Accepted #1404r 1/3/20

RECEIVED DEC 19 2019 By

PRINTED: 12/10/2019
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 _____	11/24/2019

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 a Recertification Survey. Representing the Department of Public Health: Health Facilities Evaluator, Nurse: 34396, RN, HFEN Health Facilities Evaluator, Nurse: 36394, RN, HFEN Health Facilities Evaluator, Nurse: 38551, RN, HFEN Health Facilities Evaluator, Nurse: 39028, RN, HFEN Health Facilities Evaluator, Nurse: 39085, RN, HFEN Total population: 45 Sample size: 21	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 655 SS=D	Highest Severity and Scope: E Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident	F 655	**F 655 Baseline Care Plan CFR(s): 483.21(a)(1)-(3)** **How Corrective Action will be accomplished for residents affected:** Residents 46 current care plans were reviewed and updated on 11/23/19 for the Foley Cather privacy bag and on 11/24/19 for the oxygen.	12/24/19

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

Administrator | 12/19/19

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.

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 _____	11/24/2019

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 655	Continued From page 1 including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to develop a personalized comprehensive care plan, that was updated, had measurable goals, with specific interventions for one of 1 sampled resident (46). This deficient practice placed Resident 46 at risk for not receiving the necessary care and services.	F 655	**Identification of Residents with the Potential to be Affected:** Oxygen signage, tubing change and privacy bag for Foley Catheters care plans were reviewed by Health Information Director. License Nurses updated care plans as needed. **Measures to Prevent Recurrence**: The DSD in-service the License Nursing staff on care plans to include dignity bags, changing of oxygen tubing and posting of oxygen sign on 11/24/19 and 12/14/19. **Monitoring Corrective Action and Responsibility:** Health Information Director to audit care plans after 48 hours of the patients' admission for Foley Catheter privacy bag, oxygen tubing changing and oxygen sign posting. Results will be provided to the Director of Nursing for review. Findings will be submitted to the QA&A Committee for review and recommendations x 3 months or	

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 _____	11/24/2019

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 655	Continued From page 2 Findings: A review of the admission records indicated Resident 46 was re-admitted on 08/05/2019 with diagnoses that included palliative care (specialized medical care for people with serious illness). A review of the Minimum Data Set (MDS), a standardized assessment and care-screening tool, dated 08/11/19 indicated Resident 46 made self-understood, understood others, and was dependent on staff for extensive to total care with activities of daily living. a 1. A review of physician order dated 9/17/19 on 11/23/19 at 3:00 p.m., indicated Resident 46 may receive continuous oxygen at 3 liters per minute via nasal cannula every shift for shortness of breath (SOB) to keep O2 saturation (level of oxygen carried by red blood cells through the arteries and delivered to internal organs) above 88 percent. b 2. A review of physician order dated 08/06/19 on 11/23/19 at 3:00 p.m., indicated Resident 46 had an indwelling catheter (a catheter that carries urine from your bladder into a bag outside the body) care every shift. During a record review and interview with Registered Nurse (RN 5) on 11/23/19 at 3:00 p.m., about Residents 46's Care Plan indicated there was were no identifiable steps of a measurable approach or plan did not include the following to ensure the staff knew how to care for	F 655	until substantial compliance is achieve. **Date of correction:** 12/24/19	

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 _____	11/24/2019

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 655	Continued From page 3 the resident: 1. O2 Therapy (warning sign posted outside resident door indicating oxygen was in use) and how often oxygen tubing was to be changed. 2. Indwelling catheter privacy bag (discreetly conceals a urine drainage bag from public view). A review of the facility's policy with a revised date of 11/2017 title "Care Plan, Baseline and Comprehensive", indicated the following: 1. It is the policy of this facility to develop, upon admission and following completion of the Admission Nursing Assessment interim and comprehensive care plan for the resident. 2. A baseline care plan will be implemented within 48 hours of admission. The policy indicated the addresses immediate resident needs including, Initial goals based on admission orders, Physician orders.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain	F 656	**F 656: Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1).** **How Corrective Action will be accomplished for residents affected:** Resident 35 had a diabetes care plan date 4/1/19.	12/27/19

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 _____	11/24/2019

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 656	Continued From page 4 or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the facility failed to develop a individualized plan of care with measurable objectives, timeframe, and interventions to meet one of 21 sampled residents (45) needs, which included risks of using insulin (a hormone that regulates blood sugar levels) therapy three times a day, since the admission.	F 656	**Identification of Residents with the Potential to be Affected:** Health Information Director reviewed care plans for residents with diabetes. No other residents found to be affected. **Measures to Prevent Recurrence**: DSD and DON in-service License Nurses on 11/24/19 and 12/14/19 on facility's Policy and Procedures titled "Care Plan Goals and Objectives." **Monitoring Corrective Action and Responsibility:** Health Information Director to audit care plans within 14 days of admission and quarterly. Results will be provided to the Director of Nursing for review. Findings will be submitted to the QA&A Committee for review and recommendations x 3 months or until substantial compliance is achieve. **Date of compliance:** 12/24/19	

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 _____	11/24/2019

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 656	Continued From page 5 The deficient practice had the potential to cause a serious side effect such as low blood sugar (hypoglycemia) which could endanger Resident 45's life and might result in a life-threatening situation when there was inadequate monitoring for the insulin therapy. Findings: A review of Resident 45's Admission Face Sheet indicated the resident was initially admitted to the facility on 3/20/19 and re-admitted on 11/14/19 with diagnoses including type 2 diabetes mellitus (abnormal blood sugar levels), gastro-esophageal reflux disease (a condition where acid from the stomach comes up into the esophagus), low back pain, and acquired absence of right great toe. A review of Resident 45's Minimum Data Set (MDS), a standardized assessment and care-screening tool, dated 11/20/19, indicated the resident had cognitive (ability to make decisions, learn, understand, and be understood by others) impairment with daily decision making. The MDS indicated Resident 45 required extensive assistance from staff with bed mobility, dressing, walking in room and in corridor, and limited assistance with transfer, locomotion on unit, locomotion off unit, toilet use and personal hygiene. The MDS also indicated Resident 45 was receiving insulin therapy. A review of Resident 45's Physician orders dated 11/15/19 indicated the resident received the following insulin, Determir solution 100 unit per milkier, inject 14 unit subcutaneous (underneath the fatty tissue) two times a day related to type 2	F 656		

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 _____	11/24/2019

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 656	Continued From page 6	F 656		

diabetes mellitus, Lispro solution 100 unit /ml inject 8 unit subcutaneous three times a day related to type 2 diabetes mellitus with unspecified diabetic retinopathy (a complication of diabetes that affects the eyes).

A review of Resident 45's Medication Administration Record (MARs) dated 9/2019, indicated Resident 45 was administered Humalog (Lispro) 8 unit subcutaneous three times day with finger sticks (a procedure in which a finger is pricked to obtain a small quantity of blood for testing), three times a day after blood sugar level checks. The order indicated for glucose (blood sugar levels) ranging from 201- 344 milligram per deciliter (mg/dl), to administer Humalog injection as per sliding scales (the progressive increase in the pre-meal or nighttime insulin dose, based on pre-defined blood glucose ranges). According to MAR, Resident 45 received finger sticks at 0630 A.M., 11:30 a.m., and 5 p.m. daily to manage the sliding scales for the amount of insulin therapy.

