

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 02/12/2026
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)		
F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to maintain a debris-free dumpster area when trash was not properly contained, covered, and free from overflowing for three of three trash dumpsters. This failure had the potential to result in pests (an organism that causes harm to humans such as flies, cockroaches, and rodents) entering the facility and spreading diseases to the residents. Findings: During an observation on 2/9/2026 at 8:45 a.m. in the outdoor garbage area, there were three dumpsters. The three trash dumpsters were open and overflowing with garbage. There were folded brown boxes and trash bags filled with used personal protective equipment (PPE, clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) overflowing from the three trash dumpsters onto the lid of two trash bins. During a concurrent observation and interview on 2/10/2026 at 8:20 a.m. in the outdoor garbage area, with the Dietary Services Supervisor (DSS), two of three trash dumpster lids were not completely closed. DSS stated trash dumpsters should not be overfilled. DSS stated garbage containers should be kept closed when not in use to prevent pests from getting inside. DSS stated residents could get sick from diseases that pests spread. During a review of the facility's policy and procedure (P&P) titled, Waste Control and Disposal, undated, the P&P indicated, Outside garbage bin should be kept closed at all times and surrounding areas must be kept clean. Dispose garbage in a timely manner to prevent build up.		

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observation, interview and record review the facility failed to ensure residents, who were identified at risk for fall, did not fall and sustained injury for one of three sample residents (Resident 8 and Resident 44). The facility failed to: 1. Ensure Change of Condition (COC- a sudden clinically important deviation from a patient's baseline in physical, cognitive, behavioral, or functional condition), care plan, Interdisciplinary Team (IDT team members from different departments working together with a common purpose to set goals and make decisions ensure residents receive the best care), Medical Doctor (MD) notification was initiated for Resident 8 after Rehabilitation staff (group of healthcare professionals who work together with a patient and their family to achieve maximum physical, cognitive, and functional independence) initiated a post fall assessment (evaluation performed by staff to check for injuries and identify the cause of a fall) dated 12/3/2025 .2.Ensure the licensed nurses evaluated the effectiveness of interventions of Residents 8's care plan titled, Resident has impaired vision related to Cataract (the lens of the eye becomes progressively opaque, resulting in blurred vision) initiated on 7/15/2024, after Resident 8 fell on 9/29/25, to develop new interventions to prevent the resident's fall on 12/3/2025 with injuries. 3. Ensure staff followed the facility's policy and procedure (P&P) titled, Falls and Fall Risk, Managing, revised 3/2018 the P &P indicated, If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. 4. Ensure Resident 8 who was visual impaired (restricted vision, partial or complete blindness) was supervised and assisted to the bathroom (staff member actively monitoring a person during the process of using the restroom) as indicated in the minimum data set (MDS) assessment. These failures resulted in: Resident 8 falling while in the restroom on 12/3/2025 around 1:30 p.m., sustaining a right superior (above) pubic rami (located at the front of each side of the pelvis) fracture (broken bone) of unknown age which required hospitalization in a General Acute Care Hospital (GACH) for treatment and evaluation. On 1/23/2025 Resident 8 fell down on the floor complained of (C/O) headache mostly occipital region rates her pain 8/10with bump at the back of the head. Findings: During a review of Residents 8's admission Record, the admission Record indicated Resident 8 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities), cataract (a progressive condition makes vision blurry and cloudy), and history of falling. During a review of Resident 8's Minimum Data Set [MDS- resident assessment tool) dated 12/18/2025, the MDS indicated Resident 8 had moderately impaired cognitive (ability to think, understand, learn, and remember) skills for daily decision making and needed supervision or touching assistance (helper provides verbal cues and/or touching/steadying and or contact guard assistance) when toileting and with personal hygiene. During a review of Resident 8's care plan, titled, Bowel and Bladder Retraining related to alteration in elimination pattern, dated 4/22/2024, the care plan interventions included; assist Resident 8 to the toilet, the bedside commode or offer a bedpan as indicated, before breakfast, before lunch, before dinner and as needed. During a review of Resident 8's care plan titled, Resident 8 has impaired visual functioning related to cataracts, initiated on 7/15/2024, the care plan goal for Resident 8 was to minimize the risk of injury related to visual impairment. The care plan indicated to provide a safe environment free of hazards, maintain adequate room lighting, ophthalmologist (medical specialty in diagnosing and treating the eyes) consult as needed and observe for decrease in vision and blurring. During a review of Resident 8's Social Service Note, dated 3/27/2025 timed at 10:06 a.m., the Social Service Note indicated Resident 8 had a hard time seeing and did not move her pupils (center of the eye allows light to enter so one can see) when being tested (no reaction to light indicates severe vision impairment). During a review of Resident 8's COC dated 3/31/2025 timed at 2:00 p.m., the COC indicated Resident 8 was observed with loss of vision in her right eye. The COC indicated Resident 8 (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	also verbalized she was losing vision in her left eye. The COC indicated when Resident 8 heads to the bathroom she guides herself by holding onto furniture along the path or the wall to the bathroom. During a review of Residents 8's Social Service Note dated 4/3/2025 timed at 12:29 p.m., the Social Service Note indicated the Social Worker (SW) found an ophthalmologists office takes Resident 8's insurance and the ophthalmologist's office requested Resident 8's identification card and insurance card for the referral packet and order to be sent to the office. The Social Service Note indicated Resident 8 had destroyed all of the requested documents and Resident 8's Responsible Party did not have any copies of Resident 8's insurance information. During a review of Resident 8's Care Plan titled, Risk for Falls, initiated on 7/4/2025, the Care Plan indicated the goal for Resident 8 was Resident 8 would be free from falls. The Care Plan interventions included assist resident with ambulation and transfers. During a review of Resident 8's Physician Orders dated 10/20/2025, the Physician Order indicated, Rescheduled appointment with ophthalmologist for cataract surgery on 10/21/2025 at 11:30 a.m., until 3:30 p.m. During a review of Resident 8's Eye Examination Report dated 10/21/2025, the Eye Examination Report indicated Resident 8 reported blurry vision in both eyes and it was worsening for the past 6 months, and the blurred vision was making activities of daily living more difficult. The Eye Examination Report indicated Cataract surgery was recommended as a means of improving Resident 8's visual function. During a review of Resident 8's Optometry (medical specialty testing and treating vision) report dated 11/25/2025, the Optometry Report indicated recommendations indicated further testing and evaluation with ophthalmology. During a review of Resident 8's Social Service Note dated 11/25/2025 timed at 4:24 p.m., the Social Service Note indicated ophthalmology referral from optometry was acknowledged. During a review of Resident 8's COC form dated 12/3/2025 and timed at 5:56 p.m., the COC form indicated, Resident 8 complained of right hip and leg pain. The COC form indicated Resident 8 had pain when attempting active range of motion (AROM- movement a person can produce at a joint using their own muscle power, without any outside assistance or aids). During a review of Resident 8's Rehabilitation Fall Risk Assessment form dated 12/5/2025 and timed 10:35 a.m., the Fall Risk Assessment form indicated date of incident 12/3/2025 (unknown time) unwitnessed fall, per Resident 8, Resident 8 fell in the bathroom. During a review of Resident 8's COC form dated 12/5/2025 timed at 1:30 p.m., the COC form indicated while charge nurse was making rounds, LVN 2 saw Resident 8 walking by herself to the bathroom and bumping into the bathroom door The COC form indicated LVN 2 assisted Resident 8 back to bed. The COC form indicated Resident 8 limped when she walked, complained of 5/10 right groin pain. The COC form indicated Resident 8's Medical Doctor (MD) ordered to transfer Resident 8 to the GACH for further evaluation. During a review of Resident 8's Nursing Progress notes dated 12/6/2025 timed at 12:59 a.m., the Nursing Progress notes indicated the GACH gave report Resident 8 had fracture of superior ramus of pubis (top front portion of the hip bones). During a review of Resident 8's Interdisciplinary Team (IDT team members from different departments working together with a common purpose to set goals and make decisions ensure residents receive the best care) note dated 12/8/2025 timed at 1:35 p.m., the IDT note indicated Resident 8 had a fall on 12/5/2025 and Resident 8 needed limited to maximum assistance with activities of daily living (ADL's). The IDT note indicated Resident 8 returned to facility and has fracture of superior ramus of pubis.no treatment required. it will heal itself. During a review of Resident 8's COC form dated 1/23/2026 timed 1:27 a.m., the COC form indicated at 12:24 a.m. a loud bang was heard coming from the Resident 8's room. The COC indicated Certified Nurse Assistant (unknown CNA) immediately entered the room and found Resident 8 lying on the floor near the bathroom door. The COC indicated emergency services were contacted and Resident 8 was transferred to GACH. During a review of Resident 8's Nursing Progress notes dated 1/23/2026 timed at 9:37 a.m., the Nursing Progress notes indicated Resident 8 was transferred back from the GACH emergency department with a diagnosis of, scalp hematoma (a solid swelling of clotted blood within the tissues usually due to trauma) During an observation on 2/10/2026 at 12:45 p.m., outside of Resident 8's room, Resident 8 was seen sitting at the edge of the bed trying to get up (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	from the bed by holding onto the wall. Resident 8 started to ambulate towards the restroom without assistance. During an interview on 2/12/2026 at 7:13 a.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated Resident 8 informed her she had unwitnessed fall in the bathroom back in 12/2025. LVN 2 stated if there is a report from any Residents they fell on the ground Licensed staff initiate a COC, an incident report to investigate the incident and the Licensed staff update the care plan. LVN 2 stated there was no COC initiated for the unwitnessed fall Resident 8 reported that Resident 8's MD was not notified. LVN 2 stated the care plan for Resident 8 was not updated to meet Resident 8's needs to prevent the fall on 1/23/2026. LVN 2 stated Resident 8 should always be supervised when ambulating to the restroom due to her worsening vision. During a concurrent interview and record review on 2/12/2026 at 8:06 a.m., with LVN 3, Resident 8's GACH x-ray report and physicians' orders from facility for the month of December 2025. LVN 3 stated Resident 8 came back from the GACH on 12/6/2025 with x-ray results indicating a fracture of the right superior pubic ramus, of unknown age. LVN 3 stated Resident 8 was not referred to an orthopedic (medical specialty treating conditions affecting the bones or muscles) doctor. LVN 3 stated Resident 8 should have been assessed by an orthopedic physician to clear Resident 8 for physical therapy. LVN 3 stated Resident 8 continued to have falls due to her vision problems. LVN 3 stated Resident 8 is completely blind (severe visual impairment) in the right eye and has poor vision on the left eye due to cataracts. LVN 3 stated Resident 8's ophthalmologist recommended a referral for further testing and evaluation. During a review of Resident 8's -Physical Therapy (PT- a person qualified to treat disease, injury, or physical conditions by methods such as massage, heat treatment, and exercise rather than by drugs or surgery) Progress Notes dated 12/5/2025 (unknown date), the Progress Notes indicated Due to Resident 8's diagnosis of a fracture, weight-bearing and standing activities will remain on hold until further MD order for weight bearing precaution. During a review of Resident 8's PT progress notes dated 12/31/2025 (unknown time), the PT progress notes indicated weight bearing activities remain on hold until further MD order for weight bearing precautions. During an interview and concurrent record review on 12/12/2026 at 10:45 a.m., with the Assistant Director of Nursing (ADON), Resident 8's COC report for the month of December. The ADON stated staff did not complete a COC for Resident 8's unwitnessed fall on 12/3/2025 and did not notify the physician. The ADON further stated Resident 8 was readmitted on [DATE] from a GACH with a fracture of the right rami of unknown age. The ADON explained the IDT decided no intervention or follow-up was needed, due to the fracture of unknown age. During an interview on 2/12/2026 at 2:34 p.m., with the Director of Nursing (DON), the DON stated she did not know about Resident 8's unwitnessed fall. The DON stated no investigation was conducted and Resident 8's MD was not notified. The DON stated Resident 8 returned from GACH on 12/6/2025 with an old fracture, which did not require an orthopedic follow-up as it would heal naturally. The DON stated the GACH said no treatment required we did not do anything else to monitor Resident 8's fracture. The facility didn't report the fracture to our agency because they knew the cause of the fracture. During a review of the facility's policy and procedure titled Falls and Fall Risk, managing revised on 3/2018, indicated staff will monitor and document each resident's response to interventions intended to reduce falling or the risk of falling. If falling recurs despite initial interventions, staff will implement additional or different interventions or indicate why the current approach remains relevant.		