STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056283	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bixby Knolls Towers Health Care & Rehab Center	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44898 Based on interview and record review the facility failed to ensure two of 18 sampled residents (Resident 80 and 30), was treated with respect and dignity when: 1. Resident 80's bedside commode (a piece of furniture that looks like a chair but has a container in the seat) was left with stool (feces). 2. Certified Nursing Assistant (CNA 2) was standing while feeding Resident 30. These failures resulted in Resident 80 feeling sad and had the potential to affect Resident 80 and 20's self-worth. Findings: During a review of Resident 80's Admission Record, the Admission Record indicated, Resident 80 was admitted to the facility on [DATE] with diagnoses including right below the left knee amputation (removal of the lower leg) muscle weakness and lack of coordination (the ability to use different parts of the body together smoothly and efficiently). During a review of Resident 80's Minimum Data Set [(MDS] a standardized assessment and care screening tool), dated 7/3/2024, the MDS indicated Resident 80 had the ability to understand and express ideas and wants. During a review of Resident 80's Physician Order Summary, indicated on 7/5/2024, Resident 80 had an order for a bedside commode on every shift. During an interview on 7/9/2024 at 10:09 a.m., with Resident 80, Resident 80 stated it takes the nursing staff four hours or the following day to empty the stool from his bedside commode. Resident 80 stated he feels sad because he must wait for the nursing staff to empty and cleaned the commode. Resident 80 stated the stool was left in the bedside commode every afternoon and every night and nobody cleans it. (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: 056283	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/12/2024
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 7/10/2024 at 9:11 a.m. with Resident 80, and CNA 5 in Resident 80's room, observed a was a plastic bag filled with greenish brown contents tied in a knot inside the Resident 80's bedside commode. Resident 80 stated it was a poop and the bag of poop has been there for three hours. CNA 5 stated it was poop/stool. CNA 5 stated she was going to clean the commode but got busy with another resident. During an interview on 7/10/2024 at 12:07 p.m. with CNA 5, CNA 5 stated Resident 80 had a bowel movement at 8 a.m. and needed assistance with the bedside commode. CNA 5 stated after the resident finished having a bowel movement, she should empty the bedside commode and clean it for infection control. During an interview on 7/12/2024 at 10:28 a.m. with the Director of Nursing (DON), the DON stated after each use of the bedside commode, the commode needs to be cleaned right way to ensure the room will not smell of poop. The DON stated it was a dignity issues for Resident 80 to have a stool on the bedside commode for a period. During a review of the facility's policy and procedure (P&P) titled Dignity, dated 2/2021, the P&P indicated, Demeaning practices and standards of care that compromise dignity is prohibited. Staff are expected to promote dignity and assist residents; for example .promptly responding to a resident's request for toileting assistance . 48712 2. During a review of Resident 30's Admission Record indicated Resident 30 was admitted to the facility on [DATE] with diagnoses including diabetes (abnormal blood sugar levels), lack of coordination, and heart failure (heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen). During a review of Resident 30's History and Physical (H&P), dated 6/5/2023, indicated Resident 30 does not have the capacity to understand and make decisions. During a review of Resident 30's MDS dated [DATE], the MDS indicated Resident 30 was dependent on staff with eating. During an observation on 7/9/24 at 12:55 p.m., CNA 2 stood over Resident 30 while feeding her. CNA 2 stated staff should sit when feeding a resident. CNA 2 stated she does not sit when feeding residents' (in general) because sometimes she was unable to find a chair. During an interview on 7/9/24 at 1:09 p.m., with CNA 3, CNA 3 stated you should sit at eye level with the resident so the resident can see you. CNA 3 stated sitting down while feeding the resident makes the resident feel better and respected. During an interview on 7/12/24 at 9:37 a.m., with the DON, the DON stated the CNA should be sitting at eye level with the resident during feeding. The DON stated sitting at eye level promotes engagement and allows assessment of the resident. The DON stated standing over a resident while feeding could make them feel intimidated. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P) titled, Dignity, (undated), indicated residents will be treated with dignity and respect at all times.

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45537 Based on observation, interview and record review, the facility failed to ensure one of one sampled resident (Resident 52) was provided a touch pad call light (enables residents with limited movement to call for help). This failure had Resident 52 to feel frustrated and had the potential for his needs not met which could result to delay of care and services. Findings: During a review of Resident 52's Admission Record, the Admission Record indicated Resident 52 was admitted to the facility on [DATE] with diagnoses including quadriplegia (paralysis that affects all of the person's limbs and body from neck down), bipolar disorder (a serious mental illness that causes unusual shifts in mood, ranging from extreme highs to lows) and spastic hemiplegia (a type of brain disorder that causes muscle tightness and contractions [shortening] in the limbs and one side of the body). During a review of Resident 52's Minimum Data Set ([MDS] a standardized assessment and care screening tool) dated 6/8/2024, the MDS indicated Resident 52 was able to make independent decisions that were consistent and reasonable. The MDS indicated Resident 52 had an impairment (a loss of part or ability) to both of his upper and lower extremities (limbs) and was dependent to two-person assist to complete his activities of daily living ([ADL] such as dressing, bathing, hygiene, toileting), bed mobility, and transferring from chair/bed to chair. During a review of Resident 52's care plan titled Mobility (ability to move freely) Deficit (loss) as evidenced by requiring assistance or dependent to mobility and chair/bed-to-chair transfer dated 5/1/2024, the care plan indicated a goal for Resident 52 was to participate in his personal care and maximize ADL function within the limitation of the disease process with interventions including providing assistance with care and ADL. During a concurrent observation and interview on 7/9/2024 at 9:02 a.m., Resident 52 was up sitting on his wheelchair and both of his hands were stiff and rigid. Resident 52 had a push button call light draped on his right arm and he stated he was not able to use the call light because his hands were stiff, and it makes him frustrated because this caused his care to be delayed. During a concurrent observation and interview on 7/10/2024 at 6:57 a.m., Certified Nursing Assistant 1 (CNA 1) confirmed and stated Resident 52 cannot move his hands well and he needed touch pad call light so he can be assisted with his care and activities on time. During a concurrent observation and interview on 7/10/2024 at 7:19 a.m., Licensed Vocational Nurse 1 (LVN 1) confirmed and stated Resident 52 can have spasms (a sudden involuntary muscle contraction, that can cause a cramping sensation and twitching movements) to both of his hands and can get stiff as well and it could cause him to be frustrated not being able to use his present call light effectively. LVN 1 stated Resident 52 should have been provided a touch pad call light to accommodate his needs and/ or preferences and prevent delay of care and services. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/12/2024 at 10:30 a.m., the Director of Nursing Services (DON) stated the facility staff performs rounding to assess the needs of all the residents and therefore, should not miss identifying and accommodating Resident 52's needs and/ or preferences. During a review of the facility's policy and procedure (P&P) titled Call System, Resident undated, the P&P indicated all residents of the facility are provided with a means to call staff for assistance through a communication system that directly calls a staff member, and such call devices must always remain functional. During a review of the facility's P&P titled Accommodation of Needs undated, the P&P indicated the Residents' individual needs and preferences are accommodated including adaptive devices and modifications to his physical environment, which are evaluated on admission and reviewed on an ongoing process to ensure safe independent functioning, dignity, and well-being. During a review of the facility's P&P) on Activities of Daily Living, undated, the P&P indicated All residents of the facility must be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs) and interventions will be provided in accordance with the residents' needs, preferences, goals and recognized standards of practice.

