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	10/02/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure one of three sampled residents (Resident 1) did not elope from the facility. This deficient practice resulted in Resident 1 eloping from the facility on 9/27/2025 at approximately 6:04 p.m., unbeknownst to staff. Resident 1 was returned to the facility on the same day (9/27/2025) after being found by family at a gas station four blocks from the facility at approximately 11:15 p. m. This deficient practice place Resident 1 at risk for harm because of in climate weather, motor vehicle accidents, fall, violence at the hands of others and death. Findings: During a review of Resident 1's admission Record , the admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including ventricular tachycardia (fast heart rate), hypotension (low blood pressure), and depression (a feeling of sadness). During a review of Resident 1's History and Physical (H& P) dated 8/20/2025, the H&P indicated Resident 1 could make needs known but could not make medical decisions. During a review of Resident 1's Minimum Data Set (MDS] resident assessment tool) dated 8/22/2025, the MDS indicated Resident 1 required substantial/maximal assistance (helper does more than half the effort). The MDS indicated maximum assistance with toileting hygiene, shower/bath, and personal hygiene. During a review of Resident 1's Progress Notes dated 9/27/2025, the Progress Notes indicated Resident 1 was not in his assigned room. A search for Resident 1 was initiated. The Progress Notes indicated Resident 1's family was contacted. The Director of Nursing (DON) and Administrator were also notified. The Progress Notes indicate that at 11:15 p.m., Resident 1 returned to the facility after family members found Resident 1 at a nearby gas station. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/30/2025 at 9:05 a.m. with Certified Nurse Assistant (CNA) 1, CNA 1 stated that he was working on the unit on 9/27/2025 when Resident 1 exited the facility unsupervised. CNA 1 stated that during routine rounds at approximately 3:30 p.m., he noticed that Resident 1 was not in his assigned room. He immediately checked the surrounding area and notified the Registered Nurse Supervisor (RNS). CNA 1 stated, the RNS informed him that Resident 1 was downstairs with his wife and expressed no concern that the resident might leave the facility. CNA 1 further stated that at approximately 5:30 p.m., during another routine round, he observed Resident 1 lying in bed. CNA 1 stated Resident 1 was observed attempting to pull out his gastrostomy tube (G-tube) and was trying to get out of bed. CNA 1 stated he reported this behavior to Licensed Vocational Nurse (LVN) 1 and the RNS but stated that no further interventions or actions were taken by the nursing staff. CNA 1 stated that he monitors residents every two hours and as needed. CNA 1 stated at approximately 10:00 p.m., and he discovered that Resident 1 was no longer in the facility. CNA 1 immediately notified LVN 1 and the RNS. CNA 1 stated that both nurses initiated a search of the facility, including both interior and exterior areas, in an effort to locate the resident. CNA 1 stated that residents were not permitted to go downstairs without staff supervision, and that if a resident leaves the facility or moves about unsupervised, resident were at risk for harm such as falls, injury, becoming lost, or encountering unsafe situations in the community. During an interview conducted on 9/30/2025 at 9:30 a.m. with Licensed Vocational Nurse (LVN) 1, he stated that he was responsible for the care of Resident 1 at the time of the elopement on 9/27/2025. LVN 1 stated that at approximately 3:00 p.m., during routine rounds, he observed Resident 1 in his room with his wife and another family member. LVN 1 stated approximately 5:00 p.m., while passing medications, he saw Resident 1 sitting alone in a wheelchair in the hallway. LVN 1 offered the resident his medications, which the resident refused. LVN 1 stated that at approximately 10:00 p.m., CNA 1 informed him that Resident 1 was missing from the facility. LVN 1 stated upon receiving this report, LVN 1 immediately notified the Registered Nurse Supervisor (RNS) and initiated a search of the facility, both inside and outside. LVN 1 contacted Resident 1's wife, who confirmed that the resident was not with her and stated she would come to the facility to assist in locating him. LVN 1 stated that Resident 1 was out of the facility for approximately five hours. LVN 1 stated residents must be supervised at all times when going downstairs. LVN 1 stated that if a resident elopes from the facility without supervision, they were at risk for injury, becoming lost, or encountering environmental hazards. During an interview conducted on 9/30/2025 at 11:55 a.m. with LVN 2, LVN 2 stated that residents were not permitted to go downstairs without staff supervision. LVN 2 stated that there was no nursing personnel assigned to the first floor, and it was unclear who was responsible for monitoring residents in that area. LVN 2 stated that residents who go downstairs unsupervised could be at risk for falls, medical emergencies, or elopement, which could result in injury. LVN 2 further stated that Resident 1 wears a life vest, an external medical device used for patients at risk of sudden cardiac arrest and therefore requires continuous monitoring and supervision. LVN 2 emphasized that if the vest were to become dislodged or malfunction, the resident could require immediate medical assistance. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/30/2025 at 11:55 a.m. with License Vocational Nurse (LVN) 2, LVN 2 stated that the residents were not allowed to go downstairs unsupervised. LVN 2 stated that there were no nursing personnel on the first floor to supervise residents, and it is unclear who is responsible for their monitoring. LVN 2 stated Residents could fall, have an emergency medical, or could leave the facility and become injured. LVN 2 stated that Resident 1 wears a life vest (an external medical device worn by patients at risk of sudden [cardiac death]-when the heart stops working) and requires continuous monitoring and supervision, as the vest could come off and the resident may need immediate assistance. During a concurrent observation and interview conducted on 9/30/2027 at 12:27 p.m. with the Maintenance Supervisor (MS), the dining room exit doors were observed to be locked from the outside, while staff were able to open the doors freely from the inside. The MS stated that the dining room exit doors can be secured externally but emphasized that residents and visitors were still able to exit the facility from the inside at any time. The MS acknowledged that this setup poses a safety concern for residents, stating that it was potentially dangerous and could compromise resident safety in the event of an emergency. During a concurrent observation and interview on 9/30/2027 at 1:30 p.m. with the Director of Nursing (DON), the DON stated that residents were not permitted to go downstairs, as there was no nursing personnel stationed in that area to provide supervision. The DON further stated that Resident 1 requires monitoring and supervision due to wearing a life vest, and that elopement poses a significant risk to Resident 1's safety. The DON confirmed that Resident 1 was unsupervised and away from the facility for approximately five hours. Reviewed the facility's video surveillance footage from 9/27/2025, between 5:55 p.m. and 6:04 p.m., was conducted. The footage showed Resident 1 in a wheelchair exiting through the dining room exit doors at 6:04 p.m. The DON reviewed and validated the footage, confirming that the individual captured in the video appeared to be Resident 1. During a review of the facility's policy and procedure (P&P) titled, “Safety and Supervision of Residents,” dated 2017, the P&P indicated, “Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision to prevent accidents are facility-wide priorities.”