| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056007 | A. Building<br>B. Wing | 02/04/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Pacific Care Nursing Center | 3355 Pacific Place<br>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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 1), who had an existing pressure ulcer ([PU] localized damage to the skin and/or underlying tissue usually over a bony prominence) was turned and repositioned at least every two hours. This deficient practice resulted in Resident 2 being left in the same position on his left side for over four hours and had the potential for new PUs to develop and a delay in healing for Resident 1's existing PU.Findings: During a review of Resident 2's admission Record (Face Sheet) the Face Sheet indicated Resident 2 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including type 2 diabetes mellitus ([DM] a disorder characterized by difficulty in blood sugar control and poor wound healing) without complications, unspecified (a condition where symptoms match a general category, but there is insufficient information or documentation to classify it more specifically) severe protein-calorie malnutrition (inadequate intake of protein and calories causing muscle weakness), and a stage 4 PU (a full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) in the sacral region (area above the buttocks). During a review of Resident 2's Minimum Data Set ([MDS] a resident assessment tool) dated 6/27/2025, the MDS indicated Resident 2 was dependent (resident does none of the effort to complete the activity) on staff to roll from left to right. During a review of Resident 2's Braden Scale for Predicting Pressure Sore Risk assessment dated [DATE] and 12/25/2026, the Braden Scale for Predicting Pressure Sore Risk assessment indicated Resident 2 scored nine (a score of 12 or below represent a high risk of developing PUs, placing Resident 2 at high risk for PUs. During a review of Resident 2's Weekly Pressure Injury Record dated 1/27/2026, the Weekly Pressure Injury Record indicated Resident 2 had a PU to the sacrococcyx measuring 5.7 centimeters ([cm] a unit of measurement) x 3.6 cm x 2.5 cm. During a review of Resident 2's Care Plan dated 2/4/2026, the Care Plan indicated Resident 1 had an alteration in skin integrity with an actual stage 4 pressure injury to the sacrococcyx (area above the buttock) related to immobility. The Care Plan's interventions indicated to turn and reposition Resident 2 at least every two hours and to utilize pillows as repositioning devices. During an observation of Resident 2 on 2/3/2026 at 10:25 a.m., 12:30 p.m., 1:30 p.m., 2:30 p.m., and 2:45 p.m., Resident 2 was observed lying on a low air loss mattress (a specialized therapeutic support surface often featuring alternating, inflating, and deflating air cells, designed to prevent and treat pressure ulcers) positioned on his left side and a wedge under his right buttock. During an interview on 2/3/2026 at 2:45 p.m., Certified Nursing Assistant (CNA) 1 stated Resident 1 could not turn himself and relied on him (CNA 1) to assist him to turn and reposition at least every two hours to prevent skin breakdown. During an interview on 2/3/2026 at 3:30 p.m., Licensed Vocational Nurse (LVN) 1 stated the Treatment Nurse (TN) and the Charge Nurses (CN) were responsible to make sure the residents were turned and repositioned every two hours and as needed. During an interview on 2/4/2026 at 4:12 p.m., the Director of Nursing (DON) stated licensed nurses<br><br>(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 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | were responsible for making sure CNAs turn residents every two hours. The DON stated turning was important to prevent pressure ulcers from getting worse and preventing new ones from occurring. During a review of the facility's Policy and Procedure (P&P) dated 5/2019, titled Prevention of Pressures Ulcers the P&P indicated for a resident in bed: a. Change position at least every 2 hours or more frequently as needed: |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement infection control measures for one of two sampled residents (Resident 2) by failing to:1. Ensure Certified Nursing Assistant (CNA)1 and Registered Nurse (RN)1 wore required personal protective equipment (PPE- clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) before entering Resident 2's room who was on contact isolation ( a set of safety steps used in the facility to stop the spread of germs that are passed by touching a patient or contaminated items in the resident's room).This failure had the potential to spread