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	02/28/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 46415 Based on interview and record review, the facility failed to implement its abuse reporting and prevention policy titled, unusual Occurence Reported dated 8/2018 by failing to report an unusual occurrence of swelling of the left thigh due to unkown source, to the appropriate State Agencies, including the California Department of Public Health (CDPH) and the local Ombudsman, within 24 hours after the incident occurred for one of one sampled resident (Resident 1). As a result of the facility's failure to report Resident 1's left thigh swelling due to unknown source CDPH ' s investigation regarding the circumstances of Resident 1's injury was delayed. This deficient practice placed Resident 1 and other totaly dependent residents with severely impaired cognition (ability to think, understand, learn, and remember), to be at-risk for abuse, neglect, or mistreatment. 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 dependence of renal (kidney) dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed), contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion) of muscle on multiple sites, and protein and calorie malnutrition. During a review of Resident 1 ' s History and Physical (H/P), dated 12/21/2024, the H/P indicated Resident 1 does not have the capacity to understand and make decisions. During a review of Resident 1 ' s Minimum Data Set ([MDS], a resident assessment tool), dated 12/26/2024, the MDS indicated Resident 1 ' s cognition was severely impaired. The MDS indicated Resident 1 was dependent on facility staff on all aspects of activities of daily living (ADL: bathing, toileting, eating, dressing, personal hygiene). The MDS indicated Resident 1 had impairments bilaterally (on both sides) on the upper (arm/shoulders) and lower (hips/legs) extremities During a review of Resident 1 ' s Situation, Background, Assessment and Recommendation ([SBAR] a form of communication between members of a health care team) dated 2/21/2025, the SBAR indicated Resident 1 had swelling on her left thigh (of unknown source). (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/27/2025 at 10:46 a.m., with Registered Nurse Supervisor (RNS) 3, RNS 3 stated if there was a witnessed abuse incident, she would call the police, notify the ombudsman (official appointed to investigate and resolve complaints), CDPH, and call the Administrator (ADM). RNS 3 stated any licensed nurses can fill out the Report of Suspected Dependent Adult/Elder Abuse (SOC341: form used to report suspected abuse/neglect of elder or dependent adult) and send it to the ombudsman. RNS 3 stated the incident has to be reported immediately within a two hour window. RNS 3 stated if no one reported the incident, the resident could continue to get injured or continue to experience harm. During an interview on 2/27/2025 at 2:11 p.m., with the Director of Nursing (DON), the DON stated when she found out about Resident 1's left thigh swelling, she notified the ADM and the Medical Doctor 1 (MD 1) and did a thorough investigation with a look back period of three (3) days. The DON stated this was an unusual occurrence and the initial reporting should have happened on the same day. The DON stated staff should make an initial report to the appropriate agencies, as Resident 1's left thigh swelling was an unusual occurrence, and not reporting will compromise the residents safety. During an interview on 2/27/2025 at 3:06p.m. with theADM, the ADM stated when she was notified of an abuse allegation, she gathered statements/claims, called the police, filled out a report and sent it to the ombudsman, State Survey Agency, and started the investigation the same day. The ADM stated facility staff would complete a body check and interview witnesses if there were any, which included staff that were assigned to the resident, staff that were close by or interacted with the resident. The ADM stated she would interview the resident, if the resident was alert. The ADM stated, she would then submit a conclusion of the investigation within five (5) days to the appropriate parties. The ADM stated she was supposed to report this incident right away and knew she reported it late. TheADM stated she called the State Survey Agency on 2/24/2025 to report this unusual occurrence that was discovered on 2/21/2025 and on 2/25/2025 faxed the investigation report and the 5-day summary report. The ADM stated they are supposed to report and notify anything to the department that can impact those residents. (continued on next page)

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F 0609 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, Abuse Reporting and Prevention dated 4/2024, the P/P indicated it is the policy of this facility to ensure that resident rights are protected by providing a method of investigation and reporting of alleged violations involving mistreatment, neglect, abuse including injuries of unknown sources, unusual occurrences. The administrator, as the abuse coordinator, will investigate each alleged violation thoroughly and report results to appropriate agencies and personnel. The administrator, or his/her designee, will report each alleged abuse to the Ombudsman's office and the Department of Public Health immediately or within 2 hours per Section 1418.91 of the Health and Safety Code. If the alleged violation does not involve abuse and does not result in serious bodily injury, the facility should report the violation within 24 hours. (Refer to number 1 and 2 below.) 1. Serious Bodily Injury - 2-hour limit: If the events that caused the reasonable suspicion of abuse resulted in serious bodily injury to a resident, the covered individual shall report the suspicion of abuse immediately, but not later than 2 hours after forming the suspicion. Any allegation of physical abuse should be reported within two hours. 2. All Others - Within 24 hours: If the alleged violation does not involve abuse and does not result in serious bodily injury to a resident. To summarize and simplify the above listed examples and definitions of abuse, this includes the following: Incidents of unknown origin. All alleged allegations and all substantiated incidents will be reported to the Department of Public Health and to all other agencies as required by State law, i.e., the local law enforcement agency, Certified Nursing Assistant certification board, appropriate licensing board and the local Ombudsman. The results of the investigation must be reported within 5 working days of the incident. During a review of the facility's P/P, titled, Unusual Occurrence Reporting dated 8/2018, the P/P indicated It is the facility policy that, in accordance with federal and/or state regulations, unusual occurrences or other reportable events which affect the health, safety or welfare of residents, employees or visitors be reported. The facility will report the following events to the appropriate agencies: other occurrences that interfere with facility operations and affect the welfare, safety or health of residents, employees or visitors. Unusual occurrences shall be reported via telephone to appropriate agencies as required by current law and/or regulations within twenty-four (24) hours of such incident or as otherwise required by federal and state regulations. A written report detailing the incident and actions taken by the facility after the event shall be sent or delivered to the state agency (and other appropriate agencies as required by law) within forty-eight (48) hours of reporting the event or as required by federal and state regulations.