STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056283	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bixby Knolls Towers Health Care & Rehab Center	3747 Atlantic Avenue Long Beach, CA 90807

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47092 Based on interview, and record review, the facility's nursing staff failed to monitor and assess urine output and urinary retention for a resident, who was at risk for urinary retention (difficulty completely emptying the bladder) due to a diagnosis of benign prostatic hypertrophy ([BPH] a condition that causes the prostate gland to enlarge making it harder for the bladder to push out urine and can lead to urinary retention and a urinary tract infection ([UTI] an infection in any part of the urinary system such as kidneys, bladder, ureters, and urethra) for one of three sampled residents (Resident 1). The facility failed to: 1. Ensure Certified Nursing Assistant (CNA 2) and CNA 3 reported to licensed nursing staff when Resident 1 had a dry diaper (no urine output) during their eight hour shift. 2. Ensure licensed nurses conducted a physical assessment of Resident 1 to determine if he was in pain, had abdominal distension (a condition where the bladder stretches and becomes inflamed due to pressure when the bladder does not empty properly), a decrease in urine output and/or the inability to urinate, and did not rely on CNAs to report signs and symptoms (s/s) of urinary retention, including a dry diaper that they were not trained to detect, and it was not the CNA's scope of practice. 3. Ensure nursing staff followed the facility's policy and procedure titled, Resident Hydration and Prevention of Dehydration which indicated the fluids intake and output monitoring will be initiated for those residents with the potential of inadequate intake or output and incorporated into the care plan, and nursing staff will assess factors that may be contributing to inadequate fluid intake and output, monitor and document fluid intake and output. These deficient practices resulted in licensed nurses not recognizing that Resident 1 had no documented urine output for over 24 hours. Resident 1 was transferred to a General Acute Care Hospital (GACH) for evaluation and treatment after suffering a seizure (uncontrolled electrical activity in the brain, which may produce a physical convulsion, thought disturbances, or a combination of symptoms) on 8/6/2024. At the GACH Resident 1 was diagnosed with a UTI, severe sepsis (a life-threatening condition that occurs when sepsis [an inflammatory response to an infection] causes one of more of the body's organs to malfunction because of a low blood pressure (B/P) resulting from inflammation throughout the body), and urine retention with 1900 milliliters ([ml] a unit of liquid measurement) of urine in Resident 1's bladder. Findings: (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056283	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bixby Knolls Towers Health Care & Rehab Center	3747 Atlantic Avenue Long Beach, CA 90807

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 0684 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including secondary malignant neoplasm of the brain (cancer that spread to the brain), BPH, and acute kidney failure (when kidneys suddenly lose their ability to function). During a review of Resident 1's Care Plan dated 8/2/2024, the Care Plan indicated Resident 1 had an impaired nutrition and hydration status. One of the Care Plan's interventions included to observe and report if the resident had a decreased urine output, dark urine, and increased confusion. During a review of Resident 1's Fluids Flow Sheet dated 8/3/2024 through 8/6/2024, the Fluids Flow Sheet indicated Resident 1 ingested of 300 ml of fluid on 8/3/2024, 620 ml of fluid on 8/4/2024, 420 ml of fluid on 8/5/2024, and 120 ml of fluid on 8/6/2024, a total of 1460 ml. The Fluids Flow Sheet indicated there was no documentation of Resident 1's fluid output (urine quantity). During a review of Resident 1's Documentation Survey Report dated 8/2024, the Documentation Survey Report indicated Resident 1 was incontinent (involuntary voiding of urine and/or stool) of urine on 8/1/2024, 8/3/2024, 8/4/2024, 8/5/2024, and 8/6/2024. Continued review of the Documentation Survey Report indicated there was no documentation if Resident 1 had urine output. During a review of Resident 1's Situation Background Assessment Recommendation ([SBAR] a form of communication between members of a health care team) dated 8/6/2024 and timed at 8:10 a.m., the SBAR indicated Resident 1 was to be transferred to a GACH via 911 due to uncontrolled seizures. During a review of