

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056188	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/20/2024
NAME OF PROVIDER OR SUPPLIER Long Beach Care Center, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45269</p> <p>Based on interview and record review the facility failed to ensure one of four sampled residents (Resident 1) was treated with respect and dignity by failing to honor resident ' s refusal to come back to bed for provision of personal care.</p> <p>This failure had the potential to violate resident ' s rights and led to Resident 1 having increased agitation and restlessness.</p> <p>Findings:</p> <p>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 Alzheimer ' s disease (a disease characterized by a progressive decline in mental abilities), dementia (a progressive state of decline in mental abilities), depression (a constant feeling of sadness and loss of interest which stops a person doing normal activities), and unspecified psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality).</p> <p>During a review of Resident 1 ' s History and Physical (H&P) dated 12/1/2024, the H&P indicated the Resident 1 had fluctuating capacity to understand and make decisions.</p> <p>During a review of Resident 1 ' s Minimum Data Set (MDS- a federally mandated resident assessment tool) dated 12/9/2024, the MDS indicated the resident required substantial or maximal assistance (helper does more than half the effort) with toileting hygiene, bathing, dressing, personal hygiene, transfer to and from a bed to chair, and bed mobility.</p> <p>During a telephone interview on 12/19/2024 at 10:54 a.m., and subsequent telephone interview on 12/19/2024 at 3:39 p.m., with Certified Nurse Assistant (CNA 1), CNA 1 stated the resident kicked her in the abdomen three times when she was applying the adult brief (disposable undergarments designed for people with urinary or bowel incontinence) on Resident 1. CNA 1 stated Resident 1 started kicking when she was told her adult brief would be changed. CNA 1 stated she should have stopped providing personal care when Resident 1 was agitated and physically aggressive to prevent violence and injury on the staff or resident. CNA1 stated she should have pulled away, came back, offered the care again in a later time to Resident 1 because it could violate the rights of the resident and had caused the resident to get more agitated and physically aggressive.</p> <p>(continued on next page)</p>

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 12/19/2024 at 11:51 a.m., with CNA 4, CNA 4 stated Resident 1 would get physically aggressive like scratching, hitting, punching, or kicking the staff when it is time to provide personal care by changing her adult brief. CNA 4 stated she would step back, give her a chance to relax and calm down, explain, and make resident understand to ensure resident will not get more agitated.</p> <p>During an interview on 12/19/2024 at 1:16 p.m., and subsequent interview on 12/19/2024 at 3:53 p.m., with CNA 2, CNA 2 stated Resident 1 was already agitated when the resident was directed to go to her room. CNA 2 stated Resident 1 stated Why am I coming in here? and refused to get back to bed. CNA 2 stated as they sat Resident 1 on the edge of the bed, Resident 1 mumbled I don ' t want to be here. CNA 2 stated Resident 1 tried to get out of bed, kicked CNA 1 in the stomach three times and continued to be physically aggressive while they (CNA 1 and 2) were putting the adult brief on Resident 1. CNA 2 stated she did not honor resident ' s wish about not to go back to bed and refusal to get her adult brief changed. CNA 2 stated she should have waited for Resident 1 to calm down, offer the care again twice and notify the charge nurse if the resident was still refusing to be changed.</p> <p>During an interview on 12/20/2024 at 9:53 a.m., with Licensed Vocational Nurse (LVN 6), LVN 6 stated Resident 1 had dementia and the staff should have given her space and ensure safety when she was kicking and being physically aggressive during care because Resident 1 would not be able to understand and could make the situation worse if the staff continued to provide personal care.</p> <p>During an interview on 12/20/2024 at 12:16 p.m. with the Director of Nursing (DON), the DON stated when Resident 1 was physically aggressive and agitated during provision of care, CNAs 1 and 2 should have stopped and came back later to finish care and to prevent injury or a violation of resident ' s rights. The DON stated this could violate Resident 1 ' s rights if the staff continued to perform the care when Resident 1 was refusing to get her adult brief changed.</p> <p>During a review of the facility ' s undated policy and procedure (P&P) titled, Resident Rights and Quality of Life, the P&P indicated the facility will ensure that all staff members are educated on the rights of residents and the responsibility of the facility to properly care for its residents. The P&P indicated the resident has a right to be treated with respect and dignity.</p>		