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of eight sampled residents (Resident 9), who was receiving hemodialysis (dialysis, a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) :Physician orders for specific fluid allowed in 24 hours were placed.Fluid intake was being measured.These deficient practices had the potential to place residents at risk for fluid retention and overload.Findings:a. During a review of Resident 9's admission Record (Face Sheet), the admission Record indicated the facility admitted the resident on 3/1/2022 and was readmitted on [DATE] with diagnoses including end stage renal disease (ESRD-irreversible kidney failure), diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), and chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing).During a review of Resident 9's History and Physical (H&P) dated 3/3/2025, the H&P indicated the resident had the capacity to understand and make decisions.During a review of Resident 9's Minimum Data Set (MDS- a resident assessment tool), the MDS indicated Resident 9 had no issues with thinking or memory. The MDS indicated Resident 9 required maximal assistance from staff for toileting and bathing and supervision for eating.During a concurrent interview and record review on 2/10/2026 at 11:33 a.m. with Licensed Vocational Nurse (LVN) 2, Resident 9's physician orders dated 4/1/2024 was reviewed. The physician orders indicated Fluid restriction; limited to no water pitcher at bedside. LVN 2 stated the physician order was unclear and should have the amount of fluid the resident can have in a 24 hour period. LVN 2 stated not having a clear fluid restriction order places dialysis residents at risk for fluid overload.During an interview on 2/12/2026 at 9:58 a.m. with Registered Dietician (RD), the RD stated not having a clear fluid restriction order places dialysis residents at risk for fluid overload due to impaired kidney (organ responsible for filtering blood to remove waste products and excess water) function.During a concurrent interview and record review on 2/12/2026 at 8:47 a.m. with Registered Nurse (RN) 1, Resident 9's physician orders were reviewed. RN 1 stated physician orders indicated Fluid restriction; limited to no water pitcher at bedside. RN 1 stated Resident 9's fluid restriction order was incomplete and should have the amount of fluid resident can have each day. Resident 9's Nutrition Dietary Note dated 1/30/2026 was reviewed. RN 1 stated Resident 9's fluid restriction was limited to no water pitcher at bedside. Resident 9's hemodialysis care plan report was reviewed. RN 1 stated Resident 9's fluid restriction was not documented on any interventions. RN 1 stated not having orders that specify amount of fluid Resident 9 can have in a day places resident at risk for fluid retention and overload.During a review of facility policy and procedure titled, Care of Resident Receiving Renal Dialysis undated, the P&P indicated, Fluid Restriction followed: a. MD orders for specific fluid allowed in 24 hours.b. During a concurrent interview and record review on 2/10/2026 at 11:33 a.m. with Licensed Vocational Nurse (LVN) 2, Resident 9's physician orders were reviewed. LVN 2 stated Resident 9 did not have any physician orders for intake measurements. LVN 2 stated monitoring fluid intake was important for residents on dialysis because they are at risk for fluid overload.During a concurrent interview and record review on 2/12/2026 at 8:47 a.m. with Registered Nurse (RN) 1, Resident 9's physician orders were reviewed. RN 1 stated Resident 9 did not have any physician orders for intake measurements. RN 1 stated if nurses were documenting the resident's fluid intake, nurses would document in progress notes. Resident 9's nursing progress notes were reviewed. RN 1 stated there was no documentation of Resident 9's fluid intake. Resident 9's Administration Report for fluid restriction, limited to no water pitcher at bedside was reviewed. RN 1 stated nurses document task completed to verify there was no water pitcher at Resident 9's bedside. RN 1 stated there was no documentation of amount of fluid Resident 9 consumed throughout the day. RN 1 stated there should be documentation of Resident 9's fluid intake. RN 1 stated not monitoring or documenting Resident 9's fluid intake places resident at risk of fluid overload.During a concurrent (continued on next page)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interview and record review on 2/12/2026 at 1:20 p.m. with the Director of Nursing (DON), the DON stated Resident 9 was only given fluids by the kitchen with meals. Resident 9's diet orders were reviewed. The DON stated the diet order does not indicate amount of fluid Resident 9 was being served with each meal. The DON stated monitoring fluid intake is important for dialysis residents because they are at risk for fluid overload. During a review of facility policy and procedure (P&P) undated, indicated, Fluid restriction followed: Intake measured and recorded each shift, if ordered.		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to identify and to intervene in two of three sampled residents (Resident 17 and Resident 156) history of trauma and triggers which may cause re-traumatization (a person encounters a new event or stimulus that triggers them to re-experience the intense stress, emotional distress, and even flashbacks of a previous traumatic event as if it were happening again) as evidenced by: A. Failing to assess and identify the trauma and triggers for Resident 17 related to natural/human caused disaster. B. Failing to assess and identify the trauma and triggers for Resident 156 related to homelessness. This failure had the potential to result in Resident 17 and Resident 156 experiencing re-traumatization and further psychosocial decline. Findings: A. During a review of Resident 17's admission record, the admission record indicated Resident 17 was admitted initially to the facility on [DATE] and last readmission was on [DATE] with diagnoses including post-traumatic stress disorder (PTSD - a disorder in which a person has difficulty recovering after experiencing or witnessing a traumatic event), schizophrenia (a mental illness that is characterized by disturbances in thought), and dementia (a progressive state of decline in mental abilities). During a review of Resident 17's History and Physical (H&P), dated [DATE], the H&P indicated, Resident 17 was able to make decisions for activities of daily living. During a review of Resident 17's Minimum Data Set (MDS-a resident assessment tool), dated [DATE], the MDS indicated Resident 17 required supervision or touching assistance (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) from one staff for hygiene, bed mobility, transfer, dressing, bathing, and eating. During a concurrent interview and record review on [DATE], at 9:48 a.m., with Registered Nurse Supervisor (RNS) 1, Resident 17's Care Plan Report (CPR) titled, Trauma Informed Care: ineffective coping related to past traumatic incident -Large scale natural and/or human caused disaster survivor, and adjusting to new place, revised on [DATE] was reviewed. The CPR Goal indicated, Resident 17 will have reduced episodes of behavior daily until [DATE]. The CPR Interventions indicated, implement useful interventions to reduce stress, monitor behavior episodes, and provide a safe environment and atmosphere of acceptance. RNS 1 stated, Resident 17's CPR did not indicate what the nature of the trauma was and what triggers Resident 17 had. RNS 1 stated, the CPR interventions were not individualized without identifying what might trigger Resident 17 to experience re-traumatization. RNS 1 stated, it was important to identify the triggers and implement interventions that were individualized according to Resident 17's needs to prevent re-traumatization. During a concurrent interview and record review on [DATE], at 10:41 a.m., with Social Service Assistant (SSA) 1, Resident 17's Trauma Care Evaluation (TCE), dated [DATE] was reviewed. The TCE was done and signed by SSA 1. The TCE indicated, there was no trauma and triggers identified. SSA 1 stated, the staff should have assessed and identified the triggers of PTSD and the severity of possible re-traumatization from the triggers to prevent recurrent events. SSA 1 stated, she could not get much information regarding trauma and its triggers from Resident 17. SSA 1 stated, she should have contacted Resident 17's psychiatrist (a medical practitioner specializing in the diagnosis and treatment of mental illness) and public guardian (a court-appointed public official or agency that acts as the legally authorized guardian or conservator for individuals unable to care for themselves or manage their own finances, usually due to physical or mental disability) to obtain information regarding his PTSD. B. During a review of Resident 156's admission record, the admission record indicated Resident 156 was admitted to the facility on [DATE] with diagnoses including post-traumatic stress disorder (PTSD), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 156's H&P, dated [DATE], the H&P indicated, Resident 156 was able to make decisions for activities of daily living. During a review of Resident 156's MDS, dated [DATE], the MDS indicated Resident 156 (continued on next page)		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	required supervision or touching assistance from one staff for hygiene, bed mobility, transfer, dressing, bathing, and eating. During a review of the Resident 156's Order Summary Report (OSR), dated [DATE], the OSR indicated, give Melatonin (medication to help with sleep) 3 milligram (mg) 2 tablets by mouth at bedtime was ordered on [DATE]. During an interview on [DATE], at 11:03 a.m., with Resident 156 in his room, Resident 156 stated, he was diagnosed with PTSD. Resident 156 stated, while he was homeless and someone attacked him suddenly. Resident 156 stated, he was left unconscious and was treated at General Acute Care Hospital (GACH). Resident 156 stated, when someone gets close to him without letting him know first, he gets retraumatized. Resident 156 stated, one of the night nurses came in and fixed his blanket, and it triggered him a few weeks ago. Resident 156 stated, he was having difficulty with sleeping and having nightmares since that incident and has had to take a sleeping pill. During a concurrent interview and record review on [DATE], at 9:53 a.m., with RNS 1, Resident 156's Care Plan Report (CPR) titled, Trauma Informed Care: ineffective coping related to past traumatic incident diagnosis of PTSD, revised on [DATE] was reviewed. The CPR Goal indicated, Resident 156 will have reduced episodes of behavior daily until [DATE]. The CPR Interventions indicated, implement useful interventions to reduce stress, monitor behavior episodes, and provide a safe environment and atmosphere of acceptance. RNS 1 stated, Resident 156's Care Plan was not person centered and there was no individualized and specific interventions. During a concurrent interview and record review on [DATE], at 10:48 a.m., with SSA1, Resident 156's Trauma Care Evaluation (TCE), dated [DATE] was reviewed. The TCE was done and signed by SSA 1. The TCE indicated, there was no trauma and triggers identified. SSA 1 stated, completing the trauma assessment was important, because the resident's care would be different according to the needs from the assessment. SSA 1 stated, she would refer the resident to proper services according to the trauma assessment to prevent re-traumatization. SSA 1 stated, Resident 156's care plan was not person centered because there was no assessment done for the trauma. During an interview on [DATE], at 2:09 p.m., with the DON, the DON stated, when Resident 156 who has PTSD as a diagnosis was admitted to the facility, Resident 156 should be assessed for its triggers, and past history to prevent re-traumatization. The DON stated, the care plan could not be resident centered, and resident focused if the trauma assessment was not done correctly. The DON stated, the facility has many residents who were veterans. The DON stated, staff should have assessed the residents' PTSD and made the plan of care according to the findings. The DON stated re-traumatization would harm Residents' psychosocial well-being. During a review of the facility's Policy and Procedure (P&P) titled, Trauma Informed and Culturally Competent Care, revised on 8/2022, the P&P indicated, Purpose: To guide staff in providing care that is culturally competent and trauma-informed in accordance with professional standards of practice. To address the needs of trauma survivors by minimizing triggers and/or re-traumatization. Preparation: 2. Nursing staff are trained on trauma screening and assessment tools. 3. All staff are guided in evidence-based organizational and interpersonal strategies that support trauma-informed and culturally competent care. 4. All staff receive orientation and in-service training regarding cultural competency as an aspect of resident centered care. 3. For trauma survivors, the transition to living in an institutional setting (and the associated loss of independence) can trigger profound re-traumatization. 