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	11/08/2024

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 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** 45537 Based on interview and record review, the facility failed to ensure the care plan for one of four sampled residents (Resident 1) was revised when Resident 1 had two unwitnessed falls on 10/4/2024 and 10/12/24 and the fall risk assessments on 9/17/2024 and 10/14/2024 identified Resident 1 as high risk for falls. These deficient practices resulted in Resident 1 ' s third unwitnessed fall and subsequent injury on 10/17/2024, when Resident 1 was found on the floor with bleeding on the top of the right side of his head, and later at a General Acute Care Hospital (GACH) was assessed with a subdural hematoma (bleeding in the area between the brain and the skull Findings: 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 Parkinsonism (an umbrella term that refers to brain conditions that cause slowed movements, rigidity [stiffness] and tremors), osteoporosis (a condition in which bones become weak and brittle) and a history of falls. During a review of Resident 1 ' s Minimum Data Set ([MDS] a resident assessment too) dated 9/17/2024, the MDS indicated Resident 1 was able to make decisions that were reasonable and consistent and needed a one person assist to complete his activities of daily living ([ADLs] routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) such as positioning from a sitting to standing position, chair/bed to chair transfer and toilet transfer. During a review of Resident 1 ' s Fall Risk assessment dated [DATE] and timed at 11:20 a.m., the Fall Risk Assessment indicated a score of 55 (a score of 45 and higher, was considered high risk for falls). The Fall Risk Assessment indicated, Resident 1 had a weak gait (pattern of walking), overestimates his abilities, forgets his functional limitations and needed a front wheel walker ([FWW] a mobility aid designed for people who were unstable walking or who have difficulty walking), to ambulate (the ability to walk from place to place). (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

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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 Care Plan, revised 1/22/2024, the Care Plan indicated Resident 1 had a risk for falls and injuries related to his medications and medical factors such as hypotension (low blood pressure [BP]) and Parkinson ' s disease. The Care Plan ' s goals indicated to minimize and manage Resident 1 ' s risks for falls. The Care Plan ' s interventions included assessing Resident 1 ' s toileting needs, encouraging him to use the call light, placing his personal belongings within reach and observing Resident 1 for side effects of medications. During a review of Resident 1 ' s Situation, Background, Assessment, Recommendation ([SBAR] a communication tool used by healthcare workers when there is a change is condition among the residents) Fall Report of Incident dated 10/4/2024 and timed at 9:23 p.m., the SBAR indicated Resident 1 had an unwitnessed or suspected fall incident and was found in his room on the right side of his bed with skin tears on his right arm. During a review of Resident 1 ' s Interdisciplinary Team ([IDT] a group of healthcare professionals with various areas of expertise who work together toward the goals of their residents and/or clients) Meeting Notes dated 10/8/2024 (no time was indicated), the IDT Meeting Notes indicated Resident 1 rolled off his bed and fell on the side of his bed. The IDT Meeting Notes indicated an Xray (a procedure used to capture pictures of the inside of the body) of the Cervical Spine (the bony part of the neck that supports the skull and allows for movement) was ordered. During a review of Resident 1 ' s Cervical Spine Xray dated 10/8/2024 and timed at 9:43 a.m., the Cervical Spine Xray indicated Resident 1 had subluxation (partially dislocated joints) of the cervical 3 and cervical 4 bones (the bones on the neck area of the backbone) and there was disc narrowing (narrowing of the spinal canal that occurs when the space around the spinal cord become too narrow) of the spine (back bone). During a review of Resident 1 ' s SBAR Fall Report of Incident dated 10/12/2024 and timed at 3:08 a.m., the SBAR indicated Resident 1 had an unwitnessed or suspected fall and was found on the floor by his bedside. The SBAR indicated Resident 1 reported to staff he was changing position in bed when he fell . During a review of Resident 1 ' s Fall Risk assessment dated [DATE] and timed at 8:49 a.m., the Fall Risk Assessment indicated a score of 80. The Fall Risk Assessment indicated Resident 1 had fallen in the last three months, had a weak gait and required a FWW on ambulation, overestimates his abilities and forgets his functional limitations. During a review of Resident 1 ' s SBAR Fall Report of Incident dated 10/17/2024 and timed at 3:38 p.m., the SBAR indicated Resident 1 had an unwitnessed or suspected fall incident. The SBAR indicated Resident 1 was found on the floor with superficial bleeding on the right top side of his head. The SBAR indicated because of a change in Resident 1 ' s level of consciousness (unspecified) the paramedics were called at 2:25 p.m., however, when the paramedics arrived at the facility at 2:32 p.m., Resident 1 refused to be transferred to the General Acute Care Hospital (GACH). During a review of Resident 1 ' s Nursing Progress Notes dated 10/17/2024 and timed at 7:19 p.m., the Nursing Progress Notes indicated Resident 1 agreed to be transferred to the GACH and was transported by a regular ambulance to the GACH at 7 p.m. (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 Transfer Form dated 10/17/2024 and timed at 6:50 p.m., the Transfer Form indicated Resident 1 was transferred to GACH due to a fall. During a review of the GACH ' s Emergency Department (ED) documentation dated 10/17/2024 and timed at 7:25 p.m., the ED documentation indicated Resident 1 presented with head pain, blood to the right side of his head and a 7 out of 10 pain level, on an eleven point pain scale, (where pain is rated from zero to 10; 0=no pain, 1-3=mild pain, 4-6=moderate pain, and 7-10=severe pain, and 