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	03/28/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45537 Based on interview and record review, the facility failed to ensure the physician and Responsible Party (RP) for one of four sampled residents (Resident 1), who had a history of gastrointestinal bleeding ([GI] bleeding anywhere in the digestive tract from the mouth to the rectum), anemia (when the blood doesn ' t have enough healthy red blood cells and hemoglobin [a protein in the red blood cells that carries oxygen) to carry oxygen all through the body], and a low hemoglobin, were notified when Resident 1 refused to have his blood drawn in order to obtain a Complete Blood Count ([CBC] a common blood test that measures red blood cells {specialized cells in the blood that play a crucial role in transporting oxygen throughout the body}, white blood cells {a type of blood cell that play a crucial role in the body ' s immune system}, platelets {a tiny disc shaped pieces of cells in the blood that help stop bleeding by forming clots [a mass of blood that forms when clot platelets, proteins, and cells stick together] when a blood vessel is damaged}, hemoglobin and hematocrit} a measure of the proportion of red blood cells in the total volume of blood}, per the physician ' s order. This deficient Practice resulted in a delay Resident 1 ' s critical hemoglobin results of 6.7 grams per deciliter ([g/dl] a unit of measurement; reference range is 13.5 g/dl to 16.9 g/dl), abnormal hematocrit results of 21. 5%, (reference range is 39.5% to 50.0%), and abnormal platelet count results of 52,000 platelets per microliter ([mcl] with a reference range of 150, 000 to 400,000 platelets per mcl), due to Resident 1 ' s blood sample not being obtained. This deficient practice had the potential for Resident 1 to suffer severe complications such as heart failure, organ damage, and death. 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 diagnoses including GI bleed and anemia. During a review Resident 1 ' s Minimum Data Set ([MDS] a resident assessment tool) dated 2/5/2025, the MDS indicated Resident 1 was unable to make decisions for himself that were consistent and reasonable. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s Nursing Progress Notes dated 3/7/2025 and timed at 8:12 a.m., the Nursing Progress Notes indicated Resident 1 was hypotensive (low blood pressure [BP]) with a BP of 86/48 millimeters of mercury (mm/Hg). (reference range 120/80 mm/Hg). The Nursing Progress Notes indicated the paramedics were called but Resident 1 ' s Responsible Party (RP) refused to transfer Resident 1 to a GACH due to a paracentesis (a medical procedure that removes fluid from the abdominal cavity) appointment that was scheduled for that day (3/7/2025). The Nursing Progress Notes indicated Resident 1 ' s physician was aware and ordered a STAT CBC to be completed when Resident 1 returned from his appointment. During a review of Resident 1 ' s Order Summary Report (Physician ' s Order) dated 3/24/2025, the Physician ' s Order indicated a STAT CBC was ordered on 3/7/2025 at 8:28 a.m. and reordered at 2:20 p.m. upon Resident 1 ' s return to the facility from paracentesis appointment. During a review of Resident 1 ' s Nursing Progress Notes dated 3/7/2025 and timed at 2:20 p.m., the Nursing Progress Notes indicated Resident 1 returned to the facility after his paracentesis appointment and the lab was called to confirm Resident 1 ' s lab order for a STAT CBC. During a review of the laboratory ' s Dispatch Log dated 3/7/2025, the Dispatch log indicated a phlebotomist (a healthcare professional trained to collect blood samples from patients) attempted to draw Resident 1 ' s blood on 3/7/2025 at 10:09 p.m. but Resident 1 refused. During a review of Resident 1 ' s Nursing Progress Note dated 3/7/2025 on the 3 p.m. to 11 p.m. shift, the Nursing Progress Note indicated there was no documentation that Resident 1 ' s physician or RP were notified when Resident 1 refused to have his blood drawn. During a telephone interview on 3/25/2025 at 11:25 a.m., RP 1 stated she was not notified on 3/7/2025 during the 3 p.m. to 11 p.m. shift when Resident 1 refused to have his blood drawn and stated she should have been notified and allowed to make medical decision for Resident 1. During an interview on 3/20/2025 at 3:31 p.m., Registered Nurse Supervisor (RNS) 2 stated she worked on the 3 p.m., to 11 p.m., shift on 3/7/2025 and received a report from RNS 1, who worked the 7 a.m., to 