A review of Resident 45's Care Plan confirmed by Registered Nurse (RN 5) indicated there was no plan of care for the risks involved for the use of insulin therapy and finger stick monitoring's for the resident.

On 11/24/19 at 07:25 A.M. during record review and concurrent interview RN 5 stated her job responsibilities included MDS assessment for all the resident in the facility, and implementing individualized care plans that addressed the resident's care need. RN 5 stated Resident 45 was on insulin therapy since admission into the facility. RN 5 stated insulin was a high-risk alert medication which could result in adverse side effects such as swelling of the arms and legs,

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 _____	11/24/2019

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 656	Continued From page 7 weight gain, low blood sugar (hypoglycemia) including infection and skin changes at the injection site. During and interview and review of Resident 45's Care plans did not address a plan of care for the use of insulin. MDS nurse stated "I missed to care plan Resident 45 for insulin use, and resident on insulin need to be monitored for side effect of insulin. I will add it on resident's Care Plan, that is supposed to be care planned." On 11/24/19 at 11:44 a.m., during interview Director of Nursing (DON), When asked about Resident 45 not having a personalized, comprehensive care plan for being on insulin therapy, stated "I believe a resident on insulin should have a specified Care plan for safe monitoring of insulin administration because insulin is considered as a high-risk alert medication. Insulin therapy need to be care planned to avoid complications of insulin treatment." A review of facility's policy and procedure titled "Care Plan Goals and Objectives" with a revised date 11/2012, indicated care plans will incorporate goals and objectives which lead to resident's highest obtainable level of function. The policy indicated the goals and objectives are resident oriented, behaviorally stated, measurable, and within a specified time frame.	F 656		
F 658 SS=E	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,	F 658	**F 658: Services Provided Meet Professional Standards** 12/24/19	

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 _____	11/24/2019

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 8 must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review facility failed to provide care that meet the professional standards of quality for two of 21 sampled residents (29, 89) by ensuring the following: a. Resident 89, medication administration was not adhered to the facility's policy and procedure for medication administration, when the physician ordered Ferrous Sulphate for diagnosis of anemia (low iron in the blood) and Ibuprofen (pain reliever), was to be administered with food. The deficient practice placed Resident 89 at risk of delayed and non-absorbent of the medications, to a maximum potential targeted to treat diagnosed diseases. b. The staff were not able to locate the key to station two's emergency crash cart (stores lifesaving equipment, drugs, or anything that will be required in the event of a medical emergency). The deficient practice placed the residents at risk for a delay in emergency interventions and to cause harm to the residents in need of immediate care and service until outside emergency help arrived. c. Resident 29, the physician was not informed when the resident refused to take Effexor (antidepressant) extended release (XR) for 12 of 24 days. This deficient practice had the potential for the physician not be aware of Resident 29's refusal of the antidepressant medication, which could result in the depression to go untreated.	F 658	**How Corrective Action will be accomplished for residents affected:** Resident 89 received breakfast at 10:00a.m and medications at 10:15a.m. Resident 29 was placed on 72 hours monitoring and MD notified. Immediately 11/24/19 the License Nursing staff in-service on handing off the key. **Identification of Residents with the Potential to be Affected:** All other residents receiving Iron or Ibuprofen were assessed on 12/18/19 and 12/19/19 and found no GI problems. Health Information Director reviewed those residents on antidepressant no other resident was found to be affected. **Measures to Prevent Recurrence**: The License Nurses were in-service by DSD and DON on 11/24/19 and 12/14/19 regarding administering Iron and Ibuprofen with food. The License Nurses were in-service by DSD and DON on 11/24/19 and 12/14/29 regarding refusals of	

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 _____	11/24/2019

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 9 Findings: a. A review of Resident 89's Admission Face Sheet indicated the resident was initially admitted to the facility on 10/16/15 and re-admitted on 7/25/19 with diagnoses including lack of coordination, abnormalities of gait and mobility, pain syndrome, anemia. A review of Resident 10's Minimum Data Set (MDS), a standardized assessment and tool care screening tool, dated 10/28/19 indicated Resident 89 had a mild cognitive (ability to understand and be understood by others) impairment for daily decision making. The MDS indicated Resident 89 required total dependence from staff with bed mobility, transfer, walk in room, walk in corridor, locomotion on unit, locomotion off unit, toilet use and personal hygiene. The MDS indicated the resident received opioid medication (a substance used to treat moderate to severe pains). A review of Resident 89 Physician orders dated 10/31/19, indicated an order for Ibuprofen tablet 600 milligram (mg), 1 tablet to be administered by mouth every 6 hours as needed for moderate pain. The order indicated to administer Ibuprofen with food. A review of another physician order dated 10/27/19 indicated to administer Ferrous Sulphate 325 mg, 1 tablet by mouth in the morning for anemia, to be administered with food. A review of Resident 89 Medication Administration Records (MAR) dated 9/2019, 10/2019/ 11/2019 indicated Resident 89 had been receiving Ferrous Sulphate 325 mg with the order to administer with food and give two hours	F 658	antidepressant medications, notification of physicians and facility's policy titled "Psychotropic Medication Management." Both crash carts locks were changed to soft locks on 12/16/19. License Nursing Staff in-service on the use of soft locks on the crash cart by DSD. **Monitoring Corrective Action and Responsibility:** The Pharmacy Nurse Consultant will do monthly medication pass review with the Licensed Nursing Staff. The Health Information Director will do weekly audits of refusal of antidepressant. The night shift RN Supervisor will review the crash cart daily. Findings will be provided to the DON and submitted to the QA&A Committee for review and recommendations x 3 months or until substantial compliance is met. **Date of compliance:** 12/24/19	

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 _____	11/24/2019

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 10	F 658		

separately from other medications.

A review of Resident 89 MAR dated 9/2019, 10/2019, and 11/2019 indicated Resident 89 had pain according to a pain rating scale (zero meaning no pain and 10 meaning the worst pain experienced) that ranged from 8 out of 10 (8/10), 7/10, 6/10, /8/10/, 9/10, and 10/10. The MAR indicated Resident 89 received Norco tablet 5-325 mg, 1 tab every 8 hours, and Ibuprofen 600 mg, 1 tablet by mouth every 6 hours, with instructions to administer both medications along with food.

A review of Resident 89 Care Plan dated 8/2/19 indicated the resident has altered level of comfort due to pain related to diabetic neuropathy, and a chronic pain syndrome. The resident's Care Plan interventions indicated to administer the analgesic (pain medication) as ordered.

On 11/23/19 at 10:15 a.m., during observation and concurrent interview Licensed Vocational Nurse (LVN 1) removed all Resident 89's medications including Ibuprofen 600 mg, and Ferrous Sulphate 325 mg, which was to give with meals, and two hours separately from other medications. LVN 1 administered both Ibuprofen and Ferrous Sulphate medications together with other medications. LVN 1 did not administer the two medications with food. During the interview, Resident 89 complained she needed her breakfast tray, but the tray did not arrive while the resident was being medicated. When interviewed, LVN 1 stated when not medicating the resident with medications as instructed to be given with food, could result in stomach upset, nausea and vomiting, ineffectiveness of the medication and lack of proper absorption.

