

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055995	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/08/2024
NAME OF PROVIDER OR SUPPLIER  Windsor Convalescent Center of North Long Beach		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45537</p> <p>Based on observation, interview, and record review the facility failed to ensure one of four sampled residents (Resident 1) personal belonging list (inventory list) was updated when Resident 1 received and kept a debit card in his possession and assist Resident 1 in safeguarding the key to Resident 1 ' s bedside drawer.</p> <p>These failures had the potential for Resident 1 ' s belongings to be unaccounted for and his personal items to be unsafe.</p> <p>Findings:</p> <p>During a review of Resident 1 ' s Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE] with a diagnoses including cerebral infarction (damage to the brain from interruption of its blood supply) with left side hemiplegia (paralysis to the left side of the body), hypertension (high blood pressure) with heart failure (a condition that occurs when the heart cannot pump enough blood for the body ' s needs) and depression (a constant feeling of sadness and loss of interest).</p> <p>During a review of Resident 1 ' s Minimum Data Set ([MDS] a standardized assessment and care screening tool), dated 10/13/2023, the MDS indicated Resident 1 was able to make decisions that were reasonable and consistent, had functional limitation to one side of his body and was totally dependent to two or more person assist to complete his activities of daily living (ADLs) such as showering, bed mobility and chair/bed to chair transfer.</p> <p>During a review of Resident 1 ' s Social Services Progress Notes dated 6/19/2024 timed at 3:34 p.m., the Social Services Progress Notes indicated Resident 1 received a new replacement debit card (payment card) in the mail and Resident 1 decided to keep the debit card in his wallet, despite being offered safekeeping of his debit card in the facility.</p> <p>During a review of Resident 1 ' s Inventory of Personal Effects dated 3/21/2019, the Inventory of Resident 1 ' s Personal Effects was unsigned by Resident 1 and was signed by a Certified Nursing Assistant and a Registered Nurse. The Inventory of Personal Effects indicated the following:</p> <p>(continued on next page)</p>

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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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>a. clothes- 2 pairs of jeans (color unspecified), 2 pairs of short pants (color unspecified), 2 long sleeve shirts (color/description unspecified), 4 polo shirts (color/description unspecified), 1 sweater (color/description unspecified), 5 T shirts (color/description unspecified), 2 pairs of brown and yellow pants,</p> <p>b. 1 backpack (color unspecified),</p> <p>c. 1 blue bag</p> <p>d. 1 pair of black sunglasses</p> <p>e. 1 calculator-black</p> <p>f. 1 pair of scissors</p> <p>g. 4 lighters</p> <p>h. 1 knife</p> <p>i. 1 ruler</p> <p>j. 1 cellular phone-black, LG Brand</p> <p>k. 1 HP Laptop computer</p> <p>l. 1 HP laptop charger</p> <p>m. 1 wheelchair</p> <p>n. 2 wallets (color unspecified) = 1 \$20 bill inside of a wallet</p> <p>o. 4 Identification cards= 2 Veteran ' s Association Membership Cards, 1 College Service Card, and 1 California ID Card</p> <p>During an observation and interview on 8/6/2024 at 11:45 a.m., Resident 1 was in his bed watching a television program. Resident 1 bedside drawer was open, exposing some documents, receipts, and a black wallet on top of his bedside table. Resident 1 stated he was comfortable with where his belongings were temporarily placed. Resident 1 stated he informed facility staff on several occasions (dates not specified) that he was unable to find the key to his lockable bedside drawer, leading to worries about the security of his personal items.</p> <p>During an interview on 8/6/2023 at 1:20 p.m., Certified Nursing Assistant 1 (CNA 1) stated Resident 1 liked to keep his items out in the open; however, the nursing staff must offer and/ or assist Resident with keeping his personal items safe and secure.</p> <p>During an interview on 8/6/2024 at 1:33 p.m., CNA 2 stated Resident 1 always needed assistance in organizing his personal items and he had a key to his lockable drawer, which was given to him about seven months ago.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 8/6/2024 at 1:42 p.m., Licensed Vocational Nurse 3 (LVN 3) stated Resident 1 has the right to keep his personal items by his bedside; however, all his belongings must be kept safe in his drawer when not in use and the licensed nursing staff must monitor the key to his bedside drawer.