Resident 1's Emergency Medical Services record dated 8/6/2024 and timed at 8:19 a.m., the Emergency Medical Services record indicated paramedics responded to a 911 call at the facility and upon arrival Resident 1 was noted with shortness of breath (SOB). The Emergency Medical Services Record indicated Resident 1 had an Oxygen saturation ([O2 Sat] a measurement of how much oxygen is in the blood, reference, range is 95% to 100%) level of 81% on room air (without administration of O2), was hypotensive (below normal B/P) with a B/P of 87/65 millimeters of mercury ([mmHg] a unit of B/P measurement. B/P reference range is 120/80) and tachycardic (when the heart rate (HR) is too fast) with a HR of 135 beats per minute ([bpm] HR reference range is 60-100 bpm). During a review of the GACH's Encounter Information dated 8/6/2024, the GACH's Encounter Information indicated Resident 1 arrived at the GACH's emergency room (ER) on 8/6/2024 at 8:49 a.m. During a review of the GACH's Nephrology Consult Note dated 8/6/2024 and timed at 3:02 p.m., the Nephrology Consult Note indicated Resident 1 was admitted to the Intensive Care Unit ([ICU] a unit in a hospital that manages patients who are critically ill) for acute kidney injury related to urinary retention, a UTI, severe sepsis, and hypoxic respiratory failure (occurs when the lungs are not able to get not enough oxygen in the blood and deprives the body's organs and tissues of oxygen). The Nephrology Consult Note indicated Resident 1's kidney function normalized after a urinary indwelling catheter (a flexible tube inserted into the bladder to collect and drain urine) was placed in Resident 1's bladder. During a review of the GACH's Shift Outcome Evaluation record dated 8/6/2024 and timed at 7:21 p.m., the Shift Outcome Evaluation record indicated Resident 1's urinary bladder scan (a procedure that measures the volume of urine in the bladder) indicated Resident 1's bladder had 1900 ml of urine. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056283	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bixby Knolls Towers Health Care & Rehab Center	3747 Atlantic Avenue Long Beach, CA 90807

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 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on 8/13/2024 at 1:47 p.m., CNA 2 stated she cared for Resident 1 on 8/5/2024 from 7 a. m. to 3 p.m. and on 8/6/2024 from 7 a.m. until Resident 1 was transferred to the hospital around 8:30 a.m. CNA 2 stated on 8/5/2024 Resident 1's diaper was dry until he went to radiation therapy (a cancer treatment that uses high doses of radiation to kill cancer cells and shrink tumors) at 1:30 p.m. CNA 2 stated Resident 1 did not return during her shift on 8/5/2024. CNA 2 stated on 8/6/2024 in the morning Resident 1 was lethargic (a state of weariness that involves diminished energy, mental capacity, and motivation) and confused, he could not remember how to put a spoon in his mouth during breakfast. CNA 2 stated sometime between 7:45 a.m., and 8:15 a.m., on 8/6/2024 Resident 1 had a seizure and was transferred to the GACH. During an interview on 8/13/2024 at 2:12 p.m., Licensed Vocational Nurse (LVN 1) stated if a resident had a dry diaper without any urine output halfway through the shift (four hours or more), she would assess the resident for bladder distention and she would inform the physician because the resident could be retaining urine. During an interview on 8/14/2024 at 9:40 a.m. Registered Nurse 1 (RN 1) stated, the registered nurses perform head to toe assessments ([comprehensive assessment] a physical exam that nurses perform to evaluate a resident's health status and identify potential issues) when admitting residents to the facility and when there is a change of condition ([COC] a sudden and significant change in a resident's physical, cognitive, behavioral, or functional state indicative of acute illnesses). RN 1 stated comprehensive assessments were not performed on residents daily but were prompted by concerns identified by CNAs and LVNs. During a concurrent interview and record review on 8/14/2024 at 10:22 a.m., with RN 1, Resident 1's Physician's Order dated 8/1/2024 was reviewed. The Physician's Order indicated Resident 1 was to receive Tamsulosin (used to treat men with symptoms of an enlarged prostate (benign prostate enlargement) for BPH. RN 1 stated residents who have a history of BPH should be monitored for urine output and urinary retention. During an interview on 8/15/2024 at 8:34 a.m., CNA 3 stated on 8/4/2024 during the 7 a.m. to 3 p.m., shift Resident 1's diaper was dry and without urine all shift. CNA 3 stated he did not report Resident 1's diaper was dry (without urine) for 8 