

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 01/31/2025
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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46415 Based on interview and record review, the facility failed to ensure the residents have the right to be free from abuse for one of two sampled residents (Resident 1). This deficient practice resulted in Resident 2 slapping Resident 1 on the left cheek, potential placing Resident 1 to feel unprotected and other residents at risk of further abuse. a. During a review of Resident 1 ' s Admission record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] and with diagnoses including dementia (a progressive state of decline in mental abilities), psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), any anxiety disorder (uncontrollable worry and fear about everyday situations). During a review of Resident 1 ' s History and Physical (H&P) dated 1/11/2025, the H&P indicated Resident 1 does not have the capacity to understand and make decisions. During a review of Resident 1 ' s Minimum Data Set [(MDS) a standardized assessment and care screening tool], dated 11/1/2024, the MDS indicated Resident 1 ' s cognitive skills (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) were severely impaired. The MDS indicated Resident 1 is dependent in eating, required maximal assistance (assists more than half the effort) bathing and personal hygiene, and required supervision for toilet/chair/bed-to-chair transfer, dressing upper (above waist) and lower (below waist) body, and performing oral and toileting hygiene. The MDS indicated Resident 1 did not have any impairments on both the upper (arms/shoulders) and lower (hip/legs) extremities. The MDS indicated Resident 1 had delusions (false beliefs not based on reality) and other behavioral symptoms not directed towards others (physical symptoms such as hitting or scratching self, pacing, verbal/vocal symptoms like screaming, disruptive sounds). During a review of Resident 1 ' s Licensed Personnel Weekly Progress Notes, the Licensed Personnel Weekly Progress Notes dated 1/23/2025 at 1:20p.m. indicated Resident 1 and Family Member 1 (FM 1) was sitting at a bench at Nursing Station B and Resident 2 suddenly slapped Resident 1 on the face. Resident 1 did not have any injury noted and Resident 1 was unable to verbalize what happened. The weekly progress note did not indicate whether the doctor was notified of this incident. The last weekly progress note was documented on 1/23/2025 during the 3:00p.m. to 11:00p.m. shift regarding the incident in which Resident 1 was slapped by Resident 2. (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: 555823	Facility ID: 555823 If continuation sheet Page 1 of 6

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of a Daily Log dated 1/23/2025, the daily log indicated under the 72-hour incidental charting to monitor Resident 1 from 1/23/2025 to 1/26/2025 and to monitor Resident 2 for aggressive behavior. During an interview on 1/29/2025 at 2:17p.m. with FM 1, FM 1 stated there was a bench outside Resident 1 ' s room. FM 1 stated she believes Resident was sitting there, got up, walked away, FM 1 and Resident 1 sat down on the bench, Resident 2 came by, sat down, and slapped Resident 1 on the left side of his face (cheek). FM 1 stated there was no redness on Resident 1 but did request pain medication for him as he does verbalize if he is hurting. FM 1 stated Resident 2 was sitting on the bench until the staff escorted her back to her room while Resident 1 and FM 1 continued to sit on the bench. b. During a review of Resident 2 ' s Face Sheet, the Face Sheet indicated Resident 2 was admitted to the facility on [DATE] and with diagnoses including dementia with other behavioral disturbance (condition that cause a person to behave in a way that is dangerous to themselves or others), prediabetes (elevated blood sugar levels), and insomnia (difficulty falling or staying asleep). During a review of Resident 2 ' s MDS dated [DATE], the MDS indicated Resident 2 ' s cognitive skills (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) were moderately impaired. The MDS indicated Resident 2 required moderate assistance in showering/bathing, required supervision for personal, oral, toileting hygiene, dressing the upper and lower body, and required setup for eating. The MDS indicated Resident 2 did not have any impairments on both the upper and lower extremities. The MDS indicated Resident 2 has physical behavioral symptoms (hitting, kicking) and verbal behavioral symptoms (threatening others, screaming at others) that occurred daily. During an interview on 1/29/2025 at 10:24a.m. with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated she was sitting at the Nursing Station B when she heard a slap, and when she went to see what occurred, FM 1 was sitting on the bench on the right side and Resident 1 was sitting on the left side. LVN 2 stated FM 1 informed Resident 2 slapped Resident 1. LVN 2 stated she did not hear any other noise or altercations occurring at that time. LVN 2 stated she does not recall if there was anyone else there and did not see what happened. LVN 2 stated there was no one else sitting at the bench aside from Resident 1 and FM 1. LVN 2 stated Resident 1 and Resident 2 were immediately separated, reported it to the Director of Nursing (DON), did an incident report, and assessed Resident 1 for any pain and checked his skin. LVN 2 stated Resident 1 was unable to verbalize what occurred and indicated this was the first incident between him and Resident 2. LVN 2 stated DON was the one that started the investigation, and it was reported as it was a resident-to-resident altercation and if no one reported it, Resident 2 could repeatedly