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F 0578

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 45537

Based on interview and record review the facility failed to ensure four of eleven sampled residents' (Resident 77,85,82,and 45) paper and electronic medical records (eHR) reflected documentation of advance directives (legal documents that allow you to spell out your decisions about end-of-life care ahead of time) and physician orders for life sustaining treatment (POLST, a legal form that records patients' treatment wishes in the event of a medical emergency) were discussed and written information were provided to Resident 77, 85, 82,and 45, and/or responsible parties.

These failures violated the residents' rights to be fully inform of the option to formulate an advance directive and/or POLST and had the potential to cause conflict with the residents' wishes regarding health care in the event residents became incapacitated (unable to participate in a meaningful way in medical decisions) or unable to make medical decisions that would not be identified and/or carried out by the facility staff.

Findings:

1.During a review of Resident 77's Admission Record, the Admission Record indicated Resident 77 was admitted to the facility on [DATE] with diagnoses including adult failure to thrive (a condition when an older adult has a loss of appetite, eats and drinks less than usual, and loses weight) and dementia (loss of memory, language, problem-solving and other thinking abilities).

During a review of Resident 77's Advance Directive Acknowledgement signed and dated [DATE], the Advance Directive Acknowledgement indicated Resident 77, and her family had decided to execute an advance directive.

2.During a review of Resident 85's Admission Record, the Admission Record indicated Resident 85 was admitted to the facility on [DATE] with diagnoses including chronic cholecystitis (condition of swelling and irritation of the gallbladder that continues overtime) and hypertension (a condition of an abnormally high blood pressure).

During a review of Resident 85's medical record, Resident 85 did not have an Advance Directive Acknowledgement on her record.

During an interview on [DATE] at 2:50 p.m., with Social Services Director (SSD), SSD stated she was not able to help in formulating an advance directive for Resident 85 and Resident 77 and their family members. SSD stated it was important for the residents and their family members to be offered and assisted in formulating an advance directive to honor the residents' end of life wishes.

During an interview on [DATE] at 10:30 a.m., the Director of Nursing Services (DON) stated the formulation of an advance directive must be offered and assistance provided to the residents and their family members during admission and while residing in the facility to ensure the residents' end of life decisions are respected and the nursing staff are aware of the residents' decisions on any change of condition and/ or emergency.

(continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	49573 3.During a review of Resident 82's Admission Record, the Admission Record indicated Resident 82 was admitted to the facility on [DATE] with diagnoses including hypertension (high blood pressure), hyperlipidemia (high levels of fat particles in the blood), dementia (a decline in thinking skills), bipolar disorder (mood disorder), depression (sad mood disorder), schizoaffective disorder (mood disorder), difficulty walking, and muscle weakness. During a review of Resident 82's Minimum Data Set (MDS), a standardized assessment and care screening tool, dated [DATE], the MDS indicated Resident 82 was severely impaired in cognitive skills (thought process) for daily decision-making and needed maximal assistance with bed mobility. The MDS indicated Resident 82 did not attempted to do toilet transfer, shower transfer, or walk 10 feet due to medical condition or safety concerns. During a telephone interview on [DATE] at 10:12 a.m., with Resident 82's responsible party (RP), the RP stated the facility had not discussed Advance Directive or POLST with them when Resident 82 was admitted to the facility. The RP stated the facility called them about 2 weeks ago to discuss documentations for power of attorney (POA) for medical decisions for Resident 82. The RP stated they have POA documents that they will give to the facility. During a concurrent interview with record review on [DATE] at 1:35 p.m., with the Social Service Director (SSD), the SSD stated Resident 82 does not have the capacity to execute an Advance Directive. Resident 82 Advance Directive form was reviewed, there was a check mark on resident does not have the capacity to execute an advance directive and a check mark on I have been given written materials and informed about my rights to accept or refuse medical treatment and a check mark on I have executed an advance directive. The SSD stated the Advance Directive acknowledgement form should have not been filled out by Resident 82. The SSD also stated the acknowledgement form was not valid and Advance Directive should have been discussed with Resident 82's responsible party. During a concurrent interview and record review on [DATE] at 11:12 a.m., with the Director of Nursing (DON), the DON stated if resident do not have an Advance Directive or POLST, the resident was considered full code (full life support including cardiopulmonary resuscitation [CPR]). The DON stated the importance for residents to have an Advance directive and/or POLST was for the resident's wishes of end-of-life care or emergency situations to be known. The DON stated that Resident 82 did not have a complete POLST, nor a valid Advance Directives acknowledge form. The DON stated the Advance Directive acknowledge form was filled out, but it was not valid due to Resident 82 not having the mental capacity to fill out the form. The DON stated the SSD should have discussed AD with family members or the RP. 4.During a review of Resident 45's Admission Record, the Admission Record indicated Resident 45 was admitted on [DATE] with diagnoses including dementia, atrial fibrillation (abnormal heartbeat), type 2 diabetes mellitus (high blood sugar), and hypertension. During a review of Resident 45's MDS dated [DATE], the MDS indicated Resident 45 was severely impaired in cognitive skills for daily decision making and needed maximal assistance to dependent care with self-care needs such as eating, oral hygiene, toileting, shower, and dressing. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephone interview on [DATE] at 3:35 p.m., with Resident 45's RP, the RP stated the facility did not go over Advance Directive with them, but that Resident 45 has been receiving hospice care (focuses on the care, comfort, and quality of life of a person with a serious illness who is approaching the end of life) since [DATE]. The RP stated they are the POA for Resident 45. During an interview on [DATE] at 1:46 p.m., with SSD, the SSD stated they cannot find the paper version for the Advance Directive acknowledge form for Resident 45. The SSD also stated if there was no electronic version, there was no paper version. During a concurrent interview and record review on [DATE] at 11:16 a.m., with the DON, the DON could not find the Advance Directive acknowledgement form for Resident 45 in the paper chart. The DON also stated that the SSD was responsible for discussing Advance Directive with family members if the resident was not able to do so. During a review of the facility's policy and procedure (P&P), on Advance Directive, revised in ,d+[DATE], the P&P indicated the residents had the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment and such Advance Directive are honored in accordance with state law and facility policy. The P&P indicated the residents, and their responsible party/ family must be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 50387 Based on interview and record review, the facility failed to provide Skilled Nursing Facility Advance Beneficiary Notice (SNF ABN), form CMS-10055 for two of three sampled residents (Residents 2 and 27) when residents continued to stay at the facility after the Medicare Part A coverage ended. This failure had the potential to result in responsible parties not being able to exercise their right to receive timely and specific notification. Findings: During a concurrent interview and record review on 7/12/2024 at 9:29a.m., with the Director of Nursing (DON), Resident 2's SNF Beneficiary Notification Review form indicated Resident 2's last covered day for Medicare Part A Skilled Services was 1/19/2024. Resident 2 continued to stay after the coverage ending date. The DON stated, the facility did not provide SNF ABN to Resident 2. During a concurrent interview and record review on 7/12/2024 at 9:29 a.m., with the DON, Resident 27's SNF Beneficiary Notification Review Form indicated Resident 27's last covered day for Medicare Part A Skilled Services was 2/5/2024. Resident 27 continued to stay after the coverage ending date. DON stated, the facility did not provide SNF ABN to Resident 27. DON stated that Resident 2 and Resident 27 had the right to be informed about financial liability and appeal when the coverage date ends.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50387 Based on observation, interview, and record review, the facility staff failed to assess and monitor multiple skin discolorations for one of two sampled resident's (Resident 23), who was identified to be at high risk for bleeding. This failure had the potential for Resident 23 to have unassessed internal bleeding. Findings: During a review of Resident 23's Admission Record, indicated the Resident 23 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including abscess (pus-filled mass) of the liver, reduced mobility, and muscle weakness. During a review of Resident 23's Minimum Data Set (MDS), a standardized assessment and care screening tool) dated 5/4/2024, the MDS indicated the Resident 23 had no cognitive (thought process) impairment. The resident was at risk for developing pressure ulcers and had one Stage 1 pressure injury (intact skin with no blanchable redness of a localized area usually over a bony prominence). During a concurrent observation and interview on 7/9/2024 at 12:11p.m. with Resident 23 in the resident's room, Resident 23 was observed to have skin discolorations on left hand, right arm, and left upper arm. Resident 23 stated that the skin discolorations were from scratching. During a review of Resident 23's Physician's Orders dated 6/23/2024 indicated an order for Xarelto (blood thinner) 20 milligram (mg, unit of measure) one tablet by mouth a day for sub occlusive thrombus (partially blocked blood clot) left subclavian vein (collarbone vein) and axillary vein (armpit vein) with instructions to check for signs of bleeding secondary to anticoagulant (blood thinner) intake and call the MD (physician) if signs of bleeding was present including: bruising every shift for anticoagulant usage document N if no signs of bleeding and Y for presence of bleeding and notify MD. During a review of Resident 23's care plan dated 6/23/2024, indicated staff needed to observe and report for signs and symptoms of bruising. During a concurrent interview and record review of Resident 23's medical record on 7/10/2024 at 1:29 p.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated that she did not find skin notes or documentation about skin discolorations on back of left hand, left upper arm and right arm. During a concurrent observation and interview on 7/20/2024 at 1:58 p.m. in Resident 23's room, LVN 2 assessed Resident 23's right arm, left arm and left hand. LVN 2 stated that there were red and purplish skin discolorations on the resident. During an interview and concurrent record review of Resident 23's skin check sheet with Certified Nurse Assistant (CNA) 4, stated Resident 23's was assessed skin on 6/4/2024 and marked no skin problem. There were no other records for Resident 23's skin check after 6/4/2024. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/11/2024 at 12:40 p.m., with LVN 2, LVN 2 stated signs of discolorations on the resident could be a sign of internal bleeding. Nurses are responsible to monitor a resident's skin. LVN 2 stated that even scrubbing her skin can cause bleeding since Resident 23 was on Xarelto. During a concurrent interview and record review on 7/12/2024 at 11:38 a.m. with the Director of Nursing (DON), the DON stated that there was a care plan for monitoring skin, staff should assess Resident 23's skin since the resident was on an anticoagulant. The DON stated bruising could worsen, open, and bleed. During a review of the facility's policy and procedure (P&P) titled Skin Check Sheet, revised January 2019, the P&P indicated, 3. The CNA will document skin issues using the Skin Check Sheet, completing a through and complete observation of the resident's skin to include Skin discoloration . Red areas ., 6. The Skin Check form must be completed at the time of the shower, bed bath, during care when a skin problem is identified and during weekly summary. It must have the signature of the CNA completing the form and it must be given to the charge nurse immediately following the shower, bath or after care. 7. The assigned LVN/RN will review this form and sign off on it. 8 . A copy will be forwarded to the Skin Check binder.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44898 Based on interview and record review the facility failed to ensure one of 18 sampled residents (Resident 71) received services and treatment to address hearing loss. This failure had the potential to result in Resident 71 not being able to effectively communicate with staff and understand care and services being given. Findings: During a review of Resident 71's Admission Record, the Admission Record indicated Resident 71 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses including left leg cellulitis (deep infection of the skin caused by bacteria), ulcerative proctitis (inflammatory bowel disease), and generalized abdominal pain. During a review of Resident 71's, Minimum Data Set (MDS-a standardized assessment and care screening tool) dated 4/24/2024, the MDS indicated Resident 71 had difficulty with the ability to hear. The MDS indicated Resident 71 had the ability to express ideas and wants. The MDS indicated Resident 71 was dependent on nursing staff for toileting. The MDS indicated Resident 71 needed maximal assistance from nursing staff with showering, dressing, putting on and taking off footwear, personal hygiene, moving from sitting to lying flat on the bed, ability to change positions from sitting to standing. The MDS indicated Resident 71 needed moderate assistance from nursing staff to roll from left to right, and oral hygiene. The MDS indicated Resident 71 required setup assistance and clean up assistance from nursing staff with eating. During a review of Resident 71's Care Plan, titled Risk for Communication Deficit, dated 1/29/2024, the Care Plan indicated, to refer Resident 71 to an audiologist (health care professionals who identify, assess, and manage disorders of hearing). During an interview on 7/9/2024 at 10:05 a.m., Resident 71 stated she could not hear and requested to come closer and speak louder to her ear so she can hear. Spoke louder to Resident 71's left ear but Resident 71 could not understand what was being said. During an interview on 7/10/2024 at 11:49 a.m., with Certified Nursing Assistant (CNA) 5, CNA 5 stated Resident 71 will ask her to come closer to the bedside when speaking because Resident 71 was hard of hearing. During an interview on 7/11/2024 at 10:52 a.m., with Licensed Vocational Nurse (LVN) 2, LVN 2 stated Resident 71 was hard of hearing. LVN 2 stated Resident 71 does not use a hearing aid. LVN 2 stated Resident 71 was admitted to the facility with hearing problems. LVN 2 stated residents at the facility were seen by ear, nose, and throat (ENT healthcare professionals that specialized in diagnosing and treating diseases of the ear, nose, and throat) doctor when admitted to the facility with hearing problems. LVN 2 stated the social services sets up the appointment to be seen by ENT after it has been reported the resident has problems or changes in the hearing. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Bixby Knolls Towers Health Care & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3747 Atlantic Avenue Long Beach, CA 90807	

