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	12/24/2024

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. 50387 Based on interview, and record review, the facility failed to treat resident with dignity, when Certified Nurse Assistant (CNA) 1 spoke disrespectfully to one of three residents (Resident 2). This deficient practice had the potential to compromise the resident ' s emotional well-being and violate their right to respectful and dignified care. Findings: During a review of Resident 2 ' s Admission Record, the Admission Record indicated the facility admitted Resident 2 on 5/16/2024, with diagnoses including bipolar disorder (a mental illness that causes extreme mood swings), major depressive disorder (a common mental health condition that involves a persistent low mood or loss of interest in activities), generalized anxiety disorder (a mental health condition that causes excessive and persistent feelings of fear, dread, and uneasiness that can interfere with daily life), and mental and behavioral disorders (conditions that affect your thinking, feeling, mood, and behavior). During a review of Resident 2 ' s Minimum Data Set (MDS-a resident assessment tool), dated 9/20/2024, the MDS indicated Resident 2 was cognitively (the ability to think and process information) intact. During a review of Resident 2 ' s History and physical (H&P), dated 10/31/2024, the H&P indicated Resident 2 had history of bipolar disorder. During a review of Resident 2 ' s untitled Care Plan for mood alteration behavior with increase in verbal aggression, yelling profanities and name calling toward staff members, revised 2/1/2023, the Care Plan indicated the resident explained that he was short tempered, without patience and had a fowl mouth. The care plan intervention included to provide outlet as needed and allow him to soundboard his statements and open-up about his concerns and redirect for positive outlooks when allowed and able to promote dialogue and pleasant experience/interaction. (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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 2 ' s untitled Care Plan for potential changes for mood and behavior, initiated 10/12/2023, the Care Plan indicated the resident had potential changes for mood and behavior related to history of anxiety and schizophrenia. The Care Plan interventions included to -approach resident calmly and unhurriedly, attempt to redirect behavior to something positive, notify MD for any significant change in behavior, and staff would encourage resident to verbalize his feelings and provide reassurance as needed. During a review of Resident 2 ' s Nurses Progress Note, dated 12/22/2024 at 7:20 pm, the Progress Note indicated the resident had a verbal altercation incident with a staff member. During an interview on 12/24/2024 at 10:14 a.m., the Administrator (ADM) stated that a verbal altercation occurred in Resident 2 ' s room between CNA 1 and Resident 2 on 12/22/2024 around 7 p.m. The ADM stated that Resident 2 initiated the interaction by using derogatory phrases toward CNA 1. CNA 1 walked out of Resident 2 ' s room but, upon returning to the room to pick up the resident ' s tray, Resident 2 continued speaking negatively to CNA 1. The ADM stated that it was CNA 1 ' s breaking point, and her voice was escalated as she began speaking very loudly. The ADM stated that other staff members overheard CNA 1 being upset. During an interview on 12/24/2024 at 11:31 a.m., with Resident 2, the resident refused to participate in an interview regarding the altercation. During an interview on 12/24/2024 at 11: 44 a.m., CNA 2 stated that on 12/24/2024, Resident 2 repeatedly called CNA 1 n-word and made inappropriate sexual comments. CNA 2 stated that there was a verbal exchange between Resident 2 and CNA 1. CNA 2 acknowledged that CNA 1 should have walked away and reported the incident to her supervisor to prevent further escalation. During an interview on 12/24/2024 at 12:36 p.m. Licensed Vocational Nurse (LVN) 2 stated that she arrived at the scene after hearing commotion down the hall and witnessed an altercation between Resident 2 and CNA 1. LVN 2 observed that Resident 2 and CNA 1 were yelling back and forth, with both becoming louder. LVN 2 stated that Resident 2 is known for such behaviors and staff should address his concerns and frustration to de-escalate the situations while maintaining professionalism. LVN 2 sated, that the situation could have been resolved differently without staff yelling back at the resident. During an interview on 12/24/2024 at 1:35 p.m. the Director of Nursing (DON), stated that CNA 1 ' s response to Resident 2 was not appropriate, CNA 1 could have responded calmly by expressing that the resident ' s tone was not acceptable and indicating that she would return later if the resident still required assistant. Alternatively, the CNA 1 could have requested the charge nurse to reassign another CNA to take care of the resident, which could have helped de-escalate situations. During an interview on 12/24/2024 at 1:54 p.m. with the ADM, the ADM acknowledged that the CNA did not maintain professionalism when responding to the resident ' s behavior, which was already documented in the resident ' s care plan. The ADM acknowledged that the interaction could have potentially caused distress to Resident 2. (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility ' s policy and procedure (P&P) titled, Dignity, revised February 2021, indicated that 1. Resident are treated with dignity and respect at all times, 8. Staff speak respectfully to residents at all times. 