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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>555503 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                   | (X3) DATE SURVEY COMPLETED<br><br>04/15/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Royal Oaks Manor-Bradbury Oaks |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1763 Royal Oaks Drive<br>Duarte, CA 91010 |  |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |
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| <p>F 0744</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.</p> <p>48729</p> <p>Based on observation, interview and record review, the facility failed to ensure one of three sampled residents (Resident 1) who had a diagnosis of dementia (loss of memory and other mental abilities severe enough to interfere with daily life), was assessed at high risk for falls, and elopement (a resident who's incapable of protecting himself/herself adequately and who departed the health care facility unsupervised and undetected) received care and services to prevent a fall by failing to:</p> <ol style="list-style-type: none"> <li>1. Implement Resident 1's Care Plan (CP, a form where one can summarize a person's health conditions, specific care need, and current treatments) interventions related to repetitive wandering (moving from place to place without a fixed plan) behavior and attempts to leave the facility unattended.</li> <li>2. Update Resident 1's CP interventions titled, Cognitive Loss/Dementia, and Activities, when Certified Nurse Assistant (CNA 2) recognized that Resident 1 needed a one-to-one supervision (one staff supervising one resident), and when the Social Services Director (SSD) recognized that Resident 1 made frequent elopement attempts and stated the facility was fearful that Resident 1 might leave the facility without staff noticing.</li> </ol> <p>As a result, on 3/29/2024, Resident 1 fell while running toward the front lobby and attempting to leave the facility. Resident 1 sustained a left distal radius (one of two large bones of the forearm) fracture (broken left wrist) and right humerus (long bone that runs from the shoulder and shoulder blade to the elbow) fracture. The facility transferred Resident 1 to the General Acute Care Hospital (GACH) where Resident 1 was put on a cast (a protective shell of fiberglass [a textile fabric made from woven glass filaments], plastic, or plaster [substance that becomes hard as it dries], and bandage that was molded to protect broken or fractured limb(s) as the broken bone(s) healed) on Resident 1's left arm and a sling (a device used to support and keep still (immobilize) an injured part of the body) on Resident 1's right arm.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record, (AR) the AR indicated the facility admitted Resident 1 on 2/6/2024 with diagnoses that included dementia, muscle weakness (a lack of muscle strength), and encephalopathy (a group of conditions that cause brain dysfunction).</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 0744</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>   | <p>During a review of Resident 1's Falls Risk Assessment, (FA) dated 2/6/2024, the FA indicated Resident 1 had a total score of 11 (a score of 10 or more indicated high risk for falls). The FA indicated Resident 1 was a high risk for falls due to Resident 1 had gait (manner of walking) and balance problems, needed assistant from staff with toileting and received multiple medications.</p> <p>During a review of Resident 1's Minimum Data Set, (MDS, a resident assessment and care screening tool) dated 2/12/2024, the MDS indicated Resident 1 was moderately impaired with cognitive skills (thinking, reasoning, remembering). The MDS indicated Resident 1 required substantial/ maximal assistance (helper provided more than half the effort) for eating and personal hygiene.</p> <p>During a review of Resident 1's CP, titled Cognitive Loss/Dementia, related to Resident 1 had impaired cognition related to Dementia which resulted in repetitive wandering, dated 3/8/2024, the CP indicated, Resident 1 walked aimlessly along hallways towards the front lobby, unassisted and without sense of direction. The CP's goal indicated Resident 1's safety would be maintained daily, and Resident 1 would fulfill the need to walk about in safety without distracting others. The CP's intervention indicated for staff to provide Resident 1 regular opportunities to go outdoors with supervision and assist the resident as needed.