STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056007	A. Building B. Wing	09/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pacific Care Nursing Center	3355 Pacific Place Long Beach, CA 90806

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45537 Based on interview and record review, the facility failed to ensure a verbal and physical altercation between two of six sampled residents (Resident 2 and Resident 6) was reported to the Administrator (ADM) and/or to the California Department of Public Health (CDPH), when Certified Nursing Assistant witnessed Resident 2 and Resident 6 throwing oatmeal at each other on 9/13/2024, and when Restorative Nursing Assistant 1 (RNA 1) witnessed a verbal altercation between Resident 2 and Resident 6 on 9/14/2024 and reported it to the ADM. This deficient practice resulted in the inability of CDPH to investigate the Resident to Resident altercations between Resident 2 and Resident 6 in a timely manner and had the potential for facts related to the allegations to be forgotten by staff and other witnesses. Findings: During a review of Resident 2's Admission Record (Face Sheet), the Face Sheet indicated Resident 2 was admitted to the facility on [DATE] and readmitted on [DATE], with a diagnosis of anxiety disorder (a condition in which a person has excessive worry and feelings of fear, dread, and uneasiness). During a review of Resident 2's Minimum Data Set ([MDS] a federally mandated resident assessment tool) dated 9/9/2024, the MDS indicated Resident 2 was able to make independent decisions that were reasonable and consistent. During a review of Resident 6's Admission Record (Face Sheet), the Face Sheet indicated Resident 6 was admitted to the facility on [DATE] with a diagnosis of cerebral infarction (also known as stroke, a condition that occurs when blood flow in the brain is blocked or there is a sudden bleeding in the brain). During a review of Resident 6's MDS dated [DATE], the MDS indicated Resident 6 was able to make decisions and express his needs, despite being forgetful. During a review of Resident 6's History and Physical (H&P) dated 8/27/2024, the (H&P) indicated Resident 6 had the capacity to understand and make decisions. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/26/2024 at 4:23 p.m., Resident 2 stated there was a past situation between him and a previous roommate, that he did not want to elaborate on because he already told the Administrator about it. During a telephone interview on 9/27/2024 at 1:28 p.m., Restorative Nursing Assistant 1 (RNA 1) stated Resident 2 and Resident 6 had a verbal altercation in the dining Room on 9/14/2024 (unsure of the time). RNA 1 stated Resident 2 approached Resident 6 and asked Resident 6 to be his friend, but Resident 6 did not want to talk to Resident 2 and Resident 6 started to move his hands and yell at Resident 2. RNA 1 stated Resident 2 responded to Resident 6 by using racial slurs (demeaning language that is offensive toward members of a racial or ethnic group) at Resident 6. RNA 1 stated she called the ADM on 9/14/32024 and informed her of Resident 2 and Resident 6's verbal altercation. RNA 1 stated during the same telephone call she also informed the ADM of another incident that occurred between Resident 2 and Resident 6 on 9/13/2024 during the 7 a.m. to 3 p.m. shift, that she heard from another CNA. RNA 1 stated, the CNA told her that Resident 2 and Resident 6 were throwing oatmeal at each other in their room. RNA 1 stated it is the duty of all staff at the facility to report any alleged mistreatment and/or resident altercation immediately to the ADM because the residents' safety is a priority. During an interview on 9/27/2024 at 4:06 p.m., the ADM stated she did not report the verbal altercation that occurred on 9/14/2024 between Resident 2 and Resident 6 to CDPH because she did not see the incident as mistreatment but rather a roommate incompatibility and stated the incident on 9/13/2024 was not reported to her so she did not know about it. The ADM stated it was the duty of the facility to report any allegations of mistreatment and/or resident to resident altercation to CDPH in a timely manner. During a review of the facility's Policy and Procedure (P/P) titled, Abuse Reporting and Prevention revised 4/2024, the P/P indicated the facility must ensure that the residents are protected by providing a method of investigation and reporting of any alleged violations involving mistreatment and resident to resident altercation by the administrator or his/her designee to the Ombudsman's office and the Department of public Health.