STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056007	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/02/2024
NAME OF PROVIDER OR SUPPLIER Pacific Care Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44055 Based on interview and record review, the facility failed to ensure a resident, who was admitted with intact skin did not develop a pressure injury (localized damage to the skin and/or underlying tissue usually over a bony prominence) while in the facility, and a resident who was admitted with a pressure injury had measures in place to prevent the existing pressure injury from getting worse for two of two residents (Resident 2 and 12). The facility failed to: 1. Implement Resident 2's care plan, titled Alteration in Skin integrity intervention to turn and reposition the resident at least every two hours and as needed from 1/2024 to 3/2024 to prevent Resident 2 from developing the pressure injuries to the right and left lateral (to the side of, or away from, the middle of the body) malleolus (the bone on the outside of the ankle joint). 2. Ensure Resident 2 was assessed by the Registered Dietician (RD -food and nutrition expert) on 2/11/2024 when the deep tissue injury (DTI - persistent non-blanchable [something does not fade when pressure is applied, such as a rash or skin discoloration] deep red, maroon, or purple discoloration, related to damage from pressure and/or shear) to the left lateral malleolus was first identified, as indicated in the care plan titled, Alteration in Skin integrity and as the Wound Consultant recommended on 2/13/2024. 3. Ensure Resident 2's Wound Consultants' recommendation to cleanse the wound to the left lateral malleolus with Normal Saline (mixture of salt and water solution) prior to applying Betadine (a solution that kills germs promptly) was implemented starting on 2/11/2024. 4. Implement Resident 12's care plan, titled Alteration in Skin integrity, intervention to turn and reposition the resident at least every two hours and as needed from 1/1/2024 to 3/31/2024 which had the potential to slow the healing of Resident 12's pressure injury to the sacrum (lower back area). 5. Implement the facility's policy and procedure (P&P) titled, Pressure Injury also known as, Pressure Sore Management, revised 10/2017, that indicated to prevent the development of skin breakdown/pressure injuries the staff need to implement the care plan to reposition the resident at least every two hours and follow the RD's and physician's recommendations. These failures resulted in Resident 2, who was assessed as a moderate risk for developing a skin injury and had intact skin upon admission on 1/9/2024 developing the following pressure injuries: (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: 056007	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/02/2024
NAME OF PROVIDER OR SUPPLIER Pacific Care Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0686 Level of Harm - Actual harm Residents Affected - Few	1a. A facility-acquired preventable Stage IV pressure injury (full-thickness skin and tissue loss with exposed muscle or bone) to the left lateral malleolus, measuring 2.2 centimeters (cm) long by 1.6 cm wide by 0.3 cm deep on 3/26/2024, 77 calendar days from admission. The wound bed was 30 percent (%) slough (yellowish material), 60% granulation (new tissues, bright red or pink, soft, moist, bumpy, and be raised), and 10% epithelial tissue (appears pink or pearly white, occurs in the final stage of healing). 1b. A Stage III pressure injury (full-thickness loss of skin, dead and black tissue may be visible), to the right lateral malleolus, measuring 1.2 cm long by 1.2cm wide with undetermined depth (UTD) with100% slough. 2. These deficient practices placed Resident 12 at risk for pressure injury to the sacrum (lower back area) delayed healing or to progress to worse. Findings: 1. During a review of Resident 2's Admission Record, the Admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including acute respiratory failure (when the lungs and blood are unable to exchange gases properly), generalized muscle weakness, hyperglycemia (a condition where there is too much glucose in the blood), acute kidney failure (kidneys suddenly can't filter waste products from the blood), with gastrostomy ([GT] - a soft tube surgically placed into the stomach to provide nutrition, hydration and medication) in place. During a review of Resident 2's Minimum Data Set ([MDS], a resident assessment tool) dated 1/16/2024, the MDS indicated Resident 2's cognitive (ability to think and reason) skills for daily decision-making were severely impaired. The MDS indicated Resident 2 was totally dependent on staff for all activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). The MDS indicated Resident 2's skin was intact and did not have any ulcers, wounds, and skin problems. During a review of Resident 2's Braden Scale (a scoring tool used to predict residents' risk of developing a pressure injury, total scores range from 6 - 23. A lower score indicating a higher risk of developing a pressure injury) assessment dated [DATE], the Braden Scale Assessment indicated