

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056313	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2026
NAME OF PROVIDER OR SUPPLIER Pacific Villa, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 3501 Cedar Avenue Long Beach, CA 90807	
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation, interview and record review, the facility failed to observe infection control measures for 82 of 82 sampled residents. The facility failed to: 1. Implement and document regular monitoring of water temperature for their water management plan (a written safety plan that identifies, monitors, and controls water systems to prevent the growth of legionella bacteria [bacteria commonly found in water that can cause a severe type of pneumonia known as Legionnaires disease {serious lung infection caused by legionella bacteria that grow in warm water}]) designed to minimize growth and transmission of Legionella in the facility water systems. This failure had the potential of not detecting deviations in water temperature that can create conditions conducive to Legionella growth leading to an outbreak (occurs when two or more people get sick with Legionnaire's disease [serious lung infection caused by legionella bacteria that grow in warm water] from the same contaminated water source). 2. Ensure dirty linens were placed in a plastic bag and plastic bags were closed securely before placing them in an open laundry bin intended for soiled linen outside the facility. This failure had the potential to cause cross contamination (the transfer of bacteria, viruses, microorganisms, or other harmful substances from one surface to another through improper or unsanitary equipment, procedures, or products) leading to spread of infection among the residents and staff. Findings: 1. During an interview on 2/26/2026 at 11:28 a.m. with the Maintenance Supervisor (MS), the MS stated the facility checked the water temperature daily for Legionella in the resident's room, laundry and kitchen and documented in a log. MS stated the water temperature should be at 110 degrees Fahrenheit (F- unit of measurement) to 115 degrees F. MS stated Assistant Maintenance had the binder for the water temperature log. During an interview on 2/26/2026 at 12:11 p.m. with the Assistant Maintenance (AM), the AM stated he misplaced the binder for the water temperature and he did not have it. AM stated he took the temperature of the water in the morning but unable to remember where he placed the binder. AM stated he checked the temperature of the water in the laundry and kitchen. AM stated 72 F was the temperature that was safe for the residents to use and the facility prevents the growth of Legionella in the water by monitoring and documenting the temperatures of the water. AM unable to answer what temperatures of the water should he alert the Administrator (ADM) and Infection Preventionist Nurse (IPN). During a concurrent interview and record review on 2/26/2026 at 12:29 p.m. with the IPN, the facility's policy and procedure (P&P) titled, Legionella Surveillance, revised 2022 was reviewed. The P&P indicated Legionella grows best in water temperatures of 77 degrees F to 108 degrees F. IPN stated not monitoring and documenting the temperature of the water can put all residents at risk for legionnaires disease (serious lung infection caused by legionella bacteria) because the facility will not know if the water was contaminated with Legionella. During an interview on 2/26/2026 at 3:56 p.m. with the ADM, the ADM stated he oversees the Maintenance Department and was part of a team that reviews the policy for Water Management Plan. ADM stated the AM left the binder at home and temperatures were not being checked consistently. ADM stated not monitoring the water temperature can put the residents at risk for Legionella outbreak (occurs when two or more people get sick with Legionnaire's disease from the same contaminated water source). During a review of facility's P&P titled, Legionella Surveillance, revised 2022, the P&P indicated primary strategies for prevention and control of Legionella infection (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 056313
		If continuation sheet Page 1 of 26

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	included temperature controls. The P&P indicated cold water shall be stored and distributed below 68 F, hot water should be stored above 140 F and circulated at a minimum return temperature of 124 F. During a review of facility's P&P titled, Water Management Program, revised 2022, the P&P indicated water temperature logs are used for risk assessment by the water management team to identify where legionella and other waterborne pathogens can grow and spread in the facility's water systems. 2. During a concurrent observation and interview on 2/26/2026 at 8:15 a.m. with the Housekeeping Supervisor, observed an uncovered large blue bin for dirty linens were located outside the facility. HS stated the facility outsource laundry services for their dirty linens. Observed dirty linens not placed in a plastic bag and mixed with other plastic bags filled with dirty laundry. Observed open plastic bags filled with dirty linens in the uncovered large blue bin. HS stated all dirty linens were placed in a plastic bag and securely closed before putting them in the blue bin. HS stated certified nursing assistants (CNAs) sort the dirty laundry and should place them in a closed plastic bag to prevent spread of infection. During a concurrent observation and interview on 2/26/2026 at 9:34 a.m. with Certified Nursing Assistant (CNA) 1, CNA 1 brought the rolling hampers outside the facility and tied the plastic bags filled with dirty linens before placing them in the uncovered blue bin. CNA 1 stated he closed the plastic bag securely to ensure no dirty linens will fall out of the plastic bag causing cross contamination and spread of infection in the facility. During an interview on 2/26/2026 at 11:08 a.m. with the IPN, the IPN stated dirty linens should be placed in a bag and should be closed securely before placing them in the uncovered laundry bin outside facility to ensure prevention of cross contamination and spread of infection. IPN stated leaving the dirty linens not in the plastic bags or plastic bags not securely closed can attract insects or bugs and can cause spread of infection. During a review of facility's P&P titled, Handling Soiled Linen, undated, the P&P indicated The facility will handle, process and transport linen in a safe and sanitary manner to prevent spread of infection. The P&P indicated soiled linen should be placed in a linen bag or designated lined receptacle and the bag should be closed securely and placed in the soiled utility room.		

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 provide dental services in a timely manner for two of five sampled residents (Resident 32 and Resident 59). The facility failed to: 1. Ensure appropriate follow-up for Resident 59's denture needs. 2. Provide a dental check-up and evaluation for Resident 32, who was admitted with missing and broken teeth. These failures had the potential to result in discomfort and impaired chewing ability, which could lead to decreased appetite and weight loss for both Resident 32 and Resident 59. Findings: 1. During a review of Resident 59's admission Record, the admission Record indicated Resident 59 was initially admitted to the facility on [DATE] and was readmitted on [DATE]. The admission Record indicated Resident 69 with diagnoses including heart failure (chronic condition where the heart muscles becomes too weak or stiff to pump blood efficiently in our body), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing) and anxiety disorder (mental health conditions characterized by excessive, persistent, and uncontrollable fear or worry that interferes with daily life). During a review of Resident 59's Care plan titled, Nutritional Status Risk for significant weight change due to behavior problem and mechanically altered diet related to pureed and mildly thick consistency (liquids thicker than water but easily pourable) initiated on 1/10/2026. The Care Plan interventions included monitoring tolerance to diet texture, consistency and notifying the physician if difficulties are noted. During a review of Resident 59's Minimum Data Set (MDS-a resident assessment tool) dated 1/17/2026, the MDS indicated Resident 59 had moderately impaired cognitive skills (a person is having trouble with thinking, memory, and learning). The MDS indicated Resident 59 required substantial/maximal assistance (helper does more than half the effort) with eating and oral hygiene. During a concurrent observation and interview with Resident 59 on 2/24/2026 at 10:02 a.m., observed Resident 59 had no lower teeth. Resident 59 stated he only had upper teeth and had been waiting for his lower denture for six months. Resident 59 stated he was on a pureed diet foods blended into a smooth, thick, pudding-like texture with no lumps, chunks, or seeds) because he was unable to chew regular-texture foods (normal, everyday, solid foods that require standard chewing and swallowing) due to the absence of his lower teeth. Resident 59 stated he would like to occasionally eat a sandwich or have regular-texture foods. During an interview on 2/25/2026 at 3:03 p.m., with the Social Worker (SW), the SW stated that in December 2025 the dentist made an impression for Resident 59's lower denture, but she did not follow up on its status. The SW stated it was her responsibility to follow up and determine the cause of the delay. She stated without the lower denture, Resident 59 would be unable to eat well, which could lead to weight loss. 2. During a review of Resident 32's admission Record, the admission Record indicated Resident 32 was admitted on [DATE] to the facility 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), schizophrenia (a mental illness that is characterized by disturbances in thought), and anxiety disorder. During a review of Resident 32's Order Summary Report dated 1/8/2026, the Order Summary Report indicated an order of Dental Consult with treatment as needed and as indicated. During a review of Resident 32's Oral/Dental assessment dated [DATE], the Oral/Dental Assessment indicated Resident 32's had missing and unclear teeth. During a review of Resident 32's MDS dated [DATE], the MDS indicated Resident 32 had intact cognition (thought process) and required supervision or touching assistance (helper provides verbal cues and contact guard assistance as the resident completes the activity) with eating and oral hygiene. During a concurrent observation and interview on 2/24/2026 at 12:32 p.m. and subsequent interview on 2/25/2026 at 3:43 p.m. with Resident 32, Resident 32 was eating lunch in his room. Observed missing and broken teeth on his lower and upper mouth. Resident 32 stated sometimes his teeth hurt and unable to eat harder food like apple. During an interview with the SW on 2/25/2026 at 2:49 p.m., and again during a (continued on next page)		

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	follow-up interview on 2/27/2026 at 11:42 a.m., the SW stated newly admitted residents are typically seen by a dentist within a couple of weeks. The SW stated she must have missed arranging the dental appointment for Resident 32 due to her workload, which resulted in the resident not being seen in a timely manner. The SW stated that Resident 32 may experience discomfort while eating, which could prevent him from consuming solid or harder foods. During an interview on 2/27/2026 at 2:08 p.m. with the Director of Nursing (DON), the DON stated that Resident 32 and Resident 59 could develop toothaches and experience discomfort while eating, which may lead to weight loss. During a review of facility's policy and procedure(P&P) titled, Ancillary Services, undated, the P&P indicated The facility will assess, arrange, coordinate and monitor ancillary services like dental services based on the resident's needs, physician orders, and interdisciplinary care plan. During a review of facility's P&P titled, Dental Services, undated, the P&P indicated dental needs of each resident are identified through physical assessment and identified needs as specified in resident's plan of care. The P&P indicated the facility will assist the resident with making dental appointments and obtaining routine and emergency dental care.		

