

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 12/10/2024
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 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow resident to participate in the development and implementation of his or her person-centered plan of care.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46415</p> <p>Based on interview and record review, the facility failed to ensure one of three sampled resident 's (Resident 4), who did not have capacity to understand and make decisions, Responsible Parties (RPs 1 and 2), were invited and attended an Interdisciplinary Team (IDT- the resident and or RP along with various healthcare professionals who meet to coordinate the resident's care plan) care conference on /11/22/2024.</p> <p>This deficient practice violated Resident 1 and RPs 1 and 2 right to be informed and active participants to discuss Resident 1 ' s plan of care and services with the IDT and had the potential for a delayed discussion of needed care and services.</p> <p>Findings:</p> <p>During a review of Resident 4's Admission Record (Face Sheet), the Face Sheet indicated Resident 4 was admitted to the facility on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities), type 2 diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing). The Face Sheet indicated RP 1 and RP 2 were listed as contacts.</p> <p>During a review of Resident 4 ' s History and Physical (H&P) dated 11/4/2024, the H&P indicated Resident 4 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 4's Minimum Data Set (MDS- a federally mandated resident assessment tool) dated 11/18/2024, the MDS indicated Resident 4 had moderate cognitive (ability to think and understand) impairment.</p> <p>During a review of Resident 4's Social Services Assessment and Documentation, dated 11/15/2024, the assessment indicated RPs 1 and 2 were involved in Resident 4 ' s care.</p> <p>During a review of Resident 4's Change of Condition (COC) Note, dated 11/22/2024 and timed at 12:30 a.m., the COC indicated Resident 4 was found lying on the floor to the right of his bed. The COC indicated per Resident 4; he was trying to reach for his water pitcher, slid out of bed, and hit the back of his head on the floor.</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 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 4's IDT Care Conference Note, dated 11/22/2024 and timed at 9:24 a.m., the note indicated an IDT care conference was held to discuss Resident 4 ' s fall which occurred at on 11/22/2024 at 12:30 a.m. The IDT Note indicated the Minimum Data Set Nurse (MDSN), Medical Records Director (MRD), Director of Rehabilitation (DOR), Social Services Director (SSD), Case Manager (CM), and Administrator (ADM) were in attendance. There was no documentation on the notes indicating Resident 4 ' s RPs 1 and 2 were present nor involved in what was discussed at the meeting.</p> <p>During a telephone interview on 12/2/2024 at 3:10 p.m., with RP 2, RP2 stated she was not notified by the facility nor given the opportunity to attend an IDT meeting to discuss Resident 4 ' s condition or plan of care after his fall on 11/22/2024. RP 2 stated she was very angry and frustrated with the facility for not giving her the opportunity to participate in the IDT meeting and Resident 4 ' s care. RP 2 stated she had questions regarding Resident 4 ' s fall, what the facility was doing to prevent future falls, and how the facility was monitoring him after the fall which could have been addressed at the IDT meeting.</p> <p>During an interview on 12/10/2024 at 10:45 p.m., with the SSD, the SSD stated the facility did not involve RP 2 in Resident 4 ' s IDT meeting that was conducted on 11/22/2024. The SSD stated RPs 1 and 2 were indicated as an emergency contact for Resident 4 and had the right to participate in resident ' s care planning which included IDT meetings. The SSD stated by failing to contact RPs 1 and 2 to attend the IDT meeting, the facility did not uphold Resident 4 ' s rights to ensure his family (RPs 1 and 2) were involved in his care.</p> <p>During an interview on 12/10/2024 at 12:24 p.m., with the DON, the DON confirmed the facility held an IDT meeting on 11/22/2024 to discuss Resident 4 ' s fall and revise his plan of care. The DON stated the facility should have ensured Resident 4 ' s RPs were included in the IDT meeting and failing to do so caused confusion and RP 2 to feel distrustful of the facility. The DON stated it was a violation of RP 4 ' s rights by not including his RPs in the IDT meeting. The DON stated the RPs should have been given the right to be involved in Resident 4 ' s plan of care.</p> <p>During a review of the facility ' s policy and procedure (P&P) titled, Health, Medical Condition and Treatment Options, Informing Residents of, revised 2/2021, the P&P indicated the information about the resident ' s health is presented at times that are convenient and useful for the resident/representative such as when he/she is asking questions, raising concerns or when a change of treatment is proposed.</p> <p>During a review of the facility ' s policy & procedure (P&P) titled, Resident Representative, revised 2/2021, the P&P indicated the term resident representative is defined as an individual chosen by the resident to act on behalf of the resident to support the resident in decision-making, access medical, social, or personal information of the resident, manage financial matters or receive information.</p> <p>(continued on next page)</p>		

