

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

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/15/2026
NAME OF PROVIDER OR SUPPLIER Long Beach Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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 the storage of food was done under sanitary conditions in one of one kitchen by not labeling an opened food item with a date opened and prepared food items with date prepared. These deficient practices had the potential to cause food-borne illnesses (any illness resulting from eating contaminated/spoiled foods). Findings: During a concurrent observation and interview on 1/12/2026 at 8:26 a.m., with the Dietary Supervisor (DS) in the dry storage room, a previously opened gallon container of sesame oil was without a label of open date. The DS stated the oil did not have an open date. There was a serving tray on top of a storage bin that had five prepared bowl containers of dry cereal with no label of date prepared. During an interview on 1/14/2026 at 11:53 a.m., with the Registered Dietician (RD), the RD stated opened food items should be dated and labeled. During a review of the facility's policy and procedure (P&P), titled Labeling and Dating of Foods, dated 20203 The P&P indicated all food items in the storeroom need to be labeled and dated. Newly opened Food items will need to be closed and labeled with an open date and used by date. All Prepared foods need to be covered labeled and dated. Items can be dated individually or in bulk stored on a tray with masking tape if they are going to be used for meal service. During a review of the facility's P&P, titled Storage of Food and Supplies, dated 2023, The P&P indicated Dry food items which have been opened, such as dry cereal will be tightly closed, labeled and dated.		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview, and record review, the facility failed to ensure a person-centered care plan was developed and implemented for Risperdal [anti-psychotic medication (used to manage psychosis symptoms)] for one of four sampled residents (Resident 5). This deficient practice has the potential to result in unnecessary medication use, unmonitored side effects and decline in functional status. Findings:During a review of Resident 5's admission Record (Face Sheet), the admission Record indicated the facility admitted the resident on 5/5/2025 with diagnoses including peripheral autonomic neuropathy (damage to automatic body nerves for unknown reasons), hypotension (low blood pressure), paranoid schizophrenia (brain disorder where a person may hear or see things that are not real), schizoaffective disorder (condition where someone's thoughts get mixed up and their mood swings are very strong and hard to control), and hyperglycemia (high blood sugar).During a review of Resident 25's History and Physical (H&P) dated 5/6/2025, the H&P indicated Resident 25 has fluctuating capacity to understand and make decisions.During a record review of a physician's (MD) order dated on 5/5/2025 at 9:00 p.m., the MD indicated Risperdal 3 milligram (mg, unit of weight), give one tablet by mouth at bedtime for paranoid schizophrenia and auditory hallucination to harm others.During a concurrent interview and record review on 1/12/2026 at 1:17 p.m. with Registered Nurse (RN) 1, there was no documented care plan for Risperdal 2 mg and Risperdal 3 mg, ordered for paranoid schizophrenia and auditory hallucination. RN 1 stated the care plan was not developed and implemented. RN 1 stated a licensed nurse initiates the care plan. RN 1 stated a comprehensive, patient-centered care plan was required to guide staff in identifying Resident 5's diagnosis, understanding the related needs and behaviors, and implementing individualized interventions. RN 1 stated without a care plan, Resident 5's symptoms related to paranoid schizophrenia and auditory hallucinations may be overlooked, resulting in delayed assessment and intervention.During a concurrent interview and record review on 1/14/2026 at 11:40 a.m. with the Director of Nursing (DON), Resident 5's care plan for Risperdal 2 mg and Risperdal 3 mg, ordered for paranoid schizophrenia and auditory hallucination was not found. The DON stated the absence of a care plan limits the nursing staff's ability to recognize changes in condition, provide timely support, and implement the appropriate interventions necessary to meet Resident 5's needs.During a review of the facility's policy and procedure (P&P) titled, Psychotropic Drug Treatment, dated 9/2017, indicated The purpose of this procedure is to provide psychotropic drug treatment for a resident with a specific condition as diagnosed and documented in the clinical record.Nursing services, social services and other members of the interdisciplinary team (IDT) will address the behaviors in progress notes and on the resident centered care plan.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the nursing staff failed to revise a care plan for impaired communication for one of four sampled residents (Resident 30) who was deaf (condition where an individual has a significant or complete inability to speak) and non-verbal. This deficient practice had the potential for Resident 30's needs not to be met, due to her inability to express them. During a review of Resident 30's admission Record, the admission Record indicated Resident 30 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including hearing loss, non-verbal, and idiopathic peripheral autonomic neuropathy (IPAN: nerve damage affecting automatic functions (heart rate, blood pressure [amount of pressure that takes the heart to pump blood in the body], digestion). During a review of Resident 30's History and Physical (H&P), dated 7/25/2025, the H&P indicated Resident 30 had the capacity to understand and make decisions. During a review of Resident 30's Minimum Data Set ([MDS] a resident assessment tool), dated 1/7/2026, the MDS indicated Resident 30's cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills were intact. The MDS indicated Resident 30 was independent on all aspects of activities of daily living (ADLs: routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS indicated Resident 30 did not have any impairments on the upper (arms/shoulders) and lower (hips/legs) extremities. During a concurrent interview and record review on 1/14/2026 at 1:43p.m., with Registered Nurse Supervisor (RN 1), RN 1 stated Resident 30 did not have a care plan regarding communication/language in her medical record. During an interview on 1/15/2026 at 12:22 p.m., with the Director of Nursing (DON), the DON stated care plans are individualized to ensure the staff know how to take care of the residents individually. The DON stated care plans are updated as needed, quarterly, and upon readmission. The DON stated all active care plans should be in the residents' chart. During a concurrent interview and record review of Resident 30's Impaired Communication dated 7/22/2025 on 1/15/2026 at 12:24p.m. with the DON, the DON stated the target date reflected on the care plan of 10/2025 should have been updated. The DON stated care plans are continuous and without care plans, there would be no guide on how to care for the residents. During a review of the facility's policy and procedure (P&P) titled, Comprehensive Care Planning, revised 1/2017, the P&P indicated the care plan must be reviewed and revised periodically, at least quarterly, and an ongoing basis to reflect changes in the resident and the services provided or arranged must be consistent with each resident's written plan.		