Resident 2's score was 14 indicating Resident 2 was at moderate risk for developing a pressure injury. The Braden Scale Assessment indicated Resident 2's skin was occasionally moist, the resident was chairfast (capable of maintaining a sitting position but lacking the capacity of bearing own weight), had very limited mobility (ability to change and control body position), was unable to make frequent or significant positional changes independently and required moderate to maximum assistance (helper does more than half the effort) when moving. During a phone interview on 11/26/2024 at 9:04 a.m., family member (FM 1) stated Resident 2 had a pressure sores (in reference to a pressure injuries) because the facility did not turn Resident 2 frequently. FM 1 stated she remembered one incident when the resident's indwelling urinary catheter (a soft flexible tube inserted into the urinary bladder to drain urine into a collection bag outside the body) had been accidentally removed and no one discovered it until later. FM 1 sated if they were turning the resident every two hours, they would have seen it and identified the problem with skin sooner. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056007	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/02/2024
NAME OF PROVIDER OR SUPPLIER Pacific Care Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0686 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review on 11/26/2024 at 12:36 p.m. with the Assistant Director of Nursing (ADON) Resident 2's MDS, dated [DATE], Resident 2 's Initial Nursing History and Assessment, dated 1/9/2024, and Resident 2's Braden Scale Risk Assessment, dated 1/9/2024, were reviewed. The ADON stated Resident 2 's Initial Nursing History and Assessment, and Resident 2's Braden Scale Risk Assessment indicated Resident 2's skin was intact upon admission and Resident 2 was at moderate risk for developing pressure injuries. The ADON stated Resident 2 was dependent on staff for all ADL's including turning and repositioning in bed. The ADON stated Resident 2 was totally dependent on staff to implement interventions for preventing the development of pressure injuries, since Resident 2 could not independently reposition himself. During a concurrent interview and record review on 11/26/2024 at 12:40 p.m., with the ADON, Resident 2's Situation Background Appearance Review (SBAR) Communication Form, dated 2/11/2024, was reviewed. The ADON confirmed the SBAR indicated that 32 days after the resident's admission Resident 2 developed a purplish discoloration on the left lateral malleolus measuring 2.5 cm by 2.5 cm., which was a sign of a pressure injury development. During a concurrent interview and record review on 11/26/2024 at 12:44 p.m., with the ADON, Resident 2's Wound Consultant Progress Notes, dated 2/13/2024, were reviewed and the ADON confirmed the Wound Consultant classified the purplish discoloration on the left lateral malleolus as a DTI. The ADON stated the Wound Consultant recommended to turn and reposition the resident every two hours, keep the skin clean and dry, and to avoid massaging bony prominences (areas where bones are close to the surface). The ADON stated the Wound Consultant also recommended the RD to assess Resident 2 to ensure adequate intake of protein and calories, to maintain the current level of activity, mobility, and range of motion, to use positioning devices to prevent prolonged pressure on bony prominences. The ADON stated the treatment plan was to cleanse the left lateral malleolus DTI with sterile (free of infection causing organisms) Normal Saline, pat dry, apply Betadine directly to the wound bed of the left lateral malleolus DTI and cover with dry sterile dressing. The ADON stated the treatment plan was also to change dressing daily and as needed for loss of integrity and soiling. During a concurrent interview and record review on 11/26/2024 at 12:47 p.m., with the ADON, Resident 2's care plan titled, Alteration in skin Integrity, started on 2/11/2024, was reviewed and the ADON confirmed the care plan goal indicated Resident 2's left lateral malleolus DTI would heal without complications. The ADON stated two of the care plan interventions included the RD's evaluation of Resident 2's nutritional needs for pressure injury healing to left lateral malleolus DTI, and to turn and reposition Resident 2 at least every two hours. During a concurrent interview and record review on 11/26/2024 at 12:49 p.m., with the ADON, Resident 2's Wound Consultant Progress Notes, dated 2/27/2024, were reviewed. The ADON stated the Wound Consultant Progress Notes indicated Resident 2's DTI to the left lateral malleolus opened up and it was reclassified as an unstageable pressure injury (when the stage is not clear because the base of the wound is covered by a layer of dead tissue) measuring 2.9 cm long by 2.5 cm wide with UTD depth and 100% necrotic (dead tissue in the wound itself). The Wound Consultant Progress Notes indicated a recommendation to turn the resident every two hours and to follow the registered dietitian's recommendations. The ADON stated the facility should have recommended the use of a low air loss mattress (a mattrass designed to prevent and treat pressure injuries) before Resident 2's left lateral DTI worsened to an unstageable pressure injury. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056007	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/02/2024
