STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055995	A. Building B. Wing	08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Convalescent Center of North Long Beach	260 E Market St Long Beach, CA 90805

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 - 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** 45891 Based on observation, interview and record review, the facility failed to ensure the Housekeeper (HK 1) did not run over the resident ' s foot with the laundry cart (a large, blue, storage device with wheels used to deliver residents ' clothing and clean linens in bulk) for one of two sampled residents (Resident 1). Resident 1 sustained left foot fracture. The facility failed to: 1. Ensure Housekeeper (HK 1) did not overfill a laundry cart (a large, blue, storage device with wheels used to deliver residents ' clothing and clean linens in bulk) with clean linen and clothing preventing HK1 to have a clear view when transporting the laundry cart around the facility. On 7/20/2024 HK 1 run over Resident 1 left foot with a laundry cart while transporting it to Station 2. 2. Ensure HK 1 followed the facility policy and procedure titled, Laundry Initiative Module 2: the Six-Step Laundry Process which indicated when delivering clean linen, the clean linen must not be stacked higher than the rim or top shelf of the linen cart and nothing shall be stacked on top of the cart or covering. As a result of this deficient practices Resident 1 sustained a fracture (broken bone) of the left medial (middle) cuneiform (bone in the mid foot) on 7/20/2024 at 7:00 a.m. Resident 1 was sent to a general acute care hospital (GACH) for an evaluation of the left foot fracture. Resident 1 once independent in ambulation (walking) became a wheelchair dependent for mobility after sustaining a left foot injury. Findings: During a review of Resident 1 ' s Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including type 2 diabetes (a problem in the way the body regulates and uses sugar as a fuel), unspecified nondisplaced (the bone typically stays aligned in an acceptable position for healing) fracture of neck of right humerus (upper arm bone), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with your daily life), and generalized anxiety disorder (extremely worried or nervous-even when there is little or no reason to worry about them). (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 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1 ' s Minimum Data Set ([MDS] a standardized assessment and care-screening tool) dated 6/12/2024, the MDS indicated Resident 1 ' s cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making were intact (not affected). The MDS indicated Resident 1 did not use any assistive devices for ambulation. The MDS indicated Resident 1 was able to walk 150 feet ([ft] a unit of measurement of length) with supervision or touching assistance (staff provides verbal cues and/or touching/steadying but the resident completes the activity). During a review of Resident 1 ' s Health Status Note dated 7/20/2024, the Health Status Note indicated the activity staff informed Licensed Vocational Nurse (LVN 1) Resident 1 was complaining of the left foot pain. The Registered Nurse (RN 1) and LVN 1 then assessed Resident 1 and noted Resident 1 had swelling on the left foot and she was not able to bear any weight on the left foot. Resident 1 informed nursing staff she was hit from behind by the big blue linen bucket by HK 1, while ambulating (walking) towards the double doors near the activities room. Resident 1 informed RN 1 and LVN 1 she did not tell anyone about the incident, because HK1 apologized and believed it was an accident. A STAT (immediate) x-ray (picture of the inside structures of the body), ice pack for left foot, and Motrin (medication for pain) was ordered on 7/20/2024 by Resident 1 ' s physician (MD 1). During a review of Resident 1 ' s Change of Condition ([COC] - documentation of a resident ' s sudden change from regular state of being) evaluation dated 7/20/2024, the COC evaluation indicated MD 1 was notified of Resident 1 ' s accident on 7/20/2024 at 12:45 p.m. During a review of Resident 1 ' s care plan initiated on 7/20/2024, focusing on Resident has left foot pain with swelling due to Resident 1 stating, she was bumped into from behind by the big blue laundry bucket, the care plan indicted the goal for Resident 1 was to have pain improving. The car plan interventions included for Resident 1 to wear a controlled ankle movement ([CAM] foot brace that limits ankle and foot movement) boot on the left foot at all times, except when sitting or lying, non-weight bearing (cannot put any weight on that part of the body) on the left foot and remind Resident 1 not to have weight bearing on the left foot. During