

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  08/01/2025
NAME OF PROVIDER OR SUPPLIER  Bixby Towers Post-Acute Rehab		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 0550  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.  (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  08/01/2025
NAME OF PROVIDER OR SUPPLIER  Bixby Towers Post-Acute Rehab		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)		
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> The facility failed to ensure one of two residents (Resident 99) foley catheter ( a medical device that helps drain urine from your bladder [drainage bag]- the bag attached to the end of the catheter that collects the urine) was covered with a dignity bag ( a cover or pouch designed to hide the urine collection bag) in accordance with professional standards and the residents' right to dignity. This failure resulted in potential embarrassment, compromised privacy, and a lack of respect for Resident 99's dignity. Findings: During a concurrent observation and interview on 7/29/2025 at 3:57 p.m. with Certified Nurse Assistant (CNA) 4 in room [ROOM NUMBER]A, it was observed that Resident 99's foley catheter drainage bag was not covered by a dignity bag. CNA 4 stated the dignity bag was not in place on the drainage bag. CNA 4 stated that it is all staff's responsibility to maintain the foley catheters and ensure all residents have a dignity bag. CNA 4 stated that she usually places a dignity bag to cover the residents' drainage bag. CNA 4 stated that she does not know why she did not place a dignity bag on Resident 99's drainage bag. CNA 4 stated that she believed that having an uncovered drainage bag would be considered disrespectful for Resident 99. During a concurrent observation and interview on 7/29/2025 at 4:15 p.m. with Treatment Nurse (TN) 1, TN 1 stated she was unaware of Resident 99's drainage bag not being covered with a dignity bag. TN 1 stated that it is the facility's policy and procedure that all drainage bags be always covered with a dignity bag. TN 1 stated that she understands residents' drainage bags should be covered with a dignity bag to ensure that their privacy and dignity is protected. TN 1 stated that she is responsible for ensuring dignity cover is in place for the residents. TN 1 acknowledged the absence of Resident 99's dignity bag and confirmed understanding of the facility's policy on maintaining resident dignity and privacy. During an interview on 7/31/2025 at 11:03 a.m. with the Director of Staff Development (DSD), the DSD stated it is the facility's policy and procedure to apply a dignity bag on all residents' foley catheter drainage bags. The DSD stated it is the responsibility of all staff to ensure that all the drainage bags are covered with a dignity bag. The DSD stated that staff receives in-services and huddles on how to maintain foley catheters and maintaining residents' dignity. The DSD stated that she was unaware of the incident regarding Resident 99 not having a dignity bag. The DSD stated that when residents' foley catheters are uncovered it is a violation of their dignity. During an interview on 8/01/2025 at 3:00 p.m. with the Director of Nursing (DON), the DON stated residents have the right to have privacy and their foley catheter drainage bags should be always covered with a dignity bag. The DON stated that it is the facility's practice that all residents that have a foley catheter have a dignity bag. The DON stated that the facility has policies and procedures in place to ensure that all foley catheter bags are stored and positioned in a manner that maintains resident dignity and reduces infection. The DON stated that staff receive in-services upon hire and through ongoing education to ensure that the staff are trained properly and understand the importance of keeping the residents' drainage bags covered. During a review of the facility's policy and procedures (P&amp;P) dated 2021, the P&amp;P indicated demeaning practices and standards of care that compromise dignity are prohibited. The P&amp;P indicated staff are expected to promote dignity and assist resident; for example: a. helping the resident to keep urinary catheter bags covered.</p>		

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  08/01/2025
NAME OF PROVIDER OR SUPPLIER  Bixby Towers Post-Acute Rehab		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)
<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>(continued on next page)</p>

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  08/01/2025
NAME OF PROVIDER OR SUPPLIER  Bixby Towers Post-Acute Rehab		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)		
<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to implement its abuse/neglect policy and procedures for two of three sampled residents (Resident 15 and Resident 74). Facility failed to:1. Report Resident 74's allegation of Certified Nursing Assistant (CNA 1) physical abuse. 2. Report Resident 15's fracture (broken bone) of unknown origin to California Department of Public Health ( CDPH), law enforcement, or the Ombudsman. These deficient practices resulted in a delay of an investigation and potentially increased the risk of abuse, neglect, and mistreatment of other residents. Findings1. During a review of Resident 74's admission Record, the admission Record indicated Resident 74 was admitted to the facility on [DATE] with diagnoses including osteoarthritis (a progressive disorder of the joints, caused by gradual loss of cartilage) and rheumatoid arthritis (a chronic-progressive disease-causing inflammation in the joints and resulting in painful deformity and immobility). During a review of Resident 74's MDS dated [DATE], the MDS indicated Resident 74 had severe cognitive impairment and required maximal (helper does more than half the effort) assistant with activities of daily living (ADLs- activities such as bathing, dressing, and toileting a person performs daily). During an interview on 7/29/2025 at 1:03 p.m., with Resident 74's family member, Resident 74's family member stated there was a CNA (unknown) that was rough with Resident 74 while changing her diaper (incontinent pad). At this time, Resident 74 took out her personal cell phone and showed me a picture she took of the CNA involved. Resident 74's family member stated they informed the staff of what had happened. During an interview on 7/30/2025 at 10:20 a.m., with the Assistant Director of Nursing (ADON), ADON stated Resident 74 told her a CNA on the night shift was rough with her when changing her. ADON stated depended on the situation when asked if she considers being rough with a resident a form of abuse. The ADON stated she did not report the allegation because Resident 74 told her she was fine. During an interview on 7/30/2025 at 10:50 a.m., with CNA 3, CNA 3 stated being rough with a resident was considered a form of abuse. During a phone interview on 7/30/2025 at 11:23 a.m., with CNA 1, CNA 1 stated she made aware that Resident 74 accused her of being rough with her while changing her and was going to be suspended by the facility. During an interview on 7/30/2025 at 11:39 a.m., with the Director of Staff Development (DSD), the DSD stated if a resident stated a staff member was rough with them, it was considered a form of abuse and should be reported to CDPH and investigated immediately. The DSD stated it was important to report and investigate the allegation of abuse to ensure it does not happen to another resident. During an interview on 8/1/2025 at 3:03 p.m., with the Director of Nursing (DON), the DON stated she was told Resident 74 was refusing to be changed but CNA 1 changed her anyways. The DON stated the allegation should have been reported and investigated but at the time they did not consider it a form of abuse. During a review of the facility's policy and procedure (P&amp;P) titled, Abuse Prevention Program, dated 12/1/2022, the P&amp;P indicated, To promote an environment free from any form of resident abuse, neglect, misappropriation of resident property, exploitation, and/or mistreatment. Staff training will include identifying what constitutes abuse, neglect, exploitation, and misappropriation of resident property. 2. During a review of Resident 15's admission Record, the admission Record indicated Resident 15 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities), anxiety (a common mental health condition characterized by excessive worry, fear, and nervousness), and recurrent dislocation (when bones in a joint are forced out of their normal position) of right shoulder. During a review of Resident 15's Minimum Data Set (MDS- a resident assessment tool) dated 5/26/2025, the MDS indicated Resident 15's cognition (ability to think, understand, learn, and remember) was severely impaired. The MDS indicated Resident 15 was dependent (helper does all the effort) with her activities of daily living (ADLs- activities such as bathing, dressing, and toileting a person performs daily). During a review of Resident 15's Progress Notes written by the Assistant Director of Nursing (ADON) dated 7/31/2025 at 2:34 p.m., the Progress Notes indicated the ADON received information from the General Acute Care Hospital (GACH) that Resident 15 had a right shoulder fracture (broken bone) on 7/31/2025. During a review of Resident 15's GACH Consultant Note indicated Resident 15's X-ray (images that produce pictures of the inside of the body) of the right shoulder on 7/30/2025 indicated an acute displaced fracture of the proximal (closer to the center) right humeral (upper arm bone) neck as a displaced (a broken bone where the pieces have moved out of their normal alignment) fracture of the humeral shaft. During an interview on 7/31/2025 at 1:23 p.m., with Certified Nurse Assistant (CNA) 6 CNA 6 indicated Resident 15 appeared to have increased pain in her</p>		

