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	02/09/2026

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow resident to participate in the development and implementation of his or her person-centered plan of care. Based on interview and record review, the facility failed to involve one of three sampled residents (Resident 3) in Interdisciplinary Team (IDT-team of health care professionals that work together toward and prioritize the resident 's needs) care conferences. This deficient practice violated Resident 3's rights to be informed and the right to participate in resident's plan of care.Findings:During a review of Resident 3's admission Record, the admission record indicated the facility originally admitted Resident 3 on 11/1/2022 and recently readmitted Resident 3 on 1/4/2023 with diagnoses including anxiety disorder (mental health illness causing pervasive worry and fear affecting daily life), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs).During a review of Resident 3's Minimum Data Set ([MDS] a resident assessment tool), dated 11/21/2025, the MDS indicated Resident 3 understood others and was understood. The MDS indicated Resident 3's cognition (ability to think and reason) for daily decision making was intact. The MDS indicated that it was very important to Resident 3 to participate and be involved in discussions about her care. During a review of Resident 3's History and Physical (H&P), dated 1/30/2025, the H&P indicated Resident 3 was alert, oriented to person, place, time, situation, and had the capacity to understand and make medical decisions.During an interview on 2/6/2026 at 10 a.m., Resident 3 stated she was not always made aware when her IDT team care conferences were being held. Resident 3 started to cry and stated she would like to participate in the IDT Care Conferences about her care.During a concurrent interview and record review on 2/6/2026 at 11:20 a.m., with the Infection Prevention Nurse (IPN), Resident 3's Interdisciplinary Team Conference Records, were reviewed. The IPN confirmed IDT Care Conference, dated 8/6/2025 indicated Resident 3 wanted to reschedule because she was not feeling well. The IDT meeting was not rescheduled, and the next IDT meeting was on 11/5/2025, three months later. The IPN confirmed the IDT Care Conference on 11/5/2025 had no documented evidence of Resident 3's participation. The IPN stated if residents request the meeting to be rescheduled then it should have been rescheduled. The IPN stated residents need to be part of their IDT meetings.During an interview on 2/9/2026 at 1:26 p.m. with the Director of Nursing (DON), the DON stated residents, or representatives should always be part of the IDT Care Conferences to be able to be part of their own plan of care. During a review of the facility's policy and procedure (P&P) titled, Care Planning - Interdisciplinary Team, revised 2023, the P&P indicated the resident, resident's family and/or responsible party were encouraged to participate in the development of and revisions to the resident's care plan. The P&P indicated the IDT was responsible for developing individualized care plans for each resident.During a review of the facility's document titled, Resident Rights, undated, the document indicated the resident has the right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to:The right to participate in the planning process, including the (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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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.The right to be informed, in advance, of changes to the care plan.The right to see the care plan, including the right to sign after changes to the care plan.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed ensure one of two Residents (Resident 1) was not able to throw a pitcher of water and a container of urine on Resident 2, after Resident 1 kicked Resident 2 out of the bed and onto the floor.This deficient practice resulted in Resident 1 drenching Resident 2 in water and urine, after he had kicked Resident 2 out of the bed onto the floor. Resident 2 also sustained a left maxillofacial (jaws and the face) contusion (bruise).Findings:During a review of Resident 1's admission Record, the admission record indicated the facility originally admitted Resident 1 on 3/1/2025 with diagnoses including encephalopathy (broad term for any disease, damage, or malfunction of the brain), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), and anxiety disorder (mental health condition characterized by pervasive worry and fear).During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool), dated 12/30/2025, the MDS indicated Resident 1 had severe cognitive (thought process) impairment and needed set-up assistance with eating, oral hygiene, and personal hygiene.During a review of Resident 2's admission Record, the admission record indicated the facility originally admitted Resident 2 on 9/24/2025 with diagnoses including encephalopathy, heart failure (heart cannot pump enough blood to the body), dementia (a progressive state of decline in mental abilities), schizoaffective disorder, mood disorder (mental health conditions involving long-term, extreme disturbances in emotional state, such as intense sadness or high energy elevated periods of emotional highs), and anxiety