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45537 Based on interview and record review, the facility failed to ensure a verbal altercation between two of six sampled residents (Resident 2 and Resident 2) that occurred on 9/14/2024, was investigated. This deficient practice resulted in the incident between Resident 2 and Resident 6 not being addressed and had the potential for continued conflict between the two residents. Findings: During a review of Resident 2 ' s Admission Record (Face Sheet), the Face Sheet indicated Resident 2 was admitted to the facility on [DATE] and readmitted on [DATE], with a diagnosis anxiety disorder (a condition in which a person has excessive worry and feelings of fear, dread, and uneasiness). During a review of Resident 2 ' s Minimum Data Set ([MDS] a federally mandated resident assessment tool) dated 9/9/2024, the MDS indicated Resident 2 was able to make independent decisions that were reasonable and consistent. During a review of Resident 6 ' s Admission Record (Face Sheet), the Face Sheet indicated Resident 6 was admitted to the facility on [DATE] with a diagnosis of cerebral infarction (also known as stroke, a condition that occurs when blood flow in the brain is blocked or there is a sudden bleeding in the brain). During a review of Resident 6 ' s MDS, dated [DATE], the MDS indicated Resident 6 was able to make decision, and express his needs, despite being forgetful. During a review of Resident 6 ' s History and Physical (H&P) dated 8/27/2024, the (H&P) indicated Resident 6 had the capacity to understand and make decisions. During an interview on 9/26/2024 at 4:23 p.m., Resident 2 stated there was a past situation between him and a previous roommate (Resident 6), that he did not want to elaborate on because he already told the Administrator about it. During a telephone interview on 9/27/2024 at 1:28 p.m., Restorative Nursing Assistant 1 (RNA 1) stated Resident 2 and Resident 6 had a verbal altercation in the dining Room on 9/14/2024 (the time is unknown). RNA 1 stated Resident 2 approached Resident 6 and asked Resident 6 to be his friend but Resident 6 did not want to talk to Resident 2. RNA 1 stated Resident 6 started to move his hands and yell at Resident 2. RNA 1 stated Resident 2 responded to Resident 6 by using racial slurs (demeaning language that is offensive toward members of a racial or ethnic group) at Resident 6. RNA 1 stated she call the Administrator (ADM) and informed her of the incident on 9/14/2024. RNA 1 stated during the same telephone call she also informed the ADM of another incident that occurred between Resident 2 and Resident 6 on 9/13/2024 during the 7 a.m. to 3 p.m. shift, that she heard from another CNA (unknown). RNA 1 stated, the CNA told her that Resident 2 and Resident 6 were throwing oatmeal at each other in their room. RNA 1 stated it was the duty of all staff at the facility to report any alleged mistreatment and/or resident altercation to the ADM immediately because the residents ' safety is a priority. (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/27/2024 at 4:06 p.m., the ADM stated she did not conduct an investigation of the incident between Resident 2 and Resident 6 that occurred on 9/13/2024 because she did not see it as mistreatment of the residents, but rather a roommate incompatibility and stated the incident on 9/14/204 was not reported to her so she was not aware of it. The ADM stated there was no conclusion to submit to CDPH because no investigation was conducted. The ADM stated it was necessary to conduct a thorough investigation and send the conclusion report to CDPH, to verify the findings and find solution and/or perform a corrective action to the problem. During a review of the facility ' s Policy and Procedure (P/P) titled, Abuse Reporting and Prevention revised 4/2024, the P/P indicated the facility must investigate all allegations and all substantiated incidents and the results of the investigation must be reported to CDPH, within 5 working days of the incident(s).

