

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055818	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2024
NAME OF PROVIDER OR SUPPLIER Royal Gardens Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 2339 W. Valley Blvd. Alhambra, CA 91803	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48152</p> <p>Based on interview and record review, the facility failed to ensure Resident 1 was free from physical abuse (an act where one person uses their body to inflict intentional harm or injury upon another person) when struck by Resident 2 in the face.</p> <p>This failure resulted in preventable and unnecessary physical abuse with the potential for emotional and mental trauma for Resident 1.</p> <p>Findings:</p> <p>A review of Resident 1's Admission Record indicated Resident 1 was readmitted to the facility on [DATE] with diagnoses that included difficulty in walking, type 2 diabetes mellitus (DM2 - condition that results in too much sugar circulating in the blood), dementia (a condition characterized by progressive or persistent loss of intellectual functioning) and chronic kidney disease (CKD - longstanding disease of the kidneys leading to failure).</p> <p>A review of Resident 1's Minimum Data Set (MDS - a standardized resident assessment care screening tool), dated 4/8/2024, indicated Resident 1 with severely impaired cognitive skills (ability to think, remember, and reason), set up assistance level (resident completes activity, staff assist only prior to or following the activity) with eating and oral hygiene and supervision/touching assistance level (staff may provide verbal cues and/or touching contact) for toileting, bathing and personal hygiene.</p> <p>A review of Resident 1's Change in Condition Evaluation, dated 6/19/2024, indicated Resident 1 was in activity room and received physical aggression from another resident.</p> <p>A review of Resident 1's Physical Aggression Received care plan, dated 6/19/2024 indicated the goals for Resident 1 to remain free of injuries and not experience any emotional distress.</p> <p>A review of Resident 1's Risk for Emotional Distress care plan (a document that outlines the facility's plan to provide personalized care to a resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs), initiated 6/19/2024, indicated Resident 1 was alleged slapped on the face by another resident in the facility.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 1's Psychiatric Follow-up/Therapy note, dated 6/26/2024, indicated Resident 1 was slapped by another resident on 6/19/2024.</p> <p>A review of Resident 2's Admission Record indicated Resident 2 was readmitted to the facility on [DATE] with diagnoses that included unspecified psychosis (severe mental condition involving abnormal thinking, perceptions, and loss of contact with reality), gastro-esophageal reflux disease (GERD - chronic digestive disease where the contents of the stomach refluxes and irritates the esophagus) and essential hypertension (abnormal high blood pressure that is not the result of a medical condition).</p> <p>A review of Resident 2's H&P, dated 2/23/2023, indicated Resident 2 cannot make own decisions but can make needs known.</p> <p>A review of Resident 2's Episode of Physical Altercation with Another Resident care plan initiated 10/31/2023, indicated the goal for Resident 2 to have no incidence of physical altercations and that staff will monitor as needed any signs of Resident 2 posing danger to self or others.</p> <p>A review of Resident 2's MDS, dated [DATE], indicated Resident 2 with moderately impaired cognitive skills, set up assistance level (resident completes activity, staff assist only prior to or following the activity) with eating, oral and personal hygiene, and supervision/touching assistance level (staff may provide verbal cues and/or touching contact) for toileting and bathing.</p> <p>A review of Resident 2's MAR, dated 6/20/2024, indicated an order for psychiatric evaluation (assesses a person's mental health status) s/p physical aggression (of Resident 2).</p> <p>A review of Resident 2's Change in Condition Evaluation, dated 6/19/2024, indicated Resident 2 was in the activity room, Resident 2 had increased agitation and aggression towards another resident and slapped a resident (Resident 1) on their left cheek.</p> <p>A review of Resident 2's Psychiatric Follow-up/Therapy note, dated 6/26/2024, indicated Resident 2 was in a physical altercation with a resident on 6/19/2024.</p> <p>During an interview on 7/2/2024 at 1:04 PM with the Director of Nursing (DON), the DON stated there was an altercation between Resident 1 and 2 on 6/19/2024 and after looking into it, we determined it was physical contact made.</p> <p>During an interview on 7/2/2024 at 2:37 PM with Infection Preventionist Nurse (IPN), IPN stated on 6/19/2024 around 5:45 PM, he went into the facility activities room and saw Resident 2 motioned to slap Resident 1.</p> <p>During an interview on 7/2/2024 at 3:11 PM with Assistant Activities Director (AAD), AAD stated on 6/19/2024 around 5:40 PM in the activities room, he heard Resident 2 shouting at Resident 1 and then hit Resident 1 on his forehead.</p> <p>During an interview on 7/3/2024 at 2:35 PM with Registered Nurse Supervisor (RNS), RNS stated on 6/19/2024 there was incident between Resident 1 and 2 where Resident 2 hit Resident 2 on the left cheek.