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	04/29/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one out of two sampled residents (Resident 1) had ongoing monitoring for Resident 1's condition after experiencing a change of condition (COC).This deficient practice had the potential for Resident 1 to experience emotional distress due to not receiving the necessary care needed following the incident. Findings:During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including schizophrenia (a mental illness that is characterized by disturbances in thought), unspecified mood disorder (mental health condition primarily characterized by long-term disturbances in emotional state, such as excessive sadness (depression), extreme mania, or alternating between both), and unspecified intellectual disability (developmental condition characterized by significant limitations in both intellectual functioning (learning, reasoning, problem-solving) and adaptive behavior (conceptual, social, and practical life skill). During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 4/20/2026, the MDS indicated Resident 1 was cognitively intact. The MDS indicated Resident 1was independent on all aspects of activities of daily living (ADLs, routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS indicated Resident 1 had no impairments both sides of the upper (arms/shoulders) and lower (hips/legs) extremities.During a review of Resident 1's Change of Condition (COC) dated 4/22/2026 at 11:35 a.m., the COC indicated Resident 1 will be monitored for pain, skin discoloration, and psychosocial distress for 72 hours.During a review of Resident 1's Follow-up Documentation dated 4/22/2026 at 3:56 p.m., the Follow up Documentation indicated Resident 1 is on monitoring for involvement in an accident with another resident. Resident 1 had no visible injuries and staff provided reassurance and emotional support, frequent visual checks, and safe and calm environment was provided. No other follow-up documentation was identified.During a concurrent interview and record review on 4/29/2026 at 12:18 p.m. with the Minimum Data Set Coordinator (MDSC), the MDSC stated Resident 1 only had the follow up documentation on 4/22/2026 and indicated Resident 1 should have been on a 72-hour monitoring every shift. The MDSC stated that when there is a COC, they will need to monitor the residents for emotional distress, whether they are feeling safe, and to ensure the incident did not negatively affect the residents' well-being for 72 hours. The MDSC stated if the residents are not being monitored, the residents may feel unsafe and would not know how they are feeling.During a concurrent interview on 4/29/2026 at 12:36 p.m. with the Director of Nursing (DON), the DON stated after a COC, the resident is monitored for 72 hours every shift to address the residents' needs and for delayed signs of injury. The DON stated not monitoring the resident may cause the resident to decline mentally and cause them to be upset.During a review of the facility's policy and procedure (P&P) titled, Change of Condition: Notification of effective date 8/25/2021, the P&P indicated the purpose is to ensure residents, family, and legal representatives, and physicians are informed of changes in the resident's condition. A facility must immediately inform the resident, consult with the Resident's physician and/or Nurse Practitioner (NP), and notify, consistent with his/her authority, Resident Representative where there is: an accident involving the Resident, a significant change in the Resident's physical, (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	mental, or psychosocial status (that is, a deterioration in health, mental or psychosocial status in either life-threatening conditions or clinical complications), a need to alter treatment significantly (that is, a need to discontinue or change an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the Resident from the Center. When making notification of above, the Facility must ensure that all pertinent information is available and provided upon request to the physician and/or NP.\During a review of the facility's policy and procedure (P&P) titled, Abuse Prohibition Policy and Procedure effective date 2/23/2021, the P&P indicated the Center will protect patients from further harm during an investigation. Assign a representative from Social Services or a designee to observe the patient's feelings concerning the incident, as well as the patient's involvement in the investigation.

