STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056043	A. Building B. Wing	09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Care Center	1913 E 5th Street Long Beach, CA 90802

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45425 Based on interview and record review, the facility failed to include one of three residents (Resident 1) and/or his Responsible Party (RP 1) in an Interdisciplinary Team ([IDT] a group of professionals with different areas of expertise who work together to achieve a common goal or meet the needs of a resident) Conference when Resident 1 was found sitting on the floor on 7/1/2024. This deficient practice resulted in RP 1 not being aware of Resident 1's change of condition (COC) or their ability to provide input regarding Resident 1's care. This deficient practice had the potential for Resident 1's care needs to go unmet. 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 dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities) and schizoaffective disorder (a mental illness which affects a person's mood and behavior). During a review of Resident 1's Minimum Data Set ([MDS] a standardized assessment and care screening tool) dated 6/12/2024, the MDS indicated Resident 1's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was severely impaired. The MDS indicated Resident 1 required partial to moderate assistance (helper does less than half the effort) for completion of his activities of daily living ([ADL] task such as bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet and eating). During a review of Resident 1's COC Assessment Form dated 7/1/2024, the COC indicated Resident 1 was found sitting on the floor. During a review of Resident 1's Interdisciplinary Narrative, dated 7/18/2024, the IDT Narrative indicated Resident 1 exhibited a behavior of sitting on the floor due to his culture and it was the Resident 1's preference to sit on the floor. The IDT narrative indicated Resident 1, and/or RP 1 did not attend the IDT conference. During an interview on 9/12/2024 at 12:03 p.m., RP 2 stated it was not part of Resident 1's culture to sit or pray on the floor. (continued on next page)

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

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/13/2024 at 9 a.m., RP 1 state she was not informed about an IDT meeting or that Resident 1 was found sitting on the floor. RP 1 stated Resident 1 does not like to sit on the floor. During an interview on 9/13/2024 at 9:48 a.m., the Director of Nursing (DON) stated she did not ask RP 1 if Resident 1's behavior of sitting on the floor was part of Resident 1's culture, and stated she assumed sitting on the floor was a cultural norm based on her experience with other residents' behavior of sitting on the floor. The DON stated she did not further investigate Resident 1's behavior to determine if Resident 1 should be placed on bowel and bladder training, if fall precautions should be implemented or if his medications needed adjusting. The DON stated Resident 1 was a new resident and the facility staff were in the process of getting to know him, and they should have reached out to RP 1, who was familiar with Resident 1's routine and behaviors. During a review of the facility's policy and procedure (P/P) titled Resident Rights dated 3/2023, the P/P indicated Federal and State laws guarantee certain basic rights to all residents of the facility which include being informed of and participating in, his or her care planning and treatment.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 45425 Based on interview, and record review, the facility failed to develop and implement a care plan and/develop a care plan based on an accurate assessment of for one of three residents (Resident 1) after Resident 1 was found sitting on the floor and following Resident 1's fall and fracture (break of the bone) to his nose. These deficient practices resulted in Resident 1's care needs not being addressed and/or addressed inaccurately and had the potential to result in a delay of care. 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 dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities) and schizoaffective disorder (a mental illness which affects a person's mood and behavior). During a review of Resident 1's Minimum Data Set ([MDS] a standardized assessment and care screening tool) dated 6/12/2024, the MDS indicated Resident 1's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was severely impaired. a. During a review of Resident 1's Change of Condition (COC) Assessment Form dated 7/1/2024, the COC indicated Resident 1 was found sitting on the floor. During a review of Resident 1's Interdisciplinary Narrative, dated 7/18/2024, the IDT Narrative indicated Resident 1 exhibited a behavior of sitting on the floor due to his culture and it was the Resident 1's preference to sit on the floor. During a review of Resident 1's Care Plan dated 7/2/2024, the Care Plan indicated Resident 1 had an altered behavior pattern related to diagnosis of dementia manifested by an episode of sitting on the floor. Under this care plan a goal was to minimize the risk of decline daily until the next assessment. The Care Plan's interventions included to assess what may cause the behavior and what may trigger the behavior and attempt to reduce/eliminate those triggers if possible. During an interview on 9/12/2024 at 12:03 p.m., RP 2 stated it was not part of Resident 1's culture to sit or pray on the floor. During an interview on 9/13/2024 at 9 a.m., RP 1 state she was not informed about an IDT meeting or that Resident 1 was found sitting on the floor. RP 1 stated Resident 1 does not like to sit on the floor. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/13/2024 at 9:48 a.m., the Director of Nursing (DON) stated she did not ask RP 1 if Resident 1's behavior of sitting on the floor was part of Resident 1's culture, and stated she assumed sitting on the floor was a cultural norm based on her experience with other residents' behavior of sitting on the floor. The DON stated, she did not investigate Resident 1's behavior to determine if Resident 1 should be placed on bowel and bladder training, if fall precautions should be implemented or if his medications needed adjusting. The DON stated Resident 1 was a new resident and the facility staff were in the process of getting to know him, and they should have reached out to RP 1, who was familiar with Resident 1's routine and behaviors for input into Resident 1's care needs. b. During a review of a General Acute Care Hospital (GACH) Emergency Department (ED) Physician's note dated 9/1/2024, the ED Physician's note indicated Resident 1's had a nasal bone fracture (broken nose). During a review of Resident 1's Licensed Nurse note dated 9/1/2024, the Licensed Nurse note indicated Resident 1 was readmitted to the facility with slight swelling to his nose and dried blood on his skin. The Licensed Nurse note indicated the facility would continue with Resident 1's plan of care. During a review of Resident 1's clinical record, there was no documentation to indicate a care plan was developed regarding Resident 1's broken nose. During an interview on 9/13/2024 at 9:48 a.m., and a subsequent interview at 12:35 p.m., the DON after reviewing Resident 1's clinical record, stated she could not find a care plan for Resident 1's nasal fracture. The DON stated a care plan addressing Resident 1's nasal fracture, pain, treatment, consults and monitoring should have been created. During a review of the facility's P/P titled Care Plans, Comprehensive Person Centered, dated 3/2033, the P/P indicated the IDT team to review and update the care plan when the resident has been readmitted to the facility from a hospital stay. The P/P indicated assessments of residents are ongoing and care plans are revised as information about the residents and the resident's condition change.

