

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056283	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/13/2024
NAME OF PROVIDER OR SUPPLIER Bixby Knolls Towers Health Care & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44055</p> <p>Based on interview, and record review, the facility (SNF B) failed to ensure residents were free from sexual abuse (non-consensual sexual contact of any type) for one of three sampled residents (Resident 2). The facility (SNF B) failed to:</p> <ol style="list-style-type: none"> 1. Ensure Resident 1 did not sexually assault Resident 2. 2. Ensure Certified Nursing Assistant (CNA) 1 and CNA 2 did not leave Resident 1 and Resident 2 alone in the room after Resident 1 sexually assaulted Resident 2 once, thus allowing Resident 1 to sexually assault Resident 2 second time. 3. Ensure CNA 1 and CNA 2 followed the facility (SNF B)'s policy and procedure (P/P) titled, Abuse Reporting and investigation, dated 1/10/2024, which indicated if the suspected perpetrator is the resident, the residents will be separated so they do not interact with each other or with another resident. <p>These failures resulted in Resident 1 on 10/8/2024, sexually assaulting Resident 2 twice, and placed other residents in SNF B at risk for sexual assault and aggressive behavior from Resident 1.</p> <p>On 10/11/2024 at 6:20 p.m., the California Department of Public Health (CDPH) called an Immediate Jeopardy ([IJ] a situation in which the facility's non-compliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) in the presence of the Director of Nursing (DON) and the Administrator (ADM), due to the facility (SNF B)'s failure to prevent Resident 1 from sexually abusing Resident 2 twice.</p> <p>On 10/13/2024 the facility (SNF B) provided CDPH with an acceptable Immediate Jeopardy Removal Plan (IJRP) containing the following summarized immediate corrective actions:</p> <ol style="list-style-type: none"> 1. Ensure all residents are free from abuse through training addressing the critical elements of identifying all categories of abuse and the procedures for reporting abuse. 2. Immediate action taken: <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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>a. Resident 1 was discharged from the facility (SNF B) and sent to a General Acute Care Hospital (GACH 3) on 10/09/2024 for psychiatric evaluation and treatment. As of 10/13/2024 Resident 1 remains in GACH 3.</p> <p>b. Resident 2 was transferred to GACH 2 for evaluation on 10/9/2024 and returned to the facility (SNF B) on 10/9/2024.</p> <p>c. Upon Resident 2's return to the SNF B the Social Services Director (SSD) began Resident 2's monitoring for emotional distress. Resident 2 was seen by a Psychologist (a health practitioner that specializes in the study of mind and behavior or in the treatment of mental, emotional, and behavioral disorders) and Psychiatrist (a health practitioner that specializes in the diagnosis and treatment of mental illness) on 10/9/2024.</p> <p>d. On 10/9/2024, the SSD interviewed all cognitively (ability to think, understand, learn, and remember) aware residents and inquired if the residents have experienced abuse in the facility (SNF B) or know of any abuse in the facility (SNF B). On 10/12/2024 the SSD interviewed staff regarding residents who were not able to be interviewed to see if the facility (SNF B) staff had witnessed any signs of abuse or changes in residents' behaviors. Any issues identified from the interviews will be investigated by the Abuse Coordinator/ADM.</p> <p>e. All 87 residents have the potential to be affected by alleged abuse incidents. All residents with psychiatric diagnoses admitted since 8/31/2024 (the date Resident 1 was admitted to the facility [SNF B]) will be reviewed by the interdisciplinary team ([IDT] group of health care professionals with various areas of expertise who work together toward the goals of the resident) for their psychiatric and behavioral needs, including their medication regimen and/or need for psychiatric consultation by 10/13/2024. A referral for psychological / psychiatric services for evaluation and treatment when indicated will be done. Any issues identified will be addressed by the IDT team members. The facility (SNF B)'s contracted psychiatrist was notified on 10/11/2024 to assist with any needed psychiatric consultations.</p> <p>f. Any residents admitted from 10/11/2024 will be assessed by the IDT for their medical, physical, and psychological needs and care planned accordingly.</p> <p>3.Training and education to prevent abuse:</p> <p>a. Staff training on abuse prohibition will consist of abuse prevention, identifying what constitutes abuse, recognizing signs of abuse, reporting abuse, understanding behavioral symptoms of residents that may increase the risk of abuse and neglect and how to respond. Symptoms may include aggressive behavior, wandering, resistance to care, yelling or difficulty adjusting to new routines or staff. These trainings will continue upon hire, annually and as needed.</p> <p>4.Training provided specific to the allegation of abuse:</p> <p>a. The DON, the Director of Staff Development (DSD), and/or Clinical Resources (CR) will in-service (staff education) and educate licensed nurses: 39 staff (23 Licensed Vocational Nurses [LVN]'s and 14 Registered Nurses [RN]'s) to Review admission documents thoroughly to ensure that the resident's medical, physical, and psychological needs are assessed, and care planned.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Upon identification of abuse to separate residents, immediately remove perpetrator from victim when indicated and provide immediate 1:1 supervision (a staff member assigned to monitor only that resident) to keep a resident safe from any further alleged abuse. In-services initiated on 10/11/2024 and will be completed by 10/16/2024. These trainings will continue upon hire, annually and as needed.</p> <p>b. The ADM, the DON, the DSD or CRs will in-service and educate facility (SNF B) staff: 134 staff (including housekeeping, activities, rehabilitation, social services and maintenance departments, licensed and unlicensed nursing staff and all department heads) on the immediate action required during an alleged abuse situation to include : immediate need to separate residents, immediately remove perpetrator from victim when indicated and provide immediate 1:1 supervision to keep a resident safe from any further alleged abuse. In-services initiated on 10/11/2024 and will be completed by 10/16/2024. These trainings will continue upon hire, annually and as needed.</p> <p>c. Education and training for staff on leave, vacation, per diem or registry status will be completed prior to the start of their working shift by the Administrator, the DON, the DSD and/or CRs.