do it again. (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/29/2025 at 11:24a.m. with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated when there is a change of condition (COC), the doctor is notified, and both of the residents (Resident 1 and Resident 2) will be monitored for 72 hours. LVN 1 stated if the COC is behavior related, the psychologist will be notified and will assess both of the residents. LVN 1 stated care plans are updated on the date it occurred when there are any behavioral changes and will do a care plan for the resident that was hit as well. LVN 1 stated if there are no care plans due to the new incident, a care plan will be formulated. LVN 1 stated if the Registered Nurse Supervisor (RNS) does not initiate the care plan, as the unit manager she will initiate it, however the charge nurse (CN) is responsible to do the care plan. LVN 1 stated the COC/ Situation, Background, Assessment, Recommendation (SBAR: technique used to facilitate prompt and appropriate communication) will be initiated done whether the resident sustained an injury or not. LVN 1 stated the care plan is done to formulate interventions and goals to ensure this incident/behavior will not occur again. LVN 1 stated if there are no care plans, the behavior will continue and there will be no change. LVN 1 stated the aggressor is monitored for their behavior for 72 hours to ensure it does not happen again and to identify whether they will require an increase in their medication dose or additional medication. LVN 1 stated the victim will be monitored and observed for the effect of their injuries (if sustained any) of the aftereffect of getting without injury or monitor for signs of fear and behavioral changes. LVN 1 stated if no one monitored the resident, they would not know whether the resident was affected by the incident and possibly not be protected by the incident. During an interview on 1/29/2025 at 11:36a.m. with LVN 2, LVN 2 stated they do 72-hour monitoring to ensure the incident does not occur again. LVN 2 stated she created an SBAR for Resident 2 as she is the perpetrator and only has one for Resident 2. LVN 2 stated both Resident 1 and Resident 2 would be on 72-hour monitoring. LVN 2 stated the purpose of the 72-hour monitoring is to ensure this incident does not occur again and document it as it involves the residents safety. LVN 2 stated care plans are done when an incident occurs and is updated every three months. LVN 2 stated the purpose of a care plan is to have a goal and ensure the goals are being met. During a concurrent interview and record review of Resident 1 ' s progress notes dated 1/23/2025 on 1/29/2025 at 1:23p.m. with LVN 2, LVN 2 stated Resident 1 would not need a COC unless he sustained an injury or had attempted to hit another person. LVN 2 stated she assessed Resident 1 for any discomfort, redness, grimacing, and since he did not have any discoloration, she did not think she would have to do an SBAR for Resident 1. LVN 2 stated the 72-hour monitoring applied more for Resident 2 as Resident 1 is not aggressive, so she figured Resident 1 would not require to be monitored does not know who checks the psychosocial wellbeing of the residents. LVN 2 stated per progress notes, Resident 1 did not sustain any injury and there are no other others after 1/23/2025. LVN 2 stated if Resident 1 developed any redness, they would monitor for redness on a daily log, and if there were any new changes, they would write it on the progress notes. LVN 2 stated Resident 1 did not have any monitoring done for 72 hours, did not require an SBAR, and the doctor was not notified regarding this resident. LVN 2 stated interventions will be done for minor incidents, however if it were a major incident, they would call the doctor. LVN 2 stated they will call the doctor for any COC or anything major (decline, shortness of breath) to see if they could get any recommendations. LVN 2 stated Resident 1 did not need a care plan as he did not sustain a major injury. (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/29/2025 at 2:48p.m. with DON, DON stated if there were a resident-to-resident altercation, they would do an incident report indicating resident got hit, chart on the perpetrators behavior, and review the chart to see if a similar incident had occurred before. DON stated an SBAR is created if the resident goes to the hospital and should chart for at least 24 hours. DON stated the SBAR is initiated when there is a change or if you are going to call the doctor to transfer the resident out. DON stated an example when a COC is done is if a resident has a fever, but in Resident 2 ' s case, it is a change in behavior. DON stated Resident 1 did not need an SBAR as the nurses should have called the doctor when Resident 1 got slapped. DON stated since Resident 1 and Resident 2 have the same primary physician, the notification that the doctor was notified would be on the incident report. During a concurrent interview and record review of the COC and progress notes for both Resident 1 and Resident 2 on 1/29/2025 at 2:53p.m. with DON, DON stated Resident 2 has a COC initiated on 1/23/2025 at 1:30p.m., but Resident 1 does not have one as he does not need one. DON stated upon review of Resident 1 ' s progress notes, the nurses should have continued to chart during the 11:00p.m. to 7:00a.m. shift. DON stated if the resident was injured, he would be monitored for 72 hours, and they should have continued to monitor him and should not have stopped monitoring him on 1/23/2025 (should have continued until 1/27/2025) and indicated she should have looked at it and it is her responsibility. DON stated the monitoring of the resident would be in the progress notes. DON stated he should have a care plan that