NAME OF PROVIDER OR SUPPLIER Pacific Care Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0686 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review on 11/26/2024 at 12:50 p.m., with the ADON, Resident 2's Nutrition Care Progress Notes from 1/10/2024 to 3/29/2024 were reviewed and the Nutrition Care Progress Notes indicated the RD did not make any recommendations for Resident 2's pressure injury healing until 3/5/2024, which was 23 days after the Wound Consultant's and care plan recommendations for the RD to assess Resident 2. The ADON confirmed the RD did not assess Resident 2 and make recommendations for Resident 2's wound healing interventions until 3/5/2024. The ADON stated Resident 2 should have been seen by the RD sooner so the RD's recommendations could be implemented quicker to promote Resident 2's pressure injury to start healing. A review of Resident 2's Nutrition Care Progress Notes, dated 3/5/2024, indicated the RD made recommendations as followed: a. Discontinue current GT feeding of Fibersource High Nitrogen (formula for nutrition) 1.2 at 65 milliliters/hour over 20 hours and change formula with Jevity 1.5 Cal (high protein formula) 237 milliliters ([ml] a liquid weight measurement) 5 times a day via bolus (a single dose administered all at once) at 6 a.m., 10 a.m., 2 p. m., 6 p.m., 10 p.m., to provide a1185 ml equivalent to 1778 kilocalories (unit of energy), 76 grams of protein, and 901 ml of water. b. Fluid restriction to 1500 ml was discontinued. c. Discontinue folic acid (supplement). d. Discontinue free water flush (water used to clear the g-tube before and after administering medications). e. Start free water flush of 25 ml before and after each bolus feeding. f. Zinc (supplement) 50 milligrams ([mg] weight measurement) daily for 5 days. g. Discontinue Pro- Stat (liquid protein supplement). During a concurrent interview and record review on 11/26/2024 at 12:58 p.m., with the ADON, Resident 2's Documentation Survey Reports for January, February, and March 2024 were reviewed. The Documentation Survey Reports indicated the column titled, Turn and Reposition Every Two Hours and As Needed indicated Resident 2 was not turned and repositioned every two hours and as needed on each shift in January, February, and March 2024. The ADON stated The Documentation Survey Reports indicated there were six eight-hour shifts in January, five shifts in February, and eight shifts in March 2024 that were left blank which meant there was no documented evidence Resident 2 was turned and repositioned every two hours on every shift in January, February, and March 2024. The ADON stated if it was not documented it was not done. During a review of Resident 2's Wound Consultant Progress notes, the Wound Consultant Progress notes indicated following: a. On 3/12/2024, the pressure injury on the left lateral malleolus had gotten worse and was reclassified as Stage III pressure injury (Full-thickness loss of skin, dead and black tissue may be visible) measuring 2.8 cm long by 1.5 cm wide, with undetermined depth. (continued on next page)

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	12/02/2024

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 0686 Level of Harm - Actual harm Residents Affected - Few	b. On 3/19/2024, the pressure injury on the left lateral malleolus had gotten worse and was reclassified as Stage IV pressure injury measuring 1.5 cm long by 1.8 cm wide by 0.4 cm deep. The notes indicated a new DTI was noted on right lateral malleolus DTI measuring 2.0 cm long by 2.0 cm wide with undetermined depth. c. On 3/26/2024, the notes indicated the Stage IV pressure injury to the left lateral malleolus measured 2.2 cm long by 1.6 cm wide and 0.3 cm. deep. The wound bed was 30% slough (yellowish material), 60% granulation (new tissues, bright red or pink, soft, moist, bumpy, and raised), and 10% epithelial tissue (appears pink or pearly white occurs in the final stage of healing). The right lateral malleolus DTI had gotten worse and was reclassified as a Stage III pressure injury measuring 1.2 cm long by 1.2 cm wide with undetermined depth and 100% slough. excisional debridement (surgical removal or cutting away of such tissue, necrosis, or slough) was performed on both right and left lateral malleolus pressure injuries. During an interview and record review on 12/2/2024 at 10:12 a.m., with the Director of Nursing (DON), Resident 2's Wound Consultant Notes dated 2/ 13/2024 and Physician's Orders dated 2/2024 were reviewed. The Wound Consultant Notes indicated the treatment plan for the left lateral malleolus was to cleanse the wound with sterile Normal Saline, pat dry, apply Betadine directly to wound bed and cover with dry sterile dressing. Change dressing daily and as needed for loss of integrity/soiling. Resident 2's Physician Orders dated 2/11/2024, 2/16/2024, and 2/27/2024 