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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 food items kept in the refrigerator and freezer were labeled and dated. These failures had the potential to result in foodborne illnesses (also called food poisoning caused by eating contaminated food or eating food not kept at appropriate temperatures) for all residents residing in the facility. Findings: During a concurrent observation and interview on 2/24/2026 at 8:50 a.m. in the kitchen with the Assistant Dietary Manager (ADM), the walk on freezer was observed with a bag of frozen tamales, a bag of frozen carrots, frozen turkey, frozen chicken and a frozen roast beef were scattered throughout the walk-in freezer out of the boxes unlabeled and undated. The ADM stated the tamales, carrots, turkey, chicken and roast beef should be labeled and dated. During an interview on 2/27/2026 at 12:42 p.m. with the ADM, the ADM stated the food in the walk-in freezer should be inside the correct box with an open date. The ADM stated the food needed to be labeled and dated so the facility will know what the product is and if it's expired. The ADM stated if there was an old food product it is important to know the date it was opened so the residents would not get sick from Salmonella (a common bacteria that causes food poisoning) or Escherichia coli (E. coli- bacteria spread by eating undercooked ground beef, contaminated produce or unpasteurized dairy). The ADM stated labeling and dating the food helps to prevent residents from getting sick, especially residents that are in a high-risk environment for foodborne illnesses. During an interview on 2/27/2026 at 12:55 p.m. with the Dietary Supervisor (DS) the DS stated when the kitchen received food products, the kitchen staff need to label the food product and write the date it was received. The DS stated the dietary staff needed to know how long the food has been in the freezer because expired food could cause food borne illness. During a review of the facility's policy and procedure (P&P), titled Food Receiving and Storage, undated, the P&P indicated All foods stored in the refrigerator or freezer will be covered, labeled and dated (use by date).		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 review, the facility failed to ensure one of five sampled residents (Resident 12) attempted a Gradual Dose Reduction ([GDR] an attempt to decrease or discontinue psychotropic [acting on the mind] medication three months after starting on the psychotropic medication) for Resident 12. This failure resulted in Resident 12 receiving Remeron (an antidepressant) 0.5 milligrams ([mg] unit of measurement) for depression and Risperdal (an antipsychotic medication used to treat schizophrenia) 0.5 mg for schizoaffective disorder without a documented gradual dose reduction. Findings: During a review of Resident 12's admission Record, the admission Record indicated Resident 12 was originally admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), major depressive disorder (serious mental health condition characterized by persistent sadness and loss of interest), and schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior). During an interview on 2/27/2026 at 1:25 p.m. with Registered Nurse Supervisor (RNS) 1, RNS 1 stated Resident 12 had an order for Remeron 0.5 mg for depression and Risperdal 0.5 for schizoaffective disorder. RNS 1 stated there was no documentation that a GDR was done. RNS 1 stated the GDR is to ensure Resident 12 received the right amount of medication. RNS 1 stated that the GDR is important to monitor and decrease the dosage of the medication. During an interview on 2/27/2026 at 2:34 p.m. with the Director of Nursing (DON), the DON stated the GDR is done to reduce the administration of unnecessary medications that have side effects like sleepiness which could have an effect on the residents' Activities of Daily Living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of the facility's Policy and procedure (P&P), titled Tapering Medications and Gradual Drug Dose Reduction, undated, the P&P indicated, Residents who use antipsychotic drugs shall receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to implement its abuse policy and procedure for one of 20 sampled residents (Resident 9). The facility failed to:1. Follow facility's policy and procedure (P&P) titled, Abuse, Neglect, and Injury Reporting Policy, undated, which indicated injuries of unknown origin will be promptly evaluated and reported in accordance with federal and California regulations.This failure had the potential to result in undetected abuse and compromised resident safety, affecting Resident 9 and other residents in the facility.Findings:During a concurrent observation on 2/24/2026 at 10:14 a.m. with Resident 9, Resident 9's right arm was on a sling (a supportive device typically a strap or cloth used to immobilize, support, and protect an injured arm, shoulder or wrist).During a review of Resident 9's admission Record, the admission Record indicated Resident 9 was initially admitted to the facility on [DATE] and was readmitted on [DATE]. The admission Record indicated Resident 9 diagnoses included autistic disorder (a condition related to brain development), unspecified dislocation of right shoulder joint (ball-shaped top of the upper arm bone has popped out of its socket, causing severe pain, swelling, and inability to move), schizophrenia (a mental illness that is characterized by disturbances in thought) and anxiety disorder (persistent, excessive fear or worry that interferes with life).During a review of Resident 9's Change in Condition (COC-a sudden, clinically important deviation from a patient's baseline in physical, cognitive, behavioral, or functional status which without immediate intervention, may result in complications or death) Evaluation dated 1/6/2026 timed at 12:02 p.m., the COC indicated Resident 9 was complaining of pain to right shoulder due to dislocation (a joint injury where bones are forced out of their normal positions). The COC indicated Resident 9's physician ordered to transfer Resident 9 to GACH to manage the right shoulder dislocation.During a review of Resident 9's general acute care hospital (GACH) 1 Hospital Records titled, General History of Present Illness (HPI-detailed and chronological description of the development pf the patient's present illness) dated 1/6/2026 at 5:15 p.m., the HPI indicated Resident 9 came to the emergency room for right shoulder pain from Skilled Nursing Facility (SNF). The HPI indicated Resident 9 was assaulted in another GACH.During a review of Resident 9's GACH 1 Medical Records titled, X-ray of Right Shoulder, dated 1/6/2026 timed at 6:50 p.m., the x-ray of the right shoulder indicated there is no fracture (broken bone) or dislocation and mild soft tissue swelling (a slight temporary buildup of fluid in the tissue causing puffiness) was present.During a review of Resident 9's Care Plan titled, The Resident has Alteration in comfort related to Dislocation of Right Shoulder Joint, initiated on 1/14/2026 and revised on 1/15/2026, the Care Plan indicated to monitor pain every shift, administer pain medicine and Resident 9 will wear sling for his right shoulder as ordered.During a review of Resident 9's Rehabilitation Screening (a quick initial checkup if a person needs specialized therapy to improve their daily functioning such as mobility) dated 1/15/2026, the Rehabilitation Screening indicated no Occupational Therapy (OT, profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities) or Physical Therapy (healthcare service that helps a resident move better and restores physical function after an injury, surgery or disease) was warranted. The Rehabilitation Screening indicated Resident 9 had a non-weight bearing (no weight, contact or pressure is applied on the affected area) to right upper arm with soft sling.During a review of Resident 9's History and Physical (H&P) dated 1/16/2026, the H&P indicated Resident 9 had fluctuating capacity to understand and make decisions.During a review of Resident 9's Minimum Data Set (MDS- resident assessment tool) dated 1/25/2026, the MDS indicated Resident 9 had an intact cognition (ability to think, understand, learn, and remember). The MDS indicated Resident 9 required supervision or touching assistance (helper provides verbal cues and contact guard assistance as the resident completes an activity) with transfer to and from a bed to chair, toilet transfer, oral hygiene, toileting hygiene and dressing.During a review of Resident 9's Radiology Report of right shoulder x-ray dated 2/23/2026, (continued on next page)		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the right shoulder x-ray report indicated greater tuberosity (large lateral bony prominence on the upper arm bone) minimally comminuted fracture (bone broken into 3 or 4 pieces) and acute appearing humeral head fracture (a new, sudden break in the long bone of the upper arm usually caused by a fall, accident or direct blows).During a review of Resident 9's COC Evaluation dated 2/23/2026, the COC indicated Resident 9 had a humeral fracture (broken bone in the upper arm, between the shoulder and elbow) and would be transferred to GACH 2 for orthopedic evaluation (a comprehensive assessment by a specialist to find the cause of pain or limited movement).During a review of Resident 9's Care Plan titled, The resident had a humeral head fracture, initiated 2/24/2026, the Care Plan interventions included orthopedic evaluation and administration of anti-inflammatory (medicine that decrease swelling and pain) pain medications.During an interview on 2/26/2026 at 1:52 p.m. with Registered Nurse Supervisor (RNS) 1, RNS 1 stated Resident 9 was