STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555823	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Intercommunity Care Center	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** Based on interview and record review, the facility failed to report an injury of unknown origin to the California Department of Public Health (CDPH), when one of three sampled residents (Resident 1) was found on the floor in his room, face down and unresponsive requiring CPR and who subsequently expired at the facility on [DATE] This deficient practice resulted in the CDPH being unaware of Resident 1's injury and the inability of the CDPH to conduct a timely investigation which hindered their efforts to determine the cause of the incident (e.g., fall, assault, or medical event). This deficient practice had the potential for information related to the investigation 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 that included, schizophrenia (mental illness that is characterized by disturbances in thought), glaucoma (a group of eye conditions that damages the nerve in the eye often leading to blindness) and hypertension ([HTN] high blood pressure). During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool), dated [DATE], the MDS indicated Resident 1 had severe cognitive (ability to think and reason) impairment and was sometimes able to understand and be understood by others. The MDS indicated Resident 1 required supervision or touch assistance (helper provides verbal cues and touching/steadying guard as resident completes activity, may be provided throughout the activity or intermittently) to transfer to and from a bed to a chair or wheelchair. During a review of Resident 1's Progress Note, dated [DATE], and timed at 8:20 p.m., the Progress Note indicated on [DATE] at approximately 7:20 p.m., Certified Nursing Assistant (CNA) 1 was walking past Resident 1's room when she found him face down on the floor. The Progress note indicated Licensed Vocational Nurse (LVN) 1 arrived to Resident 1's room, assessed Resident 1 and determined he was unresponsive, without a pulse, blood was coming from his nose and he was not breathing. During a review of Resident 1's Progress Note, dated [DATE], and timed at 8:40 p.m., the Progress Note indicated on [DATE] at approximately 7:45 p.m., paramedics arrived to Resident 1's room and took over resuscitation efforts. The Progress Note indicated at 7:57 p.m., per paramedic's report, Resident 1 was pronounced deceased . During an interview on [DATE], at 4 p.m., the Director of Nursing (DON) stated, she was made aware of Resident 1's injury and death by a nurse (unknown) at the facility but she did not report the incident to the CDPH because she did not consider it a usual occurrence. The DON stated, based on her investigation, Resident 1 may have become unresponsive in bed and fallen to the floor, injuring his nose. The DON stated the incident was unwitnessed, so she could not determine with certainty why Resident 1 was found face down and unresponsive and in hindsight, she should have reported this to the CDPH. During a review the facility's the facility Policy and Procedure (P/P), titled, Abuse Investigation and Reporting revised 7/2017. The P/P indicated all reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	promptly reported to local, state and federal agencies (as defined by current regulations). All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the facility Administrator, or his/her designee, to the following persons or agencies: The state licensing/certification agency responsible for surveying/licensing the facility. An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than: Two hours if the alleged violation involves abuse or has resulted in serious bodily injury, or 24 hours if the alleged violation does not involve abuse and has not resulted in serious bodily injury.

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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 0656 Level of Harm - 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to:Develop and implement an individualized fall prevention care plan, for one of three sampled residents (Resident 1) with interventions including reminding the resident to use a front wheeled walker ([FWW] a mobility aid with two wheels on the front legs and rubber-tipped or sliding legs on the back), and calling for assistance before walking.Implement the facility's Policy and Procedure (P&P) titled Care Planning-Interdisciplinary Team ([IDT]- Residents health care team consisting of variousspecialties), which indicated the Resident's IDT was responsible for the development of an individualized comprehensive care plan for each resident.These failures resulted in Resident 1 falling, sustaining a left femur (thigh bone) fracture (broken bone) which required hospitalization in a general acute care hospital (GACH) for evaluation and treatment.Findings:During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1's diagnoses included schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), bipolar disorder (mood swings that range from the lows of depression to elevated periods of emotional highs), dementia (a progressive state of decline in mental abilities) and abnormality of gait. During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool), dated 10/24/2025, the MDS indicated Resident 1 had severely impaired cognitive (thought process) function for daily decision making. The MDS indicated Resident 1 required supervision (helper provides verbal cue as resident completes activity) for self-care activities such as eating, hygiene, getting dressed and mobility such as sitting, standing and walking. The MDS indicated a mobility device walker (FWW) was used. During a review of Resident 1's Physician Order dated 1/16/2023, the Physician Order indicated Ibuprofen (medication used to treat pain) 100 milligram ([mg], a unit of measurement) give 1 tablet by mouth every eight hours as needed for pain 1-10/10 (pain scale of 0 = pain, 1-3 = mild pain, 4-6 = moderate pain, 7 -10 = severe