

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055899	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/01/2024
NAME OF PROVIDER OR SUPPLIER  Royal Palms Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  630 W. Broadway Glendale, CA 91204	

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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47467</b></p> <p>Based on interview, and record review, the facility failed to immediately contact and communicate with the attending physician/practitioner regarding any significant changes in the resident ' s status that may impact the dialysis portion of the care plan for one of two sampled residents (Resident 1), who required dialysis (a procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly) treatments. The facility ' s licensed nurse failed to notify Physician 1 on 4/13/2024 after Resident 1 missed his dialysis treatment due to transportation issues. In addition, the facility failed to promptly inform Physician 1 the second time, Resident 1 missed the second dialysis treatment rescheduled on 4/16/2024. Licensed Vocational Nurse (LVN) 1 notified Physician 1 on 4/17/2024 at 1 am.</p> <p>In addition, the facility staff did not inform resident ' s emergency contact (Family 1) of the missed dialysis treatments promptly as indicated in the facility policy and procedure on Change in Resident ' s Condition or Status.</p> <p>As a result, Resident 1 missed two dialysis treatments scheduled on 4/13/24 and 4/16/2024. In addition, Resident 1 was transferred to the General Acute Care Hospital (GACH) Emergency Department (ED) for weakness and lethargy. GACH 1 ED report dated 4/17/24 indicated Resident 1 was at risk for central nervous system [brain and spinal cord (a long, tube-like band of tissue that connects the brain to the lower back), cardiopulmonary (heart and lungs), metabolic (chemical changes that take place in a cell or an organism to produce energy and basic materials needed for important life processes), renal demise (dying of kidney) and required aggressive intervention.</p> <p>Findings:</p> <p>A review of the facility ' s Preadmission Report - Patient Analysis for Resident 1 dated 4/11/2023, indicated Resident 1 ' s diagnosis included being dialysis dependent with dialysis days being Tuesdays, Thursdays, and Saturdays. The Preadmission Report indicated blank under transportation.</p> <p>A review of Resident 1 ' s Admission Record indicated the facility admitted the resident on 4/11/24, with diagnoses that included chronic kidney disease (a condition in which the kidneys are damaged and cannot filter blood as well as they should), type 2 diabetes mellitus (a disease that occurs when the body ' s blood sugar is too high), dependence on renal dialysis, hypertension (high blood pressure). The Admission Record listed Family Member (FAM) 1 in the contact information as the Responsible Party for Resident 1.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 055899
		If continuation sheet Page 1 of 7

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<p>F 0580</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 History and Physical (H&amp;P), dated 4/11/2024, indicated Resident 1 had the capacity to make decisions or make needs known. The H&amp;P indicated Resident 1 had generalized weakness that needed maximal assist (helper does more than half the effort) for transfers, unable to balance sitting, standing and unable to ambulate.</p> <p>A review of Resident 1 ' s Clinical Physician Orders, dated 4/12/2024 (Friday), indicated Resident 1 had dialysis orders with chair time at 3:45 am to 7:30 am, scheduled every Tuesdays, Thursdays, and Saturdays.</p> <p>A review of an email communication from the facility ' s Admission Specialist (AS) dated 4/13/2024 timed at 9:56 am, addressed to the facility ' s corporate office and courtesy copies sent to the interim DON, Administrator (ADM), and the Admission Coordinator (ADC) indicated, We have an issue with transportation . The patient does not qualify for routine transportation, including dialysis, only for emergency to hospital . The courtesy ride did not show up to pick up patient today for dialysis per nursing notes.