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  08/01/2025
NAME OF PROVIDER OR SUPPLIER  Bixby Towers Post-Acute Rehab		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)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to report an abuse allegation to the California Department of Health, the Ombudsman, and the law enforcement agency for one of three sampled residents (Resident 74), when Resident 74 reported to the Assistant Director of Nursing (ADON) that Certified Nurse Assistant (CNA) 1 physically abused her while providing her with personal care. This deficient practice had the potential to place other residents at risk for physical abuse. Findings: During a review of Resident 74's admission Record, the admission Record indicated Resident 74 was admitted to the facility on [DATE] with diagnoses including osteoarthritis (a progressive disorder of the joints, caused by gradual loss of cartilage) and rheumatoid arthritis (a chronic-progressive disease-causing inflammation in the joints and resulting in painful deformity and immobility). During a review of Resident 74's MDS dated [DATE], the MDS indicated Resident 74 had severe cognitive impairment and required maximal (helper does more than half the effort) assistant with activities of daily living (ADLs- activities such as bathing, dressing, and toileting a person performs daily). During an interview on 7/29/2025 at 1:03 p.m., with Resident 74's family member, Resident 74's family member stated there was a CNA (unknown) that was rough with Resident 74 while changing her diaper (incontinent pad). At this time, Resident 74 took out her personal cell phone and showed me a picture she took of the CNA involved. Resident 74's family member stated they informed the staff of what had happened. During an interview on 7/30/2025 at 10:20 a.m., with the Assistant Director of Nursing (ADON), ADON stated Resident 74 told her a CNA on the night shift was rough with her when changing her. ADON stated depends on the situation when asked if she considers being rough with a resident a form of abuse. The ADON stated she did not report the allegation because Resident 74 told her she was fine. During an interview on 7/30/2025 at 10:50 a.m., with CNA 3, CNA 3 stated being rough with a resident was considered a form of abuse. During a phone interview on 7/30/2025 at 11:23 a.m., with CNA 1, CNA 1 stated she made aware that Resident 74 accused her of being rough with her while changing her and was going to be suspended by the facility. During an interview on 7/30/2025 at 11:39 a.m., with the Director of Staff Development (DSD), the DSD stated if a resident stated a staff member was rough with them, it is considered a form of abuse and should be reported to CDPH and investigated immediately. The DSD stated it was important to report and investigate the allegation of abuse to ensure it does not happen to another resident. During an interview on 8/1/2025 at 3:03 p.m., with the Director of Nursing (DON), the DON stated she was told Resident 74 was refusing to be changed but CNA 1 changed her anyways. The DON stated the allegation should have been reported and investigated but at the time they did not consider it a form of abuse. During a review of the facility's policy and procedure (P&amp;P) titled, Abuse Reporting and Investigation, dated 1/10/2024, the P&amp;P indicated, To promptly report all allegations of abuse as required by law and regulations to the appropriate agencies within the required time frames. To keep residents safe and prevent from future or recurrent potential abuse. All allegations of abuse, will be reported by the facility Administrator to the following agencies: The State licensing/certification agency responsible for surveying/licensing the facility, the local/State Ombudsman, and local law enforcement. Cross reference F607 and F610</p>		

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  08/01/2025
NAME OF PROVIDER OR SUPPLIER  Bixby Towers Post-Acute Rehab		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)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to implement its abuse policy and procedure (P&amp;P) titled Abuse Prevention Program, dated 12/1/2022 by failing to investigate an abuse allegation for one of three sampled Residents (Resident 74). This deficient practice had the potential to result in unidentified abuse in the facility and failure to protect residents from abuse. Findings: During a review of Resident 74's admission Record, the admission Record indicated Resident 74 was admitted to the facility on [DATE] with diagnoses including osteoarthritis (a progressive disorder of the joints, caused by gradual loss of cartilage) and rheumatoid arthritis (a chronic-progressive disease-causing inflammation in the joints and resulting in painful deformity and immobility). During a review of Resident 74's MDS dated [DATE], the MDS indicated Resident 74 had severe cognitive impairment and required maximal (helper does more than half the effort) assistant with activities of daily living (ADLs- activities such as bathing, dressing, and toileting a person performs daily). During an interview on 7/29/2025 at 1:03 p.m., with Resident 74's family member, Resident 74's family member stated there was a CNA (unknown) that was rough with Resident 74 while changing her diaper (incontinent pad). At this time, Resident 74 took out her personal cell phone and showed me a picture she took of the CNA involved. Resident 74's family member stated they informed the staff of what had happened. During an interview on 7/30/2025 at 10:20 a.m., with the Assistant Director of Nursing (ADON), ADON stated Resident 74 told her a CNA on the night shift was rough with her when changing her. ADON stated depends on the situation when asked if she considers being rough with a resident a form of abuse. The ADON stated she did not report the allegation because Resident 74 told her she was fine. During an interview on 7/30/2025 at 10:50 a.m., with CNA 3, CNA 3 stated being rough with a resident was considered a form of abuse. During a phone interview on 7/30/2025 at 11:23 a.m., with CNA 1, CNA 1 stated she made aware that Resident 74 accused her of being rough with her while changing her and was going to be suspended by the facility. During an interview on 7/30/2025 at 11:39 a.m., with the Director of Staff Development (DSD), the DSD stated if a resident stated a staff member was rough with them, it is considered a form of abuse and should be reported to CDPH and investigated immediately. The DSD stated it was important to report and investigate the allegation of abuse to ensure it does not happen to another resident. During an interview on 8/1/2025 at 3:03 p.m., with the Director of Nursing (DON), the DON stated she was told Resident 74 was refusing to be changed but CNA 1 changed her anyways. The DON stated the allegation should have been reported and investigated but at the time they did not consider it a form of abuse. During a review of the facility's policy and procedure (P&amp;P) titled, Abuse Prevention Program, dated 12/1/2022, the P&amp;P indicated, To promote an environment free from any form of resident abuse, neglect, misappropriation of resident property, exploitation, and/or mistreatment. The facility shall thoroughly investigate allegation of abuse by identifying and interviewing all involved, including the alleged victim, alleged perpetrator, witness(es) and others who might have seen, heard or have knowledge of the allegations, and with documented evidences that support the investigation. During a review of the facility's P&amp;P titled, Abuse Reporting and Investigation, dated 1/10/2024, the P&amp;P indicated, To thoroughly investigate ALL allegations of abuse, mistreatment, neglect, exploitation, misappropriation of resident property, or injuries of unknown source when appropriate. To keep residents safe and prevent from future or recurrent potential abuse. Cross reference F607 and F609</p>		

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  08/01/2025
NAME OF PROVIDER OR SUPPLIER  Bixby Towers Post-Acute Rehab		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)
<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>(continued on next page)</p>