</p> <p>5.The facility (SNF B) Medical Director was notified by the ADM and the DON on 10/11/2024 of the Immediate Jeopardy. The Medical Director will continue to assist the facility (SNF B) to meet the needs of the Residents.</p> <p>6. Prior to the Quality Assurance Performance Improvement ([QAPI] data driven approach to improve the quality of care and safety in nursing homes) meeting all training and education which includes abuse, review of admission documents thoroughly to ensure that the resident's medical, physical, and psychological needs are assessed, and care planned, separating residents, immediately remove perpetrator from victim when indicated and provide immediate 1:1 supervision to keep a resident safe from any further alleged abuse, and all resident interviews regarding any alleged abuse, will be completed. These trainings will continue upon hire, annually and as needed. Policy and procedures relating to the admission process and abuse will be reviewed and revised if necessary, during the QAPI meeting.</p> <p>7. This Immediate Jeopardy Removal Plan will be reviewed at the next scheduled QAPI Committee Meeting on 10/16/2024.</p> <p>On 10/13/2024 at 2:02 p.m., while onsite the facility (SNF B) informed the surveyors' team there were no additional instances of sexual abuse identified through their interviews of the facility (SNF B) residents and staff. After verification of the facility (SNF B)'s implementation of the IJ removal plan corrective actions, and through observations, interviews, and record review, the Department accepted the IJ removal plan and removed the IJ, in the presence of the ADM and the DON.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was admitted to SNF B on 8/31/2024 with diagnoses including schizophrenia (a mental disorder that causes a break with reality and affects how people think, perceive, and interact with others, malignant neuroleptic syndrome (life-threatening condition that can occur as a side effect of certain antipsychotic[medication that affects the brain] medications) and diabetes mellitus type 2 (condition when the body cannot regulate blood sugar).</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1's History and Physical (H&P), dated 9/3/2024, the H&P indicated Resident 1 did not have awareness of place, location, and time.</p> <p>During a review of Resident 1's Minimum Data Set [(MDS), a federally mandated screening tool], dated 7/7/2024, the MDS indicated Resident 1 had moderately impaired cognitive (ability to think, understand, learn, and remember) skills for daily decision making. The MDS indicated Resident 1 did not have any limitation in functional range of motion (range of motion required for a person to be as independent as possible).</p> <p>During a review of Resident 1's Change of Condition document [(COC] significant change in resident's status that requires intervention) dated 10/8/2024, the COC indicated Resident 1 had 'inappropriately touched' Resident 2.</p> <p>During a review of Resident 1's physician orders, dated 10/9/2024, the physician orders indicated, to transfer Resident 1 to GACH 3 for psychiatric evaluation.</p> <p>During a review of Resident 1's Nurses Notes, dated 10/9/2024, the Nurses Notes indicated Resident 1 was transferred to GACH 3 on 10/9/2024 at 7:50 a.m., for psychiatric evaluation due to inappropriately touching Resident 2.</p> <p>During a review of Resident 2's Admission Record, the Admission Record indicated Resident 2 was admitted to SNF B on 7/23/2024 with diagnoses including metabolic encephalopathy (disease affecting how s brain works), muscle weakness and adult failure to thrive (a state of decline caused by chronic diseases and functional impairments, manifestations of this condition include weight loss, decreased appetite, poor nutrition, and inactivity).</p> <p>During a review of Resident 2's H&P, dated 7/24/2024, the H&P indicated Resident 2 had decreased mental status.</p> <p>During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2 had severe impairment in cognitive skills for daily decision making. The MDS indicated Resident 2 had limitations in functional range of motion (ability to move a joint that interferes with daily functioning, including activities of daily living, or places the resident is at risk of injury) affecting his bilateral (both) upper and lower extremities. The MDS indicated Resident 2 was dependent (helper does all the effort, resident does none of the effect to complete activity) on staff for eating, hygiene, showering/bathing, dressing, toilet hygiene (ability to maintain perineal hygiene, adjust clothes before or after voiding, or having a bowel movement). The MDS indicated Resident 2 was dependent on staff to roll left to right while in bed.</p> <p>During a review of Resident 2's COC, dated 10/8/2024 the COC indicated Resident 1 was found in Resident 2's bed touching Resident 2 inappropriately.</p> <p>During a review of Resident 2's physician's orders, dated 10/9/2024, the physician's orders indicated to transfer Resident 2 to GACH 2 for further evaluation and treatment.</p> <p>During a review of Resident 2's Nurses Notes, dated 10/9/2024, the Nurses Notes indicated Resident 2 was transferred to GACH 2 on 10/9/2024 at 12:20 a.m., for further evaluation and treatment due to being touched inappropriately by another resident.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a record review of CNA 1's documented witness statement, dated 10/8/2024, the statement indicated the following: on 10/8/2024 at 6:30 p.m., CNA 1 entered Resident 1 and Resident 2's room and noticed the privacy curtain was pulled around Resident 2's bed. Behind the curtains CNA 1 observed Resident 1 and Resident 2 laying together on their left side facing away from the door. CNA 1's witness statement indicated Resident 1, and Resident 2 were naked from the waist down. Resident 1 was observed to be grinding his hips and rubbing his penis on the buttocks of Resident 2. Resident 1 had his right hand on Resident 2's right hip moving Resident 2 back and forth while he was grinding on Resident 2. CNA 1's witness statement indicated CNA 1 shouted, hey that's not okay and you can't do that!. Resident 1 stated, ok, sorry! got up, pulled down his gown and went back to sit on his bed (Bed B). CNA 1 called CNA 2 to the room and informed CNA 2 of the incident, and they together left Resident 1 and Resident 2 in the room to report the incident to Licensed Vocational Nurse 2 (LVN 2).</p> <p>During a record review of CNA 2's documented witness statement, dated 10/8/2024, the statement indicated CNA 1 notified CNA 2 that she (CNA 1) witnessed Resident 1 grinding on Resident 2, while in Resident 2's bed. CNA 2's witness statement indicated CNA 2 stated she walked with CNA 1 (to go inform LVN2 of the incident), then stopped (on the way) to inform CNA 3 of the situation. CNA 2 stated she and CNA 3 returned (from the hallway) to Resident 1 and Resident 2's room and heard someone yelling, help me, help me repeatedly. CNA 2 stated she witnessed Resident 1 sitting on Resident 2's bed, rubbing Resident 2's leg.