4. Triggers are highly individualized. Some common triggers may include a. experiencing a lack of privacy or confinement in a crowded or small space, b. exposure to loud noises, or bright/flashing lights; c. certain sights, such as objects; and/or d. sounds, smells, and physical touch. Resident Assessment: 1. Assessment involves an in-depth process of evaluating the presence of symptoms, their relationship to trauma, as well as the identification of triggers. 2. Utilize licensed and trained clinicians who have been designated by the facility to conduct trauma assessments. Resident Care Planning: 1. Develop individualized care plans that address past trauma 2. Identify and decrease exposure to triggers that may re-traumatize the residents. 3. Recognize the relationship between past trauma and current health concerns (e.g., substance abuse, eating disorders, anxiety and depression). 4. Develop individualized care plans that incorporate language needs, culture, cultural preferences, norms and values.		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure two of five sample residents (Resident 73 and Resident 99): Obtained consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) that explains the risk and benefits of bed rails (are adjustable metal or rigid plastic bars that attach to the bed) with the resident representative prior to installation. was offered other alternative attempts prior to installing side rails. These failures had the potential to result in compromised resident safety associated with unassessed bed rail use. Findings: A.)During a record review of Resident 73's admission record indicated Resident 73 was admitted on [DATE] with a diagnoses of bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), Alzheimer's disease (a disease characterized by a progressive decline in mental abilities) and Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements). During a record review of Resident73's Minimum Data set (MDS- resident assessment tool), dated 1/26/2026 indicated that Residents cognitive was impaired. The MDS indicated that Resident 73's needs maximal assistance (helper does more than half the effort)with showers, resident needs moderate assistance with toileting, upper body dressing, lower body dressing, putting on/taking off footwear and with personal hygiene. During a review of Resident 73's admission orders dated 11/18/2025 indicated Support & Safety Device Low bed with bilateral quarter rails in bed as an enabler for bed mobility, repositioning and other Activities of daily living (ADL's) (not considered a restraint- any manual method, physical or mechanical device, equipment, or material that cannot be removed easily by the resident). Padded siderails to decrease potential injury. During an observation on 2/10/2026 at 8:50 a.m. in Resident 73's room, Resident 73 was lying in bed on her back with bilateral side rails up. During a concurrent observation and interview on 2/9/2026 at 11:56 a.m. in Residents 73's room with Licensed Vocational Nurse (LVN 3), LVN 3 stated that Resident 73 should not have bilateral padded side rails because Resident 73 does not have a diagnosis of seizures. LVN 3 stated that usually bilateral side rails are implemented for residents with seizures for safety reasons. LVN 3 stated that the bilateral padded siderails should be removed for Resident 73. During a review of Interdisciplinary team (IDT- a group of health care professionals with various areas of expertise who work together toward the goals of their resident) - Madwords assessment dated [DATE] indicated that no physical restraints used and recommended at this time. The assessment did not indicate that bilateral rails were in use for support and safety. The IDT note did not indicate that alternative attempts were used prior to installing bilateral rails. During a concurrent interview and record review on 2/10/2026 at 1:09 p.m. with Registered Nurse (RN 1), RN 1 stated that Resident 73 informed consent is incomplete because it is missing padded bilateral quarter rails and the consent was not verified by a second licensed nurse since it was obtained via telephone. RN 1 stated that it is important to include the complete physician order on the consent and for a second nurse to verify the consent for it to be accurate and valid before initiating the side rails. During an interview and record review on 2/12/2026 at 10:45 a.m. with Assistant Director of Nursing (ADON), ADON stated that alternative attempts were not implemented to Resident 73 prior to installing the bilateral rails because it was not documented in the side rail assessment dated [DATE] or on IDT note dated 11/24/2025. ADON stated that it was important to use alternatives before installing bed rails to avoid using modalities and do nursing interventions first to determine if safe for Resident 73. B). During a record review of Resident 99's admission record indicated Resident 99 was admitted on [DATE] with a diagnoses dementia (a progressive state of decline in mental abilities), schizophrenia (a mental illness that is characterized by disturbances in (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	thought), and history of falling. During a record review of Resident 99's MDS dated [DATE] indicated that residents cognitive was impaired. The MDS indicated that Resident 99 needs maximal assistance with toileting, shower, lower body dressing and putting on/taking off footwear. During an observation on 2/9/2026 at 9:49 a.m. in Resident 99's room, Resident 99 was lying in bed facing the door with bilateral side rails up and call light within reach. During an interview and record review on 2/11/2026 at 12:45 p.m. with LVN 4, LVN 4 stated that Resident 99 has a low bed with bilateral quarter rails for mobility. LVN 4 mentioned that staff must obtain consent, implement alternative interventions, and complete an assessment before installing side rails LVN 4 stated that Resident 99's consent form was incomplete because it lacked the date and nurse's signature. LVN 4 emphasized the importance of obtaining a second nurse's signature to verify accuracy. The side rail assessment dated [DATE] indicated that staff implemented visual monitoring before installing the side rails. During an interview, Maintenance Staff 1 (MS 1) said he was responsible for measuring bed rails for Resident 99. The side rail/entrapment assessment(a safety check to make sure a person (usually a patient or resident) cannot get stuck or caught in dangerous gaps between their bed, mattress, and side rails from 11/24/2025 showed all zones were within guidelines (less than 4 3/4 inches). However, MS 1 admitted he did not measure all zones because he was unsure of their locations. MS 1 mentioned the measurements focus on gaps between the rail and mattress to prevent resident's hands from getting stuck. During a review of the facility's policy and procedure titled, Bed Safety and Bed Rails dated 8/2022 indicated the use of bed rails or side rails is prohibited unless the criteria for bed rails have been met, including attempts to use alternatives, interdisciplinary evaluation, resident assessment and informed consent. During a review of the facility's policy and procedure titled, Informed Consent dated 12/2024 indicated that a licensed nurse will verify the informed consent information and sign it to confirm its accuracy and completeness.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that its medication error rate was less than five percent (%). Three errors out of 29 opportunities contributed to an overall error rate of 10.34 % affecting two of five residents observed for medication administration (Residents 92 and 97). The errors noted were as follows: Incorrect strength of ferrous sulfate (an iron supplement) administered to Resident 97 Incorrect formulation of multivitamins (a vitamin supplement) administered to Resident 97 Incorrect strength of ferrous sulfate administered to Resident 92 The deficient practice of failing to administer medications in accordance with the physician's orders or professional standards increased the risk that Residents 92 and 97 may have experienced medical complications possibly resulting in hospitalization. Findings: During an observation of medication administration on 2/10/26 at 8:07 AM with the Licensed Vocational Nurse (LVN 4), LVN 4 was observed administering the following medications to Resident 92 by mouth: 7.5 milliliters (ml - a unit of measurement for volume) of ferrous sulfate 220 milligrams (mg - a unit of measurement for mass) per 5 ml. During an observation of medication administration on 2/10/26 at 9:14 AM with the LVN 4, LVN 4 was observed administering the following medications to Resident 97 via gastrostomy tube (g-tube - a tube surgically implanted into the stomach for the administration of medication and nutrition): 7.5 ml of ferrous sulfate 220 mg/ 5 ml. One tablet of a multivitamin with minerals supplement. A review of Resident 92's admission Record (a document containing diagnostic and demographic information), dated 2/11/26, indicated he was admitted to the facility on [DATE] and most recently readmitted on [DATE] with diagnoses including dementia (a decline in mental abilities including memory, thinking, language and reasoning severe enough to interfere with daily life.) A review of Resident 92's History and Physical (a record of a physician's comprehensive medical assessment), dated 7/5/25, indicated Resident 92 did not have the capacity to understand and make decisions. A review of the physician's order, dated 2/5/26, indicated Resident 92's attending physician prescribed ferrous sulfate 5 mg/ 20 ml to take 7.5 ml by mouth once daily. A review of Resident 97's admission Record (a document containing diagnostic and demographic information), dated 2/11/26, indicated he was admitted to the facility on [DATE] and most recently readmitted on [DATE] with diagnoses including cerebral infarction (stroke.) A review of Resident 97's History and Physical, dated 10/12/25, did not indicate whether Resident 97 had the capacity to understand and make decisions. A review of the physician's order, dated 2/5/26, indicated Resident 97's attending physician prescribed ferrous sulfate 5 mg/ 20 ml to take 7.5 ml by mouth twice daily via g-tube. A review of the physician's order, dated 10/12/25, indicated Resident 97's attending physician prescribed one tablet of multivitamins (without minerals) to be given once daily via g-tube. During an interview on 2/10/2026 at 10:23 AM with LVN 4, LVN 4 stated he administered the wrong dose of ferrous sulfate to Residents 92 and 97. LVN 4 stated the order was for the ferrous sulfate 5 mg/20 ml formulation and he administered 220 mg/5 ml. LVN 4 stated he failed to check that the strength of the formulation he had did not match the formulation in the physician's order prior to administering the medication. The LVN 4 stated he should have contacted the physician to clarify the order once he noted that the strength of the order did not match the product on hand. LVN 4 stated giving an incorrect dosage of any medication to a resident could result in the resident experiencing medical complications. LVN 4 stated he also administered the incorrect formulation of multivitamins to Resident 97. LVN 4 stated the order was for the regular multivitamin and he administered the multivitamin with minerals formulation. LVN 4 stated he does not have the formulation without minerals and should have called the physician to clarify prior to administering the other form. LVN 4 stated administering the wrong medications or the wrong formulations of medications to the residents could result in medical complications which could lead to harm. A review of the facility's policy Medication Administration - General Guidelines, dated October 2017, indicated Medications are administered as prescribed in accordance with good nursing (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medications. Prior to administration, the medication and dosage schedule on the resident's medication administration record (MAR) is compared with the medication label. If the label and MAR are different and the container is not flagged indicating a change in directions or if there is any other reason to question the dosage or directions, the physician's orders are checked for the correct dosage schedule.