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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 observation, interview, and record review, the facility failed to maintain complete and accurate medical records for one of three sampled residents (Resident 2). The facility failed to:1. Document Resident 2's location, condition, or communications after the resident was taken by police on 4/22/2026 and facility received an email from General Acute Care Hospital (GACH) 2.This failure had the potential for lack of continuity of care, and inability to ensure the residents' safety and wellbeing.Findings:During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including schizophrenia (a mental illness that is characterized by disturbances in thought), anxiety disorder, and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest).During a review of Resident 2's history and physical (H&P) dated 3/19/2026, the H&P indicated Resident 2 is forgetful and cannot make her own medical decisions.During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool), dated 3/25/2026, the MDS indicated Resident 2 was cognitively intact. The MDS indicated Resident 2 required set up for eating and was independent on all other aspects of activities of daily living (ADLs, routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS indicated Resident 2 had no impairments on both sides of the upper (arms/shoulders) and lower (hips/legs) extremities.During a record review of Resident 2's Progress Notes dated 4/22/2026 at 12:25 p.m., the progress note indicated Resident 2 was taken by the police. There was no other documentation after 4/22/2026.During a review of Resident 2's Notice of Transfer/discharge date d 4/22/2026, the notice of transfer/discharge indicated Resident 2 was sent to the General Acute Care Hospital (GACH) 1 indicating the transfer is necessary for Resident 2's welfare and needs could be met in the facility.During a review of Resident 2's change in condition (COC), dated 4/22/2026 at 2:56 p.m., the COC indicated Resident 2 was observed banging on the glass windows at the nurse's station.During a review of Resident 2's GACH 2 clinical notes, the clinical note indicated Resident 2 was sent to GACH 2 due to a 5150 hold (qualified officers or clinicians are allowed to involuntarily detain a person for up to 72 hours for mental health evaluation and treatment).During a review of the Director of Admissions (DA)'s email dated 4/28/2026 at 8:36 a.m., the email indicated Resident 2 is currently at the General Acute Care Hospital (GACH) 3.During an interview on 4/29/2026 at 1:13 p.m. with the Social Service Director (SSD), the SSD stated Resident 2 was altered and the police arrived. The SSD stated she does not know where Resident 2 was and does not usually follow up when a resident is taken by the police and does not know if Resident 2 would be coming back to the facility. The SSD stated Resident 2 agreed to go with the police. The SSD stated she would call within 48 hrs to follow up to ensure the resident is okay and if anything was needed.During an interview on 4/29/2026 at 2:10 p.m. with Licensed Vocational Nurse (LVN) 4, LVN 4 stated she was Nursing Station 2 when Resident 2 was hitting on the window looking for medication. LVN 4 stated the Social Service Assistant (SSA), and the PD was there at the scene and calmed Resident 2 down. LVN 4 stated that the Director of Nursing (DON) contacted the police and did not know where Resident 2 was taken. LVN 4 stated that she believes the DON and the SSD were responsible for following up on the resident's whereabouts. LVN 4 stated it was important to follow up to ensure the facility knows where the resident is going and to maintain accurate records of the resident's location. LVN 4 stated she does not know where Resident 2 was. During a concurrent interview and record review on 4/29/2026 at 3:14 p.m. with the DON, the DON stated the police were notified due to Resident 2's aggressive behavior and indicated she is not sure whether Resident 2 was still in the hospital and indicated the police took Resident 2 to the hospital. The DON stated they should have followed up the following day and indicated no documents were provided by the police when Resident 2 was taken. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON stated they are responsible for Resident 2 until the day of discharge. The DON stated the Program Director (PD) was the one that had followed up with Resident 2's whereabouts, however indicated the SSD was primarily responsible for following up. The DON stated there are no follow-up notes regarding Resident 2, however it should be. The DON stated they would not know the wellbeing of Resident 2 if they did not follow up and indicated they have emails that showed Resident 2 is at GACH 3 as of 4/28/2026.During an interview on 4/29/2026 at 3:35 p.m. with the PD, the PD stated Resident 2 was at GACH 3 since 4/25/2026. The PD stated she did not document anything as she was informed nursing would do the documentation, however indicated she should have documented it. The PD additionally stated she should have called GACH 2 on 4/27/2026 to follow up on the status of Resident 2 and indicated that following up was important for continuity of care, as the facility would not know the status of Resident 2.During a review of the facility's policy and procedure (P&P) titled, Charting and Documentation, revised July 2017, the P&P indicated all services provided to the resident, progress toward 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: treatments or services performed, changes in the resident's condition, events, incidents or accidents involving the resident; and progress toward or changes in the care plan goals and objectives. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.During a review of the facility's P&P titled, Transfer or Discharge Documentation, revised December 2016, the P&P indicated when a resident is transferred or discharged , details of the transfer or discharge will be documented in the medical record and appropriate information will be communicated to the receiving health care facility or provider. When a resident is transferred or discharged from the facility, the following information will be documented in the medical record: the basis for the transfer or discharge; if the resident is being transferred or discharged because his or her needs cannot be met at the facility, documentation will include: the specific resident needs that cannot be met, a summary of the resident's overall medical, physical, and mental condition.