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 _____	11/24/2019

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	F 658		

On 11/24/19 at 11:20 a.m., during interview Director of Nursing (DON) stated licensed nurses administering medications to Resident 89 should had read the Physician's orders well for safe administration of medications. DON stated LVN 1 administering a medication that was supposed to be administered with food, could result in non-absorption, nausea and vomiting, and in-effectiveness.

A review of facility's Policy and Procedure titled "Medication Administration" with effective date 10/2017, indicated medications are administered in accordance with written orders of the attending physician. The policy indicated medications are administered within 60 minutes of scheduled time (1 hour before and 1 hour after), except before or after meal orders, which are administered based on mealtimes. The policy indicated unless otherwise specified by the prescribe, routine medications are administered to the established medication administration schedule for the facility.
b. During an emergency crash cart inspection for station two, on 11/24/19 at 11:24 a.m., accompanied by Registered Nurse 4 (RN 4), was not able to locate the key to open the emergency crash cart in the case of a resident experiencing an emergency situation. When asked the following license staff were not able to state where the keys could be located.

1. RN 1 stated RN 3 had the key.
2. RN 4 stated License Vocational Nurse (LVN 4) had the key.
3. LVN 5 stated RN 3 had the key.
4. RN 3 stated RN 1 had the key.

During an interview on 11/24/19 at 11:35 am.,

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 _____	11/24/2019

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	F 658		

with Director of Nursing (DON), RN 1, RN 3, RN 4, LVN 4 and LVN 5 acknowledged they were not able to locate the keys to open the emergency crash cart for station two for 10 minutes.

c. A review of the admission record indicated Resident 29 was readmitted on 10/22/19 with diagnoses that included paraplegia (severe weakness of the lower extremities), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and diabetes mellitus (irregular blood sugar levels).

According to the Minimum Data Set (MDS), a standardized assessment and care planning tool, dated 6/5/19, indicated Resident 29 was cognitively (ability to make decisions of daily living) intact for daily decision making. The MDS assessment indicated Resident 29 required one to two-person physical assistance with activities of daily living such as getting dressed, toileting and personal hygiene.

A review of a physician order dated 10/22/19 indicated to administer Effexor XR, 75 milligrams (mg), give one capsule by mouth one time a day for depression.

On 11/24/19 at 11:28 a.m. a review of the medication administration records (MARs) for 11/1//2019 through 11/30/19 indicated Resident 29 had refused Effexor XR on the following days: 11/7/19, 11/8/19, 11/9/19, 11/12/19, 11/13/19, 11/14/19, 11/15/19, 11/16/19, 11/19/19, 11/21/19 and 11/24/19.

During a concurrent interview and record review, licensed vocational nurse (LVN 1) stated if a resident refused a medication 3 days in a row, the

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 _____	11/24/2019

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 13 physician should be notified. LVN 1 stated there was no documentation the physician was notified about Resident 29's refusals of Effexor XR. LVN 1 acknowledged Resident 29's depression could get worse since he was not taking the medication that was perscribed to relieve the symptoms. LVN 1 stated not notifying the physician for instructions, could affect Resident 29's quality of life. A review of the facility's policy titled "Psychotropic Medication Management" revised 10/2017 indicated it was the policy of the facility that residents with mental illness receive the necessary treatment to enable or restore function.	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, facility failed to provide a clean wheelchair for one of 21 sampled residents (34), who needed assistance with personal hygiene. Resident 34's was not provided with a clean wheelchair, eventhough witnessed by two certified Nurse Assistants (CNAs) and a Registered nurse (RN), when the wheelchair had a foul-smelling odor because it was smeared with feces. The deficient practice resulted in Resident 34's room permeating the entire hallway with malodor	F 677	**F 677 ADL Care Provided for Dependent Residents** 12/24/19 **How Corrective Action will be accomplished for residents affected:** The wheelchair of resident 34 was washed on 11/23/14. **Identification of Residents with the Potential to be Affected:** The Housekeeping Supervisor did a facility wide sweep of the other residents' wheelchairs and no other residents' found to be affected.	

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 _____	11/24/2019

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 677	Continued From page 14 from feces smeared on the wheelchair, which could potentially result in the resident feeling embarrassed and yelling out to staff that he was not smelling while staff tried to change the incontinent brief (diaper). Findings: A review of Resident 34's Admission Face Sheet indicated the resident was admitted to the facility on 6/14/19 with diagnoses including hepatic failure (a condition that occurs when the liver is damaged and no longer able to function), weakness, muscle weakness, hypoglycemia (low blood sugar level), and mild intellectual disability. A review of Resident 34's Minimum Data Set (MDS), a standardized assessment and care -screening tool, dated 9/17/19 indicated Resident 34 had severe cognitive (the ability to understand and be understood by others) impairment with daily decision making. The MDS indicated Resident 34 required limited assistance from staff with transfer, walk in room, locomotion off unit, personal hygiene, and toilet use. A review of Care Plan dated 6/27/19, indicated Resident 34 had an Activity of Daily Living self-care performance deficit related to impaired mobility and functions. The Care Plan intervention indicated to monitor, document and report to physician any changes, any potential for improvement, reasons for self-care deficit, expected course, declines in function, and encourage resident to use bell to call for assistance.	F 677	**Measures to Prevent Recurrence**: DSD in-service Nursing staff on 11/24/19 and 12/14/19 regarding ensuring residents' wheelchairs are clean and odor free after incontinence care and as needed. **Monitoring Corrective Action and Responsibility:** Department Managers to review residents' wheelchairs during Quality Rounds 5 days a week. Findings will be provided to the Administrator and submitted to the QA&A Committee for review and recommendations x 3 months or until substantial compliance is achieved. **Date of compliance:** 12/24/19	

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 _____	11/24/2019

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 677	Continued From page 15 On 11/23/19 at 8:29 A.M., during an observation, Resident 34's room permeated with foul fecal and urine odor. When asked where the smell was coming from, Registered Nurse (RN 4), who was standing opposite Resident 34's door, preparing medications, stated the smell was from the resident. RN 4 stated Resident 34 was incontinent (no control) of bowel and bladder functions. During the interview, Certified Nursing Assistant (CNA 4), who brought a tray to Resident 34, turned and left the resident's room without assisting the resident with the care. On 11/23/19 at 08:35 A.M., during interview CNA 4 stated Resident 34's room was "so stinky that the resident is incontinent." However, CNA 4 stated on resuming shift the staff should check on Resident 34, to ensure the resident was clean before being offered a breakfast tray. During a concurrent interview, RN 4 who was standing by Resident 34's room preparing medications, stated "I come in the morning, first I do is check on my resident, make sure resident is clean. when I go to the room and it smell stinky with urine, I tell the CNA to clean the resident. I am not sure staff had attended to residents this morning to be very honest with you." During observation, CNA 4 went back to clean the resident when her attention was called concerning the foul odor. CNA 4 stated Resident 34's wheelchair pad was "messed up with poop and urine, was not cleaned but kept by the resident's bed side." CNA 4 then removed the wheelchair from the resident's bedside to be cleaned. On 11/24/19 at 11:03 A.M., during interview with the Director of nursing (DON) stated the wheelchairs are usually cleaned every week with	F 677		