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(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 - Some	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** 45425 Based on interview, and record review, the facility failed to ensure Psychiatrist Evaluation Progress notes and General Acute Care Hospital (GACH) records were available in the clinical record for one of three sampled residents (Resident 1). This deficient practice resulted in Resident 1's clinical records being incomplete and had the potential for non-continuity of care. 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 dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities) and schizoaffective disorder (a mental illness which affects a person's mood and behavior). During a review of Resident 1's Minimum Data Set ([MDS] a standardized assessment and care screening tool) dated 6/12/2024, the MDS indicated Resident 1's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was severely impaired. a. During a review of Resident 1's Physician's order dated 6/7/2024, the Physician's order indicated for Resident 1 to have a psychiatrist evaluation with treatment and follow up as indicated. During a review of Resident 1's clinical records, there was no documentation indicating that a psychiatric evaluation was conducted. During an interview on 9/12/2024 at 3:44 p.m., the Assistant Director of Nursing (ADON) stated, Resident 1 was on the facility's list for a psychiatric evaluation for 7/15/2024 after his fall on 7/1/2024 and again on 8/5/2024. The ADON, after reviewing Resident 1's clinical record, stated he could not find any documentation regarding Resident 1's psychiatric evaluations. During an interview on 9/12/2024 at 3:44 p.m., the Director of Nursing (DON) stated after Resident 1 was found sitting on the floor on 7/1/2024, she requested that Resident 1 have a psychiatric evaluation to review is medication, she later did not see that a psychiatric evaluation was done, so she requested another evaluation in 8/2024. The DON, after reviewing Resident 1's clinical record, stated she could not find a psychiatric evaluation for Resident 1 during 7/2024 or 8/2024. During an interview on 9/12/2024 at 3:59 p.m., the Medical Records Director (MRD) stated Resident 1's psychiatric evaluation notes were requested and received (9/12/2024) for Resident 1's psychiatric evaluations on 7/15/2024 and 8/5/2024. b. During a review of Resident 1's nursing progress notes dated 8/31/2024, the notes indicated Resident 1 was transported via 911 to a GACH due to a fall resulting in a laceration to the bridge of Resident 1's nose. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 1's clinical records, there was no documentation from the GACH indicating the care Resident 1 received or treatment orders during his admission to the GACH on 8/31/2024. During an interview with the DON and a concurrent review of Resident 1's clinical records on 9/13/2025 at 9:48 a.m., Resident 1's clinical records indicated there were no GACH records available from Resident 1's recent admission to the GACH on 8/31/2024. The DON stated the records from the GACH should have been requested when they were not sent with Resident 1 on his return to the facility on [DATE] . The DON stated the GACH records were needed to provide information regarding the care Resident 1 received when he was at the GACH and all medical records documenting the care of Resident 1 should have been available for review by facility staff. During an interview on 9/13/2024 at 11:15 a.m., the MRD stated Resident 1's GACH record were requested and received (9/13/2024) for Resident 1's GACH stay of 8/31/2024. During a review of the facility's undated policy and procedure (P/P) titled Medical Records, the (P/P) indicated the facility shall maintain complete, accurate, readily accessible, and systemically organized medical records for each resident admitted .