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	01/29/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, Licensed Vocational Nurse (LVN) 1 failed to assess the mobility limitations and take precautions before moving one of three sampled residents (Resident 1), who was dependent on staff to roll from the left to the right side. The facility failed to ensure: LVN 1 requested assistance from another staff member before repositioning Resident 1, who per the Minimum Data Set ([MDS] a resident assessment tool), was dependent on staff to roll from the left side to the right and or the assistance of two or more helpers was required for Resident 1 to roll from the left to the right side. This deficient practice resulted in LVN 1 repositioning Resident 1 without assistance and hitting Resident 1's right knee on the resident's bed frame. Resident 1 experience pain, swelling and tenderness to the right knee, and was subsequently diagnosed with an acute (sudden-onset) right distal femur fracture (a break of the knee). Resident 1 was transferred to a General Acute Care Hospital (GACH) where the fractured knee was immobilized (to prevent from moving), she was treated for pain and monitored for bleeding and a thromboembolism (obstruction of a blood vessel by a blood clot that has become dislodged from another site in the circulation). Findings: During a review of Resident 1's admission Record (Face Sheet), the Face Sheet indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1's diagnoses included a closed fracture (broken bone that does not penetrate the skin) of lower end of right femur, dementia (a progressive state of decline in mental abilities), and Alzheimer's (disease characterized by a progressive decline in mental abilities). During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool), dated 11/17/2025, the MDS indicated Resident 1's cognition (the ability to think and reason) was severely impaired. The MDS indicated Resident 1 was dependent (helper does all the effort, resident did none of the effort to complete the activity, or the assistance of two or more helpers is required for the resident to complete the activity) on staff for rolling left to right. The MDS indicated Resident 1 had a functional limitation in range of motion ([ROM] the full, functional measurement of the distance and direction a joint can move, stretching from maximum bending to full straightening) to both of her upper (arms) and lower (legs) extremities. During a review of Resident 1's Situation, Background, Assessment, Recommendation ([SBAR] a communication tool used by healthcare workers when there is a change of condition among the residents) dated 1/2/2026, and timed at 9:30 p.m., the SBAR indicated during rounds LVN 1 observed Resident 1 at the edge of her bed, upon repositioning the resident, she (LVN 1) accidentally bumped Resident 1's knee against the resident's bed frame. The SBAR indicated Resident 1's knee was slightly swollen, tender to touch and Resident 1 was moaning with facial grimacing.During a review of Resident 1's Physician's Orders, dated 1/2/2026, and timed at 11:50 p.m., the Physician's Order indicated a STAT (immediate) radiology ([X-ray] a procedure that takes pictures of the inside of the body to diagnose broken bones and other injuries) to Resident 1's bilateral (both sides) hips, right femur and right knee due to pain. During a review of (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0689 Level of Harm - Actual harm Residents Affected - Few	Resident 1's X-ray Report, dated 1/3/2026 and timed at 12:01 p.m., the X-ray report indicated Resident 1 had a fracture of the right distal femur. During a review of Resident 1's Licensed Nurses Note, dated 1/3/2026 and timed at 3:43 p.m., the note indicated Resident 1 was transferred to a GACH due to a fracture. During a review of the GACH's Emergency Department's History of Present Illness (HPI), dated 1/3/2026, the HPI indicated Resident 1 present to the emergency room with swelling and deformity of the right distal thigh, an X-ray indicated an acute distal femur fracture. The HPI indicated Resident 1 was admitted to the GACH for pain control, immobilization, an orthopedic (a medical specialist focusing on the muscles and bones) surgical evaluation, monitoring for complications including bleeding, thromboembolism and skin breakdown. During a review of the GACH's Orthopedic Consultation report, dated 1/5/2026, and timed at 9:37 a.m., the Orthopedic Consultation indicated Resident 1's injury was likely due to malunion (a broken bone that healed in an abnormal, misaligned position) and surgery was not recommended due to Resident 1's dementia and non-ambulatory status. The report indicated Resident 1 was stable for discharge from an orthopedic standpoint. During an interview on 1/28/2026 at 4:40 p.m., Certified Nursing Assistant (CNA) 1 stated Resident 1 required a two-person assist for care. On 1/2/2026 she and CNA 2 provided care to Resident 1 during the 3 p.m. to 11 p.m., shift. CNA 1 stated sometime during the evening (time unknown), she and CNA 2 noticed Resident 1's right knee was bending weirdly. CNA 1 stated they (CNA 1 and CNA 2) informed LVN 1, LVN 1 repositioned Resident 1 and accidentally bumped the resident's right knee on bed frame. During an interview on 1/29/2026 at 10:13 a.m., LVN 1 stated on 1/2/2026, at around 9:30 p.m., while making rounds, she found Resident 1 at the edge of the right side of her bed, with her right foot hitting the bed's footboard. LVN 1 stated she knew Resident 1 was a two-person assist but everyone was busy caring for other residents', to prevent Resident 1 from falling she decided to reposition Resident 1 without assistance. LVN 1 stated she used a draw sheet (a small, folded bed sheet or specialized fabric placed across the middle of a mattress, covering the area between a patient's upper back and thighs. Primarily used to reposition, lift, or transfer patients) to pull Resident 1 up while Resident 1's right leg was crossed over the left leg; both legs were straight. LVN 1 stated Resident 1 was centered in the middle of the bed and as she proceeded to turn Resident 1 toward the left side of the bed, Resident 1 moved her legs, and her right knee hit the bed frame on the bottom of her bed that was exposed because the mattress did not cover the bed frame completely. LVN 1 stated she noticed Resident 1 was grimacing, moaning, and she observed redness and swelling on the resident's her right knee. During an interview on 1/29/2026 at 11:54 a.m., the Director of Nursing (DON) stated LVN 1 should have called for help if Resident 1 required a two-person assist. During a review of the facility's undated P/P, titled, Positioning & Moving Residents the P/P indicated before moving or lifting a resident, staff members were to assess the resident's physical abilities, mobility limitation in joints and muscles, strength, awareness of surroundings, and ability to follow directions. Staff members will use maximum precautions when moving or lifting residents, obtain assistance from other professional as needed.