

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

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 07/28/2026
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 - Minimal harm or potential for actual harm Residents Affected - Some	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 observation, interviews and record reviews, the facility failed to provide adequate supervision for three out of nine residents sampled (Resident 6, 7, and 12) in the secured Behavioral Unit of the facility. a. The facility failed to prevent a physical altercation between Resident 6 and 7 during a smoke break in the patio on 7/16/2026. This failure resulted in Resident 6 sustaining a superficial linear scratch, measured at 0.1 centimeter (cm) by 1 cm, to the left side of the bridge of the nose with scant amount of blood. Resident 6 also sustained a superficial scratch to the left upper lip with scab (dry, protective crust that forms over a cut) forming, measured at 1 cm by 0.1 cm. Resident 6 had a 5th metacarpal neck/head fracture of the right hand (broken bone in the hand) which was still healing and the current altercation caused localized swelling in the same hand. Resident 7 sustained an abrasion (minor skin wound caused by scraping or rubbing) to the upper lip and a scratch to the right ear and neck. b. The facility failed to ensure Resident 12 did not leave the facility without prior authorization. On 7/24/2026, Resident 12, who had previously exited Station 2 on 6/23/2026 through the same door, pushed a staff member aside and proceeded to walk approximately 0.2 miles, crossing three street intersections. This failure exposed Resident 12 to environmental hazards, placing Resident 12 at high risk for traffic accidents, harsh weather, and other dangerous conditions. Findings:a. During a review of Resident 6's admission record, the admission record indicated the facility admitted Resident 6 on 4/14/2026 with diagnoses including schizophrenia (a mental illness that is characterized by disturbances in thought), cannabis (commonly called marijuana, weed, or pot) dependence, psychoactive (substances that alter the central nervous system, affecting how the brain functions and changing a person's mood, thoughts, feelings, awareness, or behavior) substance dependence, and a nondisplaced fracture (broken or cracked bone where the fragments stay lined up in normal position) of the neck of fifth metacarpal bone (the narrow area of the hand's outer long bone just below the pinky knuckle). During a review of Resident 6's Minimum Data Set ([MDS] a resident assessment tool), 7/2/2026, the MDS indicated Resident 6's cognition was intact. The MDS indicated Resident 6 was independent with eating, oral hygiene, toileting hygiene, showering, and personal hygiene.During a review of Resident 6's Psychiatry ((medical specialty in treating mental illness) Progress Note, dated 7/15/2026 at 4:30 p.m., the note indicated Resident 6 continued to experience persistent psychotic (losing touch with reality) symptoms. Resident 6's admission condition to date had been notable for mood lability and an altercation on 06/23/2026, which resulted in fractures to his right hand and cheek.During a review of Resident 6's care plan titled, Resident 6 exhibits physical/aggressive behavior towards peers related to: Poor impulse control, initiated 6/23/2026. The care plan goal indicated Resident 6 will not harm others until 10/17/2026. One of the interventions indicated Programming Staff visits to provide support, as needed.During a review of (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 055995	Facility ID: 055995 If continuation sheet Page 1 of 6

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 6's Change of Condition Evaluation, 7/16/2026 at 6:02 p.m., the evaluation indicated Resident 6 reported an argument over limited smoking seating and was hit by another resident (Resident 7). During a review of Resident 6's Body Check, 7/16/2026 at 6:02 p.m., the document indicated that Resident 6 had a superficial linear scratch, measured at .1 centimeter (cm) by 1 cm, to left side of the bridge of the nose with scant amount of blood. Resident 6 also had a superficial scratch to left upper lip with scab forming 1cm by .1 cm. During a review of Resident 6's Radiology Results report, performed on 7/17/2026 at 8:27 a.m., the right hand, 2 views indicated right hand had mild swelling. The findings were consistent with healing 5th metacarpal neck/head fracture compared to 7/7/2026. During a review of Resident 7's admission record, the admission record indicated the facility admitted Resident 7 on 2/13/2026 with diagnoses including schizophrenia, Attention deficit hyperactivity disorder (condition marked by persistent patterns of inattention, hyperactivity, and impulsivity), Tourette's disorder (condition