</p> <p>During a record review of CNA 3's documented witness statement, dated 10/8/2024, the statement indicated when CNA 2 and CNA 3 came to Resident 1 and Resident 2's room they heard someone yelling, help me, help me. CNA 3's statement indicated she observed Resident 1 sitting on Resident 2's bed and rubbing Resident 2's leg up and down, Resident 2 did not have his adult briefs (a disposable undergarment designed to provide absorbency for people that cannot control their bladder and/or bowel movements) on. CNA 3's statement indicated Resident 1 got up and walked back to his bed. CNA 3's statement indicated CNA 3 asked Resident 2 if he was okay, Resident 2 responded, No. CNA 3's statement indicated Resident 2 reported to her that Resident 1 touched his penis. CNA 3's statement indicated she and CNA 1 changed Resident 2's adult briefs.</p> <p>During a record review of LVN 2's documented witness statement, dated 10/8/2024, the statement indicated the following: LVN 2 was notified by CNA 1 that Resident 1 was inappropriately touching Resident 2 in Resident 2's bed. LVN 2's witness statement indicated LVN 2 walked into the room with LVN 1 and RN 1 and questioned Resident 1 and Resident 2. Resident 2 appeared scared and said he wanted to leave; Resident 1 stated I put it in him just once. LVN 2's witness statement indicated Resident 1 and Resident 2 would be sent to the hospital for evaluations.</p> <p>During an interview on 10/11/2024, at 1:40 p.m., CNA 1 stated her documented witness statement was an accurate account of the incident on 10/8/2024 involving Resident 1 and Resident 2. CNA 1 stated she left Resident 1 and Resident 2 in the room unattended while she notified LVN 2 of the incident. CNA 1 stated, it was important to separate residents after an incident of alleged abuse to ensure residents' safety. CNA 1 stated residents must be monitored with 1:1 supervision (a single staff member is dedicated to constantly monitor one resident) to ensure the incident does not happen again.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/11/2024, at 1:00 p.m., DON-P at psychiatric SNF A (where Resident 1 resided before being transferred to GACH 1) stated at SNF A Resident 1 was receiving Clozapine (medication to treat schizophrenia, usually a last resort drug after all other medications have failed due to many side effects) and Depakote (medication to treat mood disorders) daily due to paranoid delusions (false beliefs that someone is being threatened or mistreated) and poor impulse (tendency to act without thinking) control. The DON stated when a medication dose reduction (an attempted decrease in medication dosage to manage behavior and decrease adverse side effects of the medication) was attempted (date unknown), Resident 1 required close monitoring due to increased hypersexual (a condition where a person is unable to control their sexual urges, and arousal) behaviors. The DON stated, Resident 1 cannot be without antipsychotic (medication that affects the brain) medications as he will have inappropriate aggressive sexual behaviors towards vulnerable, dependent residents.</p> <p>During an interview on 10/11/2024, at 3:20 p.m., the DON stated Resident 1's impulsive behaviors were not managed, and it resulted in Resident 1 sexually assaulting Resident 2. The DON stated they (SNF B) failed to maintain Resident 2's safety from Resident 1 when SNF B staff left Resident 1 and Resident 2 unattended and unsupervised after CNA 1 witnessed the first inappropriate sexual act performed by Resident 1 toward Resident 2.</p> <p>During a review of SNF B's policy and procedure (P/P) titled, Abuse Reporting and investigation, dated 1/10/2024, if the suspected perpetrator is another resident, the residents will be separated so they do not interact with each other or with another resident.</p> <p>During a review of SNF B's P/P titled, Residents Rights, dated 8/2022, indicated federal and state laws guarantee certain basic rights to residents of this facility. These rights include the resident's right to a dignified existence, to be treated with respect, kindness, and dignity, to be free from abuse, neglect, misappropriation of property and exploitation.</p>		

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<p>F 0711</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44055</p> <p>Based on interview and record review the facility failed to ensure:</p> <p>1. The primary care physician (PCP) signed Resident 37's admission orders from the hospital to continue to make sure the facility provided the care needed during the stay in the facility for one of one sampled resident (Resident 37).</p> <p>This deficient practice has the potential to not provide Resident ' s 37 appropriate medical intervention during facility stay.</p> <p>Findings:</p> <p>During a record review of Resident 37 ' s Admission Record, the Admission Record indicated the resident was admitted on [DATE] with diagnoses including cerebrovascular disease (group of conditions that affect blood flow and the blood vessels in the brain), diabetes mellitus (a chronic disease that occurs when the body doesn't produce enough insulin or use it properly), vascular dementia, unspecified severity without behavioral disturbance (a type of dementia that occurs when blood flow to the brain is interrupted, damaging brain cells and impairing thinking, memory, and behavior).</p> <p>During a review of Resident 37 ' s History and Physical (H & P) dated 10/9/2024, the H and P indicated Resident 37 is somewhat confused.</p> <p>During a concurrent interview and record review on 10/13/2024 at 10:03 a.m. with the Medical Records Director (MRD), MRD state that physician needs to visit within 72 hours of admission of the resident to the facility. MRD stated that the primary physician came on 10/9/2024.</p> <p>During a concurrent interview and record review on 10/13/2024 at 12:15 p.m. with the DON, the DON stated MD needs to come to the facility within 72 hours of the admission to evaluate residents ' condition, do a Hisotory and Physical (H & P) and sign Physician orders (PO), it is important to make sure MD come to ensure appropriate care and services are provided to the Resident. The DON stated that it is DON ' s responsibility to make sure this regulation is being followed.The DON stated that the PO was not signed.</p> <p>During a review of the facility ' s policy and procedure (P&P) titled, Medication Orders dated November 2014, the P&P indicated physician orders/progress notes must be signed and dated.