

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  12/03/2025
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)
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.  (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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<p>F 0580</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 interview and record review, the facility staff failed to ensure the physician for one of four sampled residents (Resident 1) was notified when Resident 1's dose of Heparin (medication to prevent the development of clots [masses of blood that form when blood cells stick together]) was missed and when Resident 1 was not transferred to a General Acute Care Hospital (GACH), per the physician's order. These deficient practices resulted in Resident 1's physician being unaware that Resident 1 did not receive a dose of Heparin, delayed evaluation, treatment and delayed transfer to the GACH. These deficient practices had the potential for development of and/or increase in the size of a deep vein thrombosis ([DVT] a blood clot in a vein, usually in the leg). Findings: a. During a review of Resident 1's admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with a diagnosis of a displaced intertrochanteric fracture (a type of broken bone in the upper part of the thigh bone (femur) near the hip, where the bone pieces are out of place) of the right femur and fracture (broken bone) of the right lower leg. During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 11/5/2025, the MDS indicated Resident 1's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was intact and Resident 1 was dependent (helper does all of the effort) on facility staff to complete her activities of daily living ([ADLs] activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 1's Physician's Order dated 10/29/2025, the Physician's Order indicated Resident 1 was to receive Heparin Injection Solution 5000 units/milliliter ([ml] a unit of measurement), one ml injected subcutaneously (under the skin) every eight hours for DVT prophylaxis (treatment to prevent disease or infection from occurring or spreading). During an interview on 12/1/2025 at 8:15 a.m., Resident 1 stated on 11/10/2025, her legs started to feel funny, as if they were swelling, she reported this to LVN 2 at the same time she reported to LVN 2 that LVN 1 did not give her, her afternoon dose of Heparin. Resident 1 stated she went to physical therapy at 12:30 p.m. and stayed there for about 45 minutes to one hour and returned to her room around 1:45 p.m. Resident 1 stated she waited for LVN 1 to give her the Heparin, but he did not. Resident 1 stated after change of shift, she informed LVN 2 she did not receive her afternoon dose of Heparin, which he (LVN 2) confirmed that it had not been given by calling LVN 1. Resident 1 stated when LVN 2 called LVN 1, LVN 1 told LVN 2 that he had forgotten to administer Resident 1's dose of Heparin. During an interview on 12/1/2025 at 11:01 a.m., LVN 2 stated on 11/10/2025 around 4:45 p.m., Resident 1 reported to him that she did not receive her afternoon dose of Heparin. LVN 2 stated he reviewed Resident 1's MAR which indicated the dose of Heparin had been given by LVN 1. LVN 2 stated he called LVN 1 to clarify the administration of Heparin and LVN 1 informed him that he (LVN 1) forgot to give the dose of Heparin to Resident 1. LVN 2 stated reflecting on the incident, he should have reported the missed dose of Heparin to Registered Nurse (RN 2) and Resident 1's physician. LVN 2 stated he did not report the missed dose of Heparin to RN 2 due to fear of being labeled a snitch. During a telephone interview on 12/1/2025 at 12:23 p.m., LVN 1 stated at approximately 2:45 p.m., he was finishing his charting and Resident 1 had not returned from physical therapy yet, which was why he did not give Resident 1 her dose of Heparin. LVN 1 stated he made a mistake, by not giving Resident 1 her dose of Heparin and not reporting the missed medication to Resident 1's physician. b. During an interview on 12/1/2025 at 1:24 p.m., Resident 1's Responsible Party (RP) stated she contacted Resident 1's physician on 11/11/2025 at 1:57 a.m., about her concerns regarding Resident 1's condition and the ultrasound doppler's (machine that uses sound waves to check how blood flows through the body) timelines. The RP stated Resident 1's physician agreed to send Resident 1 to the GACH prior taking conducting the doppler exam, however Resident 1 preferred to stay at the facility until the ultrasound doppler was completed. During a review of Resident 1's Physician's Order dated 11/11/2025, the Physician's Order indicated a Stat (immediate) venous doppler of Resident 1's left leg to rule out a DVT. During a review of facility's mobile phone text messages dated 11/11/2025 and timed at 2 a.m., the text message indicated Resident 1's physician sent a text message that indicated, Resident 1's RP requested to send Resident 1 to the GACH. During a review of Resident 1's Nursing Note dated 11/11/2025, the Nursing Note indicated the venous doppler could not be performed because a soft leg cast and leg brace were present. During a review of Resident 1's Physician Order dated 11/11/2025, the Physician Order indicated Resident 1 may transfer to the GACH for further evaluation. During an interview on 12/2/2025 at 3:09 p.m. LVN 3 stated he spoke to Resident 1 about the transfer to the GACH and Resident 1 told him she</p>		