10=worst imaginable pain) to the right lateral (the side that is away from the middle or center of) side of his chest after suffering an unwitnessed ground level fall. The ED documentation indicated Resident 1 had a Computerized Tomography scan ([CT] a diagnostic imaging procedure that uses a combination of X rays and computer technology to produce images of the inside of the body) of the cervical spine on 10/17/2024 at 9:12 p.m. The CT scan indicated Resident 1 had a contusion (a bruise) and hematoma (an abnormal pooling of blood in the body under the skin that results from a broken or ruptured blood vessel) to the left suboccipital (underneath the back of the skull) scalp extending over the left upper neck. The ED documentation indicated Resident 1 had a CT scan of his head on 10/17/2024 at 9:34 p.m. The CT scan of Resident 1 ' s head indicated Resident 1 had a trace subdural hemorrhage along the anterior falcine (an area of the skull that separates the left and right hemisphere [two halves of the brain] of the brain) and was admitted to the Intensive Care Unit ([ICU] a specialized treatment given to patients who are acutely unwell and require medical care) for frequent neurologic (pertaining to the brain and nerves) checks and close monitoring. During a review of GACH ' s Neurosurgery (a medical specialty concerned with the diagnosis and treatment of patient with an injury or disorders to the brain and spinal column [backbone]) Consultation Notes dated 10/19/2024 and timed at 12:44 a.m., the Neurosurgery Consultation Notes indicated no neurosurgical intervention was needed; however, Resident 1 should be observed with strict fall precautions. During an interview on 11/6/2024 at 2:35 p.m., Resident 1 stated, there were times he would not use his call light and would try to go to the bathroom on his own, especially if the nursing staff did not check on him or did not answer when he used his call light in a timely manner. During an interview on 11/6/2024 at 5:28 p.m., Certified Nursing Assistant 2 (CNA 2) stated she was not aware of Resident 1 ' s fall risk or any previous and/or recent fall incident before 10/12/2024, and the licensed nursing staff did not tell her about Resident 1 ' s plan of care. CNA 2 stated Resident 1 had a fall on 10/12/2024 on the 11 p.m. to 7 a.m. shift but she was not aware of how it happened. During a telephone interview on 11/7/2024 at 6:09 a.m., Registered Nurse Supervisor 1 (RNS 1) stated Resident 1 was coherent (speech was understandable and clear) with episodes of forgetfulness and he would try to do tasks beyond his capabilities. RNS 1 stated Resident 1 was at risk for falls and interventions such as frequent visual checks, offering help and assistance, cueing and anticipation of Resident 1 ' s needs should have been added to his care plan to prevent repeated fall incidents. (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 telephone interview on 11/7/2024 at 9:12 a.m., Responsible Party 1 (RP 1) stated Resident 1 could not move steadily and at times could be forgetful, he would not listen to instructions, and he would try to do tasks on his own. RP 1 stated she met with the facility a couple times and told them Resident 1 needed a bar to help him move in bed and floor mats on the floor in case he fell . RP 1 stated Resident 1 needed to be checked on frequently, given reminders, and supervised because Resident 1 had Parkinson ' s disease and had previous fall episodes at home. During an interview on 11/7/2024 at 12:17 p.m., CNA 3 stated Resident 1 told her he was trying to go to the bathroom, when he fell on [DATE] but he tripped and hit his head on the door. During an interview and record review on 11/7/2024 at 1:21 p.m., Licensed Vocational Nurse 2 (LVN 2) stated Resident 1 was forgetful and impulsive; however, those behaviors had not been added to Resident 1 ' s plan of care. LVN 2 confirmed Resident 1 had three recent episodes of unwitnessed falls on 10/4/2024, 10/12/2024 and 10/17/2024, and the fall risk assessments dated 9/17/2024 and10/14/2024 indicated Resident 1 was high risk for falls because of his weak gait, his overestimation of his abilities and forgetfulness of his functional limitations. LVN 2 stated Resident 1 ' s fall risk care plan should have been revised by the licensed nurses to reflect additional interventions to address Resident 1 ' s behaviors such frequent cueing, anticipation of Resident 1 ' s needs and offering support and/or assistance for tasks Resident 1 needed to complete, to prevent delay of care and services and to prevent fall incidents that could cause injuries and even death. During an interview on 4:14 p.m. the Director of Nursing Services (DON) stated all licensed nurses should update, revise, and modify residents ' plan of care based on the needs of the residents to ensure their safety. The DON stated Resident 1 ' s fall could have been prevented if interventions such as checking on his need for repositioning, use of the toilet were provided to Resident 1. During a review of the facility ' s Policy and Procedure (P/P) titled, Care plan, Comprehensive dated 12/2017, the P/P indicated the facility shall develop, in conjunction with the residents and their representatives, the Comprehensive Resident Care plan directed towards achieving and maintaining the optimal status of health, functional ability and quality of life of the residents, should be individualized through the identification of resident concerns, unique characteristics, strengths and individual needs and residents ' regularly evaluated to revise approaches and update as appropriate. During a review of the facility ' s Policy and Procedure (P/P) titled, Fall Prevention and Response revised 8/2023, the P/P indicated each resident of the facility will be assessed for fall risk factors and will receive care and services in accordance with individualized level of risk to minimize the likelihood of falls by implementing assessment of the residents ' risk factors utilizing a Fall Risk Assessment Scale, initiation and/or implementation of a comprehensive, resident centered fall prevention plans and/or interventions for each resident at risk for falls, or with a recent history of falls to minimize risk and reduce injuries.