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	03/23/2026

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 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 observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 1) was free from physical abuse when Resident 2 punched Resident 1 with his fist. This deficient practice resulted in Resident 1 sustaining a 1.0-centimeter ([cm] unit of measurement) V-shaped avulsion (injury in which tissue is forcibly torn away or detached) to his right lower lip, an open area to his right inner lip, and abrasion to his right upper lip. Resident 1 required immediate first aid for 14 days and transfer to a General Acute Care Hospital (GACH) for evaluation. Findings:During a review of Resident 1's admission Record (Face Sheet), the Face Sheet indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1 had diagnoses including metabolic encephalopathy (a brain dysfunction caused by chemical imbalances in the body from an underlying illness), chronic obstructive pulmonary disease ([COPD] a chronic lung disease causing difficulty in breathing) and type 2 diabetes mellitus ([DM] disorder characterized by difficulty in blood sugar control and poor wound healing).During a review of Resident 1's the Minimum Data Set (MDS] a resident assessment tool), dated 2/16/2026, 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.During a review of Resident 1's Nursing Progress Notes, dated 3/10/2025, the Nursing Note indicated on 3/10/2026 at approximately 5 p.m., Registered Nurse (RN) 1 was summoned to the dining area by staff that Resident 1 was punched by another resident. The Nursing Progress Notes indicated Resident 1 stated, Resident 2 came to his room, knocked on his door, and when Resident 1 came out of his room, Resident 2 punched him. The Nursing Progress Notes indicated Resident 1 was observed with a moderate amount of bleeding to his right lower lip and sustained a laceration to his right lower lip, an open area on his right inner lip, and an abrasion to his right upper lip. The Nursing Progress Notes indicated an order was received for Resident 1 to be sent to the GACH for evaluation. During a review of Resident 1's GACH Emergency Department (ED) Note dated 3/10/2026, the ED Note indicated Resident 1 was brought in from a Skilled Nursing Facility (SNF) after a witnessed altercation, Resident 1 was punched in the mouth and has a laceration on the right lower lip. The ED Note further indicated Resident 1's right lower lip was noted with a 1.0 cm V-shaped avulsion which was cleansed and bacitracin (an antibiotic ointment used on the skin to help prevent minor infections in small cuts, scrapes, or wounds) ointment. During a review of Resident 1's Treatment Administration Record ([TAR] a daily documentation record used by licensed nurses to document medications and treatments given to a resident) dated 3/2026, the TAR indicated to cleanse Resident 1's right lower lip laceration and right upper lip abrasion with normal saline, pat dry, and apply bacitracin ointment for 14 days.During a review of Resident 2's admission Record (Face Sheet), the Face Sheet indicated Resident 2 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 2 had diagnoses including metabolic encephalopathy, chronic obstructive pulmonary disease and DM type 2.During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2's cognition was intact. During a review of Resident 2's Nursing Progress Notes, dated 3/10/2026, the Nursing Progress Notes indicated on 3/10/2026 at (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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(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	approximately 5:40 pm, Resident 2 was interviewed and stated he was startled by Resident 1 and he (Resident 2) admitted to hitting Resident 1. The Nursing Progress Notes indicated Resident 2 stated, he did not know why he hit Resident 1 and did not intend to hit him.During an observation on 3/19/2026, at 9:25 a.m., in Resident 1's room, Resident 1 was observed to have a scab (hard, crusty layer of dried blood and cells that forms over a cut, scrape, or wound) on the right side of his lower lip. During an interview on 3/19/2026 at 9:30 a.m., Resident 1 stated another resident punched him in the face, causing a cut on his lip. Resident 1 stated he was sent to the hospital to ensure he was okay after he was punched.During an interview on 3/19/2026 at 10:00 a.m., Certified Nurse Assistant (CNA) 1 stated on 3/10/2026 at approximately 5 p.m., she was in the dining room assisting residents with their meals. CNA 1 stated she observed Resident 1 waving his hands toward Resident 2 as Resident 2 entered the dining room. CNA 1 stated Resident 1 was about six feet away from Resident 2. CNA 1 stated she continued scanning the room and when she looked back toward the residents' direction, she saw Resident 2 punch Resident 1 in the face. She observed blood on Resident 1's lip immediately after the punch. CNA 1 stated staff separated the residents right away and supervised them.During an interview on 3/23/2025 at 3:30 p.m., the Director of Nursing (DON) stated residents have the right to be free from physical abuse. The DON stated that based on the facility's investigation, the facility substantiated that Resident 2 hit Resident 1; however, it was determined that Resident 2 acted impulsively after being startled and struck out at Resident 1. The DON stated the facility felt that Resident 2's actions were unintentional and the incident was not preventable.During a review of the facility's undated policy and procedure (P&P) titled, Abuse, Neglect and Exploitation, the P&P indicated each resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation.residents must not be subject to abuse by anyone including, but not limited to facility staff, other residents.