STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555010	A. Building B. Wing	06/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Long Beach Post Acute	1201 Walnut Avenue Long Beach, CA 90813

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 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 interview and record review, the facility failed to ensure the Social Service Director (SSD) documented services provided to the Emergency Contact (EC) 1 for one of five sampled residents (Resident 1) when EC 1 was assisted and updated in initiating a guardianship (an evaluation conducted to determine whether the individual needs assistance with decision making or with accomplishing activities of daily living) evaluation and completing documents necessary for guardianship.This failure has resulted in undetermined efforts of the facility in assisting EC 1 of the guardianship evaluation and had the potential for EC 1 to miss updates of the process requested.Findings:During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE]. Resident 1 was admitted to the facility with diagnoses including schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), depression (feelings of constant sadness and loss of interest that affects normal day to day activities) and anxiety (extreme worry). During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 12/9/2025, the MDS indicated Resident 1 was able to make decisions that were reasonable and consistent and required one-person assistance from staff to complete his activities of daily living ([ADLs] activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 1's untitled Care Plan, dated 12/3/2025, the Care Plan indicated Resident 1 had the potential for foreseeable complications of clinical or social decline related to non-adherences/refusal/resistive to care. The Care Plan goals indicated Resident 1's right to choose will be honored, staff to assist Resident 1 with making healthcare decisions and the family and/or responsible party to be informed of the risks and consequences of choices that Resident 1 makes daily. The Care Plan interventions indicated involving the family and/or responsible party in coordinating and implementation of Resident 1's plan of care. During a telephone interview on 6/12/2026 at 10 a.m., the EC 1 stated she initiated filing for guardianship for Resident 1 and she gave the court document to the SSD on 2/2026 for a guardianship evaluation of Resident 1, but she did not receive an update from the SSD until the last week of 5/2026, informing her that she (SSD) needed to find another psychiatrist to assist with the evaluation and signing of the court document. EC 1 stated her efforts to contact and/or follow up with the SSD was not reciprocated and it caused her to feel left out and missed the updates. During an interview on 6/12/2026 at 2:14 p.m., the SSD stated she received the court document from EC 1 on 2/2026, but Resident 1 had not been seen by a psychiatrist for a guardianship evaluation. The SSD stated she gave EC 1 a call (did not specify the date) and informed her of the update (did not specify the date) when EC 1 visited Resident 1 the facility, however, did not document the update in Resident 1's medical record. During a review of Resident 1's Medical Records, there was no documentation indicating Resident 1's court document receipt, updates of Resident 1's guardianship evaluation nor communication of updates from the SSD to EC 1. During an interview on 6/12/2026 at 4:26 p.m., the Administrator (ADM) stated the SSD should have documented in Resident 1's medical record to reflect EC 1 was provided updates of the request for guardianship evaluation related to the process of filing for guardianship. The ADM confirmed the (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medical record of Resident 1 did not indicate any documentation from the SSD in relation to Resident 1's guardianship evaluation nor updates relayed to EC1 since 2/2026. The ADM stated all staff of the facility are responsible to ensure the residents' medical records are accurate and complete to reflect the services and/or assistance provided by the facility to the residents. During a review of the facility's policy and procedures (P&P) titled, Components of a Health Record, dated 1/ 2004, the P&P indicated the facility shall maintain a health record for each resident, including but not limited to social service evaluation and notes.During a review of the facility's P&P titled, Documentation Principles, dated 1/2004, the P&P indicated the following:a. The health records of the residents shall be kept current, accurate and detailed, consistent with good medical and professional practice based on the service provided for each resident, b. The content of the health records of the residents must contain information regarding the residents' stay at the facility and shall be centralized in the residents' medical records, and c. The health records of the resident shall be maintained in compliance with the licensing and certification governmental agency requirements and professional standards.