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure food safety, sanitary food storage and food preparation practices. These failures have the potential to result in harmful bacteria growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to food borne illness (a disease caused by consuming food or drinks that are contaminated by germs or chemicals) for the residents. Findings: During an observation on 2/9/2026 at 8:45 a.m. in the kitchen with the Dietary Services Supervisor (DSS), In Refrigerator 2 there were two open corn tortilla packages on the top shelf. One corn tortilla package with an open date of 2/7/2026 was in its original plastic packaging and open-to-air. One open corn tortilla package was stored in plastic wrap with no open date. During an observation on 2/9/2026 at 9:13 a.m. in the kitchen with the DSS, In the dry storage room there was one dented pineapple can on the same shelf as non-dented food cans. One open dried tri-colored pasta was stored in its original packaging and open-to-air. During a concurrent observation and interview on 2/10/2026 at 8:27 a.m. with the DSS in the kitchen, there was a black trash bin with a broken lid that did not close. There was a brown trash bin with no lid in the handwashing area. The DSS stated the trash bins were actively used by kitchen staff. The DSS stated uncovered trash cans are not sanitary because they attract pests by providing readily accessible food. During an interview on 2/10/2026 at 8:40 a.m. with the DSS, the DSS stated a can is dented if the surface or seam of the body is not smooth. The DSS stated there is a separate area to store dented cans to prevent kitchen staff from using them. The DSS stated dented canned foods pose a risk for botulism (a serious illness caused by a toxin that attacks the body's nerves) because air and moisture can enter the container, allowing bacteria to grow and spoil the food. During a concurrent observation and interview on 2/10/2026 at 8:51 a.m. with the DSS in the kitchen, there were three cutting boards (yellow, blue, and brown) with visible cut marks. The DSS stated that cutting boards with visible cut marks and scratches should be replaced. The DSS stated harmful bacteria can grow in the grooves of scratched cutting boards and can cause cross contamination when food product is placed on the cutting board. During an interview on 2/10/2026 at 9:01 a.m. with the DSS, DSS stated open refrigerated food products should be labeled with an open date and stored in a covered container to limit exposure to contaminants. DSS stated open dates prevent staff from using potentially expired food items that can be unsafe for residents to eat. The DSS stated pests can infest open dry goods that are not properly stored. The DSS stated residents could potentially get foodborne illness from contaminated food. During a concurrent observation and interview on 2/10/2026 at 9:32 a.m. with the DSS in the kitchen, four wet pans were stacked on top of each other. The DSS stated pots and pans should be completely air-dried before stacking them and putting them away. The DSS stated wet nesting (when wet dishes, utensils, or cookware are stacked, trapping moisture and creating ideal conditions for bacteria to grow) can occur. During a review of the facility's Dry Goods Storage Guidelines, dated 2018, the recommended storage length for opened refrigerated corn tortillas is one week. During a review of the facility's policy and procedure (P&P) titled, Dating and Labeling, undated, the P&P indicated, loose food items should be placed in containers or bins. The P&P indicated, containers or bins will be dated, labeled, and covered. The P&P indicated, food items should have an open date. During a review of the facility's P&P titled, Storage of Canned and Dry Goods, undated, the P&P indicated, containers with tight fitting lids or re-sealable plastic bags will be used for opened packages like pasta, rice, cereal, and flour. During a review of the facility's P&P titled, Storage of Canned and Dry Goods, undated, the P&P indicated, dented, leaking or bulging cans will be stored separately in a designated area. During a review of the facility's P&P titled, Waste Control and Disposal, undated, the P&P indicated, Trash bins should be covered at all times. During a review of the facility's P&P titled, Cutting Board Cleaning, undated, the P&P indicated, Dietary staff to ensure all cutting boards are in good condition. During a review of the facility's P&P titled, Dish Washing (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procedures - Dish Machine, undated, the P&P indicated, Dishes and utensils will be air dried before storage.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **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 by failing to:1. Ensure Certified Nurse Assistant (CNA) 2 did not pick up Resident 186's contaminated cloth from hallway floor and place in the resident's closet without washing.2. Follow Enhanced Barrier Precaution [EBP-an infection control measures, primarily in nursing homes, requiring staff to wear gowns and gloves during high-contact care for residents with multidrug-resistant organisms or increased risk factors like wounds/devices, expanding beyond Standard Precautions to prevent multidrug-resistant organism (MDRO) spread where direct contact is likely] while handling dirty bed linens for Resident 175.These failures had the potential to result in compromised infection control measures to prevent the spread of infection among residents, staff, and visitors. Findings: 1. During a review of Resident 186's admission record, the admission record indicated Resident 186 was initially admitted to the facility on [DATE] and last re-admission was on 4/2/2025 with dementia (a progressive state of decline in mental abilities), seizure (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness), Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and paranoid schizophrenia (a complex psychiatric disorder characterized by distorted thinking and awareness). During a review of Resident 186's History and Physical (H&P), dated 4/7/2025, the H&P indicated, Resident 186 had no capacity (ability) to understand and make decisions. During a review of Resident 186's Minimum Data Set (MDS-a resident assessment tool), dated 11/14/2025, the MDS indicated Resident 186 required dependent assistance (Helper does all of the effort) from two or more staff for shower/bath, maximal assistance (Helper does more than half the effort) from one staff for hygiene, dressing, bed mobility, transfer, and supervision or touching assistance (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) from one staff for eating. During an observation on 2/11/2026, at 11:01 a.m., in a hallway near Resident 182's room, CNA 2 was walking toward Resident 182's room with a light brown hoodie and a white sweatshirt in her hands. CNA 2 dropped the light brown hoodie on the hallway floor near Resident 182's room. CNA 2 picked up the brown hoodie from the floor and went inside Resident 182's room. CNA 2 came out of Resident 182's room without any clothes in her hands. During a concurrent observation and interview on 2/11/2026, at 11:06 a.m., with CNA 2 in Resident 182's room, CNA 2 opened Resident 182's closet door, the light brown hoodie that CNA 2 dropped on the hallway floor and picked up was hanging right next to Resident 182's clean clothes. CNA 2 stated, she should have put the light brown hoodie in the dirty linen hamper or took it back to the laundry for rewashing instead of placing it in the closet next to the clean clothes. CNA 2 stated, the hoodie got contaminated when she dropped it on the floor. CNA 2 stated, she had to take all of Resident 182's clothes from the closet to wash to prevent cross contamination (the physical movement or transfer of harmful bacteria from one person, object or place to another). During an interview on 2/12/2026, at 11:17 a.m., with the Infection Preventionist Nurse (IPN), the IPN (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated, CNA 2 should have taken the contaminated clothes to the laundry room right after picking it up from the floor instead of hanging the hoodie in the closet where the clean clothes were hung to prevent cross contamination. During an interview on 2/12/2026, at 2:02 p.m., with the Director of Nursing (DON), the DON stated, the staff should be mindful with surrounding and infection prevention measures to protect themselves and vulnerable residents from spreading infection. During a review of the facility's Policy and Procedure (P&P) titled, Standard Precautions, revised 4/2023, the P&P indicated, Policy and Procedure Implementation .Linen: a. Linen are handled and processed in a manner that prevent contamination of clothing and avoid transfer of microorganisms to other residents and environments. During a review of the facility's Policy and Procedure (P&P) titled, Infection Prevention and Control Program, revised 4/2023, the P&P indicated, Policy Statement: An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Policy Interpretation and Implementation: 11. Prevention of Infection -a. Important facets of infection prevention include: (3) educating staff and ensuring that they adhere to proper techniques and procedure. During a review of the facility's Policy and Procedure (P&P) titled, Laundry and Bedding, Soiled, revised 9/2022, the P&P indicated, Policy Interpretation and Implementation: Handling .Contaminated laundry is bagged or contained at the point of collection. Storage . Clean linen is stored separately, away from soiled linens, at all times. Clean linen is kept separate from contaminated linen. The use of separate rooms, closets, or other designated spaces with a closing door are used to reduce the risk of accidental contamination . Personal Clothing: Personal clothing that becomes soiled with blood or body fluids is covered or removed and immediate laundered before leaving the work area. 2. During a review of Resident 175's admission Record, the record indicated the facility admitted the resident on 8/3/2023, with diagnoses including but not limited to diabetes (a disorder characterized by difficulty in blood sugar control and poor wound healing), seizures, and dysphagia (difficulty swallowing). During a review of Resident 175's Minimum Data Set (MDS, a standardized care screening and assessment tool), dated 11/5/2025, the MDS indicated the resident is dependent (relies on someone else) in completing activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 175's care plan, dated 8/6/2025, the care plan indicated the resident is on EBP for high-risk infections associated with feeding tubes (a soft flexible tube that allows liquid food to enter the stomach or intestine). During an observation on 2/9/2026 at 10:20 a.m. in Resident 175's room, an EBP sign was posted on the resident's headboard. A box of open medium and large gloves was accessible on the left-hand side upon entering the room. Blue disposable gowns were stored outside to the right of Resident 175's room. During a concurrent observation and interview on 2/9/2026 at 10:23 a.m. with Certified Nursing (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Colonial Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1913 E 5th Street Long Beach, CA 90802	
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assistant (CNA) 1, CNA 1 was changing Resident 175's used bed linens. CNA 1 did not wear a gown or gloves while handling the used bed linens. CNA 1 stated that she saw the EBP sign but forgot to wear PPE. CNA 1 stated she should have worn gloves and a gown while changing Resident 175's dirty linens. During an interview on 2/11/2026 at 10:50 a.m. with Licensed Vocational Nurse (LVN) 6, LVN 6 stated staff should wear a gown and gloves when providing high contact care for residents on EBP. LVN 6 stated high contact care activities include medication administration, changing dirty bed linens, and wound care. During an interview on 2/11/2026 at 11:13 a.m. with the Infection Preventionist Nurse (IPN), the IPN stated it is important to follow the posted transmission-based precautions (TBP, used to help stop the spread of germs from one person to another) to protect against the spread of infection. During a concurrent interview and record review on 2/12/2026 at 1:58 p.m. with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, Enhanced Barrier Precautions, dated June 2024 was reviewed. The P&P indicated, wear gloves and gown prior to performing high contact resident care activities such as transferring and changing linens. The DON stated staff did not follow the EBP policy while providing care for Resident 175.		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on observation, interview, and record review, the facility failed to obtain a complete a written informed consent (voluntary agreements to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) for the use of physical restraints (devices that limit a resident's movement) prior to the use of padded bilateral upper side rails for one of one sampled resident (Resident 196). This failure resulted in a violation of Resident 196's right to be informed and participate in treatment decisions. Findings: During a review of Resident 196's admission Record, the record indicated the facility admitted the resident on 1/22/2026, with diagnoses including but not limited to tracheostomy (a surgical procedure to create an opening through the neck into the windpipe to provide an alternative airway), gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), and diabetes (a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 196's Minimum Data Set (MDS, a standardized care screening and assessment tool), dated 1/29/2026, the MDS indicated the resident is severely cognitively impaired (inability to carry out regular tasks and apply judgement). During a review of Resident 196's physician order, dated 1/31/2026, the order indicated, obtain informed consent from the resident representative (a designated individual authorized to act on behalf of another person) after explanation of risks and benefits for the use of padded bilateral upper side rails when the resident is in bed. During a review of Resident 196's care plan, dated 1/31/2026, the care plan indicated, Low bed with padded bilateral upper half side rails up and locked when in bed for safety and positioning. During a review of Resident 196's informed consent for low bed with bilateral upper half side rails, undated, the consent indicated documentation is to be completed before treatment is initiated for use of a restraint. During an observation on 2/9/2026 at 9:46 a.m. in Resident 196's room, Resident 196's bilateral upper side rails were padded and locked in position. During a concurrent interview and record review on 2/11/2026 at 1:18 p.m. with Licensed Vocational Nurse (LVN) 3, Resident 196's informed consent for low bed with bilateral upper half side rails was reviewed. The consent did not indicate a signature from the prescribing physician, resident representative, or nurse verifying the consent. LVN 3 stated she inputted the physician order into the system and forgot to ensure the informed consent form was completed. During a concurrent interview and record review on 2/16/2026 at 1:53 p.m. with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, Bed Safety and Bed Rails, dated August 2022 was reviewed. The P&P indicated, the use of bed rails or side rails is prohibited unless the criteria for the use of bed rails have been met, including attempts to use alternatives, interdisciplinary evaluation, resident assessment, and informed consent. The DON stated padded side rails are a safety device and require informed consent prior to use. The DON stated staff did not follow the facility's P&P. During a review of the facility's P&P titled, Informed Consent, dated December 2024, the P&P indicated, the prescribing physician, resident or resident representative, and verifying nurse must sign the informed consent form to ensure completeness.		