disorder.During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2 had severe cognitive impairment. The MDS indicated Resident 2 needed supervision when eating, partial assistance (helper does less than half the effort to complete the task) with oral hygiene, substantial assistance (helper does more than half the effort to complete the task) with personal hygiene, showering, and toileting hygiene.During a review of Certified Nurse Assistant (CNA) 1's signed statement, undated, the statement indicated that Resident 1 was standing at on the left side of Resident 2's bed while Resident 2 was lying on the bed. CNA 1's statement indicated Resident 1 kicked Resident 2 on the left side of his body and Resident 2 rolled and fell off the right side of the bed. CNA 1's statement indicated CNA 1 attempted to intervene and Resident 1 pushed CNA 1 and then CNA 1 called for help. CNA 1's statement indicated Resident 1 reached for and threw the water pitcher with water. The water pitcher and the water landed on Resident 2's face. Resident 1 then grabbed and threw the urinal (a portable container designed for resident to urinate into when they cannot easily access a toilet), and the urinal filled with urine landed on Resident 2's chest.During a review of Resident 2's Progress Notes titled, Nursing Note, dated 1/26/2026 at 2:15 p.m., the Nursing Notes indicated Resident 2 was hit by another resident (Resident 1). The Nursing Note indicated Resident 2 presented with slight swelling on left temporal (side of the head) area and redness on left shin (front of the leg below the knee), right knee, and redness on the chest area. The Nursing Note indicated Resident 2 responded to name by saying yes or moaning. The Nursing Note indicated on 1/26/2026 at 4:55 p.m. an ambulance transported Resident 2 to a General Acute Care Hospital (GACH) for further evaluation. During a review of Resident 2's ED (Emergency Department) Notes, Final Report, dated 1/26/2026 at 10 p.m., the notes indicated Resident 2 was hit in the face and sustained left maxillofacial contusion on 1/26/2026 at 2:30 p.m.During an interview with Resident 1, on 2/6/2026 at 11:40 a.m., Resident 1 stated he (Resident 1) kicked Resident 2 because Resident 2 stunk; Resident 1 stated he (Resident 1) then threw a water pitcher and a container of urine at Resident 2. During an interview on 2/6/2026 at 12:20 p.m., with CNA 1, CNA 1 stated on 1/26/2026 at about 2:15 p.m., Resident 1 was standing on (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the left side of Resident 2's bed when Resident 1 kicked Resident 2 on the left side of Resident 2's body while Resident 2 was lying down in bed. Resident 1 kicked Resident 2 again on the left side of his body and then Resident 2 fell off the bed to the right side and landed on the floor mat. CNA 1 stated she (CNA 1) attempted to intervene but Resident 1 pushed CNA 1 away, and CNA 1 called for help. CNA 1 stated Resident 1 reached for and threw the water pitcher, and the water pitcher and water landed on Resident 2's face. Resident 1 also grabbed and threw the urinal, and the urinal and urine landed on Resident 2's chest. During an interview on 2/6/2026 at 12:43 p.m., with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated Resident 2 was a victim of physical abuse when Resident 1 kicked him, threw a water pitcher with water and urine on Resident 2. LVN 2 stated, on 1/26/2026, she heard CNA 1 and CNA 2 calling for help and by the time LVN 2 was in the room Resident 2 was on all fours on the blue fall mattress. LVN 2 stated Resident 1 was pacing in the room very agitated saying, I beat him up. I beat him up. LVN 2 stated there were fluids (water and urine) on the floor and on Resident 2.During an interview on 12/9/2026 at 1:23 p.m., with the Director of Nursing (DON), the DON stated residents have the right to be free from abuse. The DON stated Resident 1 physically abused Resident 2. The DON stated facility staff should have physically separated Resident 2 from Resident 1 when Resident 1 first kicked Resident 2, while Resident 2 was lying in bed. The DON stated Resident 2 should not have been able to kick resident 2 again, throw a pitcher and the water it contained and then pour urine on Resident 1.During a review of the facility's policy and procedure (P&P) titled, Abuse, Neglect, Exploitation, undated, the P&P indicated residents have the right to be free from physical abuse. The P&P indicated the facility will make efforts to protect all residents after alleged abuse by responding to the needs of the resident and protect them from further incident. The P&P indicated the facility will consider utilization of the following tips for prevention of abuse of residents by training staff in appropriate interventions to deal with aggressive and/or catastrophic reactions by residents.