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	03/06/2025

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39028 Based on observation interview and record review the facility failed to protect the resident right to be free from physical abuse for one of three sampled residents (Resident 1) when Resident 2 punched Resident 1 on the left upper cheek. The facility failed to: 1. Intervene when Certified Nursing Assistant (CNA 1) and Licensed Vocational Nurse (LVN) 1 witnessed and heard Resident 1 and Resident 2 having an argument in a loud voice on 2/25/2025, at 6am. 2. Supervise Resident 1 and Resident 2 who were in the patio on 2/25/25. 3. Follow Resident 1's Care Plan titled Resident 1 has episode of aggressive behavior, believes someone is going to hurt him dated 12/29/24, with interventions to remove any resident in the immediate area if Resident 1 became aggressive. These failures resulted in Resident 1 being assaulted (punched) by Resident 2, and Resident 1 sustained a black eye discoloration, upper left cheek laceration (deep cut or tear in skin), fracture (broken bone) of the nasal (nose) bones and fracture of the medial (towards the middle) wall of the left orbit (bones that surround the eye socket) and left maxillary (upper jawbone on the left side of the face), which required evaluation and treatment at a General Acute Care Hospital (GACH) Findings: During a review of Resident 1's Admission Record, the Admission record indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including unspecified dementia, (a progressive state of decline in mental abilities), schizophrenia (a mental illness that is characterized by disturbances in thought) anxiety disorder (emotion characterized by feelings of tension, worried thoughts) and suicidal ideation (thoughts, or fantasies about ending one's life) (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056188	A. Building B. Wing	03/06/2025

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 0600 Level of Harm - Actual harm Residents Affected - Few	During review of Resident 1's Minimum Data Set (MDS a resident's assessment tool) dated 12/4/24, the MDS indicated, Resident 1 had impaired cognitive (ability to think, understand, learn, and remember) ability. The MDS indicated Resident 1 required moderate assistance (helper does less than half the effort) with toileting hygiene, shower, and personal hygiene. The MDS indicated Resident 1 required moderate assistance with walking 10 feet and had not attempted to walk 50 feet due to medical condition or safety concerns. During a review of Resident 1's History and Physical (H&P), dated 12/29/24, the H&P indicated, Resident 1 had fluctuating capacity to understand and make decisions. During a review of Resident 1's Care Plan titled Resident 1 has episode of aggressive behavior, believes someone is going to hurt him dated 12/29/24, the Care Plan indicated interventions including staff will decrease stimulation around Resident 1 by providing a calm environment, if the resident became aggressive, remove any resident in the immediate area that may be in danger, provide and encourage appropriate activities for Resident 1 to release some energy. During a review of Resident 2's Admission Record, the Admission Record indicated Resident 2 was initially admitted to the facility on [DATE] and readmitted [DATE] with diagnoses including essential hypertension (type of high blood pressure where the cause is unknown and develops gradually), blindness on one eye (lack of vision in one eye), paranoid schizophrenia (a chronic mental illness characterized by persistent delusions [fixed false beliefs that are not based on reality] and hallucinations { sensory experiences that are not real}) mood affective disorder (mental health disorder that affects a person's emotional state leading to long hours of extreme sadness), schizoaffective disorder (a mental disorder that is characterized by disturbances in thoughts) and suicidal ideation. During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2 had moderate cognitive impairment. The MDS indicated Resident 2 had delusions. The MDS indicated Resident 2 required moderate assistance with toileting hygiene, shower, upper and lower body dressing, and personal hygiene. Resident 2 required moderate assistance with bed mobility, bed to chair transfer and walking 50 feet with two turns. During a review of Resident 2's Care Plan titled Resident 2 has potential for injury to others related to suicidal ideation dated 9/16/24, the Care Plan indicated interventions including to allow Resident 2 express his feelings, refocus his attention to something positive when the resident was depressed, check the environment for potential hazards, and attempt behavioral intervention if Resident 2 was manifesting behaviors. During a review of Resident 2' s Care Plan titled Resident 2 has epidotes of delusions that is attempting to strike out at staff because Resident 2 believe people are against him dated 9/16/2024, the Care plan indicated interventions including alter resident's environment, provide activities or take resident for a walk if the resident was upset, approach Resident 2 calmly unhurriedly, and attempt to refocus Resident 2 to something positive when the resident is exhibiting behaviors. During a review of Resident 1's Nursing Progress Notes dated 2/25/25 timed at 6:32 a.m., the Nursing Progress Notes indicated Resident 1 notified licensed staff that he had a bloody nose. The Nursing Progress Notes indicated Resident 1 stated that he was hit because he would not give up his cigarettes. (continued on next page)

