PRINTED: 12/13/2018
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055995	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR CONVALESCENT CENTER OF NORTH LONG BEACH	260 E MARKET ST LONG BEACH, CA 90805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the Department of Public Health during the Recertification Survey. Representing the Department of Public Health: Surveyor ID: 40169 RN, HFEN Surveyor ID: 36356 RN, HFEN Surveyor ID: 36385 RN, HFEN Surveyor ID: 38600 RN, HFEN Surveyor ID: 38309 RN, HFEN Total Population: 72 Total Sample Size: 18	F 000	**"Preparation and/or execution of this plan of correction, does not constitute admission or agreement by the provider, of the truth of the facts alleged or the conclusions set forth in this statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of Health and Safety code section 1280 and 42CFR et seq".** **This Plan of Correction constitutes the facility's credible allegation of compliance.**	
F 583 SS=E	Highest Severity and Scope: E Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other	F 583	**F 583 Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii).** **How Corrective Action will be accomplished for residents affected:** Residents 27, 70, and 17 were appropriately provided full privacy to accommodate personal care and treatment of wound care by changing the cubicle curtain ensuring full privacy of the affected residents.	12/29/18

RECEIVED
DEC 20 2018
By

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator 12/28/18

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.

PRINTED: 12/13/2018
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055995	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR CONVALESCENT CENTER OF NORTH LONG BEACH	260 E MARKET ST LONG BEACH, CA 90805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 583	Continued From page 1 materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide full privacy during personal and wound care for three of 18 sampled residents (Resident 27, 70, and 17). This deficient practice had the potential to lower Resident 27, 70, and 17's self esteem, violating their rights and resulted in body parts being exposed. Findings: a. During a wound care observation for Resident 27 on 11/26/18 at 8:06 a.m., the resident was standing on the left side of the bed, wearing a hospital gown with his back exposed. The resident was holding on to his incontinent pad (diaper) with one hand and with the other hand attempted to reach for the telephone. On the same day at 8:08 a.m., Resident 27 was	F 583	**Identification of Residents with the Potential to be Affected:** Maintenance Director did an audit of all cubicle curtains and no other residents were found to be affected. **Measures to Prevent Recurrence**: The DSD in-service Nursing staff on providing privacy to resident while providing care and treatment on 12/15/18, 12/17/18 and 12/18/18. The DSD, Housekeeping and Laundry Supervisor conducted an in-serviced on 12/19/18 and 12/20/18 with the housekeeping staff to ensure the right size cubicle curtain is in place to provide full privacy to residents in the facility when staff is providing personal care, wound care and all other services provided at bedside. **Monitoring Corrective Action and Responsibility:** The Housekeeping and Laundry Supervisor will monitor the replacement of the cubicle curtains daily. During Quality	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/13/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055995	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR CONVALESCENT CENTER OF NORTH LONG BEACH	260 E MARKET ST LONG BEACH, CA 90805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 583	Continued From page 2 observed to let go of his diaper exposing his buttocks which was facing the bedroom door. The resident did not respond to the question, whether he needed assistance. During an interview with the maintenance supervisor (MS) on 11/26/18 at 10:30 a.m., MS was observed to attempt to pull the resident's privacy curtain around the resident's bed, however there was a gap in the curtains, not allowing full privacy for the resident. MS was observed to measure the width of the gap to be 14 inches wide. The MS stated the curtains should have no gaps. A review of Resident 27's admission record indicated he was admitted to the facility on 7/1/2004 and re-admitted on 2/22/18 with diagnoses that included hemiplegia and hemiparesis (impaired movement to one side of the body) and schizoaffective disorder (characterized primarily by symptoms of hallucinations or delusions, and symptoms of a mood disorder, such as mania and depression). A review of Resident 27's minimum data set (MDS), a comprehensive care and screening tool dated 10/8/18 indicated the resident had no cognitive impairment (ability to think, understand and make daily decisions). b. During a wound care observation for Resident 70, with Licensed Vocational Nurse (LVN 4) on 11/26/18 at 9:29 a.m., LVN 4 attempted to pull the resident's privacy curtain around the bed to begin wound care but the curtain was not wide enough to provide full privacy. However, LVN 4 proceeded with the wound care on Resident 70's sacrococcyx (tailbone) area, exposing the	F 583	Rounds the Department Managers will monitor that cubicle curtain provide full privacy for personal and wound care and other services provided at bedside. Findings will be submitted to the QA&A Committee for review and recommendations x 3 months. **Date of correction:** 12/29/18	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055995	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR CONVALESCENT CENTER OF NORTH LONG BEACH	260 E MARKET ST LONG BEACH, CA 90805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 583	Continued From page 3 buttocks during care. During an interview with the maintenance supervisor (MS) on 11/26/18 at 10:01 a.m., stated the facility sent out the cleaning of the privacy curtains to an outside company but the facility was responsible for providing the resident's privacy curtains. The MS was observed to attempt to pull the privacy curtain around Resident 70's bed but it was not wide enough to go around the bed. On the same day at 10:28 a.m., the MS was observed to measure the width of the gap of Resident 70's privacy curtain to be 56 1/2 inches wide. The MS stated the facility kept extra curtains and did not know why Resident 70 did not have the appropriate curtains. During an interview on 11/28/18 at 2:48 p.m., the LVN 4 stated Resident 70's roommate was in the room, at the same time the wound physician (MD) and the certified nurse assistant were doing wound care on 11/26/18. LVN 4 stated she attempted to pull the privacy curtain all the way around Resident 70 but the curtain was not wide enough. LVN 4 stated she could not remember the last time the curtains were changed, but stated "maybe has been three days". LVN 4 stated to provide privacy, she would close the blinds and close the door when the privacy curtains did not fully cover Resident 70. However, LVN 4 acknowledged she did not close the door at the time of wound care observation on 11/26/18 to provide full privacy for Resident 70. The LVN 4 stated the facility policy was to have the privacy curtain fully closed around the resident and she was responsible for notifying housekeeping about the curtains.	F 583		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055995	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR CONVALESCENT CENTER OF NORTH LONG BEACH	260 E MARKET ST LONG BEACH, CA 90805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 583	Continued From page 4 A review of the facility's policy titled "Privacy/ Dignity", last revised on 10/24/17 indicated staff needed to always ensure privacy and/ or dignity of residents which included closing privacy curtains during care. c. During an observation and concurrent interview on 11/26/18 at 8:05 a.m., Resident 17 was observed lying in bed with bare legs and diaper exposed. The Certified nursing assistant (CNA 3) who was with Resident 17 stated the privacy curtain was too short to close fully and she would let the maintenance supervisor know. A review of Resident 17's face sheet indicated the resident was originally admitted to the facility on 1/4/16 and readmitted on 3/9/18 with diagnoses including but not limited to urinary tract infection (infection in any part of the urinary system), chronic obstructive pulmonary disease (a chronic inflammatory lung disease that causes obstructed airflow from the lungs), schizoaffective disorder (a mental health condition including schizophrenia [a disorder that affects a person's ability to think, feel, and behave clearly] and mood disorder symptoms) and dementia (a group of thinking and social symptoms that interferes with daily functioning). A review of the Minimum Data Set (MDS), a standardized resident assessment and screening tool, dated on 9/20/18, indicated Resident 17's decision making and memory were impaired. Resident 17 required total staff assistance from staff for bed mobility, dressing, personal hygiene and toilet use.	F 583		
F 623	Notice Requirements Before Transfer/Discharge	F 623		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/13/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055995	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR CONVALESCENT CENTER OF NORTH LONG BEACH	260 E MARKET ST LONG BEACH, CA 90805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623 SS=D	Continued From page 5 CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs,	F 623	**F 623: Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8).** **How Corrective Action will be accomplished for residents affected:** Resident 75 is no longer at the facility. Resident 75 was safely discharge to SNF 2 meeting resident psychosocial and medical needs with resident's participation in the discharge process along with the resident's case worker. **Identification of Residents with the Potential to be Affected:** Health Information Director reviewed current and pending transfer and discharge plans of other residents to ensure residents and/or responsible party participation in the discharged planning process. No other residents found to be affected. **Measures to Prevent Recurrence**: Social Service Consultant to in-service Social Service staff on 12/19/18 on ensuring a safe, orderly, and participation of residents and/or	12/19/18