transferred to a GACH on 1/6/2026 because Resident 9 was not compliant with the use of a sling. RNS 1 stated she became aware on 2/23/2026 that Resident 9 had sustained a humeral fracture. She stated she did not know how the fracture occurred, and the injury was not investigated to rule out abuse or neglect. RNS 1 stated Resident 9's right humerus fracture should have been investigated and reported to the California Department of Public Health immediately per facility's policy and procedure titled Abuse, Neglect, and Injury Reporting Policy.During an interview on 2/27/2026 at 1:08 p.m., RNS 1 stated Resident 9 was admitted to the facility on [DATE] for a right shoulder dislocation and was transferred to a GACH on 1/6/2026. RNS 1 stated the right shoulder X-ray taken on 1/6/2026 showed no fracture or dislocation, with only mild tissue swelling noted. RNS 1 stated a subsequent X-ray obtained on 2/23/2026 revealed a fracture of the right humerus, and she did not know how the resident developed the injury. RNS 1 stated the facility should have initiated an investigation on 2/23/2026 when the fracture was discovered, as the cause of the injury was unknown. She stated the facility sent Resident 9 to GACH on 2/23/2026 for evaluation, and the resident returned early in the morning of 2/24/2026. RNS 1 stated the facility needed to determine what occurred, how it occurred, and why the fracture developed, and that an investigation should have been started immediately to rule out abuse or neglect. RNS 1 stated she did not know why an investigation was not initiated. RNS 1 stated the fracture should have been reported to the California Department of Public Health (CDPH) immediately because it met the definition of an injury of unknown origin under the facility's policy and required investigation to determine whether abuse occurred. RNS 1 stated she did not know what happened between 1/6/2026 and 2/23/2026 that could have resulted in the fracture. RNS 1 stated she informed the Director of Nursing (DON) of the fracture on 2/23/2026 but did not discuss initiating an investigation or reporting the incident to CDPH. She stated the facility should have investigated the injury to ensure Resident 9's safety, protect other residents, and prevent potential abuse.During an interviews on 2/26/2026 at 4:26 p.m. and on 2/27/2026 at 1:08 p.m., with the DON and a record review of the facility's policy titled Abuse, Neglect, and Injury Reporting Policy (undated), the Director of Nursing (DON) stated Resident 9 was admitted to the facility on [DATE] with a dislocated right shoulder and was wearing a sling. The DON stated she did not know how Resident 9 developed a right humeral fracture on 2/23/2026. The DON stated she neither reported the incident to the California Department of Public Health (CDPH) nor initiated an investigation to rule out abuse. The DON stated she had been sidetracked and that it was her mistake, explaining it did not occur to her that the fracture was an injury of unknown origin. The DON stated she did not notify the Administrator when Resident 9 was found to have a right humeral fracture on 2/23/2026. She stated the Administrator was aware of the prior shoulder dislocation but not of the newly identified humeral fracture on 2/23/2026. The DON stated the right humeral fracture should have been reported to CDPH immediately so that the incident could be investigated to rule out abuse or neglect.During a review of facility's policy and procedure (P&P) titled, Abuse, Neglect and Exploitation, undated, the P&P indicated to take appropriate actions when abuse, or neglect is suspected. The P&P indicated the facility will consider factors indicating possible abuse, neglect and exploitations of residents the (continued on next page)		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	following possible indicators such as physical injury of a resident from unknown source.During a review of facility's P&P titled, Abuse, Neglect, and Injury Reporting Policy, undated, the P&P indicated injuries of unknown origin will be promptly evaluated and reported in accordance with federal and California regulations. The P&P indicated an injury of unknown origin is considered when the injury was not observed by staff, injury is inconsistent with the resident's clinical condition, or there is insufficient information to determine the cause after assessment.Cross reference F609 and F610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056313	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2026
NAME OF PROVIDER OR SUPPLIER Pacific Villa, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 3501 Cedar Avenue Long Beach, CA 90807	
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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to report an injury of unknown origin (the cause of injury was not observed by any person or could not be explained by the resident) to the California Department of Public Health (CDPH) for one of 20 sampled residents (Resident 9) when Resident 9 sustained a right humeral fracture (a break in the upper arm bone between the shoulder and elbow, typically associated with falls or direct impact) on 2/23/2026. This failure had the potential to delay an investigation to determine whether abuse or neglect contributed to Resident 9's injury. Findings: During an observation on 2/24/2026 at 10:14 a.m. with Resident 9's right arm was on a sling (a supportive device typically a strap or cloth used to immobilize, support, and protect an injured arm, shoulder or wrist). During a review of Resident 9's admission Record, the admission Record indicated Resident 9 was initially admitted to the facility on [DATE] and was readmitted on [DATE]. The admission Record indicated Resident 9 diagnoses included autistic disorder (a condition related to brain development), unspecified dislocation of right shoulder joint (ball-shaped top of the upper arm bone has popped out of its socket, causing severe pain, swelling, and inability to move), schizophrenia (a mental illness that is characterized by disturbances in thought) and anxiety disorder (persistent, excessive fear or worry that interferes with life). During a review of Resident 9's Change in Condition (COC-a sudden, clinically important deviation from a patient's baseline in physical, cognitive, behavioral, or functional status which without immediate intervention, may result in complications or death) Evaluation dated 1/6/2026 timed at 12:02 p.m., the COC indicated Resident 9 was complaining of pain to right shoulder due to dislocation (a joint injury where bones are forced out of their normal positions). The COC indicated Resident 9's physician ordered to transfer Resident 9 to GACH to manage the right shoulder dislocation. During a review of Resident 9's general acute care hospital (GACH) 1 Hospital Records titled, General History of Present Illness (HPI-detailed and chronological description of the development of the patient's present illness) dated 1/6/2026 at 5:15 p.m., the HPI indicated Resident 9 came to the emergency room for right shoulder pain from Skilled Nursing Facility (SNF). The HPI indicated Resident 9 was assaulted in another GACH. During a review of Resident 9's GACH 1 Medical Records titled, X-ray of Right Shoulder, dated 1/6/2026 timed at 6:50 p.m., the x-ray of the right shoulder indicated there is no fracture (broken bone) or dislocation and mild soft tissue swelling (a slight temporary buildup of fluid in the tissue causing puffiness) was present. During a review of Resident 9's Care Plan titled, The Resident has Alteration in comfort related to Dislocation of Right Shoulder Joint, initiated on 1/14/2026 and revised on 1/15/2026, the Care Plan indicated to monitor pain every shift, administer pain medicine and Resident 9 will wear sling for his right shoulder as ordered. During a review of Resident 9's Rehabilitation Screening (a quick initial checkup if a person needs specialized therapy to improve their daily functioning such as mobility) dated 1/15/2026, the Rehabilitation Screening indicated no Occupational Therapy (OT, profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities) or Physical Therapy (healthcare service that helps a resident move better and restores physical function after an injury, surgery or disease) was warranted. The Rehabilitation Screening indicated Resident 9 had a non-weight bearing (no weight, contact or pressure is applied on the affected area) to right upper arm with soft sling. During a review of Resident 9's History and Physical (H&P) dated 1/16/2026, the H&P indicated Resident 9 had fluctuating capacity to understand and make decisions. During a review of Resident 9's Minimum Data Set (MDS- resident assessment tool) dated 1/25/2026, the MDS indicated Resident 9 had an intact cognition (ability to think, understand, learn, and remember). The MDS indicated Resident 9 required supervision or touching assistance (helper provides verbal cues and contact guard assistance as the resident completes an activity) with transfer to and from a bed to chair, toilet transfer, oral hygiene, toileting hygiene and (continued on next page)		

