Assistant (CAN unknown) sitting on the floor to the right side of the bed facing the wall. The COC Note indicated Resident 1's RP was notified at 7 a.m. During an interview on 9/10/2025 at 11:49 a.m., Resident 1's RP stated that he received a phone call from the facility staff regarding Resident 1's fall at 7:08 am. During an interview on 9/10/2025 at 2:10 p.m., the Director of Nursing (DON) stated she received a phone call from Licensed Vocational Nurse (LVN) 1 after Resident 1 was found on the floor. The DON stated LVN 1 was scared to report Resident 1's fall to the RP. The DON stated she had to guide LVN 1 to ensure everything was completed for Resident 1 post fall. The DON stated Resident 1's RP should have been notified at the time of the incident. During a review of the facility's policy and procedure (P/P) titled Change in Condition: Notification of, dated 8/25/2021, the P/P indicated the facility must inform the resident representative as soon as possible where there is an accident involving the resident.</p>		