

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: 056164	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2025
NAME OF PROVIDER OR SUPPLIER Pacific Palms Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1020 Termino Avenue 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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure call light devices were within reach for three of 26 sampled residents (Residents 7, 100, and 121). This deficient practice had the potential for residents not being able to summon health care workers for assistance as needed. a. During a review of Resident 7's admission Record, the admission Record indicated Resident 7 was initially admitted on [DATE] and was readmitted on [DATE] with diagnoses including hemiplegia (weakness to one side of the body) and hemiparesis (inability to move one side of the body) affecting left dominant side, stiffness of left shoulder, elbow, and hand, and history of falling. During a review of Resident 7's Minimum Data Set (MDS: a resident assessment tool) dated [DATE], the MDS indicated Resident 7 was cognitively intact. The MDS indicated Resident 7 was dependent on chair/bed-to-chair transfer, lying to sitting, required maximal assistance (provide more than half the effort) for toileting hygiene, bathing, lower body (waist below) dressing, required moderate assistance (provide less than half the effort) for oral/personal hygiene, upper body (waist above) dressing, and required setup for eating. The MDS indicated Resident 7 had an impairment on one side of the upper (arms/shoulders) and lower extremity (legs/hips) and utilized a wheelchair. During a concurrent observation and interview on [DATE] at 11:13 a.m., with Resident 7, Resident 7 stated he did not have a call light and did not know where it was. Resident 7 stated he calls for help by raising his hand. The call light was observed behind the resident's bed. During a concurrent observation and interview on [DATE] at 11:15 a.m. with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated Resident 7's call light was behind his bed and brought the call light to Resident 7's right side. LVN 2 stated call lights are important as when a resident requires assistance, it notifies the staff they need assistance. LVN 2 stated call lights should be placed in a reachable position. LVN 2 stated if a call light was behind the bed and not reachable, the residents may try to get up on their own to get help and increasing their risk for falls. During an interview on [DATE] at 12:42 p.m. with the Director of Nursing (DON), the DON stated call lights are important as if a resident needs assistance, the staff can respond right away, and the call light should be placed in a reachable position. The DON stated if the call light is not in a reachable position, the residents cannot use it. b. During a review of Resident 100's admission Record, the admission Record indicated Resident 100 was initially admitted on [DATE] and was readmitted on [DATE] with diagnoses including history of falling, epilepsy (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness), and Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities) . (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 100's History and Physical (H&P), dated [DATE], the H&P indicated, Resident 100 did not have the capacity (ability) to understand and make decisions. During a review of Resident 100's MDS, dated [DATE], the MDS indicated Resident 100 required maximal assistance (Helper does more than half the effort) from one staff for bed mobility, bathing/shower, toilet hygiene, moderate assistance (Helper does less than half the effort) from one staff for dressing, and set up assistance (Helper sets up or cleans up) from one staff for eating. During a concurrent observation and interview on [DATE], at 10:28 a.m., with Resident 100 in her room, Resident 100's call light was placed between left side foam padding and the left side siderails, and the call light button was dangling near the floor. Resident 100 stated, she knew how to use the call light, but she could not find it. Resident 100 stated, she would yell for help if she could not find the call light. During an interview on [DATE], at 10:31 a.m., with Certified Nurse Assistant (CNA) 2 in Resident 100's room, CNA 2 stated, the call light should be placed within reach of the resident to accommodate the needs of the resident. CNA 2 stated, she did not know why the call light was placed between the foam padding and siderail where Resident 100 could not reach. CNA 2 stated, if the call light was not within reach, Resident 100 might be at risk for fall or accident. During an interview on [DATE], at 2:28 p.m., with the Director of Staff Development (DSD), the DSD stated, the call light was the resident's lifeline (a thing on which someone or something depends, or which provides a means of survival) for emergency situations. The DSD stated, it should be within reach at all times to prevent falls and injuries. During an interview on [DATE], at 3:52 p.m., with the Director of Nursing (DON), the DON stated, the call light should be within reach of the residents at all times to provide the assistance they needed. fall stated, Resident 100 was at risk for falls due to history of falling and the staff should have ensured that the call light was within reach to prevent injuries. During a review of Resident 100's Care Plan Report (CPR), initiated on [DATE] and next review date on [DATE], the CPR Focus indicated, Resident 100 was at risk for fall related to balance problem during transition, and assistance needed during walking and bed mobility. The CPR Interventions indicated, explain or educate the resident to use the call light to ask for assistance because she could injure herself if she transfers herself without calling for help. c) During a review of Resident 121s admission Record, the admission Record indicated Resident 121 was initially admitted on [DATE] and was readmitted on [DATE] with diagnoses including Parkinson's Disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities), and dementia (a progressive state of decline in mental abilities). During a review of Resident 121's MDS, dated [DATE], the MDS indicated Resident 121 had severe cognitive impairment. The MDS indicated Resident 121 was dependent on staff for all Activities of Daily Living (activities such as bathing, dressing and toileting a person performs daily). During a concurrent observation and interview on [DATE] at 12:30 p.m., Resident 121's call light was not within Resident 121's reach and was on the left side of the bed. Certified Nurse Assistant (CNA) 1 (continued on next page)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated the call light was not in reach and needed to be in reach. During an interview on [DATE] at 12:42p.m. with the Director of Nursing (DON), the DON stated call lights are important as if a resident needs assistance, the staff can respond right away, and the call light should be placed in a reachable position. The DON stated if the call light is not in a reachable position, the residents cannot use it. During a review of the facility's policy and procedure (P&P) titled, Resident Rights, revised 12/2016, the P&P indicated communicated federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the residents' right to be treated with respect, kindness, and dignity. During a review of the facility's P&P titled, Answering the Call Light, revised 1/2010, the P&P indicated the purpose of this procedure is to respond to the resident's requests and needs. When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident. Some residents may not be able to use their call light. Be sure you check these residents frequently.		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to obtain a consent form for the use of an abdominal binder (belt used to support the abdomen after surgery, improve physical function), complete the restraint assessment, and monitor the use of abdominal binder for one of 26 sample residents (Resident 121). These deficient practices resulted in unnecessary restraint and placed the residents at risk of physical harm, skin injuries, or entrapment. During a review of Resident 121's admission Record, the admission Record indicated Resident 121 was initially admitted on [DATE] and was readmitted on [DATE] with diagnoses including Parkinson's Disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities), and dementia (a progressive state of decline in mental abilities). During a review of Resident 121's Minimum Data Set ([MDS] a resident assessment tool), dated 11/17/2025, the MDS indicated Resident 121 had severe cognitive impairment. The MDS indicated Resident 121 was dependent on staff for all Activities of Daily Living (activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 121's Admit/RE-Admit Nursing Evaluation, dated 11/12/2025 at 10:30 p.m., the evaluation indicated Resident 121 had a gastrostomy tube ([G- tube] 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 concurrent observation and interview, on 11/19/2025 at 3:45 p.m., at Resident 121's bedside, with Registered Nurse Supervisor (RNS) 1, Resident 121 was noted with an abdominal binder (wide compression belt that encircles the abdomen) in place covering the G-tube site. RNS 1 stated that Resident 121 had the abdominal binder in place to prevent Resident 121 from pulling out the G-tube. RNS 1 stated Resident 121 cannot remove the abdominal binder easily and the abdominal binder prevents Resident 121 from pulling the G-tube. During a concurrent interview and record review on 11/19/2025 at 3:45 p.m., with RNS 1, Resident 121's medical records were reviewed. RNS 1 stated there was no assessment for abdominal binder use and there was no informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) obtained from the resident or responsible party. During an interview on 11/21/2025 at 2:56 p.m. with the Director of Nursing (DON), the DON stated a restraint was a device that restricts residents' movements. During a review of the facility's policy and procedure (P&P) titled, Use of Restraints, revised 12/2007, the P&P indicated: 1) Physical restraints were defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body. 2) Prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need for restraints. The assessment shall be used to determine possible underlying causes of the problematic medical symptoms and to determine if there are less restrictive interventions (programs, devices, referrals, etcetera) that may improve the symptoms. 3) Residents and/or responsible parties shall be informed about the potential risks and benefits of all options under consideration, including the use of restraints, not using restraints, and the alternatives to restraint use.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 to develop and implement a comprehensive resident specific care plan for two out of seven sampled residents (Resident 9 and Resident 13). This deficient practice had the potential for Resident 9 and Resident 13 to not receive person-centered care. Findings: a. During a review of Resident 13's admission Record, the admission Record indicated Resident 13 was admitted to the facility on [DATE] with diagnoses of hemiplegia (unable to move one side of the body) and a contracture (a permanent tightening of muscles, tendons, or skin that causes joints to become stiff and short, restricting movement) of the left hand. During a review of Resident 13's Minimum Data Set (MDS, a resident assessment tool) dated 9/11/2025, the MDS indicated Resident 13 had severe cognitive impairment (a significant loss of mental ability, such as memory, thinking, and reasoning, that prevents a person from living independently and often requires substantial supervision) and had an impairment on one upper extremity (left). During a review of Resident 13's Occupational Therapy Treatment Encounter Note(s) dated 11/16/2025, the Occupational Therapy Treatment Encounter Note indicated Resident 13 was non-compliant in regard to wearing the left Wrist-Hand-Finger Orthosis (WHFO, a type of brace or support that extends from the forearm to the tips of the fingers and thumb, providing support and positioning for the entire hand and wrist structure). During an observation on 11/19/2025 at 9:34 a.m., Resident 13 was noted to have a left hand and wrist contracture. During an interview on 11/21/2025 at 1:02 p.m., Occupational Therapist (OT) 1 stated she reviewed Resident 13's Occupational Therapy Treatment Notes for the month of November 2025 and stated Resident 13 was being seen by occupational therapy twice a week and they were working on Resident 13's tolerance to the left WHFO splint to the left wrist. OT 1 stated Resident 13 had limitations to left upper arm, and she had a contracture on the shoulder, elbow, and hand of left upper arm. OT 1 stated Resident 13 was supposed to wear the splint for one hour total for the week but based on the Occupational Therapy Treatment notes, Resident 13 often refused to wear the left WHFO. During an interview on 11/21/2025 at 3:37 p.m., the Director of Nursing (DON) stated she reviewed Resident 13's care plans and there was no care plan created regarding refusing the left WHFO splint. The DON stated care plans for refusals were important to communicate between the different departments and for continuity of care. The DON stated care plans were important to ensure the resident was receiving proper care. A review of the facility's policy and procedure (P&P) titled Care Plans, Comprehensive Person-Centered, revised December 2016, 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 comprehensive, (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	person-centered care plan will: described the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. b. A review of Resident 9's admission Record, dated 11/20/25, indicated she was originally admitted to the facility on [DATE] and most recently readmitted on [DATE] with diagnoses including anxiety disorder (a mental illness characterized by excessive worry, fear, or panic strong enough to interfere in everyday activities) and seizure disorder (a medical condition caused by uncontrolled electrical activity in the brain.) A review of Resident 9's History and Physical (a record of a physician's comprehensive medical examination), dated 6/9/25, indicated she had fluctuating capacity to understand and make decisions. A review of Resident 9's Order Summary Report (a summary of all active physician's orders), dated 11/20/25, indicated she was prescribed the following medications: 1. Buspar 10 milligrams (mg &ndash; a unit of measure for mass) by mouth twice daily for anxiety manifested by uncontrollable screaming/yelling. 2. Depakote DR 500 mg by mouth twice daily for seizure disorder. A review of Resident 9's care plan for anxiety, initiated 11/12/23, did not indicate the use of Buspar as a targeted intervention related to Resident 9's anxiety disorder. A review of all available care plans indicated there were no other care plans to address Resident 9's use of Buspar for behavioral management. A review of Resident 9's care plan for seizure disorder, initiated 11/1/23, did not indicate the use of Depakote as a targeted intervention related to Resident 9's seizure disorder. A review of all available care plans indicated there were no other care plans to address Resident 9's use of Depakote for the management of seizure disorder. During an interview on 11/20/25 at 10:46 AM with the Director of Nursing (DON), the DON stated the facility failed to create a comprehensive care plan related to the use of Resident 9's Buspar and Depakote. The DON stated the seizure care plan does not list Depakote as a targeted intervention and the anxiety care plan does not list Buspar as a targeted intervention. The DON stated the care plans for psychotropic medications or medications with FDA black box warnings are necessary so that the nursing staff are educated in their specific risks and required monitoring for a resident's medication therapy. The DON stated if care plans are not made to address the use of high-risk medications, it is possible that the resident may experience adverse effects of those medications possibly leading to a decline in their quality of life. A review of the facility's policy Care Plans, Comprehensive Person-Centered, revised December 2016, 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 comprehensive, person-centered care plan will: described the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. A review of the facility's policy Behavioral Assessment, Intervention and Monitoring, revised December 2016, indicated The interdisciplinary team will evaluate behavioral symptoms in residents (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to determine the degree of severity, distress and potential safety risk to the resident, and develop a plan of care accordingly. The care plans will incorporate findings from the comprehensive assessment and be consistent with current standards of practice.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility's licensed nursing staff failed to provide care in accordance with professional standards for two of two sampled residents (Resident 11 and Resident 125) reviewed for unnecessary medications by failing to rotate (a method to ensure repeated injections are not administered in the same area) subcutaneous (beneath the skin) insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) administration sites. This deficient practice had the potential for adverse effect (unwanted, unintended result) of same site subcutaneous administration of insulin such as excessive bruising, lipodystrophy (abnormal distribution of fat) and impaired blood sugar control. Findings:a. During a review of Resident 11's admission Record (Face sheet), the admission Record indicated the facility admitted the resident on 12/6/2023 and was readmitted on [DATE], with diagnoses including type 2 diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed), and cataract (clouding of the eye's natural lens)During a review of Resident 11's History and Physical (H&P), dated 9/15/2025, the H&P indicated the resident had the capacity to understand and make decisions.During a review of Resident 11 Minimum Data Set (MDS - a resident assessment tool), dated 9/18/2025, the MDS indicated Resident 11 had intact cognition (ability to think and understand). The MDS indicated Resident 11 needed set up or clean up assistance from staff for eating and oral hygiene. The MDS indicated Resident 11 needed moderate assistance from staff for toileting hygiene and bathing.During a review of Resident 11's Physician Order dated 9/14/2025, the Physician Order indicated an order of insulin lispro (fast-acting insulin that works fast to lower blood sugar) injection solution 100 unit per milliliters (unit/ml, units of insulin contained within each milliliter of liquid), inject 3 unit subcutaneously three times a day for DM, hold if blood sugar is less than 100. During a review of Resident 11's Physician Order dated 9/15/2025, the Physician Order indicated an order of insulin glargine (long-acting insulin that works slowly and steadily to keep blood sugar stable) subcutaneous solution 100 unit/ml, inject 10 unit subcutaneously at bedtime for DM.During a review of Resident 11's Location of Administration Report from 11/1/2025 to 11/30/2025, indicated insulin glargine subcutaneous solution 100 units/ml was administered on:11/5/2025 at 8:53 p.m. on the arm-right11/6/2025 at 10:11 p.m. on the arm-right11/13/2025 at 10:26 p.m. on the arm-right11/14/2025 at 8:24 p.m. on the arm-right11/15/2025 at 10:12 p.m. on the arm-right11/17/2025 at 9:05 p.m. on the arm-right11/18/2025 at 8:47 p.m. on the arm-rightDuring a review of Resident 11's Location of Administration Report from 11/1/2025 to 11/30/2025, indicated insulin lispro injection solution 100 unit/ml was administered on:11/2/2025 at 5:26 p.m. on the arm-right11/3/2025 at 5:54 a.m. on the arm-right11/3/2025 at 5:48 p.m. on the arm-right11/4/2025 at 6:32 a.m. on the arm-right11/4/2025 at 5:30 p.m. on the arm-right11/5/2025 at 6:03 a.m. on the arm-right11/8/2025 at 11:51 a.m. on the arm-right11/9/2025 at 5:33 a.m. on the arm-right11/10/2025 at 6:53 a.m. on the arm-right11/13/2025 at 7:35 a.m. on the arm-right11/13/2025 at 10:26 p.m. on the arm-right11/14/2025 at 6:08 a.m. on the arm-right11/14/2025 at 8:24 p.m. on the arm-right11/15/2025 at 5:50 a.m. on the arm-right11/16/2025 at 5:40 a.m. on the arm-right11/17/2025 at 6:14 a.m. on the arm-right11/17/2025 at 6:24 p.m. on the arm-rightDuring an interview on 11/20/2025 at 9:31 a.m., with Resident 11, Resident 11 stated she preferred to receive insulin injections in her right arm, did not like injections in her abdomen and her left arm had a dialysis access site. Resident 11 stated she was not aware of the risks associated with repeated use of same site for insulin injections.During a concurrent interview and record review on 11/21/2025 at 9:53 a.m., with Licensed Vocational Nurse (LVN) 3, Resident 11's Physician Order, Medication Administration Report (MAR), and Location of Administration Report for 11/1/2025 to 11/20/2025 were reviewed. (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LVN 3 stated Resident 11 received injections to same site on multiple occasions. LVN 3 stated insulin injections should be injected to different sites because repeated injections at the same site can lead to altered subcutaneous tissue integrity, resulting in inconsistent medication absorption. b. During a review of Resident 125's admission Record (Face sheet), the admission Record indicated the facility admitted the resident on 1/2/2024 and was readmitted on [DATE], with diagnoses including type 2 diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed), and chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing).During a review of Resident 125 Minimum Data Set (MDS - a resident assessment tool), dated 11/16/2025, the MDS indicated Resident 125 had moderate impaired cognition (ability to think and understand). The MDS indicated Resident 125 needed set up or clean up assistance from staff for eating and dependent on staff for toileting hygiene and bathing.During a review of Resident 125's Physician Order dated 11/11/2025, the Physician Order indicated an order of insulin lispro injection solution 100 unit/ml, inject as per sliding scale: If 151-200=2 units; 201-250=4units; 251-300=6 units; 301-350=8 units; 351-400=10 units; If blood sugar less than 400 give 12 units and call MD, subcutaneously before meals and at bedtime for DM.During a review of Resident 125's Location of Administration Report from 11/1/2025 to 11/30/2025, indicated insulin glargine subcutaneous solution 100 units/ml was administered on:11/13/2025 at 12:36 p.m. on the abdomen-Left Upper Quadrant (LUQ)11/13/2025 at 5:31 p.m. on the abdomen-LUQ11/13/2025 at 8:08 p.m. on the abdomen-Right Lower Quadrant (RLQ)11/15/2025 at 5:33 p.m. on the abdomen-RLQ11/16/2025 at 5:42 p.m. on the abdomen-LUQ11/16/2025 at 11:02 p.m. on the abdomen-LUQDuring a concurrent interview and record review on 11/20/2025 at 11:40 a.m., with Licensed Vocational Nurse (LVN) 1, Resident 125's Physician Order, Medication Administration Report (MAR), and Location of Administration Report for 11/1/2025 to 11/20/2025 were reviewed. LVN 1 stated Resident 125 received injections to same site on multiple occasions. LVN 1 stated failure to rotate injection sites can affect the subcutaneous tissue, resulting in decreased insulin absorption and reduced effectiveness of the medication and repeated use of same site may cause tissue damage.During an interview on 11/21/2025 at 12:43 p.m., with Director of Nursing (DON), the DON stated insulin injections should follow professional standards of practice by rotating injection sites. The DON stated failure to rotate injection sites can cause bruising to the skin.During a review of facility's Policy and Procedure (P&P) titled, Insulin Administration revised 9/2014, the P&P indicated Insulin may be injected into the subcutaneous tissue of the upper arm, the anterior or lateral areas of the thighs and abdomen. Avoid the area approximately 2 inches around the navel. Injection sites should be rotated, preferably within same general area (abdomen, thigh, upper arm).		

