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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>056188 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                   | (X3) DATE SURVEY COMPLETED<br><br>08/21/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Long Beach Care Center, Inc |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>2615 Grand Avenue<br>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.

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| (X4) ID PREFIX TAG  | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |
| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>(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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review the facility failed to protect one of three sampled residents' (Resident 1) right to be free from physical abuse. This failure resulted in Resident 2 punching Resident 1 on the left side of Resident 1's eye on 8/10/2025. Resident 1 had swelling on the left side of his forehead near the left eye. 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 schizophrenia (a mental illness that is characterized by disturbances in thought) and anxiety disorder (a mental health condition characterized by excessive and persistent worry, fear, and nervousness that can significantly interfere with daily life). During a review of Resident 1's Minimum Data Set ([MDS] - a resident assessment tool), dated 05/22/2025, the MDS assessment indicated Resident 1's cognitive (ability to think, understand, learn, and remember) skills for daily decision making was severely impaired. The MDS indicated Resident 1 needs set up or clean up assistance (helper set up or cleans up; resident completes activity. Helper assists only prior to or following the activity) with eating and supervision with oral hygiene, toileting, showering and dressing. During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was initially admitted to the facility on [DATE] with diagnoses including schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior) and unspecified psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality). During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 1's cognitive skills for daily decision making was intact. The MDS indicated Resident 2 was supervision or touching assistance with oral hygiene, toileting and dressing. The MDS indicated Resident 2 needs supervision or touching assistance with transfer and ambulation. During a concurrent observation and interview on 08/20/2025 at 10:36 a.m. with Resident 1, Resident 1 was observed with left eye discoloration, confused and cannot recall what happen to his left eye. Resident 1 stated there was nothing wrong with his left eye and refused to answer questions. During a telephone interview on 08/20/2025 at 11:59 a.m., with Resident 2's family members (FM1). FM 1 stated Resident 2 currently on a different facility. FM 1 stated the reason why Resident 2 was in the facility was because of his behavioral problems. FM1stated, Resident 2 informed FM 1 that Resident 1 was wearing Resident 2's shoes and he asked Resident 1 to remove them. FM 1 stated Resident 2 got upset and punched Resident 1 because he refused to remove Resident 2's shoes FM1 stated staff did not intervene when Resident 2 was asking for his shoes from Resident 1. During a telephone interview on 08/21/2025 at 08:37 a.m., with Certified Nurse Assistant (CNA) 1, CNA 1 stated Resident 1 was assigned to her on 8/10/2025. CNA 1 stated she made her rounds during the night, but Resident 1 was asleep with his head covered up with a blanket. CNA 1 stated she did not like to bother residents at night when they sleep so she does not wake them up and look at their faces. CNA 1 stated she should have ensure to take a closer look at the residents when she makes rounds, especially at night. CNA 1 stated moving forward she would make sure she assessed residents when she makes her rounds to ensure they were okay. CNA 1 stated for safety she should not go through the shift without seeing the residents' face, because all staff are supposed to protect and keep residents safe. During a phone interview on 08/21/2025 at 10:10 a.m., with Licensed Vocational Nurse 1 (LVN 1), she was not aware Resident 1 was punched by Resident 2 in the face as no one reported it to her during her shift. LVN 1 stated she cannot recall seeing Resident 1 face during change of shift reports. LVN 1 stated she makes rounds every hour but did not see any incident that happened on 8/10/2025. LVN 1 stated she should have seen all residents faces when she makes rounds to assess residents as it is part of resident assessment regardless of whether it was the night shift or not. LVN 1 stated she should look at residents' faces to see if any abnormality can be addressed in a timely manner. During an interview on 08/21/2025 at 12:31 p.m., with the Director of Nursing (DON), the DON stated, all staff were supposed to check on all residents to make sure they were safe. The DON stated staff should see each resident face to face when they do the rounding. The DON stated regardless of any situation, all residents have the right to be free from any type of abuse. During a review of the facility's P&amp;P titled, Abuse, Neglect, and Exploitation, undated, indicated Each resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation. The P&amp;P indicated Resident must not be subject to abuse by anyone, including, but not limited to other residents.</p> |  |  |