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dressing. During a review of Resident 9's Radiology Report of right shoulder x-ray dated 2/23/2026, the right shoulder x-ray report indicated greater tuberosity (large lateral bony prominence on the upper arm bone) minimally comminuted fracture (bone broken into 3 or 4 pieces) and acute appearing humeral head fracture (a new, sudden break in the long bone of the upper arm usually caused by a fall, accident or direct blows). During a review of Resident 9's COC Evaluation dated 2/23/2026, the COC indicated Resident 9 had a humeral fracture (broken bone in the upper arm, between the shoulder and elbow) and would be transferred to GACH 2 for orthopedic evaluation (a comprehensive assessment by a specialist to find the cause of pain or limited movement). During a review of Resident 9's Care Plan titled, The resident had a humeral head fracture, initiated 2/24/2026, the Care Plan interventions included orthopedic evaluation and administration of anti-inflammatory (medicine that decrease swelling and pain) pain medications. During an interview on 2/26/2026 at 1:52 p.m. with Registered Nurse Supervisor (RNS) 1, RNS 1 stated Resident 9 was transferred to a GACH on 1/6/2026 because Resident 9 was not compliant with the use of a sling. RNS 1 stated she became aware on 2/23/2026 that Resident 9 had sustained a humeral fracture. She stated she did not know how the fracture occurred, and the injury was not investigated to rule out abuse or neglect. RNS 1 stated Resident 9's right humerus fracture should have been investigated and reported to the California Department of Public Health immediately per facility's policy and procedure titled Abuse, Neglect, and Injury Reporting Policy. During an interview on 2/27/2026 at 1:08 p.m., RNS 1 stated Resident 9 was admitted to the facility on [DATE] for a right shoulder dislocation and was transferred to a GACH on 1/6/2026. RNS 1 stated the right shoulder X-ray taken on 1/6/2026 showed no fracture or dislocation, with only mild tissue swelling noted. RNS 1 stated a subsequent X-ray obtained on 2/23/2026 revealed a fracture of the right humerus, and she did not know how the resident developed the injury. RNS 1 stated the facility should have initiated an investigation on 2/23/2026 when the fracture was discovered, as the cause of the injury was unknown. She stated the facility sent Resident 9 to GACH on 2/23/2026 for evaluation, and the resident returned early in the morning of 2/24/2026. RNS 1 stated the facility needed to determine what occurred, how it occurred, and why the fracture developed, and that an investigation should have been started immediately to rule out abuse or neglect. RNS 1 stated she did not know why an investigation was not initiated. RNS 1 stated the fracture should have been reported to the California Department of Public Health (CDPH) immediately because it met the definition of an injury of unknown origin under the facility's policy and required investigation to determine whether abuse occurred. RNS 1 stated she did not know what happened between 1/6/2026 and 2/23/2026 that could have resulted in the fracture. RNS 1 stated she informed the Director of Nursing (DON) of the fracture on 2/23/2026 but did not discuss initiating an investigation or reporting the incident to CDPH. She stated the facility should have investigated the injury to ensure Resident 9's safety, protect other residents, and prevent potential abuse. During an interview on 2/27/2026 at 1:34 p.m. with the Director of Rehabilitation (DOR), the DOR stated Resident 9 was screened for Joint Mobility on 1/15/2026 and no OT and PT were provided because of the sling on his right shoulder and Resident 9 required non- weight bearing on the right arm while moving. The DOR stated RNS 1 approached her to obtain recommendation for mobility (movement) regarding Resident 9's right shoulder dislocation on 2/23/2026. The DOR stated she consulted OT who recommended an orthopedic consultation (specialized appointment with a bone and joint physician to diagnose and treat issues with muscles, bones, joints and ligaments). The DOR stated the DON stated to obtain an x-ray of the right shoulder first before getting an orthopedic consultation for Resident 9. During an interview on 2/26/2026 at 4:26 p.m. and on 2/27/2026 at 1:08 p.m., with the DON and a record review of the facility's policy titled Abuse, Neglect, and Injury Reporting Policy (undated), the DON stated Resident 9 was admitted to the facility on [DATE] with a dislocated right shoulder and was wearing a sling. The DON stated she did not know how Resident 9 developed a right humeral fracture on 2/23/2026. The DON stated she neither reported the incident to the California Department of Public Health (CDPH) nor initiated an investigation to rule out abuse. The DON stated (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she had been sidetracked and that it was her mistake, explaining it did not occur to her that the fracture was an injury of unknown origin. The DON stated she did not notify the Administrator when Resident 9 was found to have a right humeral fracture on 2/23/2026. She stated the Administrator was aware of the prior shoulder dislocation but not of the newly identified humeral fracture on 2/23/2026. The DON stated the right humeral fracture should have been reported to CDPH immediately so that an investigation could be initiated promptly to rule out abuse or neglect. During a review of facility's P&P titled, Abuse, Neglect, and Injury Reporting Policy, undated, the P&P indicated injuries of unknown origin will be promptly evaluated and reported in accordance with federal and California regulations. The P&P indicated an injury of unknown origin is considered when the injury was not observed by staff, injury is inconsistent with the resident's clinical condition, or there is insufficient information to determine the cause after assessment. Cross reference F607 and F610		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to investigate an injury of unknown origin (cause of injury was not observed by any person or could not be explained by the resident) for one of 20 sample resident (Resident 9).The facility failed to:1. Investigate Resident 9's injury of unknown origin. Resident 9 was admitted to the facility on [DATE] with no documented fracture (broken bone) to the right shoulder, as confirmed by X`ray (imaging that create images of structures inside the body) results dated 1/2/2026 and 1/6/2026. While under the facility's care, Resident 9 developed a humeral fracture (a break in the upper arm bone connecting the shoulder and elbow) on 2/23/2026.This failure had the potential to prevent the facility from determining whether Resident 9's injury resulted from abuse or neglect.Findings:During an observation on 2/24/2026 at 10:14 a.m. with Resident 9, observed Resident 9's right arm was on a sling (a supportive device typically a strap or cloth used to immobilize, support, and protect an injured arm, shoulder or wrist).During a review of Resident 9's admission Record, the admission Record indicated Resident 9 was initially admitted to the facility on [DATE] and was readmitted on [DATE]. The admission Record indicated Resident 9 diagnoses included autistic disorder (a condition related to brain development), unspecified dislocation of right shoulder joint (ball-shaped top of the upper arm bone has popped out of its socket, causing severe pain, swelling, and inability to move), schizophrenia (a mental illness that is characterized by disturbances in thought) and anxiety disorder (persistent, excessive fear or worry that interferes with life).During a review of Resident 9's Change in Condition (COC-a sudden, clinically important deviation from a patient's baseline in physical, cognitive, behavioral, or functional status which without immediate intervention, may result in complications or death) Evaluation dated 1/6/2026 timed at 12:02 p.m., the COC indicated Resident 9 was complaining of pain to right shoulder due to dislocation (a joint injury where bones are forced out of their normal positions). The COC indicated Resident 9's physician ordered to transfer Resident 9 to GACH to manage the right shoulder dislocation.During a review of Resident 9's general acute care hospital (GACH) 1 Hospital Records titled, General History of Present Illness (HPI-detailed and chronological description of the development pf the patient's present illness) dated 1/6/2026 at 5:15 p.m., the HPI indicated Resident 9 came to the emergency room for right shoulder pain from Skilled Nursing Facility (SNF). The HPI indicated Resident 9 was assaulted in another GACH.During a review of Resident 9's GACH 1 Medical Records titled, X-ray of Right Shoulder, dated 1/6/2026 timed at 6:50 p.m., the x-ray of the right shoulder indicated there is no fracture (broken bone) or dislocation and mild soft tissue swelling (a slight temporary buildup of fluid in the tissue causing puffiness) was present.During a review of Resident 9's Care Plan titled, The Resident has Alteration in comfort related to Dislocation of Right Shoulder Joint, initiated on 1/14/2026 and revised on 1/15/2026, the Care Plan indicated to monitor pain every shift, administer pain medicine and Resident 9 will wear sling for his right shoulder as ordered.During a review of Resident 9's Rehabilitation Screening (a quick initial checkup if a person needs specialized therapy to improve their daily functioning such as mobility) dated 1/15/2026, the Rehabilitation Screening indicated no Occupational Therapy (OT, profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities) or Physical Therapy (healthcare service that helps a resident move better and restores physical function after an injury, surgery or disease) was warranted. The Rehabilitation Screening indicated Resident 9 had a non-weight bearing (no weight, contact or pressure is applied on the affected area) to right upper arm with soft sling.During a review of Resident 9's History and Physical (H&P) dated 1/16/2026, the H&P indicated Resident 9 had fluctuating capacity to understand and make decisions.During a review of Resident 9's Minimum Data Set (MDS- resident assessment tool) dated 1/25/2026, the MDS indicated Resident 9 had an intact cognition (ability to think, understand, learn, and remember). The MDS indicated Resident 9 required