STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055041	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Royal Care Skilled Nursing Ctr	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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45028 Based on interview and record review, the facility failed to ensure two of two sampled Residents (Residents 2 and 5) and/or their Responsible Parties (RPs) were informed and/or provided a written notice when Resident 2 and 5's rooms were changed. These deficient practices resulted in Residents 2 and 5 and/or their RPs not being given the option to accept or decline the room change and being unaware of and not knowing why Resident 2 and 5's rooms were changed. Findings: a. During a review of Resident 2's Admission Record (Face Sheet), the Face Sheet indicated Resident 2 was admitted to the facility on [DATE] with diagnosis including unspecified dementia (impaired ability to remember, think, or make decisions which interfere with doing everyday activities) and major depressive disorder ([MDD] a mood disorder which causes a persistent feeling of sadness and loss of interest). During a review of Resident 2's History and Physical (H/P) dated 7/22/2023, the H&P indicated Resident 2 could make his needs known but could not make medical decisions. During a review of Resident 2's Minimum Data Set ([MDS] a standardized assessment and care screening tool) dated 4/10/2024, the MDS indicated Resident 2's cognition was severely impaired. During a review of the facility's Census List dated 7/16/2024, the Census List indicated on 7/16/2024, Resident 2 was moved to another room. During a review of Resident 2's Clinical Record, there was no documentation indicating Resident 2 or his Power of Attorneys ([POA] legal authorization for a designated person to make decisions about another person's property, finances, or medical care) 1 and 2 were informed via telephone or a written notice that Resident 2 was moved to another room prior to or on 7/16/2024 when Resident 2's room change occurred. During a telephone interview on 8/7/2024 at 3:05 p.m., Resident 2's POA 1 and POA 2 stated they were not informed of Resident 2's room change via telephone or in writing on 7/16/2024 (continued on next page)

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. During a review of Resident 5's Admission Record (Face Sheet), the Face Sheet indicated Resident 5 was admitted to the facility on [DATE] with a diagnosis of an infection (the invasion and growth of germs) of the left lower extremity (an end part of a limb of the body) amputation (the surgical removal of a body part) stump (the remaining portion of an arm or leg after an amputation). During a review of Resident 5's MDS dated [DATE], the MDS indicated Resident 5's cognition was intact, and he had the ability to understand and be understood by others. During a review of the facility's Census List dated 1/24/2024, the Census List indicated Resident 5 was moved to another room. During a review of Resident 5's Clinical Record, the Clinical Record indicated there was no documentation indicating Resident 5 received a written notice when he was transferred to another room prior to or on 7/16/2024 when Resident 5's room change occurred. During an interview on 8/8/2024 at 1:07 p.m., the Social Services Director (SSD) stated, prior to changing a resident's room, staff should inform the resident and/or their RP in advance. During a review of the facility's policy and procedure (P/P) revised 5/2023, the P/P indicated prior to making a room change or roommate assignment, persons involved in the change/assignment, such as residents and their representatives, will be given advance notice of such a change as is possible. The notice of a change in room or roommate will be provided in writing, in a language and manner the resident and representative understand and will include the reason(s) why the move or change is required. The Social Service designee or Licensed Nurse should inform the resident's sponsor/family in advance of a change in the resident's room or roommate.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45028 Based on interview and record review, the facility failed to ensure six of eight sampled residents (Residents 2, 3, 4, 7, 8 and 9) were not verbally abused by Resident 1 after the facility continued to allow residents to reside with Resident 1 despite having a history of threatening and harassing behavior's with his roommates. These deficient practices resulted in Residents 2, 3, 4, 7, 8, and Resident 9 being subjected to Resident 1's verbal abuse, bullying, harassment, and intimidating behavior. These deficient practices had the potential for other resident's admitted to Resident 1's room to suffer verbal abuse. Findings: a. During a review of Resident 1's Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with diagnosis including paraplegia (a chronic [lasting for a long time or constantly recurring] condition which causes a loss of muscle