that causes sudden, repeated, and uncontrolled body movements and sounds called tics), anxiety disorder (mental health condition characterized by persistent worry and fear), and psychoactive substance dependence. During a review of Resident 7's MDS, 5/22/2026, the MDS indicated Resident 7's cognition was intact. The MDS indicated Resident 7 was independent with eating, oral hygiene, toileting hygiene, showering, and personal hygiene. During a review of Resident 7's Psychiatry Progress Note, dated 6/24/2026 at 4 p.m., the note indicated Resident 7's judgement and insight was impaired. The note indicated his placement in the current structured supervised setting is significant protective factor against substance use relapsing. During a review of Resident 7's Progress Notes, dated 7/16/2026 at 7 p.m., the note indicated Resident 6 was involved in a physical altercation. During a review of Resident 7's Body Check, 7/16/2026 at 7:43 p.m., the note indicated Resident 7 sustained an abrasion to the upper lip and a scratch to the right ear and neck. During an interview on 7/28/2026 at 7:50 a.m., in Resident 6's room, Resident 6 stated that during the last smoke break he was seated and Resident 7 went after his seat. Resident 7 socked him in the left eye and Resident 6 defended himself. Resident 6 stated staff could not see the altercation, but the residents were separated after Primary Counselor (PC) 4 saw Resident 6 and 7 fighting each other. During a concurrent interview and record review on 7/28/2026 at 11:23 a.m., with Registered Nurse Supervisor (RNS) 2, Resident 6 and 7's medical records were reviewed. RNS 2 confirmed Resident 6 and 7 both have mental health issues and were admitted in the facility and were under the Office of Diversion and Reentry (ODR) government or community agency that helps people avoid jail or criminal records by redirecting them into treatment and support services) program as a court mandate. During a concurrent interview and record review on 7/28/2026 at 11:34 a.m., with RNS 2, PC 4 statement regarding the altercation on 7/16/2026 was reviewed. RNS 2 confirmed and stated that PC 4 was behind the crowd of residents, as he moved forward the group PC 4 witnessed then finally broke off the fight. RNS 2 stated the group of residents needed more supervision. During an interview on 7/28/2026 at 1:13 p.m. with PC 4, PC 4 stated after he retrieved group 2 smoke break box (plastic receptacle that contained group 2 residents' cigarettes and lighter), he walked back to the hallway with the residents outside patio door. When PC 4 was in middle of the crowd, PC 4 told Group 2 residents to start going outside the patio. Once the crowd of residents all got in the patio, PC 4 made his way to the front and that's when PC4 saw Resident 6 and 7's physical altercation and then PC 4 separated them. PC 4 stated he was the only staff in the smoke break for fifteen residents. b. During a review of Resident 12's admission record, the admission record indicated the facility admitted Resident 12 on 3/12/2026 with diagnoses including schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), opioid (class of drugs that include prescription pain relievers, synthetic versions made in labs, and illegal drugs like heroin) and stimulant (class of (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	consumed legal substances or illicit drugs that increase alertness, energy, and cognitive focus) dependence, and anxiety disorder. During a review of Resident 12's MDS, 6/17/2026, the MDS indicated Resident 12's cognition was intact. The MDS indicated Resident 12 was independent with all activities of daily living (activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 12's History and Physical (H&P), dated 3/13/2026, the H&P indicated resident was forgetful, an inaccurate historian, and was not able to make his own medical decisions. During a review of Resident 12's Leave of Absence Without Notice (LAWN) Evaluation Form (elopement evaluation form), 6/30/2026 at 1:23 p.m., the form indicated Resident 12 had a history of exhibiting exit-seeking behavior, either while at home or from the facility without informing staff. The form indicated Resident 12 wandered in or out of the facility premises and the Interdisciplinary team (IDT the residents health care team consisting of various specialties) had determined the resident was at risk for Leave of Absence Without Notice. During a review of Resident 12's Situation Background Assessment Recommendation (SBAR) Summary for Providers, 6/23/2026 at 4:11 p.m., the note indicated Resident 12 was involved in a physical altercation, the police came to take Resident 12 to the hospital for aggression. Resident 12 refused and when mental health evaluator came to assess the resident, Resident 12 ran through the kitchen. The mental health