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NAME OF PROVIDER OR SUPPLIER Pacific Palms Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1020 Termino Avenue Long Beach, CA 90804	
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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 three of 10 sampled residents (Residents 101, 55, and 113) received appropriate services to prevent a decline in range of motion (ROM, full movement potential of a joint) and mobility by failing to: 1a. Provide Resident 101 with a Physical Therapy (PT, profession aimed in the restoration, maintenance, and promotion of optimal physical function) evaluation and assessment prior to increasing the wear time for both knee splints (rigid material or apparatus used to support and immobilize a broken bone or impaired joint) from 30 minutes to two to four hours during Restorative Nursing Aide (RNA, nursing aide program that help residents to maintain their function and joint mobility) treatment. 1b. Objectively measure Resident 101's ROM in both legs during the PT Evaluation dated 7/13/2025. 2a. Objectively measure Resident 55's ROM in the right leg during the PT Evaluation dated 9/26/2025. 2b. Objectively measure Resident 55's ROM in the left hand during the Occupational Therapy (OT, rehabilitative profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities) Evaluation dated 9/26/2025. 3. Ensure Resident 113 received appropriate interventions to prevent mobility decline. These deficient practices had the potential to cause injury and pain due to ill-fitting splints for Resident 101, prevent accurate monitoring of declines in range of motion for Residents 101 and 55, and cause decline in mobility in Resident 113. Findings: 1. During a review of Resident 101's admission Record (AR), the AR indicated Resident 101 was admitted to the facility on [DATE] with diagnoses including but not limited to primary osteoarthritis (OA, a progressive disorder of the knee joint, caused by a gradual loss of cartilage) of right hip and left shoulder, polyneuropathy (damage of the nerves that can cause weakness, numbness, and burning pain), and morbid obesity due to excess calories (disorder involving excessive body fat that increases risk for health problems). During a review of Resident 101's Minimum Data Set (MDS, resident assessment tool) dated 8/20/2025, the MDS indicated Resident 101 had no cognitive impairment (mental processes involved in gaining knowledge and comprehension, includes thinking, knowing, remembering, judging, problem-solving). The MDS indicated Resident 101 required setup assistance with eating, supervision for oral hygiene, and substantial assistance for toileting hygiene, showering, lower body dressing and sit to lying. The MDS indicated Resident 101 required dependent assistance for bed to chair transfers and walking was not attempted. The MDS indicated Resident 101 did not have any functional limitations in range of motion (ROM, full movement potential of a joint) in the upper extremities (UE, shoulder, elbow, wrist/hand) and had functional limitations in ROM on both sides of the lower extremities ([NAME], hip, knee, ankle/foot). During a review of Resident 101's Care Plan Report (CP), the CP initiated 1/3/2023 and target date of 2/17/2026 indicated Resident 101 was at risk for decline in Activities of Daily Living (ADLs, routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) functions, mobility and joint mobility related to OA, severe obesity, right knee contracture (loss of motion of a joint). The CP goal indicated Resident 101 will minimize potential declines in joint mobility. The CP interventions indicated to observe for pain or joint stiffness while providing RNA/ROM, RNA to provide both knee extension splints (splints to help keep the knee in a straight position) two to four hours three times a week or as tolerated, RNA to provide both UE active assistive range of motion (AAROM, movement at a given joint with a person's own effort and assistance from an external force or another person) three times a week or as tolerated, RNA to provide both [NAME] passive range of motion (PROM, movement at a given joint with full assistance from another person) three times a week or as tolerated. 1a. During a review of Resident 101's Order Listing Report (OLR) dated 11/20/2025, the OLR indicated an order dated 7/30/2025 and discontinued on 9/23/2025 for RNA to provide both knee extension splints for 30 minutes three times a week or as tolerated. During a review of Resident 101's Restorative Assessment/Referral (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(RAR) dated 9/23/2025, the RAR indicated to discontinue the RNA order to provide both knee extension splints for 30 minutes three times a week or as tolerated. During a review of Resident 101's Order Summary Report (OSR) dated 11/20/2025, the OSR indicated an order dated 9/23/2025 for RNA to provide both knee extension splints for two to four hours three times a week or as tolerated. During a review of Resident 101's RAR dated 9/23/2025, the RAR indicated for RNA to provide both knee extension splints for two to four hours three times a week or as tolerated. During an observation and interview on 11/18/2025 at 10:35 a.m. in Resident 101's room, Resident 101 was lying in bed to the left side. Resident 101's knees were bent and rotated to the left side. Resident 101 stated she was supposed to have splints on her legs and staff put on the splints about 40 minutes at a time. During an observation and interview on 11/20/2025 at 9:47 a.m., RNA 1 performed Resident 101's RNA treatment in Resident 101's room. Resident 101 was lying in bed and was able to move both arms up and down. Resident 101 knees were bent all the way and rotated to the left side. RNA 1 attempted to lift Resident 101's right leg up but Resident 101 refused and stated it was painful. Resident 101 was able to move the left knee from the bent position and straighten the knee a little. RNA 1 put on both knee splints that were black and had dials on the side of the knee brace. The right knee brace dial was not next to the right knee and was lower next to the calf for the right leg. RNA 1 stated it was tricky to put on both knee splints. RNA 1 stated Resident 101 wore the knee brace for usually about an hour. During an interview and record review on 11/20/2025 at 10:56 a.m., the Occupational Therapist (OT 1) stated therapy staff was the profession that had the training and education to evaluate and assess whether a splint or brace was appropriate, including establishing a safe and tolerable splint wear time for each resident. OT 1 stated during therapy treatment sessions, the therapist will trial a splint and slowly increase the wear time to assess how long a resident was able to tolerate the splint. OT 1 stated it was important for a therapist to assess and slowly increase splint wear time, because the splint can be painful or cause changes in skin integrity if the splint was not fitted correctly. During the same interview and record review, OT 1 reviewed Resident 101's medical records and stated Resident 101 had an order dated 9/23/2025 for RNA to put on both knee extension splints for two to four hours three times a week. OT 1 reviewed Resident 101's PT records and indicated Resident 101's PT evaluation dated 7/13/2025 did not indicate any goals related to knee splints. OT 1 reviewed PT treatment records from 7/13/2025 to 7/23/2025 and PT Discharge summary dated [DATE] and indicated there were no PT treatment notes indicating PT addressed the knee splint or worked on increasing wear time for both knee splints. OT 1 reviewed Resident 101's PT records and stated Resident 101 did not receive any further PT treatment after Resident 101 was discharged from PT on 7/23/2025. During an interview and record review on 11/20/2025 at 2:34 p.m., OT 1 reviewed Resident 101's Restorative Assessment/Referral (RAR) forms dated 7/23/2025 and 9/23/2025 signed by OT 1 and PT 2 (who was no longer working at the facility). OT 1 stated Resident 101's RAR dated 9/23/2025 indicated to change Resident 101's RNA order for wearing both knee splints from 30 minutes to two to four hours three times a week. OT 1 stated there was no PT intervention or assessment on or around 9/23/2025 to safely assess Resident 101's tolerance from 30 minutes to two to four hours. OT 1 stated to increase wear time for any splint from 30 minutes to two to four hours was a lot of time and PT would need to assess and wear the knee splint first for two to four hours before an RNA order for splint wear time should be changed. OT 1 stated a therapy assessment was required first, because if a resident wore a splint for longer than a resident could safely tolerate, it could put pressure on bony prominences (where a bone is close to the surface of the skin), cause pain and a decline in skin integrity. During a phone interview on 11/20/2025 at 4:12 p.m., Physical Therapist (PT 1) stated a splint helped to prevent worsening of contractures and a lot of decision making from a therapist went into whether a splint was appropriate for each individual resident or not. PT 1 stated a therapist assessed and established a program for a splint or brace. PT 1 stated a therapist had to first establish a protocol in which the therapist assessed the type of splint was appropriate for a resident and how long to wear the splint for. PT 1 stated a therapist set up the (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	parameters for splint wear time, because the tolerance for the splint needed to be assessed such as if a resident had pain, then the splint wear time needed to be decreased. During a review of the facility's policies and procedures (P&P) revised 7/2017 titled, Resident Mobility and Range of Motion - Splinting, the P&P indicated residents with limited range of motion will receive treatment and services to increase and/or prevent a further decrease in ROM. 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. 1b. During a review of Resident 101's PT Evaluation and Plan of Treatment dated 7/13/2025, the PT Evaluation indicated Resident 101's right hip, ankle, and foot were within normal limits (WNL) and the left hip, ankle, and foot were WNL. The PT Evaluation indicated Resident 101's right knee and left knee were impaired. The PT Evaluation did not include measurements of Resident 101's knees. During a concurrent interview and record review on 11/20/2025 at 10:56 a.m. with OT 1, PT Evaluation dated 7/13/2025 was reviewed. OT 1 stated the PT Evaluation dated 7/13/2025 indicated Resident 101's both knees were impaired, but the PT Evaluation did not indicate any specific ROM measurements. OT 1 stated based on the PT Evaluation, OT 1 could not tell how impaired Resident 101's knees were. OT 1 stated it was standard of practice for therapy evaluations to include ROM assessments. OT 1 stated therapy staff needed to include objective measurements for ROM to monitor changes in the joints. During a phone interview on 11/20/2025 at 4:12 p.m., Physical Therapist (PT 1) stated a PT would assess ROM during a PT evaluation. PT 1 stated if a joint had impaired ROM, the expectation would be to document the measurements and degrees of ROM the joint had. PT 1 stated PT and OT were the only disciplines that had the education and training to provide ROM measurements at a certain joint. During a review of the facility's policies and procedures (P&P) revised 7/2017 titled, Charting and Documentation, the P&P indicated documentation in the medical record will be objective, complete, and accurate. The P&P indicated documentation of procedures and treatments will include care-specific details including assessment data. During a review of the facility's policies and procedures (P&P) revised 7/2017 titled, Resident Mobility and Range of Motion - Splinting, the P&P indicated residents with limited range of motion will receive treatment and services to increase and/or prevent a further decrease in ROM. 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. 2. During a review of Resident 55's admission Record (AR), the AR indicated Resident 55 was admitted to the facility on [DATE] with diagnoses including but not limited to parkinsonism (a group of conditions that cause movement problems), anxiety disorder, muscle wasting and atrophy (gradual decline). During a review of Resident 55's Physician Progress Notes dated 6/27/2025, the Physician Progress Notes indicated Resident 55 had the capacity to understand and make decisions. During a review of Resident 55's Minimum Data Set (MDS, resident assessment tool) dated 8/12/2025, the MDS indicated Resident 55 had moderate cognitive impairment (mental processes involved in gaining knowledge and comprehension, includes thinking, knowing, remembering, judging, problem-solving). The MDS indicated Resident 55 required substantial assistance for eating, oral hygiene, toileting hygiene, showering, upper body dressing. The MDS indicated Resident 55 required dependent assistance for bed to chair transfers and walking was not attempted. The MDS indicated Resident 55 had functional limitations in range of motion (ROM, full movement potential of a joint) on one side of the upper extremities (UE, shoulder, elbow, wrist/hand) and had functional limitations in ROM on both sides of the lower extremities ([NAME], hip, knee, ankle/foot). During a review of Resident 55's Care Plan Report (CP), the CP initiated 9/25/2025 and target date of 2/9/2026 indicated Resident 55 was noted with decrease in ROM to both UE and both [NAME]. The CP goal indicated Resident 55 will not have further decrease in ROM to BUE and BLE by next review date, will show improvement. The CP interventions indicated for PT/OT as ordered. During a review of Resident 55's Occupational Therapy Evaluation and Plan of Treatment dated 9/26/2025, the OT Evaluation indicated Resident 55 had impaired ROM in the left index finger, middle finger, ring finger, and little (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	finger. The OT Evaluation did not include measurements of Resident 55's left finger joints. During a review of Resident 55's Physical Therapy Evaluation and Plan of Treatment dated 9/26/2025, the PT Evaluation indicated Resident 55 had impaired ROM in the right ankle. The PT Evaluation did not include measurements of Resident 55's right ankle. During an observation and interview on 11/18/2025 at 9:26 a.m., Resident 55 was lying in bed with head of bed up about halfway. Resident 55 stated he received exercises for his arms and legs five days a week. Resident 55 was able to lift both arms to about shoulder level and open both fingers a little. Resident 55's left and right ring and little fingers were slightly bent at two joints closer to fingertips and could not fully straighten his fingers. Resident 55 was able to move both legs a little and both ankles were pointed away from the body. Resident 55 was able to move both ankles a little. During a concurrent interview and record review on 11/20/2025 at 10:56 a.m. with Occupational Therapist (OT 1), Resident 55's OT Evaluation dated 9/26/2025 and PT Evaluation dated 9/26/2025 were reviewed. OT 1 stated Resident 55's OT Evaluation dated 9/26/2025 indicated Resident 55's left fingers were impaired, but the OT Evaluation did not indicate any specific ROM measurements. OT 1 stated based on the OT Evaluation, OT 1 could not tell how impaired Resident 55's left fingers were. OT 1 stated Resident 55's PT Evaluation dated 9/26/2025 indicated Resident 55's right ankle was impaired, but the PT Evaluation did not indicate any specific ROM measurements. OT 1 stated based on the PT Evaluation, OT 1 could not tell how impaired Resident 55's right ankle was. OT 1 stated it was standard of practice for therapy evaluations to include ROM assessments. OT 1 stated therapy staff needed include objective measurements for ROM to monitor changes in the joints. During a phone interview on 11/20/2025 at 4:12 p.m. Physical Therapist (PT 1) stated a PT would assess ROM during a PT evaluation. PT 1 stated if a joint had impaired ROM, the expectation would be to document the measurements and degrees of ROM the joint had. PT 1 stated PT and OT were the only disciplines that had the education and training to provide ROM measurements at a certain joint. During a review of the facility's policies and procedures (P&P) revised 7/2017 titled, Charting and Documentation, the P&P indicated documentation in the medical record will be objective, complete, and accurate. The P&P indicated documentation of procedures and treatments will include care-specific details including assessment data. 3. During a review of Resident 113's admission Record, the admission Record indicated Resident 113 was initially admitted to the facility 6/16/2025 with diagnoses including Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), difficulty in walking, and pressure induced deep tissue damage (discolored skin over a bony prominence caused by prolonged pressure) of sacral (base of the spine) region. During a review of Resident 113's History and Physical (H&P), dated 6/19/2025, the H&P indicated Resident 113 had the capacity to understand and make decisions. During a review of Resident 113's MDS, dated [DATE], the MDS indicated Resident 113's cognitive (ability to learn, reason, remember, understand, and make decisions) ability was intact, required setup assistance when eating and oral hygiene, required for upper body dressing, moderate assistance (helper does less than half the effort) for toileting and lower body dressing, and required maximal assistance (helper does more than half the effort) for bathing. During an interview on 11/18/2025 at 10:01 a.m. with Resident 113, Resident 113 stated they used to walk with a walker with the staff, and but has gotten weaker and does not walk with the staff anymore. During a review of Resident 113's physician orders, the orders indicated: 6/26/2025 - 11/4/2025 Restorative Nursing Aide (RNA) to provide ambulation program with front wheel walker (FWW) 3x/week or as tolerated and document walking distance 11/4/2025 RNA to provide bilateral (both) upper extremity (BUE)/Bilateral lower extremity (BLE) active range of motion (AROM- resident can move independently with instruction) 3x/week or as tolerated. During a concurrent interview and record review on 11/19/2025 at 2:21p.m. with Restorative Nursing Aide (RNA a specialized Certified Nursing Assistant who supports residents in regaining or maintaining physical function) RNA 1, Resident 113's daily and weekly RNA documentation from June 2025 to November 2025 was reviewed. RNA 1 stated the daily documentation indicated: In July 2025, Resident 113 ambulated 150 feet (ft- a unit of (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	measurement of distance) with the RNA every week The week of 8/3/2025 - 8/9/2025, Resident 113 ambulated 80 ft with the RNA The week of 8/10/2025 - 8/16/2025, Resident 113 ambulated 40 ft with the RNARNA 1 stated if a resident refuses or there are changes such as a decline, the RNA reports the change to the Licensed Vocational Nurse (LVN) or the Director of Nursing (DON) who would report it to the physician. RNA 1 stated During a concurrent interview and record review on 11/21/2025 at 10:07 a.m. with the Minimum Data Set Coordinator (MDSC), Resident 113's medical record was reviewed. The MDSC stated the physician was notified on 10/20/2025 that Resident 113 had lower back pain and right leg weakness and was notified on 10/24/2025 that Resident 113 refused to ambulate. The MDSC stated The MDSC stated if a resident's ambulation declines from 150 ft to less than 100 ft, it should be communicated to the physician. During a concurrent interview and record review on 11/21/2025 at 11:27 a.m. with LVN 1, Resident 113's medical record was reviewed. LVN 1 stated if there is a decrease in distance ambulated, they would expect the RNA to report the change to the LVN who would initiate a Change of Condition (COC) and notify the physician. LVN 1 stated they would have expected the physician to be notified by 8/11/2025 when the distance ambulated was trending down. During an interview on 11/21/2025 at 1:44 p.m. with the Director of Rehabilitation (DOR), the DOR stated any concerns or decline in resident ambulation should be discussed in the weekly RNA meetings which include the RNA's, the DON, and the DOR. During an interview on 11/21/2025 at 3:00 p.m. with the Director of Nursing (DON), the DON stated it is important to notify the physician when there is a change of condition such as a decline in ambulation so the provider is aware of the resident's condition, and so that the resident gets proper evaluation and treatment. During an interview on 11/21/2025 at 4:17 p.m. with the Medical Director (MD), the MD stated, in general, if there is a decline in ambulation the facility should notify the provider, and the provider would usually recommend a physical therapy evaluation. During a review of the facility's policy and procedure (P&P), titled Change in a Resident's Condition or Status, revised December 2016, the P&P indicated The nurse will notify the residents attending physician or physician on call when there has been a: .d. significant change in the residence physical/emotional/mental condition.f. Refusal of treatment or medication two or more consecutive times. During a review of the facility's policies and procedures (P&P) revised 7/2017 titled, Resident Mobility and Range of Motion - Splinting, the P&P indicated residents with limited range of motion will receive treatment and services to increase and/or prevent a further decrease in ROM. 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.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to monitor the urine (liquid waste product made by the kidneys, stored in the bladder, and expelled from the body through the urethra) output for two out of two sampled Residents (Resident 15 and Resident 121) who had indwelling urinary catheters (a thin tube inserted into the bladder to drain urine continuously into a collection bag). This deficient practice had the potential to cause a delay in addressing Resident 15 and Resident 121's overall hydration status (the process of replenishing water in the body), kidney function (how well the kidneys are working), and fluid balance (the body's regulation of fluid intake versus output to maintain stable hydration and electrolyte levels for essential bodily functions) issues. Findings: A. During a review of Resident 15's admission Record, the admission record indicated Resident 15 was admitted to the facility 9/22/2025 with diagnoses of history of malignant neoplasm (cancerous tumor) of the large intestine, type 2 diabetes (your body does not use insulin properly, leading to high blood sugar) and presence of urogenital implants (injections of material into the wall of the urethra to help control urine leakage [urinary incontinence] caused by a weak urinary sphincter). During a review of Resident 15's Order Summary Report, the Order Summary Report indicated a physician's order was placed 9/23/2025 for an indwelling catheter to gravity drainage (a method that uses natural gravity to move fluids (urine)). During a review of Resident 15's Minimum Data Set (MDS, a resident assessment tool) dated 9/25/2025, the MDS indicated Resident 15 had moderate cognitive impairment (a stage of decline in cognitive abilities like memory and thinking that is more significant than normal aging). During an observation on 11/20/2025 at 8:16 a.m., Resident 15 was noted to have an indwelling urinary catheter draining pale yellow liquid. B. During a review of Resident 121's admission Record, the admission Record indicated Resident 121 was initially admitted on [DATE] and was readmitted on [DATE] with diagnoses including chronic kidney disease (involves a gradual loss of kidney function [kidneys filter wastes and excess]), benign prostatic hyperplasia (a condition in which the prostate gland becomes very enlarged and may cause problems associated with urination), and presence of urogenital implants (injections of material into the wall of the urethra to help control urine leakage [urinary incontinence] caused by a weak urinary sphincter). During a review of Resident 121's MDS, dated [DATE], the MDS indicated Resident 121 had severe cognitive impairment. The MDS indicated Resident 121 was dependent on staff for all Activities of Daily Living (activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 121's Admit/RE-Admit Nursing Evaluation, dated 11/12/2025 at 10:30 p.m., the evaluation indicated Resident 121 had a foley catheter (medical device that helps drain urine from your bladder) in place. During a concurrent interview and record review on 11/20/2025 at 3:45 p.m., with Registered Nurse Supervisor (RNS) 2, Resident 15 and 121's medical records were reviewed and there was no record of foley output being recorded. RNS 2 stated the facility does not measure or record foley catheter (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	urinary output but it was a good idea to record the output to make sure the residents did not have any complications. During an interview on 11/21/2025 at 3:37 p.m. with the Director of Nursing (DON), the DON stated foley catheter output was not measured unless there was a physician order. The DON stated measuring the output was important to prevent dehydration. During a review of the facility's policy and procedure (P&P) titled, Catheter Care, Urinary revised 9/2014, the P&P indicated: 1) The purpose of this procedure was to prevent catheter-associated urinary tract infections. 2) Maintain an accurate record of the residents' daily output, per facility policy and procedure.		