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45537 Based on observation, interview, and record review, the facility failed to ensure a Hemodialysis Nurse 1 ([HDN 1] licensed nurses who specialize in the care of patients with kidney failure including treatment using hemodialysis [a lifesaving treatment and procedure for kidney failure that removes waste and extra fluids from the blood and regulates blood pressure]) and a Hemodialysis Technician 1 ([HDT 1] a healthcare professional who provides care to patients with kidney failure by performing and monitoring dialysis treatments) cleansed their hands using an alcohol-based hand rub (ABHR) or soap and water, and donned proper personal protective equipment ([PPE] clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments), a gown and gloves, before providing direct care to two of six sampled residents (Resident 7 and Resident 8). Resident 7 and Resident 8, who were undergoing hemodialysis treatment, and who were on enhanced barrier precaution ([EBP] an approach of targeted gown and glove use during high contact resident care activities, designed to reduce transmission of infectious microorganisms) due to being positive for Candida Auris ([C. auris] a yeast [type of fungus] that causes severe infections and can spread in the healthcare setting). These deficient practices resulted in HDN 1 and HDT 1 not practicing infection control methods and had the potential for the inadvertent spread of infectious microorganisms to the other residents in the facility. Findings: During a review of Resident 7's Admission Record (Face Sheet), the Face Sheet indicated Resident 7 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis including renal dialysis dependency (a condition of relying on a treatment called hemodialysis when a person's kidneys are failing), and unspecified candidiasis (yeast infection that can affect the mouth, genitals and even the blood). During a review of Resident 7's Microbial Diseases laboratory results dated [DATE], the Microbial Diseases Laboratory Results indicated Resident 7 tested positive for C. auris. During a review of Resident 8's Admission Record (Face sheet), the Face Sheet indicated Resident 8 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including dependency on renal dialysis, and chronic viral hepatitis c (a condition cause by a virus that spreads through contact with blood). During a review of Resident 8's Microbial Diseases laboratory results dated [DATE], the Microbial Diseases Laboratory Results indicated Resident 8 was tested positive for C. auris. During an observation on 9/30/2024 at 9:36 a.m., Resident 7 and Resident 8 were in their rooms when HDT 1 who was wearing a disposable gown with the front of it open, exposing his clothing that was worn under the gown, was observed sitting on a chair facing Resident 8, who was undergoing hemodialysis. HDT 1 approached Resident 8 to check on him and his exposed uniform came in contact with Resident 8's bed linens. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 9/30/2024 at 9:39 a.m., Resident 7 and Resident 8, were in their rooms undergoing hemodialysis, when HDN 1 entered their room without using an ABHR to clean her hands and without donning a gown or gloves prior to entering the resident's room. HDN 1 was holding a tray that had medical supplies on it, and he placed the medical tray on top of Resident 8's bedside table, passed by the bedside of Resident 7 and with his bare arms and uncovered uniform touched the pillow of Resident 7. HDN 1 then proceeded to touch Resident 8's bed with his bare arms while looking at the hemodialysis machine. During an interview on 9/30/2024 at 9:43 a.m., the HDT stated he was approved by the previous Infection Preventionist Nurse (IPN) to wear a gown and keep it open while providing hemodialysis care and assistance to the residents. HDT 1 stated he should have worn the proper PPE (gown) to prevent cross contamination between the residents in the facility. During an interview on 9/30/2024 at 9:58 a.m., HDN 1 stated he was aware Resident 7 and Resident 8 were on EBPs however, he forgot to use the ABHR and donn the appropriate PPEs (gloves and a gown) before entering the resident's room and before providing direct care to them. HDN 1 stated all staff were responsible in following the infection control procedures of the facility to prevent the spread of infection. During an interview on 9/30/2024 at 10:44 a.m., the IPN stated all staff in the facility, including the contracted hemodialysis staff, must abide by the infection control policies of the facility. The IPN stated non compliance with the infection control procedures could inadvertently cause an outbreak of infection in the facility. During an interview on 9/30/2024 at 11:48 a.m., the Director of Nursing Services (DON) stated the facility and its staff, in house or under contract, must be diligent in implementing all infection control procedures to observe source control and prevent cross contamination to the vulnerable residents of the facility. During a review of the facility's Policy and Procedure (P/P) titled, Hand Hygiene revised 7/2019, the P/P indicated the facility staff members must perform hand hygiene before and after direct resident care and after contact with potentially contaminated substances to prevent, to the extent possible, the spread of infection. During a review of the facility's P/P titled, Enhanced Standard Precautions revised 5/2024, the P/P indicated the health care professionals (HCP) of the facility must wear gowns and gloves while performing high contact tasks with the greatest risk for contamination of HCP's hands, clothes, and the environment during any care activity where close contact with the resident is expected to occur such as morning/evening care, toileting/incontinence care, wound care, mobility assistance, cleaning of the environment as well as any care activity involving contact with environmental surfaces likely contaminated by the resident and during care for health devices, invasive procedure sites and giving medical treatment.