indicated the order for the left lateral malleolus was to paint with Betadine, allow to dry and then cover with Silicone Foam (a type of wound dressing that seals the wound and absorbs any fluids) dressing every day shift. The DON stated the recommendations of the Wound Consultant to clean the DTI with sterile Normal Saline first before applying Betadine was not implemented and instead the DTI was just being painted with betadine without being cleaned with sterile Normal Saline first. The DON stated the physician's recommendations should have been followed to ensure proper wound healing. The pressure injury was just being painted with Betadine without being cleaned with normal saline first from 2/11/2024 to 3/11/2024. During an interview on 12/2/2024 at 11:00 a.m., the DON stated residents should be turned at least every two hours to prevent the resident from getting a pressure injury or the pressure injury getting worse. The DON stated residents should not develop a pressure injuries in the facility . The DON stated the care plan meeting to plan and implement proper interventions for Resident 2 when the DTI was first identified should have included the RD. The DON stated back in January to March of 2024, the facility was going through changes in administration, and she was not sure why the RD was not involved in Resident 2's care sooner. 2. During a review of Resident 12's Admission Record, the Admission Record indicated Resident 12 was admitted to the facility on [DATE] with diagnoses including pressure injury of sacral (lower back) region, type 2 diabetes (a disorder characterized by difficulty in blood sugar control and poor wound healing), obesity (chronic disease when someone has excessive amount of body fat that can lead to health problems) and anemia (a condition where the body does not have enough healthy red blood cells). During a review of Resident 12's MDS, dated [DATE], the MDS indicated Resident 12's cognitive skills for daily decision-making were intact. The MDS indicated Resident 12 needed maximal assistance (helper does more than half the effort) with toileting hygiene, showering, and rolling left and right on the bed. The MDS indicated Resident 12 was at high risk for developing pressure injuries and the resident had one or more unhealed pressure injuries. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056007	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/02/2024
NAME OF PROVIDER OR SUPPLIER: Pacific Care Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0686 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 12's Initial Nursing History and Assessment, dated 12/5/2022, the Initial Nursing History and Assessment indicated Resident 12 had an unstageable pressure injury to the sacrococcyx (lower back tailbone area) area measuring 4.5 cm long by 4 cm wide, with 3.0 cm. depth. During a review of Resident 12's care plan titled, Alteration in skin Integrity, started on 12/6/2022, the care plan goal indicated Resident 12 would show progress towards wound healing over the next three months. One of the care plan interventions included to provide turning and repositioning at least every two hours. During a review of the Resident Council (facility residents who meet regularly to improve their quality of life and quality of care) meeting Minutes dated 3/28/2024, the document indicated Resident 12 complained that staff was not turning and repositioning the resident every two hours. During an interview on 11/27/2024 at 1:45 p.m., in Resident 12's room, Resident 12 stated in the beginning of the year (January to March 2024), the staff were not turning and repositioning her. Resident 12 stated she complained about staff not turning her in March 2024 at the Resident Council meeting and signed a statement. During an interview on 11/27/2024 at 1:58 p.m., Certified Nurse Assistant (CNA 1) stated turning and repositioning the resident at least every two hours was important and documentation on turning and repositioning was completed after the resident was turned and repositioned. CNA 1 stated if it was not documented it was not done. During an interview and record review on 11/27/2024 at 3:00 p.m., with the ADON Resident 12's Documentation Survey Report for January, February, and March 2024, were reviewed and the task indicating Resident 12 was turned and repositioned at least every 2 hours and as needed, did not indicate Resident 12 was consistently turned and repositioned every two hours and as needed on every shift for three months in January, February, and March 2024 The ADON stated there were four shifts in January, five shifts in February, and nine shifts in March 2024, that were blank which meant there was no documented evidence Resident 12 was turned and repositioned every two hours on each shift for the months of January, February, and March 2024. The ADON stated if it was not documented it was not done. During an interview on 11/27/2024 at 3:10 p.m., the ADON stated Resident 12 consistently complained in March 2024 about not being turned every two hours. The ADON stated dependent residents should be turned at least every two hours to prevent a pressure injury development and facilitate the healing of existing pressure injuries. During a review of Pressure Injury Prevention Points Portable Document Format (PDF) published by the National Pressure Injury Prevention Advisory Panel, copyright 2020, the PDF indicated the following pressure injury prevention recommendations: a. Consider bedfast and chairfast individuals to be at risk for development of pressure injury. b. Develop a plan of care based on the areas of risk, rather than on the total risk assessment score. For example, if the risk stems from immobility, address turning, repositioning, and the support surface. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056007	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/02/2024