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to implement its facility policy to ensure the environment was free from accident hazards when one of two sampled residents' (Resident 3) bathroom floor was wet on 10/19/2025. The deficient practice resulted in Resident 3 slipping and falling onto the wet bathroom floor causing her to land on her right arm and shoulder. The slip and fall accident resulted in Resident 3's frequent complaint of right shoulder pain for a period of approximately 4 months and the accidental fall became a precipitating factor of the right shoulder full thickness tear of the supraspinatus tendon with retraction of the tendon (complete, through-and-through detachment of the tendon [connective tissue]from the shoulder bone that pulls back [retracts] from its attachment site) and fluid in the subacromial (space beneath the bony projection top of shoulder) and subdeltoid (space beneath the shoulder muscle) bursa (fluid-filled cushion) diagnosed on [DATE]. Findings: During a review of Resident 3's admission Record, the admission record indicated the facility originally admitted Resident 3 on 11/1/2022 and recently readmitted Resident 3 on 1/4/2023 with diagnoses including morbid obesity (severe and dangerous levels of obesity that significantly and negatively impacts health), and osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage). During a review of Resident 3's Minimum Data Set ([MDS] a resident assessment tool), dated 8/6/2025, the MDS indicated Resident 3 understood others and was understood. The MDS indicated Resident 3's cognition (ability to think and reason) for daily decision making was intact. The MDS indicated Resident 3 needed set-up assistance when eating, performing oral hygiene and Resident 3 needed supervision with toileting hygiene. Resident 3 can walk 10 feet, and the helper assists only prior to or following the activity.During a review of Resident 3's History and Physical (H&P), dated 1/30/2025, the H&P indicated Resident 3 was alert, oriented to person, place, time, situation, and had the capacity to understand and make medical decisions.During a review of Resident 3's fall risk assessment, dated 8/6/2025, the fall risk assessment indicated Resident 1 was at risk for falls.During a review of Resident 3's Care Plan Report, the report indicated a care plan titled, Potential for injury/falls, dated 5/4/2025, the goal indicated Resident 3's potential for injury and fall would be minimized daily. One of the care plan interventions indicated to maintain hazard free and safe environment.During a review of Resident 3's Progress Notes titled, Nursing Note, dated 10/19/2025 at 6:27 a.m., the Progress Notes indicated that Resident 3 was found on the floor of the bathroom. The Progress Notes indicated Resident stated, I lost my balance from the floor being wet. The note indicated Resident 3 stated, my arm hurts and complained of right shoulder pain with severity rated at an 8 out of 10 from the numerical pain scale (0 represents no pain, 1 to 3 indicating mild pain, 4 to 6 moderate pain, 7 to 10 severe pain). During a review of Resident 3's Progress Notes, titled Situation, Background, Assessment, Recommendation (SBAR) Summary for Providers, dated 10/23/2025 at 5:57 a.m., the Progress Notes indicated Resident 3 had a fading yellowish skin discoloration on her right upper arm and Resident 3 complained of severe right upper arm pain, 8 out of 10 from pain scale, because of the recent fall. During a review of Resident 3's Nursing Note, dated 10/23/2025 at 1:26 p.m., the Nursing Note indicated Physician 1 ordered Lidocaine ointment 5% (pain medication) twice a day for right shoulder pain management.During a review of Resident 3's Nursing Note, dated 10/26/2025 at 9:14 p.m., the Nursing Note indicated Resident 3 complained of right shoulder pain. During a review of Resident 3's Nursing Note, dated 11/3/2025 at 2 p.m., the Nursing Note indicated Resident 3 requested for an Magnetic Resonance Imaging ([MRI] diagnostic tool using strong magnets and radio waves to create detailed images of soft tissues, organs, and bones) of the right shoulder for the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	frequent right shoulder pain and Physician 1 ordered Orthopedic Surgeon (specialize in diagnosing, treating, and repairing bones, joints, muscles, tendons [connective tissue] using surgical and non-surgical methods) follow up for the MRI order.During a review of Resident 3's Orthopedic Consultation Notes, dated 11/12/2025 4:07 p.m., the notes indicated Resident 3 stated she was getting off the toilet, the floor was slippery, and Resident 3 fell landing on right shoulder and right knee. Resident 3 stated since the fall on 10/19/2025, she (Resident 3) has been having significant pain in the right shoulder and was unable to raise the arm. The Nursing Note indicated examination results revealed Resident 3 most likely had a rotator cuff (muscles that stabilize the shoulder joint) tear of the right shoulder and required an MRI. During a review of Resident 3's Nursing Note, dated 11/18/2025 at 3:24 p.m., the Nursing Note indicated Resident 3 was seen by Physician 2 for right shoulder spasticity (involuntary muscle contractions, stiffness, and abnormal posture) and continued right shoulder pain.During a review of Resident 3's SBAR Summary for Providers, dated 11/20/2025 at 5:37 p.m., the Note indicated Resident 3 claimed her shoulder popped when getting out of bed and was in pain.During a review of Resident 3's MRI of the right shoulder without contrast (special dye), performed on 12/9/2025 at 10:30 a.m., The MRI revealed Resident 3 had a full thickness tear of the tendons and fluid in the subacromial and subdeltoid bursa. During a review of Resident 3's Nursing Note, dated 1/23/2026 at 11:12 a.m., the note indicated Resident 3's surgery will be on 3/17/2026.During an interview