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/13/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055995	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR CONVALESCENT CENTER OF NORTH LONG BEACH	260 E MARKET ST LONG BEACH, CA 90805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 6 under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.	F 623	responsible party in the discharge planning process. **Monitoring Corrective Action and Responsibility:** The Health Information Director will audit new admissions for initiation of discharge planning by social services weekly x 3 months. Results will be provided to the Administrator and submitted to the QA&A Committee for review and recommendations x 3 months. **Date of compliance:** 12/29/18	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/13/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055995	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR CONVALESCENT CENTER OF NORTH LONG BEACH	260 E MARKET ST LONG BEACH, CA 90805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 7 §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to issue a 30-day discharge notice to one of 18 sampled residents (Resident 75), prior to the discharge from the facility. Resident 75 was not provided with sufficient preparation and orientation to ensure a safe and orderly transfer and did not allow their participation in the discharge planning process. This deficient practice could possibly result in the denial of Resident 75's right to make decisions and participate in his own health care. Findings: During an interview with Social Service Designee (SSD) on 11/28/18 at 10:22 AM stated that,	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055995	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR CONVALESCENT CENTER OF NORTH LONG BEACH	260 E MARKET ST LONG BEACH, CA 90805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 8 "Resident 75 was discharged 8/24/18 to Skilled Nursing Facility (SNF 2) for custodial care per resident request. I notified him of the pending discharge on 8/20/18." A medical record review of Resident 75's face sheet indicated the resident was admitted on 7/18/18. A review of the diagnoses list included weakness, anxiety disorder (extreme nervousness), paranoid schizophrenia (fear with inability to recognize reality) with auditory hallucinations (hearing sounds inaudible to others), and major depressive disorder (severe, recurrent depression). A review of Resident 75's history and physical (H&P) form dated 7/19/18, assessed by Medical Doctor (MD 1) identified a recent hospitalization at General Acute Care Hospital (GACH 2) due to hallucinations. The H&P form indicated MD 1 added the diagnosis of schizoaffective disorder (combination of schizophrenia and mood disorder features such as hallucinations along with altered mood). A review of history and physical form dated 7/3/18 assessed by MD 2 at GACH 1 described Resident 75 as homeless with psychosis who was admitted to GACH 1 and transferred to GACH 2 for psychiatric stabilization. A review of Resident 75's H&P form assessed by MD 3 dated 7/3/18 at GACH 2 indicated the resident was unable to take care of himself and was having auditory hallucinations (hearing things not there). A review of the Minimum Data Set (MDS), a standardized assessment and care screening	F 623		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/13/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055995	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR CONVALESCENT CENTER OF NORTH LONG BEACH	260 E MARKET ST LONG BEACH, CA 90805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 9 tool, dated 4/21/18 indicated Resident 75 was alert and oriented. A review of Resident 75's multidisciplinary care conference notes dated 7/19/18 showed the resident was oriented to name, place, and time with periods of forgetfulness. Resident 75 was able to make his needs known, and wanted to return to the community when stable. The notes indicated SSD was to assist Resident 75 to reach goal and assist with discharge planning. A review of the Physician's Discharge Summary dated 8/24/18 signed by MD 1 indicated Resident 75 was to be discharged to SNF 2. The summary listed Resident 75's admitting diagnoses as: HTN (high blood pressure), lack of coordination, difficulty walking, muscle weakness, vitamin D deficiency, paranoid schizophrenia (fear plus inability to accurately perceive reality), depression, and anxiety. The summary indicated Resident 75's prognosis was fair, and listed under condition on discharge was "Other - Long Term Placement." There was no final diagnosis, with the section indicated "must be completed by primary physician upon discharge." A review of the Post Discharge Plan of Care dated 8/24/18 and signed by SSD described Resident 75 with care needs. A review of facility's policy titled "Discharge Plan/Post discharge Plan Of Care" dated 11/17 indicated the IDT will develop and implement an effective discharge plan in preparation for the resident to be an active partner to effectively transition them to post-discharge care. The resident will be provided with sufficient preparation and orientation to ensure a safe and	F 623		

PRINTED: 12/13/2018
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055995	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR CONVALESCENT CENTER OF NORTH LONG BEACH	260 E MARKET ST LONG BEACH, CA 90805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 10 orderly transfer and allow their participation in the discharge planning process. Needed information for discharge planning includes projected time frame for moving resident.	F 623		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to follow professional standards of practice when administering medications through a gastrostomy ([G-tube] a tube inserted through the abdomen that delivers nutrition, hydration and medications directly to the stomach) and administering subcutaneous (administered under the skin) medications for one of 18 sampled residents (Resident 44). This deficient practice placed Resident 44 at risk for clogged G-tube, adverse reactions from medication interactions and risk for infection. Findings: a. During a medication administration observation for Resident 44 on 11/27/18 at 8:58 a.m. with Licensed Vocational Nurse (LVN 2), the following medications were taken out of their bubble packs and placed in individual plastic medication cups:	F 658	**F 658: Services Provided Meet Professional Standards** **How Corrective Action will be accomplished for residents affected:** Resident #44 the attending physician was notified and orders given to continue with current physician orders. Resident #44 was monitored x 72 hours with no change of condition. **Identification of Residents with the Potential to be Affected:** The DON reviewed Physician Orders of residents with G-Tubes and physician orders of residents with insulin and no other residents were found to have been affected. **Measures to Prevent Recurrence**: LVN #2 skills checked and in-service done by Pharmacy Nurse consultant on 12/14/18 regarding medication administration. In-service	12/29/18

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/13/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055995	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR CONVALESCENT CENTER OF NORTH LONG BEACH	260 E MARKET ST LONG BEACH, CA 90805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 11 1. Pro-heal liquid three times a day 2. Amlodipine 10 milligrams (mg) 1 tablet 3. Vitamin D 2,000 units 1 tab daily 4. Clonidine 0.1 mg 1 tab via G-tube 5. Doxazosin Mesylate (Cardura) 4 mg 1 tab via G-tube 6. Lantus 100 units/ml 12 units subcutaneous injection 7. Clonazepam 0.5 mg 1 tab via G-tube 8. Lasix 40 mg via G-tube 1 tablet daily 9. Rena vite 1 tablet daily 10. Vitamin C 250 mg (500 mg tab) 1/2 tab daily 11. Aspirin 325 mg 1 tab via G-Tube On 11/27/18 at 9:46 a.m., LVN 2 was observed to crush each medication and mixed each medication in 5 milliliters of water in the medication cup. LVN 2 was observed to check the resident's G-tube placement, then flushed (administer liquid using a syringe) the tube with 30 milliliters (ml) of water prior to administering the first crushed medication. During the observation, subsequent medications were administered without flushing water inbetween medication administrations. LVN 2 stated "the resident is on fluid restriction" as the reason for not flushing between medications. On 11/30/18 at 9:21 a.m., during an interview with the DON stated the physician had written in the progress notes but there was no order for fluid restriction and no restrictions for flushing between medications for Resident 44. The DON stated, for residents receiving medications by G-tube, the procedure included crushing medications when applicable, placing the medication in a cup, mix with water, check the G-tube placement, pre-flush the G-tube with water, then administer the	F 658	provided to Licensed Nursing staff on 12/14/18 and 12/17/18 by Pharmacy Nurse Consultant regarding medication administration. **Monitoring Corrective Action and Responsibility:** The DSD and/or Pharmacy Nurse Consultant will do bi-weekly medication pass review with the Licensed Nursing Staff. Findings will be provided to the DON and submitted to the QA&A Committee for review and recommendations x 3 months. **Date of compliance:** 12/29/18	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/13/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055995	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR CONVALESCENT CENTER OF NORTH LONG BEACH	260 E MARKET ST LONG BEACH, CA 90805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 12 medications one at a time with about 10 ml of water between medications. The DON stated flushing water between medications was needed to keep the patency of tubing and "so that medications do not mix with other medications that could counteract with each other". According to the guidelines published in 2009 by the American Society for Parenteral and Enteral Nutrition, the feeding tube should be flushed with a minimum of 15 ml of sterile water. Since it could be the cause of a physical-chemical interaction of more than one drug at the same time, the drugs should not be mixed and every drug should be given one by one. (Bankhead et al. 2009). b. On 11/27/18 at 10:03 a.m., LVN 2 was observed to administer Lantus (a type of insulin medication used to control abnormal blood sugars) on the left lower quadrant of Resident 44's abdomen without cleaning the injection site prior to administering the medication subcutaneous (below the skin). During a concurrent interview, LVN 2 stated he forgot to clean the site. On 11/29/18 at 10:59 a.m., with the Director of Nursing (DON) stated when administering insulin the injection site had to be cleaned prior to administration for infection control, to prevent microorganisms in the skin from entering the blood. A review of the facility's policy titled "Subcutaneous Medication Administration" dated December 2015, indicated to select an appropriate site for injection, and cleanse skin with alcohol swab.	F 658		

