

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: 555823	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/02/2024
NAME OF PROVIDER OR SUPPLIER Intercommunity Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2626 Grand Avenue Long Beach, CA 90815	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44088 Based on observation, interview, and record review, the facility failed to assess, monitor, and document restraint monitoring flow sheet for three of three sampled residents (Resident 1, 2 and 3). This failure had the potential to result in siderail entrapment (occurs when a resident is trapped between a bed rail and the mattress, or within the rail itself), skin injury, accident, and compromised circulation. Findings: During a review of Resident 1 ' s Admission Record, the Admission Record indicated, Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities), Alzheimer ' s disease (a disease characterized by a progressive decline in mental abilities), and nose fracture (broken bone). During a review of Resident 1 ' s History and Physical (H&P), dated 4/13/2024, the H&P indicated, Resident 1 had no capacity (ability) to understand and make decision. During a review of Resident 1 ' s Minimum Data Set (MDS-resident assessment tool), dated 11/22/2024, the MDS indicated Resident 1 required dependent assistance (helper does all of the effort) from two or more staff for hygiene, transfer, maximal assistance (helper does more than half the effort) from one staff for chair/bed to chair transfer, toilet transfer, bed mobility, dressing, and lying to sitting on side of bed. During an observation on 1/6/2025 at 1:02 p.m., in Resident 1 ' s room, Resident 1 was sitting on a wheelchair with a lap belt (a positioning belt that designed to fit across the user ' s lap and buckle securely) on. During a concurrent interview and record review on 1/6/2025 at 1:16 p.m., with Licensed Vocational Nurse (LVN) 1, Resident 1 ' s Restraint Monitoring Flow Sheet, dated from 12/1/2024 to 1/6/2025 was reviewed. The Restraint Monitoring Flow Sheet indicated, 1. On 12/6/2024 and 12/7/2024, there was no documentation for releasing restraint (at least 20 minutes), restraint assessment, and skin integrity from 8:00 a.m. to 2:00 p.m. (continued on next page)		

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

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

TITLE

(X6) DATE

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On 12/16/2024 -12/20/24, there was no documentation for releasing restraint (at least 20 minutes), restraint assessment, and skin integrity from 8:00 a.m. to 10:00 p.m. 3. On 12/21/2024- 12/23/24 there was no documentation for releasing restraint (at least 20 minutes), restraint assessment, and skin integrity from 8:00 a.m. to 10:00 p.m. 4. On 12/28/2024, there was no documentation for releasing restraint (at least 20 minutes), restraint assessment, and skin integrity from 8:00 a.m. to 10:00 p.m. 5. On 12/29/2024, there was no documentation for releasing restraint (at least 20 minutes), restraint assessment, and skin integrity from 8:00 a.m. to 2:00 p.m. 6. On 1/2/2025, there was no documentation for releasing restraint (at least 20 minutes), restraint assessment, and skin integrity from 8:00 a.m. to 10:00 p.m. 7. On 1/2/2025, there was no documentation for releasing restraint (at least 20 minutes), restraint assessment, and skin integrity from 12:00 a.m. to 2:00 p.m. 8. On 1/4/2025 and 1/5/2024, there was no documentation for releasing restraint (at least 20 minutes), restraint assessment, and skin integrity from 8:00 a.m. to 2:00 p.m. LVN 1 stated, each station had Restraint Monitoring Flow Sheet binders. LVN 1 stated, licensed staff should have monitored, assessed, and documented the residents ' restraints every two hours to prevent injuries. LVN 1 stated, staff should have documented if they release the restraints at least 20 minutes every two hours. LVN 1 stated, there was no other place to document restraint assessment. During a review of Resident 1 ' s Physician Order Report, dated 12/2/2024, the Physician Order Report indicated, safety (lap) belt restraint (non-self-releasing) when up on wheelchair for safety. During a review of Resident 1 ' s Care Plan titled Resident 1 required to have non-self-release lap belt due to history of falling, dated 12/2/2024, the approach plan indicated, to assess Resident 1 for the use of non-self-release lap belt, monitor and maintain vigilance while resident is up in the wheelchair with seatbelt, and monitor skin for red areas. During a review of Resident 2 ' s Admission Record, the Admission Record indicated, Resident 2 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities), and right femur fracture (broken bone of right thigh). During a review of Resident 2 ' s History and Physical (H&P), dated 12/14/2024, the H&P indicated, Resident 2 had no capacity (ability) to understand and make decision. During a review of Resident 2 ' s MDS, dated [DATE], the MDS indicated Resident 2 required partial/moderate assistance (helper does less than half the effort) from one staff for chair/bed to chair transfer and sit to stand. (continued on next page)		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 1/6/2025, at 1:25 p.m. with Licensed Vocational Nurse (LVN) 1, Resident 2 ' s Restraint Monitoring Flow Sheet, dated from 12/1/2024 to 1/6/2025 was reviewed. The Restraint Monitoring Flow Sheet indicated the following. 