</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>44055</p> <p>Based on interview and record review the facility failed to ensure 2 out of 2 staff members Licensed vocational nurse (LVN) LVN 1 and LVN 2 were provided with abuse training prior to providing direct patient care.</p> <p>This failure had the potential to put the residents of the facility at risk for abuse.</p> <p>Findings:</p> <p>During concurrent interview and record review on 10/12/2024 at 1:15 p.m., with Director of Staff Development (DSD implements educational programs for employees), two employee files were reviewed, Licensed Vocational Nurse (LVN) LVN 1 and LVN 2. The DSD stated employees must have abuse training prior to providing direct resident care. The DSD stated that she could not find that LVN 1 and LVN 2 had been trained on abuse prior to providing direct patient care. The DSD stated residents are at risk for abuse if staff are not trained.</p> <p>During an interview on 10/13/2024 at 12:45 p.m., with the Administrator (Adm), the ADM stated the DSD's role is to maintain the facilities education program and hire the frontline staff. The ADM stated abuse training is provided upon hire and twice a year. The ADM stated staff must have abuse training before providing direct care to the residents. The ADM stated there is a potential for abuse if staff are not trained and educated properly.</p> <p>During a review of the facilities policy and procedure titled In-service Training, All Staff dated 8/2022 indicated all staff are required to participate in regular in-service education. In service education participation is considered working time for which staff are paid their regular wages.</p> <p>Required training topics include Preventing abuse, neglect, exploitation, and misappropriation of residents properly including:</p> <ol style="list-style-type: none"> 1. Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property. 2. Procedures for reporting incidences of abuse, neglect, exploitation, or misappropriation of resident ' s property. 3. Dementia management and resident abuse prevention. <p>Training requirements are met prior to staff providing services to residents, annually, and as necessary based on facility assessment.</p>		

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<p>F 0742</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44055</p> <p>Based on interview and record review, the facility (SNF B) failed to ensure a resident, who had a history of schizophrenia (chronic mental illness that affects how a person thinks, feels, and behaves) with disorganized (jumbled, or do not make sense can cause problems with communication) thoughts, aggressive and inappropriate sexual behaviors, had behaviors under control for one of three sampled residents (Resident 1) to prevent Resident 1 from sexually assaulting Resident 2 two times on 10/8/2024.</p> <p>The facility failed to:</p> <ol style="list-style-type: none"> 1. Ensure Resident 1 was evaluated by a psychiatrist (a health practitioner that specializes in the diagnosis and treatment of mental illness) upon admission and as needed during the time he was a resident in the current Skilled Nursing Facility (SNF B). 2. Ensure Resident 1's prior history of medication regimen therapy with a total of 350 milligrams ([mg] unit of measurement of mass) daily dose of Clozapine (medication to treat schizophrenia, usually a last resort drug after all other medications have failed due to many side effects) for disorganized thoughts and to control aggressive behavior and sexually inappropriate behavior, was reviewed to evaluate if Resident 1 needed to continue Clozapine medication therapy to treat Resident 1's behaviors. 3. Ensure Resident 1's physician was notified of the resident's history of receiving a medication called Clozapine to treat aggressive behavior and to consider restarting this medication therapy. 4. Ensure Resident 1 was assessed for psychiatric needs and psychiatric medications since admission to SNF B on 8/31/2024 based on the resident's diagnosis and history of aggressive behavior. <p>These failures resulted in Resident 1, who had not received any treatment or medications for his diagnosis of schizophrenia since 8/31/2024, sexually assaulting Resident 2 who was his roommate, twice on 10/8/2024 and placed other residents in the facility (SNF B) at risk for sexual assault and aggressive behaviors from Resident 1.</p> <p>On 10/8/2024, Certified Nursing Assistant (CNA) 1 witnessed Resident 1 sexually assaulting Resident 2 and separated Resident 1 from Resident 2 but failed to maintain supervision of Resident 1. A few minutes later CNA 2 witnessed Resident 1 sexually assaulting Resident 2 a second time.</p> <p>On 10/09/2024 Resident 1 was sent to a general acute care hospital (GACH 3) for evaluation and treatment.</p> <p>(continued on next page)</p>		

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<p>F 0742</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 10/11/2024 at 6:20 p.m., the California Department of Public Health (CDPH) called an Immediate Jeopardy ([IJ] a situation in which the facility's non-compliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) in the presence of the Director of Nursing (DON) and the Administrator (ADM) due to the facility's (SNF B) failure to protect Resident 2 from being sexually abused twice by Resident 1.</p> <p>On 10/13/2024 the facility (SNF B) provided CDPH with an acceptable Immediate Jeopardy Removal Plan (IJRP) containing the following summarized immediate corrective actions:</p> <ol style="list-style-type: none"> 1. Ensure all residents are free from abuse through training addressing the critical elements of identifying all categories of abuse and the procedures for reporting abuse. 2. Immediate action taken: <ol style="list-style-type: none"> a. Resident 1 was discharged from the facility (SNF B) and sent to a General Acute Care Hospital (GACH 3) on 10/09/2024 for psychiatric evaluation and treatment. As of 10/13/2024 Resident 1 remains in GACH 3. b. Resident 2 was transferred to GACH 2 for evaluation on 10/9/2024 and returned to the facility (SNF B) on 10/9/2024. c. Upon Resident 2's return to SNF B the Social Services Director (SSD) began monitoring Resident 2 for emotional distress. Resident 2 was seen by a psychologist (a health practitioner that specializes in the study of mind and behavior or in the treatment of mental, emotional, and behavioral disorders) and Psychiatrist (a health practitioner that specializes in the diagnosis and treatment of mental illness) on 10/9/2024. d. On 10/9/2024, the SSD interviewed all cognitively (ability to think, understand, learn, and remember) aware residents and inquired if the residents have experienced abuse in the facility (SNF B) or know of any abuse in the