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	12/11/2024

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44898 Based on interview and record review the facility failed to ensure Resident 2 who has repeated threatening and abusive behavior was monitored for one of three sampled residents. This failure resulted in Resident 1 ' s being verbally abused and threatened by Resident 2. Findings: During a review of Resident 1's Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with diagnoses of but not limited to schizophrenia (a mental illness that is characterized by disturbances in thought), diabetes (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), muscle weakness and chronic kidney diseases (progressive loss of kidney function). During a review of Resident 1's History and Physical (H&P) dated 9/20/2024, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 9/22/2024, the MDS indicated Resident 1 needed maximal assistance with toileting, lower body dressing, putting on and taking off footwear. The MDS indicated Resident 1 needed maximal assistance to change positions from sitting to standing and transferring. The MDS indicated Resident 1 needed moderate assistance with upper body dressing, rolling from left to right, changing positions from lying to sitting. The MDS indicated Resident 1 needed supervision wit eating, oral hygiene and personal hygiene. During a review of Resident 2's Face Sheet, the Face Sheet indicated Resident 2 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE] with a diagnosis of disseminated intravascular coagulation (a condition which small blood clots develop throughout the bloodstream), muscle weakness and acute kidney failure (a sudden loss of kidney function that occurs within a few hours or days) blood cell count During a review of Resident 2's H&P dated 10/29/2024, the H&P indicated Resident 2 had the capacity to understand and make decisions. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2 needed moderate assistance with showering, lower body dressing, putting on and taking off footwear. The MDS indicated Resident 2 needed supervision with transferring and changing positions from sitting to standing. During an interview on 12/10/2024 at 2:30 pm with Restorative Nurse Assistant (RNA), RNA stated on 12/5/2024 at1 pm while in the dining room. Resident 1 was in his wheelchair sharing a table with other resident eating. RNA stated Resident 2 went to Resident 1's table and asked Resident 1 if he had a problem. RNA stated Resident 1 said no I am not saying anything. RNA stated Resident 2 said if you have a problem say it to my face and threatened to kill Resident 2. RNA stated Resident 2 stated he does not care if he gets kicked out from the facility. RNA stated Resident 2 kept pushing forward and hitting his chair against Resident 1's wheelchair. During an interview on 12/10/2024 at 2:52 pm with Resident 1, Resident 1 stated he was seated in the dining room and Resident 2 approached him because Resident 2 was angry he was seated at a table and speaking with another resident that Resident 2 did not like. Resident 1 stated Resident 2 rammed his wheelchair into his wheelchair and threatened to kill him. During a concurrent interview on 12/11/2024 at 9:02 am with Licensed Vocational Nurse (LVN), and record review Resident 2's Care Plan,. The Care Plan Indicated Resident 2 told another resident I will kill you. The Care Plan indicated the goal for resident 2 was for the threat not to happen again. LVN stated there is another behavior careplan dated 11/17/2024 about threatening another unknown resident and a Change of Condition (COC- change in a residents health or functioning that can be short term or significant) was not done. LVN stated a Change of Condition is done to monitor the resident's behavior. LVN stated Resident 2's behavior could have been monitored sooner if a COC was initiated was initiated and Medical Doctor(MD could have assessed sooner for any behavioral interventions. LVN stated the COC is done to monitor the resident's behavior for improvement or a decline. During an interview on 12/11/2024 at 4:29 pm with [NAME] Administrator (Adm), Adm stated a similar incident happened one month ago between the Resident 1 and Resident 2. Adm stated supervision is needed when the Resident 1 and Resident 2 are in the dining room. Adm stated Resident 1 and Resident 2 need to be on opposite sides of the dining room and have keep their distance between them both Adm stated Resident 2 was transferred to a GACH for behavior management related to the alleged abuse. During a review of the facility's policy and procedure (P&P) titled, Abuse reporting and Prevention, dated 1/2023, the P&P indicated Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, or mental anguish, or deprivation of an individual, including caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial wellbeing .Verbal abuse is the use of written oral, or gestured language that willfully used derogatory or disparaging terms regardless of their age, ability to comprehend or disability .Facility will monitor areas that have potential to lead to abusive situation, areas include .Residents with behaviors that may lead to abusive situations. During a review of the facility's policy and procedure (P&P) titled, Change of Condition, dated 3/2021, the P&P indicated, It is the policy of this facility that any change in resident's condition be thoroughly assessed and evaluated with physician notification for early clinical management to avoid unnecessary readmission to acute hospitals.