PRINTED: 12/13/2018
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055995	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR CONVALESCENT CENTER OF NORTH LONG BEACH	260 E MARKET ST LONG BEACH, CA 90805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 661	Continued From page 13	F 661	**F 661 Discharge Summary**	
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to issue a notice that included a discharge summary to one of 18 sampled residents (Resident 75), which included a recapitulation of the resident's stay with diagnoses upon discharge from the facility.	F 661	**How Corrective Action will be accomplished for residents affected:** Resident 75 is no longer in the facility. Resident 75 was safely discharged to SNF 2 with face sheet that included diagnosis, meeting resident psychosocial and medical needs with resident's participation in the discharge process along with the resident's case worker. **Identification of Residents with the Potential to be Affected:** Health Information Director reviewed current and pending transfer and discharge plans of other residents to ensure a discharge summary is included with no other residents found to be affected. **Measures to Prevent Recurrence**: DON and DSD will in-service Licensed Nursing staff on 12/18/18, 12/19/18 and 12/20/28 regarding ensuring a discharge summary is completed	12/29/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055995	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR CONVALESCENT CENTER OF NORTH LONG BEACH	260 E MARKET ST LONG BEACH, CA 90805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 661	Continued From page 14 Resident 75's discharge summary did not include all the relevant diagnoses prior to discharge. This deficient practice could possibly result in facility not communicating necessary Information Resident 75, continuing care provider and other authorized persons at the time of discharge. Findings: During an interview with Social Service Designee (SSD) on 11/28/18 at 10:22 AM stated that, "Resident 75 was discharged 8/24/18 to Skilled Nursing Facility (SNF 2) for custodial care per resident request. I notified him of the pending discharge on 8/20/18." A medical record review of Resident 75's face sheet indicated the resident was admitted on 7/18/18. A review of the diagnoses list included weakness, anxiety disorder (extreme nervousness), paranoid schizophrenia (fear with inability to recognize reality) with auditory hallucinations (hearing sounds inaudible to others), and major depressive disorder (severe, recurrent depression). A review of Resident 75's history and physical (H&P) form dated 7/19/18, assessed by Medical Doctor (MD 1) identified a recent hospitalization at General Acute Care Hospital (GACH 2) due to hallucinations. The H&P form indicated MD 1 added the diagnosis of schizoaffective disorder (combination of schizophrenia and mood disorder features such as hallucinations along with altered mood).	F 661	including diagnosis for residents being discharge. **Monitoring Corrective Action and Responsibility:** Health Information Director will audit discharges to ensure a discharge summary has been completed at time of discharge x 3 months. Findings will be provided to the DON and submitted to the QA&A Committee for review and recommendations x 3 months. **Date of compliance:** 12/29/18	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/13/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055995	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR CONVALESCENT CENTER OF NORTH LONG BEACH	260 E MARKET ST LONG BEACH, CA 90805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 661	Continued From page 15 A review of history and physical form dated 7/3/18 assessed by MD 2 at GACH 1 described Resident 75 as homeless with psychosis who was admitted to GACH 1 and transferred to GACH 2 for psychiatric stabilization. A review of Resident 75's H&P form assessed by MD 3 dated 7/3/18 at GACH 2 indicated the resident was unable to take care of himself and was having auditory hallucinations (hearing things not there). A review of the Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 4/21/18 indicated Resident 75 was alert and oriented. A review of Resident 75's multidisciplinary care conference notes dated 7/19/18 showed the resident was oriented to name, place, and time with periods of forgetfulness. Resident 75 was able to make his needs known, and wanted to return to the community when stable. The notes indicated SSD was to assist Resident 75 to reach goal and assist with discharge planning. A review of the Physician's Discharge Summary dated 8/24/18 signed by MD 1 indicated Resident 75 was to be discharged to SNF 2. The summary listed Resident 75's admitting diagnoses as: HTN (high blood pressure), lack of coordination, difficulty waiking, muscle weakness, vitamin D deficiency, paranoid schizophrenia (fear plus inability to accurately perceive reality), depression, and anxiety. The summary indicated Resident 75's prognosis was fair, and listed under condition on discharge was "Other - Long Term Placement." There was no final diagnosis, with	F 661		

PRINTED: 12/13/2018
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055995	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR CONVALESCENT CENTER OF NORTH LONG BEACH	260 E MARKET ST LONG BEACH, CA 90805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 661	Continued From page 16 the section indicated "must be completed by primary physician upon discharge." A review of the Post Discharge Plan of Care dated 8/24/18 and signed by SSD described Resident 75 with care needs. A review of facility's policy titled "Discharge Plan/Post discharge Plan Of Care" dated 11/17 indicated the IDT will develop and implement an effective discharge plan in preparation for the resident to be an active partner to effectively transition them to post-discharge care. The resident will be provided with sufficient preparation and orientation to ensure a safe and orderly transfer and allow their participation in the discharge planning process. Needed information for discharge planning includes projected time frame for moving resident.	F 661		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility	F 755	**F 755 Pharmacy Srvcs / Procedures / Pharmacist / Records** **How Corrective Action will be accomplished for residents affected:** Resident 125 is no longer in the facility. The Pharmacist Consultant along with the DON, Medical Director and Administrator completed a controlled medication storage and disposition discrepancy action plan. **Identification of Residents with the Potential to be Affected:**	12/29/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055995	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR CONVALESCENT CENTER OF NORTH LONG BEACH	260 E MARKET ST LONG BEACH, CA 90805

