| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056164 | A. Building<br>B. Wing | 04/08/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Pacific Palms Healthcare | 1020 Termino Avenue<br>Long Beach, CA 90804 |

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 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interview, the facility failed to monitor, document and record the intake and output ([I&O] the measurement and recording of all fluids entering and leaving the body over a specific period)for one of three sampled residents (Resident 1), who was readmitted to the facility on [DATE] with an indwelling urinary catheter (a hollow tube inserted into the bladder to drain or collect urine).This deficient practice resulted in the inability to determine if Resident 1's was hydrated appropriately and had the potential for fluid overload and/or infection to go unrecognized.<br>Findings:During a review of Resident 1's admission Record (Face Sheet) the Face Sheet indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE] with a diagnosis of a urinary tract infection ([UTI] an infection in the bladder/urinary tract).During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 6/27/2025, the MDS indicated Resident 1's cognition was moderately impaired. Resident 1 required partial/moderate assistance (helper does less than half the effort) with toilet hygiene, shower/bath, upper and lower body dressing.During a review of the Order Summary Report (Physician's Order), the Physician's Order indicated Resident 1 had a 16 French ([fr] size of the tubing) indwelling urinary catheter with a 10 cubic centimeter ([cc] unit of measurement) balloon. During an interview with Registered Nurse (RN) 1 and a concurrent review of Resident 1's clinical records on 3/7/2027 at 2:02 p.m., Resident 1's clinical record indicated there was no documentation of Resident 1's intake and output ([I&O] the measurement and recording of all fluids entering and leaving the body over a specific period). RN 1 stated Resident 1 was admitted to the facility on [DATE] with an indwelling catheter and the resident's I&O was not taken because there were no doctor's orders to do so. During an interview the Director of Nursing (DON) stated Resident's I&Os are monitored only if there is a problem identified.During a review of the facility's Policy and Procedures (P&P) the facility could not provide a policy on I&Os. |

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

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 056164 | A. Building<br>B. Wing | 04/08/2026 |

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| Pacific Palms Healthcare | 1020 Termino Avenue<br>Long Beach, CA 90804 |

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 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interview, the facility failed to ensure Registered Nurse (RN) 1 accurately documented one of three sampled resident's (Resident 1) blood glucose (the main sugar found in the bloodstream) results. This deficient practice resulted in an inaccurate portrayal of Resident 1's clinical status and the potential to result in unnecessary treatment and care. Findings:During a review of Resident 1's admission Record (Face Sheet) the Face Sheet indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE] with a diagnosis of 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 6/27/2025, the MDS indicated Resident 1's cognition was moderately impaired. Resident 1 required partial/moderate assistance (helper does less than half the effort) with toilet hygiene, shower/bath, upper and lower body dressing.During a review of Resident 1's Progress Note dated 3/17/2026, the Progress Note indicated Resident 1's blood glucose level was 551 grams(g)/deciliter ([dl] a unit of measure, the normal range is 80 g/dl - 100 g/dl). During an interview on 4/7/2026 at 2:02 p.m., RN 1 stated she recorded Resident 1's blood glucose as 551 g/dl but that was not the correct number. Resident 1's actual blood glucose was 350 g/dl. RN 1 stated she forgot to document the correct blood glucose number, Resident 1 transferred to a General Acute Care Hospital (GACH) so it was not necessary to correct the blood glucose result. RN 1 stated she should have corrected Resident 1's blood glucose number because it was important to document the right information correctly for accuracy and safety. During an interview on 4/8/2026 the Director of Nursing (DON) stated she was made aware by RN 1 that Resident 1's correct blood glucose level was actually 350 g/dl not 551 g/dl. RN 1 should have corrected Resident's clinical record to reflect the right blood glucose results. During a review of the facility's Policy and Procedure (P&P) revised 7/2017, titled, Charting and Documentation the P&P indicated all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psych social condition, shall be documented in the residents medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Documentation in the medical record will be objective (not opinionated not speculative) complete, and accurate. |