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  08/01/2025
NAME OF PROVIDER OR SUPPLIER  Bixby Towers Post-Acute Rehab		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)		
<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review the facility failed to ensure Preadmission Screening and Resident Review (PASARR - a federal assessment requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are placed in facilities that can provide the appropriate care) was resubmitted and documented correctly for two of two sampled residents (Resident 9 and Resident 52). This failure had the potential to result in Resident 9 and Resident 52 not receiving the necessary care and services they need. Findings: During a review of Resident 9's admission Record, the admission Record indicated Resident 9 was admitted to the facility on [DATE] with diagnoses including depression (serious mood disorder that affects how a person feels, thinks, and behaves, schizoaffective (a mental illness that can affect thoughts, mood, and behavior), anxiety (a feeling of worry, nervousness, or unease), psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality) and insomnia (difficulty sleeping). During a review of Resident 9's Physician Progress Notes, dated 1/8/2025, the Physician Progress Notes indicated that Resident 9 was able to make healthcare decisions. During a review of Resident 9's Minimum Data Set (MDS-a resident assessment tool), dated 5/28/2025, the MDS indicated, Resident 9 needed nursing staff supervision with oral hygiene, toileting, showering, dressing, transferring and walking. During a review of Resident 9's Notice of Exempted Hospital Discharge, dated 2/12/2025, the Notice of Exempted Hospital Discharge indicated, the facility must resubmit a new Level I Screening as a Resident Review on the 31st day. During a review of Resident 52's admission Record, the admission Record indicated Resident 52 was originally admitted to the facility on [DATE] and readmitted to the facility with diagnoses including schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 52's MDS dated [DATE], the MDS indicated, Resident 52 had the ability to express ideas and wants. The MDS indicated Resident 52 had the ability to understand others. The MDS indicated Resident 52 was dependent on nursing staff for toileting, lower body dressing, putting on and taking off footwear, and transferring. The MDS indicated Resident 52 needed substantial to maximal assistance from nursing staff with oral hygiene, showering, upper body dressing and personal hygiene. During a review of Resident 52's Notice of PASRR Level I Screening Results, dated 2/8/2025, the Notice of PASRR Level I Screening Results indicated Resident 52 did not have schizophrenia. During an interview on 7/31/2025 at 9:00 a.m., with Medical Records Director (MRD), MRD stated she was responsible for reviewing the PASARR. MRD stated Resident 9 did not have a new Level I Screening done. MRD stated Resident 9 needs a new Level I Screening resubmitted to determine the services needed for the resident's care. MRD stated Resident 52 PASARR was documented incorrectly and will have to resubmit another Level I Screening. MRD stated the residents' care and services can be affected if the Level I Screening was not done. During an interview on 8/1/2025 at 3:26 p.m., with the Director of Nursing (DON), the DON stated the residents need Level I Screening so they will get the proper treatment and be provided with the necessary care. During a review of the facility's policy and procedure (P&amp;P), titled Preadmission Screening &amp; Resident Review (PASARR), dated 11/20/2023, the P&amp;P indicated, Facility will coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid to the maximum extent practicable to avoid duplicative testing and effort to include incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. Referring all Level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for Level II resident review upon a significant change in status assessment. Notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review.</p>		

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  08/01/2025
NAME OF PROVIDER OR SUPPLIER  Bixby Towers Post-Acute Rehab		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)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to develop and implement a comprehensive care plan for one of three sampled residents (Resident 74) when Resident 74 reported to the Assistant Director of Nursing (ADON) that Certified Nurse Assistant (CNA) 1 physically abused her while providing her with personal care. This deficient practice resulted in failure in the delivery of necessary care and services. Findings: During a review of Resident 74's admission Record, the admission Record indicated Resident 74 was admitted to the facility on [DATE] with diagnoses including osteoarthritis (a progressive disorder of the joints, caused by gradual loss of cartilage) and rheumatoid arthritis (a chronic-progressive disease-causing inflammation in the joints and resulting in painful deformity and immobility). During a review of Resident 74's MDS dated [DATE], the MDS indicated Resident 74 had severe cognitive impairment and required maximal (helper does more than half the effort) assistance with activities of daily living (ADLs- activities such as bathing, dressing, and toileting a person performs daily). During a concurrent interview and record review on 7/30/2025 at 4:09 p.m., with the Registered Nurse Supervisor (RNS) 1, RNS 1 validated there was no care plan for the abuse allegation made by Resident 74. RNS 1 stated facility should develop and implement a plan of care for an abuse allegation, so the facility staff were aware of what occurred and what interventions should be put in place to care for Resident 74. During an interview on 8/1/2025 at 12:34 p.m., with RNS 2, RNS 2 stated following an abuse allegation, a care plan should be developed and implemented because it represents the goals and interventions for the staff to follow for Resident 74's care. RNS 1 stated the care plan was important to ensure it does not happen again and for the safety of the residents. During an interview on 8/1/2025 at 3:03 p.m., with the Director of Nursing (DON), the DON stated a care plan should have been developed and implemented for Resident 74's abuse allegation because it served as an outline of care provided based on the resident's needs. During a review of the facility's policy and procedure (P&amp;P) titled, Care Plans, Comprehensive Persons-Centered, dated 12/2016, the P&amp;P indicated, Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change. The Interdisciplinary Team must review and update the care plan when there has been a significant change in the resident's condition).</p>

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  08/01/2025
NAME OF PROVIDER OR SUPPLIER  Bixby Towers Post-Acute Rehab		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)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review the facility failed to ensure one of the sampled residents (Resident 36) was provided with incontinence care in a timely manner. This failure resulted in Resident 36 crying and left wet in urine for an hour. Findings: During a review of Resident 36's admission Record, the admission Record indicated, Resident 36 was admitted to the facility on [DATE] with diagnoses including diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), seizures (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness), hypertension (HTN-high blood pressure) and muscle weakness. During a review of Resident 36's Minimum Data Set (MDS-a resident assessment tool), dated 6/13/2025, the MDS indicated, Resident 36 rarely was able to express ideas and wants. The MDS indicated Resident 36 was rarely able to understand others. The MDS indicated Resident 36 was dependent on nursing staff for toileting, showering, oral hygiene, personal hygiene, transferring and dressing. The MDS indicated Resident 36 always had urinary incontinence (involuntary loss of urine). During a review of Resident 36's Care Plan, titled Altered bowel and bladder elimination due to incontinence related to mobility deficit, sensory deficit, chronic incontinence of the bladder, and cognitive impairment, dated 6/30/2025, the Care Plan intervention indicated to perform good skin care after each episode of incontinence and as needed. During an observation on 7/28/2025 at 12:59 p.m., at Resident 36's bedside, Resident 36 was in bed crying, Registered Nurse Supervisor (RNS) 3 and Certified Nursing Assistant (CNA) 8 were at Resident 36's room. RNS 3 checked Resident 36's adult diaper and stated Resident 36 was wet and needs to be changed. CNA 8 was at Resident 36's bedside rubbing her hand trying to console the resident. RNS 3 and CNA 8 left Resident 36's bedside without changing the resident adult diaper. During an interview on 7/28/2025 at 1:42 p.m., with CNA 8, CNA 8 stated she was going to change Resident 36 adult diaper but did not because she needed help. CNA 8 stated Resident 36 was not supposed to wait for a diaper change. During an interview on 7/30/2025 at 9:56 a.m., with CNA 2, CNA 2 stated if a resident was wet or soiled, CNA 8 should change Resident 36 adult diaper when CNA 8 observed Resident 36's adult diaper wet. CNA 2 stated if the residents must wait to be changed the residents could get a yeast infection (type of infection). skin irritation and can develop pressure ulcers (localized damage to the skin and/or underlying tissue usually over a bony prominence). During an interview on 8/01/2025 at 3:25 p.m., with the Director of Nursing (DON), the DON stated Resident that were wet or soiled need to be changed right away to prevent pressure ulcer, skin issues and skin irritation. During a review of the facility's policy and procedure (P&amp;P) titled, Activities of Daily Living (ADLs), Supporting, date revised 3/2028, the P&amp;P indicated Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs).</p>

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  08/01/2025
NAME OF PROVIDER OR SUPPLIER  Bixby Towers Post-Acute Rehab		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 0684  Level of Harm - Actual harm  Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals.  (continued on next page)