(X4) ID PREFIX. TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 17 must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to properly handle, account for, keep records of and not release controlled medications (substance is generally a drug or chemical whose manufacture, possession, or use is regulated by a government) to an unauthorized driver upon discharge for one of 18 sampled residents (125) by: a. Provide accurately documentation for narcotics (controlled medications), and b. Ensure controlled medication was not transported to another facility. The deficient practice resulted in inaccurate reconciliation, unauthorized handling, and potential for Resident 125's narcotic diversion. Findings:	F 755	Pharmacy Nurse Consultant completed a controlled medication review, count and reconciliation with no other residents found to be affected. **Measures to Prevent Recurrence**: Pharmacy Nurse Consultant and Pharmacist conducted in-service for Licensed Nursing Staff on 11/26/2018, 11/30/18 and 12/14/18 regarding the reconciliation, disposition, and storage of controlled medications. **Monitoring Corrective Action and Responsibility:** Pharmacist and Pharmacy Nurse Consultant to audit monthly the disposition, reconciliation and storage of controlled medications. Findings will be provided to the Administrator and submitted to the QA&A Committee for review and recommendations x 3 months. **Date of compliance:** 12/29/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055995	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR CONVALESCENT CENTER OF NORTH LONG BEACH	260 E MARKET ST LONG BEACH, CA 90805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 18 a. During narcotic storage inspection witnessed by the director of nursing (DON) on 11/26/18 at 9:19 a.m. the following were identified: 1. The DON provided two clear plastic bags of injectable narcotics and narcotic count sheets. 2. A bunch of keys on top of several narcotic injectable vials inside the DON's drawer, which was easily accessible to unauthorized persons. 3. A clear bag of six (6) Hydromorphone ([Dilaudid] strong controlled pain medication) 2 milligrams (mg) per (/) milliliter (ml), vials (bottle), without an identifier as to which resident the medication belonged to. There was no narcotic count sheet for the 6 Hydromorphone vials to ensure there was an accurate account of dispensing the medications. 4. One vial of Haldol (medication to control behavior and mood) with no resident's name. During a concurrent interview the DON stated the pharmacy consultant and the DON destroy discontinued medication every 30 days. The DON further stated "I don't know who the medications belongs to and I don't know when I was given the narcotics." b. A review of the Admission Records indicates Resident 125 was admitted to the facility on 9/7/18 with diagnoses not limited to discitics (inflammation that develops between the intervertebral discs of your spine), lupus (the body immune system attacking the body tissues and organs), chronic pancreatitis (inflammation of the pancreases), sciatica (nerve pain) and rheumatoid arthritis (joint inflammation) and was	F 755		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/13/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055995	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR CONVALESCENT CENTER OF NORTH LONG BEACH	260 E MARKET ST LONG BEACH, CA 90805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 19 discharged to skilled nursing facility (SNF 2) on 10/5/18. The following injectable medications for Resident 125 had no controlled substance count sheets (narcotic count sheet, potential for abuse and diversion medications): 1. 14 vials of Hydromorphone (Dilaudid) 2 mg/ml. 2. One vial Ativan (medication that control nervousness/restlessness) 2 mg/ml. 3. On multi dose brown colored vial of Hydromorphone 40 mg/20 ml (2 mg/ml) with approximately 15 ml remaining. 4. 68 vials of Diphenhyramine (medication for itch, nausea and vomiting, which may cause drowsiness) 50 mg/ml. During a concurrent interview the DON stated "I received the medications when Resident 125 was discharged on 10/5/18. The DON further stated Diphenhyramine was discontinued on 10/16/18 and the Pharmacy Consultant (P 1) destroyed discontinued medications on 10/29/18. The DON was not able to state why Ativan, Haldol, Diphenhyramine and Hydromorphone injectable medications were not destroyed when P 1 was at SNF 1. The DON further stated there must be a narcotic count sheet for all discontinued narcotics. The DON stated Ativan, Haldol, Diphenhyramine and Hydromorphone injectable medications was to have the narcotic count sheets. The DON stated "I have to compare the medication count log corresponds with the actual medication count." The DON was not able to state if all discontinued medications including the narcotics count were accurate as there was no narcotic log provided for correlation and record	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055995	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR CONVALESCENT CENTER OF NORTH LONG BEACH	260 E MARKET ST LONG BEACH, CA 90805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 20 keeping. The DON stated Hydromorphone was a narcotic pain medication and a controlled substance. During an interview on 11/26/18 at 1:18 p.m. the DON referring to Ativan, Haldol, Diphenhyramine and Hydromorphone injectable medications and stated "I am still looking for the narcotic count sheets for the discontinued narcotic medications." During a telephone interview on 11/26/18 at 11:20 p.m. P 2 stated the licensed nurses and P 1 were responsible for monitoring and recording narcotics upon delivery to the facility (SNF 1). P 2 stated P 1 was responsible for all discontinued medications destruction and that SNF 1 must have narcotic count sheets for routine and as necessary (PRN) all narcotics. P 2 stated SNF 1 must refuse narcotics if the delivered narcotic count does not correspond to delivery manifest. P 2 stated it was SNF 1's responsibility to contact the pharmacy if delivered narcotics did not have narcotic count sheets. P 2 stated the narcotic prescription number (Rx) was resident specific and must match the narcotic count sheet for a specific narcotic delivered to SNF 1. P 2 stated a page of a narcotic count sheet was adequate for each narcotic Rx delivered and administered to a resident. P 2 stated "I don't think the facility requested for narcotic count sheet." During an interview on 11/26/18 at 3:30 p.m. P 1 stated P 1 asked the DON if there are any medications to be discontinued. P 1 further stated every month the DON and P 1 destroy all discontinued medications including narcotics. P 1 continued to state "I double check the actual remaining discontinued narcotic with the narcotic count sheet. I watch the DON remove narcotics	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055995	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR CONVALESCENT CENTER OF NORTH LONG BEACH	260 E MARKET ST LONG BEACH, CA 90805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 21 from the drawer, verify and destroy the discontinued medications and narcotics with the DON, document the medication and amount destroyed, date, and sign on the narcotic log." P 1 stated, P 1 has never encountered a situation when medications and or containers are not labeled. P 1 stated, P 1 would required the DON to start investigations in a situation where medications and or container are not identifiable and narcotic count sheet was missing or did correspond to the narcotic count log. P 1 stated, P 1 was not aware that some discontinued narcotics did not have narcotic count sheet and the remaining narcotic medication count did not match the narcotic count sheets. P 1 stated she did not destroy narcotics without narcotic log "because I do not know what happened to the narcotics. I have never been in a situation whereby the narcotic count sheets were missing and narcotics, and narcotic medications were not labeled with a resident's name." P 1 stated she was concerned about narcotics diversion by the medication going missing. P 1 further stated it appeared the licensed nurses were using single dose vials multiple times when administering Hydromorphone to Resident 125. P 1 stated it was the licensed nurses responsibility to report to P 1 and the DON if the narcotic count sheet was missing and medication can not be traced to a resident. During an interview on 11/26/18 at 4:21 p.m. Registered Nurse (RN 2) supervisor stated RN 2 used single dose medication vial only once, discard remaining dose and have another licensed nurse witness and sign on the narcotic count sheet for partial dose narcotic waste. During an interview on 11/26/18 at 5:00 p.m. P 1	F 755		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/13/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055995	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR CONVALESCENT CENTER OF NORTH LONG BEACH	260 E MARKET ST LONG BEACH, CA 90805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 22 acknowledged and stated "I have an extra 18 vials of Dilaudid for Resident 125 and my guess is the nurses were using the 2 mg/ml vial multiple times to administer the Dilaudid thus the surplus. However I do not know for sure if that is what happened." During an interview on 11/27/18 at 6:59 a.m. the assistant director of nursing (ADON) stated single dose medication one can only be used once because the rubber seal has been broken and tapered with, and the manufacturer's guide indicated, for single use. The ADON stated a narcotic count sheet was important to keep track, account for amount of medication administered and amount remaining. The ADON further verified Resident 125 had a narcotic count sheet for each all narcotics delivered and administered. The ADON stated the DON was handed over the remaining narcotics and corresponding narcotic count logs when a resident was discharged, transferred to general acute care (GACH), or when expired to give the medications including narcotics for comparison and safe custody. The ADON stated licensed nurses can not give the DON narcotics without a count sheet log because the narcotic count may not be accurate. The ADON further stated "I have to ask the licensed nurse giving me the narcotics without the count sheet to find and bring me the count sheet." During an observation on 11/27/18 at 7:36 a.m. the DON counted 19 vials of Hydromorphone 2 mg/1 ml single dose use for Resident 125. During a concurrent record review Resident 125's narcotic count log indicated a zero balance. During a concurrent interview both the DON and assistant DON (ADON) were not able to state the reason for the extra Hydromorphone. The DON	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055995	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR CONVALESCENT CENTER OF NORTH LONG BEACH	260 E MARKET ST LONG BEACH, CA 90805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 23 further stated "I still can't find the count sheet for multi dose Hydromorphone 20 ml/vial. I am not giving up. I will look till I find it." During an Interview on 11/27/18 at 7:42 a.m. licensed vocational nurse (LVN 2) stated the RNs administer intravenous (IV) medications and did witness once an RN draw a partial dose and waste the remaining narcotic in a sharps container. During a witnessed record review and concurrent interview on 11/27/18 at 11:52 a.m. the social services director (SSD) stated Resident 125 was transferred to SNF 2 on 10/5/18 at 11:30 am. During a telephone interview on 11/28/18 at 7:24 a.m. RN 3 verified Resident 125 was on IV Hydromorphone every four hours for paln. RN 3 stated the pharmacy would at times supply Hydromorphone 20 ml vial or the single dose of 1 ml when the pharmacy ran out of the 20 ml. RN 3 stated "I drew up 1/2 ml and save the other 1/2 ml to give it later because it is on my shift and I did not want to waste the medication." When asked how RN 3 administered Hydromorphone 2 mg/ml, RN 3 verified Hydromorphone 2 mg/ml vial was for single dose use, stated "I did not want to waste the medication," and logged the administration in the narcotic sheet. RN 3 stated all narcotics must have a narcotic count sheet and narcotics must counted with the on coming nurse at shift change. RN 3 stated, RN 3 could not recall a time when the pharmacy dispensed narcotics without narcotic count sheet and the licensed nurses must immediately contact the pharmacy when narcotics are delivered without a count sheet. RN 3 stated "I just verbally tell the charge nurse that I am saving the rest of the	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055995	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR CONVALESCENT CENTER OF NORTH LONG BEACH	260 E MARKET ST LONG BEACH, CA 90805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 24 medication to give it later, and no, the charge nurse does not sign anywhere." During an interview on 11/28/18 at 9:36 a..m. the DON stated the DON must remove all narcotics from a drawer during narcotics inspection and "I don't remember if I gave you just some." The DON stated there was no way of proving Hydromorphone remaining in a multi dose vial was the actual narcotic and it had the correct count without a narcotic count log. During an interview on 11/29/18 at 6:34 a.m. LVN 3 stated Resident 125 was on IV 0.5 ml Hydromorphone for pain administered by the RNs, and was on 0.5 ml just before she was discharged. LVN 3 stated, RN 3 used Hydromorphone single dose vial twice to manage Resident 125's pain, store the remaining vial in the IV cart, and would tell the charge nurse he was administering the remaining 1/2 vial of Hydromorphone. LVN 3 stated the 2 mg/ml Hydromorphone vial was for single dose use meaning the vial can be used once. LVN 3 stated "I thought it is okay for RN 3 to save the remaining medication because he is the RN supervisor." LVN 3 stated "I never signed anywhere not even the narcotic sheet and I thought it was only RNs who sign the narcotic sheet." LVN 3 stated RN 3 gave Resident 125 Hydromorphone IV every four hours. During a telephone interview on 11/29/18 at 11:14 a.m. P 1 stated she became aware of the Hydromorphone discrepancy at SNF 1 when the writer informed P 1. On a concurrent interview P 1 stated single dose injectable medication can not be reused because of:	F 755		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/13/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055995	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR CONVALESCENT CENTER OF NORTH LONG BEACH	260 E MARKET ST LONG BEACH, CA 90805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 25 1. High risk of medication contamination. 2. Rubber seal residual inside the medication vial can be erroneously injected into the resident. 3. Risk of Insufficient medication dose. 4. Potential for medication Diversion During a witnessed record review on 11/29/18 at 2:09 p.m., a facility's document titled Antibiotic or Controlled Drug record for Liquids Only dated 10/8/2018 indicated SNF 1 handed over Resident 125's injectable Hydromorphone 41 ml (2 mg/ml) vials to a private transporter (PT) when the resident was discharged to SNF 2 located in another county. During a concurrent interview the ADON stated did not know who PT or related to Resident 125. The ADON stated RN 1 discharged Resident 125 with 41 vials of Hydromorphone on 10/8/18 and signed that RN 1 and PT both signed the Antibiotic or Controlled Drug Record for Liquids Only document. The ADON further stated according to Antibiotic or Controlled Drug Record for Liquids Only the facility was administering Hydromorphone 0.5 ml and saving the remaining 0.5 ml to be administered later since 9/9/19 for Resident 125. During an interview on 11/29/18 at 2:18 p.m. the DON stated the attending physician gave an order to discharge Resident 125 with Hydromorphone to SNF 2 because SNF 2 would not be able to have the medications available when the resident arrived at SNF 2. During further interview the DON stated "I received an order to discharge Resident 125 to SNF 2 with an order on 10/4/18 at 14:19 p.m. During a witnessed concurrent record review with the DON Resident 125's Physician's Order dated 10/4/18 at 14:19 p.m. indicated to discharge Resident 125 with medications, however the order did not	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055995	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR CONVALESCENT CENTER OF NORTH LONG BEACH	260 E MARKET ST LONG BEACH, CA 90805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 26 indicate which medications were to be discharged with the resident. The DON was not able to state how Hydromorphone could be accounted for once released to PT, if PT was a licensed Nurse, and did not consult with P 1 before releasing Hydromorphone to PT. The DON stated SNF 2 must be able to provide care to a resident upon admission. During a telephone interview on 11/29/18 at 3:00 p.m. P 1 stated controlled medications can not leave the facility, be handled by an unauthorized person or accompany a resident to an facility. P 1 further stated the accepting facility must be able to provide the pain medications to Resident 125 upon arrival either from SNF 2 emergency kit (Ekit) until SNF 2's pharmacy was able to supply the narcotics for Resident 125. DON stated the PT, who transported Resident 125 was not a licensed nurse, must not be given narcotics because there was no means of tracking or accountability for the narcotics. The DON stated the licensed staff at the facility must provide the remaining narcotics to the DON for safe custody and destruction by the pharmacist. During a telephone interview on 11/30/18 at 7:46 a.m. with RN 1 stated "when Resident 125 was discharged to SNF 2, gave PT Resident 125's Hydromorphone, as directed by the DON, and the attending physician orders." RN 1 stated P 1 was not consulted about the Resident 125's Hydromorphone order. The DON was not able to provide multi dose injectable Hydromorphone 40 mg/20 ml narcotic count log for Resident 125, from 11/26/18 to end of survey on 11/29/18.	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055995	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR CONVALESCENT CENTER OF NORTH LONG BEACH	260 E MARKET ST LONG BEACH, CA 90805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 27 During an interview on 11/30/18 at 9:31 a.m. P 1 stated SNF 1 did not have a policy on transferring or discharging a resident with their remaining narcotics. There was no policy submitted for review regarding how a non licensed person or staff should handle the resident's remaining narcotics when discharged. During record review of a business card provided by SNF 1 on 11/29/18 indicated PT was a driver employed by a transportation company. During record review on 11/30/18 indicated licensed nurses failed to sign after administering and or wasting injectable Hydromorphone for Resident 125 on: 1. Six doses on 9/9/2018 at 12:00 a.m., 4:00 a.m., 8:00 a.m., 12 p.m., 4:00 p.m. and 8:00 p.m. 2. Three doses on 9/10/18 at 12:00 a.m., 4:00 p.m. and 8:00 p.m. 3. Four doses on 9/11/18 at 12:00 a.m., 12:00 p.m., 4:00 p.m. and 8:00 p.m. 4. One dose on 9/12/18 at 8:00 a.m. 5. Several RNs administered 40 doses of IV Hydromorphone 0.5 ml to Resident 125 on 9/12/18 from 12:00 a.m. to 12:00 a.m. on 9/19/18, 6. Three doses on 9/19/18 at 4:00 a.m., 8:00 a.m. and 4:00 p.m. 7. Two doses on 9/20/18 at 12:00 a.m. and 4:00 a.m. 8. Three doses on 9/21/18 at 12:00 a.m., 4:00	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055995	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR CONVALESCENT CENTER OF NORTH LONG BEACH	260 E MARKET ST LONG BEACH, CA 90805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 28 a.m. and 12:00 p.m. 9. Four doses on 9/23/18 at 12:00 a.m. and 4:00 a.m. 10. One dose on 9/24/18 at 12:00 a.m. 11. Four doses on 9/30/18 at 12:00 a.m., 4:00 a.m. and 8:00 p.m. The facility's policy titled "Disposal of Medications and Medication-Related Supplies" dated 4/2008 indicated the director of nursing and consultant pharmacist are responsible for the facility's compliance with federal and state laws and regulations in the handling of controlled medications. The discharging nurse contacts the provider pharmacy for information before releasing medications. The facility's policy titled "Specific Medication Administration Procedures" dated 4/2008 indicated unused doses should be disposed of in accordance with the medication destruction policy. The facility's policy titled "Medication Labels" dated 4/2016 indicated the following: 1. Medications are labeled in accordance with the facility requirements and state and federal laws. 2. Only the dispensing pharmacy can modify or change prescription labels. 3. Contents are not transferred from one container to another. The Consultant Pharmacist Services Provider Requirements dated 8/2014 indicated the consultant pharmacist will assist the facility in: 1. Evaluating the process of receiving and	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055995	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR CONVALESCENT CENTER OF NORTH LONG BEACH	260 E MARKET ST LONG BEACH, CA 90805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 29 interpreting prescriber' orders, acquiring, receiving, storing, controlling, reconciling, compounding, dispensing, packaging, labeling, distributing, administering and or disposing of all medications, biologicals,and chemicals. 2. Identification and evaluation of medication-related issues. The facility's policy titled "Medication Storage in the Facility" dated 4/2008 indicated completed controlled medication accountability records are submitted to the director of nursing and kept on file for five years at the facility. According to an online Institute For Self Medication Practices, a global leader in patient safety as the first non-profit organization dedicated to the collaborative development, education, and advocacy of safe medication practices, article titled Partially Filled Vials and Syringes in Sharps Containers are a Key Source of Drugs for Diversion indicated: 1. Health care industries should expect diversion considering that one in 10 healthcare practitioners/workers will abuse drugs, take all the necessary steps to prevent and detect it. 2. Signs of diversion is not limited to frequent incorrect controlled substance counts and large or inconsistent amounts of wasted narcotics. 3. Drug Security and Chain of Custody requires to secure controlled substances at all times, before leaving the medication preparation area, secure vials containing leftover controlled substances yet to be discarded and walking away to administer a dose or attend to a pharmacy task without securing the vial can invite diversion. 4. Prohibit drawing more than a single dose of a controlled substance into a syringe. 5. Saving partial doses in syringes exposes the	F 755		