3 p.m. shift (3/7/2025), that Resident 1 had an order for a STAT CBC. RNS 2 stated she processed the lab order but when the lab technician came to the facility (3/8/2025) Resident 1 refused to have his blood drawn. RNS 2 stated she did not call Resident 1 ' s physician to notify him that Resident 1 refused to have his blood drawn. RNS 2 stated she should have called the physician and Resident 1 ' s RP to notify them of Resident 1 ' s refusal and to allow Resident 1 ' s physician to give instructions for Resident 1 ' s care. During a telephone interview on 3/25/2025 at 1:24 p.m., Resident 1 ' s Physician stated Resident 1 had a GI bleed and had he been notified of Resident 1 ' s refusal to have his blood drawn, he could have reordered another lab or sent Resident 1 to the GACH to be evaluated, instead of waiting. During an interview on 3/26/2025 at 5:13 p.m., the Director of Nursing Services (DON) stated the licensed nursing staff are expected to call the primary physician and the RP to notify them when there is a COC and/or difficulty in completing an order. The DON stated staff should have notified Resident 1 ' s physician as well as his RP when Resident 1 refused to have his blood drawn to prevent a delay in the care of Resident 1. (continued on next page)

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F 0580 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 Resident Rights dated 10/2022, the P/P indicated the facility shall have the residents and their responsible parties be informed of, in advance and participate in, their treatment including changes of plan of care. During a review of the facility ' s P/P titled Change of Condition dated 2016, the P/P indicated the facility shall provide treatment and services to address changes in accordance with the residents ' needs by notifying the physician of the residents ' current status, assessment findings and subsequent actions. The P/P indicated the facility shall notify the resident and /or responsible party of the resident ' s current status and subsequent actions/orders

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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 0773 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45537 Based on interview and record review, the facility failed to ensure one of four sampled residents (Resident 1), who had a history of gastrointestinal bleeding ([GI] bleeding anywhere in the digestive tract from the mouth to the rectum), anemia (when the blood doesn ' t have enough healthy red blood cells and hemoglobin [a protein in the red blood cells that carries oxygen to carry oxygen all through the body), and a low hemoglobin, their Stat (immediate) laboratory (lab) order for a Complete Blood Count ([CBC] a common blood test that measures red blood cells {specialized cells in the blood that play a crucial role in transporting oxygen throughout the body}, white blood cells {a type of blood cell that play a crucial role in the body ' s immune system}, platelets {a tiny disc shaped pieces of cells in the blood that help stop bleeding by forming clots [a mass of blood that forms when clot platelets, proteins, and cells stick together] when a blood vessel is damaged}, hemoglobin and hematocrit}a measure of the proportion of red blood cells in the total volume of blood}, was carried out, per the physician ' s order, and followed up to ensure lab results were obtained promptly (within two to six hours). These deficient practices resulted in a delay in obtaining Resident 1 ' s blood specimen in order to obtain a STAT CBC causing a delay in the CBC test results. Resident 1 ' s hemoglobin was critically (a laboratory test result that indicates a life-threatening condition and requires immediate medical attention) low, which resulted in Resident 1 ' s admission to a General Acute Care Hospital (GACH), where he received one unit of blood and was subsequently admitted to the GACH ' s Telemetry unit because his condition was unstable. This deficient practice had the potential for Resident 1 to suffer severe complications such as heart failure, organ damage, and death. On 3/27/2025 at 3:23 p.m., an Immediate Jeopardy ([IJ] a situation in which the facility's noncompliance with one or more requirements of participation caused, or was likely to cause, serious injury, harm, impairment, or death to a resident) was called in the presence of the facility ' s Regional Administrator (ADM) and the Director of Nursing (DON) due to the facility ' s inability to provide laboratory services to Resident 1 as ordered by his physician. On 3/28/2025, the facility submitted an acceptable IJ Removal Plan ([IJRP] interventions to immediately correct the deficient practices). After an onsite verification of the facility ' s IJRP ' s implementation through observation, interview, and record review, the IJ was removed on 3/28/2025 at 4:45 p.m., in the presence of the facility ' s Designated ADM, the ADM in Training (A.I.T.), and the DON. The facility ' s IJRP included the following immediate actions: How the correction(s) will be accomplished for those residents found to have been affected by the deficient practice. (continued on next page)