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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 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.  (continued on next page)

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F 0600  Level of Harm - Actual harm  Residents Affected - Few	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review, the facility failed to ensure one of four sampled residents (Resident 2) was free from physical abuse when Resident 3 entered Resident 2's room and hit Resident 2 repeatedly with a plastic water pitcher and her fists. This deficient practice resulted in Resident 2 feeling afraid while using his arms in self-defense against Resident 3's attack on him and sustaining a 1.0 centimeter ([cm]-unit of measurement) x 0.5 cm abrasion (a break in the skin when the skin rubs off) to the right side of his forehead, along with multiple areas of redness to Resident 2's right forehead and right forearm, requiring immediate first aid for seven days. Findings: During a review of Resident 2's admission Record (Face Sheet), the Face Sheet indicated Resident 2 was admitted to the facility on [DATE] with a diagnosis of metabolic encephalopathy (a brain dysfunction caused by a chemical imbalance from an underlying illness). During a review of Resident 2's Minimum Data Set (MDS) a resident assessment tool dated 9/23/2025, the MDS indicated Resident 2's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was intact and Resident 2 was dependent on facility staff for bed mobility and ambulation was not attempted. During a review of Resident 2's Change of Condition (COC) form dated 11/25/2025 and timed at 6:50 a.m., the COC form indicated Resident 3 entered Resident 2's room, went directly to him, took a water pitcher (Resident 2's water pitcher) and struck Resident 2 on his face. The COC form indicated Resident 2 and 3 were immediately separated by removing Resident 3 from Resident 2's room. The COC form indicated Resident 2 sustained an abrasion to his right temporal (side of the forehead) area measuring 1 cm x 0.5 cm and multiple areas of redness to his right forearm. During a review of Resident 2's Skin Integrity Sheet dated 11/25/2025, the Skin Integrity Sheet indicated the following: 1. A right temporal abrasion measuring 1 cm x 0.5 cm draining blood and a pink wound bed 2. Multiple areas of redness to Resident 2's right forehead. 3. Multiple areas of redness to Resident 2's right forearm. During a review of Resident 2's Treatment Administration Record (TAR) date 11/25/2025 through 12/1/2025, the TAR indicated Resident 2's right forehead with multiple areas of redness was cleansed with normal saline (a sterile, saltwater solution used in medicine to clean wounds), dried, and bacitracin ointment applied for 14 days. During a review of Resident 3's admission Record (Face Sheet), the Face Sheet indicated Resident 3 was admitted to the facility on [DATE] with a diagnosis of metabolic encephalopathy (brain dysfunction) and schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 3's MDS dated [DATE], the MDS indicated Resident 3's cognition was moderately impaired, and Resident 3 required substantial/maximal assistance (helper does more than half the effort) to complete her ADLs. During a review of Resident 3's Nursing Notes dated 11/25/2025 and timed at 6:50 a.m., the Nursing Notes indicated facility staff responded to yelling and screaming and found Resident 3 in Resident 2's room. The Nursing Note indicated Resident 3 took a water pitcher and hit Resident 2 on the right side of his face. The Nursing Note indicated Resident 3 was very aggressive when facility staff assisted her back to her room and she continued to yell and scream in the hallway. The Nursing Notes indicated Resident 3 required one-to-one (the continuous supervision of a single resident by a dedicated staff member whose sole responsibility is to watch that resident) staff monitoring. During an observation and interview on 12/2/2025 at 2:18 p.m., the right side of Resident 2's forehead