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  08/01/2025
NAME OF PROVIDER OR SUPPLIER  Bixby Towers Post-Acute Rehab		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 0684  Level of Harm - Actual harm  Residents Affected - Few	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to ensure the resident, who had developed behavioral symptoms manifested by increased confusion, cursing staff, yelling at staff, and refusing personal care and treatment, had a medical doctor's (MD) order for urinalysis with cultures and sensitivity (a urine diagnostic test used to detect presence of bacteria) carried out to determine the presence of urinary tract infection (UTI- an infection in the bladder/urinary tract) and to prevent a delay in treatment for one of one sampled resident (Resident 100). The facility failed to: 1. Ensure Resident 100's urine was collected for urinalysis with cultures and sensitivity as ordered by the resident's MD on 7/4/2025 due to Resident 100's onset of behavioral symptoms (cursing staff, yelling at staff, refused care and refusal of breathing treatment) to rule out (exclude) UTI. 2. Ensure Resident 100's MD was informed when a urine for urinalysis was not sent on 7/7/2025 as ordered by the resident's MD on 7/4/2025. 3. Follow the facility's policy and procedure (P&amp;P) titled, Lab and Diagnostic Test Results-Clinical Protocol, revised 11/2018, which indicated the staff will process ordered tests requisitions and arrange for a diagnostic test. These failures resulted in Resident 100 transferring to the General Acute Care Hospital (GACH) on 7/9/2025 where the resident was found to have pyuria (the presence of pus in the urine) and was diagnosed with acute urinary tract infection. Resident 100 was treated with intravenous (IV- into the vein) antibiotic (medication to treat infection) administration and was discharged from the GACH on 7/23/2025 with diagnosis of acute UTI. Findings: During a review of Resident 100's admission Record, the admission indicated Resident 100 was admitted to the facility on [DATE] with diagnoses including fracture (broken bone) of the sacrum (triangular bone at the base of the spine that connects the spine to the pelvis), respiratory failure (the lungs cannot properly exchange gases, causing abnormal levels of carbon dioxide and/or oxygen in the arteries), chronic kidney disease (condition where the kidneys are damaged and cannot filter blood effectively), anxiety (emotion characterized by feelings of tension, worried thoughts), and depression (persistent feeling of sadness and loss of interest). During a review of Resident 100's History and Physical (H&amp;P) dated 6/17/2025, the H&amp;P indicated, Resident 100 had the capacity to make decisions for herself. During a review of Resident 100's Minimum Data Set (MDS- a resident assessment tool), dated 6/19/2025, the MDS indicated Resident 100 did not have any evidence of an acute change in mental status including inattention (difficulty focusing and easily distracted), disorganized thinking (irrelevant conversation or unclear flow of ideas), and altered level of consciousness (when a patient is not acting like their baseline, seems confused and disoriented, or is not acting normally). The MDS indicated Resident 100 did not have behavioral symptoms including physical behavior (hitting, kicking, pushing), and verbal behavior (threatening others, screaming at others, cursing at others). The MDS indicated Resident 100 did not exhibit rejection of care (blood work, taking medications and assistance with activities of daily living [ADL]) The MDS indicated Resident 100 did not hallucinate (sights, sounds, smells, tastes, or touches that a person believes to be real but are not real) or had delusions (false beliefs). The MDS indicated Resident 100 was dependent (helper does all the effort, assistance of two or more helpers is required) on nursing staff with toileting hygiene, showering, putting on and taking off footwear. The MDS indicated Resident 100 needed substantial to maximal assistance from nursing staff with dressing, rolling from left to right, sitting, and lying down. The MDS indicated Resident 100 had urinary and bowel incontinence (inability to control urination and defecation [feces]). During a review of Resident 100's Physician's Order Summary Report dated 6/27/2025, the Physician's Order Summary Report indicated an order for urinalysis with urine cultures related to chronic kidney disease. The Physician's Order Summary Report indicated Resident 100 may have an in and out catheter (a thin, flexible tube inserted into the bladder to drain urine and then removed immediately after) to collect a urine specimen. During a review of Resident 100's Laboratory Results Report dated 6/30/2025, the Laboratory Results Report indicated that urine culture resulted in no growth of bacteria (tiny organisms that can cause infections and illnesses). During review of Resident 100's Change of Condition ([COC] a sudden, clinically important deviation from a patient's baseline in physical, cognitive [ability to think, understand, learn, and remember] behavioral, or functional status which without immediate intervention, may result in complications or death) Evaluation dated 7/4/2025, the COC Evaluation indicated Resident 100 had an increased confusion, was cursing staff, yelling at staff, refusing personal care and treatment. The COC indicated Resident 100 had altered level of consciousness. The COC Evaluation indicated Resident 100's MD was notified on 7/4/2025 at 10 a.m. of Resident 100's COC and</p>		

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  08/01/2025
NAME OF PROVIDER OR SUPPLIER  Bixby Towers Post-Acute Rehab		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)
<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>(continued on next page)</p>

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  08/01/2025
NAME OF PROVIDER OR SUPPLIER  Bixby Towers Post-Acute Rehab		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)		
<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to ensure two of nine sampled residents (Residents 21 and 36) received appropriate services to prevent a decline in the range of motion (ROM, full movement potential of a joint) and mobility by failing to: 1. Initiate a Restorative Nursing Aide (RNA, nursing aide program that help residents to maintain their function and joint mobility) program timely for Resident 21's lower extremities (hip, knee, ankle, feet) for passive range of motion (PROM, movement at a given joint with full assistance from another person) upon completion of Rehab Joint Mobility Assessment ([JMA] evaluates the range of motion, flexibility, and overall health of a joint) on 7/17/2025. 2. Complete a quarterly Rehab JMA for Resident 36's upper extremities (BUE, shoulder, elbow, wrist/hand) on 9/20/2024. Findings: 1. During a review of Resident 21's admission Record (AR), the AR indicated Resident 21 initially admitted to the facility on [DATE] and readmitted [DATE] with diagnoses including hemiplegia (weakness to one side of the body) and hemiparesis (inability to move one side of the body) following unspecified cerebrovascular disease (disease of the blood vessels, especially blood vessels to the brain) affecting left dominant side, aphasia (a disorder that makes it difficult to speak), stiffness of left wrist, stiffness of left hand, and pain in left elbow. During a review of Resident 21's Minimum Data Set (MDS, resident assessment tool) dated 4/22/2025, the MDS indicated Resident 21 had functional ROM limitations on one side of the upper extremity (UE, shoulder, elbow, wrist, hands) and on both sides of the lower extremity (BLE, hip, knee, ankle/foot). The MDS also indicated Resident 21 required dependent assistance from staff for oral hygiene, bathing, dressing, and bed to chair transfers. The MDS indicated Resident 21 rarely understood others. During a review of Resident 21's History and Physical Examination (H&amp;P) dated 7/18/2025, the H&amp;P indicated Resident 21 did not have the capacity to understand and make decisions. During a review of Resident 21's Rehab JMA dated 7/17/2025, the JMA indicated Resident 21 had moderate ROM limitation in left shoulder flexion (moving arm up and down) abduction (moving arm away from the body), moderate limitation in left elbow, minimal limitation in left wrist and left hand/fingers. The JMA indicated Resident 21 had minimal limitation in right shoulder flexion and abduction, full (no limitation to within functional limits) ROM in right elbow, right wrist, and right hand/fingers. The JMA indicated Resident 21 had full ROM in both hips and both knees, and severe ROM limitation in both ankles. The JMA indicated will place on RNA ROM program to both [lower extremities]. During a review of Resident 21's Order Summary Report (OSR) dated 7/29/2025, the OSR indicated an order dated 7/28/2025 for RNA for PROM BLE once a day, five times a week or as tolerated. During a review of Resident 21's Care Plan (CP) dated 7/28/2025, the CP indicated Resident 21 was at high risk for further decline in ROM related to impaired mobility and decreased strength for BLE. The CP goal indicated Resident 21 will maintain ROM to BLE through next review date. The CP interventions indicated PROM of BLE with RNA five days a week. During an observation on 7/30/2025 in Resident 21's room, Resident 21 was lying in bed with eyes open. Resident 21 did not respond to verbal or visual cues. Resident 21's left elbow was bent more than halfway, the left wrist was straight, and the left fingers were in a fist position with the left thumb in between the third and fourth fingers. Resident 21's right arm was straight. Resident 21's right knee was bent more than halfway and rotated away from the body. Resident 21 was able to move the right leg towards the body a little. Resident 21's left leg was straight. During a concurrent interview and record review on 7/30/2025 at 11:15 a.m. with the Rehab Director (RHB), the RHB stated physical therapy staff completed a JMA on 7/17/2025 and recommended an RNA program for PROM to BLE. The RHB stated the RNA program was not ordered until 7/28/2025 and there was a delay in the start of RNA services for Resident 21. The RHB stated Resident 21's RNA program should have started on 7/17/2025. The RHB stated Resident 21 was at risk for a decline ROM if RNA for PROM was not started timely. During an interview on 7/30/2025 at 3:36 p.m., the Director of Nursing (DON), the DON stated the RNA program was a nursing program to help prevent a resident's overall decline and could include ROM, ambulation (walking), and putting on splints (rigid material or apparatus used to support and immobilize a broken bone or impaired joint). The DON stated it was important for RNA to be ordered and completed timely, because if the RNA order was not completed timely a resident could experience a decline in mobility and ROM. During a review of the facility's policies and procedures (P&amp;P) revised 7/2017, titled, Restorative Nursing Services, the P&amp;P indicated residents will receive restorative nursing care as needed to help promote optimal safety and independence. 2. During a review of Resident 36's AR, the AR indicated</p>		