supervision or touching assistance (helper provides verbal cues and (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	contact guard assistance as the resident completes an activity) with transfer to and from a bed to chair, toilet transfer, oral hygiene, toileting hygiene and dressing. During a review of Resident 9's Radiology Report of right shoulder x-ray dated 2/23/2026, the right shoulder x-ray report indicated greater tuberosity (large lateral bony prominence on the upper arm bone) minimally comminuted fracture (bone broken into 3 or 4 pieces) and acute appearing humeral head fracture (a new, sudden break in the long bone of the upper arm usually caused by a fall, accident or direct blows). During a review of Resident 9's COC Evaluation dated 2/23/2026, the COC indicated Resident 9 had a humeral fracture (broken bone in the upper arm, between the shoulder and elbow) and would be transferred to GACH 2 for orthopedic evaluation (a comprehensive assessment by a specialist to find the cause of pain or limited movement). During a review of Resident 9's Care Plan titled, The resident had a humeral head fracture, initiated 2/24/2026, the Care Plan interventions included orthopedic evaluation and administration of anti-inflammatory (medicine that decrease swelling and pain) pain medications. During an interview on 2/26/2026 at 1:52 p.m. with Registered Nurse Supervisor (RNS) 1, RNS 1 stated Resident 9 was transferred to a GACH on 1/6/2026 because Resident 9 was not compliant with the use of a sling. RNS 1 stated she became aware on 2/23/2026 that Resident 9 had sustained a humeral fracture. She stated she did not know how the fracture occurred, and the injury was not investigated to rule out abuse or neglect. RNS 1 stated Resident 9's right humerus fracture should have been investigated and reported to the California Department of Public Health immediately per facility's policy and procedure titled Abuse, Neglect, and Injury Reporting Policy. During an interview on 2/27/2026 at 1:08 p.m., RNS 1 stated Resident 9 was admitted to the facility on [DATE] for a right shoulder dislocation and was transferred to a GACH on 1/6/2026. RNS 1 stated the right shoulder X-ray taken on 1/6/2026 showed no fracture or dislocation, with only mild tissue swelling noted. RNS 1 stated a subsequent X-ray obtained on 2/23/2026 revealed a fracture of the right humerus, and she did not know how the resident developed the injury. RNS 1 stated the facility should have initiated an investigation on 2/23/2026 when the fracture was discovered, as the cause of the injury was unknown. She stated the facility sent Resident 9 to GACH on 2/23/2026 for evaluation, and the resident returned early in the morning of 2/24/2026. RNS 1 stated the facility needed to determine what occurred, how it occurred, and why the fracture developed, and that an investigation should have been started immediately to rule out abuse or neglect. RNS 1 stated she did not know why an investigation was not initiated. RNS 1 stated the fracture should have been reported to the California Department of Public Health (CDPH) immediately because it met the definition of an injury of unknown origin under the facility's policy and required investigation to determine whether abuse occurred. RNS 1 stated she did not know what happened between 1/6/2026 and 2/23/2026 that could have resulted in the fracture. RNS 1 stated she informed the Director of Nursing (DON) of the fracture on 2/23/2026 but did not discuss initiating an investigation or reporting the incident to CDPH. She stated the facility should have investigated the injury to ensure Resident 9's safety, protect other residents, and prevent potential abuse. During an interview on 2/27/2026 at 1:34 p.m. with the Director of Rehabilitation (DOR), the DOR stated Resident 9 was screened for Joint Mobility on 1/15/2026 and no OT and PT were provided because of the sling on his right shoulder and Resident 9 required non- weight bearing on the right arm while moving. The DOR stated RNS 1 approached her to obtain recommendation for mobility (movement) regarding Resident 9's right shoulder dislocation on 2/23/2026. The DOR stated she consulted OT who recommended an orthopedic consultation (specialized appointment with a bone and joint physician to diagnose and treat issues with muscles, bones, joints and ligaments). The DOR stated the DON stated to obtain an x-ray of the right shoulder first before getting an orthopedic consultation for Resident 9. During an interviews on 2/26/2026 at 4:26 p.m. and on 2/27/2026 at 1:08 p.m., with the DON and a record review of the facility's policy titled Abuse, Neglect, and Injury Reporting Policy (undated), the DON stated Resident 9 was admitted to the facility on [DATE] with a dislocated right shoulder and was wearing a sling. The DON stated she did not know how Resident 9 developed a right humeral fracture on 2/23/2026. The DON stated she neither reported the incident to (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the California Department of Public Health (CDPH) nor initiated an investigation to rule out abuse. The DON stated she had been sidetracked and that it was her mistake, explaining it did not occur to her that the fracture was an injury of unknown origin. The DON stated she did not notify the Administrator when Resident 9 was found to have a right humeral fracture on 2/23/2026. She stated the Administrator was aware of the prior shoulder dislocation but not of the newly identified humeral fracture on 2/23/2026. The DON stated failing to investigate could place Resident 9 at risk for fear, isolation, and unsafe conditions if abuse or neglect had occurred. During a review of facility's policy and procedure (P&P) titled, Abuse, Neglect and Exploitation, undated, the P&P indicated to take appropriate actions when abuse, or neglect is suspected. The P&P indicated the facility will consider factors indicating possible abuse, neglect and exploitations of residents the following possible indicators such as physical injury of a resident from unknown source. During a review of facility's P&P titled, Abuse, Neglect, and Injury Reporting Policy, undated, the P&P indicated injuries of unknown origin will be promptly evaluated and reported in accordance with federal and California regulations. The P&P indicated an injury of unknown origin is considered when the injury was not observed by staff, injury is inconsistent with the resident's clinical condition, or there is insufficient information to determine the cause after assessment. Cross reference F607 and F609		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure one of one sampled residents (Resident 78) was assisted with eating during meals.This failure had the potential to place Resident 78 at risk for weight loss. Findings:During an observation on 2/24/2026 at 12:24 p.m. in the dining room, Resident 78 was seated in wheelchair, rocking back and forth and holding spoon in his right hand for 10 minutes before spooning food into his mouth while staff being observed by facility staff.During an observation on 2/24/2026 at 12:48 p.m. in the dining room, Resident 78 was observed with 75% of his meal still on his plate and not eaten after 30 minutes without staff assistance.During an observation on 2/24/2026 at 12:54 p.m. in Resident 78's room, Certified Nursing Assistant (CNA) 4 was observed assisting Resident 78 with his meal after not being assisted in the dining room for 30 minutes.During a review of Resident 78's admission Record, the admission Record indicated Resident 78 was admitted to the facility on [DATE] with diagnoses including lack of coordination, heart failure(heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), hyperlipidemia (abnormal high levels of fats in the blood), depression (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life) and anxiety (emotion characterized by feelings of tension, worried thoughts).During a review of Resident 78's History and Physical (H&P), dated 10/17/2025, the H&P indicated Resident 78 had the capacity to understand and make decisions.During a review of Resident 78's Minimum Data Set (MDS- a resident assessment tool) dated 1/22/2026, the MDS indicated Resident 78 was dependent (helper does all the effort) on nursing staff with showering. The MDS indicated Resident 78 needed setup or clean-up assistance with eating.During an interview on 2/24/26 at 1243 p.m. with Resident 78, Resident 78 was asked if he needed assistance with eating, and Resident 78 stated yes.During an interview on 2/25/2026 at 2:21 p.m. with CNA 4, CNA 4 stated Resident 78 takes more than a one hour to feed himself. CNA 4 stated when Resident 78 feeds himself, he takes a long time and his food gets cold. CNA 4 stated Resident 78 needs help with eating because he is unstable and rocks back and forth.During an interview on 2/25/2026 at 2:55 p.m. with CNA 5, CNA 5 stated Resident 78 eats slow and takes too long for him to finish the food due to the movement it takes resident takes an hour to eat. CNA 5 stated when she assists Resident 78 with eating, he finishes in less than hour. CNA 5 stated Resident 78 will benefit from help and assistance with eating.During an interview on 2/26/2026 at 10:40 a.m. with Registered Nursing Supervisor, (RNS) 1, RNS 1 stated Resident 78 could have a potential for weight loss with an inability to feed himself if not assessed properly.During an interview on 2/27/2026 at 2:41 p.m. with the Director of Nursing (DON), the DON stated a negative outcome for weight loss could result in actual mental health issues, muscle loss, and nutrient deficiencies, for Resident 78 due to his lack of coordination with feeding.During a review of the facility's policy and procedure (P&P), titled Activities of Daily Living (ADLs), undated, The P&P indicated The facility will ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable. This includes the resident's ability to bathe, dress, and groom, transfer and ambulate, toilet, eat and use speech, language or other functional communication systems.		