revealed a small light area of a healed scar. Resident 2 stated on the morning of 11/25/2025, Resident 3 entered his room yelling at him he's the one then proceeded to throw a banana at him, then hit him with a plastic water pitcher. Resident 2 stated it happened so fast, he put his arms up to protect himself and even went under the blanket. Resident 2 stated he had never seen Resident 3 prior to her entering his room that morning, it shocked him, and he was scared because he didn't know what Resident 3 was going to do to him. Resident 2 stated he yelled for help, closed his eyes and he could feel repeated blows to his head for 10-15 seconds, then Certified Nursing Assistants (CNA 1 and CNA 2) came and removed Resident 3 from his room. During an interview on 12/2/2025 at 2:48 p.m., Resident 7 (Resident 2's roommate) stated he was in the hallway (11/25/2025) getting coffee when he saw Resident 3 enter Resident 2's room and go straight to Resident 2 saying you're the one and that he raped her (Resident 3). Resident 7 stated he saw Resident 3 swinging her fists and hit Resident 2. During a telephone interview on 12/3/2025 at 8:54 a.m., CNA 1 stated she was taking the linen and trash barrels near the kitchen area (11/25/2025) when she saw someone (Resident 3) rush into Resident 2's room. CNA 1 stated she saw Resident 3 throw water from a water pitcher onto the floor and proceeded to hit Resident 2</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to report an allegation of sexual abuse to the California Department of Public Health (CDPH) for one of four sample residents (Resident 3) when Resident 3 was heard by facility staff accusing Resident 1 of raping her. This deficient practice resulted in CDPH being unaware of the allegation of sexual abuse and the inability to investigate the allegation timely. This deficient practice had the potential for information to be lost and/or forgotten and placed Resident 3 at risk for continued abuse. Findings: During a review of Resident 3's admission Record (Face Sheet), the Face Sheet indicated Resident 3 was admitted to the facility on [DATE] with a diagnosis of metabolic encephalopathy (brain dysfunction) and schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 3's Minimum Data Set ([MDS] a resident assessment tool) dated 9/21/2025, the MDS indicated Resident 3's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was moderately impaired and Resident 3 required substantial/maximal assistance (helper does more than half the effort) to complete her ADLs. During an interview on 12/2/2025 at 2:48 p.m., Resident 7 stated he saw Resident 3 enter Resident 2's room, go straight to Resident 2 and said, you're the one you raped me . During a telephone interview on 12/3/2025 at 8:54 a.m., Certified Nursing Assistant (CNA) 1 stated she was taking out the linen and trash barrels near the kitchen area when she saw someone (Resident 3) rush into Resident 2's room, she then saw Resident 3 throw water from a pitcher onto the floor, then proceeded to hit Resident 2 with the water pitcher. CNA 1 stated Resident 3 was screaming and cursing at Resident 2 saying he gave me a shot, and he raped me. CNA 1 stated she provided a written report to Registered Nurse (RN 1), but she did not include Resident 3's accusation that Resident 2 raped her because she thought RN 1 would report it since she (RN 1) was nearby when Resident 3 made the allegation. During an interview on 12/3/2025 at 9:43 a.m., RN 1 stated she overheard CNA 1 talking about Resident 3's allegation that Resident 2 raped her and she (RN 1) reported that allegation to the Director of Nursing (DON). During an interview on 12/3/2025 at 1:45 p.m., the DON stated he was aware of Resident 3's allegation that Resident 2 raped her but stated he forgot to include the allegations when he reported the resident to resident incident on the same day between Resident 2 and Resident 3 to CDPH. During an interview on 12/3/2025 at 3:04 pm, the Administrator (ADM) stated he was not aware of the rape allegation made by Resident 3, had he known about the allegation, he would have reported it to CDPH. The ADM stated the allegation should have been reported to CDPH because facility staff were mandated reporters. During a review of the facility's undated Policy and Procedure (P/P) titled Abuse, Neglect and Exploitation the P/P indicated when abuse, neglect, or exploitation is suspected, the Licensed Nurse should contact the State Agency to report the alleged abuse.