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NAME OF PROVIDER OR SUPPLIER Pacific Palms Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1020 Termino Avenue Long Beach, CA 90804	
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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 gastrostomy tube (GT - an opening to the stomach from the abdominal wall made surgically for the introduction of food) feeding formula was provided and documented as physician ordered for two of three sampled residents (Resident 28 and Resident 2). This failure had the potential to result in Resident 28 and Resident 2 receiving inaccurate amounts of GT feeding formula that could lead to unintended weight loss. Findings:a. During a review of Resident 28's admission Record, the admission Record indicated Resident 28 was admitted on [DATE] with diagnoses including dysphagia (difficulty swallowing), 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 cerebral infarction (loss of blood flow to a part of the brain) affecting left side of body. During a review of Resident 28's History and Physical (H&P), dated 9/6/2025, the H&P indicated, Resident 28 was alert and cooperative. During a review of Resident 28's Minimum Data Set (MDS - a resident assessment tool), dated 10/30/2025, the MDS indicated Resident 28 required dependent assistance (Helper does all of the effort) from two or more staff for transfer, hygiene, shower, maximal assistance (Helper does more than half the effort) from one staff for dressing, and moderate assistance (Helper does less than half the effort) from one staff for bed mobility. During an observation on 11/18/2025, at 11:37 a.m., in Resident 28's room, Resident 28's GT formula was dated as 11/18/2025, at 1:30 a.m. and the feeding pump was turned off. During an observation on 11/19/2025, at 2:52 p.m., in Resident 28's room, Resident 28's GT formula was dated as 11/19/2025, at 6:45 a.m. and the feeding pump was turned on. During a concurrent interview and record review on 11/19/2025, at 3:02 p.m., with Licensed Vocational Nurse (LVN) 7, Resident 28's Order Summary Report (OSR), dated 11/19/2025 was reviewed. The OSR indicated, give GT feeding with Jevity (GT feeding formula with high protein and high fibers) 1.5 at 60 cubic centimeter (cc) per hour for 20 hours to provide 1200 cc or 1800 kilocalorie (Kcal) per day. The OSR indicated, start the GT feeding at 2 p.m. till dose is completed via enteral (feeding) pump was ordered on 9/29/2025. LVN 7 stated, the label Resident 28's feeding that indicated the starting date and time of feeding formula should reflect 2 p.m. as the physician ordered. LVN 7 stated, it was important to start the feeding at 2 p.m., as ordered to ensure Resident 28 received the 1200 cc of formula per day. LVN 7 stated, the staff should have changed all tubing of the GT feeding and started a new container of GT feeding formula at 2 p.m. LVN 7 stated facility staff should document the amount of GT feeding delivered every shift to ensure 1200 cc was delivered as ordered without delays due to interruptions in administering the GT feeding due to providing hygiene care and re positioning Resident 28. During a concurrent interview and record review on 11/20/2025, at 3:52 p.m., with the Director of Nursing (DON), Resident 28's Medication Administration Record (MAR), dated 11/2025 was reviewed. The MAR indicated, there was no documentation of the amount of nutrition delivered per shift or per day. The DON stated, the nursing staff should have provided, and documented prescribed amount of GT feeding formula. The DON stated, there was no documentation regarding the amount of the GT feeding delivered. The DON stated, there could be delays due to hygiene care and therapy sessions, but this should have been communicated between the staff to ensure delivery of 1200 cc as prescribed.b. During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was initially admitted on [DATE] and was readmitted on [DATE] with diagnoses including dysphagia (difficulty swallowing), 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 cerebral infarction (loss of blood flow to a part of the brain). During a review of Resident 2's History and Physical (H&P), dated 7/11/2025, the H&P indicated, Resident 2 did not have the capacity (ability) to understand and make decisions. During a review of Resident 2's MDS, dated [DATE], the (continued on next page)		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	MDS indicated Resident 2 required dependent assistance (Helper does all of the effort) from two or more staff for transfer, hygiene, shower, dressing, and bed mobility. During an observation on 11/18/2025, at 2:20 p.m., in Resident 2's room, Resident 2's GT formula was dated as 11/17/2025, and started at 7:30 a.m., the feeding pump was turned on. During an observation on 11/19/2025, at 2:57 p.m., in Resident 2's room, Resident 2's GT formula was dated as 11/19/2025, and started at 6 p.m., and the feeding pump was turned on. During a concurrent interview and record review on 11/19/2025, at 3:08 p.m., with LVN 7, Resident 2's OSR, dated 11/19/2025 was reviewed. The OSR indicated, give GT feeding with Diabetisource (GT feeding formula for controlling blood sugar) 1.2 at 60 cc per hour for 20 hours to provide 1200 cc or 1440 kilocalorie (Kcal) per day. The OSR indicated, starting the GT feeding at 2 p.m. to 10 a.m. or until dose is completed via enteral pump (feeding pump) was ordered on 9/27/2025. LVN 7 stated, new GT feeding formula should be hung at 2 p.m. and the label should be reflected at 2 p.m. as ordered. LVN 7 stated, all tubing should be changed when the formula was newly hung at 2 p.m. During an interview on 11/20/2025, at 3:14 p.m., with the Minimum Data Set Coordinator (MDSC), the MDSC stated, Resident 28 and Resident 2's GT feeding should be changed and dated 2 p.m. daily per physician's order. The MDSC stated, the nursing staff should have followed the physician's order to start new formula at 2 p.m. daily to ensure accurate amount of GT feeding formula being delivered as ordered. The MDSC stated, the amount delivered should be documented to ensure delivery of the prescribed amount of the feeding formula to prevent weight loss. During a concurrent interview and record review on 11/20/2025, at 3:55 p.m., with the Director of Nursing (DON), Resident 2's MAR, dated 11/2025 was reviewed. The MAR indicated, there was no documentation of the amount delivered per shift or per day. The DON stated, if the nursing staff did not provide GT feeding as ordered, the residents might not get the amount as prescribed and might be at risk for weight loss. During a review of the facility's Policy and Procedure (P&P) titled, Enteral Tube Feeding via Continuous Pump, revised 3/2015, the P&P indicated, Initiate Feeding .5. On the formula label document initials, date and time the formula was hung/ administered, and initial that the label was checked against the order . Documentation: The person performing this procedure should record the following information in the resident's medical record. 1. The date and time the procedure was performed .4. Amount and type of enteral feeding .7. All assessment data obtained during the procedure. During a review of the facility's Policy and Procedure (P&P) titled, Enteral Nutrition, revised 1/2014, the P&P indicated, Policy Statement: Adequate nutritional support through enteral feeding will be provided to residents as ordered.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of two resident's (Resident 20) Bilevel positive airway pressure ([BIPAP] type of noninvasive ventilation that helps you breathe) machine was maintained as indicated in facility policy and indicated in the BIPAP User Guide. The deficient practices had the potential to result in serious health risks such as bacterial growth and infection and potential damage to the device. Findings: During a review of Resident 20's admission Record, the admission Record indicated Resident 20 was readmitted on [DATE] with diagnoses including chronic obstructive pulmonary disease ([COPD] a chronic lung disease causing difficulty in breathing) and chronic respiratory failure (condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body). During a review of Resident 20's Minimum data Set ([MDS] a resident assessment tool), dated 9/26/2025, the MDS indicated Resident 20 had intact cognition (ability to make decisions of daily living). The MDS indicated Resident 20 needed set up assistance when eating, supervision with oral hygiene, partial assistance (helper does less than half the effort) with personal hygiene, and substantial assist (helper does more than half the effort) with toileting hygiene. During a review of Resident 20's Order Summary Report, the report indicated, starting on 4/18/2025, BIPAP machine use starting at 8 p.m. and off at 7 a.m. every evening and night shift. During a concurrent observation and interview on 11/18/2025 at 12:37 p.m., at Resident 20's bedside, Resident 20's BIPAP machine was observed with water still in the humidifier canister. Licensed Vocational Nurse (LVN) 4 stated the water the staff used for the machine was purified water (water which may contain trace amounts of minerals or dissolved gases, unlike distilled water which removes nearly all impurities through evaporation and condensation). During a concurrent interview and record review on 11/20/2025 at 10:10 a.m., with Registered Nurse Supervisor (RNS) 2 Resident 20's physician orders and Medication and Treatment Administration records, dated 4/2025 to 11/2025, were reviewed. RNS 2 stated BIPAP machine, masks, tubing care and maintenance were not completed. During an interview on 11/20/2025 at 3:53 p.m. with the Director of Nursing (DON), the DON stated if BIPAP machine, masks, tubing care and maintenance was not documented it was not done. During a review of the facility's policy and procedure (P&P) titled, CPAP/BIPAP Support, revised 3/2015, the P&P indicated the policy was to promote resident safety. The P&P indicated specific cleaning instructions are obtained from the manufacturer/supplier of the device. The P&P general guidelines for cleaning, include: 1. Machine cleaning: Wipe machine with warm, soapy water and rinse at least once a week and as needed. 2. Humidifier (if used): a. Use clean, distilled water only in the humidifier chamber. b. Clean humidifier weekly and air dry. c. To disinfect, place vinegar-water solution (1:3) in clean humidifier. Soak for 30 minutes and rinse thoroughly. 3. Replace disposable filters monthly. 4. Masks, nasal pillows and tubing: Clean daily by placing in warm, soapy water and soaking/agitating for 5 minutes. Mild dish detergent is recommended. Rinse with warm water and allow it to air dry between use. 5. Headgear (strap): Wash with warm water and mild detergent as needed. Allow to air dry. During a review of Resident 20's BIPAP User manual, undated, the User guide indicated the following: 1. Regularly clean and check for damages the tubing assembly, humidifier and mask to receive optimal therapy and to prevent the growth of germs that can adversely affect your health. 2. Clean the humidifier and tubing device weekly. 3. Empty the humidifier daily and wipe it thoroughly with clean, disposable cloth and air dry. 4. Replace the air filter at least every 6 months or as needed. During a review of the guide titled, Looking after your CPAP gear, A guide to cleaning, maintenance and ongoing care, 2023, the guide indicated keeping the CPAP mask clean was key to ensuring that it fits and seals well. The guide indicated cleaning the mask cushion and tubing daily and the mask frame and headgear weekly. The guide indicated replacing the foam mask cushions a monthly.		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one out of one sampled Certified Nursing Assistant (CNA) 3 was competent and knowledgeable with a pureed (foods that are blended, mashed, or whipped to a smooth, lump-free, pudding-like consistency, which is easier to swallow and does not require chewing) texture diet when passing the meal tray to Resident 13. This deficient practice had the potential for Resident 13 to aspirate (when something other than air gets into your airways) or for Resident 13 to lose weight because she was provided with a diet not consistent with her physician's orders. Findings: During a review of Resident 13's admission Record, the admission Record indicated Resident 13 was admitted to the facility on [DATE] with diagnoses of hemiplegia (unable to move one side of the body) and a contracture (a permanent tightening of muscles, tendons, or skin that causes joints to become stiff and short, restricting movement) of the left hand. During a review of Resident 13's Minimum Data Set (MDS, a resident assessment tool) dated 9/11/2025, the MDS indicated Resident 13 had severe cognitive impairment (a significant loss of mental ability, such as memory, thinking, and reasoning, that prevents a person from living independently and often requires substantial supervision) and had an impairment on one upper extremity (left). The MDS indicated Resident 13 was receiving a mechanically altered (change in texture of food) and therapeutic diet (a meal plan designed to treat a medical condition by controlling specific nutrients, textures, or calories). During a review of the facility's Diet Type Report dated 11/20/2025, Resident 13 had a current physician's order for a fortified (adding extra vitamins, minerals, protein, or calories to foods to increase their nutritional content) pureed (foods that are blended, mashed, or whipped to a smooth, lump-free, pudding-like consistency, which is easier to swallow and does not require chewing) diet. During an observation on 11/20/2025 at 8:01 a.m., Resident 13 was sat up in bed, the meal tray was set up and placed in front of her by Certified Nursing Assistant (CNA) 3. Resident 13's meal tray contained eggs that were scrambled but not pureed. During an interview on 11/20/2025 at 12:23 p.m., CNA 3 stated she set up the meal tray this morning for Resident 13 and described Resident 13's eggs on the meal tray as soft, looked like normal scrambled eggs but they were not pureed. CNA 3 stated Resident 13 was on a puree diet. CNA 3 stated the process for serving meal trays was for nursing staff (licensed nursing staff) to check the trays compared to the orders then when the trays are ready, the CNAs pass the trays verifying the tray against the meal ticket, set up the tray and open everything for the residents. During an interview on 11/20/2025 at 12:55 p.m., [NAME] (CK) 1 stated a puree diet had to be completely smooth and no chunks so the residents would not choke. CK 1 stated that morning they served scrambled eggs with cheese sprinkled on top and if it was a puree plate it would have been very smooshed and not look the same as regular scrambled eggs. CK 1 stated it was important to follow the physician's diet order for patient safety. CK 1 stated after the meal was plated and placed on the meal carts, the meal cart is sent to the nursing unit where nursing staff was supposed to verify the diet provided matched the physician's order for a second check because everyone makes mistakes. That second check was supposed to keep the improper diet from reaching the resident. During a concurrent interview and record review on 11/21/2025 at 8:37 a.m., Registered Nurse Supervisor (RNS) 4 stated he reviewed Resident 13's Nurses Progress Notes for 10/31/2025, the day the Dentist recommended Resident 13's previous diet be discontinued (minced and moist diet (a texture-modified diet where all foods are chopped or mashed into soft, moist, small pieces, typically no larger than 4mm wide for adults, and must be easy to swallow with little to no chewing)) and changed to the puree diet due to Resident 13's dental status. RNS 4 stated it was very risky to serve the improper diet to the residents because there was a risk for aspiration. During an interview on 11/21/2025 at 3:37 p.m., the Director of Nursing (DON) stated if a resident was provided with the incorrect diet consistency, the resident may (continued on next page)		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not be able to swallow the food correctly. The DON stated the CNA role while passing meal trays was to ensure the resident was getting the proper diet. The DON stated the CNA was supposed to make sure the meal ticket matched the diet the patient received. During a review of the facility's Certified Nursing Aide Job Description undated, the job description indicated it was part of the CNAs job duty to serve food and nourishments.		

