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	05/27/2026

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 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** The facility failed to ensure the bed for one of three sampled residents (Resident 2) was locked at all times. This deficient practice resulted in Resident 2 feeling unsafe when his bed moved on several occasions when he attempted to get in it. This deficient practice had the potential for Resident 2 to be subjected to falls and injury.Findings: During a review of Resident 2's admission Record (Face Sheet), the Face Sheet indicated Resident 2 was admitted to the facility on [DATE]. Resident 2 had diagnoses including orthopedic aftercare (care and services for a person who underwent a surgery involving bones, muscles and ligaments of the body) following a surgical amputation (the surgical removal of a part of the body, such as an arm or leg), gait (the pattern or style of movement involved in walking) and mobility abnormality, and end stage renal disease ([ESRD] irreversible kidney failure). During a review of Resident 2's Minimum Data Set ([MDS] a resident assessment tool) dated 4/8/2026, the MDS indicated Resident 2 was able to make decisions that were reasonable and consistent and he required one to two person assist to complete his activities of daily living ([ADLs] routine tasks/activities such as bathing, dressing, toileting hygiene, and repositioning in bed. During an interview on 5/26/2026 at 10:50 a.m., Resident 2 stated he goes to hemodialysis (a treatment to cleanse the blood of waste and extra fluids artificially through a machine when the kidney[s] have failed) three times a week and when he comes back from hemodialysis, his bed would always be unlocked. Resident 2 stated three times in the past while waiting for a nurse to help him back to bed, his bed would sway away from him, which worried him and made him feel unsafe. During an interview on 5/26/2026 at 11:14 a.m., with Certified Nursing Assistant (CNA) 1 and a concurrent observation of Resident 2's bed, Resident 2's bed was noted to be unlocked and moved easily when pushed against it. CNA 1 stated Resident 1's bed should always be locked to make sure Resident 2 was safe. During an interview on 5/26/2026 at 11:15 a.m., Licensed Vocational Nurse (LVN) 1 stated Resident 2 needed supervision and assistance when transferring from his wheelchair to bed and vice versa, and his bed should be locked at all times to prevent an accident and injury. During an interview on 5/26/2026 at 11:22 a.m., CNA 2 stated she should have checked to make sure Resident 2's bed was locked because Resident 2 was a fall risk. During an interview on 5/27/2026 at 12:45 p.m., the DON stated it was CNA 2's responsibility to make sure Resident 2's bed was locked to prevent accidents from occurring. During a review of the facility's Policy and Procedure (P/P) titled, Safety and Supervision of Residents revised 7/2017, the P/P indicated the facility shall strive to make the residents' environment free from environmental hazards including, but not limited to:a. bed safety

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the medical records for one of three sampled residents (Resident 1) was accurately documented to reflect activity visits by the facility's activity staff, the activity provided, and Resident 1's participation level and response to the activities. This deficient practice resulted in the inability to track activity provided to Resident 1 and had the potential for Resident 1 be socially isolated and suffer from depression and loneliness. Findings: During a review of Resident 1's admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE]. Resident 1 had diagnoses including autistic disorder (a condition related to brain development that affects how people see others and socialize with them), hypertension ([HTN] high blood pressure) and lymphocytic leukemia (a type of cancer in the blood cells). During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 5/8/2026, the MDS indicated Resident 1 was able to make decisions that were reasonable and consistent and he required a one-person assist to complete his activities of daily living ([ADLs] activities such as bathing, dressing and toileting a person performs daily). The MDS indicated it was important for Resident 1 to do his favorite activities while at the facility. During a review of Resident 1's untitled Care Plan dated 5/6/2025, the Care Plan's goal was for Resident 1 to express satisfaction with the facility's accommodations of his preferences and to utilize his strength to improve his quality life. The Care Plan's interventions included respecting Resident 1's activity preferences and providing Resident 1's activity preference in a timely manner. During a review of Resident 1's Activities Note dated 3/31/2026 and timed at 1:07 p.m., the Activities Note indicated Resident 1 would continue to have regular room visits by the activity staff twice a week as requested and as preferred by Resident 1. During a review of the facility's Room Visit Sign In Sheet, the Room Visit Sign In Sheet indicated Resident 1 was visited by the activity staff on 5/2/2026, 5/5/2026, and 5/9/2026. During an interview on 5/26/2026 at 11:58 a.m., Resident 1 stated he preferred room visits twice a week, but the activity staff had not been consistent with the visits and there were times during the month of 5/2026 when the activity staff only visited him once a week. Resident 1 stated he felt deprived of social interaction. During an interview on 5/27/2026 at 11:14 a.m., with the Activity Director (AD), and a concurrent review of Resident 1's Room Visit Sign In Sheet, dated 5/2026, the Room Visit Sign In Sheet indicated only three room visits were documented by activity staff, and the Room visit Sign In Sheet did not indicate the specific activities provided to Resident 1 during each visit. The AD stated Resident 1 preferred room visits twice a week but she and the other activity staff who visited him did not document in Resident 1's medical record each time they conducted room visits. She and the other activity personnel should have documented in Resident 1's medical record after a room visit was conducted to indicate the specific individualized activities provided to Resident 1, Resident 1's participation and response to the activities provided. During an interview on 5/27/2026, the Director of Nursing (DON) stated the activity staff should have documented in Resident 1's medical record to show the specific activity provided to Resident 1, track his responses to the activities provided to ensure his satisfaction. During a review of the facility's Policy and Procedures (P/P) titled, Activity Programs revised 6/2018, the P/P indicated the facility shall design and provide activity programs that include group activities, independent/individualized activities and assisted individual activities that meet the interests and preferences of the residents. These activities shall be provided in an ongoing manner to ensure the residents' sense of well-being and to promote and/or enhance their physical, cognitive and emotional health. The P/P indicated all activities provided shall be documented in the residents' medical record. During a review of facility's P/P titled, Charting and Documentation revised 7/2017, the P/P indicated all services provided to the residents, progress toward care plan goals, or any changes in the residents' medical, physical, (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	functional or psychosocial condition, shall be documented in the residents' medical record. The P/P indicated the medical record shall facilitate communication between the interdisciplinary team regarding the residents' condition and response to care and services.