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	06/17/2026

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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident?s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility's staff failed to immediately initiate Cardiopulmonary Resuscitation ([CPR] an emergency procedure to restart a person's heart and breathing after one or both suddenly stop) to one of five sampled residents (Resident 1), when Certified Nurse Assistant (CNA) 1 and CNA 2, who were CPR certified (successfully completed a training course and received a credential that qualifies a person to perform CPR), failed to check Residents 1's pulse, breathing and obtain immediate assistance to initiate CPR, activate a code blue (a specific code used to signal a patient who is having a life threatening medical emergency, typically a patient experiencing sudden cardiac arrest [when the heart stops] and/or respiratory arrest [when a person stops breathing), and call 911 on [DATE] at approximately 7:30 a.m., when Resident 1 was found unresponsive (a person is unconscious and fails to react to any external stimulation). In addition, the facility failed to implement its Policy and Procedure (P&P), titled Cardiopulmonary Resuscitation that indicated staff should engage in concurrent/coordinated response activities, to include assessing the individual (quickly evaluating responsiveness breathlessness, pulselessness), activating 911, positioning the individual for CPR, initiating chest compressions and performing rescue efforts as indicated when Resident 1 was found unresponsive. These deficient practices resulted in a delay in providing CPR to Resident 1 and at 8:10 a.m., 40 minutes after Resident 1 was found unresponsive, Resident 1 was pronounced dead by the paramedics. On [DATE] at 5:25 p.m., an Immediate Jeopardy ([IJ] a situation in which a facility's noncompliance with one or more requirements of participation has caused, or is likely to cause serious injury, harm, impairment , or death to a resident) was called in the presence of the facility's Administrator (ADM) due to the facility's failure to provide timely BLS to Resident 1, including immediate initiation of CPR, which potentially contributed to Resident 1's death. An IJ Removal Plan ([IJRP] a plan to immediately correct the deficient practices) was requested. On [DATE], the facility submitted an acceptable IJRP. After onsite verification of the facility's IJRP implementation through observation, interview, and record review, the IJ was removed on [DATE] at 3:55 p.m., in the presence of the facility's Director of Nursing (DON), ADM, and Consultant. Non-compliance of F678 remained at the scope and severity of D no actual harm with potential for more than minimal harm that is not immediate Jeopardy. The IJRP included the following: Immediately upon identification of Immediate Jeopardy (IJ) on [DATE], the facility initiated emergency corrective actions to ensure the safety of all residents. On [DATE], all licensed nurses and CNAs on duty were immediately re-educated by the DON and the Director of Staff Development (DSD). A total of 32 licensed nurses (LN), 51 CNAs, and 7 therapy staff were educated on [DATE]. All LNs, CNAs, and therapy staff who were not present for training prior to or on [DATE] (including those on vacation, leave of absence, or off duty) will be re-educated prior to returning to work. Re-education will be provided by the DON, DSD. Reeducation consisted of immediate initiation of CPR for any resident found pulseless and/or unresponsive, immediate activation of Code Blue and calling 911 without delay, ensuring the resident was never left unattended when found unresponsive. Provide return demonstration to validate competency in immediate recognition, Code Blue activation, calling 911, and (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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	initiation of CPR. All staff demonstrated competency through return demonstration. Ensure staff follows the AHA and BLS response guidelines: Recognize unresponsiveness immediately by observing for absence of normal breathing and check for a pulse immediately. If the resident is pulseless and unresponsive, treat it as a medical emergency. Activate Code Blue immediately and direct staff to bring emergency equipment/crash cart. Call 911 immediately or direct another staff member to call 911 without delay. Initiate CPR immediately when the resident is found unresponsive, not breathing normally, and pulseless. Begin chest compressions without delay and continue until relieved by another qualified responder, the resident shows signs of life, or EMS assumes care. Do not leave the resident unattended once found unresponsive. Facility nursing staff will have every shift huddles wherein any DNR status residents will be reported and disclosed at the time of handoff to the next shift. On [DATE], DON Provided 1 to 1 (individualized instruction where a single educator works directly with one learner) re-education to CNA on duty at time of incident on following: Immediate initiation of CPR for any resident found pulseless and/or unresponsive Immediate activation of Code Blue and calling 911 without delay No delay in initiating CPR for assessments or other interventions Ensuring the resident is never left unattended when found unresponsive Follows the AHA, and BLS response guidelines A facility-wide audit was conducted to verify code status for