function in the lower half of the body, including both legs), depression (a mental health condition which causes persistent feeling of sadness, and loss of interest in activities a person normally enjoys), and a unspecified mood disorder (a disorder which describes a person's mood disturbances) During a review of Resident 1's History and Physical (H&P) dated 11/28/2023, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set ([MDS] a standardized assessment and care screening tool) dated 5/22/2024, the MDS indicated Resident 1's cognition was intact, and he had the ability to understand and be understood by others. The MDS indicated Resident 1 had behavioral symptoms that put others at risk for physical injury, significantly intruded on the privacy or activity of others, and significantly disrupted the care or living environment. During a review of Resident 1's MDS dated [DATE], the MDS indicated Resident 1 exhibited verbal behavioral symptoms directed towards others During a telephone interview on 8/5/2024 at 3:55 p.m., the Complainant stated on 7/17/2024 she received a phone call from the facility's Administrator (ADM) requesting guidance on how to handle Resident 1's behaviors towards staff and other residents in the facility. The Complainant stated, the ADM told her Resident 1 bullies or abuses his roommates and other residents and calls the police on residents so he could have his own private room. The Complainant stated on 7/18/2024 she instructed the ADM to file a report with CDPH on behalf of all residents so the allegations of abuse could be thoroughly investigated. The Complainant stated, the ADM then rescinded his previous statement to her saying he never said anything happened with other residents, only that other residents have had rough experiences with Resident 1 in the past. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/8/2024 at 2:57 p.m., Resident 1 stated he did threaten to call immigration on one of his roommates (Resident 4) because he (Resident 1) felt Resident 4 spoke too loud and did not respect his rights because he would not speak English. Resident 1 stated he mentioned to the Administrator (ADM) on several occasions that he had difficulty with roommates and sleeping at night. Resident 1 stated he like to rest during the day and his roommates would not allow him to rest during the day. Resident 1 stated he requested not to have a roommate but the ADM refused to honor his request. b. During a review of Resident 2's Face Sheet, the Face Sheet indicated Resident 2 was admitted to the facility on [DATE] with diagnosis including unspecified dementia (impaired ability to remember, think, or make decisions which interfere with doing everyday activities) and major depressive disorder ([MDD] a mood disorder which causes a persistent feeling of sadness and loss of interest). During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2's cognition was severely impaired. During a review of Resident 2's H&P dated 7/22/2023, the H&P indicated Resident 2 could make his needs known but could not make medical decisions. During an interview on 8/6/2024 at 2:11 p.m., Certified Nurse Assistant 2 (CNA 2) stated while care was provided to Resident 2, Resident 1 yelled, It smells like s**t in here. CNA 2 stated they knew Resident 1 made the comment towards Resident 2 because Resident 2 had just had a bowel movement. CNA 2 felt that Resident 1 was disrespectful to Resident 1 and Resident 2 should not have to tolerate Resident 1's behavior. CNA 2 stated looking back, they should have reported Resident 1's comments that were made toward Resident 2, to the charge nurse because what Resident 1 said could be considered verbal abuse and no resident should have to be subjected to that. During an interview on 8/6/2024 at 2:34 p.m., CNA 3 stated Resident 1 had a long history of verbally harassing his previous roommates. CNA 3 stated on several occasions, Resident 1 would say to Resident 2, You f***ing white boy, I don't want you in my room, and he would say Pendejo (a derogatory word used to insult someone and imply they were foolish, stupid, or incompetent) to Resident 2 as well as f**ker. CNA 3 stated she didn't know why the facility kept putting residents in the room with Resident 1 because it was known that Resident 1 would verbally abuse his roommates so he could have the room to himself. c. During a review of Resident 3's Admission Record (Face Sheet), the Face Sheet indicated Resident 3 was admitted to the facility on [DATE] with diagnoses including left side hemiplegia (one-sided paralysis [complete or partial loss of function especially when involving the motion or sensation in a part of the body] or weakness) and hemiparesis (weakness or inability to move one side of the body). The Face Sheet indicated Resident 3 was admitted to the same room as Resident 1. During a review of Resident 3's MDS dated [DATE], the MDS indicated Resident 3 had severe cognitive impairment and was sometimes able to understand and be understood by others. