

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

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 09/05/2025
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 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on interview and record review, the facility failed to update the facility assessment tool for 137 out of 137 residents when:1. The facility failed to include the Infection Prevention Nurse (IPN) as part of the required staff for daily facility operations; and2. The facility failed to assess the cultural and ethnic makeup of the facility's resident population. These deficient practices had the potential to result in delays of care and services and deter the facility to offer more culturally competent resident-centered care. Findings: During a concurrent interview and record review on 9/04/2025 at 8:43 a.m. with the Administrator, the Facility Assessment Tool, 7/10/2025, was reviewed. The Administrator confirmed missing that the Facility assessment Tool did not indicate that the IPN was part of the staff needed to function for the resident population every day and during emergencies. The Administrator stated the IPN needed to be included in the Facility Assessment Tool. The Administrator stated the tool was missing specific assessment on the different culture and ethnic backgrounds of the facility residents. The Administrator stated that it was important to assess the cultural backgrounds of the population to better cater to their needs. During a review of the facility's policy and procedure (P&P) titled, Facility Assessment Policy, undated, the P&P indicated that the facility conducts a comprehensive assessment that evaluates its resident population and resources. This assessment supports safe and effective care guides and staffing decisions and ensures compliance with applicable regulations.		

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record reviews, the facility failed to ensure three of six sampled residents' (Resident 7, 9 and 114) were free from unnecessary psychotropic medications (drug or other substance that affects how the brain works and causes changes in mood, awareness, thoughts, or feelings, or behavior) by: a. Failing to ensure nonpharmacological interventions (therapies and measures that do not involve taking medication like distraction, music therapy, and activities) were attempted prior to administering Ativan (medication for anxiety [mental health condition characterized by excessive fear and worry]) as needed for inability to relax for Resident 7. b. Failing to ensure Resident 9 was monitored for adverse effects for Mirtazapine (medication for depression [a mood disorder that causes a persistent feeling of sadness and loss of interest]) use. c. Failing to indicate resident specific behaviors for Risperidone (medication used to treat various mental health conditions) use for Resident 114. These deficient practices had the potential to result in the violation of residents' right to be free from chemical restraints (refers to any drug used for discipline or that makes it more convenient for staff to care for a resident and not required to treat medical symptoms) and the potential for unwanted adverse side effects. Findings: a. During a review of Resident 7's admission Record, the admission Record indicated Resident 7 was readmitted to the facility on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities) with psychotic disturbance (a mental health condition characterized by a loss of contact with reality), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) and generalized anxiety disorder (mental health condition characterized by excessive fear and worry). During a review of Resident 7's Minimum Data set ([MDS] a resident assessment tool), dated 7/28/2025, the MDS indicated Resident 7's cognitive skills (functions your brain uses to think, pay attention, process information, and remember things) for daily decision-making was severely impaired. The MDS indicated Resident 7 needed moderate assistance (helper does less than half the effort) with eating, oral hygiene, maximal assistance (helper does more than half the effort) with personal hygiene, and dependent (helper does all the effort) on staff with toileting hygiene and showering. During a review of Resident 7's Order Summary Report, as of 9/3/2025, the report indicated, starting on 8/24/2025, Ativan one milligram (mg - metric unit of measurement, used for medication dosage and/or amount), by mouth, every 6 hours as needed for inability to relax for 14 days. During a concurrent interview and record review on 9/3/2025 at 1:05 p.m. with Licensed Vocational Nurse (LVN) 1, Resident 7's Medication Administration records for 9/2025 and Order summary were reviewed. LVN 1 confirmed and stated there was no documented evidence of nonpharmacological measures attempted prior to the use of Ativan for anxiety. During an interview on 9/5/2025 at 3:15 p.m., with the Director of Nursing (DON) the DON stated that nonpharmacological measures need to be attempted prior to administration of psychotropic medications. During a review of the facility's policy and procedure (P&P) titled, "Psychotropic Medication Management Policy", undated, the P&P indicated that the interdisciplinary team would evaluate (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	non-pharmacological interventions before or alongside medication use. b. During a review of Resident 9's admission Record, the admission Record indicated Resident 9 was readmitted to the facility on [DATE] with diagnosis including major depressive disorder. During a review of Resident 9's MDS, dated [DATE], the MDS indicated Resident 9's cognitive skills for daily decision-making were severely impaired. The MDS indicated Resident 9 needed moderate assistance with oral hygiene, maximal assistance with toileting hygiene, showering, personal hygiene, and dependent (helper does all the effort) on staff with eating. During a review of Resident 9's Order Report, 7/20/2025, the order indicated, starting on 8/24/2025, Mirtazapine 15 mg, by mouth, at bedtime manifested by poor meal intake. During a concurrent interview and record review on 9/4/2025 at 10:30 a.m. with LVN 2, Resident 9's medical records were reviewed. LVN 2 confirmed Resident 9 was not monitored for adverse side effects associated with Mirtazapine use. LVN 2 stated monitoring for side effects was important to ensure the dose was appropriate. During an interview on 9/5/2025 at 3:15 p.m., with the DON, the DON stated that residents need to be monitored for adverse effects of medication use to make sure there were no complications. During a review of the facility's policy and procedure (P&P) titled, "Psychotropic Medication Management Policy", undated, the P&P indicated that the staff would monitor residents for potential adverse effects. c. During a review of Resident 114's admission record, the admission record indicated Resident 114 was admitted to the facility on [DATE] with diagnoses post-traumatic stress disorder (PTSD - a disorder in which a person has difficulty recovering after experiencing or witnessing a traumatic event), anxiety disorder (a mental health condition characterized by excessive and persistent worry, fear, and nervousness that can interfere with daily life), and dementia (a progressive state of decline in mental abilities). During a review of Resident 114's "History and Physical (H&P)", dated 6/12/2025, the "H&P" indicated, Resident 114 has the fluctuating capacity to understand and make decisions. During a review of Resident 114's MDS, dated [DATE], the MDS indicated Resident 114 required supervision or touching assistance (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) from one staff for hygiene, bed mobility, transfer, dressing, bathing, and setup or clean-up assistance (Helper sets up or cleans up) from one staff for eating. The MDS section E (Behavior) indicated, Resident 114 did not have hallucination (an experience involving the apparent perception of something not present) or delusions (having false or unrealistic beliefs). The MDS indicated, Resident 114 did not have physical and verbal behavioral symptoms directed toward others. During a review of Resident 114's "Order Summary Report (OSR)", dated 9/4/2025, the OSR indicated to give one tablet Risperidone 0.5 milligram (mg) by mouth two times a day for behavioral disorder associated with dementia manifested by aggressive behavior was ordered 6/23/2025. The OSR indicated to monitor behavior disorder associated with dementia manifested by (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	aggressive behavior and tally by episode every shift was ordered on 6/9/2025. During a review of Resident 114's "Care Plan (CP)", revised on 6/23/2025, the CP Focus indicated, Resident 114 uses antipsychotic medication Risperidone for behavioral disorder associated with dementia manifested by aggressive behavior. The CP Goal indicated, Resident 114 will receive the lowest possible dosage of the prescribed psychotropic drug to ensure maximum functional ability. The CP Interventions indicated, to administer medication as prescribed and observe effectiveness of medication by monitoring targeted behaviors. During a concurrent interview and record review on 9/4/2025, at 3:08 p.m., with Registered Nurse (RN) 1, Resident 114's "Medication Administration Record (MAR)", dated from 6/2025 to 9/4/2025 was reviewed. The MAR indicated to monitor behavior disorder associated with dementia manifested by aggressive behavior and tally by episode every shift for Risperidone use. The MAR indicated, there was no behavioral episodes and documented "episode of aggressive behavior. RN 1 stated, aggressive behaviors were not specific target behavior because it was too general, and it could be anything such as yelling, striking, and non-verbal. RN 1 stated, target behavior should be specific and measurable, so psychiatrist (a medical practitioner specializing in the diagnosis and treatment of mental illness) could refer to and consider Gradual Dose Reduction (GDR- a systematic approach to stepwise tapering of medication dosage to assess if a lower dose can effectively manage symptoms, conditions, or risks, or if the medication can be discontinued entirely). RN 1 stated, the staff should monitor specific target behaviors, not general behavior. RN 1 stated, the facility should use less restrictive measures, if possible, to prevent resident suffering from adverse reaction due to unnecessary medication. During a telephone interview on 9/5/2025, 11:08 a.m., with the Psychiatric Nurse Practitioner (PNP) 1, the PNP 1 stated, Resident 114 was on Risperidone prior to admission from the General Acute Care Hospital (GACH). The PNP 1 stated, she did not discontinue the medication abruptly, and the nursing staff reported to her that Resident 114 was trying to strike the staff. The PNP 1 stated, aggressive behaviors are not specific and measurable target behavior. The PNP 1 stated, incorrect data of target behavior could affect the resident's care and treatment. The PNP 1 stated, she was not aware of staff documented no behavior and MDS assessment regarding no behavior. The PNP 1stated, Risperidone could be unnecessary medication, and it should be tapered down as soon as possible to avoid adverse reaction (an undesired or harmful effect of a drug) and chemical restraint (the use of medications to restrict a person's movement or freedom of action, or to control behavior, when the medication is not part of a standard treatment for their condition). During an interview on 9/5/2025, at 2:24 p.m., with the Director of Nursing (DON), the DON stated, target behavior should be specific and measurable to the resident's diagnoses. The DON stated, aggressive behaviors could be many things, and this should be clarified with PNP 1. The DON stated, monitoring specific target behavior was important, because GDR would be performed based on these data. The DON stated, inaccurate data would lead to delays on treatment, and the residents continuing to receive unnecessary medication. The DON stated, the resident might suffer from unnecessary side effects/adverse reactions. The DON stated, unnecessary medication could be used as chemical restraint as well. During a review of the facility's Policy and Procedure(P&P) titled, "Behavior Management Plan", revised 2025, the P&P indicated, "Policy: Resident who exhibit behavioral concerns may require a behavior management plan to ensure they are receiving g appropriate services and interventions to meet their needs&hellip;Policy Explanation and Compliance Guidelines: 4. Behaviors (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	should be documented clearly and concisely by facility staff. Documentation should include specific behaviors, time and frequency of behaviors, observation of what may be triggering behaviors, what interventions were utilized, and the outcomes of the interventions.&rdquo; During a review of the facility's Policy and Procedure(P&P) titled, &ldquo;Psychotropic Medication Management Policy&rdquo;, undated, the P&P indicated, &ldquo;Policy: 2. Orders and Indications&hellip;Psychotropic medications will only be prescribed with a documented clinical indication. Orders must be specific, time-limited, and include target symptoms&hellip; 4. Monitoring and Review : Staff will monitor residents for effectiveness and potential adverse effects.&rdquo;		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement an individualized care plan with measurable objectives, timeframes, and interventions for 3 of 3 residents (Residents 16, 156, and 124) by failing to: Develop and implement a care plan to improve, maintain, or prevent a decline in range of motion (ROM, full movement potential of a joint) for Resident 16 who was identified as having ROM limitations in both arms and both legs. Develop and implement a comprehensive person-centered care plan for Resident 124's use of Lorazepam (Ativan, medication used to treat anxiety [a common mental health condition characterized by excessive worry, fear, and nervousness]). Develop and implement a comprehensive person centered care plan for Resident 156's diagnosis of post traumatic stress disorder ([PTSD], a mental health condition that's caused by an extremely stressful or terrifying event, either being part of it or witnessing it) with specific triggers, goals, and interventions. These deficient practices had the potential to negatively affect the delivery of necessary care and services. Findings: 1. During a review of Resident 16's admission Record, the admission Record indicated the facility initially admitted Resident 16 on 7/12/2022 and re-admitted Resident 16 on 9/24/2024 with diagnoses including Alzheimer's disease (a type of disease that affects memory, thinking, and behavior), chronic kidney disease (gradual loss of kidney function), and polyneuropathy (damage of the nerves that can cause weakness, numbness, and burning pain). During a review of Resident 16's Minimum Data Set (MDS, a resident assessment tool), dated 7/3/2025, the MDS indicated Resident 16 had severe cognitive (mental action or process of acquiring knowledge and understanding) impairment. The MDS indicated Resident 16 was dependent (helper does all the effort) in eating, hygiene, bathing, dressing, and mobility (ability to move). The MDS indicated Resident 16 had functional limitations in ROM (limited ability to move a joint that interferes with daily functioning, including activities of daily living, or places the resident at risk of injury) in both arms and both legs. During a review of Resident 16's Quarterly Joint Mobility Assessment (JMA, a brief assessment of a resident's ROM in both arms and both legs), dated 7/3/2025, the JMA indicated Resident 16 had minimal ROM limitations (75 to 100% available ROM) in the left shoulder, both wrists, and both hands, moderate/severe ROM limitations (25 to 50% available ROM) in the right shoulder and both ankles, and severe ROM limitations (0 to 25% available ROM) in both hips and both knees. During an observation and interview on 9/3/2025 at 9:35 am, Resident 16 was lying in bed with his body hunched over to the left side of the bed and blankets covering his left arm and both legs. Resident 16 moved his right shoulder and elbow slightly when trying to move the blankets. Licensed Vocational Nurse 2 (LVN 2) entered the room and assisted Resident 16 with removing the blankets. Resident 16's both legs were rotated to the left side of the body with both hips and both knees bent and both toes pointing downwards. LVN 2 stated Resident 16 had limited ROM in both arms and both legs and needed assistance with ROM. LVN 2 stated Resident 16 moved both arms every now and then but rarely moved both legs on his own. During an interview and record review on 9/5/2025 at 2:00 pm, the Minimum Data Set Coordinator 1 (MDSC 1) and Minimum Data Set Nurse (MDSN) stated an individualized care plan was developed for every resident and used as a guideline to ensure proper care was provided for each resident. MDSC 1 (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and MDSN reviewed Resident 16's MDS, dated [DATE], and confirmed Resident 16 was identified as having functional ROM limitations in both arms and both legs. MDSC 1 and MDSN reviewed Resident 16's JMA, dated 7/3/2025, and confirmed Resident 16 had ROM limitations in both arms and both legs. MDSC 1 and MDSN reviewed Resident 16's care plan and confirmed there was no care plan and interventions in place to maintain or prevent a decline in ROM of Resident 16's both arms and both legs despite ROM limitations being identified on the MDS and JMA. MDSC 1 and MDSN stated the care plan should have included goals and interventions to maintain and prevent a decline in Resident 16's both arms and both legs but did not. MDSC 1 and MDSN stated it was important Resident 16's limited ROM was care planned because Resident 16 had limited ROM in both arms and both legs, required total care, had limited mobility, and was at high risk for contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion) development. MDSC 1 and MDSN stated it was important for care plans to be developed, implemented, and accurate to ensure the appropriate care was provided to each individual resident. During an interview on 9/5/2025 at 3:33 pm, the Director of Nursing (DON) stated individualized, person-centered care plans were developed for every resident and were used as a guide for staff to identify the type of care to provide the residents in the facility. The DON stated a care plan with goals and interventions should be developed for all residents who were identified as having ROM limitations upon assessment, screens, and/or by report from the resident or staff. The DON stated it was important for care plans to be developed, implemented, and accurate to ensure the appropriate care was provided to each individual resident. The DON stated lack of care planning could negatively impact the provision of care and services. During a review of the facility's policy and procedure (P/P) titled, "Comprehensive Care plans"; revised 1/2025, the P/P indicated the facility would develop and implement a comprehensive, person-centered care plan for each resident, consistent with residents rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychological needs that were identified in the resident's comprehensive assessment. 