</p> <p>During a concurrent interview and record review on 8/6/2024 at 1:52 p.m., reviewed Resident 1 ' s Inventory of Personal Effects dated 3/21/2019. LVN 1 stated there was no accounting of the debit card on the list. LVN 1 stated all staff were responsible in ensuring the residents ' personal items were tracked and kept safe.</p> <p>During an interview on 8/6/2024 at 2:23 p.m., Registered Nurse Supervisor 1 stated the facility should have an oversight over Resident 1 ' s belongings by ensuring his personal belongings were organized and/or locked away in his bedside drawer when not in use and the designated key should always be at hand and/or kept by the designated staff to ensure his belongings were safe. RNs 1 stated the nursing department, and the social services department must work hand in hand in making sure the residents personal effects inventory lists are consistently updated to ensure accuracy and accountability.</p> <p>During an interview on 8/6/2024 at 2:51 p.m., the Social Service Assistant (SSA) stated Resident 1 ' s missing key should have been identified by facility staff. SSA stated it was the responsibility of the social service department and the nursing department to ensure all the residents ' personal effects were logged timely in the personal effects inventory list to have a baseline for confirmation and identification of a missing item.</p> <p>During an interview on 8/6/2024 at 4:30 p.m., the Director of Nursing Services (DON) stated the facility was the residents ' home and they should feel secure not only physically but also mentally/ psychosocially and all their personal items should be properly accounted for.</p> <p>During a review of the facility ' s Policy and Procedure (P&amp;P) titled, Resident ' s Personal Property dated 8/25/2021, the P&amp;P indicated all of the residents ' property will be listed on the Inventory of Personal Effects Form and any additional items must be added to the list.</p> <p>During a review of the facility ' s P&amp;P titled, Homelike Environment revised 2/2021, the P&amp;P indicated the facility shall provide all the residents with a safe, comfortable, and homelike environment.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45269</p> <p>Based on observation, interview and record review, the facility failed to implement comprehensive plan of care for the use of Plavix (blood thinner medication) on one of four sampled residents (Resident 1).</p> <p>This failure had the potential to result in inadequate monitoring and assessment of Resident 1 ' s bruises on both arms after an allegation of abuse.</p> <p>Findings:</p> <p>During a review of Resident 1 ' s Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE] to the facility with diagnoses that included atherosclerotic heart disease of native coronary artery( buildup of fats, cholesterol and other substances on the blood vessels supplying the heart) , hypertensive heart disease( group of heart problems that develop over many years due to chronic high blood pressure) and hyperlipidemia (condition where there are high levels of fats in the blood).</p> <p>During a review of Resident 1 ' s Minimum Data Set ([MDS] standardized screening tool) dated 6/28/2024, the MDS indicated the resident had an intact cognition (ability to learn, remember, understand, and make decisions), and was dependent on the staff with toileting hygiene, bathing, and bed mobility.</p> <p>During a review of Resident 1 ' s History and Physical (H &amp;P) dated 4/21/2023, the H&amp;P indicated Resident 1 had the capacity to make medical decisions.</p> <p>During a review of Resident 1 ' s Change of Condition Evaluation (COC, communication tool for staff used to document significant changes on a resident ' s condition) dated 7/26/2024, the COC indicated Resident 1 reported to the licensed nurse a Certified Nursing Assistant (CNA) grabbed his arm too hard and left bruises on his left arm. The COC indicated Resident 1 ' s left forearm had multiple scattered ecchymoses(bruising) on left forearm and back of the hand and right arm had discoloration on about 4 centimeters (cm, unit of measurement) in length.</p> <p>During a review of Resident 1 ' s Weekly Summary Documentation dated 7/23/2024, the Weekly Summary Documentation indicated had wound on the sacral coccyx (tailbone) extending to bilateral buttock and no documentation about bruises on both arms were present.