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide one of 18 sample residents (Resident 63) with activities or regular room visits as part of an ongoing program to support the resident's chosen activities. This failure had the potential to negatively impact on Resident 63's sense of self-worth and psychosocial well-being, including feelings of usefulness, social connection, and personal satisfaction. Findings: During review of Resident 63's admission Records, the admission Record indicated Resident 63 was admitted to the facility on [DATE] with diagnoses including anxiety (conditions that cause excessive and persistent feelings of fear or worry that can interfere with daily life), major depression (mood disorder that causes a persistent feeling of sadness and loss of interest) and muscle weakness (loss of muscle strength). During a review of Resident 63's Minimum Data Set (MDS- resident assessment tool) dated 02/22/2026, the MDS indicated Resident 63's cognitive (ability to think, understand, learn, and remember) skills for daily decisions making was moderately impaired. The MDS indicated Resident 63 required setup or clean up assistance (helper set up or clean up; resident completes activity) from staff for Activities of Daily Living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During an observation on 02/24/2026 at 11:11 a.m., Resident 63 was observed lying quietly in bed on his side. During a concurrent observation and interview on 02/25/2026 at 10:44 a.m. with Resident 63, Resident 63 was observed lying quietly in bed, staring at the walls of the room. Resident 63 stated, no one regularly brought him books, and it only happened occasionally during his stay. Resident 63 stated he does not like going out for activities due to personal reasons. He stated he preferred his television in his room to be working so he could watch programs. Resident 63 also stated that his wife had recently passed away, and he often feels bored. During a concurrent observation and interview on 02/25/2026 at 11:55 a.m. with the Activity Director (AD), the AD stated she was not aware that Resident 63's room television was not working. The AD stated the Resident 63 had not reported the issue, but acknowledged that it is the responsibility of all staff to observe and ensure that resident rooms are maintained in a homelike manner. The AD stated she does not provide in-room activities herself and primarily conducts rounds. The AD stated she will in-service staff to ensure resident needs were addressed before leaving their rooms and will increase the frequency of rounds to better identify and meet residents' in-room needs. During a concurrent interview and record review on 02/26/2026 at 7:55 a.m. with the Activity Assistant (AA), the activity participation logs were reviewed, including room visit and independent activity codes. The activity participation logs indicated the in-room activity option coded as V4 (movies/TV) was not offered to Resident 63 according to his preferences throughout the month of February 2026. The AA stated she thought Resident 63 did not like to watch television. The AA stated she could not recall the last time she checked whether Resident 63 wanted to watch television or movies. She stated she should be asking Resident 63 during each activity visit about his preferred activities and provide it to Resident 63 to help maintain a homelike environment for the resident. During an interview on 02/27/2026 at 1:20 p.m. with the Director of Nursing (DON), the DON stated activities should be encouraged for all residents, and that if a resident refuses one activity, staff should offer an alternative aligned with the resident's preferences. The DON stated resident preferences should be obtained, and any refusals or actions taken should be documented. During a review of the facility's policy and procedures (P&P) titled, Activities, undated. The P&P indicated, Facility to provide an ongoing program of activities designed to meet the interest's choice and preference as well as to meet the interests of and support the physical, mental and psychological well-being of each resident, encouraging both independence and interaction in the community, as well as the physical, Mental and psychological well-being of each resident, encouraging both independence and interaction in the community. Activities will be designed with intent to promote self-esteem, dignity, pleasure, comfort, education, creativity, success and independence.		

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one of one sampled resident (Resident 48) was offered functional hearing aids available for use. This failure resulted in Resident 48 not being able to hear adequately and communicate appropriately for care, safety needs and basic services for hygiene. Findings: During a review of Resident 48's admission Record (Face Sheet- front page of the chart), the admission Record indicated Resident 48 was originally admitted to the hospital on [DATE] and readmitted to the facility on [DATE]. Resident 48's diagnoses included hypertensive heart disease (heart damage leading to high blood pressure), osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), cataracts (a common age-related eye condition involving the clouding of the eye's normally clear lens) and schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 48's History and Physical (H&P) dated 6/18/2025, the H&P indicated Resident 48 was self responsible. The H&P indicated Resident 48 had hearing loss and difficulty. The H&P indicated Resident 48 could read lips. The H&P indicated Resident 48 understands if you write the questions or statements then show it to him. During a review of Resident 48's Minimum Data Set (MDS-a resident assessment tool), dated 1/7/2026, the MDS indicated Resident 48 needed substantial to maximal assistance (helper does all the effort) with toileting, showering, dressing and taking off shoes. The MDS indicated Resident 48 needed partial to moderate assistance (helper does half the effort) with eating, oral hygiene, personal hygiene, transferring and walking. During a concurrent observation and interview on 2/24/2026 at 10:43 a.m., Resident 48 was observed hard of hearing. Resident 48 stated he had hearing aids but does not wear them because the hearing aids are too big. During an interview on 2/25/2026 at 11:04 a.m. with Certified Nursing Assistant (CNA) 3, CNA 3 stated Resident 48 is unable to hear. CNA 3 stated he types messages on his phone or gives Resident 48 paper to write down what he wants when he needs to communicate with Resident 48. CNA 3 stated Resident 48 does not have hearing aids and had not seen any hearing aids at Resident 48's bedside. CNA 3 stated he is not aware of anything being done to improve Resident 48's hearing. During an interview on 2/25/2026 at 11:47 a.m. with Restorative Nurse Aide (RNA) 1, RNA 1 stated Resident 48 is hard of hearing so you must speak loudly in his ear or pull your mask down so he can read your lips. RNA 1 stated Resident 48 can not understand or hear you when you are speaking with a mask on. RNA 1 stated Resident 48 would benefit from hearing aids. During a concurrent interview and record review on 2/25/2026 at 1:33 p.m. with Licensed Vocational Nurse (LVN) 2, Resident 48's Care Plan, dated 12/19/2025 was reviewed, the Care Plan indicated Resident 48 required hearing aids to communicate. The Care Plan indicated to ensure availability and functioning of adaptive communication equipment. The Goal of the Care Plan indicated Resident 48 will be able to put on and work hearing aids. LVN 2 stated Resident 48 has difficulty hearing and has never seen Resident 48 with any hearing aids. LVN 2 stated Resident 48 would have a breakdown in communication and a problem hearing what is being said without his hearing aids. During an interview on 2/26/2026 at 11:27 a.m. with the Social Worker (SW), the SW stated her responsibility is to make sure residents have hearing aids. The SW stated Resident 48 has bilateral hearing aids that are kept in the medication cart. The SW stated the licensed staff are supposed to offer Resident 48 his hearing aids. The SW stated there is no system to check if Resident 48 is being offered his hearing aids. The SW stated Resident 48's hearing aids were not working and need to have the batteries replaced. The SW stated Resident 48 will not be able to communicate properly and would not be able to listen properly. The SW stated due to miscommunication Resident 48 may hear something different than what is said. During an interview on 2/27/2026 at 2:10 p.m. with Registered Nurse Supervisor (RNS) 1, RNS 1 stated Resident 48's hearing aids are kept in medication cart. RNS 1 stated Resident 48 would not be able to understand the care rendered without his hearing aid. During an interview on 2/27/2026 at 2:39 p.m. with the Director of Nursing, the DON stated Resident 48 (continued on next page)		