2. During a review of Resident 124's admission Record, the admission Record indicated Resident 124 was admitted to the facility 5/1/2025 with diagnoses of dementia (a group of conditions that cause a decline in cognitive abilities, such as memory, language, attention, and problem-solving, severe enough to interfere with daily life), history of falling, and anxiety. During a review of Resident 124's MDS dated [DATE], indicated Resident 124 had severe cognitive impairment (difficulties with mental functions like thinking, learning, remembering, and decision-making, affecting skills such as communication and self-help). During a review of Resident 124's Order Summary Report, indicated an order was placed 8/29/2025 for Lorazepam Tablet 0.5 milligrams (mg, a unit of measurement), Give 1 tablet by mouth every 12 hours as needed for Anxiety manifested by (M/B) irritability (a state of feeling annoyed and easily angered) for 14 Days. During a review of Resident 124's care plans, Resident 124's care plans did not address the use of Ativan until 9/5/2025 when the issue was brought to the facility's attention. During an interview on 9/5/2025 at 2:34 p.m., the Director of Nursing (DON), the DON reviewed Resident 124's active physicians orders and stated Ativan was ordered for Resident 124 on 8/29/2025. The DON reviewed Resident 124's care plans and stated the care plan with a focus on (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 124 had an episode of anxiety m/b irritability did not include interventions for Ativan until it was initiated on 9/5/2025. The DON stated the Ativan interventions should have been initiated when Resident 124 first received the order for Ativan on 8/29/2025. The DON stated a care plan specific to Ativan was important because it addressed and provided proper interventions for the residents and it was to include behaviors and monitoring. During a review of the facility's policy and procedure (P&P) titled "Comprehensive Care Plans" dated 1/2025, the P&P indicated the comprehensive care plan will describe, at a minimum, the following services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. 3. During a record review of Resident 156's admission Record, the admission Record indicated Resident 156 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest, and anxiety) and PTSD. During a record review of Resident 156's MDS dated [DATE], the MDS indicated Resident 156 had intact cognitive (thought process) skills for daily decision-making and needed assistance (helper sets up while resident completes the activities) with self-care abilities and mobility such eating, oral hygiene, dressing, and transfers. During a record review of Resident 156's History and Physical (H&P) dated 1/30/2025, the H&P indicated Resident 156 had the capacity to understand and make decisions. During a record review of Resident 156's social service assessment dated [DATE], the social service assessment did not address Resident 156's diagnosis of PTSD, what the triggers are and how the facility can help the Resident 156 receives appropriate care to address and manage trauma related needs. There was no other assessment done after this initial assessment. During a record review of Resident 156's untitled care plan, the untitled care plan indicated PTSD as a diagnosis but the goals and interventions were vague and did not address Resident 156's specific triggers or provide guidance for facility staff on how to avoid retriggering or manage symptoms and behaviors if the trauma is triggered. During an interview on 9/5/2025 at 10:35 a.m. with the Director of Staff Development (DSD), the DSD stated residents with history of trauma or diagnosis of PTSD, should have a person-centered care plan tailored to the residents specific needs . The DSD stated residents should feel safe and at home. The care plan should have interventions to avoid their triggers (a sound, smell, place or memory that suddenly reminds someone of a scary or upsetting experience from the past and make them feel afraid, sad or upset). During a concurrent interview and record review on 8/8/2025 at 10:52 a.m., with the Director of Social Services (DSS), the untitled, undated care plan for Resident 156 was reviewed. The DSS stated there should have been a person-centered care plan for Resident 156's PTSD diagnosis. The DSS stated Resident 156's care plan did not specify what the PTSD triggers are and how to avoid retriggering the trauma. The DSS stated having a person-centered care plan would be helpful for facility staff to avoid retriggering the trauma and their manifestation. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/8/2025 at 2:58 p.m., with the Director of Nursing (DON), the DON stated the importance of having a person-centered care plan was to address the residents' needs, and to provide personalized care for each resident. The DON stated residents should have a personalized care plan because each resident was different with different problems, and different issues. The DON stated the care plan should be person centered to address specific needs the residents may have. During a review of the facility's policy and procedures (P&P) titled Comprehensive Care Plans revised 1/2025, indicated, it is the policy of this facility to 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&hellip;. person-centered care means to focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives&hellip; the care planning process will include an assessment of the resident's strengths and needs, and will incorporate the resident's personal and cultural preferences in developing goals of care. During a review of the facility's P&P titled Trauma Informed Care revised 1/2025, indicated, it is the policy of this facility to ensure residents who are trauma survivors receive culturally competent, trauma-info1med care in accordance with professional standards of practice&hellip; trauma-informed care is defined as an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma.		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide services to improve or maintain range of motion (ROM, full movement potential of a joint) for two of seven sampled residents (Residents 5 and 16) with ROM concerns by failing to: Objectively measure Resident 5's ROM in both hands during the Occupational Therapy (OT, profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities) Evaluation, dated 6/27/2025. Provide ROM services to Resident 16 who was identified as having ROM limitations in both arms and both legs. These deficient practices had the potential for Residents 5 and 16 to experience a further decline in ROM resulting in contracture (loss of motion of a joint associated with stiffness and joint deformity) development and have a decline in physical functioning, mobility (ability to move), and activities of daily living (ADL, basic activities such as eating, dressing, toileting). Findings: 1. During a review of Resident 5's admission Record, the admission Record indicated the facility initially admitted Resident 5 on 8/31/2018 and re-admitted Resident 5 on 6/26/2025 with diagnoses including chronic obstructive pulmonary disease (lung disease that causes obstruction of airflow and can limit normal breathing), cerebral palsy (a group of disorders that affect a person's ability to move and maintain balance and posture), and Parkinson's disease (progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movement). During a review of Resident 5's Minimum Data Set (MDS, a resident assessment tool), dated 8/1/2025, the MDS indicated Resident 5 had severely impaired cognition (mental action or process of acquiring knowledge and understanding). The MDS indicated Resident 5 required substantial/maximal assistance (helper does all the effort) for oral hygiene, bathing, dressing, personal hygiene, and rolling to both sides and was dependent (helper does all the effort) for transfers and toileting hygiene. The MDS indicated Resident 5 had functional limitations in range of motion (limited ability to move a joint that interferes with daily functioning, including activities of daily living, or places the resident at risk of injury) in both arms and both legs. During a review of Resident 5's OT Evaluation, dated 6/27/2025, the OT Evaluation indicated Resident 5's ROM of the right hand, right thumb, right index finger, right middle finger, right ring finger, and right little finger were impaired. The OT evaluation indicated Resident 5's ROM of the left hand, left thumb, left index finger, left middle finger, left ring finger, and left little finger were impaired. During an observation of Resident 5's Restorative Nursing Aide program (RNA, nursing aide program that helps residents maintain their function and joint mobility) session on 9/4/2025 at 10:29 am, in Resident 5's room, Resident 5 was sitting in a wheelchair. Restorative Nursing Aide 1 (RNA 1) assisted Resident 5 with passive range of motion (PROM, movement at a given joint with full assistance from another person) exercises to Resident 5's both arms and right leg and applied splints to Resident 5's right hand and right knee. Resident 5 moved both shoulders to less than shoulder height, could not fully extend both elbows, and had both hands closed in fists. RNA 1 stated Resident 5 was unable to straighten the fingers of both hands. Resident 5 grimaced when RNA 1 tried to straighten Resident 5's fingers to place a carrot splint (a device that opens the hand and positions the fingers away from the palm to protect the skin from moisture, pressure, and nail puncture) in Resident 5's hand. During a concurrent interview and record review on 9/4/2025 at 3:37 pm, Occupational Therapist 1 (OT 1) stated OTs used goniometers (instrument used for the precise measurement of angles) to measure joint mobility to objectively (unbiased, based on facts) determine a resident's baseline ROM and detect changes in joint ROM. OT 1 reviewed Resident 5's OT Evaluation, 6/27/2025, and confirmed Resident 5's ROM of both hands were limited. OT 1 confirmed he did not use a goniometer to measure the joints of both hands but should have because Resident 5 had ROM limitations. OT 1 stated Resident 5's baseline ROM of both hands was not determined because the ROM limitations were not measured with a goniometer. OT 1 stated lack of objective ROM (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	measurements had the potential to negatively impact the staff's ability to detect changes such as improvements or declines in Resident 5's ROM. OT 1 stated it was important to provide objective measurements of a limited joint in the OT evaluation to ensure subtle changes of ROM could be detected which would in turn guided the treatments and services provided. During a concurrent interview and record review on 9/5/2025 at 12:25 pm, the Director of Rehabilitation (DOR) stated OT and Physical Therapists (PT, profession aimed in the restoration, maintenance, and promotion of optimal physical function) used goniometers to objectively measure ROM. The DOR stated any limitations in joint ROM observed in an OT or PT evaluation should be measured with a goniometer and documented in the evaluation because it was an objective way of establishing a resident's ROM baseline and monitoring for changes in ROM. The DOR reviewed Resident 5's OT Evaluation, dated 6/27/2025, and stated Resident 5's ROM of both hands should have been measured with a goniometer since they were impaired but was not. The DOR stated Resident 5's baseline ROM of both hands was not determined due to lack of objective measurements in the OT evaluation which in turn affected staff's ability to monitor and detect any changes in ROM. 2. During a review of Resident 16's admission Record, the admission Record indicated the facility initially admitted Resident 16 on 7/12/2022 and re-admitted Resident 16 on 9/24/2024 with diagnoses including Alzheimer's disease (a type of disease that affects memory, thinking, and behavior), chronic kidney disease (gradual loss of kidney function), and polyneuropathy (damage of the nerves that can cause weakness, numbness, and burning pain). During a review of Resident 16's Order Summary Report, the Order Summary Report indicated a physician's order, dated 9/25/2024, indicating Resident 16 was placed on Hospice Services (care focused on comfort and quality of life of a person with a serious illness who is approaching the end of life). During a review of Resident 16's MDS, dated [DATE], the MDS indicated Resident 16 had severe cognitive impairment. The MDS indicated Resident 16 was dependent with eating, hygiene, bathing, dressing, and mobility (ability to move). The MDS indicated Resident 16 had functional limitations in ROM in both arms and both legs. During a review of Resident 16's Quarterly Joint Mobility Assessment (JMA, a brief assessment of a resident's ROM in both arms and both legs), dated 7/3/2025, the JMA indicated Resident 16 had minimal ROM limitations (75 to 100% available ROM) in the left shoulder, both wrists, and both hands, moderate/severe ROM limitations (25 to 50% available ROM) in the right shoulder and both ankles, and severe ROM limitations (0 to 25% available ROM) in both hips and both knees. The JMA comments indicated Resident 16 was on hospice care and nursing was to integrate ROM exercises during care. During an observation and interview on 9/3/2025 at 9:35 am, in Resident 16's room, Resident 16 was lying in bed with his body hunched over to the left side of the bed and blankets covering his left arm and both legs. Resident 16 moved his right shoulder and elbow slightly when trying to move the blankets. Licensed Vocational Nurse 2 (LVN 2) entered the room and assisted Resident 16 with removing the blankets. Resident 16's both legs were rotated to the left side of the body with both hips and both knees bent and both toes pointing downwards. LVN 2 stated Resident 16 had limited ROM in both arms and both legs and needed assistance with ROM. LVN 2 stated Resident 16 moved both arms every now and then but rarely moved both legs on his own. LVN 2 tried but was unable to fully straighten Resident 16's both hips and knees. LVN 2 assisted Resident 16 to move both arms up to shoulder level and slowly straightened Resident 16's both elbows. LVN 2 stated Resident 16 benefitted from ROM exercises to both arms and both legs because Resident 16 did not appear to have any pain with stretches and needed it to prevent further stiffness. LVN 2 stated he thought Resident 