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F 0773 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Resident 1 was readmitted to facility on 3/11/2025. No new STAT lab orders have been ordered since his readmission. Resident 1 has not refused any labs since readmission. Resident 1 ' s Alteration for Hematological care plan for lab orders and nursing interventions was updated on 3/27/2025 to include observing, reporting, and documenting signs and symptoms of anemia, monitoring vital signs every day and as needed (PRN) and notifying the Medical Doctor (MD) via phone of abnormalities. If abnormal labs are reported or the patient refuses lab work, the MD will be notified via phone and the MD will respond in like manner. The lab report and orders will be documented in the patient ' s chart under progress notes. The pending labs and results will be tracked via the communications tab in Point Click Care ([PCC] a software platform used for electronic health records), verbal reports from nurse to nurse and progress notes documented in PCC. If the results are late (2-6 hours for STAT labs), the nurse will call the lab to follow up, and if no result are available, the MD will be notified for further orders. If the patient ' s MD doesn ' t respond timely the Medical Director will be notified. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. On 3/25/2025, DON and Medical Records Director (MRD) audited and reviewed 16 residents with STAT lab orders from the prior three months for residents with diagnoses of Anemia, GI bleeding and low hemoglobin. The audit showed no other STAT lab orders were given in last three months, all other labs were done as ordered and reported timely. On 3/27/2025, the DON and MRD audited and reviewed 14 residents who had diagnoses of Anemia, GI bleeding and low hemoglobin care plans, for lab orders and nursing interventions. The care plans were reviewed and updated to reflect lab orders and nursing interventions including observing, reporting, documenting signs and symptoms of anemia, and monitoring vital signs every day and PRN, and notifying the MD via phone for abnormalities. What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur. The DON and Registered Nurse Supervisors (RNS) provided all licensed nurses (LN) in-service training beginning 3/20/2025 through 3/27/2025 and will continue until all active LNs have been in-serviced. In-services included Stat Lab orders included policy and procedures (P/P), timely reporting of labs, timely reporting of Change of Conditions (COC) and resident refusals to physicians. How to correctly communicate accurate orders to the lab to obtain STAT lab blood draws timely, following care plans for residents, follow up procedure for all stat lab orders, facility P/P for lab results, physician orders and COC and how to properly endorse resident status to oncoming shifts. Nursing staff are to use verbal endorsements and a written endorsement log between shifts to communicate pending labs/orders. Who will monitor to ensure compliance? (continued on next page)

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F 0773 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	1. The MRD, weekend RNS or designee will complete the audit of the endorsement log and PCC communications of all new STAT lab orders daily to ensure orders are completed, and results are obtained in a timely manner. 2. The DON or designee will review prior to daily stand up meeting any COC and/or refusal of the resident using the endorsement log and PCC to ensure staff communicate with the physician to allow the physician to assess the resident ' s care needs and give instructions for treatment. 3. The MRD, weekend RNS or designee will complete an audit of all STAT lab orders daily using the endorsement log and PCC to ensure that orders are followed up and results obtained in a timely manner. 