PRINTED: 12/13/2018
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055995	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR CONVALESCENT CENTER OF NORTH LONG BEACH	260 E MARKET ST LONG BEACH, CA 90805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 30 drug to possible diversion. https://www.ismp.org/resources/partially-filled-vials-and-syringes-sharps-containers-are-key-source-drugs-diversion	F 755	**F 758 Free from Unnec Psychotropic Meds/PRN Use**	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that— §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and	F 758	**How Corrective Action will be accomplished for residents affected:** Resident #61 was assessed by the Psychiatrist Physician Assistant #1 and discontinued Trazadone. Resident #15 will be reassessed by attending Psychiatrist 12/20/18. **Identification of Residents with the Potential to be Affected:** Gradual Dose Reduction Committee reviewed residents on antipsychotic and antidepressants medications and no other residents were found to be affected. **Measures to Prevent Recurrence**: The Gradual Dose Reduction committee to review the psychotropic and antidepressant summary sheets monthly to ensure medication reduction or continuance is appropriate.	12/29/18

PRINTED: 12/13/2018
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055995	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR CONVALESCENT CENTER OF NORTH LONG BEACH	260 E MARKET ST LONG BEACH, CA 90805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 31 §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to provide unnecessary medications from two of 18 sampled residents (61, 15) medications by: Resident 61 was administered Trazodone (antidepressant), for insomnia (difficulty sleeping), without evidence of insomnia, and Resident 15 had an increase in Zyprexa (antipsychotic [It can treat mental disorders, including schizophrenia and bipolar disorder]) medication with documentation for behavior manifested by aggressive behavior as indicated in the physician order. This deficient practice could possibly result in the administration of unnecessary medications for Resident 61 and 15. Findings:	F 758	**Monitoring Corrective Action and Responsibility:** The Social Service Director will monitor through participation in the monthly Gradual Dose Reduction Committee meetings and review the findings with the Psychiatric Medical Director or Designee times monthly x 3 months. Findings will be submitted to the QA&A Committee for review and recommendations x 3 months. **Date of correction:** 12/29/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055995	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR CONVALESCENT CENTER OF NORTH LONG BEACH	260 E MARKET ST LONG BEACH, CA 90805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 32	F 758		

a. During an observation on 11/29/18 03:30 PM, Resident 61 was in the dining room. During a concurrent interview, Resident 61 was asked for her name, was alert, able to respond promptly, and appropriately to initial questions. When asked if the resident had trouble sleeping, Resident 61 replied, "Go away."

During an interview on 11/29/18 01:30 PM with licensed vocational nurse (LVN 3) stated "She (Resident 61) doesn't sleep much during the day. She usually goes to the dining room. I don't work at night, so I'm not sure how she sleeps then."

During an interview on 10/29/18 when asked if he was familiar with Resident 61, or if the facility had informed of any daytime drowsiness, nighttime insomnia, or other signs of circadian rhythm (are physical, mental, and behavioral changes that follow a daily cycle) disruption, psychiatrist (PA 1) replied, "Established circadian rhythm is important in the treatment of depression." When asked if Resident 61 was showing symptoms of disrupted circadian rhythm, PA 1 gave no response.