16 received RNA services for ROM exercises of both arms and both legs. During an interview on 9/3/2025 at 9:49 am, Certified Nursing Assistant 5 (CNA 5) stated he frequently assisted with Resident 16's daily care. CNA 5 stated Resident 16 required total assistance in daily care and had ROM limitations in both arms and both legs. CNA 5 stated Resident 16 actively moved both arms more than both legs and needed assisted with ROM. CNA 5 stated he assisted with ROM sometimes during daily care but mostly relied on RNA to assist with ROM exercises. CNA 5 stated he was unsure if other CNAs provided Resident 16 with (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	daily ROM exercises because the CNAs were not required to document whether they provided ROM exercises during daily care. During an interview and record review on 9/5/2025 at 11:00 am, the Minimum Data Set Coordinator 1 (MDSC 1) and Minimum Data Set Nurse (MDSN) stated the facility provided RNA and skilled therapy services (services that require specialized training and experience of a licensed therapist or therapy assistant) to maintain, improve, and prevent declines in ROM for the residents in the facility. MDSC 1 and MDSN stated the facility monitored for changes in ROM by staff report, RNA meetings, and JMAs done annually by the Rehabilitation Department (Rehab) and quarterly by the MDS nurses. MDSC 1 and MDSN reviewed Resident 16's MDS, dated [DATE], and confirmed Resident 16 was identified as having functional ROM limitations in both arms and both legs. MDSC 1 and MDSN reviewed Resident 16's JMA, dated 7/3/2025, and confirmed Resident 16 had ROM limitations in both arms and both legs. MDSC 1 and MDSN confirmed the JMA indicated Resident 16 was on hospice care services and ROM was to be provided during daily nursing care. MDSC 1 and MDSN reviewed Resident 16's clinical record and confirmed Resident 16 was not receiving RNA services. MDSC 1 and MDSN stated Resident 16 was at high risk for contracture development because he had ROM limitations in both arms and both legs, required total care, and had limited mobility. MDSC 1 and MDSN stated Resident 16 was a good candidate for RNA services and was unsure why RNA services were never considered. MDSC 1 and MDSN stated they did not follow up with the hospice care nurse to recommend or discuss RNA services but should have to ensure Resident 16 received the appropriate care and services to maintain and prevent a decline in ROM. MDSC 1 and MDSN stated they were unsure if CNAs provided daily ROM exercises since the CNAs did not document if ROM was provided during daily care. MDSC 1 and MDSN stated if a resident who was identified as having ROM limitations did not receive ROM services, it could potentially lead to a functional decline and contracture development. During an interview on 9/5/2025 at 3:33 pm, the Director of Nursing (DON) stated the facility provided RNA and Rehab services to maintain, improve, and prevent declines in ROM for the residents in the facility. The DON stated the facility monitored changes in ROM by staff report, observations during daily care, and JMAs done quarterly and annually. The DON stated it was important staff objectively measured ROM during ROM evaluations to ensure the facility had an accurate assessment of a resident's joints since it affected their ability to effectively monitor for changes and provide the appropriate services to address any declines. The DON stated if residents who had ROM limitations did not receive the treatment and services to maintain their ROM, it could result in a functional decline. During a review of the facility's undated Policy and Procedure (P/P) titled, Prevention of Decline in ROM, the P/P indicated residents who entered the facility without limited ROM would not experience a reduction in ROM unless unavoidable. The P/P indicated the facility in collaboration with the medical director, DON, and as appropriate physical/occupational consultant established and utilized a systemic approach for prevention of a decline in ROM, including the assessment, appropriate care planning, and preventative care. The P/P indicated the facility would provide interventions, exercises, and/or therapy to maintain or improve ROM. During a review of the facility's undated P/P titled, Joint Mobility Assessment Policy, the P/P indicated the purpose of the JMA was to establish guidelines for the evaluation and monitoring of residents' joint mobility to maintain function, prevent decline, and promote independence and quality of life. The P/P indicated all residents would have their joint mobility assessed at admission, routinely thereafter, and as clinically indicated. The P/P indicated the assessments would be used to develop individualized care plans, guide therapeutic interventions, and monitor changes over time. The P/P indicated nursing staff would document observations related to mobility during routine care and therapy staff would provide details ROM and functional assessments as appropriate.		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to identify and to intervene in two of three sampled residents (Resident 114 and Resident 156)'s history of trauma (a strong emotional reaction to something upsetting or harmful that happened). and triggers (a sound, smell, place, or even a memory-that suddenly reminds someone of a scary or upsetting experience from the past. It can make them feel afraid, sad, or upset, even if they are safe now) which may cause re-traumatization as evidenced by: A. Failing to assess and identify the triggers of Resident 114's trauma related to a war he was in. B. Failed to do an assessment and identify the triggers of Resident 156's trauma related to family health status. This failure had the potential to result in Resident 114 and Resident 156 experience re-traumatization (a person encounters a new event or stimulus that triggers them to re-experience the intense stress, emotional distress, and even flashbacks of a previous traumatic event as if it were happening again). Findings: A. During a review of Resident 114's admission record, the admission record indicated Resident 114 was admitted to the facility on [DATE] with diagnoses including post-traumatic stress disorder (PTSD - a disorder in which a person has difficulty recovering after experiencing or witnessing a traumatic event), anxiety disorder (a mental health condition characterized by excessive and persistent worry, fear, and nervousness that can interfere with daily life), and dementia (a progressive state of decline in mental abilities). During a review of Resident 114's History and Physical (H&P), dated 6/12/2025, the H&P indicated, Resident 114 had fluctuating capacity to understand and make decisions. During a review of Resident 114's Minimum Data Set (MDS-a resident assessment tool), dated 6/19/2025, the MDS indicated Resident 114 required supervision or touching assistance (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) from one staff for hygiene, bed mobility, transfer, dressing, bathing, and setup or clean-up assistance (Helper sets up or cleans up) from one staff for eating. During a concurrent interview and record review on 9/5/2025, at 12:11 p.m., with the Director of Social Services (DSS), Resident 114's "Social Service History and Initial Assessment", dated 6/9/2025 was reviewed. The Social Service History and Initial Assessment indicated, Resident 114 stated he had trauma from the Vietnam War. The Social Service History and Initial Assessment indicated, there was no documentation regarding the triggers of trauma and how they affected Resident 114. The DSS stated, she could not get much information regarding trauma and its triggers from Resident 114 and his wife. The DSS stated, she should have contacted Resident 114's psychiatrist (a medical practitioner specializing in the diagnosis and treatment of mental illness) and social service workers from the veterans' hospital to obtain information regarding his PTSD. The DSS stated, completing the trauma assessment was important, because the resident's care would be different according to the needs from the assessment. The DSS stated, she would refer the resident to proper services according to the trauma assessment to prevent re-traumatization. The DSS stated, Resident 114's care plan was not person centered because there was no proper assessment done for the trauma. During an interview on 9/5/2025, at 2:24 p.m., with the Director of Nursing (DON), the DON stated, when the resident who has PTSD as a part of diagnosis admitted to the facility, the DSS should assessed for its triggers, and past history to prevent re-traumatization. The DON stated, the care plan (continued on next page)		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	could not be resident centered, and resident focused if the trauma assessment was not done correctly. The DON stated, the facility has many residents who were veterans. The DON stated, staff should have assessed the residents' PTSD and made the plan of care according to the findings. The DON stated re-traumatization would harm Residents' psychosocial well-being. During a review of Resident 114's "Care Plan (CP)", revised on 6/23/2025, the CP Focus indicated, Resident 114 had episodes of flashbacks/nightmares from PTSD. The CP goal indicated, Resident 114's episode of flashbacks/nightmares from Vietnam war will be minimized daily through next review date (9/10/2025). The CP Interventions indicated, staff should approach resident calmly, be aware of resident's whereabouts, and observe behavior. During a review of the facility's Policy and Procedure (P&P) titled, "Trauma Informed Care", revised on 1/2025, the P&P indicated, "Policy: It is the policy of this facility to ensure residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice... Policy Explanation and Compliance Guidelines: 1. Each resident will be screened for a history of trauma upon admission...5. The facility will account for residents' experiences, preferences, and cultural differences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident." B. During a review of Resident 156's admission Record, the admission Record indicated Resident 156 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest, and anxiety (a mental health condition that cause fear, dread and other symptoms that are out of proportion to the situation). During a record review of Resident 156's MDS, dated [DATE], the MDS indicated Resident 156 had intact cognitive skills (thought process) for daily decision-making and needed assistance (helper sets up while resident completes the activities) with self-care abilities and mobility such eating, oral hygiene, dressing, and transfers. During a record review of Resident 156's H&P dated 1/30/2025, the H&P indicated Resident 156 had the capacity to understand and make decisions. During a record review of Resident 156's social service assessment dated [DATE], the social service assessment did not address Resident 156's diagnosis of PTSD, the triggers, and how the facility can help the resident with past traumas. There was no other assessment done after this initial assessment. During a concurrent interview and record review on 9/5/2025 at 12:03 p.m., with the Director of Social Services (DSS), the social service assessment dated [DATE] was reviewed. The DSS stated she does not see the question asked about any history of trauma nor if there were any triggers on the assessment that was done in 2022 when Resident 156 was first admitted to the facility. The DSS stated the importance of asking these questions during the admission process was for the overall psychosocial (relationship of social factors and individual thought and behavior) wellbeing of the residents and how the residents are doing emotionally and mentally. The DSS stated if the assessment (regarding PTSD and triggers) was done during the admission process, the staff would know and would plan Resident 156's care to avoid his triggers. During an interview on 9/5/2025 at 3:04 p.m., with the Director of Nursing (DON), the DON stated residents should be properly assessed for any trauma, so the facility staff are aware of what the (continued on next page)		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	triggers are. The DON stated the assessment should be done upon admission to the facility and when the facility staff are aware of what the triggers are, trauma informed care would be tailored to the resident from the assessment done. The DON stated if assessment was not done, facility staff would not know what the triggers are and could retrigger the trauma for the residents. During a review of the facility's policy and procedure (P&P) titled, "Trauma Informed Care", revised 1/2025, the P&P indicated it is the policy of this facility to ensure residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice; trauma is defined as an event, a series of events, or set of circumstances experienced by an individual as physically or emotionally harmful or life-threatening, that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional or spiritual well-being; 1. Each resident will be screened for a history of trauma upon admission. 2. The facility social worker or designee will conduct the screening in a private setting. 3. If the screening indicates that the resident has a history of trauma and/or trauma-related symptoms, a physician's order will be obtained for the resident to be evaluated by a mental health professional who is experienced in working with those exposed to trauma. The mental health professional should be licensed to assess, diagnose, and treat the resident accordingly; 5. The facility will account for residents' experiences, preferences, and cultural differences in eliminating or mitigate triggers that may cause re-traumatization of the resident. Potential causes of re-traumatization by staff may include, but are not limited to a. Being unaware of the resident's traumatic history, b. Failing to screen resident for trauma history prior to treatment planning, c. Challenging or discounting reports of traumatic events.		

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on interview and record review, the facility failed to ensure employee files were maintained and kept up to date when performance evaluations (a process used by organizations to assess how well employees are performing in their roles) were not completed for three out of six sampled employees. This failure had the potential to adversely impact the quality of care of residents when staff performance is not current. Findings: During a concurrent interview and record review on 9/5/2025 at 10:54 a.m. with the Director of Staff Development (DSD), the employee files for the Director of Nursing (DON), Registered Nurse Supervisor (RNS) 1, Licensed Vocational Nurse (LVN) 2, Certified Nurse Assistant (CNA) 4, CNA 5, and the DSD were reviewed. There were no annual performance evaluations for RNS 1, LVN 2, and CNA 4. The DSD stated the importance of doing performance evaluation yearly was to ensure staff are meeting the standard of care to perform the duties as licensed staff in the facility. The DSD stated performance evaluation should be done on a yearly basis. The DSD stated if the performance evaluation was not done, the licensed staff may not be up to date with the standard of practice. During an interview on 9/5/2025 at 2:50 p.m., with the Director of Nursing (DON), the DON stated performance evaluations should be done yearly. The DON stated a performance evaluation was how the facility staff perform throughout the year in their duties, their attendance, their work ethics, and if they were a team player. The DON stated if the performance evaluation was not done, it would affect the staff by not making them aware of what they need to improve on, or what they need to work on in their position. During a review of the facility's policy and procedure (P&P) titled, Performance Evaluations, revised January 2025, indicated, the job performance of each employee shall be reviewed and evaluated at least annually. a performance evaluation will be completed on each employee at the conclusion of his/her 90-day probationary period, and at least annually thereafter. The performance evaluation meeting will occur at the same time as the employee's compensation review. performance evaluations may be used in determining employee promotions, shift/position transfers, demotions, terminations, wage increases, etc., and to improve the quality of the employee's work performance. performance evaluations will be completed by the employees' department directors and supervisors and reviewed by the Human Resource Director (is responsible for planning, directing and coordinating human resources activities, policies and programs for a company) and Administrator. Each employee will be given the opportunity to review his/her evaluation with his/her department director and the Human Resource Director.		