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 _____	11/24/2019

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 677	Continued From page 16 pressure washer, and as needed. A review of facility's Policy and Procedure revised 11/2012, titled "Resident Routine Care" indicated to assist residents requiring help with toileting. A review of facility Policy and Procedure on "Cleaning Wheelchairs and Geri Chairs" dated 10/7/16, indicated to set up a schedule, with input from nursing to collect, wash and dry chairs, take chairs to an open area-basement or a shower room, use pressure washer or scrub by hand with brush or sponge and germicide solution, rinse thoroughly with water and dry completely with rags, and pay special attention to the seats and wheels.	F 677		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to verify five of 21 sampled residents (4, 8, 22, 56, and 81) got the correct physician prescribed meals. This deficient practice had the potential for Resident 4, 8, 22, 56, and 81 in receiving a wrong diet and/ or consistency of foods, which could result in the residents choking.	F 689	**F 689 Free of Accident Hazards / Supervision / Devices CFR(s): 483.25(d)(1)(2)** 12/24/19 **How Corrective Action will be accomplished for residents affected:** None of the identified Residents had any swallowing or chocking issues. **Identification of Residents with the Potential to be Affected:** All other residents in the Windsor Café Diets were checked by a License Nurse and not affected.	

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 _____	11/24/2019

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 689	Continued From page 17 Findings: a. During a dining observation in the Windsor Café dining room, on 11/23/19 at 12:15 p.m. Resident 4, 8, 22, 56, and 81 were being served their meal trays. Two dietary staff (DS 1 and 2) were plating and serving lunch from a food warmer in the dining room. DS 1 was plating the foods, and DS 2 was placing it in front of the residents. The residents were then observed eating their lunches. During a concurrent observation and interview on 11/23/19 at 12:22 p.m. Registered Nurse (RN 6) acknowledged she should have already checked to make sure the residents had the correct diet and food textures, especially the residents with difficulty chewing or swallowing, before they started eating. RN 6 stated the food should be checked before the residents started eating because they might get the wrong textured food and have a choking accident. RN 6 stated she was checking the meal trays on the meal cart and could not get to the dining room before Resident 4, 8, 22, 56, and 81 started eating. a 1. A review of the admission records indicated Resident 4 was readmitted on 3/1/18. A review of Resident 4's medical records indicated a physician order dated 8/2/18 for a mechanical soft textured (food that has been altered to make it easier to chew and swallow, usually prescribed for patients that have difficulty chewing or swallowing) diet.	F 689	**Measures to Prevent Recurrence**: DSD and DON conducted in-service for Licensed Nursing Staff on 11/23/19, 11/24/19 and 12/14/19 in regards to verifying dietary orders prior to serving meals. **Monitoring Corrective Action and Responsibility:** RN Supervisor will monitor License Nurses are verifying dietary orders prior to serving meals. Findings will be provided to the DON and submitted to the QA&A Committee for review and recommendations x 3 months or until substantial compliance is achieved. **Date of compliance:** 12/24/19	

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 _____	11/24/2019

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 689	Continued From page 18 a 2. A review of the admission records indicated Resident 8 was readmitted on 6/26/19. A review of Resident 8's medical record indicated a physician order dated 8/18/19 for a mechanical soft textured fortified diet. a 3. A review of the admission records indicated Resident 22 was readmitted on 2/11/19. A review of Resident 22's medical record indicated a physician order dated 10/16/19 for a pureed (foods which are blended until smooth and drinkable for patients with medical conditions, such as difficulty swallowing) diet. a 4. A review of the admission records indicated Resident 56 was admitted on 2/22/18. A review of Resident 56's medical record indicated a physician order dated 5/9/18 for a mechanical soft textured regular diet. a 5. A review of the admission records indicated Resident 81 was admitted on 2/26/19. A review of Resident 81's medical record indicated a physician order dated 10/16/19 for a mechanical soft textured regular diet. During an interview on 11/23/19 at 12:45 p.m. the Dietary Supervisor stated to ensure the safety of all the residents, all trays are to be checked by licensed staff before any of the residents start eating their meal.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)	F 695	**F 695 Respiratory / Tracheostomy Care and Suctioning CFR(s): 483.25(i)**	12/24/19

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 _____	11/24/2019

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 695	Continued From page 19 § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure one of 2 sampled residents (46), received the right amount of Oxygen (O2) as ordered by the physician. This deficient practice had the potential for Resident 46 not being assessed the need for increased oxygen and potential for delay in interventions as well as treatments. Findings: a. A review of the admission records indicated Resident 46 was re-admitted on 08/05/2019 with diagnoses that included palliative care (specialized medical care for people with serious illness). A review of the Minimum Data Set (MDS), a standardized assessment and care-screening tool, dated 08/11/19 indicated Resident 46 made self-understood, understood others, and was dependent on staff for extensive to total care with activities of daily living. A review of physician order dated 9/17/19 on	F 695	**How Corrective Action will be accomplished for residents affected:** Resident 46 was assessed and a change of condition was done with no negative outcome. **Identification of Residents with the Potential to be Affected:** Other residents were identified as using continues or PRN oxygen and they were assessed. The oxygen rates were found to be correct with no respiratory issues. **Measures to Prevent Recurrence**: The DSD and DON in-serviced the License Nursing Staff on 11/24/19 and 12/14/19 on the facility Policy of "Oxygen." **Monitoring Corrective Action and Responsibility:** License Nurse during medication pass will verify oxygen order, visually inspect the oxygen being delivered to the resident and sign-off on the EMAR. RN Supervisor will do random oxygen check Q-shift daily x's 12 weeks. Results	

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 _____	11/24/2019

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 695	Continued From page 20 11/23/19 at 3:00 p.m., for Resident 46 indicated may give continuous oxygen at 3 liters per minute via nasal cannula every shift for shortness of breath. The order indicated to keep O2 Saturation (level of oxygen carried by red blood cells through the arteries and delivered to internal organs) above 88 percent (%). During a tour of the facility on 11/23/19 at 8:00 a.m., Resident 46 was observed receiving oxygen via nasal cannula at 2 liters per minute. During an interview on 11/24/19 at 9:30 am., with the Director of Nursing (DON) when asked what was the rate of the oxygen for Resident 46, stated when the oxygen was administered at 2 liters per minute, the resident was not receiving the correct amount of oxygen as per ordered. According to the facility's policy titled "Oxygen" revised date of 11/2012, indicated the following: 1. It is the policy of this facility to provide oxygen support via appropriate delivery device, in a safe manner to prevent accidents, to maintain adequate oxygenation to the respiratory compromised resident and to assure proper oxygen administration during any emergency situation of respiratory distress and provide comfort for an actively dying resident.	F 695	will be provided to the DON and/or designee. Findings will be submitted to the QA&A Committee for review and recommendations x 3 months or until substantial compliance is achieved. **Date of correction:** 12/24/19	
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.	F 698	**F 698 Dialysis CFR(s): 483.25(I)** 12/24/19 **How Corrective Action will be accomplished for residents affected:** Resident 48 AV shunt hemodialysis access site was	

