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	08/06/2025

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. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056150	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/06/2025

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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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to develop and implement comprehensive plan for one of one sample residents (Residents 1) when Resident 1 fell on 7/3/2025 from the wheelchair. This deficient practice increased Resident 1's risk of further falls and injuries. Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was originally admitted to the facility on [DATE], and readmitted on [DATE] with diagnoses including acute respiratory failure (when not enough oxygen passes from your lungs to your blood), muscle weakness (a reduced ability of muscle to generate force, often resulting in difficulty performing daily tasks or feeling fatigued), type 2 diabetes (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), dependence on renal dialysis (a person's kidney no longer function adequately, and they rely on a dialysis. During a review of Resident 1's Minimum Data Set (MDS-resident assessment tool) dated 06/05/2025, the MDS indicated Resident 1 had intact cognitive (ability to think, understand, learn, and remember) function for daily decision-making. The MDS indicated Resident 1's required moderate assistance (helper does less than half the effort, helper lifts, holds, or supports trunk or limbs) from staff for activities of daily living (ADL- routine tasks/activities such as bathing, dressing and toileting) and with transfers between surfaces. The MDS indicated Residents 1 require supervision or touching assistance (helper provides verbal cues and/touching/steadying and/or contact guard assistance as resident completes activity) to transfer to chair/bed-to-chair transfer: the ability to transfer to and from a bed to a chair (or wheelchair). During an interview on 08/04/2025 09:36 a.m. with Resident 1 on Resident 1's room, Resident 1 stated on 07/03/2025 she called for help, but no one comes to assist her because facility staff were having barbeque-q at the patio. Resident 1 stated she was trying to put her prosthetic leg (an artificial limb that replaces a missing leg due to amputation [the surgical removal of a limb or part of a limb]) on, transferring from the bed to wheelchair but her wheelchair was not locked by the staff after returning from dialysis, so the wheelchair slides out and flips from under her bottom and she fell face down. Resident 1 stated there were no injuries at the time but the [NAME] of her right forehead was slightly swollen but had been resolved. During a concurrent interview and record review on 08/06/2025 at 12:15 p.m., with Licensed Vocational Nurse 1 (LVN 1), Resident 1's electronic health record was reviewed. LVN 1 stated there were no records and documentation noted in Resident 1's electronic health record that shows fall risk assessment was done and resident centered care plan for falls were initiated. Resident 1's care plan titled Resident 1 had a fall on 7/03/2025. Paramedics arrived and residents refused, claims she fine. The Care Plan interventions indicated to reassessed and reevaluate Resident 1 by Interdisciplinary team (IDT) , will continue with the IDT recommendation and intervention, re-educating Resident 1 with the use of call light when needing assistance. LVN 1 stated they have a new system where staff worked as a team and IDT to focus on the care plan and the fall assessment when the IDT team meets. During a concurrent interview and record review on 08/04/2025 at 1:06 p.m., with Registered Nurse (RN1), RN1 stated she cannot find any fall assessment that was done on Resident 1, and Resident 1's care plan was not on the actual fall assessment after the resident fall on 7/3/2025. RN 1 stated she was not part of the IDT team, and she would not know if it was done or not, because the IDT was supposed to do it. During an interview on 08/06/26 at 2:26 p.m., with the Director of Nursing (DON), the DON stated, it was important to document a resident change of condition and implement resident centered care plans, risk assessment to be able to evaluate if the residents was getting worse or stable. During a review of the facility's policies and procedures (P&P) titled Safety and Supervision of Residents dated 2021, the P&P indicated Individualized, resident centered approach to safety addresses safety and accident hazards for individual residents. The Interdisciplinary care team shall analyze information obtained from assessment and observations to identify any specific accident hazards or risks for individual residents. The care [lam shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices. Cross reference F689