</p> <p>During a review of Resident 1 ' s Medication Administration Record (MAR) for July and August 2024, the MAR indicated the resident was receiving Plavix 75 milligrams (mgs, unit of measurement), one tablet one time a day with a start date of 4/5/2023.</p> <p>During a review of Resident 1 ' s MAR for August 2024, the MAR indicated Resident 1 monitored for signs of unusual bleeding every shift for the use of Plavix.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1 ' s Care plan, the care plan indicated the resident had a high risk of bleeding, bruising, and or skin discoloration related to anticoagulant therapy (treatment that uses drug like Plavix to prevent formation of clots) for coronary artery disease (CAD, occurs when the blood vessels supplying blood and oxygen to the heart became narrow and blocked) initiated on 4/21/2023. The Care Plan ' s interventions included to administer Plavix and observe, report to the physician as needed for abnormal or unexplained bruising, petechiae (pinpoint, unraised round spots under the skin caused by bleeding), internal bleeding or other abnormal bleeding.</p> <p>During a concurrent observation and interview on 8/6/2024, at 11:45 a.m. with Resident 1, Resident 1 had diffused areas of dark purplish to maroon colored skin discoloration on left arm and hand. Observed Resident 1 ' s right forearm had scattered areas of ecchymosis. Resident 1 stated CNA1 grabbed his left arm three times.</p> <p>During a telephone interview on 8/6/2024, at 4:43 p.m. with Licensed Vocational Nurse (LVN 2), LVN 2 stated resident on anticoagulant like Plavix should be assessed and monitored for bruising and bleeding. LVN 2 stated her responsibility to observe and monitor for presence of bruises because she administered the medicine. LVN 2 stated if a resident was on Plavix, the resident should be monitored for bruising and bleeding because it was a side effect of the medication, the physician should be notified, and a COC should be done.</p> <p>During a concurrent interview and record review on 8/7/2024, at 8:29 a.m. with Treatment Nurse (TN 1), Resident 1 ' s electronic chart was reviewed. TN 1 confirmed there was no documentation in the medical records of any bruising or skin discoloration prior to the alleged altercation of Resident 1 and CNA 1. TN 1 stated Resident 1 was taking Plavix, and it was common for the resident to have bruises or skin discoloration, but the facility still had to monitor and document presence of bruises.</p> <p>During a concurrent interview and record review on 8/7/2024, 2:45 p.m. with LVN 1, reviewed Resident 1 ' s Weekly Summary dated 7/23/2024 and care Plan, LVN 1 confirmed there was no documentation indicating the resident had bruises on both arms before the alleged incident between Resident 1 and CNA 1. LVN 1 stated Resident 1 ' s bruises or skin purplish discoloration had to be documented because it was a change of condition and required assessment and investigation. LVN 1 confirmed the facility was not following or implementing the Care Plan for the use of Plavix to monitor for presence of bleeding like bruises. LVN 1 stated Care Plan was important so the staff would know the plan of care for Resident 1 who was on Plavix and be aware of the possible side effects of anticoagulant like bruising, bleeding, and low blood count.</p> <p>During a concurrent interview and record review on 8/8, at 4:03 p.m. with Director of Nursing (DON) reviewed Resident 1 ' s Care plan and Weekly Summary, the DON confirmed there was no prior documentation of the presence of bruises on both arms. The DON stated it was overlooked and missed and it was every licensed nurses ' responsibility to assess the skin of all residents. The DON stated Resident 1 could get very aggressive and might have hit an object or rail which could cause the bruising on both arms. The DON confirmed the nurses were not following the Care Plan for the use of anticoagulant. The DON stated Care Plan was important so they would have a guide on how to approach Resident 1 ' s care and treatment.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of facility ' s policy and procedure (P&amp;P) titled ' Care Plan Comprehensive dated 8/25/2021, the P&amp;P indicated The facility ' s Interdisciplinary Team, in coordination with the resident and family or representative must develop and implement a comprehensive person-centered care plan for each resident that includes measurable objectives and time frames to meet a resident ' s medical, physical, mental, and psychosocial needs that are identified. The P&amp;P indicated assessments of residents are ongoing, care plans are reviewed and revised.</p>		