all residents on [DATE] by Resource Nurse Consultant. On [DATE], a mock Code Blue drill was conducted by Resource Nursing Consultant and DON. Staff demonstrated immediate response, CPR initiated without delay and emergency system activated appropriately. On [DATE] facility scheduled outside CPR training. All licensed nurses and CNAs were audited on [DATE] for current CPR certification and all were identified as active and current by the DSD. A total 47 LNs, of the 47 LNs, 46 are active and 1 is on leave of absence (LOA). A total of 74 CNAs of the 74 CNAs, 73 are active and 1 is on leave of absence. A total 20 Therapy staff, of 20 Therapy staff, 20 are active.Findings: During a review of Resident 1's admission Record (Face Sheet) the Face Sheet indicated Resident 1 was initially admitted to the facility on [DATE] and was readmitted on [DATE]. Resident 1 had diagnoses including atrial fibrillation ([a-Fib] an irregular rapid heartbeat), arteriosclerosis of aorta (hardening of the arteries), and cardiomegaly (enlargement of the heart). During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated [DATE], the MDS indicated Resident 1's cognition (ability to think, understand, learn and remember) was intact. Resident 1 had the ability to understand and be understood by others. The MDS indicated Resident 1 required substantial/maximum assistance (helper provides more than half the effort) with toileting hygiene, showering/bathing, dressing, rolling left to right, lying to sitting on side of bed sitting to standing, transferring from chair/bed to chair, and toileting transfers. During a review of Resident 1's Physicians Orders for Life Sustaining Treatment ([POLST] a form that contains written medical orders for healthcare professionals regarding specific medical treatments that can or cannot be done at the end of life) dated [DATE], the POLST indicated if Resident 1 had no pulse and was not breathing to attempt resuscitation/CPR. During a review of Resident 1's Order Summary Report (Physician's Order) dated [DATE], the Physician's Order indicated CPR/Full Code. During a review of Resident 1's Nurses Progress Note dated [DATE] and timed 9:09 a.m., the Nurses Progress Note indicated at 7:47 a.m. ([DATE]), CNA 1 found Resident 1 unresponsive in his room. The Nurses Progress Note indicated (CNA 1) checked Resident 1 for a pulse and found none. CNA 1 yelled code blue and initiated CPR immediately. The Charge Nurse (Licensed Vocational Nurse 1 [LVN 1]) brought the crash cart and helped CNA 1 with CPR. During a review of the Emergency Medical Service Report ([EMS] a detailed document completed by emergency medical personnel that serves as a record of the resident's assessment and the care the resident received) dated [DATE], the EMS Report indicated the paramedics arrived at the facility on [DATE] at 7:56 a.m. and found Resident 1 lying in a supine (lying flat on their back with their face and torso facing upward) position in bed. Resident 1 was pulseless, apneic (not breathing), and in cardiac arrest. During an interview on [DATE] at 11 a.m., CNA 2 stated at approximately 7:45 a.m. ([DATE]) as she was walking down the hallway, CNA 1 (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	called her name and asked her to come to Resident 1's room. When she arrived in Resident 1's room, CNA 1 asked her if Resident 1 looked ok. Resident 1 was in bed in a sitting position (at a 90 degree angle), he had a nasal cannula ([n/c] a small plastic tube, which fits into the person's nostrils) in his mouth, his skin was pink, his hand warm to touch, his left leg was hanging off the bed, and he looked like he was sleeping. She (CNA 2) tried shaking Resident 1 because he sometimes would be in a deep sleep and this was what she usually did to wake him. She did not think to check his pulse or if he was breathing. She told CNA 1 to stay with the resident, while she got help. She left Resident 1's room and ran down the hallway to retrieve the crash cart (a set of trays/drawers/shelves on wheels used in hospitals or skilled nursing facility for transportation and dispensing of emergency medication/equipment), which was located across from the second floor Nurse's Station, which was about 15 feet from Resident 1's room. She saw LVN 1 in the hallway, near the Nurse's Station and notified her that Resident 1 was not waking up. She (CNA 2) then took the crash cart to Resident 1's room and LVN 1, LVN 3, and the Assistant Director of Nursing (ADON) all ran into Resident 1's room. When she entered Resident 1's room CNA 1 was attempting to wake Resident 1 up. LVN 3 gave instructions to put a back board under Resident 1 and begin CPR. She (CNA 2) placed the back board under Resident 1 and began chest compressions. CNA 2 stated she received an in-service on what to do when a resident was found unresponsive, but she did not think to check Resident 1 for breathing or a pulse, she stated it happened so fast she could not think. During an interview on [DATE] at 12:30 p.m., LVN 1 stated on [DATE] she was in the hallway (time unknown) when she saw CNA 2 and heard her say Resident 1 was not waking up. LVN 1 stated she announced code blue at 7:47 a.m. and she and CNA 2 took the crash cart to Resident 1's room. When she entered Resident 1's room CNA 1 was attempting to wake Resident 1 up. She (LVN 1) checked for a pulse, but there was none. LVN 1 stated CNA 2 began chest compressions and LVN 3 bagged Resident 1. LVN 1 stated when a resident was pulseless and