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| 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 06/25/2024 |
| 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) |
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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>44429</p> <p>Based on observation, interview, and record review, the nursing staff did not revise the diabetes mellitus (a disease occurs when a person ' s blood sugar is too high) care plan for one of three sampled residents (Resident 1) by:</p> <p>1. Not addressing Resident 1 ' s new order for longterm acting insulin- Lantus (medication to lower blood sugar) dated 6/11/24 in the current active care plan.</p> <p>These deficient practices had the potential for the residents to not receive appropriate care treatment and/or services.</p> <p>Findings:</p> <p>A review of Resident 1's Face Sheet indicated the facility readmitted Resident 1 on 8/3/2023 with diagnoses that included cerebral vascular accident/stroke (blood flow to the brain has stopped from blockage or bleeding) and diabetes mellitus (high blood sugar).</p> <p>A review of Resident 1's History and Physical dated 11/13/2023, indicated R1 had a fluctuating capacity to understand and make decision.</p> <p>A review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 4/8/2024, indicated Resident 1's cognition (ability to think and reasonably) was intact.</p> <p>A review of Resident 1 ' s Laboratory Hemoglobin A1C Record dated 6/5/2024, indicated R1 A1C results was 13.5% (percent is a unit of measurement) and the normal range was from 4% to 6%.</p> <p>A review of Resident 1 ' s Order Summary Report dated 6/25/2024, indicated a phone order on 6/11/2024 for Lantus Subcutaneous (SQ) Solution 100Units/ML (Units of measurements) inject 2 units SQ in the morning for type 2 diabetes mellitus.</p> <p>A review of Resident 1's care plan titled The resident has DM undated with RN1, RN1 stated Resdent 1's care plan was not updated regarding the medication alert for Lantus and by not updating the care plan it would have delayed treatment for R1 high blood sugar levels.</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 0657</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 on 6/25/2024 at 3:25 PM with the Director of Nursing (DON), Residents 1 ' s care plan titled The resident has MD undated, the DON stated Resident 1's care plan was not updated regarding the administration of Lantus and by not updating the care plan it would have delayed treatment for Resident 1's high blood sugar levels and R1 could have been symptomatic related to high blood sugar levels.</p> <p>During review of the facility ' s policy and procedure titled, Care Plans, Comprehensive Person-Centered revised 12/2016, indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident ' s physical, psychosocial and functional needs is developed and implemented for each resident. The policy indicated areas of concern that are identified during the resident assessment will be evaluated before interventions are added to the care plan.</p> |

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| <p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>44429</p> <p>Based on observation, interview, and record review, the facility failed to meet professional standards of quality for one of three sample residents (Resident 1) by:</p> <ol style="list-style-type: none"> 1. Not ensuring to notify the physician for a medication alert for Lantus (medication to lower blood sugar) daily dose was below the usual dose on 6/11/2024 for Resident 1. 2. Not ensuring Resident 1 endocrinology consult was ordered on 6/6/2024 for an elevated hemoglobin A1C (blood test that measures blood sugar levels that helps diagnose diabetes (a disease occurs when a person ' s blood sugar is too high)) on 6/5/2024. <p>These deficient practices had the potential to result in Resident 1 having an unintended complication related to the management of high blood sugar such as diabetic ketoacidosis (complication from high blood sugar levels) which can lead to coma or death.</p> <p>Findings:</p> <p>A review of Resident 1's Face Sheet indicated the facility readmitted Resident 1 on 8/3/2023 with diagnoses that included cerebral vascular accident/stroke (blood flow to the brain has stopped from blockage or bleeding) and diabetes mellitus (high blood sugar).</p> <p>A review of Resident 1's History and Physical dated 11/13/2023, indicated Resident 1 had a fluctuating capacity to understand and make decision.