a review of Resident 1 ' s Radiology (x-ray) Results Report, the Radiology Results Report indicated an x-ray of Resident 1 ' s left foot was done on 7/20/2024 at 2:24 p.m., and the results were reported to the facility on [DATE] at 1:05 p.m. The x-ray report result was as follows: no definite fracture identified; radiologist suggested to obtain additional x-ray views of the foot for further evaluation. During a review of Resident 1 ' s Health Status Note on 7/21/2024, the Health Status Note indicated MD 1 was informed of Resident 1 ' s left foot x-ray results and ordered for Resident 1 to be transferred to the GACH for evaluation of left foot fracture. During a review of Resident 1 ' s GACH emergency room (ER) After Visit Summary, dated 7/21/2024, the ER ' s After-Visit Summary indicated Resident 1 was seen in the ER for foot pain and was diagnosed with a fracture of the left cuneiform bone and was to follow up with an orthopedic (bone doctor) physician in 3 days. Resident 1 was discharged back to the facility on the same day she was seen in the ER, 7/21/2024. The ER ' s After Visit Summary indicated cuneiform fractures could be caused by dropping a heavy object on the foot and could be treated by wearing a boot or brace for several weeks. (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 care plan initiated on 7/21/2024, focusing on Resident has actual pain and discomfort related to incident on 7/20/2024, facility staff accidently ran over her foot with a laundry cart, the care plan indicated the goals for Resident 1 included achieving an acceptable level of pain control. The care plan interventions included obtaining a STAT x-ray, assisting Resident 1 to a position of comfort, utilizing pillows for positioning, and medicating Resident 1 as ordered for pain. During a review of Resident 1 ' s After Visit Summary 1, from her orthopedic physician visit dated 7/29/2024, the After Visit Summary 1 indicated Resident 1 was to always wear the CAM boot except when sitting or lying, needed to be non-weight bearing (on the left foot) for four to six weeks, and would need to go back to the orthopedic physician in six weeks for a repeat x-ray. During a review of Resident 1 ' s Physician ' s Orders Summary Report, the Physician ' s Orders Summary Report indicated an order dated 7/29/2024 for no weight bearing on the left foot. During an observation on 8/5/2024 at 12:35 p.m., a blue laundry cart was parked in the hallway in front of the laundry room. The laundry cart was piled high with clean linens in plastic bags and covered with a white blanket. The approximate height of the laundry cart, including the clean linens was over 5 ft tall. When standing behind it, the laundry cart obstructs the view of the hallway ahead. During an observation and concurrent interview on 8/5/2024 at 12:40 p.m., Resident 1 was sitting at the bedside eating lunch with her foot in a black orthopedic boot. Resident 1 stated that on the day she got injured she was walking toward the double doors on her unit when HK 1 came walking down the hall with the large blue laundry cart piled high with clothing and hit her from behind and ran over her left foot with the laundry cart. Resident 1 stated after HK 1 ran over her foot with the laundry cart, Resident 1 walked to her room to lay down in bed because the pain was excruciating, and she wanted to forget about it. Resident 1 stated she went back to her room, so she did not cry in front of everyone because of the pain and did not tell anyone about it because it was an accident, Resident 1 stated that a little while later HK 1 came to her room and apologized for running over her foot. Resident 1 stated she was able to walk before the accident but now she needed to use a wheelchair to move around in the facility. During an interview on 8/5/2024 at 1:04 p.m., LVN 1 stated Resident 1 was able to walk with a steady gait prior to getting her foot ran over by the laundry cart but now they had to provide her with a wheelchair because she had orders not to bear any weight on the left foot. During an interview on 8/5/2024 at 1:08 p.m., Activities Staff (ACT 1) stated Resident 1 attended activities on 7/20/2024 for a coffee social and around 11 a.m., Resident 1 asked for help back to her room which was unusual for her. ACT 1 asked Resident 1 why she needed help back to her room because she is usually ambulatory without assistance. ACT 1 stated Resident 1 informed her she could not walk because she had a bump on her left foot. ACT 1 stated she called LVN 1 over for help and LVN 1 assessed Resident 1 ' s foot with RN 1 and placed Resident 1 in a wheelchair and took her to her room. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 8/5/2024 at 2:47 p.m., LVN 1 stated that before lunch time (between 11 a.m. and 12 p. m.) on 7/20/2024, ACT 1 informed her that something was wrong with Resident 1 ' s left foot. LVN 1 stated she removed Resident 1 ' s shoes and noted the resident ' s left foot was visibly swollen on the dorsal (top) part. LVN 1 stated Resident 1 stated that her left foot was ran over by a laundry cart that had stacks of clothes in it. LVN 1 stated Resident 1 ' s MD 1 was informed of what had happened to Resident 1 and that her left foot was swollen and tender to the touch. LVN 1 stated Resident 1 verbalized her left foot hurt a lot. During an interview on 8/5/2024 at 3:36 p.m., HK1 did not speak a commonly used language (English) and a housekeeping supervisor (HKS) was translating the interview with HK1. The HK1 stated she was pushing the blue laundry cart into Station 2 from through the double doors and she did not see Resident 1 but heard ouch! HK1 stated she stopped the cart, walked around the cart, and saw Resident 1 there. HK 1 stated Resident 1 told her she (HK1) hit her with the laundry cart. HK1 stated she asked Resident 1 if she was okay and she said yes, she was okay. HK 1 stated she did not see Resident 1 walking in the hallway because the laundry cart was full of clean clothing, and it blocked her view. HK 1 stated the incident occurred around 7 a. m. on 7/20/2024. During an observation and concurrent interview on 8/6/2024 at 8:14 a.m., the blue laundry cart was parked in the hallway by the laundry room, the laundry cart was piled high with residents clothing in plastic bags on hangers and the plastic bags of clothes were covered by a white blanket. HK 1 was standing next to the blue laundry cart and the laundry cart and HK 1 was approximately the same height (HK 1 stated she was 5 ft tall). HK 1 with the scheduler (SCH) as a translator stated the blue laundry cart was the same laundry cart that she was pushing when she hit Resident 1. HK 1 stated the day of the accident, the laundry cart was piled high with clothing as it was during the observation. HK 1 acknowledged the laundry cart was piled too high and was blocking her visual field. During an interview on 8/6/2024 at 11:15 a.m., the Director of Rehabilitation ([DOR] - specializes in techniques to restore muscle function and movement) reviewed Resident 1 ' s Rehabilitation Evaluations from Physical Therapy (PT) and stated Resident 1 was previously discharged from PT Rehabilitation in February 2024 and was not using any assistive devices during that time and was able to walk 150 ft with hardly any assistance. The DOR stated Resident 1 had a high level of function at the time of discharge (2/2024) from Rehabilitation (rehab). The DOR stated Resident 1 was reevaluated for rehab services again on 7/23/2024 by PT and Occupational Therapy (OT) after her accident and now required a wheelchair and non-weight bearing on the left foot due to her injury. The DOR stated Resident 1 had a functional (ability to move and use a joint to perform activities of daily living) decline due to the left foot injury. During an interview on 8/6/2024 at 11:40 a.m., Resident 1 stated she was 5 ft 2 inches tall. Resident 1 stated she was feeling antsy from being stuck in her wheelchair because she likes to walk around. Resident 1 stated she was having a hard time propelling the wheelchair with her arms because she had an old right shoulder injury. Resident 1 stated she was stuck in her room since the accident unless staff pushed her around in the wheelchair. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 8/6/2024 at 12:06 p.m., the Director of Staff Development (DSD) stated to ensure resident safety, staff are to look around the carts when they are pushing them and not have the carts stacked too high, blocking their visual field. The DSD stated if the laundry cart was piled too high there was not a clear view, and someone could get hit with the cart. The DSD stated the accident between HK 1 and Resident 1 could have been prevented if HK 1 had a clear view and was able to see Resident 1. During an interview on 8/6/2024 at 12:37 p.m., the HKS stated HK 1 should have informed the charge nurse on duty or any nursing staff immediately about the accident, even if she thought Resident 1 was okay. The HKS stated the laundry carts should not be filled above the top of the cart. During an interview on 8/6/2024 at 2:15 p.m., the Director of Nursing (DON) stated Resident 1 was ambulatory prior to this incident and was now wearing a CAM boot and would be non-weight bearing for 4-6 weeks. During a review of the facility ' s P/P titled Laundry Initiative Module 2: the Six-Step Laundry Process revised 8/2024, the P/P indicated, when delivering clean linen, the clean linen must not be stacked higher than the rim or top shelf of the linen cart and nothing shall be stacked on top of the cart or covering.