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observations, interviews and record review, the facility failed to ensure: 1.18 residents on pureed diet (foods that do not require chewing and are easily swallowed. All food should be smooth and pureed to the consistency of pudding) received pureed sweet potato texture in form that meet their needs and in accordance with the international Dysphagia Diet Initiative-level 4 (IDDSI-a framework made up of levels and describes food textures and drink thickness) level Four (pureed foods and extremely thick drinks) when the texture of the pureed sweet potatoes was lumpy, not smooth and had large pieces of potato present requiring chewing before swallowing. This failure had the potential to result in meal dissatisfaction and increased choking risk for residents on pureed diet. During an observation of the tray line (tray line-a system of food preparation, in which trays move along an assembly line) service for lunch on 9/2/2025 at 11:56AM, it was observed that the pureed sweet potatoes looked lumpy and not smooth. It was observed during the serving of the pureed sweet potatoes that there were chunks of potato on the plate. During a concurrent observation and interview on 9/2/2025 at 12:40pm, a taste test of the pureed sweet potato with the Dietary Supervisor (DS), [NAME] AM (Cook1) and the District Manager (DM), the pureed sweet potatoes appeared lumpy. During the same interview and taste test of the pureed sweet potato with DS and Cook1 on 9/2/2025 at 12:45PM, the pureed sweet potato had a lumpy texture. There were some chunky pieces of potato that required chewing and moving around in the mouth before swallowing. The DS stated the consistency of the pureed sweet potato is not smooth and there are some lumpy pieces of potato requiring chewing before swallowing. The DS stated residents on pureed diet can have difficulty swallowing. Cook1 stated the pureed sweet potato should have been blended longer for smooth texture. During a review of the facility recipe titled Corporate Recipe-Starch-Potatoes-Sweet Potatoes, baked (can) (Not dated) the recipe indicated, Pureed-Level 4: measure desired number of servings into a food processor. Blend until smooth. Final product should have no lumps, may not be sticky, and liquids should not separate from solids. Follow applicable IDDSI testing methods to ensure appropriate texture. During a review of the IDDSI guideline website titled IDDSI, dated 7/2019, the IDSSI guideline indicated that Level 4 Pureed is usually eaten with spoon, falls off spoon in a single spoonful when tilted and continues to hold shape on the plate, no lumps, not sticky, and liquid must not separate from solid. Food testing method: Spoon tilt test and Fork drip test.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to ensure safe and sanitary food storage and food preparation practices in the kitchen when: 1. Three boxes of juice were in use and connected to a juice dispensing machine with no date and label; one box with 24 ice cream cups stored in the reach in freezer (a vertical storage unit commonly found in commercial kitchens) with date 2/2025 expired; raw shelled eggs and raw liquid eggs stored on same shelf and next to milk and a box of raw bacon stored next to a medium container of cooked macaroni. 2. One cart stored next to the food preparation area was dirty, stained with sticky residue, covered with crumbs and food particles, the coffee machine glass gauge pipe was stained with dark brown color residue and in the dry storage area there were cans of grape jelly that was covered with clear wet droplets and was sticky to touch. These deficiencies had the potential to result in harmful bacteria growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to foodborne illness in 138 out of 139 residents who received food from the facility. 1. During an observation in the kitchen on 9/2/2025 at 9:00AM, three boxes of juice (one orange flavor, one cranberry and one apple flavor) were open and connected to the juice dispenser with no date. During a concurrent observation with the Dietary Supervisor (DS) on 9/2/2025 at 9:00AM, the DS does not know when the juices were opened and connected to the juice dispenser. The DS stated there should be an open date on the juices to know when to discard. The DS stated if a juice stays longer than use by date it will go bad. During an observation in the kitchen on 9/2/2025 at 9:30AM, there was a box with 24 ice cream cups stored in the reach in freezer with a date of 2/2025 expired. During a concurrent observation and interview with the DS on 9/2/2025 at 9:30AM, the DS discarded the ice cream cups and stated the ice cream was delivered this week and we should inspect the dates carefully. During a concurrent observation and interview with the DS on 9/2/2025 at 9:45AM, raw eggs and raw liquid eggs in a box were stored on the top shelf of the refrigerator next to the milk. In the same refrigerator there was a box of raw bacon stored next to a container of cooked macaroni. The DS stated the staff made a mistake and stored them incorrectly after breakfast service. The DS stated the raw eggs, and bacon should be stored separately from ready to eat food to prevent cross contamination. The DS stated residents can get sick from cross contamination of food. During a review of facility's policy and procedure (P&P) titled Food Storage: Cold Foods (Revised 2/2023) the P&P indicated, All foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination. During a review of facility's policy and procedures (P&P) titled Receiving (Revised 2/2023) the P&P indicated, All food items will be appropriately labeled and dated either through manufacturer packaging or staff notation. During a review of the 2022 U.S. Food and Drug Administration Food Code 3-301.11 titled Packaged and unpackaged Food-Separation, segregation indicated, (A) Food shall be protected from cross contamination by: (1) Separating raw animal foods during storage, preparation, holding and display: (b) Cooked Ready-To-Eat Food. A review of the 2022 U.S. Food and Drug Administration Food Code titled Ready to Eat, Time/Temperature control for safety food, Date Marking Code#3-501.17, indicated, Ready to eat, time temperature control for safety food prepared and packaged by food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed, sold, or discarded. 2. During an observation in the dry storage area on 9/2/2025 at 10:00AM, there were 11 cans of grape jelly, 5 cans had no label, 2 of the cans had droplets of clear residue that was sticky to touch. During a concurrent observation and interview with the DS on 9/2/2025 at 10:05AM, the DS stated the labels on the cans were damaged and removed. The DS stated the sticky residue should be cleaned because it can attract flies and pests to the food storage area. During an observation in the kitchen on 9/2/2025 at 10:15 AM, observed the coffee maker machine had glass gauge pipe in front of the machine. The pipes were half (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	filled with coffee and there were dark brown stains inside the pipe. During a concurrent interview with the DS on 9/2/2025 at 10:15AM, the DS stated the coffee machine is cleaned by staff every day but not the glass gauge/pipe. The DS stated they do not have the special tool to clean the glass gauge/pipe. DS acknowledged that the glass pipe is dirty and stated will inform the coffee supplier to provide the tool to clean the coffee machine properly. The DS stated that the stained and dirty coffee maker can contaminate the coffee and change the quality of the coffee. During an observation in the food preparation on 9/2/2025 at 10:30AM, there was a cart stored next to the food preparation counter. The wheels on the cart were dusty, the cart was stained with sticky residue. There were crumbs and dried food particles on the cart and behind the cart on the floor. During a concurrent observation and interview with cook (cook1) on 9/2/2025 at 10:30AM, Cook1 stated the cart is used as a storage surface. Cook1 stated the cart needs to be cleaned. During an interview with the DS and the District manager (DM) on 9/2/2025 at 10:35AM, the DM stated the cart should not be in the food preparation area. The DS stated the cart is used to move equipment and it should be stored out of the way. The DS stated the cart is dirty and should be cleaned. The DS stated dirty work areas can attract pests and cause cross contamination of food. The DM asked to move the cart and clean the floor behind the cart. During a review of the facility's policy and procedures (P&P) titled Receiving (revised 2/2023), the policy indicated, All canned goods will be appropriately inspected for dents, rust or bulges. Damaged cans will be segregated and clearly identified for return to vendor or disposal, as appropriate. During a review of facility's policy and procedures (P&P) titled Food Storage: Dry Goods (Revised 2/2023) the P&P indicated, All packaged and canned food items will be kept clean, dry, and properly sealed. During a review of facility's policy and procedures (P&P) titled Environment (Revised 9/2017) the P&P indicated, All food preparation areas, food service areas, and dining areas will be maintained in a clean and sanitary condition; All food contact surfaces will be cleaned and sanitized after each use. During a review of facility's daily cleaning schedule log, the schedule indicated to clean and sanitize the coffee machine and did not indicate cleaning the gauge and pipe. During a review of the 2002 U.S. Food and Drug Administration Food Code, code 3-304.11 titled Food Contact with Equipment and Utensils code indicated, Food shall only contact surfaces of: (A) Equipment and utensils that are cleaned and sanitized. Pathogens can be transferred to food from utensils that have been stored on surfaces which have not been cleaned and sanitized.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure three of four sampled residents (Residents 5, 66, and 124) had complete and accurate medical records by failing to: Ensure Resident 5's Restorative Nursing Aide (RNA, nursing aide program that help residents maintain any progress made after therapy intervention to maintain their function) splinting (rigid material or apparatus used to support and immobilize a broken bone or impaired joint) orders for both hands and both knees were accurately written to indicate the recommended splint wear time and schedule (length of time and frequency a person can tolerate wearing the splint for safety, comfort, and maximal benefits). Ensure documented evidence of a conservatorship (court-ordered arrangement where a judge appoints someone [a conservator] to make decisions for an adult who can't manage their own financial or personal affairs, often due to mental or physical incapacitation) was included in the medical records for one of two residents (Resident 66). Accurately document and capture a right forearm deformity for Resident 124. These deficient practices had the potential to delay and negatively impact the delivery of necessary care and services for Resident 5, 66, and 124. Findings: 1. During a review of Resident 5's admission Record, the admission Record indicated the facility initially admitted Resident 5 on 8/31/2018 and re-admitted Resident 5 on 6/26/2025 with diagnoses including chronic obstructive pulmonary disease (lung disease that causes obstruction of airflow and can limit normal breathing), cerebral palsy (a group of disorders that affect a person's ability to move and maintain balance and posture), and Parkinson's disease (progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movement). During a review of Resident 5's Minimum Data Set (MDS, a resident assessment tool), dated 8/1/2025, the MDS indicated Resident 5 had severely impaired cognition (mental action or process of acquiring knowledge and understanding). The MDS indicated Resident 5 required substantial/maximal assistance (helper does all the effort) for oral hygiene, bathing, dressing, personal hygiene, and rolling to both sides and was dependent (helper does all the effort) for transfers and toileting hygiene. The MDS indicated Resident 5 had functional limitations in range of motion (limited ability to move a joint that interferes with daily functioning, including activities of daily living, or places the resident at risk of injury) in both arms and both legs. During a review of Resident 5's Order Summary Report, the Order Summary Report indicated a physician's order, dated 7/10/2025, for RNA to apply a hand carrot splint (a device that opens the hand and positions the fingers away from the palm to protect the skin from moisture, pressure, and nail puncture) to Resident 5's both hands, alternately, five (5) times a week for four (4) to six (6) hours. During a review of Resident 5's Order Summary Report, the Order Summary Report indicated a physician's order, dated 7/10/2025, for RNA to apply knee splints to Resident 5's both knees, alternately, 5 times a week for 4 to 6 hours. During a concurrent observation of Resident 5's RNA session and interview on 9/4/2025 at 10:29 am, in Resident 5's room, Resident 5 was sitting in a wheelchair. Restorative Nursing Aide 1 (RNA 1) assisted Resident 5 with passive range of motion (PROM, movement at a given joint with full assistance from another person) exercises to Resident 5's both arms and right leg and applied splints to Resident 5's right hand and right knee. RNA 1 stated she will return in three (3) hours to alternate (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	daily decision-making were moderately impaired. During a review of Resident 66's Social Service History and Initial Assessment, dated 7/23/2025, the Assessment indicated Resident 66 had a public guardian. During a concurrent interview and record review on 9/4/2025 at 1:45 p.m., with the Director of Social Services (DSS), Resident 66's medical records were reviewed and Residents 66's conservatorship documents were not included in the medical records. The DSS stated conservatorship papers should have been in the chart, so nurses know who to get consent from and to protect residents' rights. During an interview on 9/5/2025 at 3:15 p.m., with the Director of Nursing (DON) the DON stated that conservatorship papers need to be in the chart to indicate to staff who the responsible party was. During a review of the facility's policy and procedure (P&P) titled, "Accuracy of Medical Records Policy", revised 1/2025, the P&P indicated that all medical records are accurate, complete, timely, and maintained in compliance with regulatory requirements and professional standards, thereby supporting quality care, resident safety, and legal integrity. 3. During a review of Resident 124's admission Record, the admission Record indicated Resident 124 was admitted to the facility 5/1/2025 with diagnoses of dementia (a group of conditions that cause a decline in cognitive abilities, such as memory, language, attention, and problem-solving, severe enough to interfere with daily life), history of falling, and age-related osteoporosis (a condition that weakens bones, making them more prone to fractures [broken bones]). During a review of Resident 124's MDS, dated [DATE], indicated Resident 124 had severe cognitive impairment (difficulties with mental functions like thinking, learning, remembering, and decision-making, affecting skills such as communication and self-help). The MDS indicated Resident 124 required partial/ moderate assistance (helper does less than half the effort) for personal hygiene (combing hair, shaving, and washing/ drying face and hands. The MDS indicated Resident 124 required supervision or touching assistance (helper provides verbal cues and/ or touching/ steadying as the resident completes and activity) for bathing and showering. During a review of Resident 124's Skin Note dated 5/1/2025, the Skin Note did not mention and deformity to Resident 124's right forearm. During a review of Resident 124's Nursing Note dated 5/1/2025 regarding admission, the Nursing Note did not mention Resident 124's right forearm deformity. During a review of Resident 124's Change of Condition (COC) Evaluation dated 8/3/2025, the COC indicated a deformity was noted to the right forearm. The COC indicated Family Member (FM) 1 was called and she informed the facility the right forearm deformity was already there and not new. During an observation on 9/3/2025 at 3:59 p.m., Resident 124 was lying in bed, Resident 124 denied any pain, but his right forearm was observed to be deformed with the two bones in his forearm appearing to be criss-crossed in an unnatural position and not aligning with the bones of his hand. Resident 124 was able to open and close his hand and no swelling or bruising was noted. During an interview on 9/4/2025 at 9:05 a.m., FM 1 stated Resident 124 had an accident (fracture and cut arm) while he was working as a carpenter many years ago and never received proper treatment (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	causing his right forearm deformity. FM 1 stated Resident 124 was admitted to the facility with the right forearm deformity. During an interview on 9/5/2025, restorative nursing assistant (RNA) 2 stated Resident 124 was part of her assigned resident she provided care to. RNA 2 stated there were no new issues with Resident 124's right forearm and she has known resident 124 to have the right forearm deformity since admission. During an interview and concurrent record review on 9/5/2025 at 11:16 a.m., registered nurse (RN) 1 stated Resident 124 was admitted to the facility with the right forearm deformity. RN 1 stated after reviewing Resident 124's progress notes and skin checks since admission, the nursing staff failed to capture the right forearm deformity until 8/3/2025 when the COC was done regarding the right forearm deformity. RN 1 stated any abnormalities to a resident's body should be captured in the resident's documentation, so staff had a baseline to compare any changes too. RN 1 stated it would have been an important assessment to capture the right forearm deformity to ensure the resident was provided with the correct care and handled gently. RN 1 stated it was also important to capture baseline abnormalities, so unnecessary care was not rendered for old injuries. During a review of the facility's policy and procedure (P&P) titled "Accuracy of Assessment Policy"; undated, indicated the facility was to ensure all resident assessments were accurate, complete, and reflective of each resident's status.		

