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	05/27/2025

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 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 interview and record review, the facility failed ensure they documented interventions needed to prevent falls and injuries for one of three sampled residents (Resident 1), per the Minimum Data Set ([MDS] a resident assessment tool) assessment. This deficient practice resulted in an incomplete care plan and staff not being aware that Resident 1 was dependent (helper does all the effort, resident does none of the effort to complete the activity, or the assistance of two or more helpers is required for the resident to complete the activity) on nursing staff for toileting hygiene and rolling to the left and right side while lying on his back in bed during care. Findings: During a review of Resident 1's admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with a diagnosis including a fracture (breaking of a bone) of the left humerus (the upper arm bone), congestive heart failure ([CHF] a heart disorder which causes the heart to not pump the blood efficiently), generalized muscle weakness, and myasthenia gravis (an autoimmune disorder that causes muscle weakness and fatigue due to a breakdown in communication between nerves and muscles). During a review of Resident 1's MDS dated [DATE], the MDS indicated Resident 1 had mild cognitive impairment (memory and thinking problems). The MDS indicated Resident 1 was dependent on nursing staff for toileting hygiene and rolling to the left and right side while lying on his back in bed. The MDS indicated Resident 1 was incontinent of both bowel and bladder function. During a review of Resident 1's untitled Care Plan, dated 9/12/2024, the Care Plan indicated Resident 1 had impaired physical mobility related to a fracture of the left humerus. The Care Plan's goal indicated Resident 1 would be able to perform activities within physical limitation and be free from complications of immobility. The Care Plan's interventions included allowing Resident 1 adequate time for responses and to determine the level of assistance needed based on activities of daily living ([ADLs] activities such as bathing, dressing and toileting a person performs daily) evaluation. Continued review of the Care Plan indicated no documentation that Resident 1 was dependent on staff and needed a two person assist for turning and repositioning. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's untitled Care Plan dated 8/4/2024, the Care Plan indicated Resident 1 was at risk for falls and Injuries related to Resident 1 use of cardiovascular (heart and blood vessel) and pain medications, a previous fracture, incontinence (loss of control of bowel and/or bladder), and other medical conditions. The Care Plan's goal indicated Resident 1 would exhibit safe practices, and interventions included assessing toileting needs, encouraging the use of the call light, evaluating the room for immediate safety needs, and keeping the call light within reach. Continued review of the Care Plan indicated no documentation that Resident 1 was dependent on staff and needed a two person assist for turning and repositioning During an interview on 5/23/2025 at 9:38 a.m., the MDS Nurse stated she completed the ADL section of Resident 1's MDS and determined Resident 1 was dependent on staff when rolling from left to right, which meant he was not able to turn himself at all and required two-person assistance for turning and repositioning to prevent him from falling. The MDS Nurse stated she created a care plan based on the MDS assessment but did not include in the care plan that Resident 1 required two people for assistance when turning and repositioning because she assumed the CNAs knew what dependent in turning meant. During a review of the facility's P/P Care Plan, Comprehensive, dated 12/2017, the P/P indicated care plans should include measurable, Resident specific goals and interventions.

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1), who was dependent (helper does all the effort, resident does none of the effort to complete the activity, or the assistance of two or more helpers is required for the resident to complete the activity) on nursing staff for toileting hygiene, and rolling to the left and right side while lying on his back in bed, was provided assistance by two people when receiving incontinent (loss of control of bowel and/or bladder) care. The facility failed to: 1. Ensure Certified Nursing Assistant (CNA) 1 did not turn and reposition Resident 1 during incontinent care without the assistance of an additional staff member, per the Minimum Data Set ([MDS] a resident assessment tool) assessment. This deficient practice resulted in Resident 1 rolling out of bed when CNA 1 turned the resident during incontinent care without the assistance of two people. Resident 1 was transferred to a General Acute Care Hospital (GACH) on [DATE] where he was diagnosed with multiple injuries to his neck and spine (see below), was intubated (a tube is inserted into a person's mouth/nose and down into their airway), and placed on a ventilator (a medical device that helps a person breath when they are unable to do so on their own). Resident 1 expired on [DATE] due sequelae (lasting health problems) of blunt traumatic injuries (getting hurt by something with a lot of force but without breaking the skin) from a ground level fall. Findings: During a review of Resident 1's admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with a diagnosis including a fracture (breaking of a bone) of the left humerus (the upper arm bone), congestive heart failure ([CHF] a heart disorder which causes the heart to not pump the blood efficiently), generalized muscle weakness, and myasthenia gravis (an autoimmune disorder that causes muscle weakness and fatigue due to a breakdown in communication between nerves and muscles). During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated [DATE], the MDS indicated Resident 1 had mild cognitive impairment (memory and thinking problems). The MDS indicated Resident 1 was dependent on nursing staff for toileting hygiene and rolling to the left and right side while lying on his back in bed. The MDS indicated Resident 1 was incontinent of both bowel and bladder function. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's SBAR ([situation, background, assessment, recommendation] a communication tool used by healthcare workers when there is a change of condition among the residents) Fall Report of Incident, dated [DATE] and timed at 7:25 a.m., the SBAR indicated on [DATE] at 6:35 a.m., Resident 1 was alert, oriented, and verbally responsive when Certified Nursing Assistant (CNA) 1 adjusted his bed to her waist level and repositioned Resident 1 to his right side. The SBAR indicated Resident 1 slid out of bed and landed on a floor mat (a cushioned floor pad designed to help prevent injury should a person fall) in a prone (lying face down) position. The SBAR indicated CNA 1 called for help and Licensed Vocational Nurse (LVN) 1 responded and found Resident 1 was awake and alert but unresponsive (unable to react to stimuli like touch, sound, or pain, essentially being unconscious or unaware of their surroundings). The SBAR indicated Resident 1 was placed back in bed while LVN 1 called 911. The SBAR indicated 911 transferred Resident 1 to a GACH. During a review of Resident 1's Emergency Medical Services ([EMS] a system that provides immediate medical care to individuals experiencing serious injuries, illnesses, or medical emergencies) form, dated [DATE], the EMS form indicated EMS was dispatched to the facility on [DATE] at 6:35 a.m., and arrived at the facility at 6:46 a.m. The EMS form indicated Resident 1 had a Glasgow Coma Score ([GCS] a method used to determine a patients conscious state ranging from 3-15, a score of 3-8=coma) of 4, on a Glasgow Coma Scale (a tool medical professional's use to objectively evaluate the degree to which a person is conscious or comatose. It operates on a scale of 3 to 15). The EMS form indicated, Resident 1 was lying in bed supine (on his back), was drowsy, but able to open his eyes and hit the occipital (the back region) area of his head. The EMS form indicated Resident 1 had left sided facial droop and a low oxygen saturation ([O2 sat] a measurement of how much oxygen is carried by the blood, normal range is 95% to 100%) level of 84% on room air (without the use of oxygen supplement). During a review of the GACH's admission Record, dated [DATE], the GACH's admission Record indicated Resident 1 arrived at the GACH at 7:03 a.m., with a primary diagnosis of respiratory insufficiency (a condition that cause problems with breathing, specifically at rest) and a hospital problem of lung failure ([respiratory failure] a serious condition making it difficult to breath on your own). During a review of the GACH's Emergency Department (ED) Notes, dated [DATE] and timed at 10:32 a.m., the ED Notes indicated Resident 1 was intubated and placed on a ventilator at 7:11 a.m. During a review of the ED Provider Note dated [DATE] and timed at 7:07 a.m., the ED Provider Note indicated Resident 1 presented to the ED with a GCS of 6 and had pinpoint pupils (pupils that are abnormally small, and an indication of a severe head injury) upon initial evaluation. During a review of the GACH's Imaging Note, dated [DATE], and timed at 4:25 p.m., the Imaging Note indicated an MRI ([Magnetic Resonance Imaging] a medical technique that uses strong magnetic field and radio waves to create detailed images of the body's internal structures) of Resident 1's brain indicated the following: 1. Acute traumatic (caused by trauma such as fall or accident) ligamentous (tough bands of tissue that connect bones and help stabilize the spine) injuries with slight anterior translation (movement or displacement of a body part forward from its normal position relative to another bone or joint) of the dens (a bony projection of the second neck bone that acts as a pivotal point enabling head rotation), and C1 vertebra (a ring shaped bone that begins at the base of the skull that holds the head upright (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	2. Superimposed hematoma (a collection of blood outside of the blood vessel occurring on top of an existing hematoma, either in the same area or in a different locations) vs an inflammatory mass (a clump of tissue that has become swollen or irritated) with secondary compression of the cervical cord (a condition where the spinal cord in the neck region is squeezed) During a review of the GACH's Imaging Note, dated [DATE], and timed at 4:52 p.m., the Imaging Note indicated an MRI of Resident 1's C-spine ([cervical spine] the upper portion of the spinal column located in the neck region) indicated the following: 1. Brain stem (the lowest part of the brain responsible for functions such as breathing) and cervical cord edema over seven centimeters ([cm] a unit of measurement) in length. 2. Cervical cord hemorrhage (bleeding) at C1. 