

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

Printed: 05/28/2025
Form Approved OMB
No. 0938-0391

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 02/25/2025
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 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** 47092 Based on interview and record review the facility failed to report an injury of unknown origin for one of three sampled residents (Resident 1), when Resident 1 had an unwitnessed fall and sustained a left hip fracture (a break in the bone). This deficient practice resulted in the inability of the California Department of Public Health (CDPH) to investigate Resident 1's injury in a timely manner and had the potential for information to be lost and/or forgotten. Findings: During a review of Resident 1's Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including displaced intertrochanteric fracture of right femur (a break in the hip bone), displaced intertrochanteric fracture of the left femur, difficulty walking, and dementia During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 1/10/2025, the MDS indicated Resident 1 was severely cognitively impaired and exhibited wandering behaviors. The MDS indicated Resident 1 used a walker and wheelchair. The MDS indicated Resident 1 required supervision/touching assistance with walking more than 10 feet. During a review of Resident 1's Nursing Progress Note dated 3/22/2025 and timed at 8:30 p.m., the Nursing Progress Note indicated Resident 1 was found on the floor lying on his back in his restroom and was not able to move from side to side or lift his leg. During a review of Resident 1's Physician's Order dated 3/22/2025, the Physician's Order indicated a stat (immediate) Xray (a procedure that produces images inside the body to determine injuries) of both hips. During a review of Resident 1's Radiology Interpretation report dated 3/23/2024 and timed at 1:14 p.m., the Radiology Interpretation report indicated Resident 1 sustained a left hip intertrochanteric fracture with varus deformity (a condition where the distal [away from the center of the body or point of attachment] segment of a bone or joint angles inward [bow leg syndrome] consistent with an acute fracture (a sudden break in a bone caused by traumatic injury), and osteoporosis (weak and brittle bones). (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: 555823	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/25/2025
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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's Physician's Order dated 3/23/2025, the Physician's Order indicated to transfer Resident 1 to a General Acute Care Hospital (GACH) due to a left hip fracture and pain related to a fall. During a review of the GACH's Admission Information (Face Sheet) the Face Sheet indicated Resident 1 arrived in the emergency room (ER) on 3/23/2025 at 3:01 p.m., for a left hip fracture from an unwitnessed fall. During a review of the GACH's Imaging Report dated 3/23/2024 and timed at 4:50 p.m., the Imaging Report indicated Resident 1 sustained a left comminuted intertrochanteric fracture (a severe hip fracture where the bone in the hip region is broken into multiple pieces, with fractured fragments displaced inwards, causing a deformity where the upper leg is angled inwards at the hip joint) with varus deformity (a condition where the distal [away from the center of the body or point of attachment] segment of a bone or joint angles inward [bow leg syndrome]). During a review of the GACH's Surgery Information Record dated 3/24/2025 and timed at 6:22 p.m., the Surgery Information Record indicated Resident 1 had a left hip fracture gamma nail insertion (a surgical procedure to stabilize severe femur fractures). During an interview on 2/18/2025 at 4:32 p.m., Registered Nurse (RN) 2, stated when Resident 1 fell on [DATE] he reported the fracture to the Administrator (ADM) and Registered Nurse (RN) 1, who was the Director of Nursing (DON) at the time. During an interview on 2/19/2025 at 10:14 a.m., RN 1 stated she did not recall anyone reporting Resident 1's fracture to her on 3/22/2024 but stated Resident 1's fall and injury should have been reported to the state agency (CDPH). During an interview on 2/18/2025 at 3:20 p.m., the ADM stated he was not aware of Resident 1's fall and fracture that he sustained on 3/22/2024 and he did not know why Resident 1's fall and injury had not been reported to him. The ADM stated Resident 1's unwitnessed fall and injury, should have been reported to him and the state agency (CDPH) within 24 hours of the Xray report. During a review of the facility's Policy and Procedure (P&P) titled Abuse - Reporting dated 8/1/2024, the P&P indicated the facility shall ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than two hours after an allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and the other officials (including to the State Survey Agency and adult protective services where State law provides or jurisdiction in long-term care facilities).		