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Advance Directives ([AD]-written statement of a person's wishes regarding medical treatment made to ensure those wishes are carried out should the person be unable to communicate them to a doctor) were discussed and written information was provided to the residents and/or responsible parties and had a completed Physician Orders for Life-Sustaining Treatment ([POLST]- a medical order that helps give people with serious illness more control over their care during a medical emergency) for one of three sampled residents (Resident 18) in the medical records. These failures had the potential for delay of care and treatment and/ or inadvertently missed health care wishes/ decisions of the residents during emergencies, end of life, and changes in condition. Findings: During a review of Resident 18's admission Record, the admission Record indicated, Resident 18 was initially admitted to the facility on [DATE] and last re-admission was on [DATE] with diagnosis including senile degeneration of brain (a neurological disorder that is tied to cognitive decline, memory impairment, and changes in behavior), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), dementia (a progressive state of decline in mental abilities), and encephalopathy (a disturbance of brain function). During a review of Resident 18's History and Physical (H&P), dated [DATE], the H&P indicated, Resident did not have the capacity (ability) to understand and make decisions. During a review of Resident 18's Minimum Data Set (MDS-a resident assessment tool), dated [DATE], the MDS indicated Resident 18 required dependent assistance (Helper does all of the effort) from two or more staff for eating, hygiene, shower/bath, dressing, bed mobility, and transfer. During a concurrent interview and record review on [DATE], at 9:59 a.m., with Registered Nurse Supervisor (RNS) 1, Resident 18's Physician Orders for Life-Sustaining Treatment (POLST), dated [DATE] was reviewed. The POLST indicated, Resident 18 had order for Do Not Attempt Resuscitation (DNR- a medical order written by a doctor to instruct health care providers NOT to do cardiopulmonary resuscitation (CPR) if breathing stops or the heart stops beating). The POLST indicated, Section D for AD was left blank and it was not completed. RNS 1 stated, the POLST was not completed because there was missing information. RNS 1 stated, if the POLST was not completed, the resident would be treated as full code and all life sustaining measures would be done during the emergency per policy. RNS 1 stated, the resident would be treated against his/her wish. During a concurrent interview and record review on [DATE], at 10:36 a.m., with Social Service Assistant (SSA) 1, Resident 18's Advance Healthcare Directive Acknowledgement (AHDA), dated [DATE] was reviewed. The AHDA indicated, the written materials regarding right to formulate/ accept or refuse AD were given to Resident 18's Responsible Party (RP) via telephone. The AHDA indicated, SSA 1 completed POLST and had telephone consent from RP without other witnesses. SSA 1 stated, she did not provide written materials regarding AD. SSA 1 stated, she did not complete and update the POLST. SSA 1 stated, she should have a witness while she was getting verbal consent via telephone. SSA 1 stated, there should be two witnesses when obtaining verbal or telephone consent including herself. SSA 1 stated, Resident 18's RP stated, she did not want to formulate AD and stayed on DNR status. SSA 1 stated, it was her responsibility to ensure documenting the availability of AD and discussion regarding AD with the resident or decision maker on POLST to honor the resident's wishes regarding care and treatment. During an interview on [DATE], 2:21 p.m., with the Director of Nursing (DON), the DON stated, AD and POLST should be available for all residents regardless. The DON stated, SSA 1 and staff should have ensured the completion of POLST and provided written information regarding AD. The DON stated, AD and POLST were important to honor residents' wishes and the guideline for how to treat residents in emergency situation. During a review of Resident 18's Social Service Note (SSN), dated, [DATE], the SSN indicated, SSA 1 reviewed Resident 18's POLST (continued on next page)		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with RP and RP agreed to remain DNR, selective treatment, no artificial means of nutrition, including feeding tubes and no advance directive. During a review of Resident 18's Order Summary Report (OSR), dated [DATE], the OSR indicated, DNR was ordered on [DATE]. During a review of the facility's Policy and Procedure (P&P) titled, Advance Directives, revised 9/2022, the P&P indicated, Policy Statement: The resident has the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment. Advance directives are honored in accordance with state law and facility policy. Policy Interpretation and Implementation . 2. The resident or representative is provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so. 3. Written information about the right to accept or refuse medical or surgical treatment, and the right to formulate an advance directive is provided in a manner that is easily understood by the resident or representative. 5. If the resident is incapacitated and unable to receive information about his or her right to formulate an advance directive, the information may be provided to the residents' legal representative. During a review of the facility's Policy and Procedure (P&P) titled, POLST, revised 5/2024, the P&P indicated, Policy Interpretation and Implementation: 1. By signing POLST, which becomes a medical order, the physician, nurse practitioner or physician assistant certifies that the orders on the form are consistent with the resident's medical condition and preferences . 5. The POLST Allows both the doctor and patient (or their representative) to specify the types of medical treatment that the patient wishes to receive at the end of life.		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the nursing staff notified the physician in a timely manner when one out of three residents (Resident 122) refused tube feeding (a method of delivering liquid nutrients, fluids, and medications directly into the stomach or small intestine via a flexible tube) for the day. This deficient practice placed Resident 122 at risk for potential weight loss and malnutrition. Findings: During a review of Resident 122's admission Record, the admission Record indicated Resident 122 was originally admitted to the facility on [DATE], and readmitted on [DATE]. Resident 122's diagnoses included quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury), acute respiratory failure (a life-threatening, sudden-onset condition where the lungs cannot adequately oxygenate the blood or remove carbon dioxide), and gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). During a review of Resident 122's Minimum Data Set ([MDS], a resident assessment tool), dated 1/29/2026, the MDS indicated Resident 122 had intact cognitive (thought process) skills for daily decision-making. Resident 122 was dependent (helper does all the effort to complete the task while resident does none) on mobility (ability to move freely and easily) with transfers and self-care abilities such as eating, hygiene and dressing. During a review of Resident 122's Order Summary Report dated 11/26/2025, the Order Summary Report indicated Jevity 1.5 (a type of tube feeding brand) at 60 milliliter per hour ([mL/hr], a volume flow rate unit of measurement commonly used to define the rate at which fluids are given over a specific time) for 20 hours via (by) pump to provide 1200 mL or 1800 kilocalorie ([kcal], measure nutritional energy) per day. During a review of Resident 122's Order Summary Report dated 2/2/2025, the Order Summary Report indicated to turn feeding pump on at 12:00 p.m. and to turn feeding pump off at 8:00 a.m. the following day or when dose is completed. During an observation on 2/9/2026 at 12:06 p.m., of Resident 122 in his room, Resident 122 was awake and resting in bed. The tube feeding machine with the tube feeding formula bottle was near the resident. The tube feeding machine was connected to the resident, but the machine was off with about 1400 milli liters (mL - a unit of measure of volume) of tube feeding left in the formula bottle. During an observation on 2/9/2026 at 3:30 p.m., in Resident 122's room, Resident 122 was in bed. The tube feeding machine next to the resident was still connected to the resident but the tube feeding machine was still off with about 1400 mL of tube feeding left in the formula bottle. During a concurrent observation and interview on 2/9/2026 at 3:45 p.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated the tube feeding machine was running around 10:00 a.m. today. LVN 1 stated Resident 122 did not want the tube feeding to continue at that time, so LVN 1 turned the tube feeding machine off and flushed Resident 122's tube feeding tube. LVN 1 stated if a resident refused the tube feeding, the primary physician should have been notified. LVN 1 stated he did not notify Resident 122's primary physician about Resident 122's refusal for tube-feeding. During an interview on 2/12/2026 at 10:10 a.m., with Registered Dietician (RD), the RD stated Resident 122's order was for Jevity 1.5 at 60 mL/hr for 20 hours for total of 1200 mL and 1800 calories daily. The RD stated the nursing staff should report Resident 122's refusal of tube feeding to the primary physician and/or the RD, and document that the physician and the RD were made aware. The RD stated residents have the right to refuse, but stated the RD needed to be made aware of the resident refusing the feeding so the RD can talk to the resident and inform them of benefits of the feeding and the risks of not receiving the feeding such as weight loss, and delay in recovery. During an interview on 2/12/2026 at 1:33 p.m. with the Director of Nursing (DON), the DON stated residents have the right to refuse feeding, but nursing staff should document the refusal in the residents' chart, call the primary physician, and inform the residents about risks and benefits of the refusal. The DON stated the outcome of residents (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	when they continue to refuse tube feeding was weight loss, skin issues, and the residents not getting the nutrients needed to sustain life. During a review of the facility's policy and procedure (P&P) titled Requesting, Refusing and/or Discontinuing Care or Treatment, the P&P indicated residents, and resident representatives have the right to request, refuse and/or discontinue treatment. Treatment refers to medical care, nursing care, and interventions provided to maintain or restore health and well-being, improve functional level, or relieve symptoms. Detailed information relating to the request, refusal or discontinuation of treatment are documented in the resident's medical record. Documentation pertaining to a resident's request, discontinuation or refusal of treatment includes at least the following such as the date and time the care or treatment was attempted; the type of care or treatment; the resident's response and stated reason(s) for request, discontinuation or refusal; the name of the person who attempted to administer the care or treatment; that the resident was informed (to the extent of their ability to understand) of the purpose of the treatment and the potential outcome of not receiving the medication/or treatment; the resident's condition and any adverse effects due to the request; the date and time the practitioner was notified as well as the practitioner's response; all other pertinent observations; and the signature and title of the person recording the data. The healthcare practitioner must be notified of refusal of treatment, in a time frame determined by the resident's condition and potential serious consequences of the request.		