and transmit infections to all residents, staff and visitors.Findings:During an observation and interview on 2/4/2026 in Resident 2's room with CNA1, CNA 1 and RN 1 were inside the room without wearing an isolation gown, and gloves. Resident 2 was observed sitting on his wheelchair while CNA1 and RN 1 held the wheelchair with their bare hands. A sign for Contact Isolation was observed posted on the wall before entering Resident 2's room. CNA 1 stated they were about to put Resident 2 back to bed. CNA 1 stated Resident 2 was on contact precautions because of an urinary tract infection (UTI- an infection in the bladder/ urinary tract).During a review of Resident 2's admission Record, the admission Record indicated the Resident 2 was initially admitted on [DATE] and was readmitted on [DATE] to the facility. Resident 2 had diagnoses including UTI, extended spectrum beta lactamase (ESBL-group of bacteria that are resistant to common antibiotic and difficult to treat), depression (common, serious medical illness characterized by a persistent low mood, sadness, and loss of interest in daily activities) and chronic obstructive pulmonary disease(COPD-progressive lung disease that causes inflammation, damaging the airway and make it difficult to breathe).During a review of Resident 2's Minimum Data Set (MDS- resident assessment tool) dated 12/30/2025, the MDS indicated Resident 2 had moderately impaired cognitive skills ( a person had trouble remembering, learning, making decisions which make daily life challenging) and required substantial/ maximal assistance ( helper does more than half the effort) with transferring to and from a bed to a chair, bathing and toileting hygiene. The MDS indicated Resident was incontinent (unable to control bladder or bowels resulting in leaking urine accidentally) of urine.During a review of Resident 2's Care Plan titled, Resident on Isolation Precautions related to ESBL, dated 2/2/2026, the Care Plan interventions included maintaining contact isolation precautions as indicated and monitoring for signs and symptoms of infection.During a review of Resident 2 SBAR (Situation, Background, Assessment, Recommendation- provides a framework for communication between members of the healthcare team about a resident's condition) Communication Form dated 2/2/2026, the SBAR Communication Form indicated Resident 2 urine culture (a laboratory test that detects and identifies bacteria or yeast in a urine sample to diagnose UTI) was positive for ESBL and the physician was notified.During an interview on 2/4/2026 at 2:42 p.m. with CNA 1, CNA 1 stated he forgot Resident 2 was on contact isolation that's why he did not wear the isolation gown and gloves in the room. CNA1 stated the staff should wear an isolation gown, gloves and mask before entering Resident 2's room because he was on contact isolation.During an interview on 2/4/2026 at 2:59 p.m. with RN 1, RN 1 stated she forgot Resident 2 was on contact isolation and it was a mistake not wearing the proper PPE. RN 1 stated Resident 2 was on contact isolation because of the presence of ESBL in the urine.During a concurrent interview and record review on 2/4/2026 at 3:10 p.m. with the Infection Preventionist Nurse (IPN), Resident 2's urine culture and SBAR dated 2/2/2026 were reviewed. The IPN stated Resident 2's urine culture had ESBL in the urine and required contact isolation. The IPN stated CNA 1 and RN 1 should have worn PPE like gloves and isolation gown before entering the room. The IPN stated every time a staff member enters Resident 2's room, the staff<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | should practice hand hygiene, wear isolation gown and gloves to prevent cross contamination (the transfer of bacteria, viruses, microorganisms, or other harmful substances from one surface to another through improper or unsanitary equipment, procedures, or products) and spread of infection among residents and staff. During an interview on 2/4/2026 at 5:00 p.m. with the Director of Nursing (DON), the DON stated not practicing contact precautions on Resident 2 could cause spread of infection to other residents and can result in an outbreak (sudden, unexpected increase in the number of disease cases in a specific localized area or group).During a review of facility's policy and procedure (P&P) titled, Infection Control- Transmission Based Precautions, revised 2/2018,the P&P indicated Contact Precautions are intended to prevent transmission of infections that are spread by direct ( person-to-person) or indirect contact with the resident or environment and require the use of gown and gloves upon entering the resident's room. |