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 02/25/2025
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 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** 47092 Based on observation, interview and record review, the facility failed to ensure a resident who was a high fall risk, with severe cognitive (ability to think and reason) impairment, and dementia (a progressive state of decline in mental abilities) did not fall and sustain a right hip fracture (a break in the bone) on 1/23/2025 after a previous fall on 3/22/2024 in which he sustained a left hip fracture (10 months part) for one of three sampled residents (Resident 1). The facility failed to: 1. Monitor Resident 1, who was assessed as a high fall risk and who sustained a previous fall with injury (3/22/2024), to prevent further accidents. 2. Supervise Resident 1 while outside on the facility's patio to prevent the resident from falling. 3. Ensure there was continuous supervision on the facility's patio to monitor Resident 1 and other residents to prevent accidents. 4. Ensure staff responded to the sensor alarm leading to the facility's outside patio exit door on 1/23/2025, when Resident 1 opened the door and exited the building onto the outdoor patio unassisted and unbeknownst to facility staff. These deficient practices resulted in Resident 1 falling on 1/23/2025, sustaining a right hip fracture, which required evaluation and treatment at a General Acute Care Hospital. This deficient practice had the potential for other high fall risk residents to be unsupervised and sustain falls and injuries. On 2/21/2025 at 4:40 p.m., an Immediate Jeopardy ([IJ] a situation in which the facility's noncompliance with one or more requirements of participation caused, or was likely to cause, serious injury, harm, impairment, or death to a resident) was called in the presence of the facility's Administrator (ADM), Director of Nursing (DON), and Social Worker (SW) due to the facility's inability to monitor Resident 1's whereabouts and provide supervision to prevent him from falling and to immediately assist Resident 1 following his fall. On 2/23/2025, the facility submitted an acceptable IJ Removal Plan ([IJRP] interventions to immediately correct the deficient practices). After an onsite verification of the facility's IJRP's implementation through observation, interview, and record review, the IJ was removed on 2/25/2025 at 1:20 p.m., in the presence of the facility's DON, Social Services Director (SSD) and Nurse Consultant. The facility's IJRP included the following immediate actions: 1. The social services department completed an audit of Fall Risk Assessments for all residents to validate the total number of residents at high risk for falls on 2/22/2025 and determined it to be 53 out of 141 residents. (continued on next page)		

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 02/25/2025
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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. The ADM updated the facility's Zoning Map (a facility map showing all areas in the facility) and Monitoring Log (a log used by facility staff to document the whereabouts of residents who are monitored) to include all external walkways, patios, and interior hallways starting on 2/24/2025. 3. New job responsibilities/descriptions were created for staff assigned to zone monitoring which included 15-minute safety rounds. Staff assigned to monitoring will only be assigned to monitoring starting on 2/21/2025. 4. On 2/22/2025 the facility reviewed, and updated care plans for the 53 identified residents at risk for falls. The care plans were updated to include individualized fall prevention interventions and reassessed those residents who required mobility aids for compliance and proper support. 5. The Director of Staff Development (DSD) conducted an in-service training on the Fall/Accident Prevention Program for all nursing staff on 2/23/2025 and 2/24/2025. Topics included were Fall Prevention and Resident Supervision Policies, Timely Response to Alarms and Emergency Situations, Proper Use of Mobility Aids and Resident Transfers, and Accident Investigation and Documentation Procedures. 6. Beginning 2/24/2025 the DON/designee will collect and review Zone Monitoring Logs daily, and the DON and ADM will review trends in resident fall incidents, response times, and staff compliance. Findings: During a review of Resident 1's Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including displaced intertrochanteric fracture of right femur (a break in the hip bone), displaced intertrochanteric fracture of the left femur, difficulty walking, and dementia During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 1/10/2025, the MDS indicated Resident 1 was severely cognitively impaired and exhibited wandering behaviors. The MDS indicated Resident 1 used a walker and wheelchair. The MDS indicated Resident 1 required supervision/touching assistance with walking more than 10 feet. During a review of Resident 1's SBAR ([situation, background, assessment, recommendation] a communication tool used by healthcare workers when there is a change of condition among the residents), dated 3/22/2024, the SBAR indicated Resident 1 had an unwitnessed fall with complaints of left hip pain and slight swelling. During a review of Resident 1's Physician Order dated 3/22/2024, the Physician Order indicated a stat (immediate) Xray (a type of radiation that produces images inside the body to determine injuries) of both hips. During a review of Resident 1's Radiology Interpretation report dated 3/23/2024 and timed at 1:14 p.m., the Radiology Interpretation report indicated Resident 1 sustained a left hip intertrochanteric fracture with varus deformity (a condition where the distal [away from the center of the body or point of attachment] segment of a bone or joint angles inward [bow leg syndrome] consistent with an acute fracture (a sudden break in a bone caused by traumatic injury), and osteoporosis (weak and brittle bones). (continued on next page)		

