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	06/24/2026

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 - Minimal harm or potential for 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 facility staff were aware of a resident's history of elopement (unauthorized leave of absence) Ensure facility staff Supervised the Residents' whereabouts to prevent the Resident from leaving the facility without facility staffs knowledge for one of one residents (Resident 1) on 6/20/2026.This deficient practice resulted in Resident 1 eloping from the facility on 6/20/2026, putting Resident 1 at risk for serious injury, harm, or death from hazards in the community, including traffic accidents, falls, exposure to environmental conditions or inability to obtain needed medical assistance.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 (group of thinking and social symptoms that interfere with daily functioning), Depression (person feels very sad, hopeless, or uninterested in things they usually enjoy for a long period of time) , unspecified psychosis (a mental condition where a person has trouble telling what is real from what is not) and heart failure (heart does not circulate blood throughout the body leading to major organ failure). During a review of Resident 1's Minimum Data Set (MDS) a standardized assessment and care screening tool, dated 11/24/2025, the MDS indicated Resident 1's cognitive skills (thinking process) for daily decision-making were moderately impaired. The MDS indicated Resident 1 needed set up assistance or clean-up assistance (helper set up or clean up; resident completes activity. Helper assists only prior to or following the activity) with activities of daily living such as eating, personal hygiene and getting dressed). The MDS indicated Resident 1 used a wheelchair for ambulation.During a review of the resident care plan record titled Elopement risk /wanderer, dated 02/18/2026, Resident 1 was at risk for elopement and wandered history of attempts to leave facility unattended. Hourly monitoring for safety.During a review of Resident 1's care plan titled, Resident is at risk for unauthorized leave of absence as evidenced by wandering behavior related to cognitive loss/dementia dated 3/4/2026, the interventions included to redirect the resident if he nears an exit.During an interview on 06/23/2026 at 9:51 am with R1, R1 stated he left the facility (6/20/2026) without the staff's knowledge because he felt like he was in prison. R1 stated while contractors were working in the building, he exited the building before facility staff or the contractors saw himDuring an interview on 06/23/2026 at 4:35 pm with Certified Nursing Assistant (CNA 1), CNA1 stated she was assigned to care for R1 on the day of the elopement (6/20/2026). CNA 1 stated she last observed R1 at approximately 3:45 pm in the hallway near his room. CNA 1 stated at approximately 5:00 p.m., she delivered R1's dinner tray to his room but did not see Resident 1. CNA 1 stated she assumed R1 was in the restroom because she did not see him in the room. CNA 1 stated when she later returned to retrieve R1's dinner tray, she observed the meal had not been touched and she did not know R1's whereabouts. CNA 1 stated then staff began searching for R1. CNA 1 stated if she had known R1 had a history of elopement or was at risk for leaving the facility, she would have initiated a search immediately after noticing he was not in his room when she delivered the meal tray.During an interview 06/23/2026 at 3:58 pm with Licensed Vocational Nurse (LVN 1), LVN 1 stated she was not aware R1 had a history of elopement. LVN 1 stated she performed resident rounds (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at the beginning of her shift when she last saw Resident 1. LVN 1 stated it was important for nursing staff to be familiar with each resident's history and care needs, including any history of wandering or elopement, in order to provide appropriate supervision and ensure resident safety through ongoing monitoring.During a concurrent interview and record on 06/23/2026 at 2:10 pm with the Director of Nursing (DON). The DON stated R1 had a history of wandering and was identified as being a high risk for elopement. The DON stated facility staff should have provided closer monitoring of R1, especially while the contractors were working inside the building and staff and contractors were frequently entering and exiting the facility. The DON stated R1 required one-to-one (1:1) supervision, going forward staff were instructed to closely monitor the resident.During an interview on 06/23/2026 at 5:10 pm with the Registered Nurse Supervisor (RNS), the RNS stated he was unaware that Resident 1 had a history of wandering and elopement. The RNS stated it was very important for nursing staff to know the contents of residents' care plans. The RNS stated if staff are not aware of a resident's care plan, they cannot provide the care and supervision the resident requires. During a review of the facility's policies and procedures (P&P) titled The Leave of Absence without Notice (LAWN), Effective date 01/16/2026. Indicated: A resident deemed at risk for leave of Absence without Notice by the InterDisciplinary Team (resident's health care team consisting of various specialties) are to consider the following measures but not limited to: In the absence of a wonder guard system the IDT to collaborate and identify measures necessary to avoid leaving the facility without notice/authorization.