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/11/2024 at 1:36 p.m., with Registered Nurse Supervisor (RNS) 1, RNS 1 stated Resident 71 has a problem hearing in the left ear. RNS 1 stated based on Resident 71's care plan Resident 71 should have been referred to the audiologist. RNS 1 stated Resident 71 problems with hearing should have been reported to the social worker and the social worker will arrange for a referral to the audiologist and transportation to the audiologist. RNS 1 stated if Resident 71's hearing was not addressed, Resident 71 will not be able to communicate her needs with nursing staff. During an interview on 7/12/2024 at 8:42 a.m. with Social Services Director (SSD), SSD stated ENT doctor comes to check residents every three to four months. SSD stated she was responsible for making sure all residents were seen by the ENT doctor or the audiologist. SSD stated if resident with hearing problems was not seen by the ENT doctor or the audiologist the hearing can get worse. During an interview on 7/12/2024 at 10:09 a.m., with the Director of Nursing (DON), the DON stated as soon as the resident was identified as hard of hearing the resident should have a consult for the ENT doctor or the audiologist to see if the resident requires a hearing aid. The DON stated if the resident does not receive services for hearing the resident will not be able to hear what was being discussed. The DON stated the resident might feel depressed or withdrawn if she was not able to understand or hear what was going on around her. During a review of the facility's policy and procedure (P&P), titled Hearing Impaired Resident, Care of, dated 2/2018, the P&P indicated, Staff will assist hearing impaired residents to maintain effective communication with clinicians, caregivers, other residents, and visitors. Staff will assist the resident (or representative) with locating available resources, scheduling appointments, and arranging transportation to obtain needed services.

