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	01/24/2025

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47092 Based on interview and record review, the facility failed to ensure the resident, who had a history of acute stroke ([CVA]- loss of blood flow to a part of the brain) and complained of having a slurred speech, a headache, and severe pain in left arm was timely transferred to a general acute care hospital (GACH) to prevent ischemic (a condition that occurs when blood flow to an organ, muscle group, or tissue is reduced resulting in a lack of oxygen) stroke for one of three sampled residents (Resident 1). The facility failed to: 1. Ensure Licensed Vocational Nurse (LVN unknown) assessed Resident 1 when Certified Nursing Assistant (CNA) 1, reported on 1/9/2025 at 1 p.m. Resident 1 complained of having severe pain in left arm rated 9 out of 10 on a pain scale (pain screening tool using numerical value to assess the level of pain ranging from 0 to 3-mild pain, from 4 to 6- moderate pain, and from 7 to 9-severe pain, and 10- the worse pain possible) and verbalized of not feeling right. 2. Ensure the licensed nurses transferred Resident 1 to the GACH when Resident 1's Family Member 1 (FM) 1 reported the resident was having symptoms of Transient Ischemic Attack ([TIA] - a brief period when blood flow to the brain is cut off) such as slurred speech and difficulty speaking. 3. Ensure the Nurse Practitioner (NP) 1 ordered Resident 1's transfer to GACH to prevent a delay in transferring the resident beyond acceptable three hours window to treat the resident with thrombolytic (a medical treatment used to dissolve blood clots) to prevent ischemic stroke. 4. Ensure staff follow the facility's policy and procedure (P&P) titled Emergency Care, revised 9/2017, which indicated to provide emergent care to a resident in need of urgent service; if a resident's condition is observed to have changed, assess the resident, notify the resident's attending physician, and report any changes in condition and provide emergency care as necessary. 5. Ensure staff followed the facility's P&P titled Change in Condition, revised 3/2021, which indicated the changes in the resident's condition be thoroughly assessed and evaluated with physician notification for early clinical management; thorough assessment will include all important information related to the resident such as onset of current symptoms, including vital signs. (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 0684 Level of Harm - Actual harm Residents Affected - Few	These failures resulted in five hours delay in transferring Resident 1 to a GACH from the time Resident 1 reported having symptoms of TIA including, slurred speech, and difficulty speaking. These failures led to Resident 1 not being able to receive thrombolytic therapy to prevent from having ischemic stroke. Resident 1 was subsequently diagnosed with left frontal lobe ischemic stroke and to have permanent brain damage. Findings: During a review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), hemiparesis (weakness on one side of the body) following a cerebral infarction (also known as a stroke, where blood flow to the brain is interrupted causing brain tissue to die) affecting the left side of the body, and trigeminal neuralgia (a chronic pain disorder affecting trigeminal nerve [provides sensation and controls muscles in the face and head]). During a review of Resident 1's Minimum Data Set ([MDS] - resident assessment tool) dated 11/28/2024, the MDS indicated Resident 1's had intact cognition (ability to think and reason). The MDS indicated Resident 1 was dependent (helper does all the effort) on staff with lying to sitting on the side of the bed, from sitting to standing, and with transferring from the bed to chair. During a review of Resident 1's SBAR (situation, background, assessment, recommendation - a communication tool used by healthcare workers when there is a change of condition among the residents) form dated 1/9/2025 timed at 3:00 p.m., the SBAR form indicated Licensed Vocational Nurse (LVN) 1 notified Physician (MD) 1 about Resident 1's inability to speak and a high blood pressure (BP) of 152/96 millimeters of mercury ([mm/Hg]- a unit of pressure used to measure blood pressure. Reference range for normal BP is less than 120/80 mm/Hg). The SBAR indicated MD 1 recommendations included to monitor Resident 1. During a review of Resident 1's Nurses Progress Note dated 1/9/2025 for 7 a.m. to 3 p.m. shift, Nurses Progress Notes indicated Resident 1 was being monitored by LVN 1 when Certified