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F 0848 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide a neutral and fair arbitration process and agree to arbitrator and venue. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the Binding Arbitration agreements (a binding agreement by the parties to submit to a private process where disputing parties agree that one or several other individuals can decide about the dispute after receiving evidence and hearing arguments) provided a selection of a venue that is convenient to both parties for three of three sampled residents (Resident 29, 104, and 156). This deficient practice violated the rights of Resident 29, Resident 104 and Resident 156. Findings: During a review of Resident 29's admission Record, the admission Record indicated Resident 29 was originally admitted to the facility on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities). During a review of Resident 29's Minimum Data set (MDS), A resident assessment tool, 6/28/2025, the MDS indicated Resident 29's cognitive skills (functions your brain uses to think, pay attention, process information, and remember things) for daily decision-making were intact. During a review of Resident 29's Resident - Facility Arbitration Agreement, the agreement was signed on 3/18/2022. During a review of Resident 104's admission Record, the admission Record indicated Resident 104 was originally admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy (condition where the brain's metabolism is disrupted, leading to altered brain function). During a review of Resident 104's MDS, 6/10/2025, the MDS indicated Resident 104's cognitive skills for daily decision-making were intact. During a review of Resident 104's Resident - Facility Arbitration Agreement, the agreement was signed on 9/19/2022. During a review of Resident 156's admission Record, the admission Record indicated Resident 156 was originally admitted to the facility on [DATE] with diagnoses including anxiety disorder (mental health condition characterized by excessive and persistent worry, fear, and nervousness that can interfere with daily life). During a review of Resident 156's MDS, 6/10/2025, the MDS indicated Resident 156's cognitive skills for daily decision-making was intact. During a review of Resident 156's Resident - Facility Arbitration Agreement, the agreement was signed on 11/14/2022. During a concurrent interview and record review on 9/3/2025 at 10:15 a.m. with the Business Office Manager (BOM), a facility blank Resident-Facility Arbitration Agreement was reviewed. The BOM confirmed the Agreement does not provide for the selection of a venue that is convenient to both parties. During a review of the facility's policy and procedure titled, Binding Arbitration Agreements, undated, the policy indicated the agreement must provide for selection of a venue convenient to both parties.		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure one of three sampled resident's (Resident 7) informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) for psychotropics (drug or other substance that affects how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior) was obtained prior to administration of medications. This deficient practice violated Resident 7 and the responsible party's rights to receive all information, in advance, of risks and benefits of proposed care, treatment, treatment alternative, and choose the alternative of choice which includes information for administration of psychotropic drugs. Findings: During a review of Resident 7's admission Record, the admission Record indicated Resident 7 was readmitted to the facility on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities) with psychotic disturbance (a mental health condition characterized by a loss of contact with reality), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) and generalized anxiety disorder (mental health condition characterized by excessive fear and worry). During a review of Resident 7's Minimum Data set ([MDS] a resident assessment tool), dated 7/28/2025, the MDS indicated Resident 7's cognitive skills (functions your brain uses to think, pay attention, process information, and remember things) for daily decision-making was severely impaired. The MDS indicated Resident 7 needed moderate assistance (helper does less than half the effort) with eating, oral hygiene, maximal assistance (helper does more than half the effort) with personal hygiene, and dependent (helper does all the effort) on staff with toileting hygiene and showering. During a review of Resident 7's Order Summary Report, dated 9/3/2025, the report indicated the following: 1. Starting on 8/8/2025, Risperidone (medication for dementia with psychotic disturbance) 1 mg by mouth, one time a day. 2. Starting on 8/24/2025, Ativan (medication for anxiety) one milligram (mg - metric unit of measurement, used for medication dosage and/or amount), by mouth, every 6 hours as needed for inability to relax for 14 days. During a concurrent interview and record review on 9/3/2025 at 12:55 p.m., with Registered Nurse Supervisor (RNS) 1 and 2, Resident 7's medical records were reviewed. RNS 1 and 2 confirmed Resident 7 did not have consent for the following psychotropics: 1. Risperidone 1 mg one time a day, ordered 8/8/2025. 2. Ativan 1 mg every 6 hours as needed for anxiety, order renewed 8/24/2025. During an interview on 9/3/2025 at 1:05 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated that an informed consent was important, so the resident or family knows about treatment options the resident was receiving. During an interview on 9/5/2025 at 3:15 p.m., with the Director of Nursing (DON) the DON stated that informed consent should be obtained prior to the administration of psychotropic medications. During a review of the facility's policy and procedure (P&P) titled, Psychotropic Medication Management Policy, undated, the P&P indicated the residents written informed consent for treatment will be obtained before initiating psychotropic medications.		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, and record review, the facility failed to ensure the call light was within reach for one of eight sampled residents (Resident 124). This deficient practice had the potential for Resident 124's needs not being met. Findings: During an observation on 9/2/2025 at 2:50 p.m., Resident 124 was lying in his bed, and his call light was on the floor to the left side of his bed. Resident 124 had a gold star (indicating high-fall-risk) next to his name plaque at the entry of his door. During a review of Resident 124's admission record, the admission record indicated Resident 124 was admitted to the facility 5/1/2025 with diagnoses including dementia (a group of conditions that cause a decline in cognitive abilities, such as memory, language, attention, and problem-solving, severe enough to interfere with daily life), history of falling, and age-related osteoporosis (a condition that weakens bones, making them more prone to fractures [broken bones]). During a review of Resident 124's Minimum Data Set (MDS, a resident assessment tool) dated 8/8/2025, the MDS indicated Resident 124 had severe cognitive impairment (difficulties with mental functions like thinking, learning, remembering, and decision-making, affecting skills such as communication and self-help). The MDS indicated Resident 124 required partial/ moderate assistance (helper does less than half the effort) for personal hygiene (combing hair, shaving, and washing/ drying face and hands. The MDS indicated Resident 124 required supervision or touching assistance (helper provides verbal cues and/ or touching/ steadying as the resident completes and activity) for bathing and showering. During an observation on 9/2/2025 at 2:53 p.m., licensed vocational nurse (LVN) 3, entered Resident 124's room after being alerted Resident 124 appeared to need assistance. LVN 3 entered the room, picked the call light up off the floor and placed it within reach of Resident 124. LVN 3 verbalized Resident 124 needed to be repositioned and changed. During an interview on 9/2/2025 at 3:05 p.m., with LVN 3, LVN 3 stated the gold star next to Resident 124's name meant he was a high fall risk. LVN 3 stated the call light was found on the floor when she entered Resident 124's room. LVN 3 stated Resident 124 could utilize the call light when it was placed within reach and Resident 124 appeared calmer after they changed and repositioned him. During an interview on 9/5/2025 at 2:24 p.m., with the Director of Nurses (DON), the DON stated the call light being found on the floor meant it was not within reach for Resident 124. The DON stated it was important the call light was always within reach to ensure residents had access to the call light when they needed help and the nurses could immediately assist residents when they needed help. During a review of the facility's policy and procedure (P&P) titled Call Lights: Accessibility and Timely Response dated 2021, indicated staff were to ensure residents had access to the call light.		

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on interview and record review the facility failed to honor the choices of one of eight sampled residents (Resident 160) regarding care and cleaning of his wheelchair. This deficient practice resulted in Resident 160's wheelchair being removed from his room against his wishes, was not readily available when he wanted to use it and did not honor his resident's rights. Findings: During a review of Resident 160's admission Record (face sheet), the admission Record indicated Resident 160 was admitted to the facility 7/24/2018 with diagnoses of peripheral vascular disease (a condition in which narrowed blood vessels reduce blood flow to the limbs) and cellulitis (a common bacterial infection of the skin and underlying tissues) of left toe. During a review of Resident 160's Minimum Data Set ([MDS], a resident assessment tool) dated 7/17/2025, the MDS indicated Resident 160 was cognitively intact (describes a person whose brain functions are normal and unimpaired, enabling them to think, learn, remember, solve problems, and make decisions effectively). During a concurrent observation and interview on 9/2/2025 at 10:59 a.m., Resident 160 was observed walking in the hallway back to his room with his bilateral legs wrapped in ace bandages (helps to reduce pain and swelling). Resident 160 stated his legs were wrapped due to issues due to skin issues related to peripheral vascular disease. Resident 160 stated he was upset he could not find his wheelchair because someone took it out of his room for cleaning against his wishes. During an interview on 9/4/2025 at 2:05 p.m., with the Director of Social Services (DSS), the DSS stated Resident 160 had informed her two days (on 9/2/2025) earlier that his wheelchair was missing and he was very upset. The DSS stated there was an issue in the past when Resident 160 reported staff taking his wheelchair out of his room for cleaning when he did not want it taken from his room. The DSS stated she did not file a formal grievance (a real or imagined wrong or other cause for complaint or protest, especially unfair treatment) for Resident 160's complaint regarding his wheelchair because the issue was resolved right away and his wheelchair was returned to him as soon as she learned about it. The DSS stated it was Resident 160's right to request no one removed the wheelchair from his room and he could clean the wheelchair himself if those were his wishes. During an interview on 9/5/2025 at 11:26 a.m., with Registered Nurse (RN) 1, RN 1 stated nursing staff was not made aware that Resident 160 did not want his wheelchair removed from his room and that is why his wheelchair was removed from his room for cleaning. RN 1 stated if they had been aware of Resident 160's wishes his wheelchair would have remained in his room. During an interview on 9/5/2025 at 2:24 p.m., with the Director of Nursing (DON), the DON stated it was important the different departments of the facility communicated residents' wishes with each other because it pertained to the residents' wishes, care, and needs. The DON stated it was important to honor residents' wishes because that is the residents' right and if he did not want his wheelchair removed from his room, it should not have been removed. During a review of the facility's policy and procedure (P&P) titled Resident Rights dated 2017, the P&P indicated the facility was to ensure all staff members were educated on the rights of residents and the responsibility of the facility to properly care for its residents.		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure an Advance Directive ([AD], a legal document that outlines a person's healthcare preferences and appoints a healthcare agent to make medical decisions on their behalf if they become unable to do so) was accurate and completed as per the facility's policy and procedure (P/P) for one of two sampled residents (Residents 156). This deficient practice violated the resident's rights to be fully informed of the option to formulate an AD and had the potential to cause conflict with the residents' wishes regarding health care in the event resident became incapacitated (unable to participate in a meaningful way in medical decisions) or unable to make medical decisions that would not be identified and/or carried out by the facility staff. Findings: During a record review of Resident 156's admission Record, the admission Record indicated Resident 156 was admitted to the facility on [DATE] with diagnoses including bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest, fear, dread and other symptoms that are out of proportion to the situation), and post-traumatic stress disorder ([PTSD], a mental health condition that's caused by an extremely stressful or terrifying event, either being part of it or witnessing it). During a record review of Resident 156's Minimum Data Set ([MDS], a resident assessment tool) dated 8/6/2025, the MDS indicated Resident 156 had intact cognitive (thought process) skills for daily decision-making and needed assistance (helper sets up while resident completes the activities) with self-care abilities and mobility such as eating, oral hygiene, dressing, and transfers. During a record review of Resident 156's history and physical (H&P) dated 1/30/2025, the H&P indicated Resident 156 had the capacity to understand and make decisions. During a record review of Resident 156's AD Acknowledgment form dated 11/3/2022, the AD Acknowledgment form did not indicate if Resident 156 chose to formulate an AD or chose not to formulate an AD. The AD Acknowledgment form was signed and witnessed by facility staff. During a concurrent interview and record review on 9/4/2025 at 1:35 p.m., with the Director of Social Services (DSS), Resident 156's AD Acknowledgment form dated 11/3/2022 was reviewed. The DSS stated, the top portion the AD Acknowledgment form indicated residents' specific directives. The DSS stated the residents indicate if they want to donate their organs, whether the resident wants to be resuscitated or not. The DSS stated the AD Acknowledgment form should have been completed to indicate the residents' wishes. The DSS stated the AD Acknowledgment form was incomplete and the facility staff that gave the form to the resident should have made sure the AD Acknowledgment form was filled out and answered completely. During an interview on 9/5/2025 at 2:54 p.m., with the Director of Nursing (DON), the DON stated an AD was a document indicating the residents wishes for life saving measures if the resident becomes incapable of making those decisions. The DON stated the AD is completed when the resident is admitted . done during the admission process to the facility. The DON stated the AD Acknowledgment form was a document indicating whether residents had an AD, wanted to formulate an AD or not. The DON stated all documents should be clear, concise and complete. The DON stated staff should be making sure the AD was filled out completely. During a review of the facility's policy and procedures (P&P) titled Advance Directive Policy, dated January 2025, indicated, the purpose was to ensure that residents are informed of their rights regarding advance directives and that the facility respects, documents, and follows resident choices about medical treatment and end-of-life care. residents have the right to make decisions about their medical care, including the right to formulate advance directives such as living wills, durable powers of attorney for health care, or Physician Orders for Life-Sustaining Treatment ([POLST], a medical order for seriously ill patients that specifies their end-of-life care wishes). upon admission, residents and/or their representatives (continued on next page)		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	will be provided written information about their right to make advance directives under applicable state and federal law, staff will be available to answer questions and provide education or referral resources as needed. the Admissions/Intake Staff shall provide information on advance directives during the admission process.the nursing Staff shall ensure documentation is current, accessible, and followed in the plan of care.