on 2/6/2026 at 10 a.m., Resident 3 stated that on 10/19/2025, Sunday, at around 6 a.m., she (Resident 3) went to use the toilet, sat down, got up, pulled her pants up, then took a step forward, that's when she slipped and fell and landed on her right shoulder and right arm. Resident 3 stated she (Resident 3) then noticed her right arm hurt. Resident 3 stated she (Resident 3) called for help with no response so Resident 3 scooted to the bathroom door on her back, opened it with her left hand, called for help, and assistance came immediately.During an interview with the Housekeeping Supervisor (HKS) on 2/6/2026 at 4:35 p.m., the HKS stated floors should never be left wet. HKS stated the housekeepers clean the rooms assigned daily and housekeepers work from 8 a.m. to 4 p.m. The HKS stated outside those hours a Janitor was assigned to clean common areas and did not check resident rooms unless staff alerted them to go to a specific room. During a concurrent interview and record review on 2/9/2026 at 8:26 a.m., with Licensed Vocational Nurse (LVN)1, LVN 1 reviewed Resident 3's Nurses notes dated 10/19/2025 at 6:27 a.m., LVN 1 confirmed the notes she authored and stated that after 6 a.m. on 10/19/2025 she was alerted to go to Resident 3's room and Resident 3 was lying on the floor and complained of right shoulder and arm pain. LVN 1 stated that the floor Resident 3's bathroom floor was wet. LVN 1 was unable to quantify amount of water noted on the floor but stated it was not flooded. LVN 1 stated the paramedics were called and Resident 3 refused to go to the general acute care hospital (GACH). LVN 1 stated the floors shouldn't have been wet because of safety reasons; wet floors are hazardous and residents can slip and fall.During a concurrent interview and record review on 2/9/2026 at 1:26 p.m., with the Director of Nursing (DON), Resident 3's Fall Team Meeting Notes dated 10/19/2025 were reviewed. The notes indicated the fall appeared to be related to an environmental factor; wet floor surfaces were identified as a potential risk, especially for residents with balance limitations. The DON stated the team discussed the importance of keeping bathroom floors dry and addressing wet conditions promptly to reduce fall risk. During a review of the facility's policy and procedures (P&P) titled, Hazardous Areas, Devices, and Equipment, undated, the P&P indicated all hazardous areas in the facility will be identified and appropriately addressed to ensure resident safety and to mitigate hazards to the extent possible. A hazard is identified as anything in the that has the potential to cause injury. During a review of the facility's P&P titled, Falls and Falls Risk (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Managing, undated, the P&P indicated the staff will try to prevent resident falls with identified interventions.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review, the facility failed to ensure one of one resident's (Resident 3)'s consultation reports were in Resident 3's medical records.This deficient practice had the potential to result in a delay in care and services and depict an inaccurate and incomplete record of care and services received by Resident 3.Findings:During a review of Resident 3's admission Record, the admission record indicated the facility originally admitted Resident 3 on 11/1/2022 and recently readmitted Resident 3 on 1/4/2023 with diagnoses including anxiety disorder (mental health illness causing pervasive worry and fear affecting daily life), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs).During a review of Resident 3's Minimum Data Set ([MDS] a resident assessment tool), dated 11/21/2025, the MDS indicated Resident 3 understood others and was understood. The MDS indicated Resident 3's cognition (ability to think and reason) for daily decision making was intact. During an interview on 2/6/2026 at 10 a.m., Resident 3 stated she went to several consultation appointments in 2025 and Physician 1 informed Resident 3 that Resident 3's consultation notes were not in her (Resident 3) medical records. During a concurrent interview and record review on 2/6/2026 at 11:29 a.m., with the Medical Records Director (MRD), Resident 3's records were reviewed. The MRD confirmed that not all Resident 3's consultations for 2025 were in the medical records and it should have been placed in the chart or uploaded. The MRD stated it should be in the medical records so the physicians and staff could refer to it, and have a clearer picture of Resident 3's health. The MRD stated the missing records were Orthopedic (a medical specialty focused on diagnosing, treating, and preventing musculoskeletal system injuries and diseases, including bones, joints, ligaments, tendons, and muscles) and Neurologist (medical doctors specializing in diagnosing, treating, and managing disorders affecting the nervous system [body's command center]) consultations.During an interview on 2/9/2026 at 1:26 p.m., with the Director of Nursing (DON), the DON stated Resident 3 consultant's notes should be in Resident 3's medical records. During a review of the facility's policy and procedure (P&P) titled, Accuracy of Medical Records, undated, the P&P indicated the facility will ensure that all medical records are complete, accurate and updated to reflect care and services provided to each resident.