</p> <p>A review of Nursing Progress Notes dated 4/16/2024 timed at 6 am, the progress note authored by Licensed Vocational Nurse (LVN) 1 (11 pm to 7 am shift), indicated No transportation showed up to pick up resident for dialysis treatment. RN (registered nurse) made aware and followed up with dialysis. New schedule received for chair time (dialysis treatment] today at [1:30 pm]. Resident made aware.</p> <p>A review of the Nursing Progress Notes from 4/13/2024 to 4/16/2024, did not indicate an entry if attending physician/practitioner was notified of Resident 1 ' s missed dialysis treatments.</p> <p>A review of Resident 1 ' s Change in Condition Evaluation dated 4/17/2024, indicated LVN 1 notified Physician 1 on the missed dialysis treatments on 4/17/2024 timed at 1 am (11 pm to 7 am shift). The Change in Condition Evaluation indicated Physician 1 ordered to transfer Resident 1 to the GACH (GACH 1).</p> <p>A review of Resident 1 ' s Clinical Physician Orders, dated 4/17/2024, indicated to transfer the resident to the acute hospital (GACH 1) related to two missed dialysis treatments, poor intake, for treatment and further evaluation.</p> <p>A review of Resident 1 ' s GACH 1 record titled Physician History and Physical, dated 4/18/2024 timed at 2:09 pm, indicated Resident 1 was admitted to GACH 1 with weakness lethargy (lack of energy). The record also indicated patient is extremely lethargic, somnolent (drowsy) and difficult to verbalize complaints.</p> <p>During an interview on 4/30/2024 at 3 pm with RNS 1. RNS 1 stated if a resident missed any dialysis treatments, the licensed nurse was responsible to inform the physician and call the dialysis center to reschedule dialysis treatment for the earliest possible time available. RNS 1 stated, the licensed nurse would need to create a change in condition form and monitor the resident for any complications of missed dialysis until the next scheduled dialysis treatment.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review of the facility ' s internal communication record, titled Care Communication, dated 4/13/2024 (Saturday) timed at 6:56 am, on 4/30/2024 at 3:30 pm, RNS 1 stated, the communication record indicated Resident 1 had missed a dialysis treatment on 4/13/2024, but was not documented in the resident ' s records. RNS 1 stated the missed dialysis treatment on 4/13/2024 should be documented in Resident 1 ' s medical records to make sure everyone who took care Resident 1 be aware of the situation. RNS 1 further stated the physician should be informed on the same day for recommendations and monitoring. After reviewing Resident 1 ' s Change of Condition, Nurses Progress Notes, Orders Summary and Care Plan since admission (4/11/2024), RNS 1 stated, he could not find any documents in Resident 1 ' s record to indicate that Resident 1 had missed a dialysis treatment and if it was reported to the physician on 4/13/2024.</p> <p>During an interview on 5/1/24 at 11 am with Resident 1 ' s FAM 1, FAM 1 stated, she told the facility ' s staff nurse (could not recall the staff ' s name) when Resident 1 was admitted on [DATE] that Resident 1 was dependent on dialysis and that it was very important that he should not miss any dialysis treatment. FAM 1 stated, she was not informed that Resident 1 had missed a dialysis treatment on 4/13/2024. FAM 1 stated, when she called the facility for an update on Resident 1 (4/17/2024), she was informed that Resident 1 was already transferred to the acute hospital because he was getting very sick.</p> <p>During an interview on 5/1/2024 at 2:39 pm with LVN 1, LVN 1 stated, he worked night shift on 4/15/2024 from 11 pm to 7 am up to the morning on 4/16/2024. LVN 1 stated, Resident 1 was scheduled for dialysis treatment and was supposed to be picked up around 4 am on 4/16/2024 but the transportation did not show up. LVN 1 stated he informed the RNS in charge so she could reschedule the dialysis for another time. LVN 1 stated, Resident 1 did not refuse any dialysis treatment. LVN 1 stated, he did not inform the physician and did not ask the RNS if she reported it to the physician. LVN 1 stated, the morning shift LVN and RN (LVN 1 could not recall who) should have reported the missing dialysis treatment to the physician and received order to transfer the resident for dialysis treatment during the day of 4/16/2024. LVN 1 stated, when he came back to work on the night of 4/16/2024, he asked Resident 1 and was informed that Resident 1 did not have his dialysis treatment re-scheduled, so he informed the physician and was recommended to transfer Resident 1 to GACH 1 for dialysis.