NAME OF PROVIDER OR SUPPLIER Pacific Care Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0686 Level of Harm - Actual harm Residents Affected - Few	c. Turn and reposition all individuals at risk for pressure injury, unless contraindicated due to medical condition or medical treatments. d. Continue to reposition an individual when placed on any support surface. e. Reposition weak or immobile individuals in chairs hourly (www.npiap.com) During a review of the facility's P&P titled, Pressure Injury aka Pressure Sore Management, revised 10/2017, the P&P indicated: a. It was the policy of the facility to provide guidelines for the treatment of pressure injuries to facilitate healing. b. The diet of the resident with a pressure injury should contain nutrients adequate to support healing as recommended by the RD. c. A plan of care will be initiated upon admission and identification of residents at high risk for development of pressure injuries and implemented. d. Residents will be turned and repositioned every two hours or as needed. Frequent toileting and efforts to keep residents dry. e. Ongoing programs including emphasis on turning schedule by supervisory staff.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056007	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/02/2024

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 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44055 Based on interview, and record review the facility failed to provide rehabilitative services (services that help the resident keep, get back, or improve skills of functioning for daily living), as ordered by the physician, for one of one resident ' s (Resident 2). The facility failed to: a) Ensure Resident 2 received speech therapy (treatment that improve ability to talk and swallow) services three times a week, for the week of 3/5/2024. b) Ensure Resident 2 had documented evidence of Restorative Nursing Assistant (RNA) application of the bilateral (both) knee splints (rigid material or apparatus used to support and immobilize a broken bone or impaired joint) from 3/15/2024 to 3/31/2024. These deficient practices placed Resident 2 at risk for not restoring or maintaining highest level of function. Findings: During a review of Resident 2 ' s Admission Record, the Admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including acute respiratory failure (when the lungs and blood are unable to exchange gases properly), generalized muscle weakness, dysphagia (difficulty swallowing), and gastrostomy status (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). During a review of Resident 2 ' s Minimum Data Set (MDS), a resident assessment tool, dated 1/16/2024, the MDS indicated Resident 2 ' s cognitive skills (ability to think and reason) for daily decision-making was severely impaired. The MDS indicated Resident 2 was totally dependent on staff for all activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a record review of Resident 2 ' s Order summary report, the summary indicated: a) Ordered 1/27/2024, Speech Therapy, clarification of order, every day three times a week for 4 weeks dysphagia treatment to improve swallow safety, diet texture analysis, diet trials, Orofacial Myofunctional Therapy (OM - type of therapy with facial muscles) training and patient/care giver education. b) Ordered 2/27/2024, Continue Speech Therapy, clarification of order, every day three times a week for 4 weeks dysphagia treatment to improve swallow safety, diet texture analysis, diet trials, OM training and patient/care giver education from 2/24/2024. c) Ordered 3/15/2024, start 3/16/2024, RNA Apply bilateral knee splints for up to 6 hours or as tolerated every day (Thursday to Monday). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056007	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/02/2024

