STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055995	A. Building B. Wing	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Long Beach Post Acute	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)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure a rolling stool (a mobile seating device featuring a padded seat, a lift for adjustable height, and 360 degree swivel casters) was not left in the facility's dining/activity room where it posed a safety hazard to residents due to the rolling mechanism of the chair, for one out of three residents (Resident 1). This deficient practice resulted in Resident 1 losing her balance and falling while attempting to sit on a rolling stool. Resident 1 complained of pain to her right hip and left rib area and was transferred to a General Acute Care Hospital (GACH) where she was assessed with multiple right rib fractures (broken bones). This deficient practice had the potential to cause harm to other residents who were in the area where a rolling stool was left unattended. 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] and readmitted on [DATE]. Resident 1's diagnoses included multiple fractures of the ribs on the right side and paranoid schizophrenia (a chronic mental health condition characterized by intense, irrational, and persistent distrust, suspicion, and fear of others, along with auditory hallucinations [the perception of sounds, such as voices, music, or noises, in the absence of any external stimulus] and delusions [fixed, false beliefs firmly held despite clear, contradictory evidence]). During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool), dated 12/3/2025, the MDS indicated Resident 1's cognition (the ability to think and reason) was moderately impaired. The MDS indicated Resident 1 required supervision (helper provides verbal cues and/or touching/steadying and/or contact guard assistance [where constant, light physical contact with a patient to provide stabilization and prevent falls, without lifting or supporting their weight] as resident completes activity, provided throughout the activity or intermittently) with walking greater than 10 feet and when sitting to standing. During a review of Resident 1's Situation, Background, Assessment, Recommendation ([SBAR] a communication tool used by healthcare workers when there is a change of condition among the residents) dated 2/8/2026, and timed at 4:30 p.m., the SBAR indicated Resident 1 sustained an unwitnessed fall in the activity room, and was lying on her left side. The SBAR indicated Resident 1 verbalized she had pain to both her right hip and left rib area. During a review of Resident 1's Physician's Orders, dated 2/8/2026, the Physician's Orders indicated to transfer Resident 1 to the GACH for a suspected fall with suspected injury. During a review of the facility's Five-Day Summary, dated 2/10/2026, the Five-Day Summary indicated on 2/8/2026, at approximately 4:30 p.m., Resident 1 independently ambulated (walked) into the activity room, where Certified Nursing Assistant (CNA) 1 was present. The Five-Day Summary indicated at the time of the incident CNA 1 was assisting another resident and briefly turned away when Resident 1 attempted to sit on a rolling stool, which rolled from underneath her (Resident 1) causing her to fall on to her left side. During a review of the GACH's Information Sheet dated 2/8/2026, the GACH's Information Sheet indicated Resident 1 arrived to the GACH on (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

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 02/25/2026
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)
F 0689 Level of Harm - Actual harm Residents Affected - Few	2/8/2026, at 8:50 p.m. During a review of Resident 1's GACH Computed Tomography Scan ([CT Scan] a procedure that produces detailed images of bones, organs, and soft tissues), dated 2/9/2026 and timed at 10:34 p.m., the CT Scan indicated Resident 1 had right-sided rib fractures. During a review of Resident 1's GACH History of Present Illness (HPI), dated 2/9/2026, the HPI indicated Resident 1 presented to the emergency department (ED) after a mechanical fall (a fall caused by an external environmental factor) from losing her balance. The HPI indicated the CT scan of Resident 1's chest showed right side rib fractures, and the plan was to observe Resident 1, control her pain, provide prophylaxis (action taken to prevent disease, especially by specified means or against a specified disease) to prevent a deep vein thrombosis ([DVT], a serious condition where a blood clot forms in a deep vein, usually in the legs, causing symptoms like swelling, pain, warmth, and redness, and the clot can break loose and travel to the lungs, being potentially fatal), and to have her evaluated by physical therapy ([PT] the treatment of disease, injury, or physical conditions by methods such as massage, heat treatment, and exercise rather than by drugs or surgery). During an interview on 2/25/2026 at 11:55 a.m., the Director of Nursing (DON) stated there was a care plan created for Resident 1 related to a fall she sustained in 6/2025, but it had been resolved due to Resident 1 meeting her goals. The DON stated Resident 1 was steady on her feet and there had been no other care plan created prior to her current fall on 2/9/2026. The DON stated Resident 1 was still at risk for falls due to her use of psychotropic medications (a class of prescription drugs designed to affect the mind, emotions, and behavior by altering the chemical balance of neurotransmitters in the brain). During an interview on 2/25/2026 at 3:24 p.m., the Administrator (ADM) stated the rolling stool was from the rehabilitation/therapy room and should not have been in the activity/dining room because it was not safe and posed a safety risk to residents. The ADM stated she was not able to identify who left the rolling stool in the dining/activity room. During an interview on 2/25/2026, at 3:30 p.m., CNA 1 stated on 2/8/2026 sometime before dinner (5 p.m.), she was in the dining room/activity room supervising residents while they watched television. CNA 1 stated she witnessed Resident 1 walk into the dining room and got water from the water station. CNA 1 stated she was assisting another resident, and when she turned around, she witnessed Resident 1 fall and land on her left side as a rolling stool rolled away from her (Resident 1). CNA 1 stated she did not see the rolling stool in the dining/activity room prior to it rolling away from Resident 1 and thought it must have been pushed under a table and Resident 1 pulled it out to sit on it. During a review of the facility's Policy and Procedure (P/P), titled, Hazardous Areas, Devices and Equipment dated 7/2017, the P/P indicated hazardous areas and objects in the resident environment, such as furniture that is unstable, will be identified and addressed.