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	09/24/2024

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 46415 Based on interview and record review, the facility failed to ensure residents have the right to be free from physical abuse for one of two sampled residents (Resident 1). This deficient practice resulted in Resident 2 hitting Resident 1 on the right knee twice. Findings: a. During a review of the Resident 1 ' s Admission record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including pancytopenia (condition in which there is a significant reduction in the number of blood forming cells), hypertension (high blood pressure), heart failure (progressive heart disease affecting function of the heart), end stage renal disease (ESRD: chronic condition in which the kidneys lose the ability to remove waste and fluids), abnormalities of gait and mobility, and Type II Diabetes (diseases that affects the way the body processes blood sugar). During a review of Resident 1 ' s Minimum Data Set [(MDS) a standardized assessment and care screening tool], dated 7/5/2024, the MDS indicated Resident 1 ' s cognitive skills (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) were mildly impaired. The MDS indicated Resident 1 required moderate assistance for transferring from chair/bed to chair, sit to lying, and required maximal assistance on bathing changing, and performing oral/toileting/personal hygiene. The MDS indicated Resident 1 utilized a wheelchair and walker for mobility and does not have impairments on both the upper and lower extremities (arms and legs). During an interview on 9/23/2024 at 2:36p.m. with Resident 1, Resident 1 stated on 9/9/2024 (the day of the incident) she came back from dialysis (treatment that removes excess water and toxins from the blood due to kidney impairment) and said she wishes she could use the bathroom. Resident 1 stated after that comment, Resident 2 suddenly became irate, Resident 1 stated she asked Resident 2 why she was being such a mean b***h. Resident 1 stated Resident 2 responded asked her if Resident 1 had called her a b***h. Resident 1 stated she asked Resident 2 again, why she was being such a mean b***h. Resident 1 stated it was a just a figure of speech. Resident 1 stated Resident 1 just started hitting her. Resident 1 stated she pushed Resident 2 ' s hand away and the staff came in and separated them. Resident 1 was moved to a new room on 9/9/2024 and is currently content with her new room and roommate and feels safe being at the facility. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055041	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/24/2024
NAME OF PROVIDER OR SUPPLIER: Royal Care Skilled Nursing Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE: 2725 Pacific Avenue Long Beach, CA 90806	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. During a review of the Resident 2 ' s Face Sheet, the Face Sheet indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including hemiplegia (immobility of one side of the body) and hemiparesis (weakness on one side of the body), major depressive disorder (serious mental illness that affects how a person feels and acts), anxiety (unpleasant feeling of fear or uneasiness) disorder, and Type II Diabetes. During a review of Resident 2 ' s MDS dated [DATE], the MDS indicated Resident 2 ' s cognitive skills were intact. The MDS indicated Resident 2 was dependent in transferring from chair/bed to chair, bathing, and toilet hygiene. The MDS indicated Resident 2 utilized a wheelchair for mobility and had impairments on one side of the upper and lower extremities. The MDS indicated Resident 2 did not have any behavioral symptoms such as hitting, grabbing, threatening others, and screaming at others. During a review of a Change of Condition (COC), the COC indicated on 6/28/2024, Resident 2 had an altercation with her roommate, exchanged words, and tossed a pitcher of water on her roommates bed. Both of the residents were separated and moved to different rooms. During a review of an untitled Care Plan, the CP indicated on 8/14/2024, Resident 2 ' s roommate stated she was hot but Resident 2 was cold, and a Certified Nursing Assistant U (CNA U) offered Resident 2 a blanket, however Resident 2 refused, and attempted to pick up an item and throw it at the roommate but was prevented on 9/10/2024. During a review of an untitled Care Plan, the CP indicated on 8/14/2024, Resident 2 ' s roommate stated she was hot but her roommate Resident 2 was cold, and a CNA 32 (CNA 32) offered Resident 2 a blanket, Resident 2 refused the blanket, and attempted to pick up an item and throw it at the roommate but was prevented on 9/10/2024. During a review of a COC dated 9/9/2024 at 3:25p.m., the COC indicated Resident 1 had her call light on and wanted to be changed. Licensed Vocational Nurse 1 (LVN 1) informed Resident 1 she will get Certified Nursing Assistant 2 (CNA 2) to assist her, and when she came back to inform