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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 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** 44898 Based on interview and record review the facility failed to ensure one of 18 sampled residents (Resident 92) who was assessed as high risk for fall was on the Falling Star Program per facility's Fall Prevention policy and procedure. This failure had the potential to result in Resident 92, sustaining another fall with injury. Findings: During a review of Resident 92's Admission Record, the Admission Record indicated, Resident 92 was admitted to the facility on [DATE] with diagnoses including fall, neck fracture (broken bone), spinal stenosis (narrowing of the space around the spinal cord), muscle weakness and difficulty walking. During a review of Resident 92's, Physician Progress Notes, dated 6/21/2024, the Physician Progress Notes indicated Resident 92 had a history of frequent falls at home. During a review of Resident 92's Minimum Data Set (MDS a standardized assessment and care screening tool), dated 6/27/2024, the MDS indicated Resident 92 had the ability to understand and express ideas and wants. The MDS indicated Resident 92 was dependent on nursing staff for oral hygiene, toileting, showering, dressing, putting, and taking off footwear, personal hygiene and positioning and repositioning. During a concurrent observation and interview on 7/10/2024 with Certified Nursing Assistant (CNA) 5, in Resident 92's room, Resident 92 did not have a star (symbol placed to identify the resident as a candidate for falling star program) next her name outside the room to indicate Resident 92 was in the Star Program. Resident 92 did not have any fall prevention measures such as landing pads or a bed alarm. CNA 5 stated Resident 92 did not have a star by her name and residents that are in the Star Program have a star by their name and some residents have landing pads for falls. During an interview on 7/11/2024 at 11:31 a.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated Resident 92 was admitted to the facility with a cervical collar (neck brace), neck fracture, spinal stenosis, and unspecified fall. LVN 2 stated the Star Program was for residents with frequent fall and admitted to the facility with a diagnosis of fall, or weakness. LVN 2 stated Resident 92 had a high risk for fall score. LVN 2 stated the resident at a high risk for fall were placed in the Star Program, floor mats or landing pads, bed in the lowest position, frequent visual checks, items for activities of daily living within reach. During an interview on 7/11/2024 at 2:26 p.m. with Registered Nurse Supervisor (RNS) 1, RNS 1 stated the star program were for resident admitted to facility with multiple falls. RNS 1 stated based on Resident 92's fall risk score of 65 the resident qualifies for Falling Star Program. RNS 1 stated if staff do not see the star next to the residents name the staff may not check the resident for safety. (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 7/12/2024 10:23 a.m. with the Director of Nursing (DON), the DON stated Resident 92 was admitted to facility due to a fall at home. The DON stated Resident 92 qualifies for the star program and needs to be on the star program for safety and to prevent fall and injury. During a review of the facility policy and procedure (P&P), titled Falling Star Program, revised date 1/2020, the P&P indicated, Residents identified with history of fall prior to admission and residents with a fall/multiple falls in the facility shall participate in the falling star program .If the admitting nurse identifies the resident as a candidate for falling star program, he/she will do the following. Secure an identifying small orange Star next to the resident headboard, the wheelchair armrest, and any device such as front wheel walker if applicable. Apply an orange bracelet on the resident wrists. Include the resident name in the Falling star program lists. Initiate care plan for Fall management and Falling Star program as an intervention.

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F 0761

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 49573

Based on observations, interviews, and record reviews, the facility failed to

1.Ensure an accurate count of a controlled medication (a drug or chemical whose manufacture, possession, or use is regulated by a government,) lorazepam (a medication used to treat mood disorder) for Resident 32 in the medication storage refrigerator on the third floor.

2.Ensure one open foil pack of arformoterol tartrate inhalation solution (a medication used to treat breathing problems) for Resident 447 was stored in accordance with manufacturer's requirements and labeled with an open date in the medication storage refrigerator on the second floor.

3.Ensure the storage of semaglutide (a medication used to treat high blood sugar) for Resident 53 was in accordance with manufacturer's requirements on the second floor.

4.Ensure expired medications for multiple residents were removed from one of the medication carts on the third floor.

These failures had the potential to harm residents due to the potential loss of strength of the medication from improper storage and labeling possibly leading to health complications resulting in hospitalization or death.

Findings:

1.During a concurrent observation and record review on 7/9/24 at 3:03 p.m., of the medication storage refrigerator, observed Resident 32's lorazepam bottle with eight milliliters (mL, a unit of measure) remaining. Reviewed controlled drug reconciliation record, indicated four mL remaining in the bottle.

During a concurrent observation and interview on 7/9/24 at 3:15 p.m., with Licensed Vocation Nurse 4 (LVN 4), LVN 4 stated all medication bottles had 15 mL of medication in the bottle. LVN 4 stated when licensed staff remove the medication from the bottle, licensed staff document on the controlled drug reconciliation record the date the medication was pulled out, the time the medication was pulled out, the volume of how much was pulled out and the volume of how much should be left in the bottle. Resident 32's-controlled drug reconciliation record showed 11.25 mL was documented as given to Resident 32 and that 4 mL should be the volume left in the bottle. LVN 4 stated the bottle had 8 mL of medication left.