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  08/01/2025
NAME OF PROVIDER OR SUPPLIER  Bixby Towers Post-Acute Rehab		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)		
<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interviews, record review, the facility failed to ensure the water pitcher was within reach for one of seven sampled residents (Resident 11). This failure had the potential to increase Resident 11's risk of dehydration (a condition that occurs when the body loses more fluids than it takes in, resulting in a depletion of water and electrolytes) and resulted in Resident 11 complaining of feeling thirsty. Findings:During a review of Resident 11's record titled, Face Sheet (front page of the chart that contains a summary of basic information about the resident), dated 7/30/25, the Face Sheet indicated Resident 11 was admitted on [DATE] with diagnoses of dementia (a progressive state of decline in mental abilities), Alzheimer's Disease (disease characterized by a progressive decline in mental abilities), hypertension (high blood pressure), failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity), and generalized muscle weakness.During a review of Resident 11's record titled, Minimum Data Sheet (MDS - a resident assessment tool), dated 6/24/25, the MDS indicated Resident 11 had the ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the item is placed before the resident.During a review of Resident 11's records titled, Care Plan Report (CP), dated 7/8/25, the CP indicated, Resident 11 is at risk for dehydration or potential fluid deficit related to psychoactive medication (drugs that affect the brain and alter mental processes, emotions, and behavior) use. During a review of Resident 11's record, titled Nutritional Risk Assessment (NRA -assessment tool used to identify individuals aged 65 and older who are at risk for malnutrition), dated 7/9/25, the NRA indicated Resident 11 was on a no added salt diet with extra hydration. During a review of the Resident 11's record, titled Physician Order's, dated 7/30/25, the Physician Order's indicated, Encourage additional 8 ounce hydration three times a day (TID) with medication pass.During an observation on 7/28/25 at 9:54 a.m., in Resident 11's room, the water pitcher was on the dresser out of Resident 11's reach. During an interview on 7/28/25 at 10:00 a.m., with Resident 11, Resident 11 stated, I could not reach the water pitcher, it's too far behind me. I like to be able to reach my water. Resident 1 stated having the water pitcher out of reach made Resident 1 feel thirsty.During an interview on 7/28/25 at 10:02 a. m., with Licensed Vocational Nurse (LVN) 6, LVN 6 stated, The water pitcher is not in reach, it should be on the bedside table to prevent dehydration and possibly falls.During an interview on 8/1/25 at 9:47 a.m., with the Director of Nursing (DON), the DON stated, The water pitcher should always be within reach to prevent dehydration.During a review of the facility's policy and procedure (P&amp;P) titled, Serving Drinking Water, dated 10/10, the P&amp;P indicated, Place the water pitcher and cup within easy reach of the resident.</p>		

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  08/01/2025
NAME OF PROVIDER OR SUPPLIER  Bixby Towers Post-Acute Rehab		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)
<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>(continued on next page)</p>

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  08/01/2025
NAME OF PROVIDER OR SUPPLIER  Bixby Towers Post-Acute Rehab		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)		
<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to ensure their staff had: 1. Competence on reporting alleged allegations of abuse and injury of unknown origin by failing to: 1a. Ensure an injury of unknown origin was reported to the California Department of Health (CDPH), the Ombudsman, and law enforcement and investigated for Resident 15. 1b. Ensure an abuse allegation was reported to CDPH, the Ombudsman, and law enforcement and investigated for Resident 74. These deficient practices potentially increased the risk of abuse, neglect, and mistreatment of other residents. 2. Annual competencies (regularly scheduled evaluations that gauge an individual's knowledge, skills, and abilities in a specific role or area, typically within a healthcare or professional setting) completed for three of five sampled staff (Director of Staff Development (DSD), Activities Director (AD) and Certified Nursing Assistant (CNA) 5) This deficient practice had the potential for the facility not to be able to assess the skills necessary to provide nursing services to assure resident safety and to ensure facility staff will be performed within the acceptable standards of practice. Findings 1. During a review of Resident 74's admission Record, the admission Record indicated Resident 74 was admitted to the facility on [DATE] with diagnoses including osteoarthritis (a progressive disorder of the joints, caused by gradual loss of cartilage) and rheumatoid arthritis (a chronic-progressive disease-causing inflammation in the joints and resulting in painful deformity and immobility). During a review of Resident 74's MDS dated [DATE], the MDS indicated Resident 74 had severe cognitive impairment and required maximal (helper does more than half the effort) assistant with activities of daily living (ADLs- activities such as bathing, dressing, and toileting a person performs daily). During an interview on 7/29/2025 at 1:03 p.m., with Resident 74's family member, Resident 74's family member stated there was a CNA (unknown) that was rough with Resident 74 while changing her diaper (incontinent pad). At this time, Resident 74 took out her personal cell phone and showed me a picture she took of the CNA involved. Resident 74's family member stated they informed the staff of what had happened. During an interview on 7/30/2025 at 10:20 a.m., with the Assistant Director of Nursing (ADON), ADON stated Resident 74 told her a CNA on the night shift was rough with her when changing her. ADON stated depends on the situation when asked if she considers being rough with a resident a form of abuse. The ADON stated she did not report the allegation because Resident 74 told her she was fine. During an interview on 7/30/2025 at 10:50 a.m., with CNA 3, CNA 3 stated being rough with a resident was considered a form of abuse. During a phone interview on 7/30/2025 at 11:23 a.m., with CNA 1, CNA 1 stated she made aware that Resident 74 accused her of being rough with her while changing her and was going to be suspended by the facility. During an interview on 7/30/2025 at 11:39 a.m., with the Director of Staff Development (DSD), the DSD stated if a resident stated a staff member was rough with them, it was considered a form of abuse and should be reported to CDPH and investigated immediately. The DSD stated it was important to report and investigate the allegation of abuse to ensure it does not happen to another resident. During an interview on 8/1/2025 at 3:03 p.m., with the Director of Nursing (DON), the DON stated she was told Resident 74 was refusing to be changed but CNA 1 changed her anyways. The DON stated the allegation should have been reported and investigated but at the time they did not consider it a form of abuse. During a review of the facility's policy and procedure (P&amp;P) titled, Abuse Prevention Program, dated 12/1/2022, the P&amp;P indicated, To promote an environment free from any form of resident abuse, neglect, misappropriation of resident property, exploitation, and/or mistreatment. Staff training will include identifying what constitutes abuse, neglect, exploitation, and misappropriation of resident property. 2. During a review of Resident 15's admission Record, the admission Record indicated Resident 15 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities), anxiety (a common mental health condition characterized by excessive worry, fear, and nervousness), and recurrent dislocation (when bones in a joint are forced out of their normal position) of right shoulder. During a review of Resident 15's Minimum Data Set (MDS- a resident assessment tool) dated 5/26/2025, the MDS indicated Resident 15's cognition (ability to think, understand, learn, and remember) was severely impaired. The MDS indicated Resident 15 was dependent (helper does all the effort) with her activities of daily living (ADLs- activities such as bathing, dressing, and toileting a person performs daily). During a review of Resident 15's Progress Notes written by the Assistant Director of Nursing (ADON) dated 7/31/2025 at 2:34 p.m., the Progress Notes indicated the ADON received information from the General Acute Care Hospital (GACH) that Resident 15 had a right shoulder fracture (broken bone)</p>		