</p> <p>A review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 4/8/2024, indicated Resident 1 cognition (ability to think and reasonably) was intact.</p> <p>A review of Resident 1 ' s Laboratory Hemoglobin A1C Record dated 6/5/2024, indicated Resident 1 A1C results was 13.5% (percent is a unit of measurement) and the normal range was from 4% to 6%.</p> <p>A review of Resident 1 ' s Change of Condition (COC) dated 6/5/2024, indicated Resident 1 A1C level was 13.5% and Nurse Practitioner (NP1) was notified and awaiting orders.</p> <p>A review of Resident 1 ' s Nursing Notes dated 6/6/2024 timed at 7:06PM, indicated NP1 wrote an order for endocrinology consult for Hemoglobin A1C results.</p> <p>A review of Resident 1 ' s Order Summary Report dated 6/25/2024, indicated a phone order on 6/11/2024 for Lantus Subcutaneous (SQ) Solution 100Units/ML (Units of measurements) inject 2units SQ in the morning for type 2 diabetes mellitus.</p> <p>A review of Resident 1 ' s Electronic Physician Order Note dated 6/11/2024 timed at 8:26 PM, indicated Lantus 2units daily dose is below the usual dose of 2.3224 to 29.0299 units.</p> <p>(continued on next page)</p> |

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| <p>F 0658</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 on 6/25/2024 at 2:30PM with Registered Nurse (RN1) 1, Residents 1 ' s Electronic Physician Order Note dated 6/11/2024 was reviewed. RN1 stated that the physician order note was an electronic alert that indicated the diabetic medication Lantus 2 units SQ was below the recommend dose meaning the medication would not have any effect of lowering Resident 1 blood sugar. RN 1 stated the medication alert was electronically sent to the Pharmacist and Medical Doctor (MD). RN1 stated there was no indication on Resident 1 electronic chart or hard chart that the Pharmacist and MD were alerted because there was no MD order or note to revise or update the Lantus order. RN1 stated he should have followed up by contacting the MD and Pharmacist, but he did not. RN1 stated by not following up the electronic alerts for Lantus being below the recommended dose that Resident 1 would get sick and be hospitalized for high blood sugar levels.</p> <p>During a concurrent interview and record review on 6/25/2024 at 3:25PM with the Director of Nursing (DON), Residents 1 ' s Electronic Physician Order Note dated 6/11/2024 was reviewed. DON stated that the physician order note was an electronic alert indicated that the diabetic medication Lantus 2 units SQ was below the recommend dose. DON stated while review Resident 1 electronic chart that the MD and Pharmacist did not write a note or order regarding the Lantus medication alert. The DON stated that RN 1 should have called the Pharmacist and MD to follow up so Resident 1 could get the correct dose of insulin to lower Resident 1 blood sugar. The DON stated by not following up with the MD about medication alert for Lantus and Resident 1 high blood sugar values could have harmed Resident 1 and she would have been hospitalized .</p> <p>During a concurrent interview and record review on 6/25/2024 at 3:40PM with the Social Worker (SW2), Resident 1 ' s Nursing Notes dated 6/6/2024 timed at 12:18PM was reviewed. SW2 stated that there was an order for an endocrinology consult according to the nursing notes, but she was not notified of the endocrinology consult by RN2 or the Case Manager (CM1). SW2 stated that Resident 1 was under custodial care and the endocrine consult should have been authorized then ordered by her department. SW2 stated that there was no endocrine consult done according to her records.</p> <p>During a concurrent interview and record review on 6/25/2024 at 4:00PM with the DON, Resident 1 ' s Nursing Notes dated 6/6/2024 timed at 12:18PM was reviewed. DON stated that RN 2 should have followed up with SW2 and not CM1. DON stated CM1 should have also notified SW2 regarding the endocrine consult. DON stated as result of RN 2 not notifying SW2 that the endocrine consult was not done. DON stated since the order was not followed up and not ordered it delayed treatment for Resident 1 high blood sugars and could have caused Resident 1 harm and to be hospitalized .</p> <p>During review of the facility ' s policy and procedure titled, Nursing Services Policy and Procedure Manual revised 8/2006, indicated services provided to our residents are performed in accordance with current acceptable standards of clinical practices. The policy indicated staff are encouraged to reference such manual when needed to assure that appropriate protocol is followed in accordance with established procedures.</p> <p>During a review of the facility ' s policy and procedure titled, Telephone Orders revised 2/2014, indicated verbal telephone orders maybe accepted from each resident ' s Attending Physician. The policy indicated the orders must contain instructions form the physician, date, time, and the signature and title of the person transcribing the information.</p> | | |