A medical record review of Resident 61's chart showed the resident was originally admitted on 7/18/18. Resident 61 was readmitted on 10/26/18 with diagnoses that included right sided weakness from a stroke, cognitive communication deficit (difficulty communicating due to brain function), anxiety disorder (extreme nervousness), unspecified psychosis (inability to perceive reality), major depressive disorder (extreme depression), insomnia (difficulty sleeping), and history of falls.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055995	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR CONVALESCENT CENTER OF NORTH LONG BEACH	260 E MARKET ST LONG BEACH, CA 90805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 33 A review of medication orders for Resident 61 indicated there were five psychotropic present on re-admission, but Ativan (antianxiety) and Trazodone were discontinued prior to the survey. Resident 61 had an order for Melatonin (treat insomnia [persistent problems falling and staying asleep]) re-ordered on 11/2/18 for "circadian rhythm." A record review of the insomnia checklist for Resident 61 dated 10/26/18, for the physician to evaluate the need for Trazodone use showed no episodes of insomnia. Resident 61 had not yet been in facility for 30 days, and there was no pharmacist review. A review of the Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 11/8/18 indicated Resident 61 was cognitively intact. A review of her medication administration record for November 2018 indicated Resident 61's sleep ranged between 6-7 hours per night. A review of Resident 61's potential for insomnia care plan indicated the resident was showing depression manifested by inability to sleep. However, there was no care plan, including interventions for circadian rhythm difficulties. There was no facility policies for insomnia or unnecessary medications for review. b. During an interview on 11/29/18 at 10:10 AM, with Certified Nurse Assistant (CNA 1) described Resident 15's behavior as being "pleasant and calm." CNA 1 did not recall any display of	F 758		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/13/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055995	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR CONVALESCENT CENTER OF NORTH LONG BEACH	260 E MARKET ST LONG BEACH, CA 90805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 34 aggressive behavior by the resident. On 11/29/18 at 1:15 PM, during an interview and concurrent record review conducted with the Registered Nurse Supervisor (RNS). The RNS described the behavior of Resident 15 as being "sometimes pleasant." The RNS stated Resident 15 sometimes cried out for no reason. The RNS also stated, "One second she is quiet, and then sometimes she says things that you can not understand. The explanation sometimes doesn't make sense." When asked about any other identified behaviors, RNS stated CNAs have told her Resident 15 had refused care in the past. The RNS also stated, "I tell them to give her a minute, and then she is usually okay. That's what I know about her." The RNS was asked about any changes in Resident 15's behavior since admission. The RNS stated, "She has been like that ever since she's been here." During an interview with the Director of Rehabilitation (DOR) on 11/29/18 at 2:50 PM, stated Resident 15 "Needs frequent redirection because she is confused." The DOR added that "with cuing, the resident is able to participate in therapy. Other words that he used to describe the residents overall behaviors were "friendly" and "happy." During an interview and concurrent record review with the Director of Nursing, (DON) on 11/29/18 at 3:25 PM, the progress notes, psychiatry notes, and behavioral monitoring in the Medication Administration Record, (MAR) were reviewed. The DON described Resident 15 as being "alert, oriented, she gets up in wheelchair. She goes to activities daily." When asked to describe Resident 15's behavior, the DON stated the resident was	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055995	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR CONVALESCENT CENTER OF NORTH LONG BEACH	260 E MARKET ST LONG BEACH, CA 90805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 35 not very verbal, but will answer simple questions. The DON stated Resident 15 was usually quiet, and sometimes cried in the dining room. The DON further explained the staff had tried to redirected Resident 15 when she cries, and that Resident 15 will then stop and "mellow down." The DON noted that she has not seen the Resident aggressive or angry. The DON stated that she has not heard of the resident being "combative, or aggressive." The DON was asked to read orders for Zyprexa from the MAR: Zyprexa tablet 2.5 mg by mouth one time a day for manifested by aggressive behavior related to unspecified psychosis not due to a substance or known physiological condition. Informed consent obtained by MD from responsible party. Zyprexa tablet 5 mg Give 1 tablet by mouth at bedtime for manifested by aggressive behavior related to unspecified psychosis not due to a substance or known physiological condition. Informed consent obtained by MD from responsible party. The DON described aggressive behavior as, "fighting for no reason, verbal or physical aggression like: kicking, screaming for no apparent reason. I have maybe seen her be aggressive once." The DON stated Resident 15 was normally redirected when these behaviors are seen. The DON stated redirection was effective for behavior management. The DON stated there was an increase in the dose of Zyprexa medication on 11/23/18 for aggressive behaviors, but was unable to provide documentation from the medical record to support and justify the increase in dose.	F 758		

PRINTED: 12/13/2018
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055995	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR CONVALESCENT CENTER OF NORTH LONG BEACH	260 E MARKET ST LONG BEACH, CA 90805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 759	Continued From page 36	F 759	**F 759 Free of Medication Errors 5 Prcnt or More**	12/29/18
F 759 SS=E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure it was free of medication error rate of less than five (5) percent (%) or greater, as evidences by the identification of three (3) medication errors out of 40 opportunities for errors, to yield a cumulative error rate of 7.5 % for two residents reviewed (Resident 29, 44). a. Resident 29, an anti-hypertensive medication was not administered within the medication time frame as per facility policy, missed one tablet of a pain reliever as per physician's (MD) orders and one tablet of Gabapentin (medication used to treat pain and seizures) was not given according to MD orders. This deficient practice resulted in receiving medication late, placed Resident 29 at risk for elevated blood pressure and not receiving the appropriate medication dose and unrelieved pain. b. Resident 44, who was administered medications through a gastrostomy tube ([G-tube] a tube inserted through the abdomen into the stomach to deliver nourishment, hydration and medications), each medication was not separated by a water flushes. The deficient practice placed Resident 44 at risk for a blocked tubing and potential adverse medication interactions.	F 759	**How Corrective Action will be accomplished for residents affected:** Resident #44 and #29 the attending physicians were notified and orders given to continue with current physician orders. Resident #44 and #29 were monitored x 72 hours with no change of condition. **Identification of Residents with the Potential to be Affected:** The DON reviewed other residents the physician orders of residents with G-Tubes. The Pharmacy Nurse Consultant did medication pass review with licensed nursing staff. No other residents were found to have been affected. **Measures to Prevent Recurrence**: Pharmacy Nurse Consultant conducted a skills competency observation and inservice with LVN#1 and LVN #2 on 12/14/18 and 12/17/18 regarding medication administration. In-service	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/13/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055995	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR CONVALESCENT CENTER OF NORTH LONG BEACH	260 E MARKET ST LONG BEACH, CA 90805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 759	Continued From page 37 Findings: a. During a medication administration observation on 11/26/18 at 08:28 a.m., Resident 29's blood pressure was taken and recorded at 170/90 millimeter mercury (mm Hg) (normal range 120/80 mm Hg). Licensed Vocational Nurse (LVN 1) was observed preparing Resident 29's medications. The first medication from a bubble pack was Metoprolol 25 milligrams (mg) one tablet, LVN 1 continued with Resident 29's other medications, placed all the medication tablets together into one plastic medication cup. On 11/26/18 at 8:57 a.m., LVN 1 was observed taking Resident 29's medication from a bubble pack, and handed a bubble pack to the surveyor. One capsule fell from the bubble pack onto the surveyor's table, which went unnoticed by LVN 1. The bubble pack was labeled Gabapentin 200 milligrams (mg) by mouth (PO) two times a day for neuropathy (damage to the peripheral nerves), with two capsules in each bubble pack slot. The following were the medications and number of pills for each medications which were indicated in each bubble pack and medication bottle handed to the surveyor, totaled 16 opportunities (pills): 1. Metoprolol 25 milligram (mg) 1 tablet by mouth (PO) two times a day (BID) 2. Amitiza 24 microgram (mcg) 1 capsule PO BID with breakfast and dinner 3. Amlodipine 10 mg 1 tablet PO daily for hypertension	F 759	provided to Licensed Nursing staff on 12/14/18 and 12/17/18 by Pharmacy Nurse Consultant regarding medication administration. **Monitoring Corrective Action and Responsibility:** The DSD and/or Pharmacy Nurse Consultant will do bi-weekly medication pass review with the License Nursing Staff. Findings will be provided to the DON monthly x 3 months and submitted to the QA&A Committee for review and recommendations x 3 months. **Date of correction:** 12/29/18	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/13/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055995	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR CONVALESCENT CENTER OF NORTH LONG BEACH	260 E MARKET ST LONG BEACH, CA 90805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 759	Continued From page 38 4. Baclofen 10 mg 1 tablet PO BID for muscle spasms 5. Vitamin D for deficiency 1,000 units 5 tablets daily 6. Cymbalta 60 mg 1 capsule PO daily for depression 7. Famotidine 20 mg 1 tablet PO daily for GERD 8. Folic Acid 400 mcg 1 tablet PO daily 9. Gabapentin 100 mg 2 capsules PO BID for neuropathy 10. Oxycontin CR 20 mg 1 tablet PO every 12 hours for two weeks 11. Modafinil 200 mg 1 tablet PO daily During an interview on 11/26/18 at 8:59 a.m., LVN 1 stated the total number of medication pills in the plastic cup totaled 15 pills (16 pills should have been accounted for). During an interview with LVN 1 on 11/27/18 at 3:36 p.m., she stated she was unaware she had missed one tablet of Gabapentin. On a concurrent interview regarding the Metoprolol not given in a timely manner, LVN 1 stated the medication was due at 7:15 a.m. but she was with another resident that took longer than expected. LVN 1 stated, the facility medication administration protocol was to give medications within one hour before and one hour after the designated medication administration time. LVN 1 stated the resident's blood pressure taken at 9:00 a.m., was elevated (170/90 mm Hg) and she had to report to the MD because the resident's blood pressure "was never high". A review of Resident 29's medication administration record (MAR) dated 11/1/2018 to 11/30/2018 indicated an order for metoprolol 25 mg tablet two times a day and the times for	F 759		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/13/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055995	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR CONVALESCENT CENTER OF NORTH LONG BEACH	260 E MARKET ST LONG BEACH, CA 90805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHDULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 759	Continued From page 39 administration was 7:15 a.m. and 5:15 p.m. b. During a medication administration observation for Resident 44 on 11/27/18 at 8:58 a.m. with Licensed Vocational Nurse (LVN 2), the following medications were taken out of their bubble packs and placed in individual plastic medication cups: 1. Pro-heal liquid three times a day 2. Amlodipine 10 milligrams (mg) 1 tablet 3. Vitamin D 2,000 units 1 tab daily 4. Clonidine 0.1 mg 1 tab via G-tube 5. Doxazosin Mesylate (Cardura) 4 mg 1 tab via G-tube 6. Lantus 100 units/ml 12 units subcutaneous injection 7. Clonazepam 0.5 mg 1 tab via G-tube 8. Lasix 40 mg via G-tube 1 tablet daily 9. Rena vite 1 tablet daily 10. Vitamin C 250 mg (500 mg tab) 1/2 tab daily 11. Aspirin 325 mg 1 tab via G-Tube On 11/27/18 at 9:46 a.m., LVN 2 was observed to crush each medication and mixed each medication in 5 milliliters of water in the medication cup. LVN 2 was observed to check the resident's G-tube placement, then flushed (administer liquid using a syringe) the G-tube with 30 milliliters (ml) of water prior to administering the first crushed medication. During the observation, subsequent medications were administered without flushing water inbetween each medications. LVN 2 stated "the resident is on fluid restriction" as the reason for not flushing between medications. On 11/29/18 at 3:39 p.m., during an interview and record review of Resident 44's physician's orders	F 759		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/13/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055995	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR CONVALESCENT CENTER OF NORTH LONG BEACH	260 E MARKET ST LONG BEACH, CA 90805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 759	Continued From page 40 with the Medical Records Director (MRD), stated there was not an order for fluid restriction for Resident 44. On 11/30/18 at 9:21 a.m., during an interview with DON stated the physician had written in the progress notes but there was no order for fluid restriction and no restrictions for flushing between medications for Resident 44. The DON stated, for residents receiving medications by G-tube, the procedure included crushing medications when applicable, put the medication in a cup, mix with water, check the G-tube placement, pre-flush the G-tube with water, then administer the medications one at a time with about 10 ml water between medications. The DON stated flushing water between medications was needed to keep the patency of the tubing and "so that medications do not mix with other medications that could counteract with each other".	F 759		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 761	**F 761 Label/Store Drugs and Biological** **How Corrective Action will be accomplished for residents affected:** ADON immediately separated the oral and rectal drugs stored in the medication room to prevent any potential wrong route medication administration. **Identification of Residents with the Potential to be Affected:** Medication storage areas were	1/29/19