pain). During a review of Resident 1's Fall Risk Assessment, dated 10/8/2025, the Fall Risk Assessment indicated Resident 1 scored a two. A score above 10 was considered a risk for falls.During a review of Resident 1's Physical Therapy ([PT], a healthcare profession focused on improving movement, reducing pain, and restoring physical function through, exercise, manual therapy, and patient education) Evaluation and Plan of Treatment dated 10/2/2025, the PT Evaluation and Plan of Treatment indicated Resident 1 was to be seen for follow up PT treatments to monitor Resident 1's mobility and educate Resident 1 on safe use of FWW. During a review of Resident 1's PT Treatment Encounter Notes dated 10/2/2025 to 10/28/2025, the PT Treatment Encounter indicated Resident 1 used a FWW as an assistive device for gait training and was supervised for transfers, gait training and sitting. During a review of Resident 1's Nursing Weekly Progress Notes dated 1/6/2026 and timed at 9:50 p.m., the Nursing Weekly Progress Notes indicated (1/6/2026 at 9:40 p.m.) facility staff observed Resident 1 in the hallway walking without her FWW, past room [ROOM NUMBER] then suddenly started running and fell on her left side. The notes indicated Registered Nurse Supervisor (RNS) 1 assessed Resident 1 and assisted resident to bed. Resident stated she did not know what happened and reported a pain level of 3/10 (mild pain) on her left hip. Ibuprofen 100 mg as needed given to Resident 1 for 3 out of 10 mild pain. Resident is resting in bed. The notes indicated staff informed Resident 1's physician that Resident 1 had a fall and complained of left hip pain. New orders given to staff to do stat (immediate) x-ray (a medical imaging test produces pictures of the body's internal structures, primarily bones and dense tissues) of the left hip.During a review of Resident 1's Physician Order List dated 1/2026, the List indicated an order dated 1/6/2026 for a (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	left hip x-ray stat and safety monitoring (resident supervision increased if there is a change in resident's condition) every 30 minutes for 72 hours.During a review of Resident 1's Medication Administration Record (MAR) dated 1/2026, the MAR indicated Resident 1 received ibuprofen 100 mg as follows: 1/6/2026, at 10:00 p.m., for 3/10 left hip pain, and on 1/7/2026 at 9:00 a.m., for 10/10 left hip pain.During a review of Resident 1's x-ray interpretation dated 1/7/2026, the x-ray interpretation indicated there was an acute (sudden onset) fracture of the left thigh bone.During a review of Resident 1's Physician Order dated 1/7/2026, the Physician Order indicated, to transfer Resident 1 to a GACH for further evaluation of left hip.During a review of Resident 1's Fall Risk Assessment, dated 1/7/2026 (the day after Resident 1's fall), the Fall Risk Assessment indicated Resident 1 scored above 10 represents risk for potential fall. Resident 1 scored a ?ve.During a review of Resident 1's GACH Emergency Department (ED) records dated 1/7/2026, the GACH ED records indicated Resident 1 had a fracture of left femur due to a mechanical fall (fall is caused by an external [to the resident] factor) on 1/6/2026. The GACH ED records indicated Resident 1 had 7/10 pain (severe pain) and received ketorolac (a medication used for short-term management of moderate (4-6/10) to severe (7-10/10) pain) 60 mg injection (administered into a muscle with a needle) and a lidocaine patch (a topical, adhesive medicated patch used to relieve pain).During a review of Resident 1's GACH Orthopedic (a medical specialty focused on the diagnosis, treatment, rehabilitation, and prevention of injuries and diseases of the musculoskeletal system, including bones, joints, ligaments, tendons, muscles, and nerves) Consult records dated 1/8/2026, the GACH Orthopedic Consult records indicated Resident 1 had left hip hemiarthroplasty (a surgical procedure to replace the ball of the left hip joint) surgery on 1/8/2026. During a review of Resident 1's medical records, the medical records there was no care plan for Resident 1's risk for falls and use of a FWW. There was no care plan that was developed and/or implemented prior to Resident 1's fall with injury on 1/6/2026.During a concurrent interview and record review on 1/21/2026 at 11:51 a.m., with RNS 1, Resident 1's Nursing Weekly Progress Notes dated 1/6/2026 was reviewed. RNS 1 stated Resident 1 was not ambulating (walking)with her FWW on the day of the fall but should have ambulated with her FWW. RNS 1 stated there was no care plan in place prior to the fall that occurred on 1/6/2026. RNS 1 stated Resident 1 fall prevention care plan should have been created and implemented before Resident 1's fall on 1/6/2026.During an interview on 1/21/2026 at 1:50 p.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 1 was alert and oriented to person and place but had periods of confusion. LVN 1 stated Resident 1 ambulated with a FWW. LVN 1 stated Resident 1 should have been ambulating with a FWW on the day she fell, which may have prevented the fall. LVN 1 stated Resident 1 had periods of confusion and may have forgotten to use her walker when she came out of her room and walked down the hallway. LVN 1 stated staff that saw Resident 1 ambulating without her FWW should have noticed and stopped her from ambulating without her FWW.During a concurrent observation and interview on 1/21/2026 at 2:34 p.m., with Resident 1 in her room, Resident 1 stated on the day of the fall (1/06/2026), she exited her room and was walking down the corridor without her FWW and she fell on her left hip. Resident 1 stated she knew she needed her FWW but forgot to take it with her.During a concurrent interview and record review on 1/22/2026 at 9:41 a.m., with RNS 2, Resident 1's PT Evaluation and Plan of Treatment dated 10/2/2025, Physician Orders List dated 10/29/2025 and the resident's care plan titled Resident Care Plan dated 1/12/2026 were reviewed. RNS 2 stated Resident 1 learned to use a FWW when ambulating during PT sessions in