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the resident environment was free of potential hazard for one of one sample residents (Resident 1). Resident 1 who had an unwitnessed fall from her wheelchair on 7/3/2025. The facility failed to: 1. Ensure Resident 1's wheelchair was locked upon Resident 1's return from dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) machine to filter their blood) treatment on 7/3/2025. This deficient practice resulted in Resident 1 falling from her wheelchair on 7/3/2025 with no injury and had the potential for increased risk for further falls and injury.Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was originally admitted to the facility on [DATE], and readmitted on [DATE] with diagnoses including acute respiratory failure (when not enough oxygen passes from your lungs to your blood), muscle weakness (a reduced ability of muscle to generate force, often resulting in difficulty performing daily tasks or feeling fatigued), type 2 diabetes (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), dependence on renal dialysis (a person's kidney no longer function adequately, and they rely on a dialysis. During a review of Resident 1's Minimum Data Set (MDS-resident assessment tool) dated 06/05/2025, the MDS indicated Resident 1 had intact cognitive (ability to think, understand, learn, and remember) function for daily decision-making. The MDS indicated Resident 1's required moderate assistance (helper does less than half the effort, helper lifts, holds, or supports trunk or limbs) from staff for activities of daily living (ADL- routine tasks/activities such as bathing, dressing and toileting) and with transfers between surfaces. The MDS indicated Residents 1 require supervision or touching assistance (helper provides verbal cues and/touching/steadying and/or contact guard assistance as resident completes activity) to transfer to chair/bed-to-chair transfer: the ability to transfer to and from a bed to a chair (or wheelchair). During an interview on 08/04/2025 09:36 a.m. with Resident 1 on Resident 1's room, Resident 1 stated on 07/03/2025 she called for help, but no one comes to assist her because facility staff were having barbeque-q at the patio. Resident 1 stated she was trying to put her prosthetic leg (an artificial limb that replaces a missing leg due to amputation [the surgical removal of a limb or part of a limb]) on, transferring from the bed to wheelchair but her wheelchair was not locked by the staff after returning from dialysis, so the wheelchair slides out and flips from under her bottom and she fell face down. Resident 1 stated there were no injuries at the time but the [NAME] of her right forehead was slightly swollen but had been resolved. During a phone interview on 08/04/25 at 1:31 p.m., with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated she (LVN 1) was the charge nurse on 7/3/2025 when Resident 1 fell. LVN 1 stated she was in the hallway when she heard Resident 1 scream from her room. LVN 1 stated she went in the room and found Resident 1 on side lying position and was agitated and threw her prosthetic leg by the bathroom door. LVN 1 stated Resident 1 informed her (LVN 1) that she (Resident 1) was trying to put on her prosthetic leg, while the wheelchair slides from her bottom and falls face down on the floor. LVN 1 stated Resident 1 had just come from dialysis around 1pm where she did a post dialysis assessment, but forgot to make sure Resident 1's wheelchair was locked after assisting residents to transfer to bed. LVN 1 stated this was a lesson learned, next time she will make sure Resident 1's surrounding was safe, wheelchair was locked, asked if Resident 1 needs anything else, and everything was within reach before LVN 1 exited the resident room. During an interview on 08/04/25 at 2:15 p.m., with Certified Nursing Assistant (CNA 1), CNA 1 stated she heard Resident 1 was calling for help. CNA 1 stated she ran into the resident room and found Resident 1 on the floor in a sitting position CNA 1 stated she called the charge nurse for assistance. The nurse in charge did an assessment and took Resident 1's vital signs. CNA 1 stated Resident 1informed her she was trying to put on her prosthetic leg. CNA 1 stated there was no injury noted at that time she found Resident 1 on the floor. CNA 1 stated Resident 1 was assisted back to the wheelchair and no swollen was observed on Resident 1's face. During an interview on 08/06/2025 at 2:26 p.m., with the Director of Nursing (DON), the DON stated, staff should be mindful of Resident 1's surroundings, avoid clutter that will cause falls, check and lock wheelchair for safety and always assess the needs of Resident 1. During a review of the facility's policies and procedures (P&P) titled Fall Risk Assessment, revised in 2018,the P&P indicated The nursing staff, in conjunction with the attending physician, consultant pharmacist, therapy staff, and others, will seek to identify and document resident risk factors for falls and establish a resident-centered falls prevention plan based on relevant assessment. 1. Staff will seek to identify environmental factors that may contribute to