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/13/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055995	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR CONVALESCENT CENTER OF NORTH LONG BEACH	260 E MARKET ST LONG BEACH, CA 90805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 41 §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to store oral and rectal medications separately. The deficient practice had the potential for wrong route medication administration. Findings: During a witnessed medication room inspection on 11/26/18 11:37 AM with Registered Nurse (RN 1) verified that one per rectum (PR) enema saline laxative (medication to prevent constipation) bottle was stored on the same shelf next to oral (PO, by mouth) liquids medications. On a concurrent instead RN 1 stated "we should separate PO from PR to prevent medication route errors. A review of the facility's policy titled "Medication Storage in the Facility" dated 4/2008, indicated orally administered medications are kept separate from externally used medications such as suppositories, liquids and lotions.	F 761	audited by the ADON and medications were stored per medication storage policy. No residents found to be affected. **Measures to Prevent Recurrence**: The Pharmacy Nurse Consultant inserviced Registered Nurses, Licensed Nurses and Central Supply personnel on 12/17/2018 regarding appropriate medication storage including separating oral medications from rectal medications. **Monitoring Corrective Action and Responsibility:** The ADON and/or RN Supervisor will inspect the medication room storage through observation during rounds to ensure medications are stored appropriately. Findings will be submitted to the QA&A Committee for review and recommendations x 3 months. **Date of compliance:** 12/29/18	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/13/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055995	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR CONVALESCENT CENTER OF NORTH LONG BEACH	260 E MARKET ST LONG BEACH, CA 90805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812 SS=D	Continued From page 42 Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview record review, the facility failed to ensure the facility's kitchen was free from having peeling wall paper over the clean dish counter and rust on the bottom of detergent compartment of dish machine. Findings: a. During an observation of initial kitchen tour on 11/26/18 at 7:35 a.m., a piece of approximately quarter-size debris was observed on the counter clean dish area. There was peeling wall paper over the clean dish counter. During a concurrent	F 812 F 812	**F 812 Food Procurement, Store / Preparation / Serve-Sanitary** **How Corrective Action will be accomplished for residents affected:** The debris was removed from the clean dish area and the wall was repaired. The rust on the bottom of the detergent compartment was cleaned by the dish machine servicing company. **Identification of Residents with the Potential to be Affected:** Dietary Supervisor completed rounds in the kitchen and no other food safety concerns were identified. **Measures to Prevent Recurrence**: Dietary Staff were in-serviced by the Registered Dietician and DSD regarding the scheduled cleaning procedures for the dish machine and documenting maintenance repairs in the maintenance log on 12/19/18 and 12/20/18. **Monitoring Corrective Action and Responsibility:**	12/29/18

PRINTED: 12/13/2018
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055995	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR CONVALESCENT CENTER OF NORTH LONG BEACH	260 E MARKET ST LONG BEACH, CA 90805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 43 interview, Cook 2 acknowledged peeling wall paper over the clean dish counter and stated the facility would call maintenance to fix it. b. During an observation of the kitchen tour on 11/28/18 at 12:18 p.m., some brownish, rust like material was observed on the bottom of detergent/chemical compartment of dish machine. During a concurrent interview, dietary supervisor confirmed the finding and stated would call the contracted company to clean it. The facility's policy titled "Sanitation", revised on 7/2013, indicated that all utensils, counters, shelves and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seam, cracks and chipped area.	F 812	The Dietary Supervisor and/or RD will monitor the cleaning schedule of the dish machine through observation during daily rounds and will monitor that items identified that require repair are documented in the maintenance log. Findings will be submitted to the QA&A Committee for review and recommendations x 3 months. **Date of correction:** 12/29/18	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents,	F 880	**F 880 Infection Prevention and Control** 12/29/18 **How Corrective Action will be accomplished for residents affected:** • Resident's #21 gown was changed. • The bed remote control was cleaned for Resident #21.	

PRINTED: 12/13/2018
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055995	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR CONVALESCENT CENTER OF NORTH LONG BEACH	260 E MARKET ST LONG BEACH, CA 90805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 44 staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 880	• The cubicle curtains were replaced for Resident #24 and Resident #57 **Identification of Residents with the Potential to be Affected:** Infection Control Rounds were conducted by the DSD and no other findings were identified. **Measures to Prevent Recurrence**: Nursing staff were in-serviced by DSD on 12/10/18, 12/11/18 and 12/12/18 regarding Infection Control during resident care and bed bath. Licensed Nursing staff were in-serviced by Pharmacy Nurse consultant regarding Infection Control practices during medication administration. **Monitoring Corrective Action and Responsibility:** DSD will monitor the nursing staff for infection control compliance on a weekly basis through observation during rounds x 3 months. Findings will be presented to the QA&A Committee for review and recommendations x 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055995	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR CONVALESCENT CENTER OF NORTH LONG BEACH	260 E MARKET ST LONG BEACH, CA 90805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 45 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to follow infection control practices for three of 18 sampled residents, (Resident 21, 29, and 57), during a diaper change, bed bath, and medication administrations. These failures had the potential to result in an increased risk of infection to the residents, which could have resulted in further medical illness or even death. Findings: During on observation on 11/29/18 at 10:20 AM Certified Nurse Assistant (CNA 1) changed the diaper for Resident 21. CNA 1 cleaned Resident 21's genital region with a wipe in her gloved hand. The CNA then placed the wipe in a trash bag, and used the same hand to touch the remote control to operate the resident's bed. CNA 1 did not change gloves or perform hand hygiene (a general term that applies to routine hand washing, antiseptic hand wash, antiseptic hand rub) prior to adjusting the bed. CNA 1 also touched the resident's clean gown and adjusted it around the resident's chest and arms. When	F 880	**Date of compliance:** 12/29/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055995	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR CONVALESCENT CENTER OF NORTH LONG BEACH	260 E MARKET ST LONG BEACH, CA 90805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 46 asked to describe infection control procedures during a diaper change, CNA 1 explained the procedure was to change the diaper, put in a plastic bag, then tie it up before putting it in the soiled linen bin. When asked what is done after touching soiled linens, CNA 1 stated, "I should change my gloves and use hand sanitizer, or wash my hands." When asked about using a gloved hand that came in contact with soiled items to touch the bed remote and resident's gown, CNA 1 laughed, then said that she knew she should not have touched it, but it was already "too late." CNA 1 also stated she knows that touching clean things with dirty gloves increases infection risk for all the residents. b. The Admission Record indicated Resident 57 was readmitted to the facility on 3/6/18 with diagnoses not limited to Alzheimer's (progressive mental deterioration that can occur in middle or old age, due to generalized degeneration of the brain). A review of the Minimum Data Set (MDS), a standardized assessment and care-screening tool, dated 10/29/18 indicated Resident 57 has severe cognitive (ability to understand, make decisions and learn) impairment. During bed bath observation on 11/27/18 at 10:00 a.m., both the restorative nurse assistant (RNA 1) and certified nurse assistant (CNA 1) were observed removing Resident 57's wet diaper (incontinent brief) that was soaked with urine and then touched the privacy curtains with the same gloves. During an interview on 11/30/18 at 7:14 a.m. RNA 1 stated "I should have removed my gloves after removing Resident 57's wet diaper and before	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055995	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR CONVALESCENT CENTER OF NORTH LONG BEACH	260 E MARKET ST LONG BEACH, CA 90805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 47 touching the curtains because of infection control." c. During medication administration on 11/26/18 at 4:13 p.m. licensed vocational nurse (LVN 5) was observed wear gloves and administer insulin lispro (medication to control abnormal sugar) two (2) units subcutaneous (SQ, into body fat) to Resident 24. However, LVN 5 failed to remove contaminated gloves before she opened the privacy curtains. During an interview on 11/30/18 at 8:31 a.m. the director of staff development (DSD) stated the staff know to remove gloves, sanitize hands and change gloves when contaminated. The DSD stated to staff have trained on infection control prevention and cross contamination staff are aware not to touch any environment, surfaces, self or residents with contaminated gloves. The facility's policy titled "Hand Hygiene Program" revised 11/2017 indicated hand hygiene is not limited: 1. Before and after contact with resident or their environment. 2. Before and after glove use.	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;	F 883	**F 883 Influenza and Pneumococcal Immunizations** **How Corrective Action will be accomplished for residents affected:** Resident's #29	12/29/18