1. On 12/1/2024, 12/6/2024 and 12/7/2024, there was no documentation for releasing restraint (at least 20 minutes), restraint assessment, and skin integrity from 8:00 a.m. to 2:00 p.m. 2. On 12/16/2024 and 12/17/2024, there was no documentation for releasing restraint (at least 20 minutes), restraint assessment, and skin integrity from 4:00 p.m. to 10:00 p.m. 3. On 12/18/2024, there was no documentation for releasing restraint (at least 20 minutes), restraint assessment, and skin integrity from 10:00 a.m. to 2:00 p.m. 4. On 12/19/2024, there was no documentation for releasing restraint (at least 20 minutes), restraint assessment, and skin integrity from 8:00 a.m. to 2:00 p.m. 5. On 12/21/2024 to 12/24/2024, there was no documentation for releasing restraint (at least 20 minutes), restraint assessment, and skin integrity from 4:00 p.m. to 10:00 p.m. 6. On 12/28/2024, there was no documentation for releasing restraint (at least 20 minutes), restraint assessment, and skin integrity from 8:00 a.m. to 10:00 p.m. 7. On 12/29/2024, there was no documentation for releasing restraint (at least 20 minutes), restraint assessment, and skin integrity from 8:00 a.m. to 2:00 p.m. 8. On 1/2/2025,1/3/2025 ,1/4/2025 and 1/5/2025, there was no documentation for releasing restraint (at least 20 minutes), restraint assessment, and skin integrity from 8:00 a.m. to 2:00 p.m. During a review of Resident 3 ' s Admission Record, the Admission Record indicated, Resident 3 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including dementia, and right hip fracture (broken bone of right hip). During a review of Resident 3 ' s H&P), dated 9/19/2024, the H&P indicated, Resident 3 had no capacity (ability) to understand and make decision. During a review of Resident 3 ' s MDS, dated [DATE], the MDS indicated Resident 3 required partial/moderate assistance (helper does less than half the effort) from one staff for chair/bed to chair transfer and sit to stand. During a concurrent interview and record review on 1/6/2025, at 1:40 p.m. with LVN 1, Resident 3 ' s Restraint Monitoring Flow Sheet, dated from 12/1/2024 to 1/6/2025 was reviewed. The Restraint Monitoring Flow Sheet indicated the following. 1. On 12/2/2024, there was no documentation for releasing restraint (at least 20 minutes), restraint assessment, and skin integrity from 4:00 p.m. to 10:00 p.m. 2. On 12/3/2024, there was no documentation for releasing restraint (at least 20 minutes), restraint assessment, and skin integrity from 4:00 p.m. to 2:00 p.m. (continued on next page)		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. On 12/6/2024, there was no documentation for releasing restraint (at least 20 minutes), restraint assessment, and skin integrity from 8:00 a.m. to 2:00 p.m. 4. On 12/7/2024, there was no documentation for releasing restraint (at least 20 minutes), restraint assessment, and skin integrity from 8:00 a.m. to 2:00 p.m. 5. On 12/16/2024 and 12/17/2024, there was no documentation for releasing restraint (at least 20 minutes), restraint assessment, and skin integrity from 4:00 p.m. to 10:00 p.m. 6. On 12/18/2024 and 12/20/2024, there was no documentation for releasing restraint (at least 20 minutes), restraint assessment, and skin integrity from 8:00 a.m. to 2:00 p.m. 7. On 12/21/2024, there was no documentation for releasing restraint (at least 20 minutes), restraint assessment, and skin integrity from 8:00 a.m. to 10:00 p.m. 8. On 12/22/2024 and 12/23/2024, there was no documentation for releasing restraint (at least 20 minutes), restraint assessment, and skin integrity from 4:00 p.m. to 10:00 p.m. 9. On 12/28/2024, there was no documentation for releasing restraint (at least 20 minutes), restraint assessment, and skin integrity from 8:00 a.m. to 10:00 p.m. 10. On 12/29/2024, there was no documentation for releasing restraint (at least 20 minutes), restraint assessment, and skin integrity from 8:00 a.m. to 2:00 p.m. 11. On 1/2/2025, 1/3/2025, 1/4/2024 and 1/5/2025, there was no documentation for releasing restraint (at least 20 minutes), restraint assessment, and skin integrity from 8:00 a.m. to 2:00 p.m. LVN 1 stated, monitoring restraints were important to protect residents from restraints related injuries and unnecessary entrapment. During a review of Resident 3 ' s Physician Order Report, dated 9/16/2024, indicated, safety (lap) belt restraint (non-self-releasing) when up on the wheelchair to prevent falling due to poor safety awareness. During a review of Resident 3 ' s Care Plan, titled Resident 3 required to have non-self-release lap belt due to history of falling dated 9/16/2024, the approach plan indicated, to assess Resident 3 for the use of non-self-release lap belt, monitor and maintain vigilance while resident is up in wheelchair with seatbelt, and monitor skin for red areas. During an interview on 1/6/2025, at 3:20 p.m., with Director of Staff Development (DSD), DSD stated, she provided in-service (education or training session for employees) for use of restraints which included assessment, monitoring, and documentation. DSD stated, she was not aware of Restraint Monitoring Flow Sheet. DSD stated, licensing staff should assess, monitor, and document the restraints every two hours to prevent restraints related injuries. During an interview on 1/6/2025, at 3:35 p.m., with the Director of Nursing (DON), the DON stated, if it was not documented, it was not done. The DON stated, any services or care provided to the residents should be documented thoroughly to get the credits. (continued on next page)		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility ' s Policy and Procedure (P&P) titled, Use of Restraints, revised 4/2017, the P&P indicated, Policy Interpretation and Implementation .3. Examples of devices that are/maybe considered physical restraints include leg restraints, arm restraints, hand mitts, soft ties or vest, wheelchair safety bars, Geri-chairs and lap cushions and trays that the resident cannot remove . 12. The following safety guidelines shall be implemented and documented while a resident is in restraints .d. A resident placed in a restraint will be observed at least every 30 minutes by nursing personal and an account of the resident ' s condition shall be recorded in the resident ' s medical record. d. the opportunity for motion and exercise is provided for a period of not less than ten minutes during each two hours in which restraints are employed. e. Restrained residents must be repositioned at least every two hours on all shifts .19. Documentation regarding the use of restraints shall include .d. the type of the physical restraint used. e. the length of effectiveness of the restraint time. f. observation, range of motion and repositioning flow sheets.		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44898 Based on observation, interview and record review, the facility failed to ensure the resident, who was assessed as high risk for falls and had a self-release belt (a device designed for residents needing a reminder to call for assistance before exiting a wheelchair, for limiting unassisted exit and unwanted movement) while in a wheelchair for safety, did not fall out of the wheelchair and sustained injury for one of three sampled residents (Resident 1). The facility failed to: 1. Ensure the Velcro (a type of material that consist of two pieces of cloth that stick together with a system of very small hooks used to fasten) used to secure Resident 1's self-release belt was not worn out and was in functional condition to keep the belt's ties securely fastened to prevent Resident 1 from falling out of the wheelchair when the resident leaned forward. 2. Develop a care plan for Resident 1's use of a self-release belt for the wheelchair with interventions to ensure the resident's safety and prevent falls and injuries. 3. Followed the facility's policy and procedure (P&P) titled, Falls and Fall Risk, Managing, revised 12/2007, which indicated, the staff will identify interventions related to the resident's specific risks and causes to prevent the resident from falling and to try to minimize complications from falling .If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. These failures resulted in Resident 1 falling face forward from the wheelchair when Nursing Assistant (NA 1) was wheeling the resident to the dining room on 11/15/2024 and sustained a nose fracture (broken bone) and a head contusion (a bruise to the brain that causes bleeding and swelling in the brain tissue) requiring hospitalization from [DATE] to 11/16/2024. Findings: During a review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses including fracture (broken bone) of the nose bones, history of falling, dementia (a progressive state of decline in mental abilities), and kyphosis (an abnormally curved spine). During a review of Resident 1's Physician's Order Summary, the Physician's Order Summary indicated a physician's order dated 4/8/2020, for a wheelchair with a self-release belt to prevent resident from getting up unassisted. During a review of Resident 1's History and Physical (H&P), dated 4/13/2024, the H&P indicated Resident 1 did not have the capacity to understand and make decision. During a review of Resident 1's Fall Risk assessment dated [DATE], the Fall Risk