</p> <p>During an interview on 5/1/2024 at 3:30 pm with the interim Director of Nurses (DON), the DON stated, when Resident 1 missed the dialysis treatment the first time on 4/13/2024, the physician should already be informed, and a Change in Condition form should be completed. The DON stated, when Resident 1 missed his dialysis treatment for the second time on 4/16/2024, the physician should be informed, and Change in Condition form should be completed right away, even if the dialysis treatment could be rescheduled for a later time. The DON stated the licensed nurses should not wait for the next day when the same licensed nurse (LVN 1) to come back to notify the physician because it could cause a delay in dialysis treatment and the resident could be at risk for complications.</p> <p>A review of the facility ' s policy and procedure titled, Change in a Resident ' s Condition or Status, revised May 2017, indicated the facility shall promptly notify the resident, his or her Attending Physician, and representative of changes in the resident ' s medical/mental condition and/or status.</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47467</b></p> <p>Based on interview, and record review, the facility failed to ensure the resident ' s needs related to dialysis (a procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly) treatments for one of two sampled residents (Resident 1), who was to receive scheduled dialysis treatments, as ordered by the physician.</p> <p>The facility failed to arrange services to transport Resident 1 to and from the off-site certified dialysis facility (an entity that provides outpatient maintenance dialysis services) for dialysis treatments on 4/13/2024 and 4/16/2024.</p> <p>As a result, Resident 1 missed two dialysis treatments scheduled on 4/13/24 and 4/16/2024. In addition, Resident 1 was transferred to the General Acute Care Hospital (GACH) Emergency Department (ED) for weakness and lethargy. GACH 1 ED report dated 4/17/24 indicated Resident 1 was at risk for central nervous system [brain and spinal cord (a long, tube-like band of tissue that connects the brain to the lower back), cardiopulmonary (heart and lungs), metabolic (chemical changes that take place in a cell or an organism to produce energy and basic materials needed for important life processes), renal demise (dying of kidney) and required aggressive intervention.</p> <p>Findings:</p> <p>A review of the facility ' s Preadmission Report - Patient Analysis for Resident 1 dated 4/1120234, indicated Resident 1 ' s diagnosis included being dialysis dependent with dialysis days being Tuesdays, Thursdays, and Saturdays. The Preadmission Report indicated blank under transportation.</p> <p>A review of Resident 1 ' s Admission Record indicated the facility admitted the resident on 4/11/2024, with diagnoses that included chronic kidney disease (a condition in which the kidneys are damaged and cannot filter blood as well as they should) Stage 3, Type 2 diabetes mellitus (a disease that occurs when the body ' s blood sugar is too high), dependence on renal dialysis, hypertension (high blood pressure). The Admission Record indicated Resident 1 as self-responsible and listed Family Member (FAM) 1 in the contact information as the first contact for Resident 1.</p> <p>A review of Resident 1 ' s History and Physical (H&amp;P), dated 4/11/2024, indicated Resident 1 had the capacity to make decisions or make needs known. The H&amp;P indicated Resident 1 had generalized weakness that needed maximal assist (helper does more than half the effort) for transfers, unable to balance sitting, standing and unable to ambulate.</p> <p>A review of Resident 1 ' s Clinical Physician Orders, dated 4/12/2024 (Friday), indicated Resident 1 had dialysis orders with chair time at 3:45 am to 7:30 am, scheduled every Tuesdays, Thursdays, and Saturdays.</p> <p>A review of the facility ' s internal communication record, titled Care Communication, dated 4/13/2024 (Saturday) timed at 6:56 am, indicated a communication entry for Resident 1 that indicated, Scheduled dialysis T-Th-S (Tuesday-Thursday-Saturday) with 3:45 am chair time (dialysis appointment time). No one showed up to pick up patient this morning. Please arrange transportation.