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  08/01/2025
NAME OF PROVIDER OR SUPPLIER  Bixby Towers Post-Acute Rehab		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)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, interview, and record review the facility failed to ensure:1. Uncovered bowl of dry cereal dated 7/21/2025 to 7/25/2025 was not stored in the dry storage room uncovered passed the use by date.2. Emergency food supply of six cans of corned beef hash with an expiration date of 12/2023 and a box of canned pulled chicken with an expiration date of 6/1/2025 were thrown away.These failures had the potential to result in the residents developing food borne illnesses ( illnesses caused by consuming contaminated foods or beverages) that could lead to other serious medical complications and hospitalizations.Findings:During an observation on 7/28/2025 at 9:15 a.m., in the dry food storage room, observed an uncovered bowl of dry cereal was on a tray labeled Cereal 7/21/2025 to 7/25/2025. The Dietary Manager (DM) quickly threw the cereal in the trash. During an observation on 7/30/2025 at 11:01 a.m., with DM, in the facility basement, observed six cans of corned beef hash cans that expired on 12/2023 and a box of canned pulled chicken that expired on 6/1/2025. There were no labels on the cans. During an interview on 8/01/2025 at 12:14 p.m., with DM, DM stated he threw the cereal because it was passed the use by date. DM stated the cans need to be labeled because they could end up being in the circulating food for the residents. DM stated the expired food in the emergency food supply were slowly getting discarded. DM stated the residents could get food borne illnesses or sickness-like diarrhea (loose stool) from eating expired foods.During an interview on 8/1/2025 at 3:29 p.m., with the Director of Nursing (DON), the DON stated residents can get stomach pain, diarrhea, nausea and vomiting from eating expired foods. The DON stated resident can be exposed to botulism (rare and potentially fatal illness caused by botulinum toxin) in the expired cans.During a review of the facility's policy and procedure (P&amp;P) titled Storage of Food and Supplies, dated 2023, the P&amp;P indicated, Food and supplies will be stored properly and in a safe manner.Dry food items which have been opened, such as pudding, gelatin, biscuit mix, pancake mix, dry cereal, spices, coffee, noodles, etc., will be tightly closed, labeled and dated.</p>		

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  08/01/2025
NAME OF PROVIDER OR SUPPLIER  Bixby Towers Post-Acute Rehab		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 0825  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident.  (continued on next page)

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  08/01/2025
NAME OF PROVIDER OR SUPPLIER  Bixby Towers Post-Acute Rehab		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)		
<p>F 0825</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to provide a Physical Therapy ([PT] a rehabilitation profession that restores, maintains, and promotes optimal physical function) evaluation and treatment in accordance with a physician's order dated 7/17/2025 for Physical Therapy Evaluation and treatment for one of 10 sampled residents (Resident 21). This deficient practice had the potential to cause a decline in mobility and range of motion ([ROM] full movement potential of a joint) due to a delay in provision of PT services for Resident 21. Findings: During a review of Resident 21's admission Record (AR), the AR indicated Resident 21 initially admitted to the facility on [DATE] and readmitted [DATE] with diagnoses including hemiplegia , weakness to one side of the body) and hemiparesis (inability to move one side of the body) following unspecified cerebrovascular disease (disease of the blood vessels, especially blood vessels to the brain) affecting left dominant side, aphasia (a disorder that makes it difficult to speak), stiffness of left wrist, stiffness of left hand, and pain in left elbow. During a review of Resident 21's Minimum Data Set (MDS, resident assessment tool) dated 4/22/2025, the MDS indicated Resident 21 had functional ROM limitations on one side of the upper extremity (UE, shoulder, elbow, wrist, hands) and on both sides of the lower extremity (LE, hip, knee, ankle/foot). The MDS also indicated Resident 21 required dependent assistance from staff for oral hygiene, bathing, dressing, and bed to chair transfers. The MDS indicated Resident 21 rarely understood others. During a review of Resident 21's History and Physical Examination (H&amp;P) dated 7/18/2025, the H&amp;P indicated Resident 21 did not have the capacity to understand and make decisions. During a review of Resident 21's Rehab Joint Mobility Assessment (JMA) dated 7/17/2025, the JMA indicated Resident 21 had moderate ROM limitation in left shoulder flexion (moving arm up and down) and abduction (moving arm away from the body), moderate limitation in left elbow, minimal limitation in left wrist and left hand/fingers. The JMA indicated Resident 21 had minimal limitation in right shoulder flexion and abduction, full (no limitation to within functional limits) ROM in right elbow, right wrist, and right hand/fingers. The JMA indicated Resident 21 had full ROM in both hips and both knees, and severe ROM limitation in both ankles. During a review of Resident 21's physician's orders dated 7/17/2025, the physician order indicated Physical Therapy and Occupational Therapy (rehabilitative profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities) evaluation and treatment under Part B (type of Medicare insurance). During a review of Resident 21's Physical Therapy records, the PT records did not indicate a PT evaluation was completed. During an observation on 7/30/2025 in Resident 21's room, Resident 21 was lying in bed with eyes open. Resident 21 did not respond to verbal or visual cues. Resident 21's left elbow was bent more than halfway, the left wrist was mostly straight, and the left fingers were in a fist position with the left thumb in between the third and fourth fingers. Resident 21's right arm was straight. Resident 21's right knee was bent more than halfway and rotated away from the body. Resident 21 was able to move the right leg towards the body a little. Resident 21's left leg was straight. During a concurrent interview and record review on 7/30/2025 at 11:15 a.m., the Rehab Director (RHB) reviewed Resident 21's medical records. The RHB stated there was an order dated 7/17/2025 and ended on 7/20/2025 for Physical Therapy and Occupational Therapy evaluation and treatment under Part B. The RHB reviewed Resident 21's PT records and stated a PT evaluation was not completed. The RHB stated she was not aware of the order and usually the nursing staff would inform therapy if there was an order for therapy. The RHB stated Resident 21 should have received an PT evaluation on 7/17/2025 or at least the next day. The RHB stated it was important to complete a PT evaluation as ordered by a physician so that PT staff could evaluate any changes that would require PT intervention. The RHB stated if the PT evaluation and intervention was delayed, then Resident 21 could have more weakness due to immobility. During an interview on 7/30/2025 at 3:36 p.m. with the Director of Nursing (DON), the DON stated the therapy department should have known about the PT evaluation order and it should have been communicated to the therapy staff. The DON stated an order for PT evaluation should not have been missed and stated Resident 21 could have declined and not improved if Resident 21 did not receive PT as ordered by a physician. During a review of the facility's policies and procedures (P&amp;P) revised 1/1/2017, titled, Resident/Patient Assessment and Reassessment, the P&amp;P indicated initial resident/patient assessment and evaluation for benefits of Rehabilitation Services will be performed on all residents referred to Rehabilitation Services by an ordering physician new evaluation orders are required to be completed within 72 hours from the time written</p>		