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to investigate one of four sampled residents' (Resident 3) allegation of sexual abuse when Resident 3 yelled and screamed at Resident 2 that he (Resident 2) raped her. This deficient practice resulted in the facility's inability to determine if the allegation had actually occurred and had the potential for other uninvestigated allegations of abuse to be uninvestigated. Findings: During a review of Resident 3's admission Record (Face Sheet), the Face Sheet indicated Resident 3 was admitted to the facility on [DATE] with a diagnosis of metabolic encephalopathy (brain dysfunction) and schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 3's Minimum Data Set ([MDS] a resident assessment tool) dated 9/21/2025, the MDS indicated Resident 3's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was moderately impaired and Resident 3 required substantial/maximal assistance (helper does more than half the effort) to complete her ADLs. During a review of Resident 3's Nursing Notes dated 11/25/2025 and timed at 6:50 a.m., the Nursing Notes indicated facility staff responded to yelling and screaming and found Resident 3 in Resident 2's room. The Nursing Note indicated Resident 3 took a water pitcher and hit Resident 2 on the right side of his face. The Nursing Note indicated Resident 3 was very aggressive when facility staff assisted her back to her room and she continued to yell and scream in the hallway. The Nursing Notes indicated Resident 3 required one-to-one (the continuous supervision of a single resident by a dedicated staff member whose sole responsibility is to watch that resident) staff monitoring. During an interview on 12/2/2025 at 2:48 p.m., Resident 7 (Resident 2's roommate) stated he was in the hallway (11/25/2025) getting coffee when he saw Resident 3 enter Resident 2's room and go straight to Resident 2 saying you're the one and that he raped her (Resident 3). Resident 7 stated he saw Resident 3 swinging her fists and hit Resident 2. During a telephone interview on 12/3/2025 at 8:54 a.m., CNA 1 stated she was taking the linen and trash barrels near the kitchen area (11/25/2025) when she saw someone (Resident 3) rush into Resident 2's room. CNA 1 stated she saw Resident 3 throw water from a water pitcher onto the floor and proceeded to hit Resident 2 with the water pitcher. CNA 1 stated, Resident 3 was screaming and cursing at Resident 2 saying he gave me a shot, and he raped me. CNA 1 stated Resident 3 was very combative when she and CNA 2 removed her from Resident 2's room. During an interview on 12/3/2025 at 9:43 a.m., RN 1 stated she overheard CNA 1 talking about Resident 3's allegation that Resident 2 raped her and she (RN 1) reported that allegation to the Director of Nursing (DON). During an interview on 12/3/2025 at 1:45 p.m., the DON stated he was aware of Resident 3's allegation that Resident 2 raped her but stated he forgot to include the allegations when he reported the resident to resident incident on the same day between Resident 2 and Resident 3 to CDPH. The DON stated he interviewed Resident 2 and Resident 3 regarding Resident 3's allegation that she was raped by Resident 2, but he was told by 3 to get the Fuck out before, then she was transferred to a General Acute Care Hospital (GACH). The DON stated Resident 2 stated he did not know Resident 3. The DON stated Resident 2 could not get up without assistance, so he concluded the allegation was not true. The DON was not able to provide documentation to indicate he investigated Resident 3's allegation of rape against Resident 2. During a review of the facility's undated Policy and Procedure (P/P), titled Abuse, Neglect and Exploitation, the P/P indicated when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur, an investigation is immediately warranted. The P/P indicated components of an investigation may include interviewing the involved residents, if possible, and to document all responses. The P/P indicated to document the entire investigation chronologically.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>(continued on next page)</p>

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<p>F 0684</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 interview and record review, the facility failed to ensure Licensed Vocational Nurse (LVN) 1 administered Heparin (a medication used to prevent the formation of blood clots [masses of blood that form when blood cells stick together]) as ordered by the physician for deep vein thrombosis ([DVT] a blood clot in a vein, usually in the leg) prophylaxis (treatment to prevent disease or infection from occurring or spreading) for one of four sampled residents (Resident 1). This deficient practice contributed to Resident 1 experiencing swelling and heaviness in her left lower extremity (leg), her subsequent transfer to a General Acute Care Hospital (GACH), where she was assessed and diagnosed with an extensive acute deep vein DVT of the left lower extremity. Findings: During a