</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of an email communication from the facility ' s Admission Specialist (AS) dated 4/13/2024 timed at 9:56 am, addressed to the facility ' s corporate office and courtesy copies sent to the interim DON, Administrator (ADM), and the Admission Coordinator (ADC) indicated, We have an issue with transportation . The patient does not qualify for routine transportation, including dialysis, only for emergency to hospital .The courtesy ride did not show up to pick up patient today for dialysis per nursing notes.</p> <p>A review of Resident 1 ' s Nursing Progress Note, for April 2024 indicated the following documented information:</p> <ol style="list-style-type: none"> <li>1. On 4/11/2024 timed at 2:29 PM, the progress notes indicated Resident 1 was admitted to the facility via ambulance, with all orders verified with attending physician. The progress note indicated Resident 1 had a right chest Perma catheter intact and with dry dressing. The progress note indicated Resident 1 ' s last dialysis was performed on 4/10/2024. The progress notes indicated continue to monitor pt. (patient), endorsed.</li> <li>The Nursing Progress Notes from 4/13/2024 to 4/15/2024, did not indicate an entry indicating any missed scheduled dialysis treatment to Resident 1 on 4/13/2024 or if a dialysis treatment was rescheduled, and/or if attending physician was notified.</li> <li>2. On 4/16/2024 timed at 6 am, the progress note authored by Licensed Vocational Nurse (LVN) 1 (11 pm to 7 am shift), indicated No transportation showed up to pick up resident for dialysis treatment. RN (registered nurse) made aware and followed up with dialysis. New schedule received for chair time (dialysis treatment] today at [1:30 pm]. Resident made aware.</li> <li>3. On 4/16/2024 timed at 7:20 am, another progress note entry authored by LVN 1 (11 pm to 7 am shift), indicated Endorsed to morning shift LVN and SSD (social services designee) to follow up transportation.</li> <li>4. On 4/17/2024 timed at 1:17 am, a progress note authored by LVN 1 (11 pm to 7 am shift), indicated Resident missed dialysis. No signs of distress noted. Another note indicated, Transfer resident to [GACH1].</li> <li>5. On 4/17/2024 timed at 5:59 am, another progress note entry authored by LVN 1 (11 pm to 7 am shift), indicated Resident in bed slept in long intervals . Currently being monitored due to missed dialysis . No signs of fluid overload . Also, on monitoring for poor PO intake.</li> <li>6. On 4/17/2024 timed at 2:41 pm (7 am to 3 pm shift), the progress note authored by RN Supervisor (RNS) 2 indicated, Resident 1 was picked up by the ambulance to transfer to GACH 1 in stable condition. The progress note indicated FAM 1 was informed of the GACH 1 transfer due to missed dialysis treatment.</li> </ol> <p>A review of Resident 1 ' s Clinical Physician Orders, dated 4/17/2024, indicated to transfer the resident to the acute hospital (GACH 1) related to two missed dialysis treatments, poor intake, for treatment and further evaluation.</p> <p>(continued on next page)</p>		

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<p>F 0698</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 GACH 1 ED record, dated 4/17/2024 timed at 3:16 am, indicated Resident 1 was seen by the GACH 1 physician for dizziness and syncope with chief complaint indicating dialysis patient refusing dialysis and presented with weakness, malaise (discomfort, illness or lack of well-being)/fatigue (extreme tiredness and lack of energy). The record also indicated the patient was at risk for central nervous system, cardiopulmonary, metabolic, renal demise and required aggressive intervention.</p> <p>A review of Resident 1 ' s GACH 1 record titled Physician History and Physical, dated 4/18/2024 timed at 2:09 pm, indicated Resident 1 was admitted to GACH 1 with weakness lethargy (lack of energy). The record also indicated patient is extremely lethargic, somnolent (drowsy) and difficult to verbalize complaints.