

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  056043	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/13/2025
NAME OF PROVIDER OR SUPPLIER  Colonial Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to report immediately and not later than two hours after receiving an allegation of physical abuse (any intentional act causing injury or trauma to another person by way of bodily contact) by one of fifteen sampled residents (Resident 4) to officials, including the State Survey Agency and law enforcement. This deficient practice resulted in the inability of The California Department of Public Health (CDPH) to investigate the allegations of abuse in a timely manner and placed Resident 4 at risk for continued physical abuse. Findings:</p> <p>During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was admitted to the facility on [DATE] with diagnoses of essential hypertension (high blood pressure) and type 2 diabetes (happens when the body cannot use insulin correctly and sugar builds up in the blood).</p> <p>During a review of Resident 4's Minimum Data Set (MDS, a resident assessment tool) dated 10/9/2025, the MDS indicated Resident 4 had moderate cognitive impairment (a significant decline in thinking and memory that impairs daily functioning, making it difficult to perform complex tasks like managing finances or navigating new places).</p> <p>During a concurrent observation and interview on 11/12/2025 at 9:37 a.m., Resident 4 reported to Licensed Vocational Nurse (LVN) 2 that 2&amp;ndash;3 days prior (exact date unknown), she was in the hallway when an unknown individual pulled her hair from behind. LVN 2 was observed present during the disclosure.</p> <p>During an interview on 11/13/2025 at 8:47 a.m., with Resident 4, Resident 4 stated she could not recall the exact date of the incident but remembered being in her wheelchair in the hallway when an unknown individual came up behind her and pulled her hair. Resident 4 reported that no one was nearby to witness the incident, and she was unable to turn around to see who was responsible. Resident 4 stated that she felt the hair pulling, screamed, but no one was present to assist her at that time.</p> <p>(continued on next page)</p>

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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/13/2025 at 9:20 a.m., with LVN 2, LVN 2 stated on the previous day (11/12/2025), Resident 4 informed him that someone had pulled her hair a few days earlier, though she was unable to identify the individual responsible. LVN 2 stated that some residents in Resident 4's unit were known to be unfriendly and that there had been prior incidents of resident-to-resident altercations (dates unknown). LVN 2 stated that it was possible another resident may have pulled Resident 4's hair. LVN 2 stated hair pulling was considered a form of physical abuse. LVN 2 stated that when a resident reports an allegation of abuse, he was required to follow the facility's chain of command, which includes reporting the allegation to the Registered Nurse (RN) supervisor, or, if unavailable, to the Administrator. LVN 2 stated that he did not report the allegation made by Resident 4 on 11/12/2025.</p> <p>During an interview on 11/13/2025 at 9:35 a.m., with Registered Nurse (RN) 1, RN 1 stated that she was working alongside with LVN 2 on 11/12/2025 but was not informed that Resident 4 had reported an incident of hair pulling. RN 1 stated that the allegation should have been reported immediately so Resident 4 could be assessed promptly and an investigation initiated without delay. RN 1 stated that allegations of abuse do not need to be validated prior to reporting.</p> <p>During an interview on 11/13/2025 at 9:43 a.m., the Administrator (ADMIN) stated that Resident 4's allegation of abuse should have been reported immediately to either the supervisor or himself. The ADMIN stated prompt reporting was necessary to ensure that an investigation can be initiated without delay and that the appropriate agencies were notified.</p> <p>During an interview on 11/13/2025 at 3:12 p.m., with the Administrator (ADMIN), the ADMIN stated that LVN 2 did not follow the facility's Abuse Policy and Procedure (P&amp;P). The ADMIN stated that it was important for allegations of abuse to be reported immediately to ensure resident safety and to allow timely notification to the appropriate entities. The ADMIN stated that, per the facility's policy, allegations of abuse must be reported to the State Agency within two hours of the facility becoming aware of the incident.</p> <p>During a review of the facility's P&amp;P titled Abuse &amp; Mistreatment of Residents dated 5/3/2023, the P&amp;P indicated any mandated reporter was to report abuse to their supervisor as well as the State Agency. The facility was to notify the State Agency within 2 hours of the knowledge of alleged abuse incidents.</p>		