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 _____	11/24/2019

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 698	Continued From page 21 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to abide by the professional standards by following its own policy and the physician order to provide the necessary care and services to one of 21 sampled residents (48), who had a arteriovenous shunt ([AV shunt] a connection between a vein and an artery used as an entrance point) in order to access during hemodialysis (a process of purifying the blood of a person whose kidneys are not working normally) treatments. This deficient practice had the potential for improper assessments and monitoring of AV shunt, which could lead to complications and bleeding for Resident 48, before, during, and after hemodialysis treatments. Findings: A review of the admission records indicted Resident 48 was readmitted on 10/23/19 with diagnoses that included end stage kidney disease, diabetes mellitus (irregular blood sugar levels) and dependence on hemodialysis treatments. A review of the Minimum Data Set (MDS), a standardized assessment and care planning tool, dated 10/11/19 indicated Resident 48 was severely cognitively (ability to make decisions of daily living) impaired with daily decision making. The MDS assessment indicated Resident 48 required physical assistance for activities of daily living such as getting dressed, toileting and	F 698	assessed with no negative clinical outcome. **Identification of Residents with the Potential to be Affected:** The facility has no other hemodialysis patients at this time and no other residents were found to be affected. **Measures to Prevent Recurrence**: RN 2 was in-service on 11/24/19 by the DON on the facility's Policy of Dialysis Coordination of Care and Assessment of Resident. License Nurses were in-service on 11/24/19 and 12/14/19 by the DON and DSD on the facility's Policy of Dialysis Coordination of Care and Assessment of Resident. **Monitoring Corrective Action and Responsibility:** DSD to review the facility's policy of Dialysis Coordination of Care and Assessment of Resident for all newly hire License Nurses. HR will review all new License Nurse hires weekly x's 12 weeks. Findings will be submitted to the	

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 _____	11/24/2019

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 698	Continued From page 22 personal hygiene. A review of Resident 48's medical record indicated a physician order dated 10/27/19 to monitor hemodialysis access site for redness, swelling, drainage, pain, bruit (an audible vascular sound associated with turbulent blood flow) and thrill (when fingers are placed over the shunt, there should be a feeling of the motion of the blood flowing through it) during every shift. During a concurrent interview on 11/24/19 at 7:44 a.m. registered nurse (RN 2) stated "we do not assess the AV shunt of residents on hemodialysis unless there is an emergency, then we call 911". According to the clinical journal of American Society of Nephrology, an association of kidney health medical professionals, indicated it is important to regularly assess the AV shunt to ensure the patient can get dialyzed. To assess the AV access site one must inspect the access extremity and compare it to the other extremity looking for obvious differences. Look for swelling, change in color or temperature, redness, warmth, drainage. Auscultate (listen to sounds produced by the body using a medical device) for the presence of a bruit (indicating strong blood flow) and palpate (examine using the hands) for a thrill (a vibration). https://cjasn.asnjournals.org/content/3/3/714. A review of the facility's policy titled "Dialysis, Coordination of Care and Assessment of Resident", revised 1/2018 indicated the facility is directly responsible for the care of a dialysis resident including checking the dialysis access site for bruit and thrill per physician's order.	F 698	QA&A Committee for review and recommendations x 3 months or until substantial compliance is achieved. **Date of correction:** 12/24/19	

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 _____	11/24/2019

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 23	F 758		
F 758 SS=E	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 §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	F 758	**F 758 Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)** 12/29/19 **How Corrective Action will be accomplished for residents affected:** Resident 20 and 83 Psychiatrist Nurse Practitioner evaluated 12/10/19. Per the NP evaluation any decrease in the resident's psychoactive medications would exacerbate the patients' psychological and behavioral condition. **Identification of Residents with the Potential to be Affected:** Health Information Director to audit MAR for those patients on Psychoactive Medications and the GDR recommendations were followed as ordered by Psychiatrist. **Measures to Prevent Recurrence**: License Nursing Staff in-service by DSD and DON on 11/24/19 and 12/14/19 on Psychoactive medication	

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 _____	11/24/2019

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 24 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 ensure two of 3 sampled residents (20, 83), had behavior manifestations as indicated in physician order prior to administering psychotropic medications (medications capable of affecting the mind, emotions and behavior). This deficient practice had the potential of resulting in a broad range of adverse consequences such as medication interactions, poly-pharmacy or unnecessary medication for Resident 20 and 83. Findings: a. A review of Resident 20's Face sheet (Admission Record) indicated the resident was admitted to the facility on 2/25/18 with a most recent admission on 5/18/19. The Resident 20's diagnoses included depression (a mental disorder that affect how the resident feels, thinks, and handles daily activities, such as sleeping, eating, or working), bipolar (a mental disorder that	F 758	administration, monitoring of behaviors and documentation. **Monitoring Corrective Action and Responsibility:** IDT Psychotropic Reduction Committee meeting held weekly and findings reviewed with attending Psychiatrist. Findings will be submitted to the QA&A Committee for review and recommendations x 3 months or until substantial compliance is achieved. **Date of correction:** 12/24/19	

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 _____	11/24/2019

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 25 causes extreme mood swings including emotional highs and lows), and schizophrenia (severe mental disorder that affects the way a person thinks, acts, expresses emotions, perceives reality, and relates to others). A review of Resident 20's care plan dated 10/31/18 indicated Resident 20 had behaviors of extreme paranoia thinking someone was out to harm her, causing refusal of necessary treatments. The staff's interventions included to administer medications as ordered, monitor for changes in condition and notify the physician because resident was being treated with antipsychotic drugs which had an increased risk of death. A review of Resident 20's care plan dated 3/7/18, indicated the resident used psychotropic medications including Klonopin, Trazodone, Trintellix, Latuda and Quetiapine. The interventions included to administer medications as ordered, monitor and document side effects and effectiveness and to consult with pharmacy and physician, to consider dosage reduction when clinically appropriate. A review of Resident 20's physician orders dated 6/9/19 indicated the following: 1) administer Latuda120 milligrams (mg) through the gastrostomy tube ([GT] surgically created opening in the stomach for food and administration), every evening for schizophrenia manifested by extreme paranoia thinking someone was out to harm her causing refusal of necessary (GT) treatments, 2) Seroquel 50 mg via GT at bed time for schizophrenia manifested by resisting needed care affecting ADLS	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 _____	11/24/2019