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on interview and record review, the facility failed to ensure [NAME] (CK) 1 was competent in preparing pureed (foods that are blended, mashed, or whipped to a smooth, lump-free, pudding-like consistency, which is easier to swallow and does not require chewing) scrambled eggs and oatmeal. As a result of this deficient practice 27 residents who were on a puree diet were placed at risk for receiving eggs and oatmeal that were not completely smooth and without lumps which could lead to aspiration (when something other than air gets into your airways). Findings: During a review of the facility's Recipe titled, Pureed Eggs by Healthcare Menus Direct, LLC. 2025, the recipe indicated to prepare eggs per recipe for eggs) and then puree the eggs on low speed (food processor or blender) to a paste consistency before adding any liquid then gradually add warm milk. The finished puree item should be smooth and free of lumps, hold its shape, while not being too firm or sticky. During a review of the facility's Recipe titled, Pureed Hot Cereal (Hot Cereal of Choice i.e. Oatmeal) by Healthcare Menus Direct, LLC. 2025, the recipe indicated to prepare the hot cereal as usual, puree the hot cereal and gradually add warm milk until the hot cereal was smooth and free of lumps. During an interview on 11/20/2025 at 12:55 p.m., CK 1 stated pureed foods needed to be smooshed and free of lumps. CK 1 stated when he prepared scrambled eggs with cheese that morning he did not put the eggs in the food processor or blender and just mashed them up by hand and for the oatmeal, he just prepared it as usual without any modification. CK1 stated to be honest they never puree the oatmeal, it is very liquidy and they have not had any problems up to this point. CK 1 stated while preparing food he was supposed to check the spreadsheet for the meal of the day versus the recipe to ensure it was the correct texture. CK1 stated it was important to follow the physician's order for food texture for the resident's safety. During an interview on 11/21/2025 at 10:33 a.m., the Dietary Supervisor (DS) stated she expected her cooks to prepare the proper food texture according to the recipe and pureed foods should be put in the blender or food processor to ensure the texture was smooth and free of lumps. The DS stated she spoke with CK 1 and he confirmed he was not pureeing the oatmeal and mashed the scrambled eggs by hand on 11/20/2025. The DS stated that was incorrect and a food processor or blender should have been utilized. The DS stated it was important to prepare the proper consistency because it placed the residents at risk for choking. During a review of the facility's Job Description: Dietary [NAME] dated 3/8/2025, the job description indicated the cook was to prepare meals and cook food according to standardized recipes and special diet orders.		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to serve food that was at the correct temperature to one of three sampled residents (Resident 131). This deficient practice had the potential to result in loss of appetite and cause unplanned weight loss. Findings: During a review of Resident 131's admission Record, the admission Record indicated Resident 131 was admitted to the facility on [DATE] with diagnoses including hypoglycemia (low blood sugar), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), gastroesophageal reflux disease (digestive disorder most often causes a burning and sometimes squeezing sensation in the mid-chest), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 131's Admit/Re-Admit Nursing Evaluation, dated 11/10/2025, the Evaluation indicated Resident 131 was alert and oriented. The Evaluation indicated Resident 131 needed assistance with all Activities of daily living (activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 131's Order Summary Report, dated 11/19/2025, the report indicated, starting on 11/10/2025, a diet order for Consistent Carbohydrate (diet used for managing blood sugar in diabetics) and No Added Salt (NAS) regular texture diet. During an interview on 11/18/2025 at 10:04 a.m., with Resident 131, Resident 131 stated the food was not always delivered warm. During a concurrent observation and interview on 11/19/2025 at 6:50 a.m., at the kitchen tray line, with [NAME] 1 (CK 1), CK 1 checked the pancake temperature and stated it was 130.8 degrees Fahrenheit. During a concurrent interview and record review on 11/19/2025 at 7:00 a.m., with the Dietary Supervisor (DS), the Daily Food temperature Log and Menus for 11/2025 were reviewed. The DS stated the temperature of the pancake should have been 140 degrees Fahrenheit as indicated in the log. The DS stated that the temperature of waffles or pancakes were not checked as indicated in the log and today the temperature was below recommended temperature. During a concurrent interview and record review on 11/19/2025 at 2:00 p.m., with the Registered Dietician (RD), the Daily Food temperature Log and Menus for 11/2025 were reviewed. The RD stated the temperature of the pancake should have been 140 degrees Fahrenheit as indicated in the log. During a review of the facility policy and procedure titled, Meal Service, 2023, the policy indicated pancakes service temperature should be 140 F or higher. The policy indicated the goal was to serve hot foods hot.		