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<p>F 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility ' s P&P titled, The Care Plan Comprehensive, dated 8/25/2021, the P&P indicated the facility ' s interdisciplinary team, in coordination with the resident and or the his family or representative must develop and implement a comprehensive person-centered care plan for each resident that includes measurable objectives and times frames to meet a resident ' s medical, physical, and mental, and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan includes the services that are to be furnished to attain or maintain the resident ' s highest practicable physical, mental, and psychosocial well-being. The IDT team is responsible to evaluation and updating of care plans when there has been a significant change in the resident ' s condition.</p>

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46415</p> <p>Based on interview and record review, the facility failed to notify one of three sampled resident ' s (Resident 4) primary care doctor (MD 1) and Responsible Parties (RPs 1 and 2) when Resident 4 ' s coronavirus disease 2019 (COVID-19 an infectious disease caused by the SARS-CoV-2 virus which affects the respiratory [breathing] system) test was not completed as ordered.</p> <p>This failure resulted in Resident 4 ' s COVID-19 status being unknown and could have resulted in Resident 4 being positive for COVID-19. This deficient practice had the potential to cause a delay in treatment to Resident 4, and result in the spread of COVID-19 to all staff, residents, and visitors in the facility.</p> <p>Findings:</p> <p>During a review of Resident 4's Admission Record (Face Sheet), the Face Sheet indicated Resident 4 was admitted to the facility on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities), type 2 diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing). The Face Sheet indicated RP 1 and RP 2 were listed as contacts.</p> <p>During a review of Resident 4 ' s History and Physical (H&P) dated 11/4/2024, the H&P indicated Resident 4 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 4's Minimum Data Set (MDS- a federally mandated resident assessment tool) dated 11/18/2024, the MDS indicated Resident 4 had moderate cognitive (ability to think and understand) impairment.</p> <p>During a review of Resident 4's Social Services Assessment and Documentation, dated 11/15/2024, the assessment indicated RPs 1 and 2 were involved in Resident 4 ' s care.</p> <p>During a review of Resident 4's Physician Order Recap Report (Physician ' s Orders), dated 11/21/2024, the report indicated Resident 4 was to be tested for COVID-19 via nasal swab (soft tip on a long, flexible stick that goes into the nose to collect a specimen [body fluid sent to lab for testing]) one time only for screening for day one, ordered on 11/21/2024.</p> <p>During a review of Resident 4's Medication Administration Record (MAR), dated 11/2024, the MAR indicated under the COVID-19 test section dated 11/24/2024 and timed at 11:53 a.m., the licensed nurse documented Resident 4 was Away from Center.</p> <p>During an interview on 12/2/2024 at 2:57 p.m., with Resident 4 ' s RP 2, RP 2 stated she was informed by the nursing staff that Resident 4 ' s MD 1 ordered a COVID-19 test. RP 2 stated Resident 4 informed her he was not tested for COVID-19. RP 2 stated she was not notified by the nursing staff that Resident 4 was not tested for COVID-19 prior to his discharge from the facility on 11/24/2024.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 4 ' s Clinical Record, the Clinical Record indicated there was no documentation indicating Resident 4 ' s MD 1, nor RPs 1 and 2 were notified when Resident 4 was not tested for COVID-19 as ordered, on 11/21/2024.</p> <p>During an interview on 12/10/2024 at 12:24 p.m., with the Director of Nursing (DON), the DON stated upon her review of Resident 4 ' s physician orders, the orders indicated a COVID-19 test was to be completed on 11/21/2024. The DON stated she confirmed with the nursing staff that Resident 4 was not tested for COVID-19 as ordered. The DON stated the facility failed to complete Resident 4 ' s physician orders as directed, and the failed to inform Resident 4 ' s MD 1, and RPs 1 and 2 when the COVID-19 was not done. The DON stated this was a violation of residents ' rights and an alteration in Resident 4 ' s plan of care which resulted in a lack of ordered services.</p> <p>During a review of the facility ' s policy and procedure (P&P) titled, Resident Representative, revised 2/2021, the P&P indicated the term resident representative is defined as an individual chosen by the resident to act on behalf of the resident to support the resident in decision-making, access medical, social, or personal information of the resident, manage financial matters or receive information.</p> <p>During a review of the facility ' s P&P titled, Notification: Change in Condition, revised 8/25/2021, the P&P indicated the facility will ensure residents, legal representatives and physicians are informed of resident ' s condition. The facility must immediately inform the resident, consult with the resident physician, and notify consistent with his authority, resident representative when there is a need to alter treatment significantly (need to discontinue or change an existing form of treatment).</p> <p>During a review of the facility ' s P&P titled, Physician Orders, revised 3/22/2022, the P&P indicated the purpose of the policy is ensure that all physician orders are complete and accurate. The P&P indicated whenever possible the licensed nurse receiving the order will be responsible for documenting and implementing the order.</p> <p>During a review of the facility ' s Job description, titled, Registered Nurse (RN), revised 5/2022, the job description indicated the primary purpose of this position is to provide skilled nursing care to residents under the medical direction of the resident ' s attending physician and within the scope of nursing practice for the state. The description indicated the RN will collect and submit specimens for laboratory analysis as ordered.</p>