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	05/22/2026

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide consistent monthly billing statements, maintain appropriate billing record practices, and ensure financial privacy for two of three sampled residents (Resident 2 and Resident 3).These deficient practices resulted in Resident 2 and Resident 3 being unable to receive clear, accurate, and confidential billing information regarding charges and account balances while in the facility.Findings:1. 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, End-stage renal disease (ESRD-chronic kidney disease), Unspecified cirrhosis of the liver (advanced liver scarring where normal tissue is replaced by hard fibrous tissue), and Hyperkalemia (a serious condition where the potassium level in your blood is too high).During a review of Resident 2's MDS Minimum Data Set (a resident assessment tool) dated 02/27/2026, the MDS indicated Resident 2 was cognitively intact. The MDS indicated Resident 2 need setup or clean up assistance (helper set and or clean up) with eating and oral hygiene, supervision or touching assistance for personal and upper body dressing.During an interview on 05/22/2026 at 09:49 am with Resident 2, Resident 2 reported the facility was very poor in providing billing statements. Resident 2 stated the last billing statement he recalled seeing was months ago on top of his food tray and reported no one was accountable for properly delivering billing statements. Resident 2 stated he never received receipts from the facility and did not know exactly what he was being charged for, and staff verbally informed him of payment amounts. Resident 2 stated the facility needed to improve the way billing statements were distributed and stated he wanted his billing statements handed directly to him instead of being left on the bedside table where others could view his private financial information.During an interview on 05/22/2026 at 12:58 pm with the Activity Director (AD), the AD stated she is responsible for delivering mail to residents. The AD stated, if a resident was not in their room, she would leave the mail on the bedside table. The AD stated that for Resident 2, who regularly leaves the facility for dialysis treatments, mail was also left on the bedside table when Resident 2 was not present. The AD stated there was no system for obtaining proof of delivery or resident acknowledgment of receipt. The AD stated that leaving mail unattended on bedside tables does not ensure residents receive their correspondence. The AD stated moving forward, staff will ensure mail is handed directly to residents and will no longer leave mail unattended in resident rooms because there is no proof the residents received it.2. During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was admitted to the facility on [DATE] with diagnoses including, Chronic Obstructive Pulmonary Disease (inflammatory lung disease that restricts airflow and causes breathing difficulties), Cardiomegaly (enlarged heart), and Essential hypertension (chronic elevation of blood pressure).During a review of Resident 3's MDS dated [DATE], the MDS indicated Resident 3 was cognitively intact. The MDS indicated Resident 3 need setup or clean up assistance with eating and personal hygiene.During an interview on 05/22/2026 at 09:16 a.m. with Resident 3, Resident 3 reported she never consistently received billing statements from the facility and could not recall the last time she was provided one. Resident 3 stated, It has been a while since she received a billing statement. Resident 3 stated the facility was supposed to bring the billing statements for her (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	review.During an interview on 05/22/2026 at 10:06 am with the Business Office Director (BOD), the BOD stated she was not responsible for handing out billing statements to residents and reported the Activity Director distributed the statements. The BOD stated that moving forward the facility would develop a better process for delivering billing statements, including implementing a log and resident signature process to track distribution. The BOD acknowledged there was currently no tracking system in place for residents receiving mailed billing statements and agreed residents had the right to review their billing statements.During an interview on 05/22/2026 at 1:04 p.m. with the Director of Nursing (DON), the DON stated billing statements should have been given to Resident 2 and Resident 3 and not placed on bedside table, so they could acknowledge the mail was received. The DON stated the facility will put a system in place to track mail that is sent out and delivered to the residents in the facility.During a review of the facility's P&P titled, Billings undated, the P&P indicated, Each resident will receive an itemized statement for services rendered during billing cycle.