STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056150	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Catered Manor Nursing Center	4010 N Virginia Rd. Long Beach, CA 90807

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44055 Based on interview and record review the facility failed to involve one of one resident (Resident 1) and/or responsible party in the Interdisciplinary team (IDT) conference after Resident 1 fell on [DATE]. This deficient practice had the potential to result in poor quality of care and a delay of care and services. Findings: During a review of Resident 1 ' s Admission Record, the admission record indicated Resident 1 was originally admitted to the facility on [DATE] with diagnosis including hypoglycemia (low blood sugar) and type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 1 ' s Minimum Data Set ([MDS] a resident assessment tool) dated 4/1/2025, the MDS indicated Resident 1 ' s cognition (ability to think and reason) was intact. The MDS indicated Resident 1 needed set up assistance when eating and oral hygiene, maximal assistance (helper does more than half he effort) with toileting hygiene, and showering. During a concurrent phone interview and record review on 5/2/2025 at 11:42 a.m. with Registered Nurse (RN) 1, Resident 1 ' s SBAR (Situation background Assessment Request)- fall Report Incident, dated 4/3/2025 at 7:07 p.m. The report indicated on 4/3/2025 at 5:55 p.m. Resident 1 was found after a fall in front of the bathroom door. The IDT Notes indicated nursing, Rehabilitation team, Dietary and Activities were all part of the meeting. RN 1 stated the resident, or family was not involved in the IDT meeting, and they should have been involved. During a phone interview on 5/2/2025 at 10:40 a.m. with the Director of Nursing (DON), the DON stated the Resident, or family should be involved in IDT Care conferences. During a review of the facility ' s policy and procedure (P&P) titled, Care Plans, Comprehensive, revised 12/2017, the P&P indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident with the collaboration of the resident and IDT team to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.

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

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F 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44055 Based on interview and record review the facility failed to provide one of one family member (FM)1 medical records of Resident 1 within the required time frame. This deficient practice had the potential to result in poor quality of care and a delay of care and services. Findings: During a review of Resident 1 ' s Admission Record, the admission record indicated Resident 1 was originally admitted to the facility on [DATE] with diagnosis including hypoglycemia (low blood sugar) and type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 1 ' s Minimum Data Set ([MDS] a resident assessment tool) dated 4/1/2025, the MDS indicated Resident 1 ' s cognition (ability to think and reason) was intact. The MDS indicated Resident 1 needed set up assistance when eating and oral hygiene, maximal assistance (helper does more than half he effort) with toileting hygiene, and showering. During a review of electronic mail (email) correspondence from FM 1 and the Director of Nursing (DON) the email indicated as follows: a) On 3/21/2025 at 8:36 p.m., FM 1 requested Resident 1 ' s medical records. b) On 3/28/2025 at 5:59 p.m., the DON indicated Resident 1 ' s medical records were available. During an interview on 5/1/2025 at 2:18 p.m. with the Director of Nursing (DON), the DON stated the Resident 1 ' s medical records was requested 3/21/2025 should have been made available sooner than 3/28/2025. During a review of the facility ' s policy and procedure (P&P) titled, Access to Protected Health Information (PHI) Policy, revised 3/21/2018, the P&P indicated request of the records within two calendar days of the receipt of the valid request.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - 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** 44055 Based on interview and record review the facility failed to recheck one of one ' s resident (Resident 1) blood glucose (sugar) levels after insulin (a hormone that removes excess sugar from the blood can be produced by the body or given artificially via medication) was administered as indicated in Resident 1 ' s care plan. This deficient practice had the potential to result in poor quality of care and a delay of care and services. Findings: During a review of Resident 1 ' s Admission Record, the admission record indicated Resident 1 was originally admitted to the facility on [DATE] with diagnosis including hypoglycemia (low blood sugar) and type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 1 ' s Minimum Data Set ([MDS] a resident assessment tool) dated 4/1/2025, the MDS indicated Resident 1 ' s cognition (ability to think and reason) was intact. The MDS indicated Resident 1 needed set up assistance when eating and oral hygiene, maximal assistance (helper does more than half he effort) with toileting hygiene, and showering. During a concurrent interview on 5/1/2025 at 11:42 a.m. with Registered Nurse (RN) 1 and record review of Resident 1 ' s care plans . The untitled care plan focus indicated Resident 1 had Diabetes Mellitus. The care plan goal, initiated 3/12/2025, indicated the resident will have no complications related to diabetes. One of the care plan interventions indicated to administer insulin as ordered and the licensed Nurse will continue to monitor resident for Hypo /Hyperglycemia (low and high blood sugar) and continue rechecking blood sugar 30 to 45 minutes after administering insulin. RN 1 stated Resident 1Resident 1 ' s blood sugar should have been checked after insulin was administered as indicated in the care plan. During an interview on 5/1/2025 at 11:42 a.m. with Registered Nurse (RN) 1 and record review of Resident 1 ' s Medication Administration Record (MAR) for 3/2025 . RN1 stated Insulin was administered at 11:30 a.m., as follows: a) 3/14/2025, 1 unit for blood sugar of 163 milligrams per deciliter (mg/dL) b) 3/15/2025, 4 units for blood sugar of 345 mg/dL c) 3/20/2025, 2 units for blood sugar of 226 mg/dL d) 3/21/2025, 5 units for blood sugar of 371 mg/dL RN 1 stated the blood sugars were not checked after the insulin was administered on the dates indicated. RN 1 stated blood sugar should have been checked as indicated in the care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/1/2025 at 2:18 p.m. with the Director of Nursing (DON), the DON stated the resident care plans should be implemented as indicated. During a review of the facility ' s policy and procedure (P&P) titled, Care Plans, Comprehensive, revised 12/2017, the P&P indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The care plan describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.