facility (SNF B). On 10/12/2024 the SSD interviewed staff regarding residents who were not able to be interviewed to see if the facility (SNF B) staff had witnessed any signs of abuse or changes in residents' behaviors. Any issues identified from the interviews will be investigated by the Abuse Coordinator/ADM. e. All 87 residents have the potential to be affected by alleged abuse incidents. All residents with psychiatric diagnoses admitted since 8/31/2024 (the date Resident 1 was admitted to the facility [SNF B]) will be reviewed by the interdisciplinary team ([IDT] group of health care professionals with various areas of expertise who work together toward the goals of the resident) for their psychiatric and behavioral needs, including their medication regimen and/or need for psychiatric consultation by 10/13/2024. A referral for psychological / psychiatric services for evaluation and treatment when indicated will be done. Any issues identified will be addressed by the IDT team members. The facility (SNF B)'s contracted psychiatrist was notified on 10/11/2024 to assist with any needed psychiatric consultations. f. Any residents admitted from 10/11/2024 will be assessed by the IDT for their medical, physical, and psychological needs and care planned accordingly. 3. Training and education to prevent abuse: <p>(continued on next page)</p>		

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<p>F 0742</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>a. Staff training on abuse prohibition will consist of abuse prevention, identifying what constitutes abuse, recognizing signs of abuse, reporting abuse, understanding behavioral symptoms of residents that may increase the risk of abuse and neglect and how to respond. Symptoms may include aggressive behavior, wandering, resistance to care, yelling or difficulty adjusting to new routines or staff. These trainings will continue upon hire, annually and as needed.</p> <p>4.Training provided specific to the allegation of abuse:</p> <p>a. The DON, the Director of Staff Development (DSD), and/or Clinical Resources (CR) will in-service (staff education) and educate licensed nurses: 39 staff (23 Licensed Vocational Nurses [LVN]'s and 14 Registered Nurses [RN]'s) to Review admission documents thoroughly to ensure that the resident's medical, physical, and psychological needs are assessed, and care planned.</p> <p>Upon identification of abuse to separate residents, immediately remove perpetrator from victim when indicated and provide immediate 1:1 supervision (a staff member assigned to monitor only that resident) to keep a resident safe from any further alleged abuse. In-services initiated on 10/11/2024 and will be completed by 10/16/2024. These trainings will continue upon hire, annually and as needed.</p> <p>b. The ADM, the DON, the DSD or CRs will in-service and educate facility (SNF B) staff: 134 staff (including housekeeping, activities, rehabilitation, social services and maintenance departments, licensed and unlicensed nursing staff and all department heads) on the immediate action required during an alleged abuse situation to include : immediate need to separate residents, immediately remove perpetrator from victim when indicated and provide immediate 1:1 supervision (a single staff member is dedicated to constantly monitor one resident) to keep a resident safe from any further alleged abuse. In-services initiated on 10/11/2024 and will be completed by 10/16/2024. These trainings will continue upon hire, annually and as needed.</p> <p>c. Education and training for staff on leave, vacation, per diem or registry status will be completed prior to the start of their working shift by the Administrator, the DON, the DSD and/or CRs.</p> <p>5.The facility (SNF B) Medical Director was notified by the ADM and the DON on 10/11/2024 of the Immediate Jeopardy. The Medical Director will continue to assist the facility (SNF B) to meet the needs of the Residents.</p> <p>6. Prior to the Quality Assurance Performance Improvement ([QAPI] data driven approach to improve the quality of care and safety in nursing homes) meeting all training and education which includes abuse, review of admission documents thoroughly to ensure that the resident's medical, physical, and psychological needs are assessed, and care planned, separating residents, immediately remove perpetrator from victim when indicated and provide immediate 1:1 supervision to keep a resident safe from any further alleged abuse, and all resident interviews regarding any alleged abuse, will be completed. These trainings will continue upon hire, annually and as needed. Policy and procedures relating to the admission process and abuse will be reviewed and revised if necessary, during the QAPI meeting.</p> <p>7. This Immediate Jeopardy Removal Plan will be reviewed at the next scheduled QAPI Committee Meeting on 10/16/2024.</p> <p>(continued on next page)</p>		

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<p>F 0742</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 10/13/2024 at 2:02 p.m., while onsite the facility (SNF B) informed the surveyors' team there were no additional instances of sexual abuse identified through their interviews of the facility (SNF B) residents and staff. After verification of the facility (SNF B)'s implementation of the IJ removal plan corrective actions, and through observations, interviews, and record review, the Department accepted the IJ removal plan and removed the IJ, in the presence of the ADM and the DON.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was admitted to SNF B on 8/31/2024 with diagnoses including schizophrenia, malignant neuroleptic syndrome (life-threatening condition that can occur as a side effect of certain antipsychotic [a medication used to treat symptoms of psychosis [collection of symptoms that cause a person to lose touch with reality] medications) and diabetes mellitus type 2 (condition when the body cannot regulate blood sugar).</p> <p>During a review of Resident 1's History and Physical (H&P), dated 9/3/2024, the H&P indicated Resident 1 did not have awareness of place, location, and time.</p> <p>During a review of Resident 1's Minimum Data Set [(MDS), a federally mandated screening tool], dated 7/7/2024, the MDS indicated Resident 1 had moderately impaired cognitive skills for daily decision making. The MDS indicated Resident 1 did not have any limitation in functional range of motion (range of motion required for a person to be as independent as possible).</p> <p>During a review of Resident 1's GACH 1 Records, dated 7/19/2024 through 8/31/2024, the GACH 1 records indicated Resident 1 was admitted to GACH 1 from a psychiatric skilled nursing facility (SNF A) where he was receiving a total of 350 mg of Clozapine daily.</p> <p>During a review of Resident 1's physician's orders from SNF A, dated 3/7/2024, the physician's orders indicated the following orders:</p> <ol style="list-style-type: none"> 1. Clozapine 200 mg tablet by mouth at bedtime for disorganized thoughts and aggressive behaviors. 2. Clozapine 150 mg tablet by mouth in the morning for disorganized thoughts. 3. Depakote (medication to treat mood disorders) 150 mg tablet by mouth two times a day for mood swings. <p>The physician's orders indicated Resident 1's medication orders were active until his transfer to GACH 1 on 7/19/2024.</p> <p>During a review of Resident 1's Change of Condition document [(COC) significant change in resident's status that requires intervention) dated 10/8/2024 from SNF B, the COC indicated Resident 1 had 'inappropriately touched' Resident 2.</p> <p>During a review of Resident 1's physician's orders, dated 10/9/2024, the physician's orders indicated to transfer Resident 1 to GACH 3 for psychiatric evaluation.</p> <p>(continued on next page)</p>		