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to protect the resident's right to be free from physical abuse when Resident 96 pushed Resident 44, causing Resident 44 to fall to the ground. This deficient practice resulted in Resident 44 falling and sustaining a traumatic skin tear measuring 1 centimeter (cm unit of measure of length) long by x 0.1 cm wide on the right eyebrow, requiring an emergency visit to a General Acute Care Hospital (GACH) for treatment and management. Findings: During a review of Resident 44's admission record, the admission record indicated Resident 44 was admitted to the facility on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities), depression (constant feelings of sadness, and irritability that lasts more than two weeks) and Alzheimer's disease (a disease characterized by a progressive decline in mental abilities). During a review of Residents 44's Minimum Data [MDS] resident assessment tool, dated 12/26/2025, the MDS indicated Resident 44 cognitive (ability to make decisions of daily living) was severely impaired. The MDS indicated Resident 44 needed partial assistance with personal hygiene, putting on/taking off footwear, lower body dressing, shower, toileting, and oral hygiene. During a review of Resident 96's admission record, the admission record indicated Resident 96 was admitted to the facility on [DATE] with diagnoses including dementia, anxiety (a mental health disorder characterized by feelings of worry, anxiety or fear that are strong enough to interfere with one's daily activities), restlessness and agitation. During a review of Resident 96's care plan titled, Ineffective coping as evidenced by episodes of anger or hostility towards other residents, initiated on 10/01/2025, the care plan goals for Resident 96 included, resident needs to be met until the next assessment. The care plan intervention was to respect resident's preferences. During an observation on 2/09/2026 at 9:25 a.m., in the hallway Resident 44 was walking in the hallway and using paper towels to clean the handrails adjacent to room [ROOM NUMBER]. During an observation on 2/09/2026 at 9:27 a.m., Resident 96 was lying in bed with bilateral (both) side rails up, and call light within reach. The door of the closet in Resident 96's room was slightly ajar. During a review of Resident 44's COC assessment form dated 2/11/2026 and timed 5:45 a.m., the COC assessment form indicated Resident 44 had a cut on the right side of her forehead. The COC assessment form indicated on 2/11/2026 5:45 a.m. Resident 44 was found on the floor, bleeding from a cut on right side of her forehead. The COC assessment form indicated (LVN 6) (unknown staff) applied pressure to Resident 44's cut to minimize bleeding. The COC assessment form indicated Resident 44 was transferred to GACH emergency department. During a review of Resident 96's Change of Condition (COC- a sudden clinically important deviation from a patient's baseline in physical, cognitive, behavioral, or functional condition) assessment dated [DATE] and timed at 7:19 a.m., the COC assessment form indicated on 2/11/2026 at 5:45 a.m., Resident 96 stated she pushed her roommate (Resident 44) for being in her closet. During a concurrent observation and interview on 2/10/2026 at 12:54 p.m., with Certified Nurse Assistance (CNA) 1 in room [ROOM NUMBER], CNA 1 stated that the closets in the room were not locked because the locks did not work. CNA 1 stated that the closets in the residents' rooms must remained locked at all times. CNA 1 stated they would notify the maintenance department about the broken lock. During an observation on 2/11/2026 at 4:08 p.m. in room [ROOM NUMBER] Resident 44 was lying in bed with bilateral side rails up, wearing nonskid socks facing the window. the closet doors in Resident 44's room remained open, and accessible to all residents. During an interview on 02/11/2026 at 10:31 a.m., with Resident 96, Resident 96 stated earlier that morning (prior to the altercation with Resident 44), there was urine on the floor in their room. Resident 96 stated facility staff (unknown) instructed her (Resident 96) to return to bed. Resident 96 stated the urine was still on the floor. Resident 96 stated she went to bed, but later around 3:00 a.m., Resident 44 got out of bed and began cleaning (what) and looking at things inside her (Resident 96's) unlocked closet. Resident (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	96 reported Resident 44 searched through her (Resident 96)'s closet and was speaking in Spanish. Resident 96 stated she did not understand Spanish. Resident 96 stated she observed Resident 44 going through her belongings in her closet. Resident 96 stated she got out of bed and pushed Resident 44 away from the closet, but Resident 44 attempted to continue to look through the closet again. Resident 96 stated she pushed Resident 44 a second time, causing Resident 44 to fall to the floor. Resident 96 stated that staff (unknown) were aware of Resident 44's behavior and that both residents had been arguing since early morning. During an interview on 02/11/2026 at 10:13 a.m., with CNA 2, CNA 2 stated that Resident 44 often wandered into other residents' rooms and attempted to clean. CNA 2 stated that it was important to keep closets locked to prevent residents from accessing each other's belongings. CNA 2 stated that Resident 96 always wanted her closet locked at all times. During an interview and record review on 2/11/2026 at 12:14 p.m., with LVN 4 of Resident 44's care plan report and active physician orders for 02/2026 . LVN 4 stated that Resident 44 likes to clean and fix things in her and other residents' rooms. LVN 4 stated that staff had consistently observed Resident 44's behavior of cleaning and fixing things in other residents' room, since Resident 44 was admitted . LVN 4 stated facility staff did not monitor this behavior and there was no care plan for this behavior. LVN 4 stated the facility did not consider Resident 44's behavior of going into other residents' rooms cleaning and fixing things as a problem behavior. LVN 4 stated that Resident 44's care plan should have included monitoring this behavior of cleaning / fixing other resident's belongings. LVN 4 stated staff should have been monitoring Residents 44 behavior and potentially prevented the altercation with Resident 96 on 2/11/2026 at 5:45 a.m During an interview on 2/11/2026 at 3:56 p.m. with Social Worker (SW) 1, SW 1 stated that all the closets must be locked because residents in this unit are confused and can grab belongings from other residents since the residents wandering into other's rooms. SW 1 stated that CNAs are aware that all the closets must be locked to prevent items from going missing. SW stated that the altercation between Resident 44 and Resident 96 could have been avoided if the closet in Resident 96's room was locked. During an record review of Resident 44's tiled Licensed Nursing Note dated on 2:05 p.m indicated that Resident 44 came back from GACH, was assessed by treatment nurse and noted right eyebrow skin tear with discoloration measuring 1 cm long by x 0.1 cm wide.During an interview on 2/12/2026 at 7:13 a.m., with Licensed Vocational Nurse (LVN) 2, LVN 2 stated that approximately around 3:00 a.m., Resident 44 and Resident 96 were yelling at each other over water on the floor, which Resident 96 mistook for urine from Resident 44. LVN 2 stated unknown CNA and herself cleaned the floor and reassured Resident 96 that it was water. LVN 2 stated she put Resident 44 back to bed and did not notice whether the closet was unlocked. LVN 2 stated that she left Resident 44 and Resident 96 in the same room. During a subsequent interview on 2/12/2026 at 7:15 a.m., with LVN 2, LVN 2 stated at approximately around 5:00 a.m. while she was standing between rooms [ROOM NUMBERS], LVN 2 heard a loud noise, turned around and found Resident 44 on the floor bleeding from her head. LVN 2 stated she separated Resident 44 and Resident 96. LVN 2 stated Resident 96's closet remaining open was a major factor in the altercation. LVN 2 stated Resident 96 pushed Resident 44, because Resident 44 went into her closet. LVN 2 stated it was preventable if Resident 96's closet would have been closed and locked. During an interview on 02/12/2026 at 10:45 a.m. with the Assistant Director of Nursing (ADON), the ADON stated that residents must be free from physical abuse because they are frail and rely on staff for safety. The ADON explained that closet locks should always be used, especially in secured units (exit and entrance to the unit are managed by facility staff), since residents wander and open closets. During interview on 2/12/2026 at 1:48 p.m. with the Administrator(Admin), the Admin stated that Resident 44 and Resident 96 should have been separated when the first altercation occurred regarding the water on the floor. Admin stated that it could have been prevented since there is already a verbal altercation prior before the physical altercation about the closet. Admin stated that this would be intentional for Resident 96 since it was triggered with the water droppings on the floor prior to the closet incident. During a review of Resident 44's GACH (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Emergency Documentation (ED) titled ED physician notes dated 2/11/2026 timed at 6:23 a.m. indicated complaint of head pain with laceration to frontal head and left knee pain after assaulted by another resident. The ED notes indicated that Resident 44 laceration to right eyebrow was closed using dermabond (surgical glue). Resident 44 was discharge with diagnosis of assault (physical attack) and facial laceration. During a record review of the facility's policy and procedure (P&P) titled, Abuse & Mistreatment of Residents revised on 5/3/2023 indicated involved resident(s) shall be removed from the environment that threatens residents' health or safety if the suspect is another resident the residents shall be separated to avoid any further contact. During a record review of the facility's policy and procedures (P&P) titled, Abuse & Mistreatment of Residents revised on 5/3/2023 indicated resident with possible needs and potential for behavioral symptoms and manifestation that may lead to conflict, and anger shall be identified through comprehensive assessment, initially upon resident admission and continually thereafter. During a record review of the facility's P&P titled, Secured Unit revised (unknown date) indicated may keep resident closets locked unless resident/responsible party prefers otherwise.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure Minimum Data Set (MDS- a resident assessment tool) accurately reflects resident status for two of five sampled residents (Resident 73 and Resident 99). This failure had the potential to result in inaccurate assessment of the resident's condition, leading to inappropriate care planning, monitoring and interventions. Findings: A. During a record review of Resident 73's admission record, it indicated Resident 73 was admitted on [DATE] with a diagnoses of bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), Alzheimer's disease (a disease characterized by a progressive decline in mental abilities) and Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements). During a record review of Resident 73's Minimum Data set (MDS- resident assessment tool), dated 1/26/2026, the MDS indicated that Resident 73 cognition was impaired. The MDS indicated that Resident 73's needs maximal assistance (helper does more than half the effort) with showers, resident needs moderate assistance with toileting, upper body dressing, lower body dressing, putting on/taking off footwear and with personal hygiene. During an observation on 2/10/2026 at 8:50 a.m. in Resident 73's room, Resident 73 was lying in bed on her back with padded bilateral side rails up. During a concurrent observation and interview on 2/9/2026 at 11:56 a.m. in Resident 73's room with Licensed Vocational Nurse (LVN) 3, LVN 3 stated that Resident 73 should not have padded side rails because Resident 73 does not have a diagnosis of seizures (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness). During a review of Resident 73's order summary report dated 2/12/2026, the summary report indicated physician's order Support & Safety Device low bed with bilateral quarter rails in bed as enabler for bed mobility, repositioning and other activity of daily living (ADL's) not considered a restraint. Padded siderails to decrease potential injury. During a concurrent interview and record review with MDS Nurse on 2/12/2026 at 1:15 p.m., the was reviewed. The MDS Nurse stated that Resident 73's assessment was not completed accurately. The assessment section P of the MDS titled, Restraints and Alarms incorrectly addressing the question asking whether Resident 73 use bed rails in bed and padded side rails. MDSNurse stated that bilateral side rail was not captured on the MDS because it is not considered a restraint. During a Review of Resident 73's care plan initiated on 12/4/2024 titled Resident is low bed with bilateral quarter rails in bed as enabler for bed mobility, repositioning and other ADLs. (not considered a restraint). B. During a record review of Resident 99's admission record, the admission record indicated Resident 99 was admitted on [DATE] with a diagnoses dementia (a progressive state of decline in mental abilities), schizophrenia (a mental illness that is characterized by disturbances in thought), and history of falling. During a record review of Resident 99's MDS dated [DATE], the MDS indicated that Resident's 99 cognition was impaired. The MDS indicated that Resident 99 needs maximal assistance with toileting, shower, lower body dressing and putting on/taking off footwear. During an observation on 02/09/2026 at 9:49 a.m. in Resident 99's room, Resident 99 was lying in bed facing the door with bilateral siderails up. During a review of Resident 99's order summary Report dated 2/12/2026 the order summary report indicated physician's order Support & Safety Device low bed with bilateral quarter rails in bed as enabler for bed mobility, repositioning and other activity of daily living (ADL's) not considered a restraint. During an interview and record review on 2/12/2026 at 10:45 a.m. with Assistant Director of Nursing (ADON), ADON stated that the MDS nurse should have captured the use of bed rails in Resident 99's annual assessment and Resident 73's quarterly assessment. It is important to accurately complete the assessment to create a care plan that meets Resident 99's and 73's needs.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observation, interview and record review, the facility failed to implement the nursing interventions according to the care plan for one of three sampled residents (Resident 99). ^ This deficient practice had the potential for Resident 99 needs not being met. Findings: During a record review of Resident 99's admission record indicated Resident 99 was admitted on [DATE] with a diagnoses dementia (a progressive state of decline in mental abilities), schizophrenia (a mental illness that is characterized by disturbances in thought), and history of falling. During a record review of Resident 99's MDS dated [DATE] indicated that residents cognitive was impaired. The MDS indicated that Resident 99 needs maximal assistance with toileting, shower, lower body dressing and putting on/taking off footwear. During an observation on 02/09/2026 at 9:49 a.m. in Resident 99's room, Resident 99 was lying in bed facing the door with bilateral siderails up and call light within reach. *Resident 99 did not have any floor mats or bed alarm in room. During a review of the care plan initiated on 5/6/2021 indicated Resident 99's care plan titled Falling Star Program. The Care plan goal indicated will reduce risk for falls and/or injury through appropriate interventions daily. The care plan interventions indicated floor mats, bed/chair alarm and IDT conferences for falls. During an interview and record review on 2/11/2026 at 12:45 p.m., Licensed Vocational Nurse (LVN) 4 stated that Resident 99's care plan was not updated to reflect the resident's current needs. LVN 4 reported that the facility does not follow the care plan regarding Resident 99's floor mat and bed alarm. LVN 4 further stated that Resident 99 has never had a bed alarm. During a review of the facility's policy and procedure titled, care plans, comprehensive-person centered dated 3/2023 indicated that assessments of residents are ongoing and care plans are revised as information about the residents and the residents' condition changes.