the hallway with the Registered Physical Therapist (RPT-a licensed healthcare professional who diagnoses and treats individuals with movement limitations, injuries, or chronic pain to improve quality of life and restore function). RNS 2 stated when Resident 1 transitioned to the Restorative Nursing (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Assistant (RNA a specialized program focused on rehabilitation techniques that help individuals regain and maintain their highest level of physical functioning, mobility, and independence) Program, the RNA orders indicated Resident 1 was to ambulate with a FWW. RNS 2 stated a care plan was a comprehensive document outlining the interventions, risks, and objectives for the residents' care. RNS 2 stated Resident 1 was a fall risk and used a FWW to ambulate. RNS 2 stated licensed staff should have initiated and implemented a care plan for risk-for-falls with interventions to ensure Resident 1 always used her FWW for ambulating, and the fall could have been prevented.During a concurrent observation and interview on 1/22/2026 at 1:42 p.m., with the Director of Nursing (DON), the video surveillance of the night of the fall was viewed. At 9:43:37 p.m., Resident 1 was observed exiting the room. At 9:43:42 p.m., Resident 1 walked by Certified Nursing Assistant (CNA) 1 and increased her speed. At 9:43:47 p.m., Resident 1 lost her balance and fell to the ground. The DON stated if Resident 1 had her FWW, the FWW could have prevented the fall from happening. The DON stated the IDT did not meet and a care plan was not developed to address Resident 1's risk for falls or use of a FWW. The DON stated a fall risk care plan should have included interventions such as keeping the resident's call light within reach, remove clutter from the room, good lighting, non-skid socks, and reminding Resident 1 to use her FWW. The DON stated Resident 1 was a high fall risk and the care plan should have been implemented before she fell. During a concurrent interview and record review on 1/22/2026 at 4:32 p.m., with the DON, the Fall Risk assessment dated [DATE] and 1/7/2026 were reviewed. The DON stated on 10/8/2025, Resident 1's fall risk score was two and a score above 10 indicated the resident was high risk for falls. The DON stated on 1/7/2026, another Fall Risk Assessment was done, and Resident 1 scored a 5 which indicated Resident 1 was still not a high risk for fall even though Resident 1 fell on 1/6/2026. The DON stated the Fall Risk Assessment was not an accurate assessment of Resident 1's risk for falls because prior to the fall, Resident 1 was not considered a high risk for falls and after the fall, Resident 1 was still not considered a high risk for fall. The DON stated the Fall Risk Assessment did not assess the resident appropriately for risk for falls.During a review of the facility's P&P, titled Care Planning-Interdisciplinary Team, revised September 2013, the P&P indicated the facility's Care Planning/Interdisciplinary Team is responsible for the development of an individualized comprehensive care plan for each resident. The care plan is based on the residents' comprehensive assessment and is developed by a Care Planning/Interdisciplinary Team which includes, but is not necessarily limited to the following personnel such as the resident's Attending Physician; the Registered Nurse who has responsibility for the resident, the Therapists (speech, occupational, recreational, etc.), as applicable; the Director of Nursing (as applicable); the Charge Nurse responsible for resident care; the Nursing Assistants responsible for the resident's care; and others as appropriate or necessary to meet the needs of the residents.During a review of the facility's policy and procedures (P&P) titled, Safety and Supervision of Residents, revised July 2017, indicated resident safety and supervision and assistance to prevent accidents are facility-wide priorities. The interdisciplinary care team shall analyze information obtained from assessments and observations to identify any speci?c accident hazards or risks for individual residents. The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices. Implementing interventions to reduce accident risks and hazards shall include the following such as communicating speci?c interventions to all relevant staff; assigning responsibility for carrying out interventions; providing training, as necessary; ensuring that interventions are implemented; and documenting interventions. The type and frequency of resident supervision may vary among residents and over time for the same resident. For example, resident (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	supervision may need to be increased when there are temporary hazards in the environment (such as construction) or if there is a change in the resident's condition.During a review of the facility's P&P, titled Resident Mobility and Range of Motion, revised July 2017, the P&P indicated, residents with limited mobility will receive appropriate services, equipment and assistance to maintain or improve mobility unless reduction in mobility is unavoidable. As part of the resident's comprehensive assessment, the nurse will identify the resident's current mobility status including his or her ability to walk, limitations in movement or mobility. As part of the comprehensive assessment, the nurse will also identify conditions that place the resident at risk for complications related to ROM and mobility, including gait and balance issues that may lead to falls or fractures. The care plan will be developed by the interdisciplinary team based on. the comprehensive assessment and will be revised as needed. The care plan will include speci?c interventions, exercises and therapies to maintain, prevent avoidable decline in, and/or improve mobility and range of motion. The care plan will include the type, frequency, and duration of interventions, as well as measurable goals and objectives. The residents and representatives will be included in determining these goals and objectives.