12. Demeaning practices and standards of care that compromise dignity are prohibited.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 50387 Based on interview and record review, the facility failed to document a resident had refused a physician ' s visit for one of three residents (Resident 1) when Resident 1 refused psychiatric care and treatment. This failure has the potential to result in Resident 1 ' wishes and rights not being respected or miscommunicated among staff. Findings: During a review of Resident 1 ' s Admission Record, the Admission Record indicated the facility admitted Resident 1 on 4/26/2024, readmitted him on 10/17/2024 with diagnoses including depression (a mental health condition that involves persistent feelings of sadness, loss of interest, and difficulty functioning in daily life), and anxiety disorder (a condition that causes excessive and persistent feelings of fear, dread, and uneasiness that can interfere with daily life.) During a review of Resident 1 ' s physician ' s Subjective, Objective, Assessment, and Plan-(SOAP - a standardized method of documentation sed by healthcare providers to record patient care) note, dated 12/22/2024, the Physician ' s SOAP indicated, Resident 1 had the mental capacity to make medical decisions. During a review of Resident 1 ' s Minimum Data Set (MDS- a resident assessment tool), dated 10/29/2024, the MDS indicated that Resident 1 was cognitively (the ability to think and process information) intact and the resident did not have signs or symptoms of delirium (a sudden and sever change in brain function that causes confusion, disorientation and difficulty thinking clearly). During a review of Resident 1 ' s Nurses Progress Notes, dated 12/6/2024, the Nurses Progress Notes indicated Resident 1 declined Psychiatric Nurse Practitioner (NP) ' s visit on 11/19/2024 and the NP would attempt to see him again. During a concurrent interview and record review on 12/23/2024 at 1:58 p.m. with Licensed Vocational Nurse (LVN) 1, Resident 1 ' s Progress Note, dated 12/15/2024-12/22/2024 were reviewed. LVN 1 stated that there was no documentation regarding a physician visit or any indication of the resident refusing the visit or care on 12/16/2024. During an interview on 12/23/2024, at 2:50 p.m., Resident 1 stated that he had a Nurse Practitioner (NP) visit on 12/16/2024 and could not recall the exact name of the NP. He believed that the NP was a psychiatric NP and noted that he had previously refused psychiatric treatment and psychiatrist as his legal choice and his right to have his decision respected. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/24/2024, at 8:43 a.m., the Social Service Director (SSD) sated that she was aware of the NP ' s visit and had been informed by the Director of Nursing (DON) about Resident ' s refusal of being seen by the NP. The SSD stated a few days later, DON informed the SSD about a phone call from a detective regarding a complaint about a NP ' s visit, which the SSD assumed was related to Resident 1. The SSD acknowledged that she had not documented the NP visit in the resident ' s chart that week and sated that she should have done so as soon as possible. The SSD stated the importance of documenting physician or NP visits to ensure continuity of care, encourage patient engagement, and accurately track the care offered. The SSD also stated that proper documentation is essential for appropriate interventions while respecting the resident ' s right and decisions. During an interview on 12/24/2024 on 9 a.m., the DON acknowledged that Resident 1 ' s Progress Note did not reflect Psych NP ' s visit on 12/16/2024, nor did they document the Resident ' s wishes regarding refusal of psychiatric care or consultation. The DON sated that either Nursing or SSD should have documented the visit to facilitate communication among staff, address resident ' s needs, follow up on recommendations, and ensure concerns are properly addressed. The DON sated that documentation should be completed promptly, no later than 72hrs. During a review of the facility ' s policy and procedure (P&P) titled, Nursing Documentation, dated 6/27/2022, indicated timely entry of documentation must occur as soon as possible after the provision of care and in conformance with time frames for completion. During a review of the facility ' s P&P titled, Guidelines for Charting and Documentation, revised April 2012, indicated general rules for charting and documentation - chart as often as necessary and as the need arises. 12. Documentation should also include: each time a physician visits the resident.