Nursing Assistant (CNA) 1 reported Resident 1 was not able to speak. During a review of Resident 1's Nurses Progress Note dated 1/9/2025 timed at 2:30 p.m., the Nurses Progress Note indicated CNA 1 reported to LVN 2 that Resident 1 wanted to speak to a supervisor or desk nurse. The Nursing Progress Note indicated LVN 2 assessed Resident 1 and Resident 1 did not have any new onset of symptoms. During a review of phone text messages dated 1/9/2025 timed at 2:31 p.m., between LVN 2 and the Nurse Practitioner (NP) 1, the text messages indicated LVN 2 wrote Resident 1 complaint of hard time speaking after lunch and felt she was having another TIA. LVN 2 wrote Resident 1 was speaking right now and feels fine. NP 1 wrote back to keep an eye on Resident 1 and do neuro checks (series of tests that assess the nervous system [brain, spinal cord] that can help identify disorders of the brain) every four hours. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's Nurses Progress Note dated 1/9/2025 and timed at 3:15 p.m., the Nurses Progress Note indicated, LVN 2 asked RN 1 to assess Resident 1 as family member (FM) 1 voiced concerns of Resident 1 having slurred speech (a condition where a person's speech is difficult to understand). The Nursing Progress Note indicated Resident 1's blood pressure was 152/88 mm/Hg. The Nurses Progress Note indicated Resident 1 was awake, alert, oriented to person, place, and time, was coherent, had clear speech, and did not have expressive aphasia (a language disorder that makes it difficult to understand or express language). During a review of phone text message dated 1/9/2025 timed at 3:43 p.m., between LVN 2 to NP 1, the phone text message indicated LVN 2 informed NP 1 of Resident 1's having slurred speech and difficulty remembering. LVN 2 wrote RN 1 assessed Resident 1 which revealed no slurred speech, strong hand grip on the right hand and weak hand grip on the left hand due to previous stroke. Resident 1 was able to move right side extremities with no problem and no impaired vision. NP 1 responded Resident 1 was fine when she saw the resident the morning of 1/9/2025. NP 1 wrote if LVN 2 felt there was a change Resident 1 should have a Computerized Tomography (CT scan- medical imaging). LVN 2 responded that she did not see any issue with Resident 1 now. During a review of phone text message dated 1/9/2025 timed at 3:50 p.m. between LVN 2 to NP 1, the phone text message indicated LVN 2 wrote FM 1 was adamant that something was wrong with Resident 1. LVN 2 wrote FM 1 was requesting Resident 1 be transfer to GACH, NP 1 responded fine. During a review of Resident 1's Nurses Progress Note dated 1/9/2025, the Nurses Progress Note indicated 911 was called at 4:43 p.m. and Resident 1 was transferred to the GACH for slurred speech at 5:08 p.m. During a review of Resident 1's Emergency Transport Record (Paramedic Run Sheet) dated 1/9/2025, the Emergency Transport Record records indicated Paramedics were dispatched to the facility at 4:42 p.m. The Emergency Transport Record indicated at 4:55 p.m. Resident 1 had a blood pressure of 210/110 mmHg. The Emergency Transport Record indicated Resident 1 reported to the Paramedics of having trouble speaking around noon on 1/9/2025, and headache that has been unresolved throughout the day. During a review of Resident 1's Emergency Department (ED) Encounter Notes dated 1/9/2025, the ED Encounter Notes indicated Resident 1 presented to the GACH at 5:16 p.m. with a complaint of expressive aphasia (a disorder that makes it difficult to speak, usually seen in patients who are experiencing a TIA or stroke) and inability to speak full sentences. The ED note indicated Resident 1 had a last known well time (medical term used to describe the last time a patient was known to be free of stroke symptoms) of 12 p.m. and was not a candidate for intravenous ([IV] - medication and/or fluids given directly into the vein) thrombolytic due to the last known well time of greater than three hours. During a review of Resident 1's GACH Magnetic Resonance Imaging ([MRI] - a non-invasive test that uses radio waves and magnets to create a detailed image of the brain) dated 1/10/2025 and timed at 1:01 a.m., the MRI indicated Resident 1 had a new six millimeter (mm-unit of measurement) focus of restricted diffusion in the left frontal (at the front) cortical (outer layer of the cerebrum)/subcortical (region of the brain below the cortex) region suggesting small acute or subacute infarct (lack of adequate blood supply to the brain) (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's GACH Discharge Summary Note dated 1/14/2025 and timed at 3:36 p.m., the GACH Discharge Summary indicated Resident 1's principal diagnosis was acute left frontal lobe (the largest section of the brain which is located in the front of the head) ischemic stroke (when a blood vessel that supplies blood to the brain is blocked, cutting off oxygen and nutrients to brain cells). During an interview on 1/22/2025 at 10:16 a.