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one out of six sampled residents (Resident 13) was provided with a puree diet as ordered by the physician. This deficient practice had the potential for Resident 13 to aspirate (when something other than air gets into your airways) or for Resident 13 to lose weight because she was provided with a diet consistent with her physician's orders. Findings: During a review of Resident 13's admission Record, the admission Record indicated Resident 13 was admitted to the facility on [DATE] with diagnoses of hemiplegia (unable to move one side of the body) and a contracture (a permanent tightening of muscles, tendons, or skin that causes joints to become stiff and short, restricting movement) of the left hand. During a review of Resident 13's Minimum Data Set (MDS, a resident assessment tool) dated 9/11/2025, the MDS indicated Resident 13 had severe cognitive impairment (a significant loss of mental ability, such as memory, thinking, and reasoning, that prevents a person from living independently and often requires substantial supervision) and had an impairment on one upper extremity (left). The MDS indicated Resident 13 was receiving a mechanically altered (change in texture of food) and therapeutic diet (a meal plan designed to treat a medical condition by controlling specific nutrients, textures, or calories). During a review of the facility's Diet Type Report dated 11/20/2025, Resident 13 had a current physician's order for a fortified (adding extra vitamins, minerals, protein, or calories to foods to increase their nutritional content) pureed (foods that are blended, mashed, or whipped to a smooth, lump-free, pudding-like consistency, which is easier to swallow and does not require chewing) diet. During an observation on 11/20/2025 at 8:01 a.m., Resident 13 was sat up in bed, the meal tray was set up and placed in front of her by Certified Nursing Assistant (CNA) 3. Resident 13's meal tray contained eggs that were scrambled but not pureed. During an interview on 11/20/2025 at 12:23 p.m., CNA 3 stated she set up the meal tray this morning for Resident 13 and described Resident 13's eggs on the meal tray as soft, looked like normal scrambled eggs but they were not pureed. During an interview on 11/20/2025 at 12:55 p.m., [NAME] (CK) 1 stated a puree diet had to be completely smooth and no chunks so the residents would not choke. CK 1 stated that morning they served scrambled eggs with cheese sprinkled on top and if it was a puree plate it would have been very smooshed and not look the same as regular scrambled eggs. CK 1 stated it was important to follow the physician's diet order for patient safety. CK 1 stated after the meal was plated and placed on the meal carts, the meal cart was sent to the nursing unit where nursing staff were supposed to verify the diet provided matched the physician's order, as second verification because everyone makes mistakes. That second check was supposed to keep the improper diet from reaching the resident. During a concurrent interview and record review on 11/21/2025 at 8:37 a.m., Registered Nurse Supervisor (RNS) 4 stated he reviewed Resident 13's Nurses Progress Notes for 10/31/2025, the day the Dentist recommended Resident 13's previous diet (minced and moist diet [a texture-modified diet where all foods are chopped or mashed into soft, moist, small pieces, typically no larger than 4mm wide for adults, and must be easy to swallow with little to no chewing]) be discontinued and changed to the puree diet due to Resident 13's dental status. RNS 4 stated it was very risky to serve the improper diet to the residents because there was a risk for aspiration. During an interview on 11/21/2025 at 3:37 p.m., the Director of Nursing (DON) stated if a resident was provided with the incorrect diet consistency, the resident may not be able to swallow the food correctly leading to negative outcomes such as aspiration. During a review of the facility's policy and procedure (P&P) titled Therapeutic Diets revised a November 2015, the P&P indicated diets must be prescribed by the resident's attending physician and the food services manager would develop a tray identification system to ensure each resident received his or her diet as ordered.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to store and prepare food under safe and sanitary conditions in one of one kitchen, by failing to: a) Ensure no staff personal belongings were in the kitchen preparation area. b) Ensure the sanitizer bucket was not in the food preparation sink while food was being prepared. c) Ensure the pancake, breakfast meat, and waffles holding temperature (temperature at which food is kept) on the steam table (specifically made for holding prepared foods at a consistent temperature) were checked prior to meal service. d) Ensure the ice machine was clean. e) Ensure two of three residents' (Resident 101 and 112) refrigerated personal food items were dated on when it was opened or procured. These deficient practices had the potential to result in contamination of food items that placed residents in high risk for food borne illness (any illness resulting from eating contaminated/spoiled foods) that can lead to hospitalization and a decline in health. Findings: During a concurrent observation and interview on 11/18/2025 at 8:32 a.m., with the Dietary Supervisor (DS), in the kitchen, staff personal belongings were observed on a kitchen cart in the food preparation area. The DS stated staff's personal items do not belong in the kitchen. During an observation and interview with the Registered Dietician (RD) on 11/19/2025 at 6:45 a.m., the sink had a sign that indicated food preparation only. The food preparation sink had a red bucket labeled sanitizer. The RD stated the sanitizer should not be in the food preparation sink when food was being prepared. During an observation and interview on 11/19/2025 at 6:50 a.m., [NAME] 1 (CK 1) checked the pancake temperature and it was 130.8 degrees Fahrenheit. During an interview and record review on 11/19/2025 at 7:00 a.m., with the Dietary Supervisor (DS), the Daily Food temperature Log was reviewed, and the DS confirmed the temperature of the pancake should have been 140 degrees Fahrenheit as indicated in the log. During a concurrent observation and interview on 11/19/2025 at 8:19 a.m., with the Maintenance Supervisor (MS) the facility ice machine was observed with black colored unidentified substance on the inside of the machine. The MS stated the inside of the ice machine was dirty. During a review of Resident 101's admission Record, the admission record indicated the facility admitted Resident 101 on 12/30/2022 with the diagnosis including gastroesophageal reflux disease (digestive disorder most often causes a burning and sometimes squeezing sensation in the mid-chest). During a review of Resident 101's Minimum Data Set ([MDS] resident assessment tool), dated 8/20/2025, the MDS indicated Resident 101 had intact cognition and needed set-up assistance when eating. During a review of Resident 112's admission Record, the admission record indicated the facility admitted Resident 112 on 9/2/2025 with the diagnosis including gastroesophageal reflux disease. During a review of Resident 112's MDS, dated [DATE], the MDS indicated Resident 112 had moderate cognitive impairment and needed set-up assistance when eating. During a concurrent observation and interview on 11/19/2025 at 11:40 a.m., with the RD, the Residents refrigerator was noted with Resident 101's personal food items including an opened and undated, 8-ounce pack of sliced cheese and 16-ounce pack of deli meat. During a concurrent interview and record review on 11/19/2025 at 11:40 a.m., with the RD, the food package instructions were reviewed, and the instructions indicated the cheese slices, and the deli meat was best if used within seven days of opening. During a concurrent observation and interview on 11/19/2025 at 11:45 a.m., with the Registered Dietician (RD), the Residents' refrigerator was noted with Resident 112's box of fried chicken with food that was undated. During a concurrent interview and record review on 11/19/2025 at 2 p.m., with the RD, the menus and Food temperature Logs for 11/2/2025 to 11/19/2025 were reviewed and the logs indicated there were days that the breakfast meat, pancakes, or waffles were not checked. The RD stated prior to serving, food temperatures for pancake/toast/ breakfast meat should be checked to ensure food was warm when resident gets the food and to prevent foodborne illness. Pancake temperature should be at least 140 degrees Fahrenheit. During an (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interview on 11/19/2025 at 2 p.m. with the RD, the RD stated the following: 1. Residents' food should be dated so residents will not acquire food borne illnesses. 2. The sanitizer bucket should not be in the sink designated only for food preparation during food prepping to prevent contamination of food items.3. The ice machine should be clean to prevent infection.4. Staff personal belongings should not be in the kitchen area to prevent contamination.During a review of the facility's policy and procedure (P&P) titled, Bringing in food for a Resident, 2023, the P&P indicated food should be labeled and dated with the date food was opened to monitor for food safety.During a review of the facility's P&P titled, Food for Residents from Outside Sources, undated, the P&P indicated if food is opened, the food will be dated with the date opened and disposed of in 2 days after opening.During a review of the facility's P&P titled, Storage of Food and Supplies, 2023, the P&P indicated items such as bleach, soap and other cleaning supplies should be stored in entirely separate and specific areas. During a review of the facility's P&P titled, Employee Personal Items, 2023, the P&P indicated personal items brought in by staff from the outside will not be kept in the kitchen area.During a review of the facility's P&P titled, Ice machine Cleaning Procedures, 2023, then P&P indicated the ice machine needs to be cleaned and sanitized.During a review of the facility's P&P titled, Meal Service, 2023, the P&P indicated the staff member will take the food temperatures prior to meal service.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain accurate and complete medical records for three of nine sampled residents (Resident 13, Resident 101, and Resident 113) when: a. Restorative Nursing Aide (RNA 1) documented he provided RNA feeding program (staff provide feeding assistance) assistance to Resident 13 for two meals, when he did not. b. RNA 1 documented Resident 101 wore both knee splints (rigid material or apparatus used to support and immobilize a broken bone or impaired joint) for two hours during Restorative Nursing Aide (RNA, nursing aide program that help residents to maintain their function and joint mobility) treatment on 11/18/2025 when Resident 101 wore both knee splints for 40 minutes to one hour. c. RNA weekly documentation did not accurately reflect Resident 113's ambulation distance from 8/3/2025 - 10/4/2025. These deficient practices resulted in inaccurate medical documentation for Resident 13, Resident 113, and Resident 101 and had the potential for delayed assessment of both knee splints for Resident 101. Findings: a. During a review of Resident 13's admission Record, the admission Record indicated Resident 13 was admitted to the facility on [DATE] with diagnoses of hemiplegia (unable to move one side of the body) and a contracture (a permanent tightening of muscles, tendons, or skin that causes joints to become stiff and short, restricting movement) of the left hand. During a review of Resident 13's Minimum Data Set (MDS, a resident assessment tool) dated 9/11/2025, the MDS indicated Resident 13 had severe cognitive impairment (a significant loss of mental ability, such as memory, thinking, and reasoning, that prevents a person from living independently and often requires substantial supervision) and had an impairment on one upper extremity (left). The MDS indicated Resident 13 required supervision or touching assistance (helper provides verbal cues and/or touching/ steadying assistance during the task). During a review of Resident 13's Order Summary Report dated 11/21/2025, the Order Summary Report indicated Resident 13 had an order placed 9/30/2024 for RNA feeding program with breakfast and lunch. During an observation on 11/20/2025 at 8:01 a.m., Resident 13 was sat up in bed, the meal tray was set up and placed in front of her, but staff (unknown) did not stay with her during the meal. Resident 13 fed herself. During an observation on 11/20/2025 at 12:22 p.m., Resident 13 was feeding herself lunch. Resident 13 ate the vegetables on the plate and did not consume the meat or potatoes. RNA 1 came into the room and picked up Resident 13's meal tray. During an interview on 11/20/2025 at 2:33 p.m., the Quality Assurance Nurse (QAN) stated Resident 13 had an order for the RNA feeding program and the RNA staff were supposed to assist the resident with feeding and sit with her while she ate. The QAN stated RNA staff were not supposed to leave Resident 13 unattended until she finished her meals. The RNA staff is supposed to supervise that she was eating safely and encourage her to eat. (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/21/2025 at 10:56 a.m., RNA 1 stated he was assigned to Resident 13 the day prior (11/20/2025) for the RNA feeding program (breakfast and lunch). RNA 1 stated to be honest he only set up the meal tray for Resident 13 but then left the room because he had other residents to attend to. RNA 1 stated Resident 13 could feed herself, the staff must monitor her while she was eating. During a concurrent interview and record review on 11/21/2025 at 11:53 a.m., RNA 1 stated he reviewed Resident 13's Task Documentation for the RNA Feeding Program Task for 11/20/2025, question 1 was marked as the task was completed for breakfast and lunch and question 2 for the number of minutes spent with the resident was marked 20 minutes at both meals. RNA 1 confirmed he did not feed Resident 13 at breakfast or lunch on 11/20/2025 and he did not spend 20 minutes with the resident at mealtime. RNA 1 stated the documentation was not correct and he should not have documented something he did not do, During an interview on 11/21/2025 at 3:37 p.m., the Director of Nursing (DON) stated if a resident was on the RNA feeding program the RNA should be in the room with the resident throughout the meal. The DON stated that even though the residents were on the RNA feeding program for encouragement and queuing, the staff should still be in the room throughout the meal. The staff need to motivate the resident to eat and be there if resident needed anything. The DON stated there was a possibility for weight loss if the resident was not encouraged to eat. The DON stated if a task was not completed, then it should not have been documented as done in the resident record. The DON stated setting up the tray and taking it away was not considered completing the RNA Feeding Program Task. During a review of the facility's policies and procedures (P&P) revised 7/2017, titled, Charting and Documentation, the P&P indicated documentation in the medical record will be complete and accurate. b. During a review of Resident 101's admission Record (AR), the AR indicated Resident 101 was admitted to the facility on [DATE] with diagnoses including but not limited to primary osteoarthritis (OA, a progressive disorder of the knee joint, caused by a gradual loss of cartilage) of right hip and left shoulder, polyneuropathy (damage of the nerves that can cause weakness, numbness, and burning pain), and morbid obesity due to excess calories (disorder involving excessive body fat that increases risk for health problems). During a review of Resident 101's Minimum Data Set (MDS, resident assessment tool) dated 8/20/2025, the MDS indicated Resident 101 had no cognitive impairment (mental processes involved in gaining knowledge and comprehension, includes thinking, knowing, remembering, judging, problem-solving). The MDS indicated Resident 101 required setup assistance with eating, supervision for oral hygiene, and substantial assistance for toileting hygiene, showering, lower body dressing and sit to lying. The MDS indicated Resident 101 required dependent assistance for bed to chair transfers and walking was not attempted. The MDS indicated Resident 101 did not have any functional limitations in range of motion (ROM, full movement potential of a joint) in the upper extremities (UE, shoulder, elbow, wrist/hand) and had functional limitations in ROM on both sides of the lower extremities ([NAME], hip, knee, ankle/foot). During a review of Resident 101's Care Plan Report (CP), the CP initiated on 1/3/2023 and with a target date of 2/17/2026 indicated Resident 101 was at risk for decline in Activities of Daily Living (ADLs, routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) functions, mobility and joint mobility related to OA, severe obesity, and right knee contracture (loss of motion of a joint. The CP goal indicated Resident 101 will minimize potential (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	declines in joint mobility. The CP interventions indicated to observe for pain or joint stiffness while providing RNA/ROM, RNA to provide both knee extension splints (splints to help keep the knee in a straight position) two to four hours three times a week or as tolerated, RNA to provide both UE active assistive range of motion (AAROM, movement at a given joint with a person's own effort and assistance from an external force or another person) three times a week or as tolerated, RNA to provide both [NAME] passive range of motion (PROM, movement at a given joint with full assistance from another person) three times a week or as tolerated. During a review of Resident 101's Order Summary Report (OSR) dated 11/20/2025, the OSR indicated an order dated 9/23/2025 for RNA to provide both knee extension splints for two to four hours three times a week or as tolerated. During a review of Resident 101's November 2025 Documentation Survey Report (DSR) for RNA tasks, the DSR indicated on 11/18/2025, both knee extension splints were applied and tolerated for two hours. During an observation and interview on 11/18/2025 at 10:35 a.m. in Resident 101's room, Resident 101 was lying in bed to the left side. Resident 101's knees were bent and rotated to the left side. Resident 101 stated she was supposed to have splints on her legs and staff put on the splints about 40 minutes at a time. There were no knee splints observed on Resident 101. During an observation and interview on 11/18/2025 at 2:54 p.m. in Resident 101's room, Resident 101 was lying in bed to the left side. Resident 101's knees were bent and rotated to the left side. Resident 101 stated RNA 1 came to put on the leg splints today and Resident 101 wore the leg splints for about 40 minutes. There were no knee splints observed on Resident 101. During an interview on 11/19/2025 at 9:28 a.m. with RNA 1, RNA 1 stated he completed RNA treatment with Resident 101 yesterday 11/18/2025 and RNA 1 put on the knee splints for only 45 minutes yesterday. During an interview and record review on 11/20/2025 at 10:00 a.m. with RNA 1, RNA 1 reviewed RNA daily documentation on 11/18/2025. RNA 1 stated he documented on 11/18/2025 that Resident 101 wore and tolerated both splints for two hours. RNA 1 stated Resident 101 put on the splint for one hour, because Resident 101 could not tolerate it anymore and told RNA 1 to take off the splint. RNA 1 stated he documented two hours because that was what the order indicated. RNA 1 stated he should have documented one hour. RNA 1 stated the 11/18/2025 RNA documentation was not accurate, because the documentation did not reflect what happened during RNA treatment on 11/18/2025. RNA 1 stated staff should document accurately because the documentation showed what happened with Resident 101 and told staff how Resident 101 was progressing with wearing the knee splints. RNA 1 stated Resident 101 has not tolerated two hours of wearing the knee splints except for possibly two previous times. During an interview on 11/20/2025 at 3:52 p.m. with the Director of Nursing (DON), the DON stated the purpose of documentation was to indicate what the resident did and what happened during treatment. DON stated all documentation needed to be accurate so that whatever happened to the resident, every shift and staff member would know what happened to the resident. DON stated RNA documentation should be accurate and indicate what happened during the RNA treatment session so that if the resident could not tolerate the splint for the time ordered, RNA should let nursing and therapy staff know and have therapy look into or recommend how much a resident could tolerate the splint. (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policies and procedures (P&P) revised 7/2017, titled, Charting and Documentation, the P&P indicated documentation in the medical record will be complete and accurate. c. During a review of Resident 113's admission Record, the admission Record indicated Resident 113 was initially admitted to the facility 6/16/2025 with diagnoses including Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), difficulty in walking, and pressure induced deep tissue damage (discolored skin over a bony prominence caused by prolonged pressure)of sacral (base of the spine) region. During a review of Resident 113's History and Physical (H&P), dated 6/19/2025, the H&P indicated Resident 113 had the capacity to understand and make decisions. During a review of Resident 113's MDS, dated [DATE], the MDS indicated Resident 113's cognitive (ability to learn, reason, remember, understand, and make decisions) ability was intact, required setup assistance when eating and oral hygiene, required for upper body dressing, moderate assistance (helper does less than half the effort) for toileting and lower body dressing, and required maximal assistance (helper does more than half the effort) for bathing. During an interview on 11/18/2025 at 10:01 a.m., with Resident 113, Resident 113 stated they used to walk with a walker with the staff, and but has gotten weaker and does not walk with the staff anymore. During a review of Resident 113's physician orders, the orders indicated: 6/26/2025 &ndash; 11/4/2025 Restorative Nursing Aide (RNA) to provide ambulation program with front wheel walker (FWW) 3x/week or as tolerated and document walking distance. During a concurrent interview and record review on 11/19/2025 at 2:21p.m., with RNA 1, Resident 113's daily and weekly RNA documentation from June 2025 to November 2025 was reviewed. RNA 1 stated the Daily RNA documentation is completed daily and indicated the distance a resident ambulates in feet (ft &ndash; a unit of measurement). RNA 1 stated the Weekly RNA documentation is a summary RNA services for a week including the total distance in feet ambulated in a week. RNA 1 stated the Weekly RNA documentation indicated the week of: 8/3/2025 &ndash; 8/9/2025 Resident 113 ambulated 150 ft, the Daily RNA documentation indicated Resident 113 ambulated 80 ft 8/10/2025 &ndash; 8/16/2025 Resident 113 ambulated 150 ft, the Daily RNA documentation indicated Resident 113 ambulated 40 ft 8/17/2025 to 8/23/2025 Resident 113 ambulated 300 ft, the Daily RNA documentation indicated Resident 113 ambulated 70 ft 8/24/2025 &ndash; 8/30/2025 Resident 113 ambulated 300 ft, the Daily RNA documentation indicated Resident 113 ambulated 30 ft 9/1/2025 &ndash; 9/6/2025 Resident 113 ambulated 300 ft, the Daily RNA documentation indicated Resident 113 ambulated 30 ft (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9/7/2025 &ndash; 9/13/2025 Resident 113 ambulated 300 ft, the Daily RNA documentation indicated Resident 113 ambulated 70 ft 9/14/2025 &ndash; 9/20/2025 Resident 113 ambulated 300 ft, the Daily RNA documentation indicated Resident 113 ambulated 30 ft 9/21/2025 &ndash; 9/27/2025 Resident 113 ambulated 300 ft, the Daily RNA documentation indicated Resident 113 ambulated 30 ft 9/28/2025 &ndash; 10/4/2025 Resident 113 ambulated 300 ft, the Daily RNA documentation indicated Resident 113 ambulated 30 ft RNA 1 stated the weekly RNA documentation should accurately reflect the daily RNA documentation, but they do not match. RNA 1 stated it was important for the Weekly RNA documentation to accurately reflect the resident's status to see if the resident is improving or declining. During an interview on 11/20/2025 at 3:52 p.m. with the DON, the DON stated the purpose of documentation was to indicate what the resident did and what happened during treatment. DON stated all documentation needed to be accurate so that whatever happened to the resident, every shift and staff member would know what happened to the resident. DON stated RNA documentation should be accurate and indicate what happened during the RNA treatment session. During a review of the facility's policies and procedures (P&P) revised 7/2017, titled, Charting and Documentation, the P&P indicated documentation in the medical record will be complete and accurate.		

