

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  07/31/2024
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 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48152</p> <p>Based on interview and record review, the facility failed to ensure three of three sampled residents (Residents 1, 2 and 3) received consistent treatment to promote the healing and prevention of pressure ulcers (injury to skin and underlying tissue resulting from prolonged pressure on the skin) by failing provide treatments as ordered by physician.</p> <p>These deficient practices placed the Residents 1, 2 and 3 at risk of worsening of current pressure ulcers and increased chance for the development of new pressure ulcers.</p> <p>Findings:</p> <p>1. During a review of Resident 1's Admission Record, indicated Resident 1 was readmitted to the facility on [DATE] with diagnoses that included morbid obesity (a severe and dangerous level of being overweight that significantly and negatively impacts health and shortens the lifespan), generalized muscle weakness, congestive heart failure (CHF - a chronic condition in which a weakness of the heart leads to a buildup of fluid in the lungs) and type 2 diabetes mellitus (DM2 - condition that results in too much sugar circulating in the blood).</p> <p>During a review of Resident 1's History &amp; Physical (H&amp;P), dated 5/10/2024, indicated Resident 1 was readmitted to the facility with a sacral coccyx (low back area) deep tissue injury (DTI- purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear) and is competent to understand her medical condition.</p> <p>During a review of Resident 1's Minimum Data Set (MDS - a standardized resident assessment care screening tool), dated 5/15/2024, indicated Resident 1 with intact cognitive skills (ability to think, reason and remember). The MDS indicated Resident 1 was dependent (staff does all effort needed to complete activity) with toileting, bathing, lower body dressing, rolling left to right, and changing positions (including while lying, sitting and/or to stand). Resident 1's MDS also indicated Resident 1 had a Stage 2 pressure ulcer (partial thickness skin loss involving epidermis, dermis, or both and presents clinically as an abrasion, blister, or shallow crater) and a DTI, with treatments to include a pressure reducing device for bed, application of medications/ointments and nonsurgical dressings in addition to pressure ulcer/injury care.</p> <p>During a review of Resident 1's Order Summary Report, indicated the following:</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 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>a. Sacral coccyx DTI, apply zinc oxide (a medicated cream, ointment or paste that treats or prevents skin irritation like cuts, burns or diaper rash) on cleansed skin leave open to air for 14 days daily, ordered 5/11/2024.</p> <p>b. May have low airloss mattress (LAML- a type of mattress used for residents who are at risk of developing pressure sores or already have pressure sores) every shift for skin management, ordered 5/11/2024.</p> <p>c. Offload heels every shift for skin management, ordered 5/11/2024.</p> <p>d. Sacro-coccyx DTI, cleanse with normal saline (NS- a mixture of sodium chloride and water), pat dry, apply barrier cream daily, every day shift for skin management for 30 days, ordered 5/27/2024.</p> <p>During a review of Resident 1's Wound Care Evaluation, dated 5/20/2024, indicated Resident 1 had sacral coccyx DTI that measured 2.5 x 2.0 centimeters (cm, unit of measurement).</p> <p>During a review of Resident 1's Pressure Ulcer or Potential for Pressure Ulcer care plan, dated 5/11/2024, indicated staff interventions to administer treatments as ordered and follow facility policies for prevention/treatment of skin breakdown.</p> <p>During a review of Resident 1's Treatment Administration Record (TAR), dated 5/1/2024 through 6/30/2024, did not indicate licensed nurses' signature on the following dates:</p> <p>a. On 5/14/2024, Sacral coccyx DTI, zinc oxide application.</p> <p>b. On evening shifts of 5/19/2024, 5/26/2024, 5/30/2024, 5/31/2024, 6/18/2024 and day shift on 6/9/2024, LALM for skin management.</p> <p>c. On evening shifts of 5/19/2024, 5/26/2024, 5/30/2024, 5/31/2024, 6/18/2024 and day shift on 6/9/2024, heel offloading (elevating).</p> <p>d. On 6/9/2024, sacro-coccyx DTI, cleanse with NS and barrier cream application.</p> <p>2. During a review of Resident's 2 Admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses that included muscle wasting (deterioration of muscle tissue) and atrophy (decrease in size of an organ or tissue), stage 4 pressure ulcer (full thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer) of sacral (bone at the end of the spine) region and congestive heart failure (CHF - a chronic condition in which a weakness of the heart leads to a buildup of fluid in the lungs).</p> <p>During a review of Resident 2's MDS, dated [DATE], indicated Resident 2 has intact cognitive skills. The MDS indicated Resident 2 was maximal assistance (staff does more than half the effort to complete the activity) with toileting, bathing, lower body dressing and moderate assistance (staff does less than half the effort to complete the activity) with changing positions (including while lying, sitting and/or to stand).</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 2's H&amp;P, dated 4/3/2024, indicated Resident 3 was admitted to the facility with a stage 4 pressure ulcer of sacral region and is competent to understand her medical condition.</p> <p>During a review of Resident 2's Order Summary Report, indicated the following:</p> <p>a. Coccyx stage 4; cleanse with NS, pat dry, apply barrier cream, cover with dry dressing every dayshift for skin maintenance for 30 days, ordered 7/10/2024.