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 26 3) Trazadone 50 mg GT at bed time manifested by difficulty falling asleep related to depressive disorder 4) Trintellix 20 mg via GT one time daily for depression manifested by verbalization of hopelessness. 5) monitor for depression manifested by difficulty falling asleep and document total number of occurrence every shift 6) monitor for schizoaffective disorder manifested by resisting needed care affecting ADLs. A review of Resident 20's medication administration records (MARs) dated 9/1-30/2019, indicated Resident 20 was receiving Latuda 160 mg daily, Quetiapine 50 mg at bed time, trazadone 50 mg at bed time, Trintellix 10 mg daily and Klonopin two times daily. The MARs also indicated Resident 20 was monitored for verbalization of hopelessness, auditory hallucinations (hearing voices), and extreme paranoid thoughts. According to the MARs, Resident 20 had no episodes of verbalization of hopelessness, no episodes of resisting care and no episodes of paranoia. A review of Resident 20's MARs dated 10/1-30/2019, indicated Resident 20 was receiving Latuda 160 mg daily, Quetiapine 50 mg at bed time, trazadone 50 mg at bed time and Trintellix 20 mg on a daily basis. The MAR also indicated Resident 20 was monitored for verbalization of hopelessness, resistance to care, auditory hallucinations and extreme paranoid thoughts. According to the MARs, Resident 20 had no episodes of verbalization of hopelessness, no episodes of resisting care and no episodes of paranoia.	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 _____	11/24/2019

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 27 A review of Resident 20's MAR dated 11/4-20/2019, indicated Resident 20 received Latuda 160 mg daily, Quetiapine 50 mg at bed time, trazadone 50 mg at bed time and Trintellix 20 mg daily. The MAR indicated Resident 20 was monitored for verbalization of hopelessness, resistance to care, auditory hallucinations and extreme paranoid thoughts. The MAR indicated Resident 20 had one episode of depression manifested by feeling hopeless on 11/20/19, no episode of resisting care or extreme paranoia. A review of Resident 20's Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 28/29/19 indicated Resident 20 usually understood and was usually understood by others. The MDS indicated Resident 20 required a two-person assist with bed mobility, transfer, walking, dressing, eating, toilet use and for personal hygiene. The MDS indicated Resident 20 was receiving antipsychotic and antidepressant (medication to treat depression). A review of Resident 20's interdisciplinary team notes (IDT) dated 11/22/19 and timed at 7:47 a.m., indicated Resident 20 was resistive to care and the staff was to redirect Resident 20's behavior, provide reality orientation and encourage the resident to be corporative during treatment. A review of Resident 20's "Psychopharmaceutic Summary Sheet" indicated for the months of August, September and October 2019, Resident 20 did not manifest any symptoms of extreme paranoid thoughts. The summary sheet indicated that during September and October 2019, Resident 20 was not resistive to care.	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 _____	11/24/2019

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 28 On 11/23/19 at 09:15 a.m., during a medication pass observation, Resident 20 was in bed, awake, alert and oriented. Resident 20 was calm, quiet and received all morning medications without resistance to care. A Licensed Vocational Nurse (LVN 1) stated Resident 20 was compliant with the care and had never refused medications. LVN 1 stated that sometimes Resident 20 might prefer to be showered at a later time but not refused completely. LVN 1 added Resident 20 did no exhibit screaming behaviors. On 11/24/19 at 07:45 a.m., during an interview, LVN 3 stated Resident 20 had a GT dressing changes daily and the resident had never refused care. LVN 3 also stated Resident 20 did not have any negative behavior manifestations and was not resistive to care. On 11/24/19 at 07:49 a.m., during an interview a Certified Nursing Assistant (CNA 1) stated Resident 20 was not resistive to care. CNA 1 also stated Resident 20 never verbalized hearing voices. On 11/24/19 at 08:05 a.m., during a concurrent interview and record review of Resident 20's MARs and psychopharmaceutic summary sheet, Registered Nurse (RN 1) stated Resident 20 did not have any behavior manifestations in September, October and November of 2019, that showed resisting care or paranoid thoughts. RN 1 stated that nurses should have notified Resident 20's physician because administering Latuda, Quetiapine, trazadone and Trintellix to the resident for symptoms that were not present could lead to adverse effects including overdose and death. RN 1 also stated Resident 20's	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 _____	11/24/2019

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 29	F 758		

physician would be contacted for a possible dose reduction with the intention of discontinuing some of the antipsychotic medications.

On 11/24/19 at 10:34 a.m., during a concurrent interview and record review of Resident 20's IDT notes, the Social Services Director stated Resident 20's physician decided to continue the resident on all four antipsychotics because Resident 20 had behavioral manifestations including the preference to stay in bed and refusing activities of daily living.

b. A review of Resident 83's Face sheet indicated Resident 83 was admitted to the facility on 4/18/19 with a most recent admission on 9/2/19. Resident 83's diagnoses included major depression, anxiety (uneasy feeling), bipolar, and schizophrenia.

A review of Resident 83's care plan dated 4/26/19 indicated Resident 83 had behavior problem related to schizoaffective disorder manifested by hearing voices telling her to strike out causing physical aggression. The interventions included to administer medications as ordered, anticipate and meet Resident 83's needs, and to minimize the potential for the resident's disruptive behaviors by offering tasks which divert attention.

A review of Resident 83's care plan dated 4/26/19, indicated Resident 83 used psychotropic medications for behavior management. The interventions included to administer medications as ordered, monitor and document side effects and effectiveness and to consult with pharmacy and physician to consider dosage reduction when clinically appropriate.

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 _____	11/24/2019

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 30 A review of another care plan dated 4/26/19 indicated Resident 83 had anxiety manifested by inability to relax, screaming and yelling for no apparent reason. The interventions included to assist Resident 83 to identify strengths, positive coping skills and reinforcement, monitor and record mood to determine if problem seem to be related to external causes like medications and concern over diagnosis, observe for signs and symptoms of increased irritability, and any marked change in need for sleep and hyperactivity. A review of Resident 83's physician orders indicated the following: 1) monitored for schizophrenia and bipolar manifested by having angry outburst causing stress 2) monitor for schizophrenia manifested by hearing voices telling her to strike out 3) Depakote 125 mg by mouth four times a day for angry outburst causing stress related to schizophrenia and bipolar 4) Risperdal 3 mg by mouth at bed time related to hearing voices telling her to strike out. A review of Resident 83's MARs dated 9/1-30/2019, indicated Resident 83 was receiving Risperdal 2 mg by mouth daily, Risperdal 3 mg at bed time, Klonopin 1 mg two times daily and Depakote 125 mg four times daily. The MARs also indicated Resident 83 was monitored for anxiety manifested by screaming for no apparent reason, monitored for schizophrenia and bipolar manifested by angry outburst. According to the MARs, Resident 83 had a total of six (6) episodes of screaming in September of 2019 but no episodes of angry outburst. The MARs indicated Resident 83 was monitored for schizophrenia	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 _____	11/24/2019

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	F 758		

manifested by hearing voices to strike out and according to the MAR, the resident had no episode of striking out.

A review of Resident 83's MAR dated 10/1-31/2019, indicated Resident 83 was receiving Risperdal 2 mg by mouth daily, Risperdal 3 mg at bed time, Klonopin 1 mg two times daily, and Depakote 125 mg four times daily. The MAR also indicated Resident 83 who was monitored for anxiety manifested by screaming for no apparent reason, monitored for schizophrenia and bipolar manifested by angry outburst and hearing voices to strike out had no behavioral manifestations for the entire month of October 2019.