Assessment indicated the resident's score was 13 (total score above 10 represents high risk). (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's Incident Report, dated 4/22/2024, the Incident Report indicated Resident 1 was found on the floor in a fetal position (curled up position) with her head positioned against the bedside table and the wheelchair next to her with the self-release belt wrapped around Resident 1's waist. The Incident Report indicated Resident 1 sustained redness on the right side of the face and a small bump on the forehead. The Incident Report indicated steps taken to prevent recurrence included close supervision. During a review of Resident 1's Care Plan titled, Status Post Fall dated 4/22/2024, the Care Plan goal for Resident 1 was to have no repeat fall or injury. The Care Plan interventions included to provide a safe environment, to ensure the self-release belt properly secured, safety monitoring for 72 hours, apply ice packs to affected area, and monitor vital signs for 72 hours. During a review of Resident 1's Post Fall assessment dated [DATE], the Post Fall Assessment indicated immediate action to prevent fall from recurring included close supervision, make sure self-release belt was properly applied, and other fall precautions followed (not specified). During a review of Resident 1's Fall Risk assessment dated [DATE], the Fall Risk Assessment indicated the resident's score was 13 (total score above 10 represents high risk). During a review of Resident 1's Fall Risk assessment dated [DATE], the Fall Risk Assessment indicated the resident's score was 14 (total score above 10 represents high risk). During a review of Resident 1's Incident Report, dated 6/20/2024, the Incident Report indicated, Resident 1 was seating in the wheelchair with a certified nursing assistant (unknown) standing behind Resident 1. The Incident Report indicated Resident 1 leaned forward with self-release belt on and fell to the floor face down. The Incident Report indicated Resident 1 sustained a golf size bump on the left forehead During a review of Resident 1's Incident Investigation for the incidents occurred on 4/22/2024 and 6/20/2024, the Incident Investigation indicated recommendations to do frequent checks. There was no information documented in the Incident Investigation that resident 1's self-released belt was examined for signed of being worn out. During a review of Resident 1's Fall Risk assessment dated [DATE], the Fall Risk Assessment indicated the resident's score was 16 (total score above 10 represents high risk). During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool), dated 11/22/2024, the MDS indicated Resident 1 was dependent (needed nursing staff to do all of the effort to complete) on staff with eating, oral hygiene, toileting, showering, dressing, and putting on and taking off footwear, and personal hygiene. The MDS indicated Resident 1 was dependent (needed nursing staff to do all of the effort to complete) on staff to roll from left to right, move from sitting to lying, move from lying to sitting, stand from sitting and transferring. The MDS indicated Resident 1 used a restraint (manual method or device that limits a person's ability to move or access their body) daily while in a chair or out of bed to prevent rising. During an observation on 11/27/2024 at 12:00 p.m., in the dining room, Resident 1 was observed in a wheelchair with a self-release belt around her waist. Resident 1 was unable to engage in an interview. (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 12/2/24 at 6:57 a.m., Certified Nursing Assistant (CNA 1) stated Resident 1 used the self-release belt due to Resident 1 inability to sit upright in the wheelchair. CNA 1 stated on 11/15/2024 she witnessed NA 1 pushing Resident 1 in a wheelchair when Resident 1 threw herself out of the wheelchair. CNA 1 stated Resident 1 had the self-release belt on. CNA 1 stated Resident 1's head was bleeding. CNA 1 stated the ambulance was called to transport Resident 1 to the GACH. CNA 1 stated the Velcro on the self-release belt was worn out and did not stick to hold the belt straps (ties) together. CNA 1 stated after Resident 1 fell the facility ordered new self-release belts. During an interview on 12/2/2024 at 9:35 a.m., Restorative Nursing Assistant (RNA 1) stated the self-release belt usually applied around the resident's abdomen and around the wheelchair and secured in the back of the wheelchair with the Velcro straps. RNA 1 stated the resident had to be seated upright in the wheelchair and the resident's back should be positioned against the back of the wheelchair. RNA 1 stated Resident 1 could not stand up on her own. RNA 1 stated if the self-release belt was used a lot the Velcro would become worn out. RNA 1 stated CNA (in general) or charge nurse should notify RNAs if the belt needed to be replaced. RNA 1 stated he had seen some CNAs