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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055041 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/12/2024 |
| NAME OF PROVIDER OR SUPPLIER Royal Care Skilled Nursing Ctr | | STREET ADDRESS, CITY, STATE, ZIP CODE 2725 Pacific Avenue Long Beach, CA 90806 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36292</p> <p>Based on observation, interview and record review, the facility failed to ensure one of three sampled residents (Resident 1) was not verbally abused by a Certified Nursing Assistant (CNA 1), when CNA 1, during Resident 1's physical therapy ([PT] a branch of rehabilitative health that uses exercise and equipment to help patients improve their physical abilities) spoke to Resident 1 using a curse word in a loud, angry, and aggressive tone, in a foreign language that Resident 1 happened to understand.</p> <p>This deficient practice resulted in Resident 1's hurt feelings, because he (Resident 1) was making an effort to do the rehabilitation (a set of interventions designed to optimize functioning and reduce disability in individuals with health conditions) exercises and CNA 1 didn't have to curse at him. This deficient practice had the potential for other episodes of verbal abuse to occur.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record (Face Sheet), the Face Sheet indicated Resident 3 was admitted to the facility on [DATE] with a diagnosis of lobar pneumonia (damaged lung caused by an infection), and pulmonary embolism (a clot in lungs).</p> <p>During a review of Resident 3's Minimum Data Set ([MDS] a standardized assessment and care screening tool), dated 6/20/2024, the MDS indicated Resident 1 was able to make independent decisions that were reasonable and consistent and he had the ability to make himself understood and to be understood by others.</p> <p>During a review of Resident 1's Physician's Order dated on 6/14/2024, the Physician's Order indicated for Resident 1 to receive occupational therapy([OT] a branch of health care that helps people who have physical, sensory or cognitive [thoughts] problem) to include therapeutic exercises, therapeutic activity, and activities of daily living ([ADL] task such as bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet and eating) training three times per week, every day shift, for four weeks.</p> <p>During a review of Resident 1's Physician's Order dated 6/14/2024, the Physician's Order indicated for Resident 1 to receive PT to include neuromuscular reeducation ([NMRE] prescribed motions to re-develop normal motion with in an injured body part), therapeutic activities and gait (how a person walks) training five times per week, every day shift for five weeks.</p> <p>(continued on next page)</p> |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During a review of the facility's Summary of Investigative findings dated 7/4/2024, the Summary of Investigative findings indicated Resident 1 was in the facility's PT gym with Physical Therapy Assistant 1 ([PTA 1] a licensed clinician who works with patients to help them improve their movement and regain independence) attempting to stand up from his wheelchair to use the parallel bars. The Summary of Investigative findings indicated Resident 1 expressed fear of falling and if the small woman who were assisting him would be able to catch him if he fell during PT. The Summary of Investigative findings indicated the PTA 1 attempted to get Resident 1 to stand but Resident 1 was not interested. The Summary of Investigative findings indicated CNA 1 who was outside of the PT room was invited inside the PT room by the PTA 1 to help accommodate Resident 1. The Summary of Investigative findings indicated Resident 1 was sitting in his wheelchair as CNA 1 encouraged Resident 1 to stand up saying, let's go man, followed by an expletive (an oath or swear word) in Tagalog. Resident 1 responded with the same expletive, in English, back to CNA 1, saying I know what that means, I have Filipino friends.</p> <p>During an interview on 7/12/2024, at 11:49 a.m., Resident 1 stated CNA 1 cursed him out using an expletive in another language (Tagalog). Resident 1 stated that language usually does not bother him, he knows and works with Filipinos, and he chooses not to say anything in order to keep the peace, but why did he (CNA 1) talk and act like that? Resident 1 stated his feelings were hurt and he was embarrassed and humiliated in front of people because he (Resident 1) was making an effort to do the rehabilitation exercises, he stopped to catch his breath and CNA 1 said putang [NAME] mo to him. Resident 1 stated it means F*** you in Tagalog, he knows because he has many friends who are Filipinos.</p> <p>During an interview on 7/12/2024 at 11:55 a.m., the Director of Rehabilitation (DOR) stated Resident 1 wanted to take a break while doing parallel bar (a pair of bars that provide two-sided support, helping people maintain their balance during ambulation and coordination exercises) exercises, CNA 1 said f*** you in Tagalog, to Resident 1, in response to Resident 1 taking a break. The DOR stated she was caught off guard and shocked and did not know why CNA 1 used that word towards Resident 1.</p> <p>During an interview on 7/12/2024 at 12 p.m., PTA 1 stated she was present (6/28/2024) and heard CNA 1 speaking to Resident 1 in a loud, aggressive tone and stated CNA 1 should not have spoken to Resident 1 that way just because Resident 1 wanted to stop and catch his breath while doing rehabilitation exercises.</p> <p>During an interview on 7/12/2024 at 12:10 p.m., PTA 2 stated she was shocked at what she heard from CNA 1, CNA 1 used an expletive toward Resident 1 during patient care.</p> <p>During an interview on 7/12/2024 at 12:14 p.m., the Director of Staff Development (DSD) stated all residents have the right to be free from any form abuse including verbal abuse, expletives, and profanities.</p> <p>During an interview on 7/12/2024 at 12:22 p.m., the Director of Nursing (DON) stated residents are here at the facility to recuperate and heal and how they are treated or if they are mistreated could affect them psychologically and physically.</p> <p>(continued on next page)</p> | | |

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| <p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During an interview on 7/12/2024 at 1:24 p.m., the Administrator (ADM) stated he learned about the allegation of verbal abuse during an Interdisciplinary ([IDT] a group of healthcare professionals from different fields who work together to provide the best care for a resident) meeting, during his investigation it was reported to him that Resident 1 and CNA 1 were laughing it off like it was a joke. The ADM stated CNA 1 was unprofessional with poor bedside manners but stated he did not believe what CNA 1 said to Resident 1 qualified as verbal abuse because it was meant to encourage and motivate Resident 1.</p> <p>During a review of the facility's Policy and Procedure (P/P), titled, Abuse, suspected abuse, reporting, revised 10/2022, the P/P indicated the residents of the facility have the right to be free from verbal abuse. The facility must protect the residents from abuse by anyone including facility staff.</p> | | |