not breathing staff was supposed to initiate CPR immediately to increase the resident's chance of survival. During a telephone interview on [DATE] at 1 p.m., CNA 1 stated she arrived in Resident 1's room at approximately 7:30 a.m. ([DATE]) to give him his breakfast tray, she said good morning to Resident 1, your breakfast is here, but Resident 1 did not respond. She shook Resident 1 for a couple minutes but did not check to see if he was breathing, or if he had a pulse, and she did not begin CPR because she thought Resident was sleeping. She called CNA 2 to come to Resident 1's room and told her that Resident 1 was unresponsive. CNA 2 came to Resident 1's room and shook him for a couple of minutes, then instructed me to stay with the resident while she (CNA 2) went to get help. During an interview on [DATE] at 4 p.m., the DON stated the staff have had in-services and participated regularly in mock codes (a simulated emergency drill in healthcare settings used to practice and evaluate a medical team's response to life-threatening crises, such as a cardiac arrest). They were instructed to check for breathing, a pulse, call for help, call 911, and begin chest compressions immediately when a resident is found unresponsive. During a review of the facilities policy & procedure (P&P) titled, Cardiopulmonary Resuscitation (CPR) revised [DATE], The P&P indicated properly trained personnel will be available to provide basic life support, including cardiopulmonary resuscitation (CPR), to those requiring emergency care, prior to arrival of emergency medical personnel, and subject to accepted professional guidelines, advance directives and physicians orders. The P&P indicated facility staff should engage in concurrent/coordinated response activities , to include assessing individual (i.e. quickly evaluating responsiveness, breathlessness, pulselessness), activating 911, positioning individual for CPR, initiating chest compressions and performing rescue efforts as indicated, retrieving crash cart, verifying code status, and preparing records for emergency transfer as indicated.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a plan that describes the process for conducting QAPI and QAA activities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility's QA/QAPI ([Quality Assurance/Quality Assurance Performance Improvement] data driven proactive approach to improvement used to ensure services are meeting quality standards) committee failed to ensure continued oversight of the facility's IJ Removal Plan ([IJRP] a plan to immediately correct the deficient practices) of a deficient practice identified during a previous abbreviated survey ([DATE]) that resulted in an Immediate Jeopardy ([IJ] a situation in which a facility's noncompliance with one or more requirements of participation has caused, or is likely to cause serious injury, harm, impairment, or death to a resident) being called. This deficient practice resulted in a repeat deficiency in Quality of Care (F678) and a delay in Cardiopulmonary Resuscitation ([CPR] an emergency procedure to restart a person's heart and breathing after one or both suddenly stop) for one of five sampled residents (Resident 1), when Certified Nurse Assistant (CNA) 1 and CNA 2, who were CPR certified (successfully completed a training course and received a credential that qualifies a person to perform CPR), failed to check Residents 1's pulse, breathing and obtain immediate assistance to initiate CPR, activate a code blue (a specific code used to signal a patient who is having a life threatening medical emergency, typically a patient experiencing sudden cardiac arrest [when the heart stops] and/or respiratory arrest [when a person stops breathing), and call 911 on [DATE] at approximately 7:30 a.m., when Resident 1 was found unresponsive (a person is unconscious and fails to react to any external stimulation).Findings: During a review of the facility's QAPI Plan dated [DATE], the QAPI Plan indicated on [DATE] and [DATE], in response to an IJ they received ([DATE]) the facility conducted audits of all current resident's code status, licensed nurses and Certified Nursing Assistants (CNA) CPR certification and competency as well as a mock code (a simulated medical emergency drill) was conducted. Continued review of the QAPI indicated other than a possible one time mock code there was no documentation to indicate verification staff was competent and confident in actually responding to a code blue and subsequent performance of CPR, there was only paperwork compliance and audits conducted. During an interview on [DATE] at 4 p.m., the Administrator (ADM) stated staff were educated on how to respond during a code blue, per the QAPI plan, but staff were not consistently monitored to determine if they were confident/comfortable initiating and conducting CPR. During a review of the policies and procedures (P&P), dated 7/2016 titled Quality Assurance and Performance Improvement (QAPI) Committee. The P&P indicates this facility must establish and maintain a Quality Assurance and Performance Improvement Committee (QAPI) that oversees the implementation of the QAPI program. 1. Coordinate the development, implementation, monitoring, and evaluation of performance improvement projects to achieve specific goals; and 2. Coordinate and facilitate communication regarding the delivery of quality resident care within and among departments and services, and between facility staff, residents, and family members.