During a concurrent observation and interview on 7/9/24 at 3:20 p.m., with LVN 2, LVN 2 stated if there were extra medications in the bottle and the controlled drug reconciliation record was signed as given that the medication was given to the resident but was not given to the resident, the resident can have seizures (sudden uncontrolled burst of activities in the brain) or feelings of anxiety.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2.During a concurrent observation and record review on 7/10/24 at 11:03 a.m., of the storage medication refrigerator on the second floor, observed LVN 2 open the medication refrigerator, observed temperature of 34 degrees Fahrenheit (F unit of temperature) was on the thermostat (regulating device component which senses the temperature of a physical system). The refrigerator temperature log indicated temperature should be between 36 F -46 F. Observed inside the medication refrigerator Resident 447's medication of arformoterol tartrate inhalation solution with no open date label. During a concurrent observation and interview on 7/10/24 at 11:10 a.m., with LVN 2, LVN 2 stated if there was no open date label written on the packaged of when the medication was first opened, expired medication can be given to the resident which could result in the medication not working which could lead to the resident requiring additional doses. LVN 2 stated medication won't be effective, and the resident won't get the full dosage of the medication. LVN 2 stated medication should be stored between 36 F -46 F according to manufacturer's requirements. During a review of arformoterol manufacturer's product labeling indicated that once the foil packs were open, vials should be used immediately upon opening of the foil pouch. Store arformoterol tartrate inhalation solution in the protective foil pouch under refrigeration at 36 F -46 F. 3. During a concurrent observation and record review on 7/10/24 at 11:03 a.m., of the storage medication refrigerator on the second floor, observed LVN 2 open the medication refrigerator, observed temperature of 34 F was on the thermostat. The refrigerator temperature log indicated temperature should be between 36 F -46 F. Observed inside the medication refrigerator Resident 53's semaglutide. During concurrent interview and record review on 7/10/24 at 11:12 a.m., of the manufacturer's product labeling, LVN 2 stated that if the refrigerator was too cold, the temperature would change the chemical component of the medication and the resident would not get the full effect of the medication. LVN 2 stated Resident 53's medication should be stored in the refrigerator with the temperature between 36 F to 46 F or room temperature of 59 F to 86 F according to the manufacturer's product labeling. During a review of the manufacturer's product labeling indicated store new, and unused semaglutide pens in the refrigerator between 36 F to 46 F and pen in use for 56 days at room temperature between 59 F to 86 F or in refrigerator between 36 F to 46 F. 4. During an observation on 7/10/24 at 12:25 p.m., of the medication cart on the third floor, observed nine medications with expired dates of 5/6/24, 5/6/24, 5/31/24, 6/10/24, 6/10/24, 6/13/24, 6/13/24, 6/23/24, 6/23/24. During a review of Resident 36's Admission Record indicated Resident 36 was admitted to the facility on [DATE] with diagnoses including asthma (narrowing of the airways in the lungs), type 2 diabetes mellitus (abnormal blood sugar), and hypertension (high blood pressure). During a review of Resident 36's medication bubble pack indicated cyclobenzaprine tablet 5 milligram ([mg] unit of measure), give 1 tablet every eight hours as needed for muscle spasms (involuntary movement of muscles). The medication bubble pack had an expiration date of 6/23/24. Resident 36's three medication bubble packs indicated ondansetron tablet 4 mg, give 1 tablet every 6 hours as needed for nausea (feeling an urge to throw up) or vomiting (throwing up contents from stomach out of the mouth). The medication bubble packs had an expiration date of 6/13/24, 6/23/24 and 6/23/24. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 40's Admission Record, indicated Resident 40 was admitted to the facility on [DATE] with diagnoses including schizoaffective disorder (mood disorder), hypertension 9hugh blood pressure), osteoporosis (weak bones), and insomnia (sleep disorder). During a review of Resident 40's medication bubble pack indicated trazodone tablet 50 mg with expiration date of 6/23/24. Resident 40's medication bubble pack indicated ondansetron tablet expiration date of 5/6/2024. During a review of Resident 19's Admission Record indicated Resident 19 was admitted to the facility on [DATE] with diagnoses including type 2 diabetes mellitus (a condition in which the body fails to metabolize (process) glucose (sugar) correctly), seizures, and hypertension. During a review Resident 19's medication bubble pack indicated hydralazine tablet 25 mg had an expiration date of 6/10/24. Resident 19's medication bubble pack indicated metoclopramide 5 mg had an expiration date of 6/10/24. During a review of Resident 32's Admission Record indicated Resident 32 was admitted to the facility on [DATE] with diagnoses including of type 2 diabetes, and hypertension. During a review of Resident 32's medication bubble pack indicated hyoscyamine sulfate tablet 0.125 mg had an expiration date of 5/31/2024. During a concurrent observation and interview on 7/10/24 at 12:40 p.m., with LVN 5, LVN 5 stated the expired medications were in the cart and should have been discarded. LVN 5 stated residents that take expired medications were not getting the full effect of the medication. LVN 5 stated the efficacy of the medication can be reduced in residents that take expired medication. During a review of the facility's policy and procedure (P&P), titled Medication Storage in the Facility, dated April 2008, indicated Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier .storage at room temperature are kept at temperatures ranging from 50 F to 86 F . medication requiring refrigeration or temperature between 36 F and 46 F are kept in a refrigerator with a thermometer to allow temperature monitoring. Refrigerator medications are kept in close and labeled container. Outdated, contaminated, or .are immediately removed from stock, disposed of according to procedures for medication disposal. Medication storage is kept clean .and from extreme temperatures . are monitored on a routine basis and corrective actions taken if problems are identified.