indicates he was slapped on the face to indicate if there was any swelling or any changes and indicated he should have had a care plan, and he does not have one. During a concurrent interview and record review of Resident 2 ' s Medication Administration Record (MAR: document to track every dose the resident received) dated 1/1/2025 to 1/31/2025 and Resident 2 ' s care plan on 1/29/2025 at 3:01p.m. with DON, DON stated monitoring of the behavior is documented on the MAR every shift. DON stated on 1/23/2025, it indicated Resident 2 had an order to target behavior (threatening manifested by (m/b) attempting to hit peers). At the end of each shift mark frequency-how often behavior occurred & Intensity-hot resident responded to redirection. Intensity Code: 0=Did Not Occur; 1=Easily Altered; 2=Difficult to Redirect every shift. The MAR indicated Resident 2 was difficult to redirect during the day (7:00a.m. to 3:00p.m.) for both the frequency and intensity. DON stated on 1/24/2025, Resident 2 was difficult to redirect with a number two or three, but the behavior is not specific as to what occurred (do not know if she was pacing). DON stated Resident 2 had a care plan for being aggressive dated 3/20/2023 for verbal aggression wandering, refusing to wear socks, threatening manifested by attempting to hit peers and the care plan was updated on 1/23/2025 noted as striking out at peers, but the interventions were not updated. DON stated despite this new incident, the interventions would remain the same and would not know what other interventions would be implemented separately from what is already implemented (redirect the resident, talk to them, getting medications. DON stated they do not read the care plans and believes they are not necessary as the communication and interacting with peers is more important than a care plan, but without a care plan, they would not know whether the intervention is working or not. (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review of Resident 1 ' s progress record dated 1/23/2025 at 1:20p. m. on 1/30/2025 at 9:20a.m. with DON, the DON stated the incident report and progress report are two separate things and according to the progress notes, it looks as if the nurse did not contact the doctor regarding the incident and would not know whether the doctor was called if there was no incident report and indicated it would be best if the licensed nurses had documented they notified the doctor on the progress notes as part of the residents record. DON stated Resident 1 should have continued monitoring for 72 hours, care plans should have been updated and implemented for Resident 1. During a concurrent interview and record review of the policy Change in a Resident ' s Condition of Status dated May 2017 on 1/30/2025 at 9:23a.m. with DON, the DON stated the policy indicated to notify the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including (for example) information prompted but the Interact SBAR Communication Form. DON stated based on the policy, they should do an SBAR and Resident 1 should have had an SBAR. DON stated the COC is done as it is what the policy states. During a review of the facility ' s P&P titled, Abuse Investigation and Reporting revised 7/2017, the P&P indicated the Administrator will ensure that any further potential abuse, neglect exploitation or mistreatment is prevented. The Administrator will inform the resident and his/her representative of the status of the investigation and measures taken to protect the safety and privacy of the resident. During a review of the facility ' s P&P titled, Change in a Resident ' s Condition or Status revised 5/2017, the P&P indicated a significant change of condition is a major decline or improvement in the resident ' s status that: will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions (is not self-limiting), impacts more than one area of the resident ' s health status; requires interdisciplinary review and/or revision to the care plan. Prior to notifying the Physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including (for example) information prompted by the Interact SBAR Communication Form. The nurse will record in the resident ' s medical record information relative to changes in the resident ' s [NAME]/mental condition or status. During a review of the facility ' s P&P titled, Resident Rights revised 12/2016, the P&P indicated Federal and state laws guarantee certain basic rights to all residents of this facility. these rights include the resident ' s rights to be free from abuse. During a review of the facility ' s P&P titled, Care plans, Comprehensive Person-Centered revised 12/2016, the P&P indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident ' s physical and functional needs is developed and implemented for each resident. The comprehensive, person-centered care plan will: a. Include measurable objectives and timeframes b. Describe the services that are to be furnished to attain or maintain the resident ' s highest practicable physical, mental, and psychosocial wellbeing; g. Incorporate identified problem areas. (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Areas of concern that are identified during the resident assessment will be evaluated before interventions are added to the care plan. Identifying problem areas and their causes and developing interventions that are targeted and meaningful to the resident, are the endpoint of an interdisciplinary process. Care plan interventions are chosen only after careful data gathering, proper sequencing of events, careful consideration of the relationship between the resident ' s problem areas and their causes, and relevant clinical decision making. Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents ' conditions change.		