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	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bixby Towers Post-Acute Rehab	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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47092 Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1 ' s), Family Member (FM) 1 who was also the appointed Durable Power of Attorney (DPOA - a legal document where an agent is appointed to make financial, medical, and/or legal decisions on behalf of the appointor if they become unable to make rational decisions due to a mental or physical condition) was notified prior to Resident 1 ' s ophthalmology (a medical specialty focused on the medical and surgical care of the eyes and vision) and ear, nose and throat (ENT) appointment. These failures resulted in Resident 1 being seen by the ophthalmologist on 6/10/2024 and by the ENT on 11/14/2024, without the DPOAs knowledge. These failures also resulted in a violation of Resident 1 ' s rights. Findings: During a review of Resident 1 ' s Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including cognitive communication deficit (difficulty with cognitive processes like attention, memory, and reasoning) Alzheimer ' s disease (a progressive disorder that affects memory, thinking, and behavior), and legal blindness (poor vision that interferes with daily activities). During a review of Resident 1 ' s Minimum Data Set (MDS - resident assessment tool) dated 2/21/2025, the MDS indicated Resident 1 ' s cognition (ability to think and reason) was mildly impaired. The MDS indicated Resident 1 required maximum assistance (helper does more than half the effort) for toileting hygiene, showering/bathing, and dressing the upper/lower body. During a review of Resident 1 ' s Health Care Directive - Living Will/Health Care Power of Attorney (Health Care Directive), dated 4/8/2010, the Health Care Directive indicated FM 1 was the DPOA. During a review of Resident 1 ' s Interdisciplinary Team (IDT) Note, dated 4/30/2024, the IDT Note indicated the Director of Nursing (DON), and Minimum Data Set Coordinator (MDSC) spoke with the resident ' s representative, FM 1, over the phone and confirmed with FM 1 Resident 1 should only be seen by the primary care physician, podiatrist, and dentist/dental hygienist. The IDT Note indicated no other specialists are allowed to evaluate the Resident 1. The IDT Note further indicated nurses were reminded to notify and update FM 1 after every physician or specialist visit. (continued on next page)

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s Ophthalmology Consult Note, dated 6/10/2024, the Ophthalmology Consult Note indicated Resident 1 had an eye exam on 6/10/2024. During an interview on 4/16/2025 at 9:32 a.m., with the MDSC, the MDSC stated she recalled having a meeting with FM 1 back in 4/2024 about FM 1 ' s request to be notified before Resident 1 sees any new physicians, and FM 1 was very involved, making all of Resident 1 ' s medical decisions. MDSC stated if there was a referral to a physician or specialist, they should let FM 1 know, and document it since she was the DPOA and had the authority to make those decisions. The MDSC stated after every appointment with a physician or specialist it should be documented in Resident 1 ' s chart. The MDSC stated there was no documentation indicating FM 1 was notified or authorized Resident 1 ' s ophthalmology consult on 6/10/2024. During an interview and concurrent record review on 4/16/2025 at 10:53 a.m. with the Social Services Director (SSD), the Social Services Note, dated 11/21/2024, was reviewed. The Social Services Note indicated Resident 1 was seen ENT on 11/14/2024, but did not indicate FM 1 authorized it or was notified. The SSD stated FM 1 made Resident 1 ' s medical decisions and all ancillary (supplemental services that support diagnostic, therapeutic, and custodial care) services such as ophthalmology and ENT should be authorized by FM 1, and visits/notification documented in Resident 1 ' s chart to have proof of keeping their agreement with FM 1. The SSD stated she recalled having a conversation with FM 1 about not wanting Resident 1 to see ophthalmology sometime in 2024 but did not remember the date. During an interview on 4/16/2025 at 2:35 p.m., with Resident 1, Resident 1 stated all care decisions have always gone through FM 1 since he had been at this facility, and she (FM 1) made all his medical decisions. Resident 1 stated he designated her to make all his medical decisions and did not make any of his own. During a review of the facility ' s policy and procedure (P&P) titled Resident Rights, dated 8/2022, the P&P indicated the resident has the right to be informed of, and participate in, his or her care planning and treatment. The P&P further indicated the resident has the right to appoint a legal representative of his or her choice, in accordance with state law.

