STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056188	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Long Beach Care Center, Inc	2615 Grand Avenue Long Beach, CA 90815

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49862 Based on observation, interview and record review, the facility failed to ensure the Certified Nursing Assistance (CNA)1 closed the privacy curtain while performing Activities of Daily Living(ADL ' s - daily task in life) for 2 out of 3 sample Residents (Resident 4) and (Resident 5). This deficient practice placed Resident 4 and Resident 5 visually exposed to other staff and residents . Findings: During a record review of Resident 4 ' s Admission Records), the Admission record indicated Resident 4 was admitted to the facility on [DATE] with diagnoses anxiety (conditions that cause excessive and persistent feelings of fear or worry that can interfere with daily life), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest.Spondylolysis (is a stress fracture in the pars interarticularis, a thin bone that connects two vertebrae in the spine). During a record review of Resident 4 ' s Minimum Data Set (MDS a resident assessment tool), dated 10/01/2024, the MDS indicated Resident 4 ' s cognitive (the ability to think and process information) skills for daily decisions making was severely impaired. The MDS indicated Resident 4 ' srequired dependent (helper does more than half the efforts, helper lifts or hold trunk or limbs and provides more than half the effort.) During a record review of Resident 5 ' s Admission Records was admitted to the facility on [DATE] with diagnoses anxiety (conditions that cause excessive and persistent feelings of fear or worry that can interfere with daily life), muscle weakness (loss of muscle strength). major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest, schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior. During a record review of Resident 5 ' s MDS, dated [DATE], the MDS indicated Resident 5 ' s cognitive (the ability to think and process information) skills for daily decisions making was severely impaired. The MDS indicated Resident 5 ' s required dependent. (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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/4/2024 at 9:04 a.m. with CNA 1, CNA1 stated that privacy curtain should have closed all the way while doing ADLs on Resident 4. Resident 4 will feel embarrassed since she is expose to others while during ADLs. During an interview on 12/4/2024 at 10:17 a.m. with CNA 2, CNA 2 stated privacy curtain should be close all the way, even if the Resident refuses to have the privacy curtain closed all the way because she is paranoid. During an interview with CNA 3, on 12/04/2024 at 10:19 a.m. CNA 3 stated privacy curtain needs to close for resident privacy and dignity. CNA 3 stated, this would cause resident to feel embarrassed when expose to others. During an interview on12/5/2024 at 10:02 a.m. with License Vocational nurse 2, (LVN 2) , LVN 2 stated that CNA should provide privacy for all residents, privacy curtain should be closed all the way During a record review of the facility's undated policies and procedures titled Privacy and confidentiality, indicated resident has a right to personal privacy and confidentiality of his or her personal care.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49862 Based on, interview and record review, the facility failed to ensure the resident, who had impairment (loss of function or ability) on both sides of upper extremity (shoulder, elbow, wrist, and hand) and lower extremity (hip, knee, ankle, and foot), did not sustained injury to left leg during transfer from a wheelchair to a bed for one of three sampled residents (Resident 1). The facility failed to: 1. Ensure Certified Nursing Assistant (CNA) 4 asked another staff member to assist her with transferring Resident 1 from a wheelchair to bed per care plan titled, Needs Assistance with Activities of Daily Living (ADL-basic tasks that residents need to do to care for themselves such as eating, dressing and toileting) dated 1/26/2024 and revised on10/14/2024, which indicated Resident 1 required a total assistance of two to three persons for transfers. 2. Ensure staff followed facility ' s policy and procedure (P&P) titled, Safe Resident Handling/ Transfers undated which indicated the residents should be handled and transferred safely to prevent or minimize risks for injury and to provide and promote a safe, secure, and comfortable experience for the resident. These failures resulted in Resident 1 ' s left leg caught on the wheelchair wheels and sustaining a laceration (a deep cut or tear in the skin) to the left posterior (back) lower leg requiring ten sutures (a stitch or row of stitches holding together the edges of a wound). On 11/22/2024 Resident 1 was transferred to a General Acute Care Hospital (GACH) for evaluation and treatment of his left leg laceration. Findings: During a review of Resident 1 ' s Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), hemiparesis (weakness on one side of the body) following cerebral infarction(stroke -a medical condition