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 1's Social Service Note dated 6/5/2024 and timed at 4:26 p.m., the Social Service Note indicated Resident 1 turned the volume of his television very loud because Resident 3 and his family were speaking a language other than English. The Social Service Note indicated Resident 3 and his family had difficulty having a conversation because of the volume of the television, but Resident 1 refused to turn the volume down. The social Service Note indicated Resident 3 was moved to another room. d. During a review of Resident 4's Admission Record (Face Sheet), the Face Sheet indicated Resident 4 was admitted to the facility on [DATE] and was admitted to the same room as Resident 1. During a review of Resident 1's General Note dated 7/31/2024 and timed at 10:54 p.m., the General Note indicated Resident 1 made rude comments to Licensed Vocational Nurse (LVN) 3 saying You suck his d*cK mother f**ker (referring and pointing to the Resident 4) During a review of Resident 1's General Note dated 8/1/2024 and timed at 12:12 a.m., the General Note indicated Resident 1 was made disrespectful comments to his roommate (Resident 4). The General Note indicated, Resident turned the volume of his television to the loudest volume in order to make Resident 4 uncomfortable and upset. During an interview on 8/6/2024 at 1:22 p.m., Resident 4 stated, when he was in the room with Resident 1, Resident 1 called him a f***ing Mexican, then said he (Resident 1) was going to report him to immigration so he (Resident 4) would be deported. Resident 4 stated Resident 1 threatened him and said he had a gun and was going to kill him. Resident 4 stated he later found out that Resident 1 had a history of threatening several of his (Resident 1) previous roommates and he (Resident 4) would have preferred not to be in a room with Resident 1 knowing of his behaviors. e. During a review of Resident 7's Admission Record (Face Sheet), the Face Sheet indicated Resident 7 was admitted to the facility on [DATE] with diagnoses including dementia. During a review of Resident 7's MDS dated [DATE], the MDS indicated Resident 7 cognitive skills for daily decision making was severely impaired. During a review of Resident 7's Census List dated 6/19/2024, the Census List indicated Resident 7's was roommates with Resident 1. During an interview on 8/8/2024 at 2:47 p.m., Resident 7's Family Member (FM 1) stated they would report to the facility staff that Resident 1 was loud at night and would force her (FM 1) to keep the curtains in the room closed and lights in the room off during the day. FM 1 stated she felt Resident 7 was harassed by Resident 1 because he (Resident 1) forced herself and Resident 7 to go by his rules. FM 1 stated she was worried because Resident 7 could not speak for himself and she was concerned that his health would decline. FM 1 stated they pleaded with staff on several occasions to have Resident 7's room changed, but it did not happen for several days. d. During a review of Resident 8's Face Sheet, the Face Sheet indicated Resident 8 was admitted to the facility on [DATE] with diagnosis including schizophrenia (a mental health disorder which is characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions) and bipolar disorder (a serious mental illness which causes unusual shifts in mood). (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 8's MDS dated [DATE], the MDS indicated Resident 8 had no cognitive impairment and usually had the ability to understand and was usually understood by others. During a review of Resident 1's General Note dated 2/22/2024 and timed at 12:24 a.m., the General Note indicated Resident 1 verbally threatened his roommate (Resident 8). The General Note indicated Resident 1 screamed derogatory phrases at Resident 8 and Resident 8's family members e. During a review of Resident 9's Face Sheet, the Face Sheet indicated Resident 9 was admitted to the facility on [DATE] with diagnosis including urinary tract infection (a condition in which bacteria [germs] invade and grow in the urinary tract [kidneys, ureters, bladder, and urethra]). The Face Sheet indicated Resident 9 was admitted to the same room as Resident 1. During a review of the facility's Grievance/Complaint Resolution Report dated 8/2/2024, the Grievance/Complaint Resolution Report indicated Resident 9's Family Member 2 (FM 2) reported that Resident 1 would have his television's volume up loud, he would play loud machine gun sounds through his cell phone, would use vulgar language toward Resident 9 and his family, and not allow Resident 9 to sleep at night. The Grievance/Complaint Resolution Report indicated Resident 9 was moved to another room due to roommate incompatibility. During an interview on 8/6/2024 at 1:15 p.m., Resident 9 stated he was admitted to the facility to recover and get better and needed his rest and Resident 1 wouldn't allow him to sleep at night. Resident 9 stated he didn't know why they would put