Resident 1 CNA 2 would be there shortly, Resident 2 had scooted towards Resident 1 screaming I am not a b***c. At this time the Case Manager (CM) entered the room, and took Resident 1 away from Resident 2 . The COC indicated Resident 2 struck Resident 1 on the right knee. During a review of the Order Summary (doctor ' s notes), the order summary indicated a physician's order dated 9/16/2024 (7 days after the abuse incident) to monitor Resident 2 related to aggression on 9/9/2024. During an interview on 9/23/2024 at 11:31 a.m., with Resident 2, Resident 2 stated both herself and Resident 1 were in their room in their respective wheelchairs and all of a sudden Resident 1 called Resident 2 a b***h and did not know why she called her that so she hit Resident 1. Resident 2 stated she hit Resident 1 twice on her right leg. Resident 2 stated what else do you do when someone called you a b***h. Resident 2 stated Resident 1 had never said anything like this before and never had any issues with Resident 1. Resident 2 stated she had no issues with her current roommates and feels safe being at the facility. During an on 9/23/2024 at 1:27 p.m., with LVN 1, LVN 1 stated this was considered abuse and the facililty followed it's abuse protocol, reporting, investigating, and monitoring the resident. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/23/2024 at 3:01p.m. with the Director of Nursing (DON), the DON stated this is considered abuse, and once this incident was reported by LVN 1, it was reported to the Administrator, reported within two hours, called the ombudsman, law enforcement, did COC, and initiated an in service about abuse. The DON stated the facility investigated the incident. The DON stated Resident 2 has angry outbursts due to the diagnosis of anxiety and depression. During a concurrent interview and record review on 9/23/2024 at 4:33 p.m., with the Minimum Data Set Nurse (MDSN), the MDSN stated Resident 2 has a history of being aggressive. The MDSN stated on 6/28/2024 after Resident 2 tossed the water pitcher at her roommate, Resident 2 was monitored for 72 hours for her behavior. The MDSN stated she has heard Resident 2 gets agitated and frustrated regarding small things. The MDSN stated Resident 2 could have benefited from continuous monitoring, due to her behaviors and the doctor could have adjusted her medications as needed, increased psychologist (a physician that treats mental illness) meetings, or involved the family more. The MDSN stated this is incident should be reported to the Californai Department of Health and all other authorities per facility policy. The MDSN stated residents have the right to be free from abuse, and if no one reportes incidents of abuse, Resident 2 could have harmed someone else or could have harmed herself. During a review of the facility ' s policy and procedure (P&P), titled, Alleged or Suspected Abuse and Crime Reporting, revised 11/2016, the P&P indicated each resident has the right to be free from abuse, neglect, misappropriation or resident property, and exploitation. The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation that achieves the identification, ongoing assessment, care planning for appropriate interventions, and monitor of residents with needs and behaviors which might lead to conflict or neglect. The facility will monitor the adequacy of assessment, care planning and monitoring of residents with needs ot behaviors that may likely lead to conflict, altercation, abuse, neglect, exploitation, and misappropriation and mistreatment such as physically aggressive or self-injurious behaviors and verbally abusive behavior towards others.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 46415 Based on interview and record review, the facility failed to initiate a person-centered base line care plan for one of two sampled residents (Resident 2) for a behavior of throwing water at her previous roommate. This deficient practice potentially led to Resident 2's agression not being addressed and escalating, compromising other residents' safety. Findings; During a review of the Resident 2 ' s Face Sheet, the Face Sheet indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including hemiplegia (immobility of one side of the body) and hemiparesis (weakness on one side of the body), major depressive disorder (serious mental illness that affects how a person feels and acts), anxiety (unpleasant feeling of fear or uneasiness) disorder, and Type II Diabetes. During a review of Resident 2 ' s miminum data set (MDS-a standardized assesment and care screening tool) dated 7/11/2024, the MDS indicated Resident 2 ' s cognitive skills were intact. The MDS indicated Resident 2 was dependent in transferring from chair/bed to chair, bathing, and toilet hygiene. The MDS indicated Resident 2 utilized a wheelchair for mobility and had impairments on one side of the upper and lower extremities. The MDS indicated Resident 2 did not have any behavioral symptoms such as