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	05/16/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 44055 Based on observation, interview, and record review the facility failed to ensure three of the five sampled staff (Receptionist 1, Certified Nurse Assistant 1, and Maintenance 1) wore an identification badge as indicated in the facility ' s policy. This deficient practice did not promote a culture of safety and transparency and violated residents ' right to know who was providing care and to be treated with respect. Findings: During an observation and interview on 5/16/2025 at 10:08 a.m., with Receptionist 1, Receptionist 1was not wearing a name badge and Receptionist 1 stated she was new, and she was still waiting for her name badge to be issued. During an observation and interview on 5/16/2025 at 10:10 a.m., with Certified Nurse Assistant 1 (CNA 1), CNA 1 was not wearing a name badge and CNA 1 stated she forgot to wear her name badge today. During an observation and interview on 5/16/2025 at 10:20 a.m., with Maintenance 1, Maintenance 1was not wearing a name badge and Maintenance 1 stated he was not wearing his name badge right now while doing rounds in residents ' rooms. During an interview on 5/16/2025 at 12:47 p.m. with the Assistant Director of Nursing ADON), the ADON stated all staff need to always wear a name badge so residents can identify facility staff. During a review of the facility's policy and procedure (P&P) titled, Identification Badge Policy, updated 1/2021, the P&P indicated: 1) The purpose of the policy was to establish a process for the issuance of approved identification badges and designate the responsibilities associated with maintaining compliance for ALL employees. 2) An identification badge, including; employees 1) full name (in at least 18 p An identification badge, including; employees 1) full name (in at least 18-point font), 2) position/ title and 3) current professional picture, must be worn by all staff members, always while on the facility premises. This is an important aspect of both security and resident rights. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3) All staff were responsible for: a. Wearing the company always issued picture identification badge while at work, on facility premises and not outside the premises unless on official business; b. Wearing the identification badge above waist level and fully visible with face and name side facing outwards: c. Ensuring that identification badges are easily read and not obscured by clothing, stickers or anything else that could inhibit a patient or visitor from seeing/reading the badge.

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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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44055 Based on observation, interview, and record review the facility failed to ensure one of four sampled resident ' s (Residents 3) call light (device that allows residents to request assistance from nursing staff) was within reach. This deficient practice resulted in a delay of care and services. Findings: During a review of Resident 3 ' s Admission Record, the Admission Record indicated Resident 3 was originally admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy (brain disorder) and muscle weakness. During a review of Resident 3's Minimum data Set (MDS), a resident assessment tool, dated 2/20/2025, the MDS indicated Resident 3 ' s cognition was intact. The MDS indicated Resident 3 needed setup assistance with eating, oral hygiene, personal hygiene, and partial assist (helper does less than half the effort) with showering. During an interview and observation 5/16/2025 at 10:30 a.m. with licensed vocational nurse 2 (LVN2), Resident 3's called light was not in reach. LVN 2 stated Resident 3 ' s call light should be within reach so he can call for help. During an interview on 5/16/2025 at 12:47 p.m. with the Assistant Director of Nursing ADON), the ADON stated call lights should always be in reach so residents can call for assistance when needed. During a review of the facility's policy and procedure (P&P) titled, Call Light Answering, revised 12/2023, the P&P indicated the facility will provide the residents a means of communication with the nursing staff. The P&P indicated the call light need to be within the residents ' reach before the staff leaves the room.