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<p>F 0742</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1's Nurses Notes, dated 10/9/2024, the Nurses' Notes indicated Resident 1 was transferred to GACH 3 on 10/9/2024 at 7:50 a.m., for psychiatric evaluation due to inappropriately touching another resident.</p> <p>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 metabolic encephalopathy (disease affecting how a brain works), muscle weakness and adult failure to thrive (a state of decline caused by chronic diseases and functional impairments, manifestations of this condition include weight loss, decreased appetite, poor nutrition, and inactivity).</p> <p>During a review of Resident 2's H&P, dated 7/24/2024, the H&P indicated Resident 2 had a decreased mental status.</p> <p>During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2 had severe impairment in cognitive skills for daily decision making. The MDS indicated Resident 2 had limitations in functional range of motion (ability to move a joint that interferes with daily functioning, including activities of daily living, or places the resident at risk of injury) affecting his bilateral (both) upper and lower extremities. The MDS indicated Resident 2 was dependent (helper does all the effort, resident does none of the effort to complete activity) on staff for eating, hygiene, showering/bathing, dressing, toilet hygiene (ability to maintain perineal hygiene, adjust clothes before or after voiding, or having bowel movement). The MDS indicated Resident 2 was dependent on staff to roll left to right while in bed.</p> <p>During a review of Resident 2's COC, dated 10/8/2024 the COC indicated Resident 1 was found in Resident 2's bed touching Resident 2 inappropriately.</p> <p>During a record review of CNA 1's documented witness statement, dated 10/8/2024, the statement indicated the following: on 10/8/2024 at 6:30 p.m., CNA 1 entered Resident 1 and Resident 2's room and noticed the privacy curtain was pulled around Resident 2's bed. Behind the curtains CNA 1 observed Resident 1 and Resident 2 laying together on their left side facing away from the door. CNA 1's documented witness statement indicated Resident 1, and Resident 2 were naked from the waist down. Resident 1 was observed to be grinding his hips and rubbing his penis on the buttocks of Resident 2. Resident 1 had his right hand on Resident 2's right hip moving Resident 2 back and forth while he was grinding on Resident 2. CNA 1's documented witness statement indicated CNA 1 shouted, hey that's not okay and you can't do that!. Resident 1 stated, ok, sorry! got up, pulled down his gown and went back to sit on his bed (Bed B). CNA 1 called CNA 2 to the room and informed CNA 2 of the incident, and they together left Resident 1 and Resident 2 in the room to report the incident to Licensed Vocational Nurse 2 (LVN 2).</p> <p>During a record review of CNA 2's documented witness statement, dated 10/8/2024, the statement indicated CNA 1 notified CNA 2 that she (CNA 1) witnessed Resident 1 grinding on Resident 2, while in Resident 2's bed. CNA 2's witness statement indicated CNA 2 stated she walked with CNA 1 (to go inform LVN 2 of the incident), then stopped (on the way) to inform CNA 3 of the situation. CNA 2 stated she and CNA 3 returned (from the hallway) to Resident 1 and Resident 2's room and heard someone yelling, help me, help me repeatedly. CNA 2 stated she witnessed Resident 1 sitting on Resident 2's bed, rubbing Resident 2's leg.</p> <p>(continued on next page)</p>		

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<p>F 0742</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a record review of CNA 3's documented witness statement, dated 10/8/2024, the statement indicated when CNA 2 and CNA 3 came to Resident 1 and Resident 2's room they heard someone yelling, help me, help me. CNA 3's statement indicated she observed Resident 1 sitting on Resident 2's bed and rubbing Resident 2's leg up and down, Resident 2 did not have his adult briefs (a disposable undergarment designed to provide absorbency for people that cannot control their bladder and/or bowel movements) on. CNA 3's statement indicated Resident 1 got up and walked back to his bed. CNA 3's statement indicated CNA 3 asked Resident 2 if he was okay, Resident 2 responded, No. CNA 3's statement indicated Resident 2 reported to her that Resident 1 touched his penis. CNA 3's statement indicated she and CNA 1 changed Resident 2's adult briefs.</p> <p>During a review of Resident 2's Physician's Orders, dated 10/9/2024, the Physician's Orders indicated, to transfer Resident 2 to GACH 2 for further evaluation and treatment.</p> <p>During a review of Resident 2's Nurses Notes, dated 10/9/2024, the Nurses Notes indicated Resident 2 was transferred to GACH 2 on 10/9/2024 at 12:20 a.m., for further evaluation and treatment due to being touched inappropriately by another resident.</p> <p>During an interview on 10/11/2024, at 1:00 p.m., the Director of Nursing (DON-P) from SNF A stated Resident 1 had been a resident of SNF A since 2019 until he was transferred to GACH 1 in July 2024. DON-P stated Resident 1 was transferred to GACH 1 because he required a higher level of care due to generalized weakness and because his oxygen saturation was below normal levels (the percentage of oxygen [O2] in person's blood: reference range is 95% to 100% without the use of supplemental oxygen)]. DON-P stated, Resident 1 was receiving Clozapine and Depakote daily at their facility (SNF A) due to paranoid (false beliefs that someone is being threatened or mistreated) delusions (a false belief or judgment about external reality) and poor impulse (tendency to act without thinking) control. DON-P stated when a medication dose reduction (an attempted decrease in medication dosage to manage behavior and decrease adverse side effects of the medication) was attempted (date unknown), Resident 1 required close monitoring due to increased hypersexual (a condition where a person is unable to control their sexual urges, and arousal) behaviors. DON-P stated, Resident 1 cannot be without antipsychotic medications as he will attempt inappropriate sexual behaviors and aggression towards vulnerable, dependent residents.