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interview and record review, the facility failed to follow the care plan and implement nonpharmacological interventions (any healthcare intervention not involving medications) for pain for one of eight sampled residents (Resident 20). This deficient practice had the potential to place the resident at risk for ineffective pain management and untreated pain. Findings: During a review of Resident 20's admission Record (Face Sheet), the admission Record indicated the facility admitted the resident on 11/15/2021 with diagnoses including hypertension (HTN- high blood pressure), schizophrenia (a mental illness that is characterized by disturbances in thought) and low back pain. During a review of Resident 20's History and Physical (H&P) dated 12/21/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 20's Minimum Data Set (MDS- a resident assessment tool), dated 11/20/2025, the MDS indicated Resident 20 had moderate cognitive (ability to think and understand) impairment. The MDS indicated Resident 20 was dependent on staff for toileting and bathing and required maximal assistance with dressing and personal hygiene. During an interview on 2/11/2026 at 9:41 a.m. with Resident 20, Resident 20 stated pain medications sometimes help with the recurrent pain he had in his right shoulder. Resident 20 stated he had never been offered anything besides pain medications for the pain. Resident 20 stated a hot pack might help with the pain and he was interested in trying alternative interventions. During a concurrent interview and record review on 02/11/2026 at 9:46 a.m. with Licensed Vocational Nurse (LVN) 2, Resident 20's care plan titled Actual Pain: Right Shoulder Pain indicated nonpharmacological interventions including hot pack, cold pack, massage and distraction. LVN 2 stated he had never offered Resident 20 a hot pack for pain because Resident 20 usually had a lidocaine patch (a topical medication applied to the skin to relieve localized pain) on his right shoulder. LVN 2 stated care plan interventions should have been followed to better manage Resident 20's pain. LVN 2 stated care plans should have been followed to address Resident 20's pain. LVN 2 stated not implementing care plan interventions places residents at risk for ineffective pain management and untreated pain. During a concurrent interview and record review on 2/12/2026 at 8:47 a.m. with Registered Nurse (RN) 1, Resident 20's nurses progress notes were reviewed. RN 1 stated if nonpharmacological interventions for pain were implemented, documentation would be present in nurses progress notes. RN 1 stated there was no documentation of nonpharmacological interventions implemented to address Resident 20's pain. RN 1 stated following care plans were important because goals and interventions address resident specific needs. RN 1 stated not implementing care plan interventions for pain places residents at risk for untreated pain. During a review of facility policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered dated March 2023, the P&P indicated, The comprehensive, person-centered care plan: b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Services provided for or arranged by the facility and outlined in the comprehensive care plan are: provided by qualified persons.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on interview and record review, the facility failed to ensure nursing staff used behavioral signs of pain (observable non-verbal actions that indicate distress such as facial grimacing, moaning, irritability) to assess pain for one of eight sampled residents (Resident 20). This deficient practice had the potential to result in inaccurate pain assessments and untreated pain. Findings: During a review of Resident 20's admission Record (Face Sheet), the admission Record indicated the facility admitted the resident on 11/15/2021 with diagnoses including hypertension (HTN- high blood pressure), schizophrenia (a mental illness that is characterized by disturbances in thought) and low back pain. During a review of Resident 20's History and Physical (H&P) dated 12/21/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 20's Minimum Data Set (MDS- a resident assessment tool), dated 11/20/2025, the MDS indicated Resident 20 had moderate cognitive (ability to think and understand) impairment. The MDS indicated Resident 20 was dependent on staff for toileting and bathing and required maximal assistance with dressing and personal hygiene. During an interview on 2/11/2026 at 9:41 a.m. with Resident 20, Resident 20 stated he had recurrent pain in his right shoulder and his current pain level was a six out of ten on a numeric pain scale (self-report tool used to quantify pain intensity utilizing a numeric scale of zero to ten, zero indicating no pain and ten as severe pain). Resident 20 stated he had pain in right shoulder in the morning and Licensed Vocational Nurse (LVN) 2 administered pain medication to treat the pain. Resident 20 stated pain remained unrelieved after taking pain medication. During a concurrent interview and record review on 2/11/2026 at 9:46 a.m. with Licensed Vocational Nurse (LVN) 2, Resident 20's Pain Level Summary, dated 2/11/2026 was reviewed. Resident 20's Pain Level Summary indicated, pain level on 2/11/2026 at 8:45 a.m. was zero out of ten on a numeric scale. LVN 2 stated when he assessed Resident 20's pain level, Resident 20 yelled he was in pain but refused to state his pain level on a numeric scale. LVN 2 stated he administered Resident 20's scheduled pain medication, but documented pain level as zero out of ten. LVN 2 stated his documentation of Resident 20's pain of zero out of ten was inaccurate and he should have assessed Resident 20's pain using behavioral signs of pain (observable non-verbal actions that indicate distress such as facial grimacing, moaning, irritability). LVN 2 stated inaccurate pain assessments place residents at risk of prolonged discomfort and untreated pain. During an interview on 2/12/2026 at 1:20 p.m. with the Director of Nursing (DON), the DON stated licensed nurses are expected to assess the pain of residents each shift and as needed. The DON stated when residents are unable to verbalize pain level using a numeric scale, licensed nurses should assess residents' behavioral signs of pain. The DON stated not assessing residents' behavioral signs of pain places residents at risk of inaccurate pain assessments. The DON stated inaccurate pain assessments place residents at risk for untreated pain. During a review of facility policy and procedure (P&P) titled, Pain Assessment and Management dated March 2020, the P&P indicated, Recognizing pain: Observe the resident (during rest and movement) for physiologic and behavioral (non-verbal) signs of pain. Document the resident's reported level of pain with adequate detail (i.e., enough information to gauge the status of pain and the effectiveness of interventions for pain) as necessary and in accordance with the pain management program.		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **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 15) received Restorative Nursing Assistant ([RNA], a certified nursing assistant who works with patients in skilled nursing facilities to help them regain their ability to perform daily tasks) services ordered for the resident. This deficient practice had the potential to negatively have a decline in range of motion and mobility leading to contractures. Findings: During a review of Resident 15's admission Record, the admission Record indicated Resident 15 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 15's diagnoses including schizophrenia (a mental illness that is characterized by disturbances in thought), dementia (a progressive state of decline in mental abilities), and diabetes mellitus ([DM]-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 15's history and physical (H&P) dated 7/5/2025, the H&P indicated Resident 15 had the capacity to understand and make decisions. During a review of Resident 15's Minimum Data Set ([MDS], a resident assessment tool) dated 12/31/2025, the MDS indicated Resident 15 had intact cognitive (thinking process) skills. The MDS indicated Resident 15 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) with self-care abilities such as eating, hygiene, and dressing. The MDS indicated Resident 15 was dependent with mobility abilities such as sitting to lying position, and transfers. During a review of Resident 15's Order Summary Report, the Order Summary Report indicated an order dated 1/14/2025 RNA to perform passive range of motion ([PROM], a movement of a joint through its available range by an external force without the patient using their own muscles) to bilateral lower extremities ([BLE], both legs) every day five times a week or as tolerated. The Order Summary Report indicated an order dated 10/10/2024 RNA to perform PROM to bilateral upper extremities ([BUE], both arms) every day five times a week or as tolerated. The Order Summary Report indicated an order dated 10/10/2024 RNA to apply soft hand rolls (soft, cushioned, or inflatable orthotic devices designed to manage hand dysfunction, specifically finger flexion contractures) to bilateral hands up to four hours every day five times a week or as tolerated. During a review of Resident 15's Documentation Survey Report for December 2025, the Documentation Survey Report for December 2025 indicated RNA to perform PROM to BLE every day, five times a week or as tolerated was completed five days a week but there was documentation of NA on 12/30/2025 and 12/31/2025. The Documentation Survey Report for December 2025 indicated RNA to perform PROM to BUE every day five times a week or as tolerated was completed five days a week but there was documentation of NA on 12/30/2025 and 12/31/2025. The Documentation Survey Report for December 2025 indicated that RNA to apply soft hand rolls to bilateral hands up to four hours every day five times a week or as tolerated was completed five days a week but there was documentation of NA on 12/25/2025, 12/30/2025 and 12/31/2025. During an observation and interview on 2/9/2026 at 10:31 a.m., with Resident 15 in his room, Resident 15 was resting on his left side and turned to his back when surveyor greeted Resident 15. Resident 15 stated he can't use his hands which also meant he (Resident 15) was not able to use his wheelchair as before. Resident 15 stated he was not getting any physical therapy right now and was not sure about getting any RNA services. During a concurrent interview with record review on 2/12/2025 at 12:13 p.m. with RNA 1, the Documentation Survey Report for December 2025 was reviewed. RNA 1 stated Resident 15 has orders for RNA services five times a week as ordered. RNA 1 stated RNA services could possibly be provided for the dates that indicated NA and the nursing staff might have input the information incorrectly but if it was not documented, the services were not provided. RNA 1 stated the importance of residents getting RNA services every day was so staff are providing the services to the residents based on the orders. RNA 1 stated the staff do RNA services to prevent the residents from getting worse. During an interview (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on 2/7/25 at 4:44 p.m. with Director of Nursing (DON), the DON stated residents who are in the RNA program should be getting the services provided to them as ordered by the physician. The DON stated the importance of accurate documentation was if the residents were getting the services, the documentation should reflect the services provided to the residents. The DON stated that if it was not documented that the services were provided, it means the services were not provided as ordered. The DON stated residents can have a decline with their movement and mobility if RNA services were not provided to the residents. During a review of the facility's policy and procedure (P&P) titled, Resident Mobility and Range of Motion, revised July 2017, indicated, residents will not experience an avoidable reduction in range of motion (ROM). residents with limited range of motion will receive treatment and services to increase and/or prevent a further decrease in ROM. residents with limited mobility will receive appropriate services, equipment and assistance to maintain or improve mobility unless reduction in mobility is unavoidable. interventions may include therapies, the provision of necessary equipment, and/or exercises and will be based on professional standards of practice and be consistent with state laws and practice acts. During a review of the facility's P&P titled Job Title: Restorative Nursing Aid (RNA), revised 11/13/2025, indicated restorative nursing approaches on residents to assist the residents in reaching their maximum potential mobility assists in providing a clean, safe, dignified, happy and healthy environment for residents by performing the duties as described below. assists residents with range of motion exercises (passive/active), other general strengthening exercises, and ambulation/transfer exercises per physician's orders to improve or maintain mobility and independence in the resident. provides daily and weekly documentation for each resident in the restorative program, including weekly progress summaries for each resident. provides residents with routine restorative nursing care and services in accordance with the resident's assessment, care plan and as directed by supervisors. does required daily documentation as required by policy and procedure.