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

Printed: 05/28/2025
Form Approved OMB
No. 0938-0391

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 02/25/2025
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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of Resident 1's Fall Risk assessment dated [DATE], the Fall Risk Assessment indicated a score of 10 (a score of 10 or higher means there is a high risk for falls). During a review of Resident 1's Physician Order dated 3/28/2024, the Physician Order indicated Resident 1 was to use a front wheel walker ([FFW] (a walking aid with two front wheels and no rear wheels). During a review of Resident 1's at risk for falls Care Plan dated 4/6/2024, the Care Plan indicated its goal was to minimize Resident 1's fall episodes to decrease significant injuries. The Care Plan's interventions indicated staff will anticipate/intervene factors that caused prior falls such as mobility problems, and to use appropriate devices as ordered. During a review of Resident 1's self-care deficit care plan dated 7/12/2024, the Care Plan indicated Resident 1 needed supervision for walking in the room and the corridor, and staff were to assist Resident 1 to ambulate (walk) with his FWW. During a review of Resident 1's Resident Care Conference Note, dated 1/17/2025, the Resident Care Conference Note indicated Resident 1 needed frequent reminders to use his FWW During a review of Resident 1's Nursing Progress Note dated 1/23/2025 at 3:30 p.m., the Nursing Progress Note indicated Resident 1 was found outside on the patio, had an unwitnessed fall, and was unable to move. During a review of the facility's video surveillance footage dated 1/23/2025 and timed at 2:20 p.m., Resident 1 was observed walking on the facility's outdoor patio (known as the Bar B Que patio [a patio where meat is cooked on an outside grill]) unassisted without the use of his FWW as ordered. At 2:39 p.m., (19 minutes after Resident 1 entered the outside patio) Resident 1 attempted to sit down in a chair that was located on the patio but missed the chair and fell to the ground. At 3:23 p.m., (one hour and three minutes after Resident 1 arrived on the outside patio and 44 minutes after Resident 1 fell) staff were seen coming to assist Resident 1. During a review of Resident 1's Progress Note dated 1/23/2025, the Progress Note indicated Resident 1 was transferred to a GACH via 911 at 4 p.m. During a review of the GACH's Admission Information (Face Sheet) dated 1/23/2025, the Face Sheet indicated Resident 1 arrived in the GACH's emergency room (ER) on 1/23/2025 at 4:21 p.m. During a review of the GACH's Xray report dated 1/23/2025, and timed at 5:10 p.m., the Xray report indicated Resident 1 sustained an acute fracture of the right hip. During a review of the GACH's Clinical Note dated 1/25/2025 the Clinical Note indicated Resident 1 had a right hip percutaneous reduction internal fixation with cephalomedullary nail (a surgery that restores length, alignment, and rotation of the femur). (continued on next page)		