3. Suspected ligamentous tears from the skull base (the bony floor of the skull that separates the brain from the upper neck) and C2 (second vertebra of your neck) region to the C6 through C7 (sixth and seventh vertebra of your neck) vertebra. 4. Likely disc (involves the cushion-like discs in the spine that allow movement, provide shock absorption, ad maintain spinal stability) injury at C3 through C7. 5. Indications of interspinous (located between spines, specifically between the bone projections of the adjacent vertebrae in the spine) ligamentous tears from C2 through C5. 6. Suspected acute fracture on C4 vertebral body (the main component of each vertebra in the spine, providing support and structure)/osteophyte ([bone spur] an abnormal bony projection that forms on the edges of the bones which can develop due to injury) and C3 vertebrae. 7. Multi-level cervical spinal stenosis (narrowing of the space within the neck bones where the spina cord and nerve roots run, causing compression of these delicate structures) C5 through C6 (mild), C5 through C5 (moderate). During a review of the GACH's Medicine Discharge summary, dated [DATE] the Medicine Discharge Summary indicated Resident 1 was still on a ventilator on [DATE] and neurosurgery (a medical specialty concerned with diagnosis and treatment of patients with injury of the brain, spine, spinal cord, and other nerve related body parts) consulted with Resident 1's family, and decided on comfort care (care that focuses on an end of life approach such as managing pain symptoms, and spiritual/emotional needs of both patient and family). The Medicine Discharge Summary indicated Resident 1's family was aware of Resident 1's poor prognosis (a low likelihood of recovery of improvement of a condition/disease) and was ready to withdrawal care (a discontinuation of life-prolonging treatments such as ventilators). Resident 1 was taken off the ventilator on [DATE]. The Medicine Discharge Summary indicated Resident 1 Resident 1 passed away on [DATE]. During a review of Resident 1's Certificate of Death, dated [DATE] and timed at 6:05 p.m., the Certificate of Death indicated Resident 1's immediate cause of death was sequelae (lasting health problems) of blunt traumatic injuries (getting hurt by something with a lot of force but without breaking the skin) from a ground level fall. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on [DATE] at 2:47 p.m., Family Member (FM) 1 stated Resident 1 passed away on [DATE] at the GACH due to breaking his neck with a spinal cord injury from his fall on [DATE] at the facility. FM 1 stated she last talked to Resident 1 on [DATE] over the phone and he was alert, oriented, and able to speak to her normally. FM 1 stated she visited Resident 1 at the GACH from [DATE] through [DATE], and Resident 1 was not able to move, talk, or breath without the use of a ventilator. During an interview on [DATE] at 5:10 a.m., Licensed Vocational Nurse (LVN) 1 stated on [DATE] at 6:30 a.m., Certified Nursing Assistant (CNA) 1 called for help and he (LVN 1) rushed into Resident 1's room and observed Resident 1 lying on the floor face down on the right side of his bed on a floor mat. LVN 1 stated Resident 1's bed was without siderails and was approximately three feet high from the floor. LVN 1 stated when they (LVN 2 and CNA 2) turned Resident 1 over onto his back he had no visible injuries, his eyes were open, but he did not blink, and he was not able speak. LVN 1 stated when he asked CNA 1 what happened she informed him Resident 1 fell when she was changing him by herself. During an interview on [DATE] at 8:05 a.m., CNA 1 stated on [DATE], sometime in the early morning (exact time unknown) she went into Resident 1's room to provide care to him. CNA 1 stated she raised Resident 1's bed to the level of her waist (exact height unknown) and pulled Resident 1 to the left side of his bed using a draw sheet (a small bed sheet placed crosswise over the middle of the bottom sheet of a mattress to cover the area between the person's upper back and thighs, often used by medical professionals to move patients). CNA 1 stated Resident 1 was facing the window with his back to the front of her body and as she pulled him towards her he suddenly slipped out of the bed. CNA 1 stated she had worked with Resident 1 two to three times in the past and she was never informed that he required two-person assistance, and she did not think she needed help turning him because he was able to assist in turning himself. During an interview on [DATE] at 9:01 a.m., the Director of Staff Development (DSD) stated if Resident 1 was totally dependent for his care needs, for safety purposes and to prevent falls there should have been two people assisting during his care. The DSD stated he found out about Resident 1's fall on [DATE] at 8:15 a.m., during morning huddle (a meeting where nurses discuss resident updates). The DSD stated due to a suspected head/neck injury Resident 1 should have been left on the floor until the paramedics arrived to protect his head/neck from more damage. During an interview on [DATE] at 9:38 a.m., the MDS Nurse stated she completed the ADL section of the MDS and determined Resident 1 was dependent on staff when rolling from left to right, which meant he was not able to turn himself at all and required two-person assistance for turning and repositioning to prevent him from falling. During a review of the facility's P/P titled Turning and Repositioning dated [DATE], the P/P indicated the protocol for turning and repositioning included use of appropriate number of staff to perform tasks safely.