evaluator called the police; resident was taken to the General Acute care hospital for 5150 (person is placed on a 72-hour involuntary psychiatric hold during a mental health crisis). During a review of Resident 12's Change in Condition Evaluation, 7/24/2026 at 1:30 p.m., Resident 12 left the facility through the kitchen door and staff immediately followed the resident. During an observation and interview on 7/27/2026 at 10:56 a.m., with Certified Nurse Assistant (CNA) 5, CNA 5 stated on 7/24/2026 She was punching the security code on the kitchen door to open the door when Resident 12 then pushed her and ran down the hallway. CNA 5 stated there was another door in the kitchen hallway and on that day (7/24/2026), the kitchen hallway door was propped open with a chair so Resident 12 was able to go outside. CNA 5 showed how the chair was positioned to hold the door open. During an interview on 7/27/2026 at 11 a.m., with Resident 12, Resident 12 stated he left the facility last Friday (7/24/2026). During a concurrent interview and record review on 7/27/2026 at 2 pm with the staff scheduler (SCH), Google maps showing the map of the facility with the surrounding neighborhood were reviewed. The SCH pointed where Resident 12 traveled. The map indicated Resident 12 walked approximately 0.2 miles away from the facility and had to cross three street intersections. The SCH stated that when Resident 12 left the facility, SCH, who was amongst other staff (unidentified), followed Resident 12 on the street on foot. Licensed Vocational Nurse 1 and CNA1 brought their car, so the SCH jumped in the car and the three staff were able to follow Resident 12 more closely. SCH stated Resident 12 walked out of the facility through Market street, then made a left on [NAME] street then right on [NAME] street then when he was on Elm street. SCH stated that before getting to 55th street, CNA 3, who was not working that day, was riding his scooter and SCH, LVN 1, and CNA 1 waved him down for assistance and CNA 3 on his scooter was able to go in front of Resident 12, Resident 12 stopped, and was convinced to walk back to the facility. During an interview and record review on 7/28/2026 at 11:39 a.m., with RNS 2, Resident 12's medical records were reviewed. RNS 2 confirmed and stated Resident 12 had previously run out of the building through the kitchen door on 6/23/2026 but was apprehended by authorities. RNS 2 stated that on 7/24/2026 at approximately 1:30 p.m., Resident 12 exited the facility through the kitchen door without prior notice. RNS 2 stated he should not have been able to leave facility premises twice. RNS 2 stated Resident 12 should have been redirected, have more activities, or supervision may not have been enough. During an interview with the Interim Director of Nursing (IDON) on 7/8/2026 at 1:45 p.m., the IDON stated adequate (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	monitoring and supervision of residents in the Behavioral Unit was important. The IDON stated residents have the right to be free from abuse. The IDON stated Resident 12 should not have been able to exit the facility without advanced notice. During a review of the facility's policy and procedure (P&P) titled, Abuse Prohibition, revised 10/25/2024, the P&P indicated, the facility prohibits abuse and the facility will implement an abuse prohibition program by preventing occurrences. During a review of the facility's P&P titled, Smoking, effective 8/9/2022, the P&P indicated the facility will provide a safe environment for residents. During a review of the facility's P&P titled, Safety of Residents, effective 6/27/2022, the P&P indicated the facility will provide a safe environment for residents and residents who display combative behaviors will receive prompt and appropriate intervention. The P&P indicated residents will be monitored for behavioral triggers like increased anger and frustration.		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on interviews and record reviews the facility failed to accommodate one of one resident's (Resident 11) family member's (FM 1) request to not have Certified Nurse Assistant (CNA) 6 as a care giver. The failure violated residents' rights and had the potential to result in negative psychological outcomes. Findings: During a review of Resident 11's admission Record, the admission Record record indicated the facility readmitted Resident 11 on 3/30/2021, with diagnoses including hepatic failure (liver loses ability to function), spinal stenosis (narrowing of the spaces within your spine that puts pressure on your spinal cord and nerves) lumbar region, dementia (a progressive state of decline in mental abilities), and cataracts (eye problem causing blurry vision). During a review of Resident 11's minimum data set (MDS a resident assessment tool), dated 6/8/2026, the