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	would not be able to communicate his needs with hearing aids that are not working. During a review of the facility's policy and procedure (P&P), titled Ancillary Services, undated, the P&P indicated the Purpose is to ensure residents receive ancillary services in a timely, coordinated, and safe manner to support their highest practicable, mental and psychosocial well-being.		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide effective pain management for one of four sampled residents (Resident 9). The facility failed to:1. Ensure Resident 9 was provided with pain medicine based on his assessed pain level.This failure had the potential to result in Resident 9 having unrelieved pain or overmedication (receiving too much medication and taking excessively high doses). Findings:During an observation on 2/24/2026 at 10:14 a.m. with Resident 9, observed Resident 9's right arm was on a sling (a supportive device typically a strap or cloth used to immobilize, support, and protect an injured arm, shoulder or wrist).During a review of Resident 9's admission Record, the admission Record indicated Resident 9 was initially admitted to the facility on [DATE] and was readmitted on [DATE]. The admission Record indicated Resident 9 diagnoses including autistic disorder (a condition related to brain development), unspecified dislocation of right shoulder joint (ball-shaped top of the upper arm bone has popped out of its socket, causing severe pain, swelling, and inability to move), schizophrenia (a mental illness that is characterized by disturbances in thought) and anxiety disorder (persistent, excessive fear or worry that interferes with life).During a review of Resident 9's Care Plan titled, Alteration in Comfort related to dislocation of right shoulder joint, initiated on 1/14/2026 and revised on 1/15/2026. The Care plan goals indicated Resident 9 will not have an interruption in normal activities due to pain. The Care plan interventions included to monitoring of pain every shift and administering Ibuprofen (medicine used to reduce fever, pain, and inflammation) and monitoring for its side effects (unwanted or unexpected reactions to medicine or treatment).During a review of Resident 9's History and Physical (H&P) dated 1/16/2026, the H&P indicated Resident 9 had fluctuating capacity to understand and make decisions.During a review of Resident 9's Minimum Data Set (MDS- resident assessment tool) dated 1/25/2026, the MDS indicated Resident 9 had an intact cognition (ability to think, understand, learn, and remember). The MDS indicated Resident 9 required supervision or touching assistance (helper provides verbal cues and contact guard assistance as the resident completes an activity) with transfer to and from a bed to chair, toilet transfer, oral hygiene, toileting hygiene and dressing.During a review of Resident 9's Medication Administration Report (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for the month of January and February 2026, the MAR indicated an order of Ibuprofen 600 milligrams(mgs.-unit of measurement) dated 1/15/2026 to administer 1 tablet by mouth every 12 hours as needed for moderate pain (pain rating using numerical rating of 1 to 10 that quantifies pain intensity from 0- no pain,1-3 mild pain, 4-6 moderate pain and 7 to 10 is severe pain). The MAR indicated Resident 9 received Ibuprofen 600 mgs. on the following days:On 2/2/2026 at 9:00 a.m. for a pain level of 2/10.On 2/5/2026 at 8:43 a.m. for a pain level of 9/10.On 1/25/2026 at 2:30 p.m. for a pain level of 2/10.On 1/27/2026 at 9:23 a.m. for a pain level of 2/10.During a concurrent interview and record review on 2/26/2026 at 2:40 p.m. with Licensed Vocational Nurse (LVN) 1, Resident 9's MAR for February 2026 was reviewed. LVN 1 stated that Resident 9 would sometimes receive ibuprofen for mild discomfort. LVN 1 stated he should have notified the physician when Resident 9's pain level reached 9, because ibuprofen was ordered only for moderate pain levels of 5 to 7. LVN 1 stated he assessed Resident 9's pain level after giving the ibuprofen but did not document. LVN 1 stated he did not call Resident 9's physician regarding pain level of 9/10. LVN 1 stated that not providing pain medication appropriate for the assessed pain level could result in uncontrolled pain and ineffective pain management.During an interview on 2/26/2026 at 4:26 p.m. with the Director of Nursing (DON), the DON stated the licensed nurse should have notified the physician when Resident 9's pain level was 9/10 because Ibuprofen would not be enough to relieve the pain. The DON stated Resident 9 can be at risk for unrelieved pain because the licensed nurse administered pain medicine not appropriate to the assessed pain level of the resident.During a review of facility's policy and procedure (P&P) titled, Pain Assessment and Management, undated, the (continued on next page)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	P&P indicated the facility will identify pain in the resident and will develop interventions consistent with the resident's goals and needs.		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure staff competency in cardiopulmonary resuscitation (CPR- emergency lifesaving procedure that is performed when someone's stopped breathing or heartbeat has stopped) for one of three reviewed staff members (CNA 2). The facility failed to:1.Ensure CNA 2 demonstrates the knowledge and skills necessary to perform CPR by obtaining Basic Life Support (BLS-verifies training in essential, life-saving techniques for healthcare professionals and first responders focusing on CPR) certification that includes an online training and in-person skills demonstrations.The failure to ensure CNA 2 completed the required hands-on CPR skills competency had the potential to result in CNA 2 performing CPR ineffectively during life-threatening emergencies (dangerous or serious that it could kill or pose a very high risk of death if not handled or treated immediately) in the facility.Findings:During a concurrent interview and record review on [DATE] at 10:13 a.m. with the Director of Staff Development (DSD), CNA 2's Basic Life Support (BLS (BLS- trains participants to promptly recognize several life-threatening emergencies, give high-quality CPR, deliver appropriate breaths and provide early use of an automated defibrillator [AED used to treat sudden cardiac arrest by delivering a controlled electrical shock to restore a normal heart rhythm]) certificate and the facility's policy titled Cardiopulmonary Resuscitation were reviewed. The DSD stated CNA 2 completed an online-only BLS course, and she acknowledged that she had accepted the certificate at that time. The DSD stated the facility's policy requires CPR training to include hands-on competency for BLS, and because CNA 2 did not complete an in-person skills demonstration, she would not be competent to perform CPR during an emergency.During an interview on [DATE] at 2:08 p.m., with the Director of Nursing (DON), the DON stated CNAs obtaining BLS certification through online-only courses could negatively impact resident care, as staff would be unable to perform proper CPR safely or respond appropriately during emergencies.During a review of facility's policy and procedure (P&P) titled, CPR, undated, the P&P indicated Facility's staff will maintain current CPR certification for healthcare providers through a CPR provider who evaluates proper technique through in-person demonstration of skills. The P&P indicated CPR certification which includes an online knowledge component still requires in-person skills demonstrations to obtain certification.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement their protocol for Antibiotic Stewardship (the effort to measure and improve how antibiotics are prescribed by clinicians and used by patients) for one of five sampled residents (Resident 48) who was prescribed an antibiotic drug without meeting the McGeers Criteria (a set of clinical definitions used for surveillance to define the resident symptoms and other clinical criteria that are used to meet infection surveillance definitions). This failure had the potential to result in Resident 48 developing antibiotic resistance (when bacteria develop defenses against the antibiotics designed to kill them) from unnecessary or inappropriate antibiotic use. Findings: During a review of Resident 48's admission Record, the admission Record indicated Resident 48 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Resident 48's diagnoses included hypertensive heart disease (heart damage leading to high blood pressure), osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), cataracts (a common age-related eye condition involving the clouding of the eye's normally clear lens) and schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 48's History and Physical (H&P) dated 6/18/2025, the H&P indicated Resident 48 was self responsible. During a review of Resident 48's Minimum Data Set (MDS-a resident assessment tool), dated 1/7/2026, the MDS indicated Resident 48 needed substantial to maximal assistance (helper does all the effort) with toileting, showering, and dressing. The MDS indicated Resident 48 needed partial to moderate assistance (helper does half the record) with eating, oral hygiene, personal hygiene, transferring and walking. During a concurrent interview and record review on 2/26/2026 at 1:05 p.m., with the Infection Preventionist Nurse (IPN), Resident 48's Order Summary, dated 1/10/2026, was reviewed. The Order Summary indicated Resident 48 had an order for metronidazole external cream (an antifungal antibiotic cream) to treat rosacea (a chronic long-term inflammatory skin) 0.75 percent ([%] unit of measurement) for 30 Days. The IPN stated today is the first-time she has heard about Resident 48's order for the antibiotic. The IPN stated the McGeer's criteria were not followed because it was not communicated that Resident 48 was on antibiotics. The IPN stated Resident 48 could develop a Multi Drug Resistant Organism (MDRO-bacteria or germs resistant to multiple types of antibiotics) if there is no monitoring if the antibiotic is effective. During an interview on 2/26/2026 at 3:29 p.