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the tube feeding (a method of delivering liquid nutrients, fluids, and medications directly into the stomach or small intestine via a flexible tube) machine was on and functioning properly to administer the feeding for one of three sample residents (Resident 5) when the tube feeding machine was on but not administering the feeding to Resident 5 for over three hours. This deficient practice placed Resident 5 at risk for weight loss and nutritional deficit. Findings: During a review of Resident 5's admission Record, the admission Record indicated Resident 5 was originally admitted to the facility on [DATE], readmitted on [DATE]. Resident 5's diagnoses included acute respiratory failure (a life-threatening, sudden-onset condition where the lungs cannot adequately oxygenate the blood or remove carbon dioxide), gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) and persistent vegetative state (a disorder of consciousness following severe brain injury where the patient is awake but completely unaware of themselves or their environment). During a review of Resident 5's Minimum Data Set (MDS), a resident assessment tool, dated 12/22/2025, the MDS indicated Resident 5 was rarely/never understood. The MDS indicated Resident 5 was dependent (helper does all the effort to complete the task while resident does none) on mobility (ability to move freely and easily) with transfers and self-care abilities such as eating, hygiene and dressing. During a review of Resident 5's Order Summary Report dated 2/9/2026, the Order Summary Report indicated Jevity 1.5 (a type of tube feeding brand) at 60 milliliter per hour (mL/hr, a units of measurement used to calculate how much fluids an individual receives) for 20 hours via (by) pump to provide 1200 milliliter (mL, unit of measurement) or 1800 kcal (measure nutritional energy) per day, start enteral feeding at 12:00 p.m. and stop at 8:00 a.m. During a review of Resident 5's Order Summary Report dated 12/4/2025, the Order Summary Report indicated turn pump on at 12 p.m. and turn off at 8 a.m. the following day or until dose is completed. During an observation on 2/9/2026 at 11:06 a.m., in Resident 5's room, Resident 5 was resting in bed with eyes closed. The tube feeding machine with the tube feeding formula bottle was near the resident. The tube feeding tubing was connected to the resident but was not on. The formula bottle was full at 1500 mL of formula in the bottle. During an observation on 2/9/2026 at 3:16 p.m., in Resident 5's room, Resident 5 was lying in bed. The tube feeding machine next to the resident was connected to the resident and the machine was on but the feeding in the tube was not moving into the resident. The tube feeding machine was on but the tube feeding machine was not moving the tube feeding formula into Resident 5's abdomen for feedings. During a concurrent observation and interview on 2/9/2026 at 3:38 p.m., with Licensed Vocational Nurse (LVN) 1 in Resident 5's room, LVN 1 stated LVN 1 turned on the tube feeding at 12:00 p.m. today. LVN 1 stated there was about 1500 mL left in formula bottle. LVN 1 stated LVN 1 does not know why the tube feeding was not infusing the feedings into Resident 5 and started to troubleshoot the cause of the delay. LVN 1 was able to start the tube feeding after troubleshooting the machine and tube feeding formula started moving along the tube into the resident. During an interview on 2/12/2026 at 10:10 a.m., with Registered Dietician (RD), the RD stated Resident 5's order was for Jevity 1.5 @ 60 mL/hr for 20 hours. The RD stated Resident 5 was in a vegetative state (a person is awake but not aware of themselves or their surroundings because the thinking part of their brain is severely damaged) and unable to communicate his needs. The RD stated if the tube feeding was started at 12:00 p.m. and at 3:38 p.m. and there was still 1500 mL of formula feeding in the bottle, it means that Resident 5 did not receive any tube feeding. The RD stated negative outcome of not receiving the tube feeding was potential weight loss, and the resident's recovery would be affected. During an interview on 2/12/2026 at 1:33 p.m., with the Director of Nursing (DON), the DON stated the tube feeding was not (continued on next page)		

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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.			
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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	given to the resident if the tube feeding was started at 12:00 p.m., and formula bottle was still full at 1500 mL at 3:38 p.m. on same day. The DON stated that it was over three hours of no tube feeding given. The DON stated she would expect the formula bottle to be less than full if the tube feeding was started at 12:00 p.m. and by 3:38 p.m., the formula bottle would reflect amount given since the time it started. The DON stated it was the expectation for the nursing staff to assess the resident, make a change in condition assessment, notify primary physician, and start the tube feeding right away. The DON stated the negative outcome of residents not receiving the tube feeding as ordered was weight loss, skin issues can develop or become worse, and the residents were not getting the nutrients needed. During a review of the facility's policy and procedure (P&P) titled Enteral Nutrition, revised November 2018, indicated adequate nutritional support through enteral nutrition is provided to residents as ordered. some examples of potential benefits of using a feeding tube include addressing malnutrition and dehydration; and promoting wound healing. the nursing staff and provider monitor the resident for signs and symptoms of inadequate nutrition, altered hydration, hypo- or hyperglycemia, and altered electrolytes. The nursing staff and provider also monitor the residents for worsening of conditions that place the residents at risk for the above. During a review of the facility's P&P titled Enteral Feedings-Safety Precautions, revised November 2018, indicated to ensure the safe administration of enteral nutrition. all personnel responsible for preparing, storing and administering enteral nutrition formulas will be trained, qualified and competent in his or her responsibilities.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to store two unopened Humalog insulin pens (a medication used to treat high blood sugar) in the refrigerator per the manufacturer's requirements affecting Residents 160 and 207 in one of five inspected medication carts (Station 3 Cart A.)The deficient practices of failing to store unopened insulin pens in the refrigerator per the manufacturer's requirements increased the risk that Residents 160 and 207 could have received medication that had become ineffective or toxic due to improper storage possibly leading to health complications resulting in hospitalization or death.Findings: During a concurrent observation and interview on [DATE] at 1:25 PM of Station 3 Medication Cart A with the Licensed Vocational Nurse (LVN 5), the following medications were found either expired, stored in a manner contrary to their respective manufacturer's requirements, or not labeled with an open date as required by their respective manufacturer's specifications:Two unopened Humalog insulin pens were found stored in the medication cart at room temperature. According to the product labeling, unopened Humalog insulin pens should be stored in the refrigerator. During a concurrent interview, LVN 5 stated the Humalog insulin pens for Residents 160 and 270 are stored at room temperature and not labeled with an open date. LVN 5 stated unopened insulin should be stored in the refrigerator because once stored at room temperature it is only good for 28 days. LVN 5 stated if insulin in the medication cart does not have an open date on it, we won't be able to know accurately when it expires. LVN 5 stated giving expired insulin to residents could cause poor blood sugar control possibly leading to medical complications.A review of the facility's policy titled Storage of Medications, revised [DATE], indicated Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. medications requiring refrigeration. are kept in a refrigerator with a thermometer to allow temperature monitoring.		

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of two sampled residents (Resident 18) who was under hospice care (compassionate care for people who are near the end of life provided at the person's home or within a health care facility) was visited by hospice licensed nurses weekly per hospice care agreement. This failure had the potential to result in Resident 18 not having their hospice needs met, as they agreed upon. Findings: During a review of Resident 18's admission Record, the admission Record indicated, Resident 18 was initially admitted to the facility on [DATE] and last re-admission was on 10/3/2025 with diagnoses including senile degeneration of brain (a neurological disorder that is tied to cognitive decline, memory impairment, and changes in behavior), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), dementia (a progressive state of decline in mental abilities), and encephalopathy (a disturbance of brain function). During a review of Resident 18's History and Physical H&P, dated 10/4/2025, the H&P indicated, Resident did not have the capacity (ability) to understand and make decisions. During a review of Resident 18's Minimum Data Set (MDS-a resident assessment tool), dated 1/19/2026, the MDS indicated Resident 18 was dependent on staff and required assistance (Helper does all of the effort) from two or more staff for eating, hygiene, shower/bath, dressing, bed mobility, and transfer. During a concurrent interview and record review on 2/11/2026, at 9:59 a.m., with Registered Nurse Supervisor (RNS)1, Resident 18's Patient Calendar, dated 2/2026 was reviewed. The Patient Calendar indicated, there was no initial on 2/10/2026 for Hospice Registered Nurse (RN). RNS 1 stated, the hospice RN should have put her initials when she came to see Resident 18 and documented assessment in communication note. RNS 1 stated, there was no sign-in sheet for the hospice staff. RNS 1 stated, RN or Licensed Nurses should have visited Resident 18 once a week (every Tuesday) per hospice agreement. RNS 1 stated, the facility staff did not follow up with the hospice staff, regarding the missing visit on 2/10/2026. RNS 1 stated, Hospice nurses visits should be done weekly according to the hospice agreement, and Resident 18 would not receive specialty care and assessment if the hospice nurses' visits were not ensured as agreed. During an interview on 2/12/2026, at 2:15 p.m., with the Director of Nursing (DON), the DON stated, the staff should have followed up with weekly hospice licensed nurses' visit to ensure Resident 18 received the care agreed upon. The DON stated, the facility staff had the responsibility for ensuring Resident 18 who was under hospice care received the best care, especially specialty care such as hospice assessment and palliative care (a medicine or form of medical care that relieves symptoms without dealing with the cause of the condition) as agreed. During a review of Resident 18's Hospice Communication Update, dated from 1/2026 to 2/2026, the Hospice Communication Update indicated, there was no assessment and documentation on 2/10/2026 from RN or Licensed Nurse. During a review of Resident 18's Hospice Certification of Terminal Illness, dated 1/8/2026, the Hospice Certification of Terminal Illness indicated, Hospice would provide Skilled Nursing Service from RN or Licensed Nurse once a week for 13 weeks and Aide Service twice a week for 13 weeks. During a review of Resident 18's Care Plan Report titled, Resident 18 was at risk for unavoidable declines, revised 2/4/2025 and 11/13/2025, the Care Plan Interventions indicated, provide Resident 18 to have comfortable and dignified dying process and refer to Hospice services as ordered. During a review of Resident 18's Order Summary Report (OSR), dated 2/11/2026, the OSR indicated, admit to the hospice care on routine level of care with diagnosis of senile degeneration of the brain was ordered on 10/13/2025. During a review of the facility's Policy and Procedure (P&P) titled, Hospice Program, revised 7/2017, the P&P indicated, Policy Interpretation and Implementation: 5. Hospice providers who contract with this facility: a. must have a written agreement with the facility outlining (in detail) the responsibilities of the facility and the hospice agency; and b. are held (continued on next page)		

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	responsible for meeting the same professional standards and timeliness of service as any contracted individual or agency associated with the facility. 9. (in general, it is the responsibility of the hospice to manage the resident's care as it relates to the terminal illness and related conditions, including the following: a. Determining the appropriate hospice plan of care; b. Changing the level of services provided when it is deemed appropriate; c. Providing medical direction, nursing and clinical management of the terminal illness; d. Providing spiritual, bereavement and/or psychosocial counseling and social services as needed; and e. Providing medical supplies, durable medical equipment, and medications necessary for the palliation of pain and symptoms. 10. In general, it is the responsibility of the facility to meet the resident's personal care and nursing needs in coordination with the hospice representative and ensure that the level of care provided is appropriately based on the individual resident's needs.		