4.The MRD, weekend RNS or designee will complete audit of new STAT lab orders daily using PCC to verify the communication between the lab and the nurse matches the physician ' s order. This is to ensure orders are communicated accurately to the lab to obtain STAT lab blood draws, and results are obtained in a timely manner. 5. The DON or designee will audit residents ' new or changed care plans pertaining to lab work or COCs during daily stand-up meetings. The Interdisciplinary Team (IDT) will review, and update care plans as needed to ensure they follow lab orders and that nursing interventions are measurable. 6. The MRD, weekend RNS or designee will complete an audit of all STAT lab orders daily to ensure orders are followed up on, and results are obtained in a timely manner. 7. The MRD, weekend RNS or designee will complete an audit of all STAT lab orders daily to ensure lab test results are completed and results are obtained and reported in a timely manner. The MRD or designee will audit any COCs and new physician orders prior to daily stand-up meetings to ensure physician orders and COC P/P are followed correctly. 8. The DON or designee will audit the shift endorsement log and PCC communications daily to ensure that facility staff are endorsing resident status and COCs to oncoming shifts for continuity of care. Facility plan to monitor the process and sustain compliance/Integrate into the Quality Assurance System. The DON or Administrator will report the findings of the audits to the Quality Assurance meeting monthly until sustained compliance is achieved for at least one month, then quarterly for 6 months or according to the Quality Assessment and Assurance (QAA) committee to ensure STAT lab orders are completed and results obtained and reported in a timely manner. 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 diagnoses including GI bleed and anemia. (continued on next page)

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F 0773 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During a review Resident 1 ' s Minimum Data Set ([MDS] a resident assessment tool) dated 2/5/2025, the MDS indicated Resident 1 was unable to make decisions for himself that were consistent and reasonable. During a review of Resident 1 ' s Care Plan on anemia dated 2/18/2025, the Care Plan indicated a goal for Resident 1 was to maintain his laboratory values within acceptable parameters and to be free from signs/symptom (s/s), and complications of anemia with interventions that included observing, documenting, and reporting to Resident 1 ' s physician any s/s of fatigue, dizziness, change in cognition, paleness, low hemoglobin, obtain and monitor laboratory work as ordered, report the results to Resident 1 ' s physician and follow up as indicated. During a review of Resident 1 ' s COC dated 3/5/2025 and timed at 5:37 a.m., the COC indicated Resident 1 had increased confusion, hit his right leg on the bed frame and was bleeding from a skin tear on his right lower leg. During a review Resident 1 ' s COC dated 3/5/2025 and timed at 6:01 a.m., the COC indicated Resident 1 was tired, more confused and drowsier after an incident of a bleeding from his right leg skin tear and swelling on his right lower leg. During a review of Resident 1 ' s Fall Incident Report dated 3/5/2025 and timed at 11:27 a.m., the Fall Incident Report indicated Resident 1 had an unwitnessed fall and was found on the floor near his bathroom with more confusion. During A review of Resident 1 ' s COC dated 3/6/2025 and timed at 2:09 p.m., the COC indicated Resident 1 had a small amount of black tarry stool (occurs when there is bleeding in the upper digestive system, black or brown in color, with a sticky consistency and may have an unpleasant odor), Resident 1 ' s physician ordered a STAT CBC. During a review of Resident 1 ' s Lab Results Report dated 3/6/2025 and timed at 8:05 p.m., the Lab Results Report indicated Resident 1 ' s hemoglobin result was 7.0 grams per deciliter ([g/dl] a unit of measurement; reference range is 13.5 g/dl to 16.9 g/dl). During a review of Resident 1 ' s Nursing Progress Notes dated 3/6/2025 and timed at 11:31 p.m., the Nursing Progress Notes indicated Resident 1 ' s physician was notified of Resident 1 ' s hemoglobin result, pending a response (order). During a review of Resident 1 ' s Nursing Progress Notes dated 3/7/2025 and timed at 8:12 a.m., the Nursing Progress Notes indicated Resident 1 was hypotensive (low blood pressure [BP]) with a BP of 86/48 millimeters of mercury (mm/Hg). (reference range 120/80 mm/Hg). The Nursing Progress Notes indicated the paramedics were called but Resident 1 ' s Responsible Party (RP) refused to transfer Resident 1 to a GACH due to a paracentesis (a medical procedure that removes fluid from the abdominal cavity) appointment that was scheduled for that day (3/7/2025). The Nursing Progress Notes indicated Resident 1 ' s physician was aware and ordered a STAT CBC to be completed when Resident 1 returned from his appointment. During a review of Resident 1 ' s Order Summary Report (Physician ' s Order) dated 3/24/2025, the Physician ' s Order indicated a STAT CBC was ordered on 3/7/2025 at 8:28 a.m. and reordered at 2:20 p.m. upon Resident 1 ' s return to the facility from paracentesis appointment. (continued on next page)

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F 0773 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During a review of Resident 1 ' s Nursing Progress Notes dated 3/7/2025 and timed at 2:20 p.m., the Nursing Progress Notes indicated Resident 1 returned to the facility after his paracentesis appointment and the lab was called to confirm Resident 1 ' s lab order for a STAT CBC. During a review of the Laboratory Call Log Recording on 3/7/2025 at 2:20 p.m., the Laboratory Call Log Recording indicated Licensed Vocational Nurse (LVN) 1 spoke to laboratory personnel indicating she was following up on an order for a CBC for Resident 1. The Laboratory Call Log Recording did not indicate that LVN 1 said the lab order was STAT. During a review of the laboratory ' s Dispatch Log dated 3/7/2025, the Dispatch Log indicated a phlebotomist (a healthcare professional trained to collect blood samples from patients) attempted to draw Resident 1 ' s blood on 3/7/2025 at 10:09 p.m. (approximately eight hours after the order was placed on 3/7/2025 at 2:20 p. m.) but Resident 1 refused. During a review of Resident 1 ' s untimed Nursing Progress Note dated 3/7/2025, the Nursing Progress Note indicated there was no documentation that Resident 1 ' s physician or RP were notified when Resident 1 refused to have his blood drawn. During a review of Resident 1 ' s Physician ' s order dated 3/7/2025, and timed at 11:59 p.m., the Physician ' s Order indicated a STAT CBC for Resident 1. During a review of Resident 1 ' s Lab Results Report dated 3/8/2025, the Lab Results Report indicated Resident 1 ' s labs were drawn on 3/8/2025, at 9:44 a.m., (almost 10 hours after the order was made on 3/7/2025 at 11:59 p.m.). The Lab Results Report indicated Resident 1 ' s hemoglobin result was critical at 6.7 g/dl, his hematocrit count was 21.5%, (reference range is 39.5% to 50.0%) and his platelet count was 52, 000 platelets per microliter ([mcl] with a reference range of 150, 000 to 400,000 platelets per mcl). The Lab Results Report indicated Resident 1 ' s lab results were available at 11 a.m., on 3/8/2025, and the lab attempted several times to notify the facility of Resident 1 ' s critical lab value but was unable to reach the facility until 3/8/2025 at 1:31 p.m., because no one at the facility picked up the phone. During a review of the Laboratory Call Log dated 3/8/2025, the Laboratory Call Log indicated lab personnel attempted to report Resident 1 ' s critical hemoglobin result to the facility at 11 a.m., 11:54 a.m., 12:19 p.m., 12:53 p.m., and 1:14 p.m. The Laboratory Call Log indicated Resident 1 ' s critical laboratory result (hemoglobin) was finally reported to the facility on [DATE] at 1:31 p.m. During a review of Resident 1 ' s Transfer Form dated 3/8/2025 and timed at 2:17 p.m., the Transfer Form indicated Resident 1 was transferred to a GACH at 3:30 p.m., due to black tarry stools, a decreased hemoglobin, a low hematocrit and a low platelet count. (continued on next page)