review of Resident 1's admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with a diagnosis of a displaced intertrochanteric fracture (a type of broken bone in the upper part of the thigh bone (femur) near the hip, where the bone pieces are out of place) of the right femur and fracture (broken bone) of right lower leg. During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 11/5/2025, the MDS indicated Resident 1's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was intact and Resident 1 was dependent (helper does all of the effort) on facility staff to complete her activities of daily living ([ADLs] activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 1's Physician's Order dated 10/29/2025, the Physician's Order indicated Resident 1 was to receive Heparin Injection Solution 5000 units/milliliter ([ml] a unit of measurement), 1.0 ml injected subcutaneously (under the skin) every eight hours for DVT prophylaxis (treatment to prevent disease or infection from occurring or spreading). During a review of Resident 1's Change in Condition (COC) form dated 11/10/2025 and timed at 11:44 p.m., the COC form indicated Resident 1 reported to LVN 2 that her legs were swollen. The COC form indicated Resident 1's left lower extremity was observed to be swollen. The COC form indicated Resident 1's physician was made aware. During a review of Resident 1's Physician's Order dated 11/11/2025, the Physician's Order indicated an order for venous doppler (a medical ultrasound technique that uses high frequency sound waves to create images of the veins, primarily to check blood flow and detect any blockages or clots, commonly used to diagnose conditions such as DVTs) diagnostic test of Resident 1's left leg to rule out a DVT. During a review of Resident 1's Nursing Note dated 11/11/2025, the Nursing Note indicated the venous doppler diagnostic test could not be performed because a soft leg cast and leg brace were present on the resident's left leg. During a review of Resident 1's Physician's Order dated 11/11/2025, the Physician's Order indicated to transfer Resident 1 a GACH for further evaluation. The Nursing Note indicated Resident 1 was transferred to GACH via ambulance. During a review of the GACH's Emergency Department (ED) Encounter Note dated 11/11/2025, the ED Encounter Note indicated Resident 1 presented with bilateral (both) thigh swelling, worse on the left thigh, status post (indicates a patient has undergone a specific event or procedure in the past) multiple fractures after a car accident (date of care accident unknown). The ED Encounter Note indicated Resident 1 reported missing a dose of Heparin, had sudden swelling of her thigh, and her leg brace felt tighter. During a review of GACH's Ultrasound (a medical test that uses sound waves to create images of the inside of the body) of Resident 1's lower extremity dated 11/11/2025, the Ultrasound results indicated extensive acute (a condition that is severe and sudden in onset) DVTs of Resident 1's left lower extremity. During an interview on 12/1/2025 at 8:15 a.m., Resident 1 stated on 11/10/2025, her legs started to feel funny, as if they were swelling, she reported this to LVN 2 at the same time she reported to LVN 2 that LVN 1 did not give the afternoon dose (2 p.m.) of Heparin. Resident 1 stated she went to physical therapy at 12:30 p.m. and stayed there for about 45 minutes to one hour and returned to her room around 1:45 p.m. Resident 1 stated she waited for LVN 1 to give her the Heparin, but LVN 1 did not. Resident 1 stated after the change of shift, she informed LVN 2 she did not receive her afternoon dose of Heparin. LVN 2 confirmed that it had not been given by calling LVN 1. Resident 1 stated LVN 2 told her documentation he reviewed (the MAR) indicated LVN 1 had given her the afternoon dose (2 p.m.) of Heparin. Resident 1 stated when LVN 2 called LVN 1, LVN 1 told LVN 2 he had forgotten to administer Resident 1's dose of Heparin. During an interview on 12/1/2025 at 11:01 a.m., LVN 2 stated on 11/10/2025 around 4:45 p.m., Resident 1 reported to him that she did not receive her afternoon dose of Heparin. LVN 2 stated he reviewed Resident 1's MAR which indicated the dose of Heparin had been given by LVN 1 at 2 p.m. LVN 2 stated he called LVN 1 to clarify the</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>(continued on next page)</p>

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  12/03/2025