anyone in the room with Resident 1 knowing that he was up all night. During a telephone interview on 8/7/2024 at 9:21 a.m., Resident 9's Family Member 1 (FM 1) stated on 8/2/2024 while visiting Resident 9, Resident 1 yelled at her and Resident 9 and saying, Get out of my f**king room. FM 1 stated Resident 1 continued with this behavior, and she reported this to facility staff (identity of staff is unknown). During an interview on 8/6/2024 at 3:13 p.m., the Admissions Coordinator (AC) 1, stated the ADM was aware of Resident 1's history of verbally abusing his previous roommates but was instructed by the ADM to continue to admit residents to Resident 1's room despite her concerns. During an interview on 8/6/2024 at 4:31 p.m., the Social Service Director (SSD) stated the facility shouldn't have continued to have residents share a room with Resident 1 because of his history of roommate incompatibility but the ADM insisted on placing residents in the same room with Resident 1. The SSD stated she worried not only about residents who are placed in the room with Resident 1 being subjected to verbal abuse by Resident 1, but was also concerned that Resident 1 would be verbally abused and/or assaulted by his roommates. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/7/2024 at 11:59 a.m., the ADM stated he was not aware of the alleged verbal abuse between Resident 1 and Residents 4 and 7 or any alleged verbal abuse between Resident 1 and 2. The ADM stated he knew that Resident 2 was not a good fit to be Resident 1's roommate because of Resident 1's behaviors. When asked what behaviors the ADM would only say, it wasn't a good fit. The ADM stated he was aware of the incident between Resident 1, Resident 9, and FM 1, but after interviewing Resident 9, Resident 9 only stated, he (Resident 1) was a jerk and did not consider the incident between them as verbal abuse because he thought it only involved Resident 1's family, not Resident 9, and he did not think it needed to be reported. The ADM stated the licensed nurses should have reported the allegations of verbal abuse between Resident 1 and Residents 4 and 7 to me, the Director of Nursing (DON), CDPH, the Ombudsman office, and the local PD as necessary. During an interview on 8/8/2024 at 9:10 a.m., the Director of Nursing (DON) stated all residents have the right to be free from verbal abuse including threats, others, harassment, intimidation, and mental abuse. The DON stated after the incident on 2/22/2024 between Resident's 1 and 8, no one should have been admitted to Resident 1's room The DON stated they had an obligation to protect the residents in the facility and could have prevented the verbal abuse from occurring. During an interview on 8/8/2024 at 1:29 p.m., the Regional Administrator (RADM) stated it was not acceptable for any resident to be subjected to any type of abuse because the residents should have a positive and pleasant environment which is safe and comfortable for them to live in. The RAM stated the abuse could have been avoided had the facility attempted to get to the root cause of the problem with Resident 1. The RAM stated moving forward, the facility would no longer place residents in the same room with Resident 1 because there was a potential for Resident 1 to continue abusing his roommates. During a review of the facility's policy and procedure (P/P) titled, Alleged and Suspected Abuse and Crime Reporting, revised 10/2022, the P/P indicated each resident has the right to be free from abuse, neglect, . The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, .The facility will monitor the adequacy of assessment, care planning and monitoring of residents with needs or behaviors that may likely lead to conflict, altercation, abuse, neglect, exploitation, and misappropriation and mistreatment.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45028 Based on interview, and record review, the facility failed to report four allegations of resident to resident verbal abuse to the California Department of Public Health (CDPH), the State Long Term Care Ombudsman (a public advocate) and local law enforcement, within the regulated time frame of two hours for four of five sampled residents (Resident's 2, 4, 8, and 9). These deficient practices resulted in CDPH not being aware of the abuse allegations that occurred between 2/22/2024 and 8/1/2024 until 8/6/2024 and the inability to investigation the allegations. These deficient practices had the potential for pertinent information to be lost and/or forgotten, more allegations of abuse to go unreported. Findings: a. During a review of Resident 1's Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with diagnosis including paraplegia (a chronic [lasting for a long time or constantly recurring] condition which causes a loss of muscle function in the lower half of the body, including both legs), depression (a mental health condition which causes persistent feeling of sadness, and loss of interest in activities a person normally enjoys), and a unspecified mood disorder (a disorder which describes a person's mood disturbances) During a review of Resident 1's History and Physical (H&P) dated 11/28/2023, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set ([MDS] a standardized assessment and care screening tool) dated 5/22/2024, the MDS indicated Resident 1's cognition was intact, and he had the ability to understand and be understood by others. The MDS indicated Resident 1 had behavioral symptoms that put others at risk for physical injury, significantly intruded on the privacy or activity of others, and significantly disrupted the care or living environment. During a review of Resident 1's MDS dated [DATE], the MDS indicated Resident 1 exhibited verbal behavioral symptoms directed towards others During a telephone interview on 8/5/2024 at 3:55 p.m., the Complainant stated on 7/17/2024 she received a phone call from the facility's Administrator (ADM) requesting guidance on how to handle Resident 1's behaviors towards staff and other residents in the facility. The Complainant stated, the ADM told her Resident 1 bullies or abuses his roommates and other residents and calls the police on residents so he could have his own private room. The Complainant stated on 7/18/2024 she instructed the ADM to file a report with CDPH on behalf of all residents so the allegations of abuse could be thoroughly investigated. The Complainant stated, the ADM then rescinded his previous statement to her saying he never said anything happened with other residents, only that other residents have had rough experiences with Resident 1 in the past. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. During a review of Resident 2's Face Sheet, the Face Sheet indicated Resident 2 was admitted to the facility on [DATE] with diagnosis including unspecified dementia (impaired ability to remember, think, or make decisions which interfere with doing everyday activities) and major depressive disorder ([MDD] a mood disorder which causes a persistent feeling of sadness and loss of interest). During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2's cognition was severely impaired. During a review of Resident 2's H&P dated 7/22/2023, the H&P indicated Resident 2 could make his needs known but could not make medical decisions. During a review of Resident 2's Census List dated 6/21/2024, the Census List indicated Resident 2, and Resident 1 were roommates. During an interview on 8/6/2024 at 2:11 p.m., Certified Nurse Assistant 2 (CNA 2) stated while care was provided to Resident 2, Resident 1 yelled, It smells like s**t in here. CNA 2 stated they knew Resident 1 made the comment towards Resident 2 because Resident 2 had just had a bowel movement. CNA 2 felt that Resident 1 was disrespectful to Resident 1 and Resident 2 should not have to tolerate Resident 1's behavior. CNA 2 stated looking back, they should have reported Resident 1's comments that were made toward Resident 2, to the charge nurse because what Resident 1 said could be considered verbal abuse and no resident should have to be subjected to that. During an interview on 8/6/2024 at 2:34 p.m., CNA 3 stated Resident 1 had a long history of verbally harassing his previous roommates. CNA 3 stated on several occasions, Resident 1 would say to Resident 2, You f***ing white boy, I don't want you in my room, and he would say Pendejo (a derogatory word used to insult someone and imply they were foolish, stupid, or incompetent) to Resident 2 as well as f**ker. CNA 3 stated she didn't know why the facility kept putting residents in the room with Resident 1 because it was known that Resident 1 would verbally abuse his roommates so he could have the room to himself. c. During a review of Resident 4's Face Sheet, the Face Sheet indicated Resident 4 was admitted to the facility on [DATE] with diagnosis including pleural effusion (a buildup of fluid between the layers of tissue that line the lungs and chest cavity). The Face Sheet indicated Resident 4 was admitted to the same room as Resident 1. During a review of Resident 1's General Note dated 7/31/2024 and timed at 10:54 p.m., the General Note indicated Resident 1 made rude comments to Licensed Vocational Nurse (LVN) 3 saying You suck his d_cK mother f**ker (referring and pointing to the Resident 4) During an interview on 8/6/2024 at 1:22 p.m., Resident 4 stated, when he was in the room with Resident 1, Resident 1 called him a f***ing Mexican, then said he (Resident 1) was going to report him to immigration so he (Resident 4) would be deported. Resident 4 stated Resident 1 threatened him and said he had a gun and was going to kill him. Resident 4 stated he later found out that Resident 1 had a history of threatening several of his (Resident 1) previous roommates and he (Resident 4) would have preferred not to be in a room with Resident 1 knowing of his behaviors. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. During a review of Resident 8's Face Sheet, the Face Sheet indicated Resident 8 was admitted to the facility on [DATE] with diagnosis including schizophrenia (a mental health disorder which is characterized by disruptions in thought processes ,perceptions, emotional responsiveness, and social interactions) and bipolar disorder (a serious mental illness which causes unusual shifts in mood). During a review of Resident 8's MDS dated [DATE], the MDS indicated Resident 8 had no cognitive impairment and usually had the ability to understand and was usually understood by others. During a review of Resident 1's General Note dated 2/22/2024 and timed at 12:24 a.m., the General Note indicated Resident 1 verbally threatened his roommate (Resident 8). The General Note indicated Resident 1 screamed derogatory phrases at Resident 8 and Resident 8's family members e. During a review of Resident 9's Face Sheet, the Face Sheet indicated Resident 9 was admitted to the facility on [DATE] with diagnosis including urinary tract infection (a condition in which bacteria [germs] invade and grow in the urinary tract [kidneys, ureters, bladder, and urethra]). The Face Sheet indicated Resident 9 was admitted to the same room as Resident 1. During a review of the facility's Grievance/Complaint Resolution Report dated 8/2/2024, the Grievance/Complaint Resolution Report indicated Resident 9's Family Member 2 (FM 2) reported that Resident 1 would have his television's volume up loud, he would play loud machine gun sounds through his cell phone, would use vulgar language toward Resident 9 and his family, and not allow Resident 9 to sleep at night. The Grievance/Complaint Resolution Report indicated Resident 9 was moved to another room due to roommate incompatibility. During a telephone interview on 8/7/2024 at 9:21 a.m., Resident 9's Family Member 1 (FM 1) stated on 8/2/2024 while visiting Resident 9, Resident 1 yelled at her and Resident 9 and saying, Get out of my f**king room. FM 1 stated Resident 1 continued with this behavior, and she reported this to facility staff (identity of staff is unknown). During an interview on 8/7/2024 at 11:59 a.m., the ADM stated he was not aware of the alleged verbal abuse between Resident 1 and Residents 4 and 7 or any alleged verbal abuse between Resident 1 and 2. The ADM stated he knew that Resident 2 was not a good fit to be Resident 1's roommate because of Resident 1's behaviors. When asked what behaviors the ADM would only say, it wasn't a good fit. The ADM stated he was aware of the incident between Resident 1, Resident 9, and FM 1, but after interviewing Resident 9, Resident 9 only stated, he (Resident 1) was a jerk and did not consider the incident between them as verbal abuse because he thought it only involved Resident 1's family, not Resident 9, and he did not think it needed to be reported. The ADM stated the licensed nurses should have reported the allegations of verbal abuse between Resident 1 and Residents 4 and 7 to me, the Director of Nursing (DON), CDPH, the Ombudsman office, and the local PD as necessary. During an interview on 8/7/2024 at 4:28 p.m., LVN 5 they (facility staff) reported Resident 1's verbal abuse to the ADM on several occasions, and he was aware of Resident 1's verbal abuse towards his roommates. During a telephone interview on 8/7/2024 at 5:39 p.m., LVN 2 stated they (facility staff) reported the verbal abuse between Resident 1 and his roommates to the Registered Nurse Supervisors, the DON, and the ADM several times. (continued on next page)

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	055041	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Royal Care Skilled Nursing Ctr	2725 Pacific Avenue Long Beach, CA 90806

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/8/2024 at 1:29 p.m., the facility's Regional Administrator (RADM) stated all allegations of abuse should be reported immediately to CDPH, the Ombudsman and the local PD. During a review of the facility's policy and procedure (P&P) titled, Alleged or Suspected Abuse and Crime Reporting, revised 10/2022, the P&P indicated each resident has the right to be free from abuse, neglect . and exploitation. It is the responsibility of all employees to immediately report to facility administrator, and to other officials in accordance with Federal and State law, any incident of suspected or alleged abuse, neglect . to treat the resident's medical symptoms. Alleged violations involving abuse or resulting in serious bodily injury will be reported immediately, but not later than two hours after the allegation is made.