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of four residents (Resident 13) written notice of transfer was provided to the State Long-term Care Ombudsman (an advocate for residents of nursing homes, board and care centers, and assisted living facilities). This deficient practice resulted in violation of resident rights because the ombudsman could not advocate for the residents and investigate potential violations. Findings: During a review of Resident 13's admission Record, the admission Record indicated Resident 13 was originally admitted to the facility on [DATE] with diagnoses including post-traumatic stress disorder (PTSD - a disorder in which a person has difficulty recovering after experiencing or witnessing a traumatic event), homicidal (thought pattern characterized by the desire to kill another person or persons) and suicidal ideations (thinking about or planning to kill ones' self), and paranoid schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 13's Minimum Data Set ([MDS] a resident assessment tool), dated 8/11/2025, the MDS indicated Resident 13's cognition (ability to think and reason) was intact. During a review of Resident 13's Progress Notes, dated 8/29/2025 at 8:59 a.m., the note indicated Resident 13 was noncompliant with medications and treatments and continued to have episodes of responding to internal stimuli and the physician was notified and ordered to transfer the resident to the general acute care hospital (GACH) for further evaluation. During a review of Resident 13's Progress Notes, dated 8/29/2025 at 1:12 p.m., the notes indicated Resident 13 was transferred to the GACH. During a concurrent interview and record review on 9/4/2025 at 10:30 a.m., with Registered Nurse Supervisor (RNS) 2, Resident 13's clinical records were reviewed. RNS 2 stated the facility did not notify the ombudsman of Resident 13's transfer on 8/29/2025. RNS 2 stated the notice was important, so ombudsman knows about Resident 13's transfer. During an interview with the Medical Records Director (MRD) on 9/4/2025 at 2:31 p.m., the MRD stated there was no documented evidence that fax was sent informing the Ombudsman of Resident 13's transfer to the GACH. During an interview on 9/5/2025 at 3:15 p.m. with the Director of Nursing (DON), the DON stated the written Notice of Proposed Transfer and Discharge Form needed to be faxed to the ombudsman to inform them of the transfer. During a review the facility's policies and procedure (P&P) titled, Transfer and Discharge (including AMA), the P&P indicated a copy of the Notice of Proposed Transfer and Discharge will be sent to the ombudsman.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record reviews, the facility failed to update one of the two sampled residents' (Resident 9) care plans. This deficient practice had the potential to result in delays of care and services. Findings: During a review of Resident 9's admission Record, the admission Record indicated Resident 9 was readmitted to the facility on [DATE] with diagnosis including major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), metabolic encephalopathy (change in how your brain works due to an underlying condition), type 2 diabetes a disorder characterized by difficulty in blood sugar control), Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), chronic kidney disease (condition where the kidneys gradually lose their ability to filter waste products from the blood) and hypertension (high blood pressure). During a review of Resident 9's Minimum Data set ([MDS] a resident assessment tool), dated 8/23/2025, the MDS indicated Resident 9's cognitive skills (functions your brain uses to think, pay attention, process information, and remember things) for daily decision-making were severely impaired. The MDS indicated Resident 9 needed moderate assistance (helper does less than half the effort) with oral hygiene, maximal assistance (helper does more than half the effort) with toileting hygiene, showering, personal hygiene, and dependent (helper does all the effort) on staff with eating. During a concurrent interview and record review on 9/4/2025 at 11:05 a.m., Licensed Vocational Nurse (LVN) 1, Resident 9's care plans were reviewed and Resident 9's care plans indicated care plans should have been updated or reviewed on 8/21/2025. LVN 1 stated the MDS nurse should have updated all the care plans to ensure if interventions should have been revised or continued. During an interview on 9/5/2025 at 3:15 p.m., with the Director of Nursing (DON) the DON stated that care plans need to be updated and reviewed to evaluate the effectiveness of the interventions for the residents. During a review of the facility's policy and procedure (P&P) titled, Comprehensive Care Plans, revised 1/2025, the P&P indicated that the comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on observation, interview, and record review, the facility failed to provide treatment and care in accordance with professional standards of practice for the assessment and application of splints (rigid material or apparatus used to support and immobilize a broken bone or impaired joint) for one of seven sampled residents (Resident 4) by failing to: Ensure the Director of Rehab (DOR) who was a Physical Therapist (PT, profession aimed in the restoration, maintenance, and promotion of optimal physical function) performed an assessment to determine the appropriateness and fit of Resident 4's right wrist/hand splint and right elbow splint. Ensure the DOR monitored and established Resident 4's right wrist/hand and right elbow splint wear time tolerance (length of time and frequency a person can tolerate wearing the splint for safety, comfort, and maximal benefits). These deficient practices had the potential to cause Resident 4 to have skin break down (tissue damage caused by friction, shear, moisture, or pressure), pain, discomfort, joint (where two bones meet) dislocation (an injury where the joint is forced out of the normal position), deformity (malformation), and/or bone fractures (a crack or break in the bone). Findings: During an observation on 9/2/2025 at 3:04 pm, in Resident 4's room, Resident 4 was sleeping in bed and wearing a splint on the left elbow. During a review of Resident 4's admission Record, the admission Record indicated the facility initially admitted Resident 4 on 1/14/2018 and re-admitted Resident 4 on 1/30/2025 with diagnoses including quadriplegia (weakness or paralysis to all four extremities) and end stage renal disease (ESRD, chronic kidney disease that causes gradual loss of kidney function). During a review of Resident 4's Minimum Data Set (MDS, a resident assessment tool) dated 7/15/2025, the MDS indicated Resident 4 was cognitively (mental action or process of acquiring knowledge and understanding) intact. The MDS indicated Resident 4 was dependent (helper does all the effort) in eating, hygiene, bathing, dressing, and mobility (ability to move). The MDS indicated Resident 4 had functional limitations in ROM (limited ability to move a joint that interferes with daily functioning, including activities of daily living, or places the resident at risk of injury) on one arm (shoulder, elbow, wrist, hand) and both legs (hip, knee, ankle, foot). During a review of Resident 4's Order Summary Report, the Order Summary Report indicated a physician's order, dated 7/22/2025, for Restorative Nursing Aide (RNA, nursing aide program that help residents maintain any progress made after therapy intervention to maintain their function) to apply a right wrist/hand splint for four (4) to six (6) hours, every day, 6 times a week. During a review of Resident 4's Order Summary Report, the Order Summary Report indicated a physician's order, dated 7/22/2025, for RNA to apply a right elbow splint for four 4 to 6 hours, every day, 6 times a week. During a review of Resident 4's re-admission Rehabilitation Screening (Rehab Screen, brief assessment of a resident's level of function and recommendations for skilled therapy services [services that require specialized training and experience of a licensed therapist or therapy assistant] or RNA), signed by the DOR and dated 7/23/2025, the Rehab Screen indicated Resident 4 would benefit from a right elbow and right-hand splint. The Rehab Screen indicated skilled therapy services were not warranted. During an interview on 9/4/2025 at 4:00 pm, the Medical Records Director (MRD) stated there were no PT and/or Occupational Therapy (OT, profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities) notes for Resident 4 in the electronic medical records. During a concurrent observation and interview on 9/5/2025 at 9:43 am, in Resident 4's room, Resident 4 was laying in bed with the right arm bent at the elbow and fingers curled inward toward the palm. Resident 4 stated he was paralyzed from the neck down, was unable to actively move both arms and both legs and could not feel anything below the upper chest. Resident 4 stated he wore a right elbow and right wrist/hand splint almost every day. Resident 4 stated he was unable to feel the splints on his right arm because his arms felt asleep and required staff to ensure the splints fit correctly and were not pressing on his skin. During a concurrent interview on 9/5/2025 at 12:25 pm, the DOR stated the purpose of splints was to improve or maintain a resident's range of motion (ROM, full movement potential of a joint) to prevent (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	contractures. The DOR stated a licensed PT or OT must assess a resident's need for splints if indicated. The DOR stated the licensed therapist must determine the wear tolerance and splint wear schedule by periodically assessing the splint for safety, comfort or need for modification. The DOR stated that once the therapist assessed a resident for the correct type of splint to be issued, wear tolerance was established, and the resident was able to tolerate the splint, the resident's splinting plan of care was transitioned to the RNA program. The DOR reviewed Resident 4's clinical record and confirmed Resident 4 was never formally evaluated by PT and/or OT during his entire stay at the facility. The DOR reviewed Resident 4's Rehab Screen, dated 7/23/2025, and confirmed that the DOR recommended and issued a right hand/wrist splint and a right elbow splint. The DOR confirmed there was no documented evidence to indicate splint assessments for Resident 4's right hand/wrist and right elbow were completed and determination of the splint wear time for both splints were evaluated by a therapist. The DOR stated the standard of practice in therapy for a patient requiring a new splint included: an initial evaluation of the patient's ROM, assessment for the type of splint to issue, application of the splint, periodic splint checks to determine the splint wear schedule, tolerance, and if modification was required, training the patient and/or caregiver, RNA, and nursing on the use of splint and any precautions and documentation of all findings in the clinical record. The DOR stated the splint assessment and wear time tolerance should have been documented in the medical record but were not. The DOR stated if a resident was not properly assessed for the correct splints and wear time tolerance, the resident could potentially have skin breakdown, pain, and discomfort. During an interview on 9/5/2025 at 3:33 pm, the Director of Nursing (DOR) stated Rehab was responsible for assessing the types of splints and determining the splint wear time for all residents in the facility. The DON stated residents could potentially experience a functional decline, pain, discomfort, and skin concerns if they were not properly assessed for the correct splint and a wear time schedule was not established. During a review of a textbook, titled The Guide to Physical Therapist Practice, second edition, pages 76 and 77, revised 2003 by the American Therapy Association, indicated a physical therapist used tests and measures to assess the need for orthotic devices in patients and evaluated the appropriateness and fit of the device. The Guide to Physical Therapy Practice indicated physical therapists performed assessments to determine a patient's alignment and fit of the orthotic device, components of orthotic device, level of safety with device, and functional benefit of the device. During a review of the facility's undated Policy and Procedure (P/P) titled Splinting Policy, the P/P indicated splints were applied, maintained, and monitored safely for residents who required them, while protecting skin integrity, mobility, and overall comfort. The P/P indicated staff would ensure the proper fit and alignment, skin circulation would be assessed before and after application, and at intervals consistent with facility standards, and residents would be monitored for signs of discomfort, impaired circulation, or skin breakdown. The P/P indicated ongoing monitoring, assessments, and any issues or concerns would be recorded in the resident's medical record.		