A review of Resident 83's MAR dated 11/1-23/2019, indicated Resident 83 was receiving Risperdal 1 mg by mouth daily, Risperdal 3 mg at bed time, Klonopin 1 mg two times daily and Depakote 125 mg four times daily. The MAR indicated Resident 83 who was monitored for anxiety manifested by screaming for no apparent reason, monitored for schizophrenia and bipolar manifested by angry outburst and hearing voices to strike out, had no behavioral manifestations from 11/1-23/2019.

A review of Resident 83's MDS assessment dated 10/22/19 indicated the resident could understand and be understood by others. The MDS indicated Resident 83 required a two-person assist with bed mobility, walking, dressing, eating, toilet use and for personal hygiene. The MDS indicated Resident 83 was receiving antipsychotic and antianxiety (medication to treat mental disorders) medications.

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 _____	11/24/2019

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 On 11/23/19 at 08:55 a.m., during a medication pass observation, Resident 83 was in bed awake, alert and oriented with no disruptive behavior noted. LVN 1 stated Resident 83 was calm and compliant with care. On 11/24/19 at 08:15 a.m., during a concurrent interview and record review of Resident 83's MARs, RN 1 stated the resident did not have any behavior manifestations in October and November of 2019 for resisting care or creaming or hearing voices. RN 1 stated Resident 83 was receiving Depakote, Risperdal and Klonopin to treat symptoms that were no longer present. According to RN 1, this could cause adverse reactions including overdose and death. RN 1 added Resident 83's physician would be updated on the condition for a dose reduction with the intention of discontinuing some of the antipsychotic medications. On 11/24/19 at 09:25 a.m., during an interview an Activities Assistant (AA 1) stated Resident 83 was very calm and was never disruptive during activities. AA 1 stated Resident 83 would sometimes go back and forth in the hallway but was never loud. On 11/24/19 at 09:38 a.m., during an interview LVN 1 stated Resident 83 never displayed any behavioral problems like refusing care, hearing voices, screaming or angry outburst. LVN 1 stated Resident 83 was compliant with care, wheeled herself around the facility and was always calm. On 11/24/19 at 10:56 a.m., during an observation and interview, Resident 83 was in a wheelchair	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 _____	11/24/2019

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 going up and down the hallway without screaming. Resident 83 stated the preference to stay in his room sometimes but attended activities and smoked at times. Resident 83 denied hearing any voices or refusing care. According to Resident 83, "I like to stay clean all the time, but the staff took too long to answer call lights." On 11/24/19 at 11:01 a.m., during an interview the Behavior Unit Monitor (BUM 1) stated that upon admission on 4/18/19, Resident 83 was in the behavior unit briefly and was transferred to the acute section because the resident did not meet criteria to be in the behavior unit. BUM 1 stated Resident 83 did not scream or refuse care like the residents in the behavior unit. A review of the facility's policy titled "Psychotropic Medication Management" with a revised date of 10/24/17, indicated the facility would ensure residents in need of psychotherapeutic medications received appropriate assessment and intervention in order to achieve their highest practicable level of functioning, that residents with mental illness received the necessary treatment to enable or restore their function and that psychotropic medications were evaluated regularly and opportunities for reduction identified and attempted as needed. The policy also indicated that a gradual dose reduction and behavioral intervention would be done on residents who used psychotropic drugs, in an effort to discontinue these drugs. This policy also indicated	F 758		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its-	F 760	**F 760 Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2)** 12/24/19	

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 _____	11/24/2019

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 760	Continued From page 34 §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the staff failed to administer insulin (a hormone that allows the body to use sugar and helps keeps the blood sugar level from getting too high or too low for one of 1 sampled resident (33), as ordered. This deficient practice had the potential to result in an increased and dangerous blood sugar levels which could let to comma or death. Findings: On 11/23/19 at 9:25 a.m., during medication pass observation, licensed vocational nurse (LVN 6) did not administered sixteen (16) units of Levemir insulin that was scheduled to be administered to Resident 33 on the same day at 7:15 a.m. During a concurrent interview with LVN 6 stated she was not sure if Resident 33 had scheduled insulin administration. When asked if the 16 units of Levemir was given at 7:15 a.m., LVN 6 stated no. A review of Resident 33's Admission Record (Face Sheet) indicated the resident was admitted to the facility on 2/3/2019 and readmitted on 9/11/2019 with diagnoses that includes but were not limited to dysphagia (inability to swallow) gastrostomy (small tube surgically inserted into the stomach for nutrition and medication) status, and type 2 diabetes mellitus (abnormal blood sugar levels) requiring insulin administrations.	F 760	**How Corrective Action will be accomplished for residents affected:** Resident 33 blood sugar was checked at 7:15a.m. with a reading of 210 mg/dl and rechecked at 10:46a.m. with a reading of 168 mg/dl. **Identification of Residents with the Potential to be Affected:** The DON reviewed other residents EMAR on 11/23/19 for residents with Diabetes and no other residents were found to have been affected. **Measures to Prevent Recurrence**: LVN 6 was in-service on 11/23/19 on Insulin Administration. License Nurses in-service by DSD and DON on 11/23/19 and 12/14/19 regarding Insulin administration. **Monitoring Corrective Action and Responsibility:** Health Information Director to audit the EMAR x's 5 weeks x's 12 weeks. Findings will be provided to the DON and	

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 _____	11/24/2019

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 760	Continued From page 35 A review of Resident 33's Minimum Data Set (MDS), a standardized resident assessment and care screening tool, dated 9/17/2019, indicated the cognitive skills for daily decision making were severely impaired. The MDS also indicated the resident required total assistant with the activities of daily living with the aide of two staff members. A review of Resident 33's physician order dated 11/23/2019, indicated to administer insulin Detemir solution pen, 100 units per milliner, inject 16 unit subcutaneous two times a day related to type 2 diabetes mellitus. A review of the medication administration records (MARs) dated 11/1 to 23/19, indicated on 11/23/2019 at 7:15 a.m., Resident 33's blood sugar reading was documented at 210 milligram per deciliter. On 11/23/19 at 03:53 p.m., during an interview with LVN 6 stated the blood sugar value of 210 milligram per deciliters for Resident 33 was documented by her. On 11/23/19 at 04:32 p.m., during an interview when asked what are the consequences if insulin was not given to Resident 33, LVN 6 stated blood sugar levels may go up further, and the resident had the potential of suffering from a shock, coma or death.	F 760	submitted to the QA&A Committee for review and recommendations x 3 months or until substantial compliance is achieved. **Date of correction:** 12/24/19	
F 812 SS=E	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	F 812	**F 812 Food Procurement, Store / Prepare / Serve – Sanitary CFR(s): 483.60(i)(1)(2)** 12/24/19	