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47092 Based on interview and record review, the facility failed to ensure all nursing staff were trained on the proper use of the Tilt-in-space wheelchair (a type of wheelchair where the entire seat and backrest tilt backward as a single unit) prior to its use for one out of three sampled residents (Resident 1). This deficient practice had the potential to place Resident 1 at risk for falls and/or injuries due to the nursing staff ' s lack of training. Findings: During a review of Resident 1 ' s Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including cognitive communication deficit (difficulty with cognitive processes like attention, memory, and reasoning) Alzheimer ' s disease (a progressive disorder that affects memory, thinking, and behavior), and legal blindness (poor vision that interferes with daily activities). During a review of Resident 1 ' s Minimum Data Set (MDS - a resident assessment tool) dated 2/21/2025, the MDS indicated Resident 1 had mild cognitive (ability to think and reason) impairment. The MDS further indicated Resident 1 required maximum assistance (helper does more than half the effort) for toileting hygiene, showering/bathing, and dressing the upper/lower body. During a review of Resident 1 ' s Witnessed Fall Report dated 4/2/2025 and timed at 12:20 p.m., the Witness Fall Report indicated on 4/2/2025, Certified Nursing Assistant (CNA) 1 and Licensed Vocational Nurse (LVN) 1 transferred Resident 1 from a mechanical lift (a device designed to lift and move a resident from one place to another) into the Tilt-in-space wheelchair. The Witness Fall Report indicated Resident 1 was seated in an upright position after being transferred, then began to slide down towards the floor. During an interview on 4/15/2025 at 9:16 a.m., LVN 1 stated on 4/2/2025, she was assisting CNA 1 with transferring Resident 1 into his Tilt-in-space wheelchair. LVN 1 stated after Resident 1 was fully transferred from the mechanical lift, he was noted to be crooked, leaning towards his left side, then began to slide down the chair. During an interview on 4/15/2025 at 9:32 a.m. with CNA 1, CNA 1 stated on 4/2/2025 at around 12:15 p.m. she got Resident 1 out of bed with the help of LVN 1. CNA 1 stated during the transfer the Tilt-in-space wheelchair was in a tilted back position and after the transfer was completed, she (CNA 1) brought the chair upright with Resident 1 ' s head at a 90-degree angle. CNA 1 stated Resident 1 began to slide down the chair once he was upright. During an interview on 4/15/2025 at 10:58 a.m., with the Director of Staff Development (DSD), the DSD stated the Director of Rehabilitation (DOR) was the one who trained the staff on the use of the Tilt-in-space wheelchairs. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/15/2025 at 11:19 p.m. the Director of Rehab (DOR) stated a Tilt-in-space wheelchair is different than a regular wheelchair and the rehabilitation staff should train all nursing staff on how to adjust the chair properly for resident comfort and safety. The DOR stated she did not personally train CNA 1 on how to use the Tilt-in-space wheelchair prior to 4/2/2025. The DOR stated all staff should be trained on the use of all equipment prior to any staff member using the equipment to ensure resident ' s safety and to prevent injuries. During an interview on 4/15/2025 at 12:27 p.m. with CNA 1, CNA 1 stated she was never trained on the use of the Tilt-in-space wheelchair until after 4/2/2025. During an interview on 4/15/2025 at 2:27 p.m. with the Director of Nursing (DON), the DON stated all nursing staff should be trained on the Tilt-in-space wheelchair because it is different than a regular wheelchair and training would prevent resident injury from misuse. During an interview on 2:47 p.m. with LVN 1, LVN 1 stated she had not been trained on the use of a Tilt-in-space wheelchair. During a review of the facility ' s policy and procedure (P&P) titled, Use of Uncommon Wheelchairs, dated 6/17/2023, the P&P indicated staff unfamiliar with a wheelchair model must receive on-the-spot instruction or guidance before use.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47092 Based on interview and record review, the facility failed to obtain the manufacturer ' s guidelines and maintain a Tilt-in-space wheelchair (a type of wheelchair where the entire seat and backrest tilt backward as a single unit) per the manufacturer ' s guidelines for one out of three sampled residents (Resident 1). This deficient practice had the potential place Resident 1 at risk for injury from improperly maintained equipment. Findings: During a review of Resident 1 ' s Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including cognitive communication deficit (difficulty with cognitive processes like attention, memory, and reasoning), Alzheimer ' s disease (a progressive disorder that affects memory, thinking, and behavior), and legal blindness (poor vision that interferes with daily activities). During a review of Resident 1 ' s Minimum Data Set (MDS - a resident assessment tool) dated 2/21/2025, the MDS indicated Resident 1 had mild cognitive (ability to think and reason) impairment. The MDS further indicated Resident 1 required maximum assistance (helper does more than half the effort) for toileting hygiene, showering/bathing, and dressing the upper/lower body. During an interview on 4/15/2025 at 11:19 p.m. with the Director of Rehabilitation (DOR), the DOR stated she did not possess the user manual for the Tilt-in-space wheelchair because it was Resident 1 ' s personal wheelchair. During an interview on 4/15/2025 at 12:08 p.m., with the Maintenance Supervisor (MS), the MS stated he did not possess the user manual for the Tilt-in-space wheelchair because the chair was owned by Resident 1. The MS stated they have adjusted it in the past and make sure it is working but should have the user manual to know exactly what needs to be done to maintain the chair, and what to look for to prevent any safety issues. During a review of the facility ' s policy and procedure (P&P) titled, Maintenance Service, dated 12/2009, the P&P indicated the Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times, and the maintenance personnel shall follow the manufacturer ' s recommended maintenance schedule.