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 0842</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 interview and record review, the facility staff failed ensure a Medication Administration Record ([MAR] a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for one of four sampled residents (Resident 1) was not falsified, when Licensed Vocational Nurse (LVN) 1 documented he administered a dose of Heparin (a medication to prevent the formation of clots [masses of blood that form when blood cells stick together]) to Resident 1 on 11/10/2025 at 2 p.m., when he had not given it to her and then on 11/17/2025 documented another incorrect entry also indicating he had administered the Heparin dose to Resident 1. This deficient practice resulted in the inaccurate depiction of Resident 1's medication management and had the potential for non-continuity of care based on the inaccurate documentation. Findings: During a review of Resident 1's admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with a diagnosis of a displaced intertrochanteric fracture (a type of broken bone in the upper part of the thigh bone (femur) near the hip, where the bone pieces are out of place) of the right femur and fracture (broken bone) of right lower leg. During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 11/5/2025, the MDS indicated Resident 1's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was intact and Resident 1 was dependent (helper does all of the effort) on facility staff to complete her activities of daily living ([ADLs] activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 1's Physician's Order dated 10/29/2025, the Physician's Order indicated Resident 1 was to receive Heparin Injection Solution 5000 units/milliliter ([ml] a unit of measurement), 1.0 ml injected subcutaneously (under the skin) every eight hours for DVT prophylaxis (treatment to prevent disease or infection from occurring or spreading). During a review of Resident 1's MAR dated 11/10/2025 and timed at 2 p.m., the MAR indicated a 9 signifying Resident 1 was not available because she was participating in therapy and Resident 1 preferred to receive her medication after completing her session. During a review of Resident 1's Medication Administration Audit Report ([MAAR] document of medication administration in the exact time the record was documented by staff), the MAAR indicated Resident 1's Heparin was administered on 11/10/2025 at 2:18 p.m., continued documentation indicated a change to the original time and date for 11/17/2025 at 10:20 a.m. During an interview on 12/1/2025 at 8:15 a.m., Resident 1 stated on 11/10/2025, her legs started to feel funny, as if they were swelling, she reported this to LVN 2 at the same time she reported to LVN 2 that LVN 1 did not give the afternoon dose (2 p.m.) of Heparin. Resident 1 stated she went to physical therapy at 12:30 p.m. and stayed there for about 45 minutes to one hour and returned to her room around 1:45 p.m. Resident 1 stated she waited for LVN 1 to give her the Heparin, but LVN 1 did not. Resident 1 stated after the change of shift, she informed LVN 2 she did not receive her afternoon dose of Heparin. LVN 2 confirmed that it had not been given by calling LVN 1. Resident 1 stated LVN 2 told her documentation he reviewed (the MAR) indicated LVN 1 had given her the afternoon dose (2 p.m.) of Heparin. Resident 1 stated when LVN 2 called LVN 1, LVN 1 told LVN 2 he had forgotten to administer Resident 1's dose of Heparin. During an interview on 12/1/2025 at 11:01 a.m., LVN 2 stated on 11/10/2025 around 4:45 p.m., Resident 1 reported to him that she did not receive her afternoon dose of Heparin. LVN 2 stated he reviewed Resident 1's MAR which indicated the dose of Heparin had been given by LVN 1 at 2 p.m. LVN 2 stated he called LVN 1 to clarify the administration of Heparin and LVN 1 informed him that he (LVN 1) forgot to give the dose of Heparin to Resident 1. LVN 2 stated throughout the shift (3 p.m. - 11 p.m.), Resident 1 complained that her left leg was swollen. LVN 2 stated he assessed Resident 1 when the resident initially complained but around 9 p.m. LVN 2 stated the resident's left leg swelling was obvious and he reported it to Registered Nurse (RN 2) and Resident 1's physician. During a telephone interview on 12/1/2025 at 12:23 p.m., LVN 1 stated at approximately 2:45 p.m., he was finishing his charting and Resident 1 had not returned from physical therapy yet, which was why he did not give Resident 1 her dose of Heparin. LVN 1 stated he accidentally documented that he administered the dose of Heparin to Resident 1, and he should not have done that. LVN 1 stated he did not think one missed dose of Heparin could contribute to the development of a DVT because he believed Heparin stayed in the body long enough to prevent DVTs from forming. During a telephone interview on 12/1/2025 at 12:23 p.m., LVN 1 stated at approximately 2:45 p.m., he was finishing his charting and Resident 1 had not returned from physical therapy yet, which was why he did not give Resident 1 her</p>		