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/13/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055995	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR CONVALESCENT CENTER OF NORTH LONG BEACH	260 E MARKET ST LONG BEACH, CA 90805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 883	Continued From page 48 (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits	F 883	Pneumococcal Vaccination was offered, given and documented. **Identification of Residents with the Potential to be Affected:** Health Information Director audited the current residents' immunization records and no other residents found to be affected. **Measures to Prevent Recurrence**: Nursing staff were in-serviced by DSD on 12/11/18, 12/13/18 and 12/19/18 regarding assessing and offer pneumococcal vaccination to residents and/or resident representative. **Monitoring Corrective Action and Responsibility:** Health Information Director to audit new admission immunization records to ensure residents were assessed and offered pneumococcal vaccination on a weekly basis x 3 months. Findings will be presented to the QA&A Committee for review and recommendations x 3 months. **Date of compliance:** 12/29/18	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/13/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055995	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR CONVALESCENT CENTER OF NORTH LONG BEACH	260 E MARKET ST LONG BEACH, CA 90805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 883	Continued From page 49 and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to assess and offer pneumococcal (an infection caused by the bacteria that can cause an infection of the covering of the brain and spinal cord that can lead to confusion, coma, and death as well as other physical effects, such as blindness or paralysis) vaccine (a substance used to stimulate the production immunity against one or several diseases) to one of 18 sampled residents (Resident 29). The failure had the potential to cause Resident 29 infections. Findings: A review of Resident 29's immunization records in the electronic health records (eHR) indicated influenza vaccine was administered on 11/4/18 but there was no documentation that pneumococcal vaccination was ever offered. A review of Resident 29's admission records indicated the resident was admitted on 4/5/18 with diagnoses that included respiratory syncytial virus pneumonia (an infection of the lungs and respiratory tract). The admission record indicated the resident was 68 years of age.	F 883		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/13/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055995	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR CONVALESCENT CENTER OF NORTH LONG BEACH	260 E MARKET ST LONG BEACH, CA 90805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 883	Continued From page 50 A review of Resident 29's Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 10/8/18 indicated the resident had no cognitive deficits (ability to think, understand and make daily decisions). During an interview with the Director of Staff Development (DSD) on 11/28/18 at 10:45 a.m., stated for the pneumonia immunizations, the facility attempts to obtain records from the resident's history. The DSD stated the admission records were reviewed by the Director of Nursing, the Registered Nurse supervisor and himself. During a concurrent review of the resident's electronic health records (eHR) with the DSD, the record indicated Resident 29's pneumonia vaccine was not offered. The DSD stated the pneumonia vaccine could have been historical but there was no nursing notes indicating Resident 29 was asked about his pneumonia vaccine status. The DSD stated he was going to check the other documents to determine whether the resident had received the pneumonia vaccine. During a follow up interview with the DSD on 11/28/18 at 3:05 p.m., stated he spoke with Resident 29 and the resident stated he could not remember if he had given consent for the pneumonia vaccine. The DSD stated "we were unable to find the consent in the chart (medical record)". During an interview with Resident 29 on 11/28/18 at 3:09 p.m., stated he was not sure he received the pneumonia vaccine while he was at his previous facility. The resident stated he did not recall signing paperwork for consent when he was admitted to the facility but "was asked to sign a consent today". The resident stated he recalled	F 883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055995	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR CONVALESCENT CENTER OF NORTH LONG BEACH	260 E MARKET ST LONG BEACH, CA 90805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 883	Continued From page 51 receiving the influenza vaccine and was asked for consent by the Assistant Director of Nursing (ADON) but he needed to confirm with his previous facility before he consented to the pneumonia vaccine. The resident stated however he was not asked again regarding the pneumonia vaccine after the initial inquiry during admission. During an interview with the ADON on 11/30/18 at 9:49 a.m., stated she asked Resident 29 about his history of receiving the pneumonia vaccine or not but the resident was not sure and told her he needed to consult with his previous facility. The ADON stated the resident was admitted on 4/5/18 and the staff nurses had asked the resident several times about his pneumonia vaccination. The ADON was requested to provide documentation or nursing notes indicating when the resident was followed up regarding his pneumonia vaccine. Before and after exit conference, the ADON did not provide documentation regarding the pneumonia vaccine follow up. A review of the facility's policy titled "Pneumococcal Disease, Preventing Transmission to Residents" last revised on 1/2018 indicated streptococcus pneumonia (pneumococcal) remains a leading infection cause of serious illness among older adults. The recommendation from the Advisory Committee Immunization Practices says adults 65 years of age or older who have not previously received pneumococcal vaccine or whose previous vaccination history is unknown should receive a dose of pneumococcal conjugate vaccine (PCV 13, Prevnar 13) first, followed by a dose of pneumococcal polysaccharide vaccine (PPSV23,	F 883		

PRINTED: 12/13/2018
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055995	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR CONVALESCENT CENTER OF NORTH LONG BEACH	260 E MARKET ST LONG BEACH, CA 90805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 883	Continued From page 52 pneumovax) 6 to 12 months later. On admission, residents will be evaluated for pneumococcal vaccination needs.	F 883		
F 908 SS=D	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, Interview, and record review the facility failed to provide a privacy curtain that reached completely around one of 18 sampled residents (Resident 64) bed. This deficient practice could possibly result in a loss of privacy and dignity for Resident 64, exposing the resident's body to others during personal care. Findings: During interview and observation of Resident 64's room on 11/27/18 at 9:10 AM, the bed had several privacy curtain panels connected to enclose the bed. However, whenever one side was pulled completely, the other side gapped open leaving a three foot space. There was no complete curtain coverage that shielded Resident 64 from the rest of the other residents in the room. During a concurrent interview with Director of Housekeeping (DH) was asked to show if he could pull the curtains completely closed. When DH tried to close Resident 64's privacy curtain, the panels gaped open three feet away from the	F 908	**F 908 Essential Equipment, Safe Operating Condition** **How Corrective Action will be accomplished for residents affected:** Resident #64 was appropriately provided full privacy to accommodate personal care by changing the cubicle curtain. **Identification of Residents with the Potential to be Affected:** Maintenance Director did an audit of all cubicle curtains and no other residents were found to be affected. **Measures to Prevent Recurrence**: The DSD, Housekeeping and Laundry Supervisor conducted an in-serviced on 12/19/18 and 12/20/18 with the housekeeping staff to ensure the right size cubicle curtain is in place to provide full privacy to residents in the facility	12/29/18

PRINTED: 12/13/2018
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055995	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR CONVALESCENT CENTER OF NORTH LONG BEACH	260 E MARKET ST LONG BEACH, CA 90805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 908	Continued From page 53 wall, even when pulled taut. DH stated "Yes. I will have my staff add more curtain panels and WD-40 the tracks so they move easier." During a review of facility's policy titled "Cleaning Cubicle Curtains", revised 10/7/16 indicated "Curtains must reach completely around bed."	F 908	**Monitoring Corrective Action and Responsibility:** The Housekeeping and Laundry Supervisor will monitor through observations that replacement cubicle curtains are the correct size for privacy during rounds. Department Managers will monitor that cubicle curtains provide full privacy during weekly Quality Rounds. Findings will be submitted to the QA&A Committee for review and recommendations x 3 months. **Date of compliance:** 12/29/18	