</p> <p>During an interview on 10/11/2024, at 2:18 p.m., SNF B's pharmacist (PharmD) stated upon her review of Resident 1's medication regimen on 9/6/2024, Resident 1 was noted to have a diagnosis of schizophrenia and the SNF B physician did not prescribe antipsychotic medication for Resident 1. PharmD stated if a resident was receiving an antipsychotic medication prior to admission to the current facility (SNF B), it was important for the nursing staff to inquire why Resident 1 did not continue to have a prescription for antipsychotic medications, since the resident has diagnoses and history of sexual behaviors and aggression toward other residents.</p> <p>During an interview on 10/11/2024 at 2:25 p.m., PharmD stated she was not aware Resident 1 was previously a resident at SNF A and was receiving antipsychotic medications. PharmD stated Clozapine is an antipsychotic medicine used to treat schizophrenia after other treatments have failed. PharmD stated the nursing staff should have notified Resident 1's medical doctor (MD) and provided the information pertaining to Resident 1's previous Clozapine orders and psychiatric history. PharmD stated the MD would determine if psychiatric follow up is necessary, which it likely would be.</p> <p>(continued on next page)</p>		

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<p>F 0742</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review, on 10/11/2024, at 3:00 p.m., with the MDS nurse (MDSN), Resident 1's GACH 1 records, dated 7/19/2024 through 8/31/2024 were reviewed. The MDSN stated she along with the DON, Assistant Director of Nursing (ADON), and Medical Records Director (MDR) failed to review the chart thoroughly and missed the portion addressing Resident 1's psychiatric history. The MDSN stated the nursing staff failed to ensure Resident 1 was receiving the proper behavioral care and services which placed Resident 1 at a higher risk for displaying sexually inappropriate behaviors toward Resident 2.</p> <p>During an interview on 10/11/2024, at 3:12 p.m., the DON stated when a resident is newly admitted to the facility, she together with the MDSN Infection preventionist, ADON, and MDR will review all documents from the discharging facility to ensure all orders and medications were carried out. The DON stated she overlooked the information in Resident 1's hospital records that indicated Resident 1 was previously a resident at a psychiatric facility, SNF A. The DON stated she failed to note that Resident 1 was receiving Clozapine.</p> <p>During an interview on 10/11/2024, at 3:20 p.m., the DON stated had she taken note of Resident 1's history, she would have reached out to DON-P and likely would not have admitted Resident 1 to the facility. The DON stated she should have called Resident 1's physician to notify him about Resident 1's psychiatric history to ensure Resident 1 received the necessary assessment, treatments, and services to meet his behavioral needs. The DON stated, Resident 1 did not receive the appropriate behavior care and services due to our failure of looking over his psychiatric history. The DON stated Resident 1's impulsive behaviors were not managed and resulted in Resident 1 sexually assaulting Resident 2.</p> <p>During a review of the Facility Assessment (foundation for the facility to assess its resident population and determine the direct care staffing and other resources to provide the required care to their residents) updated 6/19/2024, the Facility Assessment indicated the following: Residents will be admitted to this facility as long as their nursing and medical needs can be met by the facility. The DON or designee reviews perspective inquiry documentation to determine if the facility can meet the needs and the care perspective of the residents. Residents who are admitted to the facility will have an admission assessment and patient center care plan developed. When a resident has been admitted to the facility and who's care needs cannot be met, the resident's physician will be immediately notified in effort to receive an order for the resident to be transferred to a facility that can meet the needs, care and services required. The Facility Assessment indicated that a comprehensive care plan be developed for each resident to provide specific information to include resident's strengths, goals, life history and preferences, discharge planning and will be completed within seven days of the Care Area Assessment ([CAA] tool to identify and address potential problems for residents) completion.</p>		

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<p>F 0868</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Have the Quality Assessment and Assurance group have the required members and meet at least quarterly</p> <p>44055</p> <p>Based on interview and record review, the facility ' s Quality Assessment and Assurance ([QAA] to develop and implement appropriate plans of action to correct identified quality deficiencies) and Quality Assurance Performance Improvement ([QAPI] designated to bring about constant and measurable improvement in the services provided at the facility for continual improvement of quality care) committee failed to ensure the facility ' s Medical Director attended the monthly meetings.</p> <p>This deficient practice has a potential for the QAA committee not to identify and to respond on the QAPI program that identifies systemic problems to improve services for the residents.</p> <p>Findings:</p> <p>During an interview on 10/13/2024 at 11:46 a.m., with the Director of Nursing (DON), the DON stated that they do the monthly QAPI meeting to identify the concerns of the residents to improve the services and care of the residents in the facility.</p> <p>During a concurrent interview and record review of the QAA minutes meeting for the months of 07/2024-09/2024, on 10/14/2024 at 12:00p.m., with the DON, the DON stated that the Medical Director (MD) needs to attend the QAA meeting since they collaborate with MD about any medical concerns, and do a root cause analysis of any concerns in the facility. The DON stated it was the responsibility of the DON to inform and make sure that they adjust the schedule according to the MD's availability. The DON stated that MD did not attend on July 2024. The DON further added that she did not inform or relay the minutes of the meeting to MD.</p> <p>During a concurrent interview and record review on 10/14/2024 at 1:30 p.m., with the Administrator (Admin), the Admin stated that it is very important for the MD to attend the meeting since he is one of our governing bodies who is a resource for any medical concerns and helps implement corrective actions,. The Admin stated that the facility should inform the MD ahead of time and if the MD is not available the facility should adjust the meeting date to ensure the MD can attend.</p> <p>During a record review of the facility ' s 2024 Quality Assurance and Performance Improvement (QAPI) program policy and procedure (P&P) effective 02/01/2023 the P & P indicated the primary purpose of the QAPI is to establish data-driven, facility wide processes that improve the quality of care, quality of life and clinical outcomes of our residents. Governing body refers to individuals who are legally responsible to establish and implement policies regarding the management and operations of the facility.</p>		