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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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44898 Based on observation, interview, and record review the facility failed to ensure one of 18 sampled residents (Resident 87) was provided with dental services to ensure Resident 87 could eat adequately. This failure had the potential to result in Resident 87 losing weight. Findings: During a review of Resident 87s Admission Record, the Admission Record indicated Resident 87 was admitted to the facility on [DATE], with diagnoses including diabetes mellitus (a condition in which the body fails to metabolize (process) glucose (sugar) correctly), Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements), muscle weakness and gastro-esophageal reflux (when the contents of the stomach persistently move back up into the esophagus). During a review of Resident 87's History and Physical (H&P), dated 5/28/2024, the H&P indicated Resident 87 had the capacity to make decisions. During a review of Resident 87's Minimum Data Set ([MDS] a standardized assessment and care screening tool), dated, 6/1/2024, the MDS indicated Resident 87 was dependent on nursing staff for showering, putting on and taking off footwear, changing positions from sitting to standing, and transferring to a chair. The MDS indicated Resident 87 required maximal assistance with toileting, and lower body dressing. During a concurrent observation and interview on 7/9/2024 at 9:34 a.m., in Resident 87's room, Resident 87 was cutting her food in to tiny pieces. Resident 87 stated she has to cut her food into tiny pieces because it was uncomfortable for her to eat. Resident 87 stated she has dentures, but the dentures were loose and fall out. During an interview on 7/11/2024 at 11:10 a.m., with Licensed Vocational Nurse (LVN) 2, LVN 2 stated if a resident was complaining while eating or drinking or has missing teeth she will report dental concerns to the Registered Nurse Supervisor (RNS), physician, and Social Services Director (SSD). During an interview on 7/11/2024 at 2:07 p.m., with RNS 1, RNS 1 stated, the doctor was notified when a resident was complaining of having a hard time chewing their food. RNS 1 stated Resident 87 has been cutting her food in to tiny pieces since she was admitted to the facility. RNS 1 stated it was not normal for Resident 87 to cut her food in to tiny pieces and was referred to the speech therapist on 7/9/2024 for having trouble with eating. RNS 1 stated Resident 87 might choke, loose weight, or have respiratory problem if she was not able to eat her food properly. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/12/2024 at 10:14 a.m., with the Director of Nursing (DON), the DON stated during mealtimes certified nursing assistance (CNA), licensed vocational nurses (LVN), and registered nurses (RN), should be able to identify if Resident 87 was having a hard time chewing or swallowing. The DON stated the CNA should report to the charge nurses and the charge nurses reassess the resident and call doctor to get a speech therapist swallow evaluation and a dentist consult to assess fitting of the dentures. The DON stated, since May 2024 Resident 87 has loss 3 pounds and should have been addressed right away so Resident 87 can eat properly. During a review of the facility's policy and procedure (P&P), titled Dental Services, dated 12/2016, the P&P indicated, Routine and emergency dental services are available to meet the resident's oral health services in accordance with the resident's assessment and plan of care. If dentures are damaged or lost, residents will be referred for dental services within 3 days. If the referral is not made within 3 days, documentation will be provided regarding what is being done to ensure that the resident is able to eat and drink adequately while awaiting the dental services; and the reason for the delay.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 49573 Based on observation, interview and record review, the facility failed to ensure one of one sampled resident (Resident 70) had their food preferences taken into consideration. This failure had the potential to result in Resident 70 having an undesirable weight loss when nutritional preferences were not being considered. Findings: During a concurrent observation and interview on 7/9/24 at 10:04 a.m. with Resident 70, Resident 70 stated she gets chopped meat at mealtimes. Resident 70 stated she does not like the chopped meats. Resident 70 stated she get chopped meats for lunch and dinner and does not want to eat it. Resident 70 stated she wanted regular not chopped meats for lunch and dinner. During a review of Resident 70's Physician Order Summary dated 2/16/24, Resident 70's diet was regular diet, mechanical soft texture (diet designed for resident who have trouble chewing and swallowing) with thin liquid consistency, large portions at breakfast with fortified cereal and with fortified soup at lunch and dinner. During a review on 7/11/24 at 12:09 p.m., of Resident 70's Dietary Profile (Quarterly/Annual) dated 6/25/24 indicated Resident requested to upgrade from mechanical soft to regular. We will proceed with care plan to ensure resident's nutritional needs are met to prevent unplanned weight changes, dehydration, and skin breakdown. During a concurrent interview and record review on 7/12/24 at 10:41 a.m. with Dietary Manager 1 (DM 1), DM 1 stated he wrote the Dietary Profile dated 6/25/24 for Resident 70. DM 1 stated he does not recall making licensed staff aware of Resident 70's preference and request for the upgrade to regular diet. DM 1 stated he does not recall if Resident 70's request to upgrade from mechanical soft diet to regular diet was discussed in the morning meeting. DM 1 stated Resident 70's physician and speech language pathologist (SLP, a health professional who diagnoses and treats communication and swallowing problems) would have changed the diet order for resident. During a concurrent interview and record review on 7/12/24 at 11:59 a.m., with the Director of Nursing (DON), reviewed the Dietary Profile, the DON stated this was the first time seeing this request on the Dietary Profile dated 6/25/24 for Resident 70. The DON stated no discussion took place for Resident 70's request for regular diet and that Resident 70's preferences was not taken into consideration. The DON stated there can be a potential weight loss for residents if they do not eat the food on the menu. During a review of the facility's policy and procedure (P&P), titled Resident's Rights, revised February 2021, indicated Certain basic rights to all residents of this facility including the resident's right to communication with and access to people and services, both inside and outside the facility .exercise his or her rights as a resident of the facility .be supported by the facility in exercising his or her rights .be informed of, and participate in, his or her care planning and treatment.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48712 Based on observation, interview and record review, the facility failed to ensure a safe and sanitary food storage practices in the kitchen when: 1. Food items in the walk-in refrigerator had no open date label. 2. Ensure facility staff personal items were not placed near the food in the dry storage room. These failures had the potential to result in harmful bacteria growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to foodborne illness (illness caused by food contaminated with bacteria, viruses, and parasites). Findings: 1. During an observation on [DATE] at 8:43 a.m. in the walk-in refrigerator, a bag of salad was noted without a received or expiration date. During an interview on [DATE] at 8:46 a.m., with [NAME] 1, [NAME] 1 stated the bag of salad must be labeled so you know when it was received. If you serve it to someone, they could get sick. During an interview on [DATE] at 11:10 a.m., with Dietary Manager 1 (DM 1), DM1 stated food must be labeled to indicate when it was received and when it needs to be discarded. Residents were vulnerable and a high risk of getting food borne illnesses if they consumed expired food items. 2. During an observation on [DATE] at 11:19 a.m., in the dry storage room, observed a bag of staff personal items on a shelf beside a box of elbow macaroni. Observed a hat hanging from the corner of the shelf above a bag of spaghetti noodles. During an interview on [DATE] at 11:20 a.m., with Dietary Aide 1 (DA 1), DA 1 stated the personal bag and the hat belonged to him. DA 1 stated the bag contained his apron and other items. DA 1 stated he always keeps his personal bag in the dry storage room. DA1 was unable to state reason why personal items should not be stored with the food storage. During an interview on [DATE] at 11:25 a.m., with DM 1, DM 1 stated staff should keep personal items in the staff locker. DM 1 stated it was unsafe and unsanitary to keep personal items stored with resident food. During an interview on [DATE] at 11:34 a.m., with DA 2, DA 2 stated personal items should not be stored with facility food. DA 2 stated placing personal items with food can cause cross contamination. During a review of the facility's policy and procedure (P&P) titled Refrigerator and Freezer, (undated), indicated staff will be mindful of expiration and use by dates.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056283	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/12/2024
NAME OF PROVIDER OR SUPPLIER Bixby Knolls Towers Health Care & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. 48712 Based on observation, interview, and record review, the facility failed to dispose garbage and refuse properly by not closing dumpster (a large trash container designed to be emptied into a truck) completely This failure had a potential to attract flies, insects, cats, and other animals to the dumpster area. Findings: During an observation on 7/11/2024 at 11:30 a.m., outside the kitchen, observed one dumpster to have the lid off. Observed an empty box sitting on top of one of the closed dumpsters. Another dumpster was stuffed with trash preventing the lid from closing completely. During an interview on 7/11/2024 at 11:45 a.m., with Dietary Manager 1(DM 1), DM 1 stated dumpsters should be completely closed to prevent the attraction of flies and mice. DM 1 stated if flies and mice get into the facility, they can contaminate the food. During an interview on 7/11/2024 at 1:40 p.m., with Maintenance Supervisor (MS) 1, MS1 stated the dumpster should be closed at all times so it will not attract rodents that can potentially enter the facility. MS 1 stated that the dumpster should not be filled to capacity so that the lid can be closed. During a review of the facility's policy and procedure (P&P) titled Food-Related Garbage and Rubbish Disposal, (undated), the P&P indicated all garbage containers must be kept covered when not in continuous use. Garbage will be stored in a manner that is inaccessible to vermin (pests, animals that spread disease).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056283	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/12/2024