hours because he did not realize it was unusual and needed to be reported. During an interview on 8/15/2024 at 10:52 a.m., LVN 2 stated she was Resident 1's assigned nurse on 8/5/2024 from 7 a.m. to 3 p.m., and during that time Resident 1 was awake but did not respond to questions. LVN 2 stated she was not aware that this was a change in Resident 1's condition because this was her first time caring for Resident 1. LVN 2 stated she should have reviewed Resident 1's clinical record to determine if this was Resident 1's normal behavior or not. LVN 2 stated she was not aware that she should monitor Resident 1 for urinary retention, and no one informed her that Resident 1's diaper had been dry, without urine on 8/5/2024 during the day shift. During an interview on 8/15/2024 at 12:20 p.m., the Director of Staff Development (DSD) stated CNAs cannot perform assessments and are not taught the s/s of urinary retention or dehydration, but they are instructed to report to a licensed nurse about dry diapers, refusal of care, and refusal to eat. The DSD stated licensed nurses should look at the resident's care plan and they are responsible for communicating care needs and what CNAs should look out for while caring for a resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056283	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bixby Knolls Towers Health Care & Rehab Center	3747 Atlantic Avenue Long Beach, CA 90807

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 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on 8/15/2024 at 1:48 p.m., LVN 2 stated she was Resident 1's assigned nurse on 8/5/2024 from 7 a.m. to 3 p.m. and was not aware of Resident 1's hydration care plan because during morning report, only Resident 1's increased confusion was mentioned. LVN 2 stated licensed nurses were responsible for assessing residents for dehydration and they should have been monitoring Resident 1 for urinary retention every shift as ordered by the physician for administration of Seroquel. During an interview on 8/15/2024 at 2:13 p.m., the Assistant Director of Nursing (ADON) stated licensed nurses were responsible for reviewing resident's care plans to implement interventions, especially when working with a resident for the first time. The ADON stated CNAs do not have access to care plans so licensed nurses were responsible for communicating the plan of care to the CNAs. The ADON stated when a care plan's interventions indicated to observe and report s/s of dehydration it was not appropriate to rely on CNAs to assess and report information to the licensed nurse, because assessment required a licensed nurse to lay their eyes on the resident to determine the resident's status. During a review of facility's Policy and Procedure (P&P), titled Resident Hydration and Prevention of Dehydration, dated 10/2017, the P&P indicated the fluids intake and output monitoring will be initiated for those residents with the potential of inadequate intake or output and incorporated into the care plan. The P&P indicated nursing staff will assess factors that may be contributing to inadequate fluid intake and output, monitor and document fluid intake and output.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056283	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bixby Knolls Towers Health Care & Rehab Center	3747 Atlantic Avenue Long Beach, CA 90807

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47092 Based on interview and record review, the facility failed to ensure for one of three sampled residents (Resident 1), who was prescribed and administered an anti-psychotic medication (a class of medication primarily used to manage psychosis [a condition of the mind that results in difficulties determining what is real and what is not real) (Seroquel), that the medication was prescribed and administered for appropriate indications, detailed evidence of Resident 1's behavior(s) were documented, non-pharmacologic interventions were attempted and evaluated prior to the administration/continuance of the medication, physician, psychiatric and/or psychological and nursing evaluations were conducted and evaluated to determine if continued use of Seroquel was warranted. This deficient practice resulted in Resident 1 receiving an unnecessary anti-psychotic medication and placed Resident 1 at risk for adverse reactions associated with the medication's use, chemical restraints, falls and death. Findings: During a review of Resident 1's Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including secondary malignant neoplasm of the brain (cancer that spread to the brain), and traumatic hemorrhage (bleeding) of the right cerebrum (part of the brain) with