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 _____	11/24/2019

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 36 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, and record review, the facility failed to distribute, store and serve foods under sanitary conditions. These deficient practices had the potential for the food to become contaminated with harmful microorganisms causing foodborne illness (illness caused by food contaminated with bacteria, viruses, parasites, or toxins), placing the residents at increased risk of spreading infectious agents to susceptible residents. Findings: During the initial tour of the kitchen, inspection of the facility food preparation area and breakfast tray line was conducted on 11/23/19 at 6:45 a.m., the following was observed: 1. One of 6 nozzle attached to the juice	F 812	**How Corrective Action will be accomplished for residents affected:** 1. The nozzle of the juice dispenser was cleaned and cap. 2. The three bags of undated boneless chicken were discarded. 3. The Dietary Supervisor was in-service by Registered Dietician on wearing gloves during food preparation on 11/27/19. 4. Assistant Maintenance Supervisor was in-service by the DSD on hand washing on 11/27/19. 5. The green stained bowls were discarded and replaced with new bowls. 6. Dietary Aide wore apron. **Identification of Residents with the Potential to be Affected:** 1. No other nozzle of the juice dispenser was affected. 2. No other food was found to be undated. 3. The Dietary Supervisor was in-service by Registered Dietician on wearing gloves during food preparation on 11/27/19 no other staff member was found to be affected. 4. Assistant Maintenance Supervisor was in-service by the DSD on	

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 _____	11/24/2019

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 37 dispenser was open to air without a cap or cover. 2. Three bags of undated boneless chicken breast in the freezer. 3. During breakfast tray line Dietary Supervisor (DS) handled raw eggs and or was frying eggs without gloves on. 4. During breakfast tray line Assistant Maintenance Supervisor (AMS) open the kitchen door, reached in and dumped a liquid substance from a cup into the kitchen sink, but did not sanitize the hands (a solution generally used to decrease infectious agents on the hands). 5. More than 48 ounces of green serving bowls used to served food in to the residents had brown residue stains on the inside. 6. Dietary Aide (DA 1) was working in kitchen but was not wearing an apron. During an interview with the Dietary Cook (DC) and Dietary Supervisor (DS) on 11/23/19 at 8:15 a.m., both acknowledged all the findings in the kitchen. During an interview with (AMS) in the presence of Maintenance Supervisor (MS) on 11/23/19 at 8:45 a.m., both acknowledged should not have dumped a liquid substance from a cup into the kitchen sink. A review of the facility's undated policy, title "Labeling and Dating of Food", indicated the following: 1. All products must clearly be labeled with the date when the product was opened. A review of the facility's undated policy, title "Food Handling Practices," indicated the following: 1. Practice good personal hygiene. 2. Wear clean cloths/apron.	F 812	hand washing on 11/27/19 no other staff member was found to be affected. 5. The green stained bowls were discarded and replaced with new bowls no other dietary equipment was found to be affected. 6. No other Dietary Aide was affected. **Measures to Prevent Recurrence**: The Registered Dietician in-serviced the Dietary Staff on 11/27/19, 12/4/19 and 12/18/19 regarding capping / covering the juice nozzles when not in use, dating all items placed in the freezer, dietary staff on wearing aprons while working in the kitchen, facility's policy on Dish Washing and DS to wear gloves during food preparation. **Monitoring Corrective Action and Responsibility:** The RD to do visual checks of the kitchen's juice machine, food stored being dated, staff wearing gloves during food preparation, dietary staff wearing aprons and a review of the kitchen equipment for stains and dish washing. The report will	

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 _____	11/24/2019

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 38 3. Gloves are worn during food preparation when direct contact with raw food is necessary, e.g., making sandwiches, slicing tomatoes for salads etc. 4. Change plastic gloves as frequently as hand-washing would indicate. 5. Change gloves before and after non-food contact and between contacts with raw and cooked food. A review of the facility's policy with a revised date of 7/2013, title "Dish Washing", indicated the following: 1. All dishes will be properly sanitized through the dishwasher. The dishwasher will be kept clean and in good working order. 2. Appropriate chemicals will be used to was, de-stain, and rinse dishes	F 812	be reviewed by the Administrator. Findings will be submitted to the QA&A Committee for review and recommendations x 3 months or until substantial compliance is achieved. **Date of compliance:** 12/24/19	
F 880 SS=D	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 & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)** **How Corrective Action will be accomplished for residents affected:** Resident 29 had no infection or negative outcome. **Identification of Residents with the Potential to be Affected:** Review of the treatment record on the patients receiving treatment	12/24/19

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 _____	11/24/2019

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 39 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	on 12/16/19 and none were found to have an infection. **Measures to Prevent Recurrence**: RN 3 was in-service by the DON on the facility's policy of Hand Hygiene and Wound Management Guidelines. License Nurses were in-service by the DSD and DON on the facility's policy of Hand Hygiene and Wound Management Guidelines. **Monitoring Corrective Action and Responsibility:** DSD to monitor hand hygiene of the treatment nurses twice a week x's 12 weeks. Results will be provided to the DON and findings will be submitted to the QA&A Committee for review and recommendations x 3 months or until substantial compliance is achieved. **Date of correction:** 12/24/19	

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 _____	11/24/2019

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 40 §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 maintain an infection prevention and control for one of 21 sampled residents (29) by: a. not observing infection control measures, when the pressure ulcer (injury to skin and underlying tissue resulting from prolonged pressure on the skin) wound was not covered after it came off during morning care. b. not performing hand hygiene (the act of cleaning hands for the purpose of removing soil, dirt, and microorganisms) and changing gloves before applying a clean dressing during a wound treatment observation. These deficient practices had the potential for exposure to infections and delay of Resident 29's pressure ulcer from healing. Findings: a 1. A review of the admission records indicated Resident 29 was readmitted on 10/22/19 with diagnoses that included paraplegia (severe weakness of the lower extremities), diabetes mellitus (irregular blood sugar) and pressure	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 _____	11/24/2019

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 41	F 880		

ulcer (injury to skin and underlying tissue resulting from prolonged pressure on the skin) of sacral region (base of spine area), stage four (wound that extends to underlying muscle tissue, and bone).

According to the Minimum Data Set (MDS), a standardized assessment and care planning tool, dated 6/5/19, indicated Resident 29 was cognitively (ability to make decisions of daily living) intact with daily decision making. The MDS assessment indicated Resident 29 required one to two-person physical assistance in activities of daily living such as getting dressed, toileting and personal hygiene.

On 11/23/19 at 11:12 a.m. during a wound care observation and interview with Registered Nurse (RN 3) acknowledged Resident 29's wound did not have any dressing on it. During interview, Resident 29 stated it came off during early a.m. care, and it had not been replaced. RN 3 stated leaving the wound exposed without dressing could make the wound get worse by getting infected or slowing the healing process.

a 2. During an observation on 11/24/19 at 11:38 a.m. RN 3 cleaned Resident 29's wound, with saline (a mixture of salt and water), and gauze. RN 3 did not change gloves or perform hand hygiene before continuing to place the clean wound dressing on the sacral pressure ulcer.

During an interview on 11/24/19 at 12:04 p.m. RN 3 stated she should have performed hand hygiene and changed gloves after cleaning Resident 29's wound in order decrease the risks for contaminating the wound, which she had just cleansed.

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 _____	11/24/2019

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 42 A review of the facility's policy titled "Wound Management Guidelines", revised 6/2018 indicated that it is the goal of the facility to maintain skin integrity, and assist in wound healing. A review of the facility's policy titled "Hand Hygiene", revised 1/2019 indicated employees are required to wash their hands thoroughly between procedures on a patient, after touching objects that may be soiled and after removing gloves.	F 880		