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated after lunch, around 1 p.m. to 1:30 p.m. Resident 1 verbalized not wanting to go back to bed which was unusual for Resident 1. CNA 1 stated Resident 1 complained of having severe pain 9 out of10 on a pain rating scale on her left arm. CNA 1 stated Resident 1 verbalized not feeling right. CNA 1 stated she reported it to a charge nurse (LVN) but could not remember which LVN she spoke to. During an interview on 1/22/2025 at 10:53 p.m. with FM 1, the FM 1 stated on 1/9/2025 around 1:30 p.m. he received a phone call from Resident 1 stating she believed she was having a stroke. FM 1 arrived at the facility around 2:30 p.m. and noticed Resident 1 was having slurred speech, difficulty in finishing her sentences, and difficulty remembering events throughout the day. FM 1 stated he asked the nurses to talk to the doctor, as he was concerned about Resident 1's worsening condition and requested Resident 1 to be transfer to the GACH as soon as possible FM 1 stated the nurse (unknown) told him the NP 1 said to continue to monitor Resident 1. FM 1 stated he insisted a second time to the licensed nurses to transfer Resident 1 to the GACH and Resident 1 was eventually transferred to the GACH at 5:03 p.m. via 911 (four hours after Resident 1 started to verbalize having difficulty to talk and not feeling well). During an interview on 1/22/2025 at 1:35 p.m., the NP 1 stated she saw Resident 1 on 1/9/2025 in the a.m. (time unknown) when Resident 1 reported to have a headache. The NP 1 stated Resident 1 had a history of trigeminal neuralgia, so she ordered her pain medication. NP 1 stated she had received a phone text messages around 2:30 p.m. on 1/9/2025 from unknown nursing staff who stated Resident 1 complained of difficulty to talk. The NP 1 stated vital signs were not provided in the phone text messages, but nurse (LVN 2) stated Resident 1 seems fine, so she recommended to monitor Resident 1 every four hours. The NP 1 stated she believed Resident 1 was having a transient ischemic attack ([TIA] known as a mini stroke with a temporary interruption of blood flow to the brain which causes stroke like symptoms but usually resolves within 24 hours). The NP 1 stated it was not a medical emergency because she did not present neurological symptoms based on nurse's report and therefore it must have resolved. The NP 1 stated the reason why she did not recommend sending Resident 1 to the GACH emergency department was because they would just treat it with blood thinners, and the resident was already on Aspirin (a blood thinner). The NP 1 stated around 3:30 p.m. she received a phone text message again from nursing staff (LVN 2) who stated FM 1 was insisting on Resident 1's transfer to the hospital, so she agreed since FM 1 insisted. During an interview on 1/22/2025 at 2:59 p.m., MD 1 stated he does not recall getting notified about Resident 1's change of condition on 1/9/2025. The MD 1 stated if he would have been notified that Resident 1 was having a slurred speech, he would order to send the resident to the hospital right away because monitoring would be a loss of time when Resident 1 was having a cerebral infarction. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on 1/22/2025 at 3:50 p.m. RN 1 stated when she arrived to work at 3 p.m. LVN 2 reported to her Resident 1 was complaining about slurred speech. RN 1 stated she went to check on Resident 1 around that time, but her assessment was negative for any neurological changes. RN 1 stated she informed LVN 3 to check Resident 1's vital signs but did not actually witness vital signs being taken and does not know what time they were taken. RN 1 stated she was not the one to contact the physician or communicate to the physician about Resident 1's change of condition. During an interview on 1/22/2025 at 4:22 p.m., LVN 2 stated CNA 1 reported to her around 2:30 p.m. that the Resident 1 was having trouble speaking and she was the one who was in contact with NP 1 throughout the day. LVN 2 stated she told LVN 1 to take Resident 1's vital signs and fill out the SBAR form, but she did not relay the vital signs to NP 1. During an interview on 1/23/2025 