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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 interview and record review, the facility failed to document nursing assessment for the use of Continuous Positive Airway Pressure (CPAP, a machine that delivers air through a mask to keep the airway open during sleep and prevent breathing pauses) for one of three sampled residents (Resident 78). This deficient practice had the potential to result in inaccurate and incomplete resident records and delayed identification of respiratory support needs. Findings: During a review of Resident 78's admission Record (Face sheet), the admission Record indicated the facility admitted the resident on 1/9/2026, with diagnoses including alcohol dependence, nicotine dependence, major depressive disorder (mood disorder characterized by persistent sadness and loss of interest in daily activities) and insomnia (trouble falling asleep or staying asleep). During a review of Resident 78's Minimum Data Set (MDS, a resident assessment tool), dated 1/15/2026, the MDS indicated Resident 78 had intact cognition (ability to think and understand). The MDS indicated Resident 78 needed supervision from staff for eating, toileting hygiene, dressing and bathing. During an interview on 1/13/2026 at 4:10 p.m. with Resident 78, Resident 78 stated he informed a licensed nurse on day of admission on [DATE] regarding CPAP needs and his missing mask. Resident 78 stated he had been using CPAP machine daily for 2 years for his sleep apnea (a condition that causes breathing to stop and start several times during sleep). During a concurrent interview and record review on 1/14/2025 at 9:22 a.m., with Licensed Vocational Nurse (LVN) 3, Resident 78's Resident's Clothing and Possessions (Belonging List) for 1/9/2026 and Licensed Nurses Notes for 1/9/2026 were reviewed. LVN 3 stated Belonging List indicated Resident 78 had CPAP machine with him on admission. LVN 3 stated there was no documentation indicating Resident 78 had informed licensed nurse of need for CPAP use on admission day. During a concurrent interview and record review on 1/15/2026 at 10:41 a.m., with LVN 1, Resident 78's Licensed Nurses Notes for 1/9/2026 was reviewed. LVN 1 stated on 1/9/2026, Registered Nurse Supervisor (RN) 1 was made aware of Resident 78's history of CPAP use at home. LVN 1 stated there was no documentation indicating a report was made by LVN 1 to RN 1. During an interview on 1/15/2026 at 11:32 a.m., with Registered Nurse Supervisor (RN) 1, RN 1 stated the RN was responsible for completing the resident admission assessment. RN 1 stated when a medical device was present upon admission, the RN was expected to inquire whether the resident was using the device. RN 1 stated there was no documentation indicating an assessment was completed regarding Resident 78's use of a CPAP machine. RN 1 stated documentation of the medical device was important to ensure resident needs were identified and addressed and symptoms were managed. RN 1 stated failure to assess and document CPAP use could place the resident at risk for complication such as sleep apnea and respiratory compromise while sleeping. During an interview on 1/15/2026 at 12:22 p.m., with Director of Nursing (DON), the DON stated there should have been an interdisciplinary team meeting done for Resident 78 CPAP use and a licensed nurse had to document the history of use of the CPAP. The DON stated no documentation meant care was not done. The DON stated lack of documentation for CPAP use could result in inaccurate medical records and poor communication among staff, which could lead to failure to provide appropriate respiratory support. During a review of facility's policy and procedures (P&P) titled, Documentation Principles dated 1/2004, the P&P indicated Health records shall be kept for each resident and the content shall be in compliance with the licensing and certification government agency requirements and professional standards. All health information regarding a resident's stay shall be centralized in the resident's health record. Resident's health record shall be current and kept in detail consistent with good medical and professional practice based on the service provided to each resident.		