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Bixby Knolls Towers Health Care & Rehab Center	3747 Atlantic Avenue Long Beach, CA 90807

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 45537 Based on observation, interview and record review, the facility failed to ensure one of four sampled residents (Resident 28) was free from contracting an infection when the nebulizer (a respiratory [breathing] device that turns the liquid medicine into a mist which is then inhaled through a mouthpiece or mask) tubing was not stored securely in a bag (bag open) and was not on the floor. This failure had the potential to spread germs and bacteria from the floor to Resident 28. Findings: During a review of Resident 28's Admission Record, indicated Resident 28 was admitted at the facility on 1/28/2023 with diagnoses including metabolic encephalopathy (a problem of the brain caused by a chemical imbalance in the blood from an illness or body organs that are not working properly as they should), diabetes mellitus (a serious condition where the blood glucose, also knowns as blood sugar is too high) and chronic kidney disease (a long-term condition where the kidneys do not work as well as they should). During an observation on 7/9/2024 at 8:15 a.m., in Resident 28's room, Resident 28's nebulizer tubing, which was inside an unsecured bag (open) was found on the floor on the left side of Resident 28's bed. During an interview on 7/9/2024 at 9:39am, Licensed Vocational Nurse 3 (LVN 3) confirmed Resident 28's nebulizer tubing was on the floor and at risk of exposure to germs that can cause infection to Resident 28. During an interview on 7/12/2024 at 10:30 a.m., the Director of Nursing Services (DON) stated the residents' medical tubing including nebulizer tubing must not be in contact with the floor because of contamination and risk of infection. During a review of the facility's policy and procedure (P&P) titled Cleaning and Disinfection of Resident-Care Items and Equipment revised 10/2018, the P&P indicated resident devices such as respiratory therapy equipment must be free from microorganisms.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056283	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0881

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Implement a program that monitors antibiotic use.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 44898

Based on interview and record review, the facility failed to implement their protocol for Antibiotic Stewardship (refers to a set of commitments and actions designed to optimize the treatment of infections while reducing the adverse events associated with antibiotic use) for one of 18 sampled residents (Resident 58).

This failure had the potential for Resident 58 to develop antibiotic resistance (not effective to treat infection) from prolonged or inappropriate antibiotic use.

Findings:

During a review of Resident 58s Admission Record, the Admission Record indicated, Resident 58 was admitted to the facility on [DATE] with diagnoses including end stage renal disease (the gradual loss of kidney function), diabetes mellitus (a group of diseases that affect the body uses blood sugar), systemic lupus erythematous (a chronic autoimmune disease that affects various parts of the body), and cardiomyopathy (a disease that affects the heart muscles).

During a review of Resident 58's History and Physical (H&P), dated 6/29/2024 the H&P indicated Resident 58 had the capacity to understand and make decisions.

During a review of Resident 58's Minimum Data Set (MDS-a standardized assessment and care screening tool), dated 6/28/2024, the MDS indicated Resident 58 needed maximal assistance from nursing staff for toileting, showering, and lower body dressing. The MDS indicated Resident 58 needed moderate assistance from nursing staff for oral hygiene, upper body dressing, putting on and taking off footwear, changing positions from sitting to lying, and changing positions from lying to sitting.

During an interview on 7/11/2024 at 8:38 a.m., with the Infection Preventionist Nurse (IPN), the IPN stated Resident 58 was started on Amoxicillin (antibiotic-treat infection) 400 milligram (mg unit of measurement) every 12 hours for status post fistulogram (a test to look for abnormal areas in the dialysis [procedure to clean up waste product] graft {access}) prophylaxis for 23 days. IPN stated prophylaxis means to prevent a disease. The IPN stated she did not follow up with the Resident 58 physician regarding the duration of the Amoxicillin prescription. The IPN stated she should check with the resident physician (in general) regarding the duration of antibiotic used. The IPN stated prolonged use of antibiotics can build up resistance to the medication and will not be able to fight off bacteria.

During an interview on 7/12/2024 at 9:59 a.m., with the Director of Nursing (DON), the DON stated Resident 58 was prescribed Amoxicillin for 23 days to prevent the resident from getting an infection. The DON stated the licensed nurses were supposed to check the resident for signs of swelling, drainage, redness, pain, and fever and if the resident does not have any signs or symptoms of infection the nursing staff should notify the doctor if the resident should continue the antibiotic. The DON stated the IPN should have followed up with physician for prolong use of the antibiotic because the resident can develop resistance to the antibiotic.

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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	07/12/2024

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P), titled Antibiotic Stewardship Program, dated 6/2021, the P&P indicated, Facility will utilize Antibiotic Time Out (ATO) to reassess and review the need and choice of antibiotics based on diagnostic information and consider a stop order if diagnostic results do not support the use of antibiotics.