at 9:28 a.m. RN 2 stated if Resident 1 reported having slurred speech, which could be a sign of a stroke, but she did not observe a resident have it upon assessment, she would still send a resident to the hospital right away for evaluation. RN 2 stated there is a four-hour window to treat certain stroke, such as tissue plasminogen activator ([tPA] a medication approved to treat ischemic strokes within the first 4.5 hours of a stroke.) that would help Resident 1. RN 2 stated she would monitor the resident vital signs which should be taken once there was reported change of condition. During an interview on 1/23/2025 at 12:13 p.m. with the Director of Nursing (DON), the DON stated that vital signs should be taken when there is a change of condition and document on the SBAR form and report to the physician because vital signs could indicate what was going on with the resident and will determine the course of treatment/action. The DON stated if a resident was reporting difficulty speaking, and a family member was reporting the resident experienced slurred speech, that was enough to send Resident 1 to GACH for evalution and treatment. The DON stated when the resident exhibiting symptoms of a slurred speech the licensed nurses do not need permission from the MD to call 911 and must have immediate interventions to transfer the resident to GACH During an interview on 1/24/2025 at 1:16 p.m. LVN 1 stated she filled out the SBAR form but did not actually speak with MD 1 or any other physician regarding Resident 1's change of condition when Resident first reported difficulty to talk. LVN 1 stated she did not check Resident 1's blood pressure upon the change of condition and documented Resident 1's vital signs taken on 1/9/2025 at 9:27 a.m. on SBAR form timed at 3 p. m. on 1/9/2025. LVN 1 stated when there was a change of condition vital signs should be done at the time of a condition change because they reflect the status of the resident for the doctor to decide what the plan of care. LVN 1 stated the reason why she did not take Resident 1's blood pressure was because she assumed another nurse did it. LVN 1 stated she did not receive any report from the CNA 1 that Resident 1 had severe headache but does recall that Resident 1 did not want to get back into bed. LVN 1 stated it was not until around 2 p.m. to 2:30 p.m. on 1/9/2025 when Resident 1 notified staff she had trouble speaking. LVN 1 stated she did not notify RN 3 when Resident 1 had a change of condition for RN 3 to assess Resident 1's slurred speech. During a review of facility's policy and procedure (P&P) titled Emergency Care, revised 9/2017, the P&P indicated it is the policy of the facility to provide emergent care to a resident in need of urgent service. The P&P indicated if a resident's condition is observed to have changed, assess the resident, notify the resident's attending physician, and report any changes in condition and provide emergency care as necessary. Always take, report, and document the resident's vital signs when a resident is assessed to have a change in condition. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During a review of an online article titled, American Heart Association Guidelines for the Early Management of Patients With Acute Ischemic Stroke: 2019 Update to the 2018 Guidelines for the Early Management of Acute Ischemic Stroke, revised 2019, the article indicated tPA is recommended for selected patients who may be treated within 3 hours of ischemic stroke symptom onset or patient last know well or at baseline state and is also recommended for selected patients who can be treated within 3 and 4.5 hours of ischemic symptoms onset or patient last known well. The article indicated treatment should be initiated as quickly as possible within the listed time frames of 3 to 4.5 hours because time to treatment is strongly associated with outcomes. https://www.ahajournals.org/doi/10.1161/STR.0000000000000211#sec-2 During a review of facility's P&P titled Change in Condition, revised 3/2021, the P&P indicated the purpose of the policy for changes in the resident's condition be thoroughly assessed and evaluated with physician notification for early clinical management to avoid unnecessary readmissions to acute hospitals. The P&P indicated thorough assessment will include all important information related to the resident such as onset of current symptoms, including vital signs. The P&P indicated thy physician is responsible for making the decision for the resident to be treated at the facility or be transferred to the acute hospital for treatment.