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	06/25/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the following for two of five sampled residents (Resident 1 and Resident 5): 1. Failed to ensure Resident 1 did not develop a Moisture Associated Skin Damage (MASD: skin inflammation caused by prolonged exposure to various sources of moisture such as urine and stool) to her peri-area (region between the buttocks and female reproductive area). 2. Failed to ensure Resident 1's family was able to contact Resident 1 via telephone while residing in the facility. 3. Failed to address ongoing concerns expressed in written grievances for answering call lights for Resident 1 and Resident 5. A. During a review of Resident 1's admission Record (Face Sheet), the admission Record indicated Resident 1 was admitted to the facility 5/9/2025 with diagnoses including dislocation of right shoulder joint (two or more bones connect), injury of axillary (armpit) artery (major blood vessel in the upper limb that supplies blood to shoulder and arm put) on right side, and generalized muscle weakness. During a review of Resident 1's history and physical (H&P) dated 5/12/2025, the H&P indicated Resident 1 has the capacity to make decisions for herself. During a review of Resident 1's Minimum Data Set (MDS: a resident assessment tool) dated 5/16/2025, the MDS indicated Resident 1 was cognitively (having problems remembering things, concentrating, making decisions and solving problems) intact. The MDS indicated Resident 1 is dependent on chair/bed-to-chair transfer, toilet transfer, roll left and right, putting on footwear, required maximal assistance (provides more than half the effort) for toileting hygiene, bathing, upper (above waist) and lower body (waist below) dressing, personal hygiene, and required supervision for eating and oral hygiene. The MDS indicated Resident 1 is frequently incontinent (having no control) for both urine and bowel. 1. During a review of Resident 1's Treatment Administration Record (TAR: document that tracks the administration of medications and other treatments to residents) dated 5/1/2025-5/31/2025, the TAR indicated Resident 2 received treatment of Nystatin Powder (antifungal medication) 100,000 unit (system used to measure weight, distance, volume)/gram (gm: unit of mass) to apply to peri area every shift for MASD. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's progress note dated 5/22/2025 at 3:50 a.m., the progress note indicated Resident 1 was evaluated due to reported discomfort and visible irritation in the peri-area. The progress note indicated Resident 1's skin was erythematous, warm to touch, and shows signs of early maceration (the softening and breakdown of skin due to prolonged exposure to moisture). Resident 1 expressed pain during hygiene care related to prolonged exposure to urine. During a review of Resident 1's Change of Condition (COC) dated 5/22/2025 at 3:57a.m., the COC indicated Resident 1's groin area appeared to be inflamed, with moist erythematous (abnormally red) regions and visible signs of irritation in peri-genital area. The COC indicated to notify the doctor for topical treatment orders, implement more frequent incontinence checks and do prompt cleansing. During a review of the grievance/complaint resolution report dated 5/22/2025 at 10:25a.m., Resident 1's Family Member 1 (FM 1) filed a grievance report with an initial allegation date of 5/21/2025 during the 11:00p.m. to 7:00a.m. shift. The grievance report indicated FM G stated her concerns as Resident 1 had verbalized the CNAs during the 11:00p.m. to 7:00a.m. shift did not change her for the whole night. During a review of the grievance/complaint resolution report dated 6/2/2025 at 1:50p.m. was filed by FM 1 indicated Resident 1 stated it takes too long for the CNAs to change her. During an interview on 6/23/2025 at 9:29a.m. with FM 1, FM 1 stated Resident 1 had complained about not getting changed frequently. During an interview on 6/23/2025 at 2:43p.m. with Certified Nursing Assistant 2 (CNA 2), CNA 2 stated they have used sheets to cover Resident 1 as a diaper and has reported that she has not been cleaned all night. CNA 2 stated she has received in service for perineal care as no residents should be left like that. CNA 2 stated everyone should be able to answer the call lights to assist residents so see what they need to fulfill their needs. CNA 2 stated if no one responded to call lights, the residents could fall and hurt themselves. 2. During a review of the grievance/complaint resolution report dated 5/22/2025 at 11a.m., Resident 1's FM 1 filed a grievance report with an initial allegation date of 5/13/2025 during 5:00p.m. to 5:10p.m. The grievance indicated FM 1 complained on 5/13/2025, she called the facility multiple times around 5:00p.m. with no answer. The front desk phone log history indicated some calls were not being answered. During a record review on 5/30/2025 at 11:28a.m., an email was received from IT indicated the phone rings, but no one picked up on some calls. During a review of the grievance/complaint resolution report dated 6/2/2025 at 12:42p.m., Resident 1's FM 1 filed a grievance report with an initial allegation date of 5/31/2025 during 3:00 p.m. to 11:00 p.m., FM 1 expressed concerns again stating on 5/31/2025 at 10:21p.m., she called numerous times, however no one answered in the facility. The grievance report indicated the receptionist inspected the nursing station call log and front desk and identified that calls are not being transferred automatically to the nursing station after receptionist hours. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/23/2025 at 9:29a.m. with FM 1, FM 1 stated she has called the facility about 30 times, and they did not answer the phone calls. FM 1 stated she has been unable to get a hold of the facility ever since Resident 1 was admitted to the facility. During an interview on 6/23/2025 at 1:41p.m. with the Social Service Director (SSD), the SSD stated there were 4 grievances filed for Resident 1. SSD stated there is a receptionist from 7:00a.m. to 9:00p.m. every day and on the weekends, and after 9:00p.m., the calls go directly to the nursing station. The SSD stated there was an incident regarding the night shift (11:00p.m. to 7:00a.m.) not assisting Resident 1 and the phone calls not being answered. The SSD stated another issue about the phone not being answered after 9:00p.m. was brought to their attention two weeks later. The SSD stated the phone calls are supposed to go to the nursing station, however the phone was not getting transferred automatically after 9:00p.m. The SSD stated the family will feel worried if they cannot get a hold of the facility and indicated their phone system changed about 6 months ago. During a concurrent interview and record review on 6/24/2025 at 3:14p.m. with the Receptionist (RECPST), the RECPST stated during the first incident on the grievance dated 5/22/2025, some of the calls were not picked up because they were on the line with someone. RECPST stated she was not sure if someone just neglected the calls. The RECPST stated she saw a number that was called multiple times and indicated this was a technical issue and should have been set for all calls to be transferred automatically to the nursing station after hours. The RECPST stated if they had full control over their phone system, this could have been avoided. B. During a review of Resident 5's Face Sheet, the admission Record indicated Resident 5 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including fracture of unspecified part of right clavicle (collarbone: long curved bone that connects arm to body), rheumatoid arthritis (a chronic progressive disease-causing inflammation in the joints and resulting in painful deformity and immobility), and systemic lupus erythematosus (chronic autoimmune disease where the body immune system attacks health tissues and organs). During a review of Resident 5's H&P dated 3/1/2025, the H&P indicated Resident 5 has the capacity to make her own medical decisions at this time. During a review of Resident 5's MDS dated [DATE], the MDS indicated Resident 5 was cognitively intact. The MDS indicated Resident 5 required maximal assistance for toileting hygiene, bathing, lower body dressing, chair/bed-to-chair transfer, toilet transfer, and required moderate assistance (provides less than half the effort) for eating, oral hygiene, upper body dressing, and personal hygiene. 3.During a review of the Resident Council Meeting Minutes dated 3/27/2025, the Resident Council Minutes indicated a resident (un-named) had noticed their roommates call light is always disconnected and is worried if she needs the call light, no one will get her attention. During a review of the Resident Council Meeting Minutes dated 5/15/2025, the Resident Council Meeting Minutes indicated on 5/14/2025 during the 3:00p.m. to 11:00p.m. shift, a resident has waited almost 2 hours for her call light to be answered. During a review of the Resident Council Meeting Minutes dated 6/19/2025, the Resident Council Meeting Minutes indicated call lights were not being answered in a timely manner and licensed staff need to help out when Certified Nurse Assistants (CNA) are not available. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/24/2025 at 3:31p.m. with the Director of Nursing (DON), the DON stated an in service regarding the family member not being able to reach the facility was done and indicated this incident could have been avoided if there was an open and proper communication. The DON stated from the first grievance that was filed, the second incident of the family not being able to get a hold of the facility should have been avoided. The DON stated everyone answers call lights and should be answered in a timely manner. The DON stated if no one answered call lights, the residents could develop skin issues. During a review of the facility's policy and procedure (P&P) titled, Resident Rights dated 10/2022, the P&P indicated the facility will ensure that all direct and indirect care staff members, including contractors and volunteers, are educated on the rights of residents and the responsibility of the facility to properly care for its residents. The resident has the right to be informed of, and participate in, his or her treatment, including the right to receive the services and/or items included in the plan of care. The resident has the right to be treated with respect and dignity, including: the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences. During a review of the facility's P&P titled, Call Lights: Accessibility and Timely Response dated 10/28/2023, the P&P indicated all staff members who see or hear an activated call light are responsible for responding. If the staff member cannot provide what the resident desires, the appropriate personnel should be notified. During a review of the facility's policy and procedure (P&P) titled, Dignity-Promoting/Maintaining Dignity dated 10/2022, the P&P indicated it is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality. Staff members involved in providing care or interacting with residents must promote and maintain resident dignity and respect's Resident Rights. Respond to requests for assistance in a timely and courteous manner.