loss of consciousness (a state in which an individual lacks normal awareness of self and the surrounding environment). During a review of Resident 1's Physician's Order dated 8/1/2024, the Physician's Order indicated Resident 1 was to receive Seroquel 100 milligrams ([mg] a unit of measurement) three times daily for schizophrenia (a chronic mental illness that affects a person's thoughts, feelings, and behaviors with psychotic symptoms). The Physician's Order had no behavior's listed related to Resident 1's diagnosis of schizophrenia. During a review of Resident 1's Medication Administration Record (MAR) dated 8/2024, the MAR indicated Resident 1 received Seroquel 100 mg on 8/2/2024, 8/3/2024, and 8/5/2024 at 9 a.m., 1 p.m., and 5 p.m., and 1 p.m. and 5 p.m. on 8/4/2024. During a review of Resident 1's Clinical Record, the Clinical Record indicated there was no documentation of a detailed description of Resident 1's behavior, no documentation that non-pharmacologic interventions were conducted prior to obtaining an order for and administering Seroquel, and there was no comprehensive evaluation of Resident 1 by a physician, psychiatrist, psychologist, and/or nursing staff to determine if Seroquel was indicated for Resident 1's use. During a telephone interview on 8/14/2024 at 7 a.m., Resident 1's Family Member (FM) 1 stated Resident 1 did not have a history/diagnosis of schizophrenia (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056283	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bixby Knolls Towers Health Care & Rehab Center	3747 Atlantic Avenue Long Beach, CA 90807

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/14/2024 at 4:04 p.m., the Assistant Director of Nursing (ADON) stated prior to administering antipsychotic medications to residents the healthcare team should try to determine why a resident was acting out by fully assessing them, and non-pharmacologic interventions should be attempted due to the side effects of such medications. The ADON stated non-pharmacologic interventions prior to antipsychotic medication administration to Resident 1 was not documented as done anywhere in Resident 1's chart. During a telephone interview on 8/15/2024 at 10:36 a.m., Resident 1's Psychiatrist (a medical practitioner specializing in the diagnosis and treatment of mental illness) stated Resident 1 was diagnosed with delirium (a mental state that causes confusion, disorientation, and difficulty thinking or remembering caused by a severe or long illness or imbalance in the body) and psychosis (a serious mental illness that affects a person's ability to determine what is real presenting symptoms such as experiencing stimuli that is not real, having false beliefs, disordered thinking and speech, and disorganized behavior) in the hospital prior to his admission to the facility (8/1/2024), but since delirium was considered an acute condition, Resident 1 should not have been discharged from the hospital with a diagnosis of delirium so he (the Psychiatrist) made a preliminary diagnosis of schizophrenia. Resident 1's Psychiatrist stated nursing facilities cannot admit residents with a diagnosis of psychosis since it was a symptom which was why he made a preliminary diagnosis of schizophrenia for Resident 1. Resident 1's Psychiatrist stated he received a phone call from the facility on 8/2/2024 reporting that Resident 1 was agitated and paranoid (unreasonably suspicious and mistrustful of people often believing people are out to harm you) manifested by hallucinations so he ordered Seroquel 100 mg three times a day for paranoia and agitation. Resident 1's Psychiatrist stated he never got a chance to assess Resident 1 since he (Resident 1) was transferred to the GACH, the same day he planned to visit the facility(8/6/2024). During a review of facility's Policy and Procedure, (P&P), titled Psychotropic Medications, dated 10/2017, the P&P indicated an antipsychotic medication should be used only for conditions/diagnosis as documented in the record and as meets the definition(s) in the Diagnostic and Statistical Manual of Mental Disorders. The P&P indicated the clinician in conjunction with the IDT (interdisciplinary team, a group of professionals with different areas of expertise who work together to achieve a common goal) must evaluate and document the situation to identity and address any contributing and underlying causes of the acute condition and verify the need for a psychotropic medication. The P&P indicated pertinent non-pharmacological interventions must be attempted, unless contraindicated, and documented that do not require a physician intervention following the resolution of the acute psychiatric situation.