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	07/11/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure the call light (alerts care givers that the resident required assistance) were within reach for two out of four sampled residents (Resident 4 and Resident 5).As a result of this deficient practice Resident 4 and Resident 5 were at risk of not having their needs met in a timely manner Findings:During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was admitted to the facility on [DATE] with diagnoses including hemiplegia (unable to move one side of the body) affecting the left side, muscle weakness, and contractures (shortening of muscles, tendons, skin, and nearby soft tissues that causes the joints to shorten and become very stiff, preventing normal movement) of the left hand and left ankle.During a review of Resident 4's minimum data set (MDS, a resident assessment tool) dated 4/1/2025, the MDS indicated Resident 4 had moderate cognitive impairment (a slight decline in thinking and memory). The MDS indicated Resident 4 was dependent (helper does all the effort) on staff for toileting, bathing, dressing, and personal hygiene.During a review of Resident 5's admission Record, the admission Record indicated Resident 5 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), muscle weakness, and contractures.During a review of Resident 5's MDS dated [DATE], the MDS indicated Resident 5 was severely cognitively impaired. The MDS indicated Resident 5 was dependent on staff for toileting, bathing, dressing, and personal hygiene.During an observation and concurrent interview on 7/10/2025 at 3:49 p.m., Resident 4 was lying in bed in his room calling out for help into the hallway. Upon entering Resident 4's room, Resident 4's call light along with his roommate (Resident 5)'s call light were on the floor next to the residents' beds, out of reach. Resident 4 stated he needed help and needed his call light off the floor.During an observation and concurrent interview on 7/10/2025 at 3:51 p.m., the Director of Nursing (DON) entered the room of Resident 4 and Resident 5's room, picked the call lights off the floor and put them within reach for both residents. Resident 4 informed the DON he wanted his laptop out of the social services director's (SSD) office. The DON stated when she entered Resident 4 and Resident 5's room the call light was not in reach for either resident and there was a potential the residents' needs would not be met.During a review of the facility's policy and procedure (P/P) titled Answering the Call Light dated 10/24/2025, the P/P indicated facility staff were to ensure the call light was accessible to the resident when in bed.

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect two out of four sampled residents (Resident 1 and Resident 2) from verbal abuse (mental abuse that involves the use of oral or written language directed to a victim. Verbal abuse can include the act of harassing [unwanted offensive or humiliating comments or behavior], insulting [a rude expression intended to offend or hurt), scolding (point out and criticize some fault or error, often angrily], criticize sharply, or excessive yelling towards an individual) and neglect (in the context of caregiving, neglect is a form of abuse where the perpetrator, who is responsible for caring for someone who is unable to care for themselves, fails to do so) by certified nursing assistant (CNA) 1.As a result of this deficient practice Resident 1 felt upset and Resident 2 felt bad, like a burden, and upset. Both Resident 1 and Resident 2 requested that CNA 1 was not assigned (designated) as their CNA anymore. 1.During a review of Resident 1's admission Record (face sheet), the admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including hemiplegia (unable to move one side of the body) affecting the left side, contractures (a shortening of muscles, tendons, skin, and nearby soft tissues that causes the joints to shorten and become very stiff, preventing normal movement) of multiple sites, and major depressive disorder (persistent feelings of sadness and loss of interest).During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool) dated 6/18/2025, the MDS indicated Resident 1 was cognitively (the processes of thinking and reasoning) intact. The MDS indicated Resident 1 was dependent (helper does all the effort) on staff for toileting, dressing, showering, rolling left to right, and personal hygiene. 2. During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was admitted to the facility on [DATE] with diagnoses including dysarthria (weakness in the muscles used for speech, which often causes slowed or slurred speech), encephalopathy (damage or disease that affects the brain), and lack of coordination.During a review of Resident 3's MDS dated [DATE], the MDS indicated Resident 3 had moderate cognitive impairment.3. During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including cervical spine (uppermost segment of the spine that's located in the neck) injury, lack of coordination, and neuromuscular dysfunction of bladder (refers to what happens when an injury or disease interrupts the electrical signals between your nervous system and bladder function).During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2 was cognitively intact. The MDS indicated Resident 2 used a wheelchair for mobility. The MDS indicated Resident 2 was dependent on staff for showering and lower body dressing. The MDS indicated Resident 2 required substantial/ maximum assistance (helper does more than half the effort) for toileting, oral hygiene, upper body dressing, and to move from lying to sitting. The MDS indicated Resident 2 required partial/ moderate assistance (helper does less than half the effort) to transfer from the bed to the chair.During a review of CNA 1's Employee Corrective Action notice dated 6/5/2025, the Employee Corrective Action Notice indicated CNA 1 performed unsatisfactory customer service and failed to follow instructions, by CNA 1 being observed standing right across two resident rooms (unknown) that had call lights on, and CNA 1 failed to answer the call buttons for either room. The Employee Corrective Action note indicated CNA 1 refused to sign the corrective action.During a review of the facility's Nursing Assignment 7 a.m.