hitting, grabbing, threatening others, and screaming at others. During a review of a Change of Condition (COC), the COC indicated on 6/28/2024 at 9:58p.m., Resident 2 had an altercation with her roommate, exchanged words, and tossed water on her roommates bed. Both of the residents were separated and moved to different rooms. The COC indicated Resident 2 had behavioral symptoms (agitation, psychosis). A follow up nursing note on 6/28/2024 at 10:00p.m. indicated under the Interdisciplinary (IDT: group of specialized individuals meeting to determine plan of care) comments/other recommendations to continue to monitor Resident 2 and notify her Medical Doctor (MD) of any issues or further behavioral problems. The follow up notes did not specify what type of behavior Resident 2 had. During a review of Resident 2 ' s medical record, Resident 2 did not have a care plan for the incident that occurred on 6/28/2024. During a review of Resident 2 ' s untitled CP dated 9/11/2022, the CP indicated potential behavioral disturbance related to depression as evidenced by verbalization of sadness initiated on 9/11/2022. The CP intervention indicated to monitor for behavior of agitation and remove from situation if behavior seen initiated and revised on 9/11/2022. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 2 ' s untitled CP dated 8/23/2024, the CP indicated on 8/14/2024, Resident 2 ' s roommate stated she was hot but Resident 2 was cold, and a Certified Nursing Assistant 32 (CNA 32) offered Resident 2 a blanket, however Resident 2 refused the blanket, and attempted to pick up an item and throw it at the roommate but was prevented. The CP intervention indicated to monitor resident ' s increase in behaveiors and notify the medical doctor (MD). This CP intervention indicated it was resolved on 9/10/2024. During a review of Resident 2 ' s behavioral notes, the behavioral note dated 7/30/2024 indicated Resident 2 experiences periods of agitation and anxiousness and can be short tempered. The behavioral note treatment objective indicated Resident 2 will recognize the precursors that lead to her depressed mood and agitated state and her feelings of loneliness .understand how her thoughts and feelings regarding her experiences of loneliness lead to depressive and agitated states and will improve her mood and lessen her agitation. During a concurrent interview and record review on 9/23/2024 at 4:33 p.m., of the COC dated 6/28/2024 with the Minimum Data Set Nurse (MDSN), the MDSN stated they do not have a care plan for the incident of Resident 2 tossing water at her roommate. During a concurrent interview and record review on 9/24/2024 at 10:19 a.m., of the COC dated 6/28/2024 with the Director of Nursing (DON), the DON stated they should have had a care plan for this incident. The DON stated the purpose of the care plan is to address the behavior Resident 2 had based on her medical diagnosis, current medications, and side effects. During a concurrent interview and record review of the Medication Administration Record (MAR: electronic document that indicates medications administered to the residents) for August on 9/24/2024 at 10:52p.m. with the DON, the DON stated Resident 2 was being monitored for behaviors for depressive mood/sad feelings which included frustration and agitation but does not have a specific monitoring behavior for agitation. During a review of the facility ' s policy and procedure (P&P), titled, Baseline Care Plan, dated October 2022, the P&P indicated the facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care for the resident that meet professional standards of quality care. During a review of the facility ' s policy and procedure (P&P), titled, Care Plan, Comprehensive, dated December 2017, the P&P indicated care plans should be developed by the interdisciplinary Team (IDT), which includes activities, dietary, nursing management, social services, and therapy and includes input from direct care staff including Licensed Nurses and Nursing Assistants. Plans are reviewed and revised by the IDT at least quarterly, following completion of the MDS assessment or following an assessment for a significant change of condition. Care plans are individualized through the identification of resident concerns, unique characteristics, strengths, and individual needs. Resident progress is regularly evaluated, and approaches revised or updated as appropriate. Care plan documentation guidelines: actual or potential individualized resident centered problems, goals, and approaches. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility ' s policy and procedure (P&P), titled, Behavioral Health Services, dated October 2022, the facility utilizes the comprehensive assessment process for identifying and assessing a resident ' s mental and psychosocial status and providing person-centered care. This process includes, but not limited to ongoing monitoring of mood and behavior and care plan development and implementation.