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F 0773 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During a review of the GACH ' s Emergency Department (ED) Note dated 3/8/2025 and timed at 4:10 p.m., the ED Note indicated Resident 1 was admitted to the ED with a chief complaint of three episodes of black tarry stools within two days, a hemoglobin of 6.7 g/dl, and a chronic (last for an extended period, typically, for three months or more) hematoma (a pool of mostly clotted blood that forms in an organ, tissue, or body space) to Resident 1 ' s lower extremities (legs). The ED Note indicated Resident 1 received 1 unit of packed red blood cells ([PRBC] a concentrated preparation of red blood cells [specialized cells that circulate in the blood steam] obtained from whole blood after the plasma {the liquid component of whole blood}is removed) and was admitted to the GACH ' s telemetry unit (a specialized ward where patients requiring continuous cardiac monitoring receive care) because his condition was unstable. During an interview on 3/20/2025 at 1:20 p.m., Registered Nurse Supervisor (RNS) 1 stated a STAT lab order should be completed within four hours and the lab result should be reported to the facility within two hours. During a subsequent interview on the same day at 2:05 p.m., RNS 1 stated Resident 1 had an order for a STAT CBC on 3/7/2025 at 8:28 a.m., but Resident 1 ' s blood was not drawn until 3/8/2024 at 9:44 a.m. RNS 1 stated there was a miscommunication between the licensed nursing staff on 3/7/2024 on all shifts which delayed Resident 1 ' s STAT lab order. RNS 1 stated there was no follow up on Resident 1 ' s lab order to ensure his labs were completed and results obtained. During an interview on 3/20/2025 at 3:31 p.m., RNS 2 stated she worked on the 3 p.m., to 11 p.m., shift on 3/7/2025 and received a report from RNS 1, who worked the 7 a.m., to 3 p.m. shift (3/7/2025), that Resident 1 had an order for a STAT CBC. RNS 2 stated she processed the lab order but when the lab technician came to the facility (3/8/2025) Resident 1 refused to have his blood drawn. During a subsequent interview on 3/24/2025 at 6:24 p.m., RNS 2 stated she reordered another STAT CBC for Resident 1 on 3/7/2025 11:59 p. m., and verbally endorsed the order to the 11 p.m. to 7 a.m. shift and documented the endorsement in the facility ' s communication board through their electronic medical record system. RNS 2 stated she did not call Resident 1 ' s physician to notify him that Resident 1 refused to have his blood drawn. RNS 2 stated she should have called the physician and Resident 1 ' s RP to notify them of Resident 1 ' s refusal and to allow Resident 1 ' s physician to give instructions for Resident 1 ' s care. During an interview on 3/20/2025 at 3:50 p.m., RNS 3, who worked from 7 a.m., to 3 p.m., on 3/8/2025, stated he did receive an endorsement from the 11 p.m., to 7 a.m. shift regarding a STAT CBC for Resident 1. RNS 3 stated he checked the facility ' s Electronic Communication Board after conducting resident rounds and saw an order for a STAT lab for Resident 1. RNS 3 stated the STAT lab order had not been completed and there was no documentation in Resident 1 ' s Progress Notes, why it had not been done. During a telephone interview on 3/25/2025 at 1:24 p.m., Resident 1 ' s Physician stated Resident 1 had a GI bleed and had he been notified of Resident 1 ' s refusal to have his blood drawn, he could have reordered another lab or sent Resident 1 to the GACH to be evaluated, instead of waiting. During an interview on 3/25/2025 at 2 p.m., the ADM acknowledged and stated there was a gap of time between Resident 1 ' s lab order and results of his labs caused by the licensed nursing staff. (continued on next page)

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	03/28/2025

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 0773 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 3/25/2025 at 5 p.m., after listening to the Laboratory Audio Call Log, LVN 1 stated she did not tell the lab that Resident 1 ' s lab order was STAT. LVN 1 stated she should have communicated with the lab that Resident 1 ' s lab order was STAT to ensure the labs were done based on the doctor ' s order and to prevent a delay in obtaining the blood sample and results. During an interview on 3/26/2025 at 5:13 p.m., the DON stated there was a lack of communication amongst the licensed nurses and because of that they did not ensure Resident 1 ' s lab were completed, and results obtained. The DON stated staff should have notified Resident 1 ' s physician as well as Resident 1 ' s RP when Resident 1 refused to have his blood drawn to prevent a delay in the care of Resident 1. During a review of the facility ' s P/P titled Processing Physician Orders dated 8/2017, the P/P indicated the facility shall maintain accuracy of physician orders to provide appropriate care and services related to patients/residents ' risks. During a review of the facility ' s undated P/P titled Reporting Laboratory Test Results the P/P indicated the facility shall ensure all emergency laboratory draws should have results in two to six hours.