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 02/25/2025
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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of the GACH's Discharge Summary dated 1/31/2025, the Discharge Summary indicated Resident 1 had acute (something that begins suddenly and last for a short time) anemia (lack of blood) following a surgical procedure. The Discharge Summary indicated Resident 1's hemoglobin ([HGB] a protein containing iron that facilitates the transportation of oxygen in red blood cells) was 8.8 grams/deciliters ([g/dL] a unit of measurement) (normal range is 13.5 g/dL to 17.5 g/dL) and his hematocrit ([HCT] the volume percentage of red blood cells in the blood) was 26.4% (normal range is 41 to 51%). During an interview on 2/14/2025 at 1:25 p.m., Certified Nursing Assistant (CNA) 2 stated on 1/23/2025, during the 3 p.m. to 11 p.m. shift, she was making rounds when she found Resident 1 on the ground outside on the BBQ patio. CNA 2 stated there were no staff on the patio and Resident 1 did not have his FWW. CNA 2 stated, no one responded to the sensor alarm when Resident 1 exited to the patio, to prevent the resident from falling. During an interview on 2/14/2025 at 4:21 p.m., the DON stated during the facility's daily staff meetings, nursing staff discuss high fall risk residents and residents who require increased supervision. The DON stated she did not recall Resident 1 ever being discussed during those meetings. The DON stated Resident 1 was confused and cognitively impaired and he should have been monitored by nursing staff at least every 15 minutes. The DON stated the frequency of Resident 1's supervision was not documented in his clinical record, and it should have been because he was a high fall risk, had fallen previously (3/22/2024) with a fracture. The DON stated there should have been staff monitoring the BBQ patio exit to prevent high risk residents from falling and getting injured. The DON stated when Resident 1 fell on [DATE], he was alone on the patio and staff did not respond to the exit door alarms to ensure Resident 1's safety. During an interview on 2/18/2025 at 11:19 p.m., Licensed Vocational Nurse (LVN) 2, stated she was assigned to Resident 1 from 7 a.m. to 3 p.m., the day of his fall (1/23/2025) but she was not aware of his fall until the next day (1/24/2025). LVN 2 stated staff was supposed to monitor Resident 1 every 30 minutes because he was confused and would forget to use his FWW, which he needed due to his unsteady and wobbly gait (the manner or pattern of walking). LVN 2 stated she discussed with staff Resident 1's constant need for reminders to use his FWW but nothing was done. LVN 2 stated she did not think about the fact that Resident 1 did not have the ability to learn how to use the FWW or understand the importance of using it. LVN 2 stated staff only monitors the BBQ patio consistently during smoking breaks and it was not safe for Resident 1 to be outside on the patio by himself. During an interview on 2/18/2025 at 2:50 p.m., the DON stated Resident 1 was confused and forgetful and should have been monitored every 15-30 minutes because he was a high fall risk and had previously fallen on 3/22/2024 breaking his left hip. (continued on next page)		

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 02/25/2025
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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 2/19/2025 at 10:14 a.m., the Director of Staff Development (DSD) stated on 1/23/2025, CNA 7 and CNA 8 were assigned to monitor the hallways near the outside patio between 12 p.m. and 3 p.m., and they were also assigned to provide care to other residents. The DSD stated no one was given a dedicated monitoring assignment and everyone was responsible to monitor the residents in the hallway. The DSD stated Resident 1 had a history of not using his FWW and constantly needed redirection, but he was not able to retain information on how to use the FWW since the summer of 2024. The DSD stated it was inappropriate to continue teaching Resident 1 to use the FWW or expect him to use it when he had poor cognition and forgetfulness. The DSD stated staff could not watch Resident 1 all the time, even though he was prone to falls unless they assigned a one-to-one sitter (staff that are immediately at hand to help prevent a fall or redirect a resident from engaging in harmful acts). The DSD stated Resident 1 was not monitored appropriately and should have been, because of his unsteady gait, his previous fall on 3/22/2024 and his confusion/forgetfulness to prevent him from falling and sustaining a fracture on 1/23/2025. During a concurrent interview and record review on 2/20/2025 at 1:23 p.m., with the DON, the Resident Care Conference Note dated 1/17/2025 was reviewed. The Resident Care Conference Note indicated Resident 1 needed frequent reminders to use his FWW. The DON stated the Resident Care Conference Note indicated Resident 1's need for constant reminders to use his FWW was inappropriate because Resident 1 was not able to retain information or learn due to his severe impaired cognition. During an interview on 2/20/2025 at 4:20 p.m., the ADM stated in addition to staff who were assigned to monitor the hallway/exits and the BBQ patio, the facility also had an alarm sensor that sounded off when residents were near the exits, which triggered a camera at the nursing stations as a second line of defense to monitor residents. The ADM stated once the alarms triggered the nurses at the nursing stations and staff who were near the exit doors were supposed to assess the situation in person and via the cameras. The ADM stated on 1/23/2025, no one was monitoring the exits when Resident 1 exited the building onto the BBQ patio. The ADM stated if someone had been monitoring the hallway, patio and cameras, they would have noticed Resident 1 go outside and could have intervened before the resident fell and broke his hip. During a review of the facility's undated Policy and Procedure (P&P) titled Fall/Accident Prevention Program the P&P indicated the interdisciplinary team will determine patterns, situations, and behaviors associated with the fall incidence. The P&P indicated staff will be alerted to those residents at risk and trained in the care plan interventions designed to prevent or reduce repeat falls. The P&P indicated the facility will establish a common method of communication to remind staff to monitor residents to prevent falls on the change of shift report or assignment sheets, and staff will be trained on the care plan interventions designed to prevent or reduced repeated falls.		