</p> <p>During a concurrent interview and record review of the facility ' s internal communication record, titled Care Communication, dated 4/13/2024 (Saturday) timed at 6:56 am, on 4/30/2024 at 3:30 pm, RNS 1 stated, the communication record indicated Resident 1 had missed a dialysis treatment on 4/13/2024, but was not documented in the resident ' s records. RNS 1 stated the missed dialysis treatment on 4/13/2024 should be documented in Resident 1 ' s medical records to make sure everyone who took care Resident 1 be aware of the situation. RNS 1 further stated the physician should be informed on the same day for recommendations and monitoring. After reviewing Resident 1 ' s Change of Condition, Nurses Progress Notes, Orders Summary and Care Plan since admission (4/11/2024), RNS 1 stated, he could not find any documents in Resident 1 ' s record to indicate that Resident 1 had missed a dialysis treatment and if it was reported to the physician on 4/13/2024.</p> <p>During an interview on 4/30/2024 at 4:21 pm, with the Admission Specialist (AS), the AS stated, Resident 1 was admitted to the facility on [DATE] and had a scheduled dialysis treatment on 4/13/2024. The AS stated, the transportation did not come to pick up Resident 1 on 4/13/2024, so the AS was informed by the facility ' s staff nurse (unable to recall nurse). The AS stated, he contacted Resident 1 ' s insurance company and was informed that Resident 1 did not have transportation benefits. The AS stated, he emailed the facility ' s department heads, including the Admission Coordinator (ADC), the Administrator, and the interim DON to inform them about Resident 1 ' s transportation benefit issues on 4/13/2024.</p> <p>During an interview on 4/30/2024 at 4:44 pm with the ADC, the ADC stated, the Social Service Worker (SSW) usually takes care of dialysis transportation. The ADC stated, she did not inform the SSW when she was informed by the AS on 4/13/2024 that Resident 1 had missed his scheduled dialysis treatment on 4/13/2024, due to no transportation benefit because it was a Saturday.</p> <p>During an interview on 4/30/2024 at 5 pm with the SSW, the SSW stated, she did not know that Resident 1 had missed his scheduled dialysis treatment on 4/13/24, due to transportation benefit issue. The SSW stated, she was made aware of Resident 1 ' s missing dialysis treatment on 4/16/2024 but did not know that it was the second time Resident 1 missed his dialysis treatment. The SSW stated, if she was made aware on 4/13/2024 and was sure that it was because of the transportation benefit issue, she would provide other solutions so that Resident 1 would not miss his second dialysis treatment on 4/16/2024. The SSW stated, the second missed dialysis treatment should had been prevented if SSW was notified by facility staff (AS, ADC, ADM, DON) on 4/13/2024.</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/1/24 at 11 am with Resident 1 ' s FAM 1, FAM 1 stated, she told the facility ' s staff nurse (could not recall the staff ' s name) when Resident 1 was admitted on [DATE] that Resident 1 was dependent on dialysis and that it was very important that he should not miss any dialysis treatment. FAM 1 stated, she was not informed that Resident 1 had missed a dialysis treatment on 4/13/2024. FAM 1 stated, when she called the facility for an update on Resident 1 (4/17/2024), she was informed that Resident 1 was already transferred to the acute hospital because he was getting very sick.</p> <p>During an interview on 5/1/2024 at 1:12 pm, with the interim Director of Nurses (DON), the DON stated, he received the email from the AS on 4/13/2024, but did not check the situation so he was not aware of the resident ' s transportation issue. The DON stated, if he was aware of the transportation issue on 4/13/2024, he would follow up with the physician and the SSW to resolve it timely, which could prevent the second missed dialysis treatment on 4/16/2024.</p> <p>During an interview on 5/1/2024 at 2:39 pm with LVN 1, LVN 1 stated, he worked night shift on 4/15/2024 from 11 pm to 7 am up to the morning on 4/16/2024. LVN 1 stated, Resident 1 was scheduled for dialysis treatment and was supposed to be picked up around 4 am on 4/16/2024 but the transportation did not show up. LVN 1 stated he informed the RNS in charge so she could reschedule the dialysis for another time. LVN 1 stated, Resident 1 did not refuse any dialysis treatment.</p> <p>A review of the facility ' s policy and procedure titled, End Stage Renal Disease, Care of a Resident With, dated September 2010, indicated Residents with End Stage Rebal Disease will be cared for according to currently recognized standards of care. The policy indicated The resident ' s comprehensive care plan will reflect the resident ' s needs related to ESRD/dialysis care.</p>		