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 7/3/2024 at 4:12 PM with LVN 2, LVN 2 stated on 6/19/2024, around 4 PM she witnessed Resident 2 yelling at Resident 1 in the activities room and asked Resident 2 to calm down while asking Resident 1 to move to another table and lefty the activities room. LVN 2 stated she returned to the activity room approximately 15 mins later after hearing a loud voice coming from the activities room and she entered to see Resident 2 standing in front of Resident 1 (at the new table) and hit Resident 1 in the face. LVN 2 stated I saw in the cheek, left cheek Resident 2 actually hit Resident 1. LVN stated at the time of the incident, there was no staff in the activities room, so she yelled for help then IP, AAD and RNS entered the activities room and assisted with removing Resident 2 and initiating facility protocol for resident- to- resident altercation. LVN 2 also stated Resident 1 had redness in the face that subsided after the ice pack was used.</p> <p>A review of facility's policy and procedure (P&P) titled Abuse Prevention Program, revised 12/2016, indicated:</p> <ol style="list-style-type: none"> 1. Residents have the right to be free from abuse including physical abuse. 2. Facility will protect residents from abuse by anyone including other residents. 3. Implement measures to address factors that may lead to abusive situations. 		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48152</p> <p>Based on interview and record review, facility failed to revise the care plan (a document that outlines the facility's plan to provide personalized care to a resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs) for one of one resident (Resident 2), to include revised specific interventions for the care and safety of Resident 2 after a physical altercation with Resident 1.</p> <p>This failure had the potential for Resident 2 to receive care that is not revised to meet the changes in his condition and needs, which could result in decreased quality of care and safety for Resident 2 and other residents in the facility.</p> <p>Findings:</p> <p>A review of Resident 2's Admission Record indicated Resident 2 was readmitted to the facility on [DATE] with diagnoses that included unspecified psychosis (severe mental condition involving abnormal thinking, perceptions, and loss of contact with reality), gastro-esophageal reflux disease (GERD - chronic digestive disease where the contents of the stomach refluxes and irritates the esophagus) and essential hypertension (abnormal high blood pressure that is not the result of a medical condition).</p> <p>A review of Resident 2's History & Physical (H&P), dated 2/23/2023, indicated Resident 2 cannot make own decisions but can make needs known.</p> <p>A review of Resident 2's Minimum Data Set (MDS - a standardized resident assessment care screening tool), dated 4/19/2024, indicated Resident 2 with moderately impaired cognitive skills, set up assistance level (resident completes activity, staff assist only prior to or following the activity) with eating, oral and personal hygiene and supervision/touching assistance level (staff may provide verbal cues and/or touching contact) for toileting and bathing.</p> <p>A review of Resident 2's Change in Condition Evaluation, dated 6/19/2024, indicated Resident 2 was in the activity room, Resident 2 had increased agitation and aggression towards another resident and slapped a resident on their left cheek.</p> <p>A review of Resident 2's Psychiatric Follow-up/Therapy note, dated 6/26/2024, indicated Resident 2 was in a physical altercation with a resident on 6/19/2024.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent record review and interview on 7/3/2024 at 2:35 PM with Registered Nurse Supervisor (RNS), Resident 2's With Episode of Physical Altercation with Another Resident care plan revised on 6/19/2024, indicated the revised intervention of notifying police, ombudsman, and California Department of Public Health per facility protocol. RNS states the care plan did not have new interventions added for Resident 2's physical incident with another resident (Resident 1) on 6/19/2024 and there should have been new interventions and goals added for this new incident to allow staff to monitor what is happening and the resident's behavior. RNS stated examples of appropriate revisions in the interventions include doing constant checks, if aggressive separate the residents instead of waiting and make sure they are getting psychiatric evaluations (assesses a person's mental health status) and proper medications. RNS also stated without having new goals and interventions developed and implemented, staff cannot prevent an incident of physical altercation from happening again and Resident 2 could injure himself or others.</p> <p>A review of facility's P&P titled Change in a Resident's Condition or Status, revised 2/2021, indicated a significant change of condition in the resident's status will not normally resolve itself without intervention by staff. and requires interdisciplinary review and/or revisions to the care plan.</p> <p>A review of facility's policy and procedure (P&P) titled Care Plans, Comprehensive Person-Centered, revised 3/2022, indicated care plans are revised as information about the residents and the residents' conditions change.</p>		