- 3 p.m., Shift dated 7/3/2025, CNA 1 was assigned to Resident 2.During a review of the facility's Nursing Assignment 7 a.m.- 3 p.m., shift dated 7/8/2025, CNA 1 was assigned to Resident 1.During a review of Resident 1's Complaint/ Grievance Report filed on 7/8/2025, the Complaint/ Grievance Report indicated Resident 1 complained CNA 1 had poor customer service and he did not want CNA 1 assigned to him anymore.During a review of Resident 2's Complaint/ Grievance Report filed 7/8/2025, the Complaint/ Grievance Report indicated Resident 2 complained CNA 1 had poor customer service and Resident 2 stated he had to wait awhile to get changed.During an interview on 7/10/2025 at 2:01 p.m., CNA 2 stated she felt as though CNA 1 was just coming to work to collect a paycheck and it did not seem as though she wanted to be at work. CNA 2 stated a few days prior (7/8/2025), Resident 1 complained about CNA 1's attitude.During an interview on 7/10/2025 at 3:23 p.m., Resident 1 stated CNA 1 was mean, always seemed angry, and made it seem as though she did not want to be at work. Resident 1 stated he reported CNA 1 to the Director of Staff Development (DSD) because on 7/8/2025 he needed help getting changed because his adult incontinence briefs (disposable garments designed for individuals experiencing lack of voluntary control of urinary or bowel) were wet and CNA 1 did not respond when he pressed his call button (alerts care givers that the

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to monitor the fluid intake (the amount of liquids consumed by an individual) for one out of two sampled residents (Resident 6), who was at risk of dehydration (a dangerous loss of body fluid caused by illness, sweating, or inadequate intake).As a result of this deficient practice Resident 6 was placed at risk for developing dehydration. Resident 6 was readmitted to a general acute care hospital (GACH) with a diagnosis of severe dehydration on 6/29/2025.During a review of Resident 6's admission Record, the admission Record indicated Resident 6 was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses of hypernatremia (high concentration of sodium [salt] in blood which most often occurs from not drinking enough fluids), acute kidney failure (AKI, when the kidneys suddenly can't filter waste products from the blood), and Alzheimer's disease (a progressive disease that destroys memory and other important mental functions).During a review of Resident 6's minimum data set (MDS, a resident assessment tool) dated 6/9/2025, the MDS indicated Resident 6 had severe cognitive (relating to or involving the processes of thinking and reasoning) impairment and required partial/ moderate assistance (helper does less than half the effort). During a review of Resident 6's untitled Care Plan dated 6/23/2025, the focus of the care plan was, Resident 6 was at risk for dehydration as evidenced by AKI, recent hospitalization (5/26/2025), and hypernatremia. The care plan goal was Resident 6 would not exhibit signs or symptoms of dehydration. The Care Plan interventions included monitoring for signs and symptoms (S/S) of dehydration (S/S not specified) and offering/ encouraging/ assisting Resident 6 with fluid intake. During a review of Resident 6's Documentation Survey Report- Tasks for the months of 6/2025 and 7/2025, Resident 6 did not have any entries for Fluid Intake every shift.The Documentation Survey Report indicated facility staff were not monitoring and documenting Resident 6's fluid intake during the months of 6/2025 and 7/2025.During a review of Resident 6's GACH record titled History and Physical (H&P) dated 6/29/2025, the H&P indicated Resident 6 was readmitted to the GACH on 6/29/2025. The H&P indicated Resident 6 appeared very dehydrated and had severe hypernatremia likely due to dehydration.During a concurrent interview and record review on 7/10/2025 at 2:26 p.m., with certified nursing assistant (CNA) 3, Resident 6's Task documentation was reviewed. CNA 3 stated Resident 6 was not able to eat and drink on his own, he was a total feeder (staff must feed him and provide fluids). CNA 3 stated staff always offer Resident 6 water with his meals, but he always pushes it away. CNA 3 stated the CNAs chart how much a resident drinks each shift under Tasks- Fluid Intake. CNA 3 reviewed Resident 6's Task and stated Resident 6 did not have a Task to monitor Fluid Intake. CNA 3 stated there was nowhere else the CNAs would chart how much a resident was drinking each shift.During a concurrent interview and concurrent interview on 7/11/2025 at 10:53 a.m., with the director of nursing (DON), Resident 6's Task- Fluid Intake were reviewed. The DON stated Resident 6 was elderly and had advanced Alzheimer's disease placing him at risk of dehydration. The DON stated it was important to track Residents' (general) fluid intake for residents at risk of dehydration. The DON stated the facility tracked residents' fluid intake by inputting the information under Tasks-Fluid Intake. The DON stated she reviewed Resident 6's Tasks- Fluid Intake but there was no active task, and she did not know why because Resident 6 was at risk for dehydration. The DON stated it was important to monitor fluid intake because they want to maintain hydration and nutrition.During a review of the facility's policy and procedure (P/P) titled Resident Hydration and Prevention of Dehydration dated 3/4/2025, the P/P indicated if a resident had potential inadequate intake or signs and symptoms of dehydration, intake and output monitoring was to be initiated and incorporated into the plan of care.