</p> <p>b. Low air loss therapy bed for treatment and management of pressure ulcer every shift, check for functionality and correct weight setting, ordered 4/3/2024.</p> <p>c. Monitor LALM for any leakage and adjust static button according to resident's weight every shift, ordered 4/16/2024.</p> <p>During a review of Resident 2's TAR, dated 7/1/2024 through 7/31/2024, did not indicate licensed nurses' signature on the following dates:</p> <p>a. On 7/24/2024, coccyx stage 4, clean with NS, barrier cream application and dry dressing.</p> <p>b. On day shift 7/24/2024, evening shifts of 7/13/2024, 7/20/2024, 7/27/2024, 7/28/2024, and night shifts on 7/13/2024, 7/20/2024 and 7/26/2024, LALM for treatment and pressure ulcer management.</p> <p>c. On day shift 7/24/2024, evening shifts on 7/13/2024, 7/20/2024, 7/27/2024, 7/28/2024 and night shifts on 7/13/2024, 7/20/2024 and 7/26/2024, LALM leak and setting monitoring.</p> <p>3. During a review of Resident 3's Admission Record indicated Resident 3 was readmitted to the facility on [DATE] with diagnoses that included hemiplegia (paralysis of one side of the body) and hemiparesis (inability to move one side of the body), generalized muscle weakness (lack of muscle strength requiring extra effort to move) and unstageable pressure ulcer (full thickness tissue loss in which actual depth of the pressure ulcer is completely masked by slough [by-product of the inflammatory phase] and/or eschar [dead tissue that forms in the wound] bed of sacral region).</p> <p>During a review of Resident 3's MDS, dated [DATE], indicated Resident 3 has moderately impaired cognitive skills and was dependent assistance for toileting, bathing, lower body dressing, rolling left to right, and changing positions (including while lying and sitting). Resident 3's MDS also indicated Resident 3 had an unstageable pressure ulcer with treatments to include a pressure reducing device for bed, turning/repositioning program, application of medications/ointments and nonsurgical dressings in addition to pressure ulcer/injury care.</p> <p>During a review of Resident 's H&amp;P, dated 7/9/2024, indicated Resident 3 was readmitted to the facility with a pressure ulcer of sacral region and is not competent to understand her medical condition.</p> <p>During a review of Resident 3's Order Summary Report, indicated the following:</p> <p>a. Unstageable wound on sacrococcyx area extended to bilateral buttocks: clean with NS, pat dry, apply skin barrier, cover with dry dressing, every day and evening shift, ordered 4/17/2024.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>b. Monitor LALM for any leakage and adjust static button according to resident's weight every shift, ordered 7/8/2024.</p> <p>c. Unstageable wound on sacrococcyx area extended to bilateral buttocks: clean with wound cleaner, pat dry, apply skin barrier, cover with dry dressing, every shift, ordered 7/8/2024.</p> <p>d. LALM for wound healing and skin maintenance every day during the day shift, ordered 7/8/2024.</p> <p>During a review of Resident 3's TAR, dated 7/1/2025 through 7/31/2024, did not indicate licensed nurses' signature on the following dates:</p> <p>a. On day shift on 7/6/2024 and evening shifts on 7/6/2024 and 7/7/2024, unstageable wound on sacrococcyx area extended to bilateral buttocks, clean with NS, barrier cream application and dry dressing.</p> <p>b. On day shifts 7/6/2024, 7/7/2024, evening shifts on 7/6/2024, 7/20/2024, 7/27/2024 and night shifts on 7/20/2024, 7/26/2024 and 7/27/2024, LALM leak and setting monitoring.</p> <p>c. On evening shifts 7/20/2024, 7/27/2024 and night shifts on 7/20/2024, 7/26/2024 and 7/27/2024, unstageable wound on sacrococcyx area extended to bilateral buttocks: clean with wound cleanser, barrier cream application and dry dressing.</p> <p>During an interview on 7/30/2024 at 11:56 AM with Treatment Nurse 1 (TN 1), TN 1 stated a LALM improves pressure ulcer healing and prevents worsening and return of a pressure ulcer in a resident with a history of pressure ulcers. TN 1 also stated facility's policy is to document on the TAR during the shift what was the treatment provided and not to leave blank entries [no licensed staff signature], and a blank entry on the TAR indicates the treatment was not done. TN 1 stated the importance of providing treatments/services to the residents with pressure ulcers as ordered to ensure the wellbeing of the resident and prevent worsening of their pressure ulcer.</p> <p>During a review of the facility P&amp;P titled, Charting and Documentation, revised 7/2017, indicated all services provided to the resident shall be documented in the resident's medical record including medications administered and treatments performed. The policy also indicated documentation of treatments will include the date and time the treatment was provided, the name and title of the individual who provided the care, how the resident tolerated the treatment, whether the resident refused the treatment and the signature and title of the individual documenting.</p> <p>During a review of the facility policy and procedure (P&amp;P) titled Wound Management, dated 4/1/2023, indicated the purpose of the policy is for residents with wounds [including pressure ulcers] to receive necessary treatment and services to promote healing and prevent infection and prevent new pressure ulcers from developing. The policy indicated licensed nurses will implement wound treatment per physician's order and utilize interventions for pressure redistribution and wound management per physician's order.</p>		