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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 observation, interview, and record review, the facility failed to ensure one of seven sampled residents (Resident 45) was sitting upright when eating lunch. This deficient practice placed Resident 45 at risk for choking and aspiration (inhaling small particles of food or drops of liquid into the lungs). Findings: During a review of Resident 45's admission Record, the admission Record indicated the facility initially admitted Resident 45 on 8/25/2023 and re-admitted Resident 45 on 11/7/2024 with diagnoses including asthma (condition in which your airways narrow and swell making breathing difficult) and chronic obstructive pulmonary disease (lung disease that causes obstruction of airflow and can limit normal breathing). During a review of Resident 45's Minimum Data Set (MDS, a resident assessment tool), dated 6/2/2025, the MDS indicated Resident 45 had severely impaired cognition (mental action or process of acquiring knowledge and understanding). The MDS indicated Resident 45 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) for eating and upper body dressing, partial/moderate assistance (helper does less than half the effort) for oral hygiene, lower body dressing, and personal hygiene, and substantial/maximal assistance (helper does all the effort) for toileting hygiene and bathing. During a review of Resident 45's Speech Therapy (ST, profession aimed in the prevention, assessment, and treatment of speech, language, communicative, and swallowing disorders) Discharge summary, dated [DATE], the ST Discharge Summary indicated Resident 45 had a diagnosis of dysphagia (difficulty swallowing). The ST Discharge Summary indicated the ST recommended a pureed diet (texture modified diet that involves eating soft foods that can be swallowed and digested without chewing) with aspiration precautions (measures taken to prevent the accidental inhalation of food, liquid, or other foreign objects into the lungs). During a review of Resident 45's care plan, the care plan indicated Resident 45 was on a puree diet and had the potential for choking. The care plan interventions to address the goal of minimizing Resident 45's risk of choking episodes was to maintain aspiration precautions which included assisting Resident 45 during meals as needed and sitting Resident 45 upright while eating. During a concurrent observation and interview on 9/3/2025 at 12:38 pm, in the resident's room, Resident 45 was lying in bed with the head of the bed elevated to less than 30 degrees with his eyes closed and both knees bent toward the chest. Certified Nursing Assistant 2 (CNA 2) was seated in a chair next to Resident 45's bed, feeding Resident 45 pureed food and sips of juice. CNA 2 stated he was feeding Resident 45 lunch while Resident 45 was laying down with the head of bed slightly elevated. CNA 2 stated he was not feeding Resident 45 in a safe position because Resident 45 was not in an upright position. CNA 2 stated Resident 45 should be seated in an upright position and should not be laying down with the head of bed slightly elevated while eating because he could choke. During a concurrent interview and record review on 9/4/2025 at 1:44 pm, Speech Therapist 1 (ST 1) reviewed Resident 45's ST Discharge summary, dated [DATE], and confirmed Resident 45 had dysphagia. ST 1 stated residents should always be seated upright while eating. ST 1 stated the ideal and recommended body position for eating was the upper body fully upright with the head of bed at an 80-to-90-degree angle and no slouching to minimize the risk of aspiration and choking. ST 1 stated eating while laying down with the head of bed slightly elevated could potentially cause choking and aspiration, particularly with residents who had dysphagia (difficulty swallowing). During an interview on 9/5/2025 at 3:33 pm, the Director of Nursing (DON) stated all residents should be seated upright while eating to prevent choking and aspiration. During a review of the facility's undated Policy and Procedure (P/P) titled Meal Supervision and Assistance, the P/P indicated residents would be prepared for a well-balanced meal in a calm environment, location of his/her preferences and with adequate supervision and assistance to prevent accidents, provide nutrition, and assure an enjoyable event by implementing (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Long Beach Care Center, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 2615 Grand Avenue Long Beach, CA 90815	
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interventions to reduce hazards and risks. The P/P indicated the resident should be positioned so his or her head and upper body were as upright as possible and with the head tipped slightly forward. The P/P indicated to use wedges and pillows to achieve a nearly upright position if a resident was served his or her mail in bed.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure for two of two residents (Resident 114 and Resident 7):1. Ensure Resident 114's buspirone (a medication used to treat anxiety [a medical condition described by feeling of fear or uneasiness]) was available in stock to be administered within 60 minutes of scheduled time of administration in accordance with physician orders and as per facility's policy and procedure (P&P) titled, Medication Administration, undated, affecting one of six sampled residents during medication administration. 2. Ensure facility's licensed nurse signed the controlled drug record (CDR- a log signed by the nurse with the date and time each time a controlled medication [medications that the use and possession of are controlled by the federal government] is received from the pharmacy or given to a resident) to indicate Resident 7's morphine sulfate concentrate (a controlled medication used to manage severe pain) was received from pharmacy, as per the facility's P&P titled, Controlled Substances, undated, affecting one of three inspected medication carts (Station B Medication Cart 3). These deficient practices failed to provide buspirone on time in accordance with physician orders, had the potential to result in anxiety and mental disturbances for Resident 114, and facility licensed nurse failed to sign on the controlled drug record to indicate accountability and receipt of Resident 7's morphine sulfate concentrate (a controlled medication) from the pharmacy, which had the potential to result in inaccurate quantity, unintended use and/or loss of a controlled medication.Findings:During a review of Resident 114's admission Record , dated 9/3/2025, the admission Record indicated, Resident 114 was admitted to the facility on [DATE] with diagnoses including but not limited to, anxiety disorder, dementia [a progressive state of decline in mental abilities] in other diseases classified elsewhere, unspecified severity, with other behavioral disturbance and post-traumatic stress disorder.During a review of Resident 114's History and Physical (H&P), dated 6/12/2025, the H&P indicated, Resident 114 had fluctuating capacity to understand and make decisions.During a review of Resident 114's Minimum Data Set ([MDS], a resident assessment tool) dated 7/1/2025, the MDS indicated Resident 114's cognition (mental action or process of acquiring knowledge and understanding through thought and senses) was severely impaired. The MDS indicated, Resident 114 needed setup or clean-up assistance from the facility staff for performing activities of daily living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) such as eating, and needed supervision level assistance for oral hygiene, toileting hygiene, showering, upper and lower body dressing and putting on or taking off footwear. During a concurrent observation, interview and record review on 9/3/2025 at 12:31 p.m. with Licensed Vocational Nurse (LVN) 5 outside of Resident 114's room, LVN 5 stated she would prepare medications to administer to Resident 114. LVN 5 then stepped away for something and returned around 12:36 p.m. LVN 5 stated she went to look for Resident 114's buspirone 10 milligrams ([mg] unit of measurement for mass) medication pack, because she ran out of the medication in medication cart. LVN 5 showed the pharmacy's medication card or bubble pack for Resident 114's buspirone 10 mg that was empty. LVN 5 stated the facility did not have Resident 114's buspirone 10 mg in stock to administer at that time and would request pharmacy to send the medication to the facility as soon as possible. During a review of Resident 114's Order Summary Report (a document containing a summary of all active physician orders), dated 9/3/2025, the order summary report indicated, but not limited to the following physician order: Buspirone hydrochloride (HCl) oral tablet 10 mg, give 1 tablet by mouth three times a day for anxiety d/o verbalization of feeling anxious, order date 6/9/2025, start date 6/9/2025.During a concurrent interview and record review on 9/3/2025 at 4:47 p.m. with LVN 5, the pharmacy delivery receipt for Resident 114's buspirone 10 mg was reviewed. LVN 5 informed the surveyor that she received Resident 114's buspirone 10 mg from the pharmacy on 9/3/2025 at 2:11 (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	p.m. and she was able to administer the medication. During a review of Resident 114's medication administration audit report (a document containing the exact dates and times when the medications were scheduled, administered and documented as administered), dated 9/4/2025, the document indicated, buspirone 10 mg for Resident 114 was administered on 9/3/2025 at 2:32 p.m. instead of its scheduled administration at 1:00 p.m. During an interview on 9/4/2025 at 1:30 p.m. with the Director of Nursing (DON), the DON stated the licensed nurse staff should order medications at least five to seven days in advance before running out of stock. The DON stated that not having Resident 114's buspirone in stock delayed its administration and management of resident's anxiety which could cause the resident to continue to feel anxious. During an interview on 9/5/2025 at 2:47 p.m. with the DON, the DON stated the facility policy required licensed nursing staff to administer medications within 60 minutes before or after the scheduled time of medication administration. The DON stated Resident 114's buspirone was scheduled to be administered on 9/3/2025 at 1:00 p.m. and if it was administered on 9/3/2025 at 2:32 pm because it was not in stock, it would be considered as a late administration. 2. During a review of Resident 7's admission Record, dated 9/4/2025, the admission Record indicated Resident 7 was originally admitted to the facility on [DATE], and readmitted on [DATE] with diagnoses including but not limited to, Alzheimer's Disease (a progressive neurodegenerative disorder that primarily affects memory, cognition, and behavior), unspecified dementia, unspecified severity with psychotic disturbance. During a review of Resident 7's hospice visit note, dated 10/16/2024, the document indicated Resident 7's condition continued to deteriorate, was ambulatory, but needed redirection constantly and would benefit from hospice services. During a review of Resident 7's MDS, dated [DATE], the MDS indicated Resident 7 needed moderate assistance from the facility staff for eating, oral hygiene, upper body dressing, maximal assistance for lower body dressing, putting on or taking off footwear, personal hygiene, and dependent on facility staff for toileting hygiene and showering. During a concurrent inspection, interview and record review on 9/4/2025 at 12:18 p.m. with LVN 2 of Station B Medication Cart 3, Resident 7's medication container and facility's-controlled drug record or narcotic count sheet (CDR) for morphine sulfate oral concentrate solution 100 mg/5 milliliters ([mL] a unit of measurement for volume) were reviewed. Resident 7's morphine sulfate oral concentrate container was sealed with a quantity of 15 mL. The facility's CDR indicated a quantity of 15 mL without a documented signature from licensed nursing staff and the date received from the pharmacy. LVN 2 stated for controlled medications he would write in the narcotic binder, document in the electronic medication administration record (eMAR) when the medication was administered to the resident. LVN 2 stated the narcotic sheet for Resident 7's morphine sulfate oral concentrate solution did not have a signature or initials of the licensed nurse who received the medication but there was a quantity of 15 mL documented. LVN 2 stated he would need to find out about the process for documentation upon receipt of medication from the pharmacy. During a review of pharmacy delivery receipt for Resident 7's morphine sulfate oral concentrate, dated 6/27/2025, the document indicated morphine sulfate oral solution was delivered to the facility on 6/27/2025. During a review of Resident 7's order summary report, dated 9/5/2025, the order summary report indicated but not limited to the following physician orders: Morphine sulfate (concentrate) solution 20 mg/mL, give 0.25 mL by mouth every 2 hours as needed for severe pain/shortness of breath 0.25 mg = 5 mg, order date 10/16/2024, start date 10/16/2024. Morphine sulfate (concentrate) solution 20 mg/mL, give 0.25 mL by mouth every 4 hours as needed for moderate pain/shortness of breath 0.25 = 5 mg, order date 10/16/2024, start date 10/16/2024. During a review of Resident 7's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for the months of June 2025, July 2025, August 2025 and September 2025, there was no documented administration of morphine sulfate oral concentrate. During a review of Resident 7's MAR, dated 5/1/2025 to 5/31/2025, morphine sulfate oral concentrate was administered to Resident 7 on 5/27/2025 for a pain level of 6 (a pain level of 6 is considered moderate pain). During an interview on 9/4/2025 at 1:30 p.m. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with the DON, the DON stated it was important for licensed nursing staff to document the quantity and sign on Resident 7's morphine sulfate oral concentrate narcotic sheet when it was received from the pharmacy to aid in proper tracking of medications and to prevent diversion. During a review of the facility's P&P titled, Medication Administration, undated, the P&P indicated, Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice. infection. The P&P indicated, Compare medication source (bubble pack, vial, etc.) with MAR to verify resident name, form, dose route, and time. b. Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by physician. During a review of the facility's P&P titled, Controlled Substances, undated, the P&P indicated, Controlled substances must be counted upon delivery. The nurse receiving the medication, along with the person delivering the medication, must count the controlled substances together. Both individuals must sign the designated controlled substance record.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure medications requiring refrigeration were stored in accordance with manufacturer specifications and per facility's policy and procedure (P&P) titled, Medications Storage, undated, at a temperature range of 36 Fahrenheit [(F) is a unit of temperature] to 46 F or 2 Celsius [(C) is a unit of temperature] to 8 C, affecting one of two facility's medication room refrigerators (Station B Medication Room Refrigerator). This deficient practice had the potential to result in facility residents receiving medications that had become expired, ineffective, or toxic due to improper storage and labeling possibly leading to adverse health consequences such as hyperglycemia (high blood glucose), neuropathy (disease or dysfunction of one or more nerves, typically causing numbness or weakness in the hands and feet), inadequate comfort care and hospitalization. Findings: During a concurrent inspection and interview on [DATE] at 1:39 p.m. with Licensed Vocational Nurse (LVN) 1 of the medication refrigerator in Station B Medication Room, the following medications were found stored at temperature of 50 F, indicated by the thermometer in the refrigerator, which were in a manner contrary to its manufacturer's requirements: 1. One bottle of gabapentin (a medication used to treat neuropathy) 250 milligrams ([mg] a unit of measurement for mass) / 5 milliliters ([mL] a unit of measurement for volume), almost full bottle in a quantity of 473 mL 2. One opened vial of tuberculin (a solution to test for infection) 5 tuberculin units (TU)/0.1 mL 3. One sealed vial of tuberculin 5 TU/0.1 mL 4. One sealed vial of Lantus (a type of insulin [a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication]) 100 units/mL 5. One open Lantus Solostar Pen 100 units/mL 6. One sealed Comfort Kit containing the following: a. 15 mL of Morphine sulfate (a controlled medication [medications that the use and possession of are controlled by the federal government] used to manage severe pain) 20 mg/mL b. 30 mL of Lorazepam (a medication used to treat anxiety) 2 mg/mL c. Two suppositories of Bisacodyl (a medication used to relieve constipation) 10 mg d. Four suppositories of acetaminophen (a medication used to treat pain and fever) 650 mg e. Five tablets of Zofran (generic name - ondansetron [a medication used to treat nausea and vomiting] orally disintegrating tablet [ODT - a formulation of table that dissolves on tongue]) 8 mg f. Two mL of Atropine (an emergency medication used for heart complications) 1 percent ([%] a unit of measure) 7. One sealed Comfort Kit containing the following: a. One bottle of hyoscyamine (a medication used for a wide range of indications including heart complications) tablet (strength not provided by facility) b. One bottle of senna (a medication used to relieve constipation) (strength not provided by facility) c. Bisacodyl (a medication used to relieve constipation) suppository (quantity not listed by facility) d. One bottle of morphine sulfate (a medication used to treat severe pain) 100 mg/5 mL (quantity not provided by facility) e. Four suppositories of acetaminophen 120 mg (facility provided strength as 10 mg, incorrect) f. Four vials of Duoneb (generic name - ipratropium and albuterol [a combination of two medications used to treat breathing difficulties]) According to the manufacturer's product labeling, medications requiring refrigeration should be stored in refrigerator between 36 F and 46 F. LVN 1 stated the temperature in medication refrigerator was off and they were adjusting the refrigerator to ensure it had corrected range. LVN 1 stated earlier the temperature was at 32 F and now it's at 50 F. During an interview on [DATE] at 1:30 p.m. with the Director of Nursing (DON), the DON stated the temperatures should have been checked during each shift for Station B Medication Refrigerator. The DON stated if the temperature was not in the required range, the facility would move the refrigerated medications to a working refrigerator. The DON stated the refrigerated medications should have been stored at reference range of 36-to-46 F. The DON stated if the medication refrigerator temperature was out of range, there would be a risk that medications might not continue to be safe or effective to (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	be administered to residents. During a review of the facility's P&P titled Medication Storage, undated, the P&P indicated, It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. The P&P indicated, 6. Refrigerated Products: a. All medications requiring refrigeration are stored in refrigerators located in the pharmacy and at each medication room. b. Temperatures are maintained within 36-46 degrees F. Charts are kept on each refrigerator and temperature levels are recorded daily by the charge nurse or other designee. c. In the event that a refrigerator is malfunctioning, the person discovering the malfunction must promptly report such finding to Maintenance Department for emergency repair.		