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| <p>F 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to ensure one of six sampled resident (Resident 2) who resided at the facility and was transferred to General Acute care hospital (GACH) on 8/10/2025 was readmitted to the facility. This deficient practice resulted in Resident 2 being denied readmission by the facility. Resident 1 did not return to the facility. Findings: During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was initially admitted to the facility on [DATE] with diagnoses including schizoaffective disorder ( a mental illness that can affect thoughts, mood, and behavior) and unspecified psychosis ( a severe mental condition in which thought, and emotions are so affected that contact is lost with reality). During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 1's cognitive skills for daily decision making was intact. The MDS indicated Resident 2 was supervision or touching assistance with oral hygiene, toileting and dressing. The MDS indicated Resident 2 needs supervision or touching assistance with transfer and ambulation. During a record review of Progress Notes dated 08/10/25 signed by Registered Nurse (RN 2) timed at 13:54 p.m., the Progress Note indicated Resident 2 was transferred to GACH on 08/10/2025 for further evaluation after hitting Resident 2' s roommate (Resident 1) in the head using his fist. During an interview on 08/20/2025 at 11:59 a.m., with Resident 2's Family member (FM1), FM1 stated he felt bad that Residents 2 was not able to return to the facility because FM 1 lives closer to the facility and it was convenient for Resident 2 family to visit the resident. FM 1 stated he was surprised when he received a phone call from the facility about Resident 2's new facility after Resident 2's hospitalization. FM 1 stated that as much as the facility was close to FM 1 residence, he will let Resident 2 stay where he was right now and not return to the previous facility because he does not want Resident 2 to be treated wrongly. FM 1 stated Resident 2 does not hit someone unprovoked. FM 1 stated it happens because Resident 1 does not want to return Resident 2's shoes. During an interview on 08/21/2025 at 12:31 p.m., with the Director of Nursing (DON), the DON stated, informed GACH case workers to find another facility for Resident 2 and not to return to the facility because Resident 2 was a danger to others. The DON stated this was the first-time Residents 2 hit another resident, and he has not done it before. The DON stated there was no documentation in Resident 2's medical record to show evidence that the facility made efforts to determine if Resident 2 needs cannot be met in the facility and he was a danger to other residents. The DON stated he did not request any documents from GACH to assess resident's needs. The DON stated facility Interdisciplinary team (IDT) team members from different departments working together with a common purpose to set goals and make decisions that ensure residents receive the best care) made the decision for Resident 2 to transfer to another facility because the DON felt Resident 2 was a danger to others. The DON stated that he should have requested GACH reports and treatments plan, contact Resident 2's physician before making the decision for Resident 2 not to return to the facility as this was the first-time Resident 2 had a behavior of hitting another resident. The DON stated the facility should evaluate all plans of care, treatment, medications, and services needed of Resident 2 before making a decision not to have Resident 2 back to the facility. During a review of the facility's policy and procedure (P&amp;P) titled, Return to Facility Policy (undated) the P&amp;P indicated To establish clear guidelines for determining when a resident is clinically appropriate and safe to return to the facility after hospitalization. The P&amp;P indicated the Administrator, and the DON will review the discharge plan, current conditions care needs, the review include diagnosis and treatment plan and medication changes, behavioral or psychosocial support needs.</p> |  |  |

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| <p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive care plan with goals and interventions for one of six sampled residents (Resident 1) when Resident 1 was punched by Resident 2 on the left side of Resident 1's left eye on 8/10/2025. This deficient practice placed Resident 1 at risk for insufficient provision of care and services and had the potential for continued abuse. 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 schizophrenia (a mental illness that is characterized by disturbances in thought) and anxiety disorder (a mental health condition characterized by excessive and persistent worry, fear, and nervousness that can significantly interfere with daily life). During a review of Resident 1's Minimum Data Set ([MDS] - a resident assessment tool), dated 05/22/2025, the MDS assessment indicated Resident 1's cognitive (ability to think, understand, learn, and remember) skills for daily decision making was severely impaired. The MDS indicated Resident 1 needs set up or clean up assistance (helper set up or cleans up; resident completes activity. Helper assists only prior to or following the activity) with eating and supervision with oral hygiene, toileting, showering and dressing. During the concurrent interview and record review on 08/21/2025 at 2:50 p.m., with the Director of Nursing (DON), Resident 1 care plan was reviewed. The DON stated, upon review of Resident 1's care plan Resident 1 had no updated care plan on physical abuse, that shows resident to resident altercation noted on Resident 1's electronic health record. The DON stated there was a care plan for Resident 1's hematoma and redness on his left eye but no care plan for physical abuse. The DON stated there should be a care plan develop with goals and interventions for Resident 1's physical abuse but was not done. During a review of the facility's P&amp;P titled, Care Planning-Interdisciplinary Team undated, indicated Our facility's Care Planning/Interdisciplinary Team is responsible for the development of an individualized comprehensive care plan for each resident. The Interdisciplinary Team may review and make recommendations for the safety of a resident.</p> |  |  |