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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 staff failed to: a. Perform hand hygiene when entering and exiting Resident 5's room. b. Replace Resident 96's tube feeding line when it was found on the floor without a cap. c. Implement and document control measures per water management policy and procedure. d. Monitor, document, and implement contact isolation precautions (infection control measures used to prevent the spread of germs by direct contact) for Resident 131. These deficient practices had the potential to transmit infectious microorganisms (living organisms that are too small to be seen with the naked eye) and increase the risk of infection for the residents. Findings: a. During a review of Resident 5's admission Record, the admission Record indicated Resident 5 was initially admitted to the facility on [DATE] with diagnoses including hemiplegia weakness to one side of the body) and hemiparesis (inability to move one side of the body) affecting right dominant side, gastrostomy (g-tube: a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), and stiffness of right shoulder, elbow, and hand. During a review of Resident 5's History and Physical (H&P), dated 3/18/2025, the H&P indicated Resident 5 did not have the capacity to understand and make decisions. During a review of Resident 5's Minimum Data Set ([MDS] a resident assessment tool), dated 9/17/2025, the MDS indicated Resident 5's cognitive skills (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) were moderately impaired. The MDS indicated Resident 5 was dependent on chair/bed-to-chair transfer, bathing, upper (above waist) and lower (below waist) body dressing, and required maximal assistance (provide more than half the effort) for oral and personal hygiene. The MDS indicated Resident 5 had impairments on one side of the upper (arms/shoulders) and lower (hips/legs) extremities and utilized a wheelchair. During a review of Resident 5's Order Summary (physicians order) dated 11/20/2025, the Order Summary indicated there was an order dated 8/31/2025: on Enhance Barrier Precaution (EBP: infection control measure requiring staff to wear a gown and gloves during high-contact activities with residents who have a g-tube and to prevent transmission of multidrug resistant organisms (MDROs infectious microorganisms that are resistant to multiple anti-infection medications): G-tube. During a concurrent observation and interview on 11/20/2025 at 10:23 a.m., Licensed Vocational Nurse 1 (LVN 1), LVN 1 was observed not performing hand hygiene prior to entering (before wearing personal protective equipment (PPE: equipment worn to minimize exposure to hazards that can cause serious injuries and illnesses) and exiting (post PPE removal) Resident 5's room. The LVN 1 stated hand hygiene is performed before and after exiting the resident room, prior to interacting with the resident, or prior to providing treatment. The LVN 1 stated he did not do hand hygiene prior to and exiting Resident 5's room and indicated he had contact with Resident 5 when observing her abdominal binder (belt used to support the abdomen after surgery, improve physical function). The LVN 1 stated hand hygiene prevents the spread of infection and cross contamination. b. During a review of Resident 96's admission Record, the admission Record indicated Resident 96 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including hemiplegia and hemiparesis affecting left non-dominant side, gastrostomy (g-tube), and Type 2 Diabetes Mellitus (DM: a disorder characterized by difficulty in blood sugar control and poor (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	wound healing) During a review of Resident 96's H&P, dated 8/22/2025, the H&P indicated Resident 96 could make needs known but could not make medical decisions. During a review of Resident 96's MDS, dated [DATE], the MDS indicated Resident 96's cognitive skills were moderately impaired. The MDS indicated Resident 96 is dependent on all aspects of activities of daily living (ADLs: routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS indicated Resident 96 did not have any impairments on both sides of the upper and lower extremities and utilized a wheelchair and walker. During an observation on 11/19/2025 at 11:16 a.m., in Resident 96's room, the feeding tube that connected to the resident was on the floor with no cap covering the end that is connected to the resident. The tube feeding was dated 11/18/2025 at 9:20 p.m. and the fluids (water) bag was dated 11/18/2025 at 9:30 p.m. During a concurrent observation and interview on 11/19/2025 at 2:42 p.m. with the Licensed Vocational Nurse 3 (LVN 3), LVN 3 was shown what was observed on 11/19/2025 at 11:16 a.m. (feeding tube on the floor) and confirmed the current feeding observed running into Resident 96 and the feeding tube that was observed at 11:16 a.m. were the same. LVN 3 stated when she arrived at the room if she observed the tubing was on the floor, she would have to replace it to keep the resident safe as the tubing was on the floor exposed to dirt, which increases the risk of infections due to contamination. During an observation on 11/20/2025 at 9:51 a.m., Resident 96's feeding bag was dated 11/20/2025 at 12:30 a.m.(indicating the feeding was started 9 hours and 21 minutes ago). During an interview on 11/21/2025 at 12:42 p.m. with the Director of Nursing (DON), the DON stated hand hygiene should be done every time care is provided to the resident, and prior to entering and exiting the resident room to prevent infection. The DON stated if the tube feeding line is on the floor, they will replace the whole thing right away due to infection control. During a review of the facility's policy and procedure (P&P) titled, Handwashing/Hand Hygiene, revised 8/2019, the P&P indicated this facility considers hand hygiene the primary means to prevent the spread of infections. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: before and after direct contact with residents; after contact with objects (e.g., medical equipment) in the immediate vicinity of the resident; before and after entering isolation precaution settings. Hand hygiene is the final step after removing and disposing of personal protective equipment. c. During a concurrent interview and record review on 11/20/2025, at 9:56 a.m., with the Maintenance Supervisor (MS), the facility's Water Management Program Binder, dated 2025 was reviewed. The Water Management Program (comprehensive plan aimed to prevent waterborne illnesses by controlling germs in the water) Binder indicated, Residents' room water temperature was documented daily, and Boiler and water heater maintenance log was documented on 1/3/2025, 2/14/2025, 3/20/2025, 3/24/2025, 4/22/2025, 5/1/2025, 6/10/2025, 7/22/2025, 8/12/2025, 9/19/2025, 10/14/2025, and 11/12/25. The MS stated, the facility was monitoring and documenting water (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	temperature for randomly selected residents' room daily and maintenance log for Boiler and water. The MS stated, there were no other monitoring logs for control measures (actions taken to eliminate or reduce the likelihood or severity of exposure to a hazard) and limit (a specific, measurable, and quantitative range for a particular parameter that indicates when a water system is operating acceptably). The MS stated, he should have monitored and documented all control measures and limits as the policy indicated to prevent Legionella (a type of bacteria that is naturally found in [NAME] environments) outbreak (two or more linked cases of the same illness or the situation where the observed number of cases exceeds the expected number). During a concurrent interview and record review on 11/20/2025, at 10 a.m., with the Infection Preventionist Nurse (IPN), the facility's Policy and Procedure (P&P) titled, Legionella Policy: Water Management Program, undated was reviewed. The P&P indicated, Record Keeping: The following records shall be kept on file for a period of five years in a log book .Completed report sheets for: weekly flushing of infrequently used outlets, Monthly hot and cold water temperature checks including flow and return temperature, quarterly shower head cleaning, Annual domestic water tank visual inspection and cleaning, and annual calorifier visual sampling of drain valve water. The IPN stated, the water management program committee should have follow through monitoring and documenting control measures and limit to reduce and prevent the risk of getting Legionella infection. During an interview on 11/20/2025, at 3:52 p.m., with the Director of Nursing (DON), the DON stated, all control measures and limits should be monitored and documented per policy to prevent Legionella outbreak and to protect vulnerable residents. During a review of the facility's Policy and Procedure (P&P) titled, Legionella Water Management Program, revised 7/2017, the P&P indicated, Policy Statement: Our facility is committed to the prevention, detection, and control of water-borne contaminants, including Legionella. Policy Interpretation and Implementation: 3. The purpose of the water management program is to identify areas in the water system where Legionella bacteria can grow and spread, and to reduce the risk of Legionnaire's disease .5. The water management program includes the following elements .e. specific measures used to control the introduction and /or spread of legionella. f. the control limits or parameters that are acceptable and that are monitored .h. A system to monitor control limits and the effectiveness of control measures. d. During a review of Resident 131's admission Record, the admission Record indicated, Resident 1 was admitted to the facility on [DATE] with diagnoses including urinary tract infection (UTI- an infection in the bladder/urinary tract), pseudomonas infection (a group of bacteria commonly found in the environment, like in soil and water that can cause a range of infections, including lung infections) and Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 131's History and Physical (H&P), dated 11/11/2025, the H&P indicated, Resident 131 had the capacity (ability) to understand and make decisions. During a review of Resident 131's Minimum Data Set (MDS &ndash; a resident assessment tool), dated 11/17/2025, the MDS indicated Resident 131 required maximal assistance (Helper does more than half the effort) from one staff for bed mobility, bathing/shower, toilet hygiene, toilet transfer, moderated assistance (Helper does less than half the effort) from one staff for bed mobility, dressing and supervision or touching assistance (Helper provides verbal cues and/or touching/steadying and /or contact guard assistance as resident competes activity) from one staff for eating. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 11/18/2025, at 10:04 a.m. with Resident 131 in Resident 131's room, there was a signage indicated Enhanced Barrier Precaution [EBP-an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes] near the entrance of Resident 131's room. Resident 131 stated, she was recently diagnosed with clostridium difficile (C. diff- a highly contagious bacteria that causes severe diarrhea) and still having active diarrhea even this morning. Resident 131 stated, she had few episodes of diarrhea on 11/16/2025 and 11/17/2025 as well. Resident 131 stated, her nurse gave her the medication to stop diarrhea, but she still having diarrhea due to antibiotics (medicines that fight bacterial infections in people and animals) use for her UTI. During a concurrent observation and interview on 11/19/2025, at 9:20 a.m., with House Keeping Staff (HKS) 1, in a hallway near Resident 131's room, HKS 1 came out of Resident 131's room and did not perform hand hygiene. HKS 1 stated, she did not wash her hand because she just went in to check for trash can. HKS 1 stated, she should have washed her hands regardless she touched objects or not to prevent spreading infection. During an interview on 11/19/2025, at 9:27 a.m., with Certified Nurse Assistant (CNA) 5, CNA 5 stated, Resident 131 was on EBP that required to wear personal protective equipment (PPE - clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) and hand hygiene with hand sanitizer. CNA 5 stated, hand washing with soap and water was not required for after caring Resident 131. CNA 5 stated, Resident 131 had diarrhea this morning and did not know if Resident 131 was having active C-diff infection. During a concurrent interview and record review on 11/19/2025, at 3:35 p.m., with the Infection Preventionist Nurse (IPN), Resident 131's Order Summary Report (CSR), dated 11/19/2025 was reviewed. The CSR indicated, contact isolation precaution (intended to prevent transmission of infectious agents which are spread by direct or indirect contact with the person or the person's environment) due to stool C-diff was ordered 11/14/2025. The IPN stated, Resident 131 was admitted to the facility on [DATE] and was not on contact isolation until 11/14/2025. The IPN stated, Resident 131 was having diarrhea upon admission and stool sample for C-diff was collected on 11/11/2025. The IPN stated, Resident 131 should have placed the contact isolation precaution while waiting for stool C-diff testing result to reduce the risk of spreading infection. During a concurrent interview and record review on 11/19/2025, at 3:45 p.m., with the IPN, Resident 131's Nurse Practitioner (NP-an advanced practice registered nurse who serve as primary and specialty care providers, delivering advanced nursing services to residents) Skilled Nursing Home Progress Note, dated 11/18/2025 was reviewed. The NP Skilled Nursing Home Progress Note indicated, Resident 131 had mild abdominal pain and diarrhea on 11/17/2025. The NP Skilled Nursing Home Progress Note indicated, continue with Vancomycin (antibiotics) and contact isolation. The IPN stated, she did not follow through with NP's progress note. The IPN stated, she was not aware of the episodes of diarrhea. The IPN stated, the staff should have confirmed with physician or NP before discontinuing contact isolation precaution on 11/18/2025 to ensure Resident 131 was free of C-diff infection. The IPN stated, the staff should have washed hands with soap and water after caring for the residents with C-diff because the friction from rubbing removes the C-diff spores (an inactive form of the germ and have a protective coating allowing them to live for months or years on surfaces). The IPN stated, there was no documentation regarding the reason why the contact isolation precaution was discontinued. During a review of Resident 131's General Acute Care Hospital (GACH) Laboratory Report, dated (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11/12/2025, the GACH Laboratory Report indicated, Resident 131 tested positive (confirmation for infection) C-diff stool test on 11/12/2025. During a review of Resident 131's Bowel and Bladder (B&B) Elimination Task, dated from 11/11/2025 to 11/20/2025, the B&B Elimination Task indicated, Resident 131 had loose stool on 11/16/2025 and 11/17/2025. During a review of Resident 131's Medication Administration Record (MAR), dated 11/2025, the MAR indicated, Resident 131 received Imodium 2 milligram (mg) by mouth for control of diarrhea on 11/11/2025. During a review of Resident 131's McGeer's Criteria for Infection Control Surveillance (standardized surveillance definitions used to identify and monitor infections in long-term care facilities), dated on 11/10/2025 and 11/13/2025, the McGeer's Criteria for Infection Control Surveillance indicated, Resident 131 had C-diff infection on contact isolation and had three or more liquid or watery stools above what is normal for the resident within a 24 hours period. During a review of the facility's Policy and Procedure(P&P) titled, Infection Prevention and Control Manual Guidelines for Clostridium Difficile Infection (CDI), revised 2020, the P&P indicated, Isolation Precautions . A. Contact precautions should be used for CDI residents with diarrhea. B. Hands should frequently be washed with soap and water. An alcohol-based waterless hand cleanser is not effective against CDI spores . F. Precautions should continue until diarrhea ceases. (If no episodes of diarrhea are noted x 48 hours, DC Contact Isolation). During a review of the facility's Policy and Procedure(P&P) titled, Infection Control Guidelines for All Nursing Procedures, revised 8/2012, the P&P indicated, General Guidelines: 3. Employees must wash their hands for ten (10) to fifteen (15) seconds using antimicrobial or non&shy;antimicrobial soap and water under the following conditions . When there is likely exposure to spores (i.e., C. difficile or Bacillus anthracis) (Note: Alcohol-based hand rubs are inactive against spores. For effective mechanical removal of spores, wash hands for 30- 60 seconds with soap and water. During a review of the facility's Policy and Procedure(P&P) titled, Isolation - Notices of Transmission-Based Precautions, revised 8/2019, the P&P indicated, Policy Statement: Notices will be used to alert personnel and visitors of transmission-based precautions, while protecting the privacy of the resident. Policy Interpretation and Implementation . b. Contact Precautions: (1) A notice at the doorway instructing visitors to report to the nurses' station before entering the room. (2) A sign indicating contact precautions on the door to the resident's room.		

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to: a. 1. Administer the coronavirus vaccination for one of five sampled residents (Resident 5). b. 2. Offer and educate coronavirus vaccinations for staff per facility's policy for three of five sampled employees. These failures had the potential to place all residents at risk for exposure to infection of coronavirus. Findings: 1. During a review of Resident 5's admission Record, the admission Record indicated Resident 5 was initially admitted to the facility on [DATE] with a diagnosis of hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness or paralysis on one side of the body) following cerebral infarction (stroke - loss of blood flow to a part of the brain). During a review of Resident 5's History and Physical (H&P), dated 3/18/2025, the H&P indicated Resident 5 did not have the capacity to understand and make decisions. During a review of Resident 5's Minimum Data Set (MDS - a resident assessment tool), dated 9/17/2025, the MDS indicated Resident 5 had severe cognitive (ability to learn, reason, remember, understand, and make decisions) impairment, required maximal assistance (helper does more than half the effort) when for oral hygiene and dependent (helper does all the effort) for toileting hygiene, upper and lower body dressing, and bathing. During a concurrent interview and record review on 11/20/2025 at 3:10 p.m., with the Infection Preventionist Nurse (IPN), Resident 5's medical record was reviewed. The IPN stated Resident 5's responsible party (RP) gave consent for Resident 5 to receive the coronavirus vaccine on 9/17/2025. The IPN stated there is no documentation that Resident 5 received the coronavirus vaccine. During an interview on 11/20/2025 at 3:52 p.m., with the Director of Nursing (DON), the DON stated if it is not documented, it was not done. During a review of the facility's policy and procedure (P/P), titled Coronavirus Disease (Covid-19) - Vaccination of Residents, revised December 2021, the P/P indicated Covid-19 vaccine education, documentation and reporting are overseen by the infection preventionist and coordinated by his or her designee. The individual who coordinates these responsibilities in the facility is: Infection preventionist. 2. During a concurrent interview and record review on 11/20/2025 at 3:16 p.m., with the IPN the Employee Tracking Record for Vaccination for 2025 was reviewed. The IPN stated the coronavirus vaccine booster and vaccines are encouraged to all employees. The IPN stated all employees should have the vaccine consent form. The IPN stated the vaccine consent form is proof that the facility educated the employee about the vaccination risks and benefits. The IPN stated Registered Nurse Supervisor (RNS) 3, Licensed Vocational Nurse (LVN) 8, and Certified Nurse Assistant (CNA) 4 do not have a vaccine consent form for the 2025 coronavirus vaccine. The IPN stated it is important that all employees are educated about the risks and benefits of the coronavirus vaccines so the employees do not acquire coronavirus which could be transferred to the residents. During an interview on 11/21/2025 at 2:56 p.m. with the DON, the DON stated it was important to educate and document staff coronavirus vaccinations in order to protect residents and staff from a coronavirus outbreak. The DON stated respiratory season is from November 1st to March 31st. The DON stated 100% of employees should have been educated and offered the coronavirus vaccine before during the respiratory season. The DON stated a declined vaccine consent form is proof that the employee was educated. During a review of the facility's policy and procedure (P/P), titled Coronavirus Disease (Covid-19) - Vaccination of Staff, revised January 2022, the P/P indicated all staff are required to be fully vaccinated for COVID-19 in accordance with 483.80(i). The facility maintains documentation related to staff COVID-19 vaccination that includes, at a minimum, the following (as applicable): a. That staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; b. That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; c. A copy of the informed consent; and d. Verification of vaccination or documentation of exemption/delay.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to inform one of two sampled residents (Resident 11) of the risks associated with repeated subcutaneous (beneath the skin) insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) injections administered in the same anatomical site. This deficient practice had the potential to limit Resident 11's ability to make informed decisions regarding treatment. Findings: During a review of Resident 11's admission Record (Face sheet), the admission Record indicated the facility admitted the resident on 12/6/2023 and was readmitted on [DATE], with diagnoses including type 2 diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed), and cataract (clouding of the eye's natural lens). During a review of Resident 11's History and Physical (H&P), dated 9/15/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 11's Minimum Data Set (MDS, a resident assessment tool), dated 9/18/2025, the MDS indicated Resident 11 had intact cognition (ability to think and understand). The MDS indicated Resident 11 needed set up or clean up assistance from staff for eating and oral hygiene. The MDS indicated Resident 11 needed moderate assistance from staff for toileting hygiene and bathing. During a review of Resident 11's Physician Order dated 9/14/2025, the Physician Order indicated an order of insulin lispro (fast-acting insulin that works fast to lower blood sugar level) injection solution 100 unit per milliliters (unit/ml, units of insulin are contained within each milliliter of liquid), inject 3 unit subcutaneously three times a day for DM, hold if blood sugar is less than 100. During a review of Resident 11's Physician Order dated 9/15/2025, the Physician Order indicated an order of insulin glargine (long-acting insulin that works slowly and steadily to keep blood sugar stable) subcutaneous solution 100 unit/ml, inject 10 unit subcutaneously at bedtime for DM. During an interview on 11/20/2025 at 9:31 a.m., with Resident 11, Resident 11 stated she preferred to receive insulin injections in her right arm, did not like injections in her abdomen and her left arm had a dialysis access site. Resident 11 stated she was not aware of the risks associated with repeated use of same site for insulin injections. During a concurrent interview and record review on 11/21/2025 at 9:53 a.m., with Licensed Vocational Nurse (LVN) 3, Resident 11's Physician Order for 11/2025, Medication Administration Report (MAR) for 11/2025, Location of Administration Report for 11/1/2025 to 11/20/2025 and Progress Notes for 11/13/2025 to 11/17/2025 were reviewed. LVN 3 stated Resident 11 received injections to same site on multiple occasions. LVN 3 stated when a resident preferred a specific insulin injection site, nursing staff should educate the residents on the risks of repeated injections and benefits of rotating sites to make residents aware and able to make informed decisions regarding care. LVN 3 stated there was no documentation in Resident 11 Progress Notes and MAR indicating that Resident 11 had been educated regarding insulin site rotation. During an interview on 11/21/2025 at 12:43 p.m., with Director of Nursing (DON), the DON stated residents had rights to refuse care and treatment, but nursing staff must educate residents that repeated injections in the same site can cause bruising or harm. During a review of facility's policy and procedures (P&P) titled, Resident Rights revised 12/2016, the P&P indicated Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's rights to be informed of, and participate in, his or her care planning and treatment. participate in decision making regarding his or her care.		

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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 interview and record review, the facility failed to notify the physician when Resident 113's ambulation (walking or moving from one place to another) distance declined. This failure had the potential to result in a delay of care and further decline of ambulation. Findings: During a review of Resident 113's admission Record, the admission Record indicated Resident 113 was initially admitted to the facility on [DATE] with diagnoses including Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), difficulty in walking, and pressure induced deep tissue damage (discolored skin over a bony prominence caused by prolonged, unrelieved pressure) of the sacral (base of the spine) region. During a review of Resident 113's History and Physical (H&P), dated 6/19/2025, the H&P indicated Resident 113 had the capacity to understand and make decisions. During a review of Resident 113's Minimum Data Set (MDS - a resident assessment tool), dated 9/23/2025, the MDS indicated Resident 113's cognitive (ability to learn, reason, remember, understand, and make decisions) ability was intact, required setup assistance when eating and oral hygiene, required for upper body dressing, moderate assistance (helper does less than half the effort) for toileting and lower body dressing, and required maximal assistance (helper does more than half the effort) for bathing. During an interview on 11/18/2025 at 10:01 a.m., with Resident 113, Resident 113 stated they used to walk with a walker with the staff, but has gotten weaker and does not walk with the staff anymore. During a review of Resident 113's physician orders, the orders indicated: 6/26/2025 - 11/4/2025 Restorative Nursing Aide ([RNA] certified nursing aide program that helps residents to maintain their function and joint mobility) to provide ambulation program with front wheel walker ([FWW]) a tool that helps people walk more safely that has two wheels in the front and two legs in the back) 3x/week or as tolerated and document walking distance 11/4/2025 RNA to provide bilateral(both) upper extremity (BUE)/Bilateral lower extremity (BLE) active range of motion (AROM- resident can move independently with instruction) 3x/week or as tolerated. During a concurrent interview and record review on 11/19/2025 at 2:21p.m., with RNA 1, Resident 113's daily and weekly RNA documentation from June 2025 to November 2025 was reviewed. RNA 1 stated the daily documentation indicated: In July 2025, Resident 113 ambulated 150 feet (ft- a unit of measurement of distance) with the RNA every week The week of 8/3/2025 - 8/9/2025, Resident 113 ambulated 80 ft with the RNA The week of 8/10/2025 - 8/16/2025, Resident 113 ambulated 40 ft with the RNARNA 1 stated if a resident refuses or there are changes such as a decline, the RNA reports the change to the Licensed Vocational Nurse (LVN) or the Director of Nursing (DON) who would report it to the physician. During a concurrent interview and record review on 11/21/2025 at 10:07 a.m., with the Minimum Data Set Coordinator (MDSC), Resident 113's medical record was reviewed. The MDSC stated the physician was notified on 10/20/2025 that Resident 113 had lower back pain and right leg weakness and was notified on 10/24/2025 that Resident 113 refused to ambulate. The MDSC stated if a resident's ambulation declines from 150 ft to less than 100 ft, the decline should be communicated to the physician. During a concurrent interview and record review on 11/21/2025 at 11:27 a.m. with LVN 1, Resident 113's medical record was reviewed. LVN 1 stated if there is a decrease in distance ambulated, they would expect the RNA to report the change to the LVN who would initiate a Change of Condition (COC) and notify the physician. LVN 1 stated they would have expected the physician to be notified by 8/11/2025 when the distance ambulated was trending down. During an interview on 11/21/2025 at 3:00 p.m., with the Director of Nursing (DON), the DON stated it is important to notify the physician when there is a change of condition such as a decline in ambulation so the provider is aware of the resident's condition, and so that the resident gets proper treatment. During an interview on 11/21/2025 at 4:17 p.m. with the Medical Director (MD), the MD stated if there is a decline in ambulation the facility should notify the provider. During a review of the facility's policy and (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Pacific Palms Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1020 Termino Avenue Long Beach, CA 90804	
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	procedure (P/P), titled Change in a Resident's Condition or Status, revised December 2016, the P/P indicated The nurse will notify the residents attending physician or physician on call when there has been a: .d. significant change in the residence physical/emotional/mental condition.f. Refusal of treatment or medication two or more consecutive times.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the use of mirtazapine (a medication used to treat mental illness) was used to treat a medical condition diagnosed and documented in the medical record between 7/7/25 and 11/9/25 for one of five residents sampled for unnecessary medications (Resident 9.)The deficient practice of using psychotropic medications (medications that affect brain activities associated with mental processes and behavior) to treat medical conditions without sufficient documentation of their diagnosis increased the risk that Resident 9 may have experienced adverse effects (unwanted or dangerous medication-related side effects) related to the use of mirtazapine.A review of Resident 9's admission Record, dated 11/20/25, indicated she was originally admitted to the facility on [DATE] and most recently readmitted on [DATE] with diagnoses including anxiety disorder (a mental illness characterized by excessive worry, fear, or panic strong enough to interfere in everyday activities) and seizure disorder (a medical condition caused by uncontrolled electrical activity in the brain.) Further review of the admission Record indicated there was no diagnosis of major depressive disorder (depression - a mental illness characterized by depressed mood, difficulty sleeping, social withdrawal, or lack of interest in usually enjoyable activities) listed.A review of Resident 9's History and Physical (a record of a physician's comprehensive medical examination), dated 6/9/25, did not indicate depression of major depressive disorder as a current diagnosis or part of her past medical history.A review of Resident 9's Order Summary Report (a summary of all active physician's orders), dated 11/20/25, indicated on 7/7/25 she was prescribed mirtazapine 7.5 milligrams (mg - a unit of measure for mass) by mouth at bedtime for depression manifested by poor appetite.A review of Resident 9's clinical record and psychiatric progress notes (a record of a comprehensive psychiatric examination from a psychiatric care provider), dated 8/18/25 and 9/14/25, did not indicate depression or major depressive disorder listed as active diagnoses.A review of Resident 9's MDS (minimum data set - a comprehensive resident assessment) assessment Section I (active diagnoses), dated 9/17/25, indicated Resident 9 did not have depression as an active diagnosis.During an interview on 11/20/25 at 10:46 AM with the Director of Nursing (DON), the DON stated the facility failed to ensure Resident 9's mirtazapine was used for a diagnosis that was clearly documented in her medical record between 7/7/25 and 11/9/25. The DON stated Resident 9's admission record, MDS section I, and most recent psychiatric notes (prior to 11/9/25) do not contain any evidence that Resident 9 has depression or major depressive disorder. The DON stated the psychiatric note on 11/9/25, which was not included in her clinical record, is the first documentation available regarding the diagnosis of depression though the medication has been in continuous use since 7/7/25. The DON stated using psychotropic medications for a diagnosis that is not clearly documented in the resident's medical record increases the risk that the resident may experience adverse effects related to the use of those medications possibly leading to a decline in quality of life. A review of the facility's policy Behavioral Assessment, Intervention and Monitoring, revised December 2016, indicated Residents who do not display symptoms, or have not been diagnosed with, a mental, psychiatric, psychosocial adjustment or post-traumatic stress disorder will not develop a pattern of decreased social interaction or increased withdrawn, angry, or depressive behaviors that cannot be explained or attributed to a specific clinical condition that makes the pattern unavoidable. When medications are prescribed for behavioral symptoms, documentation will include: rationale for use. potential underlying causes of the behavior.		

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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 interview and record review, the facility failed to ensure the Minimum Data Set (MDS - a resident assessment tool) assessment accurately reflected one of three sampled Residents (Resident 74). This failure had the potential to negatively affect Resident 74's plan of care and delivery of necessary care and services. Findings: During a review of Resident 74's admission Record, the admission Record indicated Resident 74 was initially admitted to the facility on [DATE] with diagnoses including major depressive disorder. During a review of Resident 74's MDS dated [DATE], the MDS indicated Resident 74 had moderate cognitive (ability to learn, reason, remember, understand, and make decisions) impairment, required setup assistance when eating, required moderate assistance (helper does more than half the effort) for oral hygiene and upper body dressing, and was dependent for toileting hygiene, bathing, and lower body dressing. During a concurrent interview and record review 11/21/2025 at 9:55 a.m., with the MDS Coordinator (MDSC), Resident 74's medical record was reviewed. Resident 74's physician order summary indicated Ativan oral tablet 0.5 milligrams (MG- a unit of measurement) - give 1 tablet by mouth every 6 hours as needed for anxiety manifested by (m/b) physical restlessness for 14 days. Resident 74's care plans indicated on 8/5/2025 Resident 74 experienced new episodes of anxiety m/b physical restlessness and combativeness. The MDSC stated the psychiatry note dated 10/27/2025 indicated Resident 74 was diagnosed with anxiety. The MDSC stated the MDS dated [DATE] did not indicate that resident 74 had an anxiety disorder. The MDSC stated the anxiety disorder should have been reflected in the MDS. During an interview on 11/21/2025 at 2:56 p.m. with the Director of Nursing (DON), the DON stated the MDS assessment should accurately reflect the resident to ensure that the resident is receiving proper care and treatment. During a review of the facility's policy and procedure (P/P), titled Charting and Documentation, revised July 2017, the P/P indicated documentation in the medical record we'll be objective (not opinionated or speculative), complete, and accurate.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to revise a comprehensive care plan for one of two sampled residents (Resident 11), who preferred not to have subcutaneous (beneath the skin) insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) injection sites rotated, to include individualized goals and interventions addressing resident preference and associated risks. This deficient practice placed Resident 11 at risk for skin tissue damage and inconsistent insulin absorption due to unmet care needs related to the absence of a revised, individualized care plan. Findings: During a review of Resident 11's admission Record (Face sheet), the admission Record indicated the facility admitted the resident on 12/6/2023 and was readmitted on [DATE], with diagnoses including type 2 diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed), and cataract (clouding of the eye's natural lens. During a review of Resident 11's History and Physical (H&P), dated 9/15/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 11 Minimum Data Set (MDS - a resident assessment tool), dated 9/18/2025, the MDS indicated Resident 11 had intact cognition (ability to think and understand). The MDS indicated Resident 11 needed set up or clean up assistance by staff for eating and oral hygiene. The MDS indicated Resident 11 needed moderate assistance from staff for toileting hygiene and bathing. During a review of Resident 11's Physician Order dated 9/14/2025, the Physician Order indicated an order of insulin lispro (fast-acting insulin that helps control blood sugar levels) injection solution 100 unit per milliliters (unit/ml, units of insulin contained within each milliliter of liquid), inject 3 unit subcutaneously three times a day for DM, hold if blood sugar is less than 100. During a review of Resident 11's Physician Order dated 9/15/2025, the Physician Order indicated an order of insulin glargine (long-acting insulin that works slowly and steadily to keep blood sugar stable) subcutaneous solution 100 unit/ml, inject 10 unit subcutaneously at bedtime for DM. During an interview on 11/20/2025 at 9:31 a.m., with Resident 11, Resident 11 stated she preferred to receive insulin injections in her right arm, did not like injections in her abdomen and her left arm where she had a dialysis access site. Resident 11 stated she was not informed of the risks associated with repeated use of same site for insulin injections. During a concurrent interview and record review on 11/21/2025 at 9:53 a.m., with Licensed Vocational Nurse (LVN) 3, Resident 11's Physician Order for 11/2025, Medication Administration Report (MAR) for 11/2025, Location of Administration Report for 11/1/2025 to 11/20/2025 and Care Plan Report were reviewed. LVN 3 stated Resident 11 received injections to same site on multiple occasions. LVN 3 stated care plan should be updated by either a Registered Nurse (RN) or LVN when residents insist on getting their insulin injection on same site. LVN 3 stated there was no documentation of an updated care plan addressing resident preference and associated risks. During an interview on 11/21/2025 at 12:43 p.m., with Director of Nursing (DON), the DON stated residents had rights to refuse care and treatment, but nursing staff must educate residents that repeated injections in the same site can cause bruising or harm. The DON stated care plan must be updated by an RN or LVN for any changes to resident care or condition. During a review of facility's policy and procedures (P&P) titled, Care Plans, Comprehensive Person-Centered revised 12/2016, the P&P indicated Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change.		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is 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 out of two sampled Residents (Resident 13) on the restorative nursing assistant (RNA) feeding program (staff provide feeding assistance) was supervised during two meals. This deficient practice had the potential for Resident 13 to aspirate (when something other than air gets into your airways) or for Resident 13 to lose weight if she was not encouraged to consume the meal. Findings: During a review of Resident 13's admission Record, the admission Record indicated Resident 13 was admitted to the facility on [DATE] with diagnoses of hemiplegia (unable to move one side of the body) and a contracture (a permanent tightening of muscles, tendons, or skin that causes joints to become stiff and short, restricting movement) of the left hand. During a review of Resident 13's Minimum Data Set (MDS, a resident assessment tool) dated 9/11/2025, the MDS indicated Resident 13 had severe cognitive impairment (a significant loss of mental ability, such as memory, thinking, and reasoning, that prevents a person from living independently and often requires substantial supervision) and had an impairment on one upper extremity (left). The MDS indicated Resident 13 required supervision or touching assistance (helper provides verbal cues and/or touching/ steadying assistance during the task). During a review of Resident 13's Order Summary Report dated 11/21/2025, the Order Summary Report indicated Resident 13 had an order placed 9/30/2024 for RNA feeding program with breakfast and lunch. During an observation on 11/20/2025 at 8:01 a.m., Resident 13 was sat up in bed, the meal tray was set up and placed in front of her, but staff (unknown) did not stay with her during the meal. Resident 13 fed herself. During an interview on 11/20/2025 at 9:42 a.m., certified nursing assistant (CNA) 3 stated Resident 13 just needed her meal tray set up for her, but the staff do not stay in the room with her while she eats. During an observation on 11/20/2025 at 12:22 p.m., Resident 13 was feeding herself lunch. Resident 13 ate the vegetables on the plate and did not consume the meat or potatoes. RNA 1 came into the room and picked up Resident 13's meal tray. During an interview on 11/20/2025 at 2:33 p.m., the Quality Assurance Nurse (QAN) stated Resident 13 had an order for the RNA feeding program and the RNA staff were supposed to assist the resident with feeding and sit with her while she ate. The QAN stated RNA staff were not supposed to leave Resident 13 unattended until she finished her meals. The RNA staff is supposed to supervise that she was eating safely and encourage her to eat. During an interview on 11/21/2025 at 10:56 a.m., RNA 1 stated he was assigned to Resident 13 the day prior (11/20/2025) for the RNA feeding program (breakfast and lunch). RNA 1 stated to be honest he only set up the meal tray for Resident 13 but then left the room because he had other residents to attend to. RNA 1 stated Resident 13 could feed herself, the staff must monitor her while she was eating. During an interview on 11/21/2025 at 3:37 p.m., the Director of Nursing (DON) stated if a resident was on the RNA feeding program the RNA should be in the room with the resident throughout the meal. The DON stated that even though the residents were on the RNA feeding program for encouragement and queuing, the staff should still be in the room throughout the meal. The staff need to motivate the resident to eat and be there if resident needed anything. The DON stated there was a possibility for weight loss if the resident was not encouraged to eat. During a review of the RNA Job Description dated 2/2001, the RNA job Description indicated the RNA was to perform the restorative feeding program and notify the occupational therapist of any feeding problems, referrals, and reassessment needs. During a review of the RNA Task List undated, the RNA Task List indicated the RNAs were to help feed residents that needed to be fed and monitor residents on self-help feeding programs, if any.		