MDS indicated Resident 11 had severely impaired cognition (make decisions regarding tasks of daily life). The MDS indicated Resident 11 was dependent on facility staff for all activities of daily living (activities such as bathing, dressing and toileting a person performs daily). During an interview on 7/27/2026 at 9:57 a.m., with Resident 11's Family Member (FM 1), FM 1 stated they did not want CNA 6 to take care of Resident 11. FM 1 stated one day two weeks ago CNA 6 was assigned to take care of Resident 11 and FM 1 was upset. During a concurrent interview and record review on 7/27/2026 at 11:55 a.m., with the facility staff Scheduler, an untitled signage dated 7/16/2026 was reviewed. The signage indicated that effective 7/16/2026, CNA 6 should not be assigned to Resident 11. The scheduler stated the signage was in Station 1 to make sure that CNA 6 did not get assigned to Resident 11 as requested by FM1. During a concurrent interview and record review on 7/28/2026 at 11:20 a.m., with Registered Nurse Supervisor (RNS) 2, the 11 p.m. to 7 a.m. Shift Assignment for 7/16/2026 was reviewed. RNS 2 confirmed and stated CNA 6 was assigned to Resident 11 on 7/16/2026 11 a.m. to 7 p.m. shift and should not have been. During an interview on 7/28/2026 at 1:45 p.m., with the Interim Director of Nursing (IDON), the IDON stated residents' preferences need to be honored and respected. During a review of the facility's policy and procedure (P&P) titled, Accommodation of Needs, revised 1/2020, the P&P indicated the residents' preferences will be accommodated to the extent possible.		

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to complete an annual performance evaluation (a regular check-in where a company looks at how well an employee does their job) for Certified Nurse Assistant (CNA) 6 who was facing allegations of abuse from one out of five sampled residents (Resident 8) and complaints from Resident 11's family member (FM 1). The failure to conduct a performance evaluation on an employee facing complaints places the residents at risk for compromised safety, poor service and poor quality of care which can be detrimental to the residents' health. Findings: During a review of Resident 8's admission Record, the record indicated the facility readmitted Resident 8 on 3/26/2026 with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness or partial paralysis affecting one entire side of the body), following cerebral infarct(death of brain tissue) affecting the right dominant side, osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 8's Minimum Data Set ([MDS] a resident assessment tool), dated 6/30/2026, the MDS indicated Resident 8 can make herself understood and understand. The MDS indicated Resident 8 needed supervision eating and was dependent (helper does all effort to perform task) on staff for oral hygiene, toileting hygiene, dressing, showering, and personal hygiene. During a review of Resident 8's Situation Background Assessment Recommendation Communication (SBAR) Form, dated 7/17/2026, Resident 8 complained that CNA 6 slapped her on the right hand. During a review of Resident 11's admission Record, the record indicated the facility readmitted Resident 11 on 3/30/2021 with diagnoses including hepatic failure (liver loses ability to function), spinal stenosis (narrowing of the spaces within your spine that puts pressure on your spinal cord and nerves) lumbar region, dementia (a progressive state of decline in mental abilities), and cataract (eye problem causing blurry vision). During a review of Resident 11's MDS, dated [DATE], the MDS indicated Resident 11's had severely impaired cognition (make decisions regarding tasks of daily life). The MDS indicated Resident 11 was dependent on all activities of daily living (activities such as bathing, dressing and toileting a person performs daily). During an interview on 7/27/2026 at 9:57 a.m. with Resident 11's family member (FM 1), FM 1 stated they did not want CNA 6 to take care of Resident 11, FM 1 was unsatisfied with CNA 6's work. During an interview on 7/28/2026 at 7:35 a.m. with Resident 8 in Resident 8's room, Resident 8 stated CNA 6 slapped her and pointed to her right wrist. During a concurrent interview and record review on 7/28/2026 at 1:45 p.m., with the Interim Director of Nursing (IDON), CNA 6's personnel files were reviewed. The IDON confirmed and stated CNA 6's last documented performance evaluation was 2012. The Interim DON stated it was important to complete performance evaluations so the facility can see what the staff was lacking in and areas of improvement that need to be addressed. During a review of the facility's policy and procedure (P&P) titled, Performance Evaluations, revised 2/2026, the P&P indicated the job performance of every employee was reviewed and evaluated at least annually.		