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	03/06/2025

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 0600 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's Nursing Progress Notes dated 2/25/25 timed at 7 a.m., the Nursing Progress Notes indicated Resident 1 had swelling on the left lateral upper nose bridge measuring 0.1 centimeters (cm-unit of measurement) by 0.2 cm, left forehead swelling measuring 4.0 cm by 3.0 cm and a left eye black discoloration with swelling measuring 5.0 cm by 2.0 cm. During a review of Resident 1's Nursing Progress Notes dated 2/25/2025 timed at 7:28 a.m., the Nursing Progress Notes indicated Resident 1 had a cut on his nose and a bump on his forehead. The Nursing Progress Notes indicated Resident 1 stated a big black guy hit him after Resident 2 took Resident 1's cigarette. The Nursing Progress Notes indicated Resident 2 stated Resident 1 had kicked him in the past, so he hit Resident 1. During a review of Resident 1's Emergency Department (ED) Report dated 2/25/25 timed at 9:39 a.m., the ED report indicated Resident 1, arrived at the ED with a swollen left eye and complained of pain after being assaulted by another resident. During a review of Resident 1's Computed Tomography (CT -diagnostic imaging procedure) report dated 2/25/25 timed at 2:35 p.m., the CT report indicated Resident 1 had a fracture of the nasal bones and fracture of the medial wall of the left orbit and left maxillary. During a concurrent observation and interview on 3/5/25 at 10:55 a.m., with Resident 1 in the activity room, Resident 1 had a laceration on the left upper cheek close to the nose and left eye with sutures (a stitch or row of stitches holding together the edges of a wound or surgical incision). Resident 1 stated he did not know how he sustained his injury. During an interview on 3/5/25 at 2:15 p.m., with CNA 1, CNA 1 stated on 2/25/25 she witnessed the incident (argument) between Resident 1 and Resident 2 in the smoking patio, while CNA 1 was giving Licensed Vocational Nurse LVN 1 report on the list of resident's risk for elopement (leaving a supervised area without permission or awareness). CNA 1 stated she observed Resident 1 and Resident 2 argue but she (CNA 1) did not intervene because she did not know the argument would escalate (become more intense or serious) as it happened very fast, and Resident 2 punched Resident 1 in the face. CNA 1 stated Resident 1 liked to stay at a particular place in the patio and when another resident was at that place, Resident 1 would scream because he preferred to be the first one at that place. CNA 1 stated Resident 2 was a quiet and not aggressive. During an interview on 3/5/25 at 2:30 p.m., with LVN 1, LVN 1 on 2/25/25 while making rounds with CNA 1, LVN 1 observed Resident 1 and Resident 2 arguing in the patio area. LVN 1 stated he did not know what they were arguing about. LVN 1 stated before he could separate them, Resident 2 punched Resident 1 on his left upper cheek bone, with his fist. LVN 1 stated Resident 1 was very upset and wanted to retaliate (make an attack or assault in return for a similar attack) at Resident 2 when LVN 1 was separating the two residents. LVN 1 stated residents should be separated immediately at the onset of argument and when they start to be aggressive. LVN 1 stated the incident should have been avoided if staff separated both residents as soon as the residents started arguing. LVN 1 stated Resident 1 had behavioral problems, a history of angry outburst, and talked to himself. LVN 1 stated Resident 2 had a diagnosis of schizophrenia and talked to himself. LVN 1 stated both residents should not be left unsupervised. (continued on next page)

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	03/06/2025

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 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 3/5/25 at 3 p.m., with the Director of Staff Development (DSD), the DSD stated when residents were having angry outbursts, the staff nearby or anyone should intervene immediately by separating the residents. The DSD stated there should be staff assigned in the patio to supervise residents because residents are always out in the patio. The DSD stated it was unusual behavior for Resident 2 to punch another resident as he was always quiet. The DSD stated when the staff hear loud and angry exchange or verbal outburst between residents, staff should intervene and deescalate (reduce the intensity of a conflict or potentially violent situation) immediately. During a review of the facility's policy and procedure (P&P) titled, Abuse, Neglect and Exploitation (undated), the P&P indicated Each resident has the right to be free from abuse, misappropriation of resident property, and exploitation. The P&P, indicated the facility must: a.Train staff in appropriate interventions to deal with aggressive and catastrophic reactions by residents. b.Observe resident behavior and their reactions to other residents, roommates, tablemates. Place residents in accommodations and environments that keep them calm. c.Provide instruction to staff on care needs of residents. d.Assess monitor and develop appropriate plans of care for residents with needs and behaviors which might lead to conflict or neglect, such as residents with history of aggressive behaviors.