that occurs when blood flow to the brain is disrupted) affecting left dominant (preferred) side. During a review of Resident 1 ' s Physical Therapist ' s ([PT]- licensed professional aimed in the restoration, maintenance, and promotion of optimal physical function) Discharge Summary dated 4/4/2024, the PT Discharge Summary indicated Resident 1 required partial/moderate assistance (helper does less than half the effort) with transfers from wheelchair to bed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1 ' s Minimum Data Set ([MDS] resident assessment tool), dated 10/14/2024, the MDS indicated Resident 1 had intact cognitive (ability to think, understand, learn, and remember) skills for daily decision-making. The MDS indicated Resident 1 was able to understand others and was understood by others. The MDS indicated Resident 1 had impairment on both sides of upper extremity (shoulder, elbow, wrist, and hand) and lower extremity (hip, knee, ankle, and foot). The MDS indicated Resident 1 used a wheelchair for mobility and needed partial/moderate assistance with toileting hygiene, shower, and upper body dressing. The MDS indicated Resident 1needed partial/moderate assistance (helper does less than half the effort, helper lifts, holds, or supports trunk or limbs) with chair/bed to chair transfer (the ability to transfer to and from a bed to a chair (or wheelchair). During a review of Resident 1 ' s Transfer Form dated 11/22/2024 timed at 11:30 p.m., the Transfer Form indicated Resident 1 was transferred to GACH due to skin wound (unspecified location) on 11/22/2024 at 10:20 p.m. During a record review of Resident 1 ' s GACH ' s Emergency Department (ED) documentation dated 11/22/2024, the ED documentation indicated Resident 1 was brought to the emergency room (ER) due to laceration to left lower leg. The ED Documentation indicated Resident 1 had laceration repair with ten sutures. During an interview on 12/4/2024 at 10:30 a.m., Resident 1 stated Certified Nursing Assistant (CNA 4) assisted him in transferring from wheelchair to the bed when his left leg got caught in the wheelchair. Residents 1 stated CNA 4 lifted him by placing one arm under his armpit and with another arm holding his pants. Resident 1 stated when CNA 4 turned him towards the bed, his left leg was caught in the wheelchair ' s wheel. Resident 1 stated CNA 4 called the charge nurse (Registered Nurse 1 [RN 1]) who assessed his left leg as it was bleeding profusely (great extent). Resident 1 stated he was transferred to GACH where he received sutures to his left leg. Resident 1 stated that he required a two-person assistance with transfers because he had paralysis in his left leg and was unable to fully support his body when moving from the wheelchair to the bed. During an interview on 12/4/2024 at 11:20 a.m., CNA 5 stated a resident (in general) who had a stroke (cerebral infarction) with one-sided weakness or paralysis should always be transferred with two-person assistance for safety. CNA 5 stated Resident 1 should have been transferred with two-person assistance to prevent any injury. During an interview on 12/05/24 at 09:25 a.m., CNA 4 stated that on 11/22/2024 around 10 p.m. she transferred Resident 1 from the wheelchair to the bed. CNA 4 stated she held Resident 1 under his armpit with one hand and with another held the resident ' s pants. CNA 4 stated when she transferred Resident 1 in bed the resident ' s left leg got caught on the wheelchair ' s wheels. CNA 4 stated she was not aware Resident 1 had a wound until she removed his pants and saw the resident left leg was bleeding. CNA 4 stated Resident 1 should have been transferred with two-person assistance for safety as he had left sided paralysis. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review on 12/5/2024 at 10:02 a.m., with Licensed Vocational Nurse (LVN 2) Resident 1 Care Plan Needs Assistance with ADL- dated 1/26/2024 and revised on10/14/2024 was reviewed. LVN1 confirmed the care plan indicated Resident 1 required a total assistance with transfer and should be transferred with two to three (2-3) staff assistance. LVN 1 stated Resident 1 had left sided hemiplegia and a stroke (cerebral infarction) and therefore should be transferred with two-person assistance for safety. During a concurrent interview and record review on 12/5/2024 at 10:46 a.m., with MDS Coordinator (MDSC) Resident 1 ' s MDS dated [DATE] was reviewed. The MDS indicated Resident 1 had impairment on both sides of upper extremity and lower extremity.MDSC stated it was not safe to transfer Resident 1 with assistance of one person because the resident had the impairment in both upper and lower extremities. During a review of the facility ' s P&P tiled, Safe Resident Handling/ Transfers undated, the P&P indicated it was the policy of the facility to ensure that resident was handled and transferred safely to prevent or minimize risks for injury and provided and promote a safe, secure, and comfortable experience for the resident. During a review of the facility ' s P&P titled, Safety and Supervision of Residents undated, the P&P indicated Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities.