

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  12/18/2025
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 0600  Level of Harm - Minimal harm or potential for 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)

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:  056188	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/18/2025
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 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 interview and record review, the facility failed to ensure one of four sampled residents (Resident 2) was not subjected to abuse when Resident 1, who had aggressive behaviors and required one-to-one monitoring (a care approach where a dedicated staff member is assigned to closely observe and attend to the needs of a specific resident. This level of monitoring is crucial in managing residents with aggressive tendencies or other complex needs, ensuring that any potential incidents can be promptly addressed), was not assigned staff to monitor him. This deficient practice resulted in Resident 1 punching Resident 2 on the left side of his chest and had the potential for Resident 2's continued abuse and other residents to be assaulted by Resident 1. 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 schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 10/2/2025, the MDS indicated Resident 1's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was moderately impaired and Resident 1 required supervision or touch assistance (helper provides verbal cues and/or touching steady and/or contact guard assistance as resident complete activity) from facility staff to complete his activities of daily ([ADLs] activities such as bathing, dressing and toileting a person performs daily). Resident 1's MDS indicated Resident 1 exhibited physical behavior symptoms such as kicking, hitting and pushing towards others. During a review of Resident 1's Care Plan dated 12/4/2025, the Care Plan indicated Resident 1 had a potential for complications related to episodes of yelling/screaming, verbal aggression, and attempts to strike out at staff. Under this Care Plan a goal for Resident 1 was to minimize his behaviors daily. The Care Plan's interventions included one-to-one monitoring for Resident 1. During a review of Resident 1's Nursing Note dated 12/4/2025, the Nursing Note indicated Resident 1 required constant supervision. During a review of Resident 1's COC form dated 12/7/2025, the COC form indicated while on the smoking patio, Resident 1 put his hands on another resident's (Resident 2) left chest and activity staff immediately separated both residents. During a review of Resident 2's admission Records (Face Sheet), the Face Sheet indicated Resident 2 was admitted to the facility on [DATE] with a diagnosis of schizophrenia. During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2's cognition was intact, and Resident 2 required supervision/touch assistance from facility staff to complete his ADLs. During a review of Resident 2's COC form dated 12/7/2025, the COC indicated while Resident 2 was on the smoking patio with the activities staff, another resident (Resident 1) put his hands on the left side of Resident 2's chest, and the activities staff immediately separated the residents. During an interview on 12/18/2025 at 9:16 a.m., Resident 2 stated he was on the smoking patio, just standing there when Resident 1 out of nowhere punched him (Resident 2) on the left side of his chest. During an interview on 12/18/2025 at 9:18 a. m. and a subsequent interview at 1:45 p.m., the Activities Assistant (AA) stated he was on the smoking patio monitoring the residents when he saw Resident 1 punch Resident 2 on the left side of his chest. The AA stated he was the only staff member present on the smoking patio when the incident occurred. During an interview on 12/18/2025 at 2 p.m., Licensed Vocational Nurse (LVN) 1 stated on 12/5/2025, he saw Resident 1 trying to leave through the front door. LVN 1 notified the Director of Nursing (DON), who placed Resident 1 on one-to-one monitoring due to his exit-seeking behavior. LVN 1 stated the AA was present on the smoking patio to provide smoking supplies and to monitor the residents who were smoking but the AA was not assigned as Resident 1's one-to-one monitor. During an interview on 12/18/2025 at 2:56 p.m., the DON stated Resident 1 needed one-to-one monitoring due to prior verbal aggression and exit-seeking behavior. The DON stated the assignment for the one-to-one monitoring for Resident 1 was missed. The DON stated, an assigned one-to-one staff would have been immediately beside Resident 1, potentially preventing the incident between Resident 1 and Resident 2 from occurring. During a review of the facility's undated Policy and Procedure (P/P) titled Abuse, Neglect and Exploitation the P/P indicated residents should not be subject to abuse by anyone including but not limited to facility staff, other residents .</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  12/18/2025
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 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>(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  12/18/2025
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 0656</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 the care plan for one of four sampled residents (Resident 1) whose interventions included one-to-one-monitoring (a care approach where a dedicated staff member is assigned to closely observe and attend to the needs of a specific resident. This level of monitoring is crucial in managing residents with aggressive tendencies or other complex needs, ensuring that any potential incidents can be promptly addressed) was implemented. This deficient practice resulted in Resident 1 not being provided one-to-one-monitoring, Resident 2 being left unsupervised and punching Resident 2 on the left side of his chest. This deficient practice had the potential for continued assault to Resident 2 as well as other residents who resided in the facility. 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 schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 10/2/2025, the MDS indicated Resident 1's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was moderately impaired and Resident 1 required supervision or touch assistance (helper provides verbal cues and/or touching steadying and/or contact guard assistance as resident complete activity) from facility staff to complete his activities of daily ([ADLs] activities such as bathing, dressing and toileting a person performs daily). Resident 1's MDS indicated Resident 1 exhibited physical behavior symptoms such as kicking, hitting and pushing towards others. During a review of Resident 1's Care Plan dated 12/4/2025, the Care Plan indicated Resident 1 had a potential for complications related to episodes of yelling/screaming, verbal aggression, and attempts to strike out at staff. Under this Care Plan a goal for Resident 1 was to minimize his behaviors daily. The Care Plan's interventions included one-to-one monitoring for Resident 1. During a review of Resident 1's COC form dated 12/7/2025, the COC form indicated while on the smoking patio, Resident 1 put his hands on another resident's (Resident 2) left chest and activity staff immediately separated both residents. During an interview on 12/18/2025 at 9:16 a.m., Resident 2 stated he was on the smoking patio, just standing there when Resident 1 out of nowhere punched him (Resident 2) on the left side of his chest. During an interview on 12/18/2025 at 9:18 a.m. and a subsequent interview at 1:45 p.m., the Activities Assistant (AA) stated he was on the smoking patio monitoring the residents when he saw Resident 1 punch Resident 2 on the left side of his chest. The AA stated he was the only staff member present on the smoking patio when the incident occurred. During an interview on 12/18/2025 at 2 p.m., Licensed Vocational Nurse (LVN) 1 stated on 12/5/2025, he saw Resident 1 trying to leave through the front door. LVN 1 notified the Director of Nursing (DON), who placed Resident 1 on one-to-one monitoring due to his exit-seeking behavior. LVN 1 stated the AA was present on the smoking patio to provide smoking supplies and to monitor the residents who were smoking but the AA was not assigned as Resident 1's one-to-one monitor. LVN 1 stated one-to-one monitoring was on Resident 1's care plan and should have been followed, it was an intervention created after Resident 1 had a previous episode of yelling and being aggressive to staff. During an interview on 12/18/2025 at 2:56 p.m., the DON stated Resident 1 needed one-to-one monitoring due to prior verbal aggression and exit-seeking behavior. The DON stated the assignment for the one-to-one monitoring for Resident 1 was missed. The DON stated, an assigned one-to-one staff would have been immediately beside Resident 1, potentially preventing the incident between Resident 1 and Resident 2 from occurring. During a review of the facility's undated Policy and Procedure (P/P) titled Comprehensive Care Plans, the P/P indicated the facility will develop and implement a comprehensive person centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing and mental and psychosocial needs that are identified in the resident's comprehensive assessment.</p>		