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure one out of four sampled residents (Resident 2) received care and services to promote wound healing and to prevent worsening pressure injuries (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) from occurring by failing to implement interventions such as a special low air-loss mattress (designed to prevent pressure injuries, treat pressure injuries) and vitamin supplements such as zinc (mineral that plays a crucial role in numerous bodily functions, including immune system support and wound healing), vitamin C (form protein called collagen to make skin and blood vessels), and a multivitamin (dietary supplement that provides foundational support for daily nutritional needs that is not taken through diet) to promote wound healing for Resident 2. This deficient practice resulted in Resident 2's sacrococcyx (fused bone structure that consist of the sacrum [triangular bone at the base of the spine] and coccyx [tail bone]) wound progressing from a stage I (non-blanchable redness of intact skin indicating localized damage due to pressure) to a stage 2 (skin loss appearing as a shallow open ulcer with a red or pink wound bed) with a deep tissue pressure injury (DTI: a form of pressure-induced damage to underlying tissues, including muscles, bones, and subcutaneous layers, while the skin surface might remain intact leading to decreased blood flow and dead tissue). During a review of Resident 2's admission Record (Face Sheet), the admission Record indicated Resident 2 was admitted to the facility 5/19/2025 with diagnoses including radiculopathy (condition caused by pinched nerve in your spine that leads to pain, numbness, and weakness), vertebrogenic low back pain (low chronic back pain caused by layers of bone and cartilage at the top and bottom of each back bone become damaged), fusion of spine (surgical procedure that connects two or more bones in the spine to alleviate pain and restore stability), and Type II Diabetes Mellitus (a chronic disease that affects how the body processes sugar). During a review of Resident 2's history and physical (H&P: initial visit and evaluation) dated 5/21/2025, the H&P indicated Resident 2 does not have the capacity to make decisions for himself but can make needs known. During a review of Resident 2's minimum data set (MDS: a resident assessment tool) dated 5/28/2025, the MDS indicated Resident 2 was cognitively (mental action or process of acquiring knowledge and understanding ability) intact. The MDS indicated Resident 2 is dependent on chair/bed-to-chair transfer, shower transfer, required maximal assistance (provides more than half the effort) for toileting hygiene, bathing, lower body (waist below) dressing, sit to lying, lying to sitting on side of bed, required supervision for rolling left to right), and required set up for eating, oral hygiene, and personal hygiene. The MDS indicated Resident 2 was frequently incontinent for both bowl and bladder. During a review of Resident 2's CP untitled, dated 5/20/2025, the CP indicated actual pressure ulcer; sacrococcyx pressure injury stage 1. The CP interventions included to notify MD as needed if ulcer fails to show progress in healing and provide offloading of ulcer site. During a review of Resident 2's Order Summary Report dated 6/23/2025, the report indicated Resident 2 had the following wound care orders placed: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1.Sacrococcyx pressure injury stage 1: cleanse with normal saline station (NSS: a mixture of salt and water used to clean wounds, hydration), pat dry. Apply zinc oxide (medication applied to specific area of the body to aid in wound healing and act as a skin protectant) and leave open to air (LOA) every shift ordered 5/20/2025. 2. Sacrococcyx with non-blanchable redness moist: cleanse with NSS, pat dry. Apply zinc oxide and leave open to air every shift ordered 5/20/2025. During a review of Resident 2's Skin Inspection assessment dated [DATE] at 9:08 a.m., the skin inspection assessment indicated Resident 2 had a sacrococcyx area pressure injury stage I. During a review of Resident 2's Skin Inspection assessment dated [DATE] at 9:57a.m., the skin inspection assessment indicated Resident 2 had a sacrococcyx pressure injury stage II with surrounding area DTI measuring size 6cm x 5cm x 0.1cm, eight days later. During a review of the Braden Scale (assessment tool used to predict a resident's risk of developing pressure injuries) dated 5/19/2025 at 7:28p.m., the Braden Scale indicated Resident 2 was at moderate risk (score range 13-14) with a score of 13. During a review of the Braden Scale dated 5/26/2025 at 12:54p.m., the Braden Scale indicated Resident 2 was at risk (score range 15-18) with a score of 18. During an interview on 6/23/2025 at 11:39 a.m. with the Infection Preventionist Nurse (IPN), the IPN stated residents who are bed bound or residents who have a stage II to stage IV (deep wounds that may impact muscle, tendons, ligaments, and bone) need a low air mattress. During a concurrent interview and record review on 6/24/2025 at 2:09 p.m. with the Treatment Nurse (TXN), the TXN stated the primary