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 stated on 10/31/2025 Resident 48 developed redness on the face and scalp. LVN 3 stated the doctor ordered the metronidazole external cream 0.75 %, on 12/12/2026, 1/10/26, and 2/13/2026. LVN 3 stated she did not notify the IPN Resident 48 was taking metronidazole cream, because she thought she only had to inform the IPN for antibiotics taken by mouth. LVN 3 stated Resident 48 was not monitored for effectiveness of metronidazole cream. During an interview on 2/27/2026 at 1:57 p.m. with Registered Nurse Supervisor (RNS) 1, RNS 1 stated metronidazole cream is an anti-fungal medication and needed to be monitored for Resident 48 for side effects to see if the skin infection was getting better. RNS 1 stated all skin issues should be documented, to know the condition of the skin. During a review of the facility's policy and procedure (P&P), titled, Unnecessary Drugs-Without Adequate Indication for Use, undated, the P&P indicated, each resident's drug regimen will be reviewed on an ongoing basis, taking into consideration the following elements dose, duration of use, indications for use, adequate monitoring, presence of adverse consequences which indicate the dose should be reduced or discontinued, any combination of the reasons stated above. The P&P indicated the use of any drug will be documented in the medical record to facilitate adequate care planning, including appropriate monitoring and resident centered care.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 Activity Assistant accurately documented on Activity Attendance Record provided for one of five sampled residents (Residents 63) in 2/12/2026, 2/13/2026, 2/14/2026 and 2/24/2026. This deficient practice had the potential for confusion in the care and services provided to Resident 63 and placed the resident at risk of not receiving appropriate care due to inaccurate and incomplete medical information. Findings: During review of Resident 63's admission Records, the admission Record indicated Resident 63 was admitted to the facility on [DATE] with diagnoses including anxiety (conditions that cause excessive and persistent feelings of fear or worry that can interfere with daily life), major depression (mood disorder that causes a persistent feeling of sadness and loss of interest) and muscle weakness (loss of muscle strength). During a review of Resident 63's Minimum Data Set (MDS- resident assessment tool) dated 02/22/2026, the MDS indicated Resident 63's cognitive (ability to think, understand, learn, and remember) skills for daily decisions making was moderately impaired. The MDS indicated Resident 63 required setup or clean up assistance (helper set up or clean up; resident completes activity) from staff for Activities of Daily Living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a concurrent interview and record review on 02/26/2026 at 7:55 a.m. with the Activity Assistant (AA), Resident 63's Activity Attendance record was reviewed. The AA stated she did not know why the dates 2/12, 2/13, 2/14, and 02/24/2026 were not signed in the activity records. AA stated other activity staff sometimes assist with activities, and staff may have failed to sign the records. The AA stated she believed the activities were completed for Resident 63 on those dates. The AA stated if an activity was not recorded or documented, then it was considered not done. The AA stated failing to document accurately and timely prevent staff from knowing what activities were provided and when they were completed for Resident 63. During an interview on 02/27/2026 at 1:20 p.m. with the Director of Nursing (DON), the DON stated any activities completed for each resident must be documented to reflect that they were provided. The DON stated that all staff should know and understand the importance of documenting what was done, as documentation demonstrates the service was provided. During a review of the facility's policy and procedures (P&P) titled, Documentation, undated the P&P indicated Facility to maintain accurate, complete, and reliable documentation as part of the residents' medical records and designated service log. Staff are responsible for documenting service they personally provide in a clear, objective, and timely manner. The entry is completed and signed by the individual who provided the service.		

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Antibiotic Stewardship Program (process for improving how antibiotics [medication used to treat infection] are prescribed and used by residents) was implemented for one of three residents (Resident 90). The facility failed to monitor antibiotic use and review the appropriateness of the prescribed antibiotic. This failure had the potential to put Resident 90 at risk for antibiotic resistance (ability of bacteria and other microorganisms to withstand the effects of antibiotics, rendering them ineffective) or inappropriate use of antibiotic. Findings: During a review of Resident 90's admission Record, the admission Record indicated Resident 90 was initially admitted to the facility on 1/13/2023 and was readmitted on [DATE]. The admission Record indicated Resident 90 diagnoses including urinary tract infection (UTI- an infection in the bladder/urinary tract), anxiety disorder (persistent, excessive fear or worry that interferes with life), diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), and schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior). During a review of Resident 9's General Acute Hospital (GACH) Record titled, Urinalysis (laboratory test that analyzes a sample of urine to check for signs of health issue), dated 2/6/2026 at 6:30 a.m., the Urinalysis indicated presence of white blood count (WBC presence of white blood count in urine often signals infection) 25 to 50 A (A- level of WBC in the urine and normal reference range is 0) in the urine. During a review of Resident 9's GACH Record titled, Urine Culture, dated 2/6/2026 timed at 11:10 a.m., the Urine Culture (laboratory test that is used to see if germs specifically bacteria or yeast grow from the sample of the urine) indicated normal genitourinary flora (laboratory found harmless bacteria that normally live in the skin or genital area) and presence of 25,000 colony forming units per milliliter (cfu/ ml- measurement of how many bacteria grew from the sample) in the urine sample. During a review of Resident 90's Physician Order dated 2/9/2026 timed at 2:21 p.m., the Physician Order indicated an order of Ciprofloxacin Hydrochloride (antibiotic used to treat serious bacterial infections like UTI) 500 milligrams (mgs. - unit of measurement) 1 tablet by mouth two times a day for UTI for 4 days. During a review of Resident 90's Minimum Data Set (MDS- a resident assessment tool) dated 2/16/2026, the MDS indicated Resident 90 had moderately impaired cognitive skills (a person has trouble remembering, thinking, learning and making decisions). The MDS indicated Resident 90 required partial/moderate assistance with eating, oral hygiene, bathing and toilet transfer (ability to get on and off a toilet or commode). During a concurrent interview and record review on 2/26/2026 at 9:57 a.m. with the Infection Preventionist Nurse (IPN), Resident 90's physician order for Ciprofloxacin dated 2/9/2026, Resident 90's urinalysis and urine culture obtained from GACH on 2/6/2026, were reviewed. The IPN stated she did not verify whether a urine culture had been obtained prior to initiating Ciprofloxacin for Resident 90. The IPN indicated that the urine culture from 2/6/2026 showed a bacterial count below the threshold required to start antibiotic therapy. She stated the culture also did not include sensitivity testing, which identifies which antibiotics would be effective for the specific bacteria. The IPN stated that, according to McGeer Criteria (standardized, evidence-based definitions used in long-term care facilities to determine true infections and ensure antibiotics are prescribed only when appropriate) a urine culture should show greater than 100,000 CFU/mL to indicate a urinary tract infection. The IPN acknowledged she should have confirmed whether a urine culture was obtained and clarified the order with the physician before starting the antibiotic. The IPN stated Ciprofloxacin was initiated in the facility for Resident 90, who received the full course of the medication. She stated it was her responsibility to track and monitor antibiotic use to ensure compliance with the Antibiotic Stewardship Program. The IPN stated that implementing the Antibiotic Stewardship Program was important to prevent the development of multidrug-resistant organisms (MDRO- bacteria that have become resistant to multiple antibiotic making infections difficult to treat) in the facility. During an interview on 2/27/2026 at 2:08 p.m. with the Director of (continued on next page)		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056313	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2026
NAME OF PROVIDER OR SUPPLIER Pacific Villa, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 3501 Cedar Avenue Long Beach, CA 90807	
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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing (DON), the DON stated Resident 90 will develop resistance to most antibiotic leading to MDRO if an antibiotic was administered without proper indication. During a review of facility's policy and procedure (P&P) titled, Antibiotic Stewardship Program, undated, the P&P indicated the program includes antibiotic use protocols and a system to monitor antibiotic use including laboratory testing will be used in accordance with current standards of practice. The P&P indicated antibiotic orders obtained upon admission, new admissions or readmission to the facility will be reviewed for appropriateness,		