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45028 Based on interview and record review, the facility failed to ensure a care plan was developed for one sampled resident (Resident 1), who had a history of verbal abuse, threats, and harassment towards residents who were admitted in his room, to include not allowing admission of other residents to Resident 1's room. This deficient practice resulted in subjecting Residents 2, 3, 4, 8, and 9, who were admitted to Resident 1's room, to Resident 1's known and continued behavior of verbal abuse, threats, and harassment. Findings: a. During a review of Resident 1's Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with diagnosis including paraplegia (a chronic [lasting for a long time or constantly recurring] condition which causes a loss of muscle function in the lower half of the body, including both legs), depression (a mental health condition which causes persistent feeling of sadness, and loss of interest in activities a person normally enjoys), and a unspecified mood disorder (a disorder which describes a person's mood disturbances) During a review of Resident 1's Minimum Data Set ([MDS] a standardized assessment and care screening tool) dated 5/22/2024, the MDS indicated Resident 1's cognition was intact, and he had the ability to understand and be understood by others. The MDS indicated Resident 1 had behavioral symptoms that put others at risk for physical injury, significantly intruded on the privacy or activity of others, and significantly disrupted the care or living environment. During a review of Resident 1's MDS dated [DATE], the MDS indicated Resident 1 exhibited verbal behavioral symptoms directed towards others. During a review of Resident 1's History and Physical (H&P) dated 11/28/2023, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Clinical Record (Care Plan section), Resident 1's Care Plans had no interventions preventing residents from being admitted to Resident 1's room. b. During a review of Resident 2's Admission Record (Face Sheet), the Face Sheet indicated Resident 2 was admitted to the facility on [DATE] with diagnosis including unspecified dementia (impaired ability to remember, think, or make decisions which interfere with doing everyday activities) and major depressive disorder (MDD] a mood disorder which causes a persistent feeling of sadness and loss of interest). During a review of Resident 2's Census List dated 6/21/2024, the Census List indicated Resident 2 was roommates with Resident 1. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 1's General Note dated 7/31/2024 and timed at 10:54 p.m., the General Note indicated Resident 1 said you suck his d**k, Mother F***er (referring to and pointing at Resident 4). During a review of Resident 1's General Note dated 8/1/2024 and timed at 12:12 a.m., the General Note indicated Resident 1 made disrespectful comments to Resident 4. The General Note indicated, Resident 1 turned the television up to the loudest volume in order to make Resident 4 uncomfortable and upset. The General Note indicated; Resident 4 was moved to another room on 8/1/2024. During an interview on 8/6/2024 at 2:34 p.m., Certified Nurse Assistant 3 (CNA 3) stated on several occasions, Resident 1 would say to Resident 2, You f***ing white boy, I don't want you in my room and say pendejo (a derogatory word used to insult someone and imply they are foolish, stupid, or incompetent), and said f***er to him. c. During a review of Resident 3's Admission Record (Face Sheet), the Face Sheet indicated Resident 3 was admitted to the facility on [DATE] with diagnoses including left side hemiplegia (one-sided paralysis [complete or partial loss of function especially when involving the motion or sensation in a part of the body] or weakness) and hemiparesis (weakness or inability to move one side of the body). The Face Sheet indicated Resident 3 was admitted to the same room as Resident 1. During a review of Resident 1's Social Service Note dated 6/5/2024 and timed at 4:26 p.m., the Social Service Note indicated Resident 1 turned the volume of his television very loud because Resident 3 and his family were speaking a language other than English. The Social Service Note indicated Resident 3 and his family had difficulty having a conversation because of the volume of the television, but Resident 1 refused to turn the volume down. The social Service Note indicated Resident 3 was moved to another room. During a review of Resident 3's Room/Roommate Change Form dated 6/5/2024, the Room/Roommate Change Form indicated Resident 3 was moved to another room due to roommate incompatibility with Resident 1. d. During a review of Resident 4's Admission Record (Face Sheet), the Face Sheet indicated Resident 4 was admitted to the facility on [DATE] and was admitted to the same room as Resident 1. During a review of Resident 4's Census List dated 8/1/2024, the Census List indicated Resident 4's room was changed. During an interview on 8/6/2024 at 1:22 p.m., Resident 4 stated, when he was in the room with Resident 1, Resident 1 called him a f***ing Mexican, then said he (Resident 1) was going to report him to immigration so he would be deported. Resident 4 stated Resident 1 threated him and said he had a gun and was going to kill him. Resident 4 stated he later found out that Resident 1 had a history of threatening several of his previous roommates and stated he would have preferred not to be in a room with Resident 1 knowing how he had treated his previous roommates. e. During a review of Resident 8's Admission Record (Face Sheet), the Face Sheet indicated Resident 8 was admitted to the facility on [DATE] with diagnosis including schizophrenia (a mental health disorder which is characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions) and bipolar disorder (a serious mental illness which causes unusual shifts in mood). The Face Sheet indicated Resident 8 was admitted to the same room as Resident 1. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 1's General Note dated 2/22/2024 and timed at 12:24 a.m., the General Note indicated Resident 1 screamed derogatory phrases at Resident 8 and Resident 8's family members and threatened to have staff and other residents killed and/or beaten up by his (Resident 1) friends and/or family. Resident 8 was moved to another room on 2/22/2024. During a review of Resident 8's Room/Roommate Change Form dated 2/22/2024, the Room/Roommate Change Form indicated Resident 8 was moved to another room due to roommate incompatibility with Resident 1. f. During a review of Resident 9's Admission Record (Face Sheet), the Face Sheet indicated Resident 9 was admitted to the facility on [DATE] and was admitted to the same room as Resident 1. During a review of the facility's Grievance/Complaint Resolution Report dated 8/2/2024, the Grievance/Complaint Resolution Report indicated Resident 9's Family Member 2 (FM 2) filed a grievance against Resident 1 indicating Resident 1 played his television loud, played loud machine gun sounds through his cell phone, and used vulgar language towards Resident 9 and his family. The Grievance/Complaint Report indicated Resident 1 did not allow Resident 9 to sleep at night. The Grievance/Complaint Report indicated Resident 9 was moved to another room due to roommate incompatibility. During an interview on 8/6/2024 at 1:15 p.m., Resident 9 stated he was admitted to the facility to recover and get better and needed his rest and Resident 1 wouldn't allow him to sleep at night. Resident 9 stated he doesn't know why they would put anyone in the room with Resident 1 knowing that he (Resident 1) was up all night. During a telephone interview on 8/7/2024 at 9:21 a.m., FM 1 stated on 8/2/2024 while visiting Resident 9, Resident 1 yelled at Resident 9 saying Get out of my f***ing room. During an interview on 8/8/2024 at 9:10 a.m., the Director of Nursing (DON) stated after the incident on 2/22/2024 between Resident's 1 and 8, no one should have been admitted to Resident 1's room, and his care plan should have been updated. During a review of the facility's policy and procedure (P/P) dated 12/2017, the P/P indicated the care plan is directed toward achieving and maintaining optimal status of health, functional ability, and quality of life. The P/P indicated care plans are individualized through the identification of resident concerns, unique characteristics, strengths, and individual needs.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 45028 Based on observation, interview and record review, the facility failed to ensure a medication cart (a movable piece of equipment used in healthcare facilities to store, transport, and dispense medicines, medical supplies, and emergency equipment), located on Station two was locked. This deficient practice resulted in unsecured medications and had the potential for resident's, visitors, and other unauthorized staff to access medications that were left unsecured and out of visual sight of the licensed nurse assigned to the medication cart, which could lead to theft, loss, and/or ingestion of medications not intended for resident's use. Findings: During an observation on 8/6/2024 at 12:11 p.m., on the Station two hallway, an unlocked and unattended medication cart was observed. During an interview on 8/6/2024 at 12:12 p.m., Licensed Vocational Nurse 1 (LVN 1) stated she forgot to lock the medication cart prior to stepping away from it. LVN 1 stated if the medication cart was left unlocked and unattended, everyone in the facility had access to the medications in the cart. During an interview on 8/8/2024 at 5:27 p.m., the Director of Nursing (DON) stated all licensed nurses who are assigned a medication cart are responsible for ensuring the cart was locked prior to stepping away from it. The DON stated there was a potential for residents, staff, and/or visitors to take medications from the unlocked/unsecured medication cart and consume the medications not intended for their use. During a review of the facility's policy and procedure (P&P), titled, Medication Storage in the Facility IDI 1: Storage of Medications, updated 8/2019, the P&P indicated medications and biologicals are stored safely, securely, the medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications, only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medications are allowed access to medications, and medication rooms, carts, and medication supplies are locked or attended by persons with authorized access.