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<p>F 0943</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation.</p> <p>44055</p> <p>Based on interview and record review the facility failed to ensure 2 out of 2 staff members Licensed vocational nurse (LVN) LVN 1 and LVN 2 were provided with abuse training prior to providing direct patient care.</p> <p>This failure had the potential to put the residents of the facility at risk for abuse.</p> <p>Findings:</p> <p>During concurrent interview and record review on 10/12/2024 at 1:15 p.m., with Director of Staff Development (DSD implements educational programs for employees), two employee files were reviewed, Licensed Vocational Nurse (LVN) LVN 1 and LVN 2. The DSD stated employees must have abuse training prior to providing direct resident care. The DSD stated that she could not find that LVN 1 and LVN 2 had been trained on abuse prior to providing direct patient care. The DSD stated residents are at risk for abuse if staff are not trained.</p> <p>During an interview on 10/13/2024 at 12:45 p.m., with the Administrator (Adm), the ADM stated the DSD's role is to maintain the facilities education program and hire the frontline staff. The ADM stated abuse training is provided upon hire and twice a year. The ADM stated staff must have abuse training before providing direct care to the residents. The ADM stated there is a potential for abuse if staff are not trained and educated properly.</p> <p>During a review of the facilities policy and procedure titled In-service Training, All Staff dated 8/2022 indicated all staff are required to participate in regular in-service education. In service education participation is considered working time for which staff are paid their regular wages.</p> <p>Required training topics include Preventing abuse, neglect, exploitation, and misappropriation of residents properly including:</p> <ol style="list-style-type: none"> 1. Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property. 2. Procedures for reporting incidences of abuse, neglect, exploitation, or misappropriation of resident ' s property. 3. Dementia management and resident abuse prevention. <p>Training requirements are met prior to staff providing services to residents, annually, and as necessary based on facility assessment.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056283	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/13/2024
NAME OF PROVIDER OR SUPPLIER Bixby Knolls Towers Health Care & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0949</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide behavior health training consistent with the requirements and as determined by a facility assessment.</p> <p>44055</p> <p>Based on interview and record review the facility failed to ensure a tracking system was maintained for staff participation and competency in the facility's on- line learning program.</p> <p>This failure had the potential to put the resident ' s safety at risk when not maintaining a tracking system to ensure staff are completing and competent in the assigned on-line learning.</p> <p>Findings:</p> <p>During a concurrent interview on 10/12/2024 at 1:15p.m., with the Director of Staff Development (DSD) and record review of the 2024 in-service binder, the DSD stated she was responsible for managing the education program in the facility. The DSD stated that the facility uses an online continuing education software The DSD stated she also provides in person classroom learning. The DSD stated she does not keep any data regarding the staff's progress for the online learning in her binder. The DSD stated she could not retrieve lesson plans from the online education application software. The DSD stated she needed to learn how to use the software better. The DSD stated the residents' safety is at risk when staff are not trained.</p> <p>During an interview on 10/13/2024 at 12:45 p.m., with the Administrator (Adm), the ADM stated that the DSD's role is to maintain the facility's education program and hire the frontline staff. The ADM stated the DSD is responsible for maintaining the facility's on- line learning program. The ADM stated the DSD needs to know how the use the on-line learning application and how the program works. The ADM stated there was a possibility of not catching who completed the in-services and who did not if the DSD does not know how to retrieve that information. The ADM stated there is a risk for residents not to receive the appropriate care for their medical conditions.</p> <p>During a review of In-service /Director/ Educator job description dated 2003 indicated duties and responsibilities.</p> <ol style="list-style-type: none"> 1. Plan develop, direct, evaluate and coordinate educational and on the job training programs. 2. Incorporate commercially produced instructional material and training aids into existing in-service programs as deemed necessary. <p>During a review of the facilities policy and procedure titled, staffing, Sufficient and Competent Nursing dated 8/2022 indicated Competency requirements and training for nursing staff are established and monitored by nursing leadership with input from the medical director to ensure that:</p> <ol style="list-style-type: none"> a. programming for staff training results in nursing competency. b. gaps in education are identified and addressed. c. education topics and skills needed are determined based on the resident population. <p>(continued on next page)</p>		

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<p>F 0949</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>d. tracking or other mechanisms are in place to evaluate effectiveness of training; and</p> <p>e. training includes critical thinking skills and managing care in a complex environment with multiple interruptions.</p>		