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44898 Based on interview and record review the facility failed to ensure resident was turned every 2 hours to prevent the progression of a pressure injury (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence)as care planned for one of three sampled Residents (Resident 3) This failure had the potential to result in Resident 3's pressure injury to worsen and develop an avoidable pressure injury. Findings: During a review of Resident 3's Admission Record (Face Sheet) , the Face Sheet indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses of but not limited to stage four pressure ulcer (Full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) of the sacral (bottom of the spine) region, diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), dependence on a ventilator (a person unable to breathe on their own and requires a mechanical device called a ventilator to assist with breathing) and heart failure (a condition that develops when the heart does not pump enough blood). During a review of Resident 3's History and Physical (H&P) dated 11/4/2024, the H&P indicated Resident 3 did not have the capacity to understand and make decisions. During a review of Resident 3's Minimum Data Set (MDS - a resident assessment tool) , dated 11/6/2024, the MDS indicated Resident 3 was dependent on staff for oral hygiene, toileting, showering, dressing, putting on and taking of footwear, sitting, lying, and rolling from left to right. The MDS indicated Resident 3 did not attempt to eat, stand, or transfer due to medical condition or safety concerns. During an interview on 12/11/2024 at 7:10 am with Registered Nurse Supervisor (RNS), RNS stated on 11/17/2024 he saw Resident 3 at 8 pm with his daughter. RNS stated at 9:30 pm he made rounds and peeked in the room and saw the daughter asleep. RNS stated at 10:30 pm the daughter came to him looking for Certified Nursing Assistant (CNA) 1 stating no one came to reposition her dad for 4 hours. RNS stated he called two licensed Vocational nurses to help assist him with changing Resident 3's diaper and to turn and reposition Resident 3. RNS stated Resident 3 had a bowel movement and does not know the last time Resident 3 was changed, turned, or repositioned. RNS stated Resident 3 is supposed to be turned and repositioned every two hours to prevent pressure ulcers. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/11/2024 at 9:08 am with Treatment Nurse/Licensed Vocational Nurse, TX/LVN stated Resident 3 was admitted to facility on 10/25/2024 with a pressure ulcer. TX/LVN stated Resident 3 is being seen by the wound care doctor weekly for debridement. TX/LVN stated Resident 3 requires turning and repositioning every two hours and as needed and any nursing staff's responsibility TX/LVN stated two hours is the maximum a resident can go without being turned or repositioned due to a risk for further skin breakdown. TX/LVN stated the facility plays music every two hours, 24 hours a day to remind staff to turn and reposition the residents. During an interview on 12/11/2024 at 2:48 pm with CNA 1, CNA 1 stated on 11/17/24 at 4pm he saw Resident 3 and took vital signs. CNA 1 stated at 6:30 pm he changed Resident 3's diaper. CNA 1 stated at 7:30 pm he saw the daughter at the bedside when he passed by the room on the way to take a break and she got busy in room [ROOM NUMBER] after coming from break at 8 pm. CNA 1 stated at 10 pm he saw RNS changing the resident. CNA stated at 11 pm he saw Resident 3 and his daughter after the resident was already cleaned and repositioned, charted and went home. CNA 1 stated every two hours a song plays throughout the facility to remind staff to turn and reposition residents. CNA 1 stated when came back from break he heard the song playing but was busy cleaning another resident. CNA 1 stated it is important to turn and reposition Resident 3 every two hours to avoid developing a pressure injury. During an interview on 12/11/2024 at 3:46 pm with the Director of Nursing (DON), DON stated Resident 3 should have been repositioned every two hours for comfort and to prevent the development of pressure injury or skin breakdown. DON stated every two hours music plays to remind staff to reposition the resident every two hours. DON stated licensed nurses can reposition residents the cna's just need to communicate it's a team effort and not only the responsibility of the cna. During a review of Resident 3's Care Plan, titled Alteration in Skin Integrity, dated 10/25/2024, the Care Plan Indicated, provide turning and repositioning at least every two hours. During a review of Resident 3's Physician Progress Note for wound care, dated 12/3/2024, the Physician Progress Notes indicated, Resident 3 to turn resident every two hours and to keep the skin clean and dry. During a review of Resident 3's Interdisciplinary Wound progress Notes , dated 12/4/2024, the Interdisciplinary Wound progress Notes indicated turning and repositioning every two hours and as needed to redistribute pressure. During a review of the facility's policy and procedure (P&P), titled Pressure Injury aka Pressure Sore Management , dated 10/2027, the P&P indicated, Residents will be turned/repositioned every two hours or as needed.