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to discontinue an intravenous (IV, in the vein) catheter (flexible tube inserted into a vein to deliver fluids and medications into the blood stream) for two of two sampled residents (Resident 15 and Resident 121) per the facility's policy and procedure (P&P) titled Removal of a Peripheral IV (Over the needle, Peripheral Short) Catheter. As a result of this deficient practice, Resident 15 and Resident 121 were placed at risk for discomfort and infection at the IV site. Findings: A. During a review of Resident 15's admission Record, the admission record indicated Resident 15 was admitted to the facility 9/22/2025 with diagnoses including history of malignant neoplasm (cancerous tumor) of the large intestine and type 2 diabetes (your body does not use insulin properly, leading to high blood sugar). During a review of Resident 15's Minimum Data Set (MDS, a resident assessment tool) dated 9/25/2025, the MDS indicated Resident 15 had moderate cognitive impairment (a stage of decline in cognitive abilities like memory and thinking). During a concurrent observation and interview on 11/18/2025 at 3:05 p.m., with Resident 15, Resident 15 was observed with an IV on the right wrist wrapped with a dry dressing. Resident 15 stated she had pain at the IV site and was unsure why she had the IV because it was no longer in use. During a concurrent observation and interview on 11/19/2025 at 3:04 p.m., with Registered Nurse Supervisor (RNS)1, RNS 1 stated Resident 15 had a physician's order placed 11/11/2025 for two days of IV hydration (the process of replenishing water in the body) and the IV hydration was completed on 11/13/2025. RNS 1 stated Resident 15 did not have a current order for IV hydration. RNS 1 checked Resident 15's right wrist and confirmed there was an IV catheter still in place that was dated with an insertion date of 11/11/2025 (8 days prior). RNS 1 stated it was facility policy to remove an IV catheter after 3-4 days or once IV therapy was completed. B. During a review of Resident 121's admission Record, the admission Record indicated Resident 121 was initially admitted on [DATE] and was readmitted on [DATE] with diagnoses including chronic kidney disease (involves a gradual loss of kidney function [kidneys filter wastes and excess]), benign prostatic hyperplasia (a condition in which the prostate gland becomes very enlarged and may cause problems associated with urination), and presence of urogenital implants (injections of material into the wall of the urethra to help control urine leakage [urinary incontinence] caused by a weak urinary sphincter). During a review of Resident 121's MDS, dated [DATE], the MDS indicated Resident 121 had severe cognitive impairment. The MDS indicated Resident 121 was dependent on staff for all Activities of Daily Living (activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 121's Admit/RE-Admit Nursing Evaluation, 11/12/2025 at 10:30 p.m., the evaluation indicated Resident 121 had an IV on the right-hand side. During a concurrent observation and interview on 11/20/2025 at 3:45 p.m., with RNS 1, Resident 121 was observed with an IV line on the right forearm. RNS 1 stated Resident 121 had an IV line in place. (continued on next page)		

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 11/20/2025 at 3:55 p.m., with RNS 1, Resident 121's medical records were reviewed and there was no physician order for an IV line, and no IV hydration or medications ordered. RNS 1 stated Resident 121 did not have any indication of having an IV line so it should be discontinued. During an interview on 11/21/2025 at 3:37 p.m. with the Director of Nursing (DON), the DON stated IVs can stay in place for up to 4 days and if the IV treatment was completed the IV should be discontinued as soon as possible because it can cause discomfort for the patient and it was a potential risk for infection. During a review of the facility's policy and procedure (P&P) titled, Intravenous Administration of Fluids and Electrolytes, revised 4/2016, the P&P indicated a physician order was needed to give IV fluids and electrolytes. During a review of the facility's P&P titled, Removal of a Peripheral IV (Over the needle, Peripheral Short) Catheter, revised 9/2011, the P&P indicated the peripheral IV catheter was to be removed when therapy was discontinued.		

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **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 113) was assessed by a neurologist and wound doctor as ordered by the physician. This deficient practice had the potential to result in delay in the delivery of care and services. Findings: During a review of Resident 113's admission Record, the admission Record indicated Resident 113 was initially admitted to the facility on [DATE] with diagnoses including Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), difficulty in walking, and pressure induced deep tissue damage (discolored skin over a bony prominence caused by prolonged, unrelieved pressure) of sacral (base of the spine) region. During a review of Resident 113's History and Physical (H&P), dated 6/19/2025, the H&P indicated Resident 113 had the capacity to understand and make decisions. During a review of Resident 113's Minimum Data Set (MDS - a resident assessment tool), dated 9/23/2025, the MDS indicated Resident 113's cognitive (ability to learn, reason, remember, understand, and make decisions) ability was intact, required setup assistance when eating and oral hygiene, required for upper body dressing, moderate assistance (helper does less than half the effort) for toileting and lower body dressing, and required maximal assistance (helper does more than half the effort) for bathing. During a concurrent interview and record review on 11/21/2025 at 11:27 a.m., with Licensed Vocational Nurse (LVN) 1, Resident 113's medical record was reviewed. LVN 1 stated there is a physician order dated 6/23/2025 indicating a consult to neurology. LVN 1 stated the physician order dated 6/30/2025 indicated Resident 113 was scheduled for an appointment with a neurologist on 10/28/2025 at 9:00 a.m. LVN 1 stated there is no documentation indicating that Resident 113's transportation was arranged or that Resident 113 went to the scheduled neurologist appointment. During a concurrent interview and record review on 11/21/2025 at 12:29 p.m., with the Social Services Director (SSD), Resident 113's medical record was reviewed. The SSD stated there was no documentation that Resident 113's transportation was set up for the scheduled appointment with the neurologist on 10/28/2025. The SSD stated there is no documentation that the neurologist saw Resident 113. During a concurrent interview and record review on 11/21/2025 at 1:02 p.m., with the Treatment Nurse (TN), Resident 113's medical record was reviewed. The TN stated there is a physician order dated 10/6/2025 indicating a consult with the wound doctor for bilateral (both) heel intact, blood filled blisters. The TN stated there was no documentation that the wound doctor saw Resident 113. During an interview on 11/21/2025 at 3:00 p.m., with the Director of Nursing (DON), the DON stated If a resident does not get their consultation as ordered, there was a risk for delay of care, treatment, or services. During a review of the facility's policy and procedure (P/P), titled Referrals, Social Services, revised December 2008, the P/P indicated 1. Social Services shall coordinate most resident referrals and or consultations. Exceptions might include emergency or specialized services that are arranged directly by a physician or the nursing staff. Two referrals for medical services must be based on physician evaluation of resident need and related physician order. 3 social services will collaborate with the nursing staff or other pertinent disciplines to arrange for services that have been ordered by the position. For social services we'll document the referral in the residence medical record.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to monitor the valproic acid level (a lab value used to determine the effectiveness of certain medications used to treat seizures) related to the use of Depakote (a medication used to treat seizure disorder) per the physician's order in one of five residents sampled for unnecessary medications (Resident 9.)The deficient practice of failing to monitor valproic acid levels for the use of Depakote according to the physician's instructions increased the risk that Resident 9 could have experienced seizures or adverse effects related to the use of Depakote possibly leading to medical complications resulting in hospitalization.A review of Resident 9's admission Record (a record containing diagnostic and demographic resident information), dated 11/20/25, indicated she was originally admitted to the facility on [DATE] and most recently readmitted on [DATE] with diagnoses including anxiety disorder (a mental illness characterized by excessive worry, fear, or panic strong enough to interfere in everyday activities) and seizure disorder (a medical condition caused by uncontrolled electrical activity in the brain.)A review of Resident 9's History and Physical (a record of a physician's comprehensive medical examination), dated 6/9/25, indicated she had fluctuating capacity to understand and make decisions.A review of Resident 9's Order Summary Report (a summary of all active physician's orders), dated 11/20/25, indicated, on 9/15/25, she was prescribed Depakote DR 500 mg (milligrams - a unit of measure for mass) by mouth twice daily for seizure disorder.A review of the Medication Regimen Review (a monthly list of medication-related recommendations from the consultant pharmacist), dated 10/7/25, indicated the consultant pharmacist recommended to monitor the valproic acid level related to the use of Depakote with the next scheduled lab draw.A review of Resident 9's Order Summary Report, dated 11/20/25, indicated, on 10/30/25, Resident 9's attending physician ordered routine laboratory monitoring, including the valproic acid level, to be drawn every three months in November, February, May, and August on the second Tuesday of the month. Further review of the Order Summary Report indicated there were no other physician's orders to hold, cancel, or delay the valproic acid level.A review of the final lab report, dated 11/19/25, indicated that all other lab tests ordered by the physician were drawn for Resident 9 on 11/19/25 and results were reported the same day. Further review of the lab report indicated there was no requisition made for a valproic acid level, despite the physician order, and no indication that the valproic acid level was canceled by the attending physician. During an interview on 11/20/25 at 10:46 AM with the Director of Nursing (DON), the DON stated the facility failed to monitor Resident 9's valproic acid level as required by the physician's order from 10/30/25. The DON stated all the other laboratory orders from the physician order were drawn on 11/19/20 and reported the same day. The DON stated the valproic acid was not taken with the others as required in the physician order. The DON stated that failure to monitor the valproic acid level for a resident on Depakote for seizure disorder increases the risk that the resident may experience seizures or adverse effects related to the use of Depakote possibly leading to medical complications requiring hospitalization. A review of the facility's policy Lab and Diagnostic Test Results - Clinical Protocol, revised September 2012, indicated The physician will identify and order diagnostic and lab testing based on diagnostic and monitoring needs. The staff will process test requisitions and arrange for tests. The laboratory. will report test results to the facility.		

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to serve regular texture toast to one of three sampled residents (Resident 98).The deficient practice had the potential to result in loss of appetite and cause unplanned weight loss.Findings:During a review of Resident 98's admission Record, the admission Record indicated Resident 98 was readmitted to the facility on [DATE] with diagnoses including diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), gastroesophageal reflux disease (digestive disorder most often causes a burning and sometimes squeezing sensation in the mid-chest), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest).During a review of Resident 98's Minimum Data Set ([MDS] a resident assessment tool), dated 9/1/2025, the MDS indicated Resident 98 had intact cognition. The MDS indicated Resident 98 needed set-up assistance when eating.During a review of Resident 98's Order Summary Report, the report indicated, starting on 11/11/2025, Consistent Carbohydrate (diet used for managing blood sugar in diabetics) diet and No added salt, regular texture diet.During an interview on 11/19/2025 at 2:20 p.m., Resident 98 stated she wanted regular toast, but she receives it chopped up and mushy.During a concurrent interview and record review on 11/19/2025 at 2:45 p.m., with the Dietary Supervisor, (DS) Resident 98's Diet Profile card was reviewed and the card notes indicated mechanical soft, toast not toasted. The DS stated the notes were wrong because her diet order was for Regular diet texture and not mechanical soft. The DS stated she will update the notes immediately.During an interview on 11/21/2025 at 2:26 p.m., with the Registered Dietician (RD), the RD stated staff should follow the menu They are supposed to follow the diet texture ordered for good tolerance so they can eat it and prevent weight loss.During a review of the facility policy and procedure titled, Menu Planning, 2023, the policy indicated the facility's diet manual and the diets ordered by the physician should mirror the nutritional care provided by the facility.		

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the binding arbitration agreement (a contract in which a person agrees to settle future disputes with the facility outside of court, through a private, neutral decision-maker instead of a judge or jury) was explained in a language that a resident could understand for two of three sampled residents (Resident 78 and Resident 82). This deficient practice had the potential to limit Resident 78 and Resident 82's understanding of the binding arbitration agreement and their legal rights. Findings: a. During a review of Resident 78's admission Record (Face sheet), the admission Record indicated the facility admitted the resident on 10/11/2023, with diagnoses including type 2 diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), hypertension (HTN-high blood pressure) and hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body). During a review of Resident 78's History and Physical (H&P), dated 7/7/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 78 Minimum Data Set (MDS, a resident assessment tool), dated 9/18/2025, the MDS indicated Resident 78's preferred language was Spanish. The MDS indicated Resident 78 had intact cognition (ability to think and understand). The MDS indicated Resident 78 needed set up or clean up assistance from staff for eating and oral hygiene. The MDS indicated Resident 78 needed supervision assistance from staff for personal and toileting hygiene. During a review of Resident 78's Arbitration Agreement, dated 10/12/2023, the Arbitration Agreement indicated Resident 78 signed the arbitration agreement provided in English. During an interview on 11/20/2025 at 10:09 a.m., with Resident 78, Resident 78 stated he was unable to recall signing an arbitration agreement. Upon presentation of the signed arbitration agreement, Resident 78 stated would have remembered and understood the content of the agreement if the document was written in Spanish. b. During a review of Resident 82's admission Record (Face sheet), the admission Record indicated the facility admitted the resident on 5/31/2023, and was readmitted on [DATE], with diagnoses including type 2 diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), hypertension (HTN-high blood pressure) and muscle weakness. During a review of Resident 82's History and Physical (H&P), dated 1/30/2025, the H&P indicated the resident had memory impairment and forgetful. During a review of Resident 82 Minimum Data Set (MDS, a resident assessment tool), dated 9/18/2025, the MDS indicated Resident 82 had moderately impaired cognition (ability to think and understand). The MDS indicated Resident 82 needed set up or clean up assistance from staff for eating. The MDS indicated Resident 82 needed maximal assistance (helper does more than half the effort) from staff for toileting hygiene and bathing. During a review of Resident 82's Arbitration Agreement dated 6/6/2023, the Arbitration Agreement indicated Resident 82 signature. During an interview on 11/20/2025 at 10:30 a.m. with Resident 82, Resident 82 stated she was unable to recall what she had signed or the purpose of the arbitration agreement. During an interview on 11/20/2025 at 2:40 p.m., with the admission Assistant (AA), the AA stated the arbitration agreement should have been explained in a manner residents could understand, including through an interpreter and using simple terms. The AA stated the resident's responsible party (RP) should have been contacted if a resident was confused or forgetful. The AA stated when residents do not understand arbitration agreement, residents would be unaware of available options for addressing issues with the facility and unable to exercise their legal rights. During an interview on 11/21/2025 at 3:23 p.m., with Director of Nursing (DON), the DON stated if residents' preferred language was a language other than English, the facility had to use an interpreter to ensure understanding of arbitration agreement before signing. The DON stated the RP had to be contacted for resident who were confused or forgetful, otherwise, residents had no way of knowing what was being signed. During a review of facility's policy and procedure (continued on next page)		

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(P&P) titled Arbitration Agreement, undated, the P&P indicated By signing this arbitration agreement below, the parties agree to be bound by the provisions of this Arbitration Agreement. Further the Resident (or Resident's Legal Representative and/or Agent on behalf of Resident) acknowledges that: (A) The agreement has been explained to the Resident (or Resident's Legal Representative and/or Agent on behalf of the Resident) by a representative of the Facility in a form and manner that the Resident understands, including in a language that the Resident understands; and (B) The Resident (or Resident Legal Representative or Agent on behalf of Resident) understands this agreement.		

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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 six sampled residents (Resident 2) 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 2 did not receiving hospice care as they agreed upon. Findings: During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was initially admitted on [DATE] and was readmitted on [DATE] with diagnoses including respiratory failure (a condition in which the blood does not have enough oxygen or has too much carbon dioxide), dysphagia (difficulty swallowing), 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 cerebral infarction (loss of blood flow to a part of the brain) affecting right side of body. During a review of Resident 2's History and Physical (H&P), dated [DATE], the H&P indicated, Resident 2 did not have the capacity (ability) to understand and make decisions. During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool), dated [DATE], the MDS indicated Resident 2 required dependent assistance (Helper does all of the effort) from two or more staff for transfer, hygiene, shower, dressing, and bed mobility. During a concurrent interview and record review on [DATE], at 10:58 a.m., with Licensed Vocational Nurse (LVN) 7, Resident 2's Hospice Staff Visitation Flow Sheet, dated from [DATE] to [DATE] was reviewed. The Hospice Staff Visitation Flow Sheet indicated, Hospice Licensed Nurses visited on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. LVN 7 stated, Licensed Nurses should have visited Resident 2 once weekly per hospice agreement. LVN 7 stated, Hospice Nurses did not visit weekly during 9/2025, as well as early 10/2025, and the facility staff did not follow up to find out regarding missing visits on 9/2025 and early 10/2025. LVN 7 stated, Hospice nurses visits should be done weekly according to the hospice agreement, and Resident 2 would not receive specialty care and assessment if the hospice nurses' visits were not ensured as agreed. During a concurrent interview and record review on [DATE], at 3:55 p.m., with the Director of Nursing (DON), Resident 2's Physician's Certification for Hospice Benefit, dated [DATE] was reviewed. The Physician's Certification for Hospice Benefit indicated, family agreed to skilled nursing visit once weekly and Certified Home Health Aids (CHHA) visit twice weekly. The DON stated, the staff should have followed up with weekly hospice licensed nurses' visit to ensure Resident 2 received the care as agreed. The DON stated, the facility staff had responsibility for ensuring Resident 2 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 2's Order Summary Report (OSR), dated [DATE], the OSR indicated, admitted Resident 2 into Hospice care under routine level of care, and call hospice for any changes in condition was ordered on [DATE]. The OSR indicated, skilled nursing visit once a week and CHHA visit for twice a week was ordered on [DATE]. During a review of Resident 2's Care Plan Report (CPR), initiated [DATE], the CPR Focus indicated, Resident 2 was on hospice care with expected deterioration. The CPR Interventions indicated, Hospice staff render care during their visits. 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: 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 (continued on next page)		

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.		