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  08/01/2025
NAME OF PROVIDER OR SUPPLIER  Bixby Towers Post-Acute Rehab		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)
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>(continued on next page)</p>

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  08/01/2025
NAME OF PROVIDER OR SUPPLIER  Bixby Towers Post-Acute Rehab		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)		
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to maintain accurate records for two out of 10 sampled residents (Resident 21 and Resident 52) by failing to:1. Indicate how long Resident 21 could wear a left elbow extension (straightening the elbow) splint (rigid material or apparatus used to support and immobilize a broken bone or impaired joint) and left resting hand splint during Restorative Nursing Aide program (RNA, nursing aide program that helps residents to maintain their function and joint mobility) treatment. 2. Accurately indicate how long Resident 52 could wear a left knee splint during RNA treatment. These deficient practices had the potential to cause injury to Residents 21 and 52 due to wearing splints for too long (skin integrity and pain) or for too little time (decline in ROM). Findings:1. During a review of Resident 21's admission Record (AR), the AR indicated Resident 21 initially admitted to the facility on [DATE] and readmitted [DATE] with diagnoses including hemiplegia (weakness to one side of the body) and hemiparesis (inability to move one side of the body) following unspecified cerebrovascular disease (disease of the blood vessels, especially blood vessels to the brain) affecting left dominant side, aphasia (a disorder that makes it difficult to speak), stiffness of left wrist, stiffness of left hand, and pain in left elbow. During a review of Resident 21's Minimum Data Set (MDS, resident assessment tool) dated 4/22/2025, the MDS indicated Resident 21 had functional ROM limitations on one side of the upper extremity (UE, shoulder, elbow, wrist, hands) and on both sides of the lower extremity (LE, hip, knee, ankle/foot). The MDS also indicated Resident 21 required dependent assistance from staff for oral hygiene, bathing, dressing, and bed to chair transfers. The MDS indicated Resident 21 rarely understood others. During a review of Resident 21's History and Physical Examination (H&amp;P) dated 7/18/2025, the H&amp;P indicated Resident 21 did not have the capacity to understand and make decisions. During a review of Resident 21's medical records, the medical records indicated a previous order dated 6/17/2025 for RNA to see resident for BUE PROM and application of LUE elbow extension splint and resting hand orthotic (an external device to support, align, or correct a movable part of the body) five times a week or as tolerated. During a review of Resident 21's June 2025 Documentation Survey Report (DSR), the RNA intervention/task indicated RNA to see [resident] for BUE PROM and application of LUE elbow extension and resting hand orthotic five times a week or as tolerated. The DSR did not indicate how long Resident 21 could wear the LUE elbow extension and resting hand orthotic. During a review of Resident 21's Occupational Therapy Discharge Summary (OT DC) dated 6/17/2025, the OT DC indicated discharge recommendations for Resident 21 to wear an elbow extension splint and a resting hand splint on LUE for up to six hours. During a concurrent interview and record review on 7/30/2025 at 11:15 a.m. with the Rehab Director (RHB), Resident 21's June 2025 RNA records were reviewed. The RHB stated the RNA order dated 6/17/2025 indicated for RNA treatment for BUE PROM and application of LUE elbow extension splint and resting hand orthotic five times a week or as tolerated. The RHB stated the RNA order did not indicate the wear time and schedule for how long the RNAs should put on the left elbow extension splint or for the left resting hand splint. The RHB stated therapy needed to indicate in the RNA order how long to wear splints because it was the time therapy established Resident 21 could safely tolerate the splint. The RHB stated RNAs needed to know how long to put on the splint, because if RNA put on the splint for too long, the splint could cause skin problems and if the RNAs put on the splint for too little time, the resident would not maximize the tolerance and benefit of the splint. During an interview on 7/30/2025 at 3:36 p.m. with the Director of Nursing (DON), the DON stated RNA orders needed to include the type of splint and the splint wear time. The DON stated the RNA orders needed to be accurate because the time to wear the splint was how long the resident could tolerate the splint to prevent injury to the resident. During a review of the facility's policies and procedures (P&amp;P) revised 1/1/2017, titled Splinting, the P&amp;P indicated there must be a physician's order for splinting and to provide splint guidelines for application, wear, and care. 2. During a review of Resident 52's AR, the AR indicated Resident 52 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including spina bifida (birth disorder in which the spine does not fully develop) and primary generalized osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage). During a review of Resident 52's MDS, dated [DATE], the MDS indicated Resident 52 had severe cognitive impairments (mental processes involved in gaining knowledge and comprehension, includes thinking, knowing, remembering, judging, problem-solving). The MDS indicated Resident 52 did not have any functional range of motion (ROM full movement potential of a joint) limitations</p>		

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  08/01/2025
NAME OF PROVIDER OR SUPPLIER  Bixby Towers Post-Acute Rehab		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)		
<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>Based on interview and record review the facility failed to correct deficiencies during the prior recertification survey (inspections conducted by the California Department of Public Health (CDPH), Licensing and Certification Division, or its authorized entities, to ensure that healthcare facilities and providers maintain compliance with state and federal regulations and continue to meet the standards for their license or certification) dated 7/12/2024, for Resident Rights, Quality of Care, Food Safety and Infection Control. These failures had the potential to result in a loss of dignity, lack of quality of care, infection and food borne illness (a disease or infection that is transmitted through the consumption of contaminated food or beverages) for all residents in the facility. Findings: During an interview on 8/1/2025 at 3:17p.m. with the Administrator (ADM), the ADM stated the Quality Assurance and Performance Improvement (QAPI) a fundamental concept in healthcare, particularly in long-term care settings like nursing homes, where it's mandated by federal regulations) program is an ongoing comprehensive, and date driven approach to improve the quality of care and quality of life for the residents. The ADM stated the QAPI meets monthly and includes the Medical Director, Administrator, Director of Nursing, Infection Preventionist, Rehab Director, and all department heads. The ADM stated during the meetings that the committee members review data from, in order to determine and track trends. Admin stated that he is responsible for ensuring that the QAPI program is fully implemented into the facility's daily operations. Admins stated that he oversees and ensures that the QAPI program aligns with all regulatory requirements. The ADM stated he ensures all departments are engaged and contributing to the QAPI efforts by performing spot checks and observing all functions in departments. Admin stated when issues are identified internally or externally QAPI will conduct a root cause analysis in order to determine the causative factor. The ADM stated the QAPI committee is currently working on fall prevention. The ADM stated his role is to help facilitate the QAPI program during the meetings. The ADM stated staff are provided with in-services which are important because it ensures that staff stay current with the best practices and changes with regulatory requirements. The ADM stated all staff are responsible for ensuring residents are treated with dignity, providing quality care, food safety, and infection control. The ADM stated the previous deficiencies were not fully resolved and contributed to factors that could be inconsistent in staff education, lack of monitoring and follow-through on corrective action plans. The ADM stated there is a need for improvement and will be working on the issues identified as deficient practices. During a review of the facility's policy and procedures (P&amp;P) titled, Quality Assurance Performance Improvement (QAPI) Program, revised dated 2/20214, the P&amp;P indicated, The primary purpose of the Quality Assurance and Performance Improvement Program is to establish data-driven, facility-wide processes that improve the quality of care, quality of life and clinical outcomes of our residents.</p>		