tie the restraint belt in a knot due to lack of grip from the Velcro. RNA 1 stated the last time (unknown time) the self-release belt was replaced because the Velcro straps were not sticking together because they were worn out. RNA 1 stated Resident 1's self-release belt was replaced after Resident 1 fell on [DATE] and returned to the facility after hospitalization. RNA 1 stated the fall could have been avoided if the resident was checked to ensure she was sitting up straight, not leaning forward, not slouching, and the self-release belt was properly secured with the Velcro. During an interview on 12/2/2024 at 10:29 a.m., Licensed Vocational Nurse (LVN 1) stated Resident 1 was a high risk for fall. LVN 1 stated Resident 1 was unable to follow instructions, was leaning forward while in the wheelchair and was unable to reposition without staff assistance. LVN 1 stated the reason why Resident 1 had the self-release belt was to ensure Resident 1's safety. LVN 1 stated Resident 1's fall could have been prevented if the self-release restraint belt was well secured with the Velcro. LVN 1 stated the Velcro should have been checked if it was securely fastened. During an interview on 12/2/2024 at 1:29 p.m., Registered Nurse Supervisor (RNS 2) stated Resident 1 needed assistance with transferring and was dependent on nursing staff for Activities of Daily Living (ADLs) and needed to be wheeled around. RNS 2 stated Resident 1 was unable to stand up or follow instructions. RNS 2 stated the self-release belt was used to protect the resident from falling while seated in the wheelchair. RNS 2 stated some residents were strong enough to lean forward in the wheelchair and fall if the self-release belt was not fasten/ secured properly. RNS 2 stated after Resident 1's fall on 11/15/2024 a new self-release belts were ordered that have a larger Velcro and were fasten better. RNS 2 stated the self-release belts previously used for Resident 1 had a thinner strip of Velcro. RNS 2 stated Resident 1 was a high risk for falls because Resident 1 was confused, did not know what was safe and tried to move unassisted. (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 12/2/24 at 3:00 p.m., NA 1 stated that in the morning of 11/15/2024, prior to breakfast, NA 1 was instructed to assist Resident 1 to get to the dining room. NA 1 stated Resident 1 was seated in a wheelchair and had a self-release belt on. NA 1 stated while wheeling Resident 1 to the dining room, Resident 1 was sitting back in the wheelchair when she suddenly leaned forward. NA 1 stated that the self-release belt came off from the wheelchair and Resident 1 fell from the wheelchair landing face forward on the floor and was moaning. NA 1 stated she called for help and LVN 2 and RNS 1 came to her summon for help and applied towels and ice packs to Resident 1's face, nose, and head. NA 1 stated Resident 1 was transferred back to her bed after the fall. NA 1 stated Resident 1's fall was avoidable if the self-release belt was well secured/fastened and in working condition. NA 1 stated before wheeling Resident 1 to the dining room, she did not check if the Velcro was securely fastened before wheeling Resident 1 to the dining room. During an interview on 12/2/2024 at 3:47 p.m., Registered Nurse Supervisor (RNS 1) stated Resident 1 had a recent fall on 11/15/2024 before 7 a.m. RNS 1 stated Resident 1 had a wound on the bridge of the nose with minimal bleeding as a result of this fall. RNS 1 stated he was told Resident 1 leaned forward while in the wheelchair and fell forward. RNS 1 stated Resident 1 had the self-release belt on during the fall. RNS 1 stated the self-release belt was used to prevent falls and prevent the resident from getting up unassisted. RNS 1 stated when the resident has a self-release belt the resident should not fall out of the wheelchair when resident leans forward. RNS 1 stated the self-release belt should prevent the resident from falling. During an interview on 12/2/2024 at 4:06 p.m., the Director of Nursing (DON) stated on 11/15/2024 she saw Resident 1 on a gurney (used for transporting residents) transported to the GACH by an ambulance. The DON stated Resident 1 had an injury to her nose. The DON stated Resident's 1 fall could have been avoided if the self-release belt was in good condition without worn out Velcro. The DON stated a new self-release belts were ordered to replace old self-release belts. During a record review of Resident 1's GACH records, titled General Inpatient History and Physical, dated 11/16/2024, the General Inpatient History and Physical, indicated Resident 1 had a right frontal (front) scalp contusion (bruise) and bilateral (affecting two sides) nasal bone fractures. During a review of the facility's policy and procedure (P&P) titled, Falls and Fall Risk, Managing, revised 12/2007, the P&P indicated, Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant.		