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow up with status of unfitting dentures (a removable plate or frame holding one or more artificial teeth) for one of three sampled residents (Resident 63). This Failure had the potential to result in Resident 63 having discomfort while eating or chewing foods that could lead to unintended weight loss and low self-esteem. Findings: During a review of Resident 63's admission Record, the admission Record indicated, Resident 63 was initially admitted to the facility on [DATE] and last re-admission was on 9/24/2022 with diagnoses including moderate protein-calorie malnutrition (an imbalance between the nutrients your body needs to function and the nutrients it gets) and dementia (a progressive state of decline in mental abilities). During a review of Resident 63's History and Physical (H&P), dated 8/13/2025, the H&P indicated, Resident 63 was oriented to person, place, and time. During a review of Resident 63's Minimum Data Set (MDS - a resident assessment tool), dated 8/28/2025, the MDS indicated Resident 63 required dependent assistant (Helper does all of the effort) from two or more staff for toileting hygiene, bed to chair transfer, and maximal assistance (Helper does more than half the effort) from one staff for bathing, dressing, bed mobility, eating. During a review of Resident 63's Order Summary Report (OSR), dated 9/4/2025, the OSR indicated, provide dental consult with treatment as needed and as indicated was ordered on 9/24/2022. During a review of Resident 63's Care Plan (CP), revised 8/29/2025, the CP Focus indicated, Resident 63 was at risk for decreased food intake related to mission teeth. The CP Goal indicated, Resident 63's potential for decreased food intake will be minimized daily through the next review. The CP Interventions indicated, check dental condition and refer for dental evaluation. During a concurrent observation and interview on 9/2/2025, at 11:33 a.m., with Resident 63 in his room, Resident 63 did not have natural teeth. There was no dentures observed at the bedside. Resident 63 stated, he was having issue with unfitting denture since the beginning of 2025. Resident 63 stated, unfitting denture caused him pain while he was eating or chewing. Resident 63 stated, he was supposed to get a new one or adjusted one, but he has not heard anything since June or July. Resident 63 stated, he felt embarrassed to talk to people and having a hard time eating food without his denture. During a concurrent interview and record review on 9/4/2025, at 1:22 p.m., with the Director of Social Services (DSS), Resident 63's Onsite Mobile Dental Note, dated 7/28/2025 was reviewed. The Onsite Mobile Dental Note indicated, Resident 63 was edentulous (a medical term for having no natural teeth). The Onsite Mobile Dental Note indicated, full upper and lower dentures adjusted. The DSS stated, she did not know the status of Resident 63's denture. The DSS stated, she should have followed up with dental office to see if it was delivered to Resident 63. The DSS stated, she should have followed up with Resident 63 regarding his adjusted denture. The DSS stated, poor fitting denture could cause dental pain and unintended weight loss. During a concurrent interview and record review on 9/4/2025, at 1:30 p.m., with the DSS, Resident 63's Social Service Progress Notes, dated from 7/28/2025 to 9/4/2025 were reviewed. The Social Service Progress Notes indicated, there was no note documented regarding Resident 63's denture. The DSS stated, she did not follow up and document regarding the denture. During an interview on 9/5/2025, at 2:24 p.m., with the Director of Nursing (DON), the DON stated, providing well-fitting denture in a timely manner was important because it could affect the ability to eat, and it could lead to social isolation. The DON stated, the DSS should have followed up with Resident 63 after dental visit of 7/28/2025 to find out if the resident received his denture and it was fitting well. The DON stated, poor fitting denture could lead to weight loss due to pain. During a review of the facility's Policy and Procedure (P&P) titled, Dental services, revised 11/2017, the P&P indicated, Policy Explanation and Compliance Guidelines: 9. All actions and information regarding dental services, including any delays related to obtaining dental services, will be documented in the resident's medical record. During a review of the facility's Policy and Procedure (P&P) titled, Job (continued on next page)		

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Description: Social Services Director, undated, the P&P indicated, Major Duties and Responsibilities: The Social Services Director is responsible for overseeing the development, implementation, supervision and ongoing evaluation of the Social Services Department designed to meet and assist residents in attaining or maintaining their highest practicable well-being. This includes identifying the need for medically related social services and ensuring that these services are provided in accordance with State and Federal regulations.		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview and record review, the facility failed to ensure the lunch menu and spreadsheet (food portions and serving guide) was followed on 9/2/2025 for one of one residents (Resident 30) on a renal diet (a diet intended for residents with decreased kidney function. This diet regulates the dietary intake of sodium, potassium and protein to lighten the work of the diseased kidney) received the baked sweet potato instead of the mashed potato and received brown gravy instead of no gravy per the menu and renal diet guidelines. This deficient practice had the potential to result in meal dissatisfaction, and inadequate nutritional status when the menu is not followed to reflect the needs of the residents. During a review of Resident 30's physician diet order, dated 5/22/2025, Resident 30's physician diet order indicated Resident 30 diet was Renal CCHO small portions diet (a diet aimed to reduce the amount of sodium, potassium and carbohydrates in the food for people who have kidney disease and high blood sugar levels). (CCHO-Controlled Carbohydrate Diet-diet for blood sugar control for residents with diabetes) During a review of the facility's lunch menu for CCHO Renal diet on 9/2/2025, the lunch menu indicated the following items would be served: Glazed Baked pork chop, No [NAME] Gravy; [NAME] Peas; Mashed Potatoes, Dinner roll and sliced pears. During an observation of the tray line service for lunch (tray line-a system of food preparation, in which trays move along an assembly line) on 9/2/2025 at 12:00PM, Resident 30 who was on CCHO Renal diet the cook (cook1) served chopped beef patty with [NAME] Gravy and baked sweet potatoes instead of mashed potatoes. During a concurrent observation and interview with the Dietary Supervisor (DS) and Cook1 on 9/2/2025 at 12:45PM, the DS stated resident 30 is on CCHO renal diet and received beef patty with brown gravy when the menu indicated glazed pork chop and no gravy and received sweet potato instead of mashed potatoes. The DS stated resident 30 did not receive lunch according to the menu and renal diet guidelines. The DS stated residents on renal diet should avoid salty food and foods high in potassium (an electrolyte that needs to be limited in the renal diet). The DS stated brown gravy is salty and sweet potatoes are high in potassium and can make residents sick. The DS stated cooks should follow the menu. During the same interview cook1 stated cook1 made a mistake and did not follow the menu, and they should have served mashed potatoes and no gravy. [NAME] 1 stated they served beef patty because they did not prepare glazed baked pork chop. During a review of facility's Diet and Nutrition Care Manual titled Renal Diet (dated 2021), the manual indicated, Individuals placed on this diet are often limited in the amount of sodium, fluid, potassium. they consume. they should avoid high sodium foods. avoid high potassium foods. During a review of facility's policy and procedures (P&P) titled Menus (Revised 10/2022) the P&P indicated, Menus will be planned in advance to meet the nutritional needs of the residents/patients. Menu cycles will include standardized recipes. Menus will be served as written, unless a substitution is provided in response to preference, unavailability of an item, or a special meal.		

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 09/05/2025
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 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure one of three sampled resident's (Resident 7) informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) for Valproic Acid ([psychotropics]drug that affects how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior) was renewed after 6 months. This deficient practice violated Resident 7 and the responsible party's rights to receive all information, in advance, of risks and benefits of proposed care, treatment, treatment alternative, and choose the alternative of choice which includes information for administration of psychotropic drugs. Findings: During a review of Resident 7's admission Record, the admission Record indicated Resident 7 was readmitted to the facility on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities) with psychotic disturbance (a mental health condition characterized by a loss of contact with reality), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) and generalized anxiety disorder (mental health condition characterized by excessive fear and worry). During a review of Resident 7's Minimum Data set ([MDS] a resident assessment tool), dated 7/28/2025, the MDS indicated Resident 7's cognitive skills (functions your brain uses to think, pay attention, process information, and remember things) for daily decision-making was severely impaired. The MDS indicated Resident 7 needed moderate assistance (helper does less than half the effort) with eating, oral hygiene, maximal assistance (helper does more than half the effort) with personal hygiene, and dependent (helper does all the effort) on staff with toileting hygiene and showering. During a review of Resident 7's Order Summary Report, as of 9/3/2025, the report indicated, starting on 10/17/2024, Valproic Acid (medication for labile mood) 250 mg/5 milliliters by mouth two times a day. During a concurrent interview and record review on 9/3/2025 at 1:05 p.m. with Licensed Vocational Nurse (LVN) 1, Resident 7's Valproic acid consent was reviewed, and the consent was dated 9/5/2024. LVN 1 confirmed the facility does not renew the consents every 6 months as required by State law. LVN 1 stated that informed consent was important, so the resident or family knows about treatment options the resident was receiving. During an interview on 9/5/2025 at 3:15 p.m., with the Director of Nursing (DON) the DON stated that informed consent should be obtained prior to the administration of psychotropic medications. During a review of the facility's policy and procedure (P&P) titled, Psychotropic Medication Management Policy, undated, The P&P indicated the policy will be revised as needed to remain in compliance with federal and state regulations. The P&P did not indicate consents need to be renewed every 6 months. During a review of the All Facilities Letter ([AFL] from the state that may include changes in requirements in healthcare, enforcement, new technologies, scope of practice, or general information that affects the health facility) 24-07, the AFL indicated facilities must renew the written informed consent every six months. At that time, the facility must provide the residents with any recommended dosage adjustments and the option of revoking consent. Facilities must review and revise their P&Ps to ensure compliance with the new law. The P&Ps must specifically consider and plan for how the facility will verify that the resident provided informed consent or refused treatment or a procedure pertaining to the administration of psychotherapeutic drugs.		

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 09/05/2025
NAME OF PROVIDER OR SUPPLIER Long Beach Care Center, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 2615 Grand Avenue Long Beach, CA 90815	
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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure Restorative Nursing Aide 1 (RNA 1) wore an isolation gown (protective apparel used to protect the wearer from the transfer of microorganisms and body fluids) while providing Restorative Nursing Aide (RNA, nursing aide program that helps residents maintain any progress made after therapy intervention to maintain their function) exercises to one of seven sampled residents (Resident 5) who was on Enhanced Barrier Precautions (EBP, infection control intervention using gown and gloves during high contact resident care activities designed to reduce the transmission of multi-drug resistant organisms). This deficient practice had the potential to transmit infectious microorganisms and increase the risk of infection among the residents and staff members. Findings: During a review of Resident 5's admission Record, the admission Record indicated the facility initially admitted Resident 5 on 8/31/2018 and re-admitted Resident 5 on 6/26/2025 with diagnoses including chronic obstructive pulmonary disease (lung disease that causes obstruction of airflow and can limit normal breathing), cerebral palsy (a group of disorders that affect a person's ability to move and maintain balance and posture), and Parkinson's disease (progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movement). During a review of Resident 5's Order Summary Report, the Order Summary Report indicated a physician's order, dated 7/8/2025, for Resident 5 to be on EBP due to the presence of a gastrostomy tube (G-tube - a tube placed directly into the stomach for long-term feeding) and Multi-Drug Resistant Organisms (MRDO, bacteria resistant to many antibiotics) in the nares (nostrils or nasal cavity). During an observation of Resident 5's RNA session on 9/4/2025 at 10:29 am, in Resident 5's room, Resident 5 was sitting in a wheelchair. RNA 1 entered Resident 5's room, put on gloves and did not put on an isolation gown. RNA 1 assisted Resident 5 with passive range of motion (PROM, movement at a given joint with full assistance from another person) exercises to Resident 5's both arms and right leg and applied a splint (rigid material or apparatus used to support and immobilize a broken bone or impaired joint) to Resident 5's right hand and right knee. RNA 1 completed exercises and applied Resident 5's splints, RNA 1 removed both gloves, performed hand hygiene, and exited the room. During an interview on 9/4/2025 at 11:01 am with RNA 1, RNA 1 confirmed she did not wear an isolation gown while providing RNA services for Resident 5 was on EBP. RNA 1 stated she should have worn an isolation gown while assisting Resident 5 with exercises and applying splints because she had direct contact with Resident 5 who was on EBP. RNA 1 stated it was important to follow infection control protocols to prevent the spread of infection. During an interview on 9/4/2025 at 2:12 pm, with the Infection Preventionist Nurse (IPN), the IPN stated the purpose of EBP precautions was to reduce the transmission of infection for residents with non-healing wounds (injury to the body that typically involves a laceration or breaking of a membrane) and indwelling devices (medical devices inside the body) such as g-tubes and foley catheters (thin, flexible tube inserted into the bladder to drain urine). The IPN stated all staff providing direct patient care which included RNA exercises to residents on EBP must wear the appropriate personal protective equipment (PPE, equipment worn to minimize exposure to hazards that can cause serious injuries and illnesses) which included an isolation gown and gloves to prevent the spread of infection. During an interview on 9/5/2025 at 3:33 pm, with the Director of Nursing (DON), the DON stated it was important for staff to follow the proper infection control protocols to prevent the spread of infection. During a review of the facility's Policy and Procedure (P/P) titled, Enhanced Barrier Precautions, revised 1/2025, the P/P indicated it was the policy of the facility to implement EBP for the prevention of transmission of MRDO. The P/P indicated EBP referred to the use of gown and gloves during high-contact resident care activities for residents known to be infected with MDRO as well as those at risk of MDRO acquisition.		