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  08/01/2025
NAME OF PROVIDER OR SUPPLIER  Bixby Towers Post-Acute Rehab		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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to follow infection control precautions for two of three sampled residents (Resident 86 and Resident 64.). Facility failed to: a. Ensure family members wore appropriate Personal Protective Equipment (PPE) clothing and equipment that is worn or used to provide protection against hazardous substances and/or environment) while visiting and assisting Resident 86. b. Implement enhanced barrier precautions (EBP - an infection control intervention designed to reduce transmission of multidrug-resistant organisms) for Resident 64. These deficient practices had the potential to result in cross contamination (physical movement or transfer of harmful bacteria from one person, object, or place to another) and place residents at risk for the spread of infection. Findings:</p> <p>1. During a review of Resident 86's admission Record, the admission Record indicated Resident 86 was admitted to the facility on [DATE] with diagnoses including hypertension (HTN- high blood pressure) and urinary retention (when your bladder does not completely empty).</p> <p>During a review of Resident 86's Order Summary Report, the Order Summary Report indicated an order was placed on 7/23/2025 for Enhanced Barrier Precautions (EBP- infection control strategy focused on reducing the spread of multidrug-resistant organisms (MDROs- a germ that has become resistant to the medicines used to fight it). The Order Summary Report indicated an order was placed on 7/22/2025 for a urinary catheter (a hollow tube inserted into the bladder to drain or collect urine) for urinary retention.</p> <p>During an observation on 7/28/2025 at 10:43 a.m., in Resident 86's room, Resident 86's wife was observed at the bedside assisting the resident while not wearing PPE.</p> <p>During a concurrent observation and interview on 7/29/2025 at 1:11 p.m., in Resident 86's room, Resident 86's family member at bedside was observed not wearing PPE. Licensed Vocational Nurse (LVN) 2, LVN 2 stated Resident 86 has a urinary catheter and was on EBP. LVN 2 stated Resident 86's family should be wearing PPE to prevent the spread of infection and to protect the resident, visitors, and staff.</p> <p>During an interview on 7/31/2025 at 9:22 a.m., with the Infection Prevention Nurse (IPN), the IPN stated the family member for Resident 86 should be wearing PPE because not doing so could place the resident at risk for developing an infection and possibly spreading infection to others.</p> <p>During an interview on 8/1/2025 at 3:03 p.m., with the Director of Nursing (DON), the DON stated when a resident was on EBP, staff and visitors should wear PPE to prevent the resident from developing an infection and prevent the spread of infection.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, "Infection Prevention and Control Program," dated 3/6/2025, the P&amp;P indicated, "The facility has established policies and procedures regarding infection control among employees, contractors, vendors, visitors, and volunteers including precautions to prevent these individuals from contracting bloodborne pathogens from residents to others. Those with potential direct exposure to blood or body fluids are trained in and required to use appropriate precautions and personal protective equipment."</p> <p>(continued on next page)</p>		

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  08/01/2025
NAME OF PROVIDER OR SUPPLIER  Bixby Towers Post-Acute Rehab		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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. During a review of Resident 64's admission Record, dated 7/30/25, the admission Record indicated Resident 64 was admitted to the facility on [DATE] with diagnoses including dysphagia (difficulty swallowing), gastrostomy tube (G-tube - a surgically placed tube that provides direct access to the stomach for feeding, hydration, or medication administration, often used when someone has difficulty swallowing or cannot meet their nutritional needs orally), myocardial infarction (blood flow to the heart is severely reduced or blocked, causing damage or death to heart muscle tissue), depression, heart failure (a condition where the heart can't pump enough blood to meet the body's needs), and respiratory failure (a condition where the lungs cannot adequately remove carbon dioxide or oxygenate the blood).</p> <p>During a review of the Resident 64's record titled, Physician Order, dated 7/30/25, the Physician Order indicated, and order to apply enhanced barrier precautions to prevent the spread of infections .</p> <p>During an observation on 7/28/25 at 10:24 a.m., in Resident 64's room, Certified Nurse Assistant (CNA) 7 was not wearing an isolation gown (type of personal protective equipment (PPE) worn by healthcare professionals to protect themselves and patients from the spread of infectious diseases) while changing Resident 64's gown.</p> <p>During an interview on 7/28/25 at 10:27 a.m., with CNA 7, CNA 7 stated she gave Resident 64 a bed bath and changed her gown. CNA 7 stated she should have been wearing gloves and an isolation gown to adhere to EBP.</p> <p>During an interview on 7/31/25 at 8:41 a.m., with the Infection Prevention Nurse (IPN - nurse specializing in preventing and controlling the spread of infectious diseases in healthcare settings), the IPN stated that EBP was a preventive measure to protect resident from catching any infections from vulnerable sites such as the G-tube for Resident 64. The IPN stated staff providing direct patient care need to wear a gown and gloves.</p> <p>During an interview on 8/1/25 at 9:47 AM with the Director of Nurses (DON), the DON stated EBP is initiated for residents with wounds or indwelling medical devices. The DON stated, "Staff and family need to follow EBP when providing care or in contact with the resident."</p> <p>During a review of the facility's P&amp;P titled, "Enhanced Barrier Precautions," dated 6/20/2024, the P&amp;P indicated, "to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. To reduce the transmission and spread of Centers for Disease Control and Prevention (CDC)- targeted and epidemiologically important multi-drug-resistant organism (MDRO) causing infection when contact precautions do not apply."</p>		

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  08/01/2025
NAME OF PROVIDER OR SUPPLIER  Bixby Towers Post-Acute Rehab		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)		
<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Keep all essential equipment working safely.</p> <p>Based on observation, interview, and record review, the facility failed to maintain three of three electrical rehabilitation therapy (therapy given to restore an individual back to their highest possible level of physical, mental, and psychosocial well-being) equipment for resident use. This deficient practice had the potential for injury to any resident using the therapy equipment. Findings: During an observation and interview on 7/28/2025 at 1:21 p.m., with the Rehabilitation Director (RHB), the RHB stated the rehabilitation gym was downstairs on the first floor. The RHB stated the therapy department had three electrical therapy equipment including an ultrasound (equipment used to produce high-frequency sound waves that travel deep into tissue and create therapeutic heat), transcutaneous electrical nerve stimulation (TENS, a machine that uses electrical currents through a device to stimulate the nerves for therapeutic purposes) combination unit, Therapy Equipment (TE 1), an adjustable therapy mat (TE 2), and a bicycle (TE 3). The RHB provided a tour of the therapy gym on the first floor and located inside the therapy were TE 1, TE 2, and TE 3. The RHB stated she was not sure when the last maintenance check or calibration was for the three electrical therapy equipment. During an interview on 7/30/2025 at 11:15 a.m., with the RHB, the RHB stated TE 1 was purchased last year. The RHB stated no therapy staff or maintenance staff have checked or maintained TE 1, TE 2 and TE 3 and there were no records of any maintenance of the therapy equipment. The RHB stated it was important to maintain therapy equipment because the therapy equipment could cause injury to residents using the equipment if the equipment was not working correctly. During an interview on 7/30/2025 at 2:54 p.m. with the Maintenance Director (MND), the MND stated the maintenance staff did not check the therapy equipment or have a process for frequent preventive maintenance checks. The MND stated if the equipment was broken, then therapy staff could create a work order for the maintenance staff to fix the equipment, but maintenance staff did not perform general maintenance on the therapy equipment. During an interview on 7/30/2025 at 3:36 p.m. with the Director of Nursing (DON), the DON stated it was important to perform general preventive maintenance on therapy equipment, because it was to provide safe equipment for the residents using the therapy equipment during therapy. During a review of the facility's policy and procedure revised 12/2009, titled Maintenance Service, indicated the Maintenance Director is responsible for developing and maintaining a schedule of maintenance service to assure the equipment are maintained in a safe and operable manner at all times. During a review of the facility's policy and procedure revised 1/1/2017, titled, Equipment Servicing and Maintenance, indicated inspection shall include functioning, general condition of equipment and a record will be kept in the department for each piece of equipment that is inspected.</p>		