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 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and record review on 11/27/2024 at 2:03 p.m. with the Director of Rehabilitation Services (DOR), Resident 2 ' s Speech Therapy Treatment Encounters (1/2024 to 2/2024) were reviewed. The DOR confirmed and stated there was one week of 3/3/2024 to 3/9/2024, where Resident 2 was only seen twice, on 3/5/2024 and 3/9/2024. The DOR stated Resident 2 should have been seen three times that week to ensure the resident received the prescribed therapy to make sure increasing maximum potential. During an interview and record review on 12/2/2024 at 10:00 a.m. with the Director of Nursing (DON) Resident 2 ' s physician order, dated 3/15/2024 at 2:20 p.m. was reviewed and the order indicated RNA: Apply bilateral knee splints up to 6 hours or as tolerated every day (Thursday to Monday) every dayshift. The DON stated there was no documented evidence splinting was done in March 2024. The DON stated if not charted it was not done. During a review of the facility ' s policy and procedure (P&P) titled, Speech language Pathologist, reviewed 7/29/2017, the P&P indicated as part of the duty of the Speech- language pathologist was to implement treatment plans for residents to restore and maintain their highest level of functioning and reassess treatment results. The therapist will follow relevant physician orders. During a review of the facility ' s P&P titled, Restorative Nursing Assistant referrals, revised 9/2016, the P&P indicated a resident with a limited range of motion will be assessed and provided with appropriate treatment and services to increase the range of motion.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056007	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/02/2024

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 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** 44055 Based on interview, and record review the facility failed to ensure one of two resident ' s (Resident 2) documentation was complete and accurate when Resident 2 ' s left lateral malleolus (the bone on the outside of the ankle joint) pressure injury (localized damage to the skin and/or underlying tissue usually over a bony prominence) was described differently. Resident 2 ' s Wound consultant notes for 3/5/2024 indicated the pressure injury was a Stage III pressure injury (full-thickness loss of skin, dead and black tissue may be visible) and Resident 2 ' s Preliminary wound consultant notes for 3/5/2024 indicated it was an unstageable (when the stage is not clear because the base of the wound is covered by a layer of dead tissue) pressure injury. The deficient practices indicated an inaccurate depiction of Resident 2 ' s status. Findings: During a review of Resident 2 ' s Admission Record, the Admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including acute respiratory failure (when the lungs and blood are unable to exchange gases properly), generalized muscle weakness, hyperglycemia (a condition where there is too much glucose in the blood), and acute kidney failure (kidneys suddenly can't filter waste products from the blood). During a review of Resident 2 ' s Minimum Data Set (MDS), a resident assessment tool, dated 1/16/2024, the MDS indicated Resident 2 ' s cognitive skills (ability to think and reason) for daily decision-making was severely impaired. The MDS indicated Resident 2 was totally dependent on staff for all activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). The MDS indicated Resident 2 did not have any unhealed pressure injuries. The MDS indicated Resident 2 ' s skin was intact and did not have any ulcers, wounds, and skin problems. During a review of Resident 2 ' s Preliminary Wound Report, 3/5/2024, the report indicated the left lateral malleolus, ankle pressure injury was unstageable. During a review of Resident 2 ' s Weekly Pressure Injury record, dated 3/5/2024, the record indicated Resident 2 ' s pressure injury in the left lateral malleolus was unstageable. During a review of Resident 2 ' s dictated Wound Consultant Progress Notes, 3/5/2024, the notes indicated the left lateral malleolus pressure injury was a Stage III pressure injury. During an interview and record review on 12/2/2024 with the Director of Nursing (DON) Resident 2 ' s Preliminary Wound Report and Wound Consultant Progress notes, dated 3/15/2024 were reviewed. The DON stated the wound consultant progress notes was erroneous and the facility notified the company to issue an amended progress note. The DON stated the facility needed complete and accurate medical records to get an accurate picture of the resident and accurate account of care rendered to the resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056007	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/02/2024
NAME OF PROVIDER OR SUPPLIER Pacific Care Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility ' s policy and procedure (P&P) titled, Record Content: Documentation Principles, dated 1/2014, the P&P indicated clinical records shall be current and kept in detail consistent with good medical and professional practice based on care provided to each resident. The P&P indicated completed entries must be accurate, timely, objective, specific, concise, legible, clear, and descriptive. During a review of the facility ' s P&P titled, Documentation Principles, revised 10/2018, the P&P indicated it was the policy of the facility that resident's clinical records shall be current and kept in detail consistent with good medical and professional practice based on the care provided to each resident, and entries must be accurate, timely, objective, specific, concise, legible, clear, and descriptive.