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| <p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>44429</p> <p>Provide medically-related social services to help each resident achieve the highest possible quality of life.</p> <p>Based on interview and record review, the facility failed to provide social services for one out of three sampled residents (Resident 1) by failing to follow up on the physician's order for endocrinology consult for an elevated hemoglobin A1C (blood test that measures blood sugar levels that helps diagnose diabetes (a disease occurs when a person ' s blood sugar is too high) on 6/5/2024.</p> <p>This deficient practice had the potential for delay in the delivery of care and services.</p> <p>Findings:</p> <p>A review of Resident 1's Face Sheet indicated the facility readmitted Resident 1 on 8/3/2023 with diagnoses that included cerebral vascular accident/stroke (blood flow to the brain has stopped from blockage or bleeding) and diabetes mellitus (high blood sugar).</p> <p>A review of Resident 1's History and Physical dated 11/13/2023, indicated Resident 1 had a fluctuating capacity to understand and make decision.</p> <p>A review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 4/8/2024, indicated Resident 1 cognition (ability to think and reasonably) was intact.</p> <p>A review of Resident 1 ' s Laboratory Hemoglobin A1C Record dated 6/5/2024, indicated Resident 1 A1C results was 13.5% (percent is a unit of measurement) and the normal range was from 4% to 6%.</p> <p>A review of Resident 1 ' s Nursing Notes dated 6/6/2024 timed at 7:06PM, indicated NP1 wrote an order for endocrinology consult for Hemoglobin A1C results.</p> <p>During a concurrent interview and record review on 6/25/2024 at 3:40PM with Social Worker (SW) 2, Resident 1 Nursing Note dated 6/6/24 timed at 12:18PM was reviewed. SW2 stated that there was an order for an endocrinology consult according to the nursing note, but she was not notified of the endocrinology consult by Resident Nurse (RN) 2 or the Case Manager (CM) 1. SW 2 stated that Resident 1 was under custodial care and the endocrine consult should have been authorized then ordered by the SW department. SW 2 stated that there was no endocrinology consult done according to her records. SW2 stated by not ordering the endocrinology consult on 6/6/24 it had delayed treatment for Resident 1.</p> <p>During a concurrent interview and record review on 6/25/2024 at 4 PM with the Director of Nursing (DON), Resident 1 Nursing Note dated 6/6/24 timed at 12:18PM was reviewed. The DON stated that RN 2 should have followed up with SW2 and not CM 1. The DON stated CM1 should have notified SW 2 regarding the endocrine consult. DON stated as result of RN 2 not notifying SW2 that the endocrine consult which was ordered on 6/6/24 was not done. The DON stated since the order was not followed up and not ordered delayed treatment for R1 high blood sugar levels and could have caused R1 harm and she would have been hospitalized .</p> <p>During an interview on 6/25/2024 at 4:15PM with RN3, stated that RN 2 should have notified SW2 and not CM1 because R1 was under custodial care and led to the endocrinology consult not being ordered.</p> <p>(continued on next page)</p> | | |

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| <p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During a review of the facility ' s policy and procedure titled, Social Services revised 10/2010, indicated Our facility provides medically related social services to assure that each resident can attain or maintain his/her highest practicable physical. mental. or psychosocial well-being. The policy indicated the director or social services is a qualified social worker and is responsible for: consultation with other departments regarding program planning, policy development, and priority setting of social services.</p> |