physician (MD 1) will give an order for a wound consult and indicated if she notices a stage II (open) pressure ulcer during the wound assessment, she will request a wound consult from the MD 1. The TXN 1 stated Resident 2's sacrococcyx wound was getting worse because he only had a stage I on 5/20/2025, but on the day of discharge (5/28/2025), when she checked his skin, it got worse. The TXN stated if a resident has a stage II or if a wound became worse, she would request supplements or nourishments from the MD. The TXN stated Resident 2's did not have any vitamins ordered by the MD. During an interview on 6/24/2025 at 2:50p.m. with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated the day she noticed any changes to Resident 2's skin was on the day of his discharge on [DATE]. During an interview on 6/24/2025 at 6:22p.m. with Family Member 2 (FM 2), FM 2 stated Resident 2's wound was getting worse, and he should not go home. FM 2 stated she believes Resident 2 was not getting turned at the facility. During a concurrent interview and record review on 6/25/2025 at 3:47p.m. with Dietary Assistant Manager (DAM), the DAM stated if a resident has altered nutrition with a wound, she will inform the dietitian, review the resident, and would order vitamins, zinc with the treatment nurse and provide protein. The DAM stated she did not see any vitamin C or zinc orders for Resident 2 and indicated they should have been recommended. The DAM stated it is important for residents to receive adequate nutrition and hydration to promote wound healing. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/25/2025 at 4:50p.m. with MD 1, MD 1 stated he was aware of Resident 2's stage I pressure injury upon admission MD 1 stated ordering vitamin supplements for Resident 2 would have been beneficial since Resident 1 came to the facility with a wound and the supplements (Vitamin C, Multivitamins) would aid in wound healing. During a concurrent interview and record review on 6/25/2026 at 5:10p.m. with the DON, the DON stated if Resident 2's stay at the facility was short, it might have been preventable. The DON stated on the IDT initial assessment date 5/19/2025, the skin integrity is assessed by the RD, DON, and TXN. The DON stated the RD was not present during the initial assessment for the IDT to give recommendations. During a review of the facility's policy and procedure (P&P) titled, Resident Rights dated 10/2022, the P&P indicated the facility will ensure that all direct and indirect care staff members, including contractors and volunteers, are educated on the rights of residents and the responsibility of the facility to properly care for its residents. The resident has the right to be informed of, and participate in, his or her treatment, including the right to receive the services and/or items included in the plan of care. The resident has the right to be treated with respect and dignity, including: the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences. During a review of the facility's P&P titled, Title: Nutrition Assessment, dated 2/09, the P&P indicated each resident receives a comprehensive nutritional assessment upon admission and annually and whenever a resident is identified as having a significant change in status. The Nutritional Screening and Assessment includes the information noted on the form as well as additional pertinent information with may include: a. Physical appearance, noting any signs of malnutrition or dehydration b. Vitamin and mineral supplements c. Condition of the skin, noting any pressure ulcers or wounds d. Identification of medical nutritional therapy needs goals and approaches that will be addressed on the interdisciplinary plan of care During a review of the facility's P&P titled, Title: Nutritional Wound Therapy, dated 2/09, the P&P indicated purpose: to provide appropriate nutrition to prevent development of wounds. To facilitate healing of wounds while considering resident's individual preferences and needs. All residents with wounds will be assessed and documented upon by nursing and a Registered Dietitian. Based on a review of the medical record, interviews with the resident and caregivers, and observation of the resident at meals, a Registered Dietitian should evaluate the resident's nutritional status, write a nutritional assessment, and make recommendations for medical nutrition therapy in conjunction with nursing. The assessment of residents should include: 1. Diagnosis and recent changes in condition. 2. Risk factors for pressure ulcer development: immobility (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Below 18 score on a Braden Skin Risk Assessment (identify current skin condition). 4. Food and fluid intake adequacy compared to calculated nutritional needs (calories, protein, Vitamin C, Zinc, fluids). 5. Nutrition-related lab values (albumin, hemoglobin, serum transferrin, additional indicators: pre-albumin, cholesterol, hematocrit, and serum cholesterol). During a review of the facility's P&P titled, Registered Dietitian, undated, the P&P indicated: evaluate the nutrition care of residents and document in the medical record, using the Company formulary, recommends dietary interventions according to the status of the resident, provide high quality service to everyone, as though they are your 'family,' and takes the initiative whenever they can to identify clinical or service problems, identify solutions, and works with our fellow employees and managers to implement them.