</p> <p>During a review of Resident 1's Elopement Risk Assessment, (EA) dated 3/11/2024, the EA indicated Resident 1's total score was a 29 (a score of 10 or more indicated at risk for elopement). The EA indicated Resident 1 was at high risk for elopement due to Resident 1 made attempts to get out of the facility (elope) and Resident 1 stated Resident 1 wanted to get out of the facility but Resident 1 did not know where Resident 1 would go.</p> <p>During a review of Resident 1's CP titled, Activities, related to Resident 1 attempted to leave the facility unattended, dated 3/25/2024, the CP's goal indicated Resident 1 would not try to leave the facility unattended. The CP's intervention indicated Resident 1 would walk two to three times a week.</p> <p>During a review of Resident 1's Interdisciplinary (IDT, a group of dedicated healthcare professionals who work together to provide personalized health care for the resident/patient) Notes, dated 3/29/2024, the IDT notes indicated Resident 1 was sent to the GACH after sustaining a fall and the hospital Registered Nurse (RN) reported to the facility that Resident 1 had a left distal radius fracture and right humerus fracture. The IDT notes indicated Resident 1 returned to the facility on the same day (3/29/24) with a sling on Resident 1's right arm and cast on Resident 1's left arm.</p> <p>During a review of Resident 1's Fall Situation, Background, Assessment and Recommendation (SBAR, structured communication framework that helps teams share information about the condition of a resident), dated 3/30/2024, timed at 8:08 a.m., late entry for 3/29/2024, the SBAR indicated Resident 1 had a witnessed fall to the floor. The SBAR indicated Resident 1 was found flat on the resident's back and was transferred to the emergency room (GACH) for further evaluation. The SBAR indicated Resident 1 was taken to the nurse's station for close monitoring, and Resident 1 kept getting up and going to other resident's rooms. The SBAR indicated re-direction did not work and Resident 1 was seen by staff running down the main hall around 9:30 a.m. and at 9:35 a.m., Resident 1 had an unwitnessed fall. The SBAR indicated Resident 1 had a knot on top of Resident 1's right temple (the side of the head behind the eyes) and Resident 1 mentioned she had pain (unrated) on the right shoulder shooting down to Resident 1's arm. The SBAR indicated Resident 1 had swelling on the right arm and right wrist.</p> <p>(continued on next page)</p> |  |  |

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| <p>F 0744</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>   | <p>During a concurrent observation and interview on 4/15/2024 at 9:30 a.m., Resident 1 had a sling on the right arm and a cast on the left wrist/arm. Resident 1 stated [the day of the fall (3/29/24)] Resident 1 was running with Resident 1's daughter at the park and Resident 1 fell .</p> <p>During an interview on 4/15/2024 at 10:18 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated the interventions implemented for Resident 1 included frequent visual checks every one to two hours due to Resident 1's high risk for elopement and falls.</p> <p>During an interview on 4/15/2024 at 10:27 a.m. with the Activities Coordinator (AC), the AC stated prior to Resident 1's fall (3/29/2024), Resident 1 was always saying, I have to go, I have to go, and tried to leave the facility. The AC stated, before the fall, Resident 1 used to walk up and down the hallways all the time.</p> <p>During an interview on 4/15/2024 at 11:48 a.m. with Certified Nursing Assistant (CNA) 2, CNA 2 stated prior to Resident 1's fall (3/29/24), Resident 1 was known to be very confused and known to wander. CNA 2 stated despite attempts at keeping Resident 1 near the nursing station, it was difficult to monitor (watch) Resident 1 when the staff were busy with other tasks. CNA 2 stated the morning when Resident 1 fell , Resident 1 had verbalized wanting to leave the facility and tried wandering toward the front lobby. CNA 2 stated no staff was specifically designated to watch Resident 1when the residents were at the nursing station. CNA 2 stated a staff should be at the nursing station watching the residents. CNA 2 stated Resident 1 wandered frequently, and it ultimately led to Resident 1 falling and sustaining a fracture on Resident 1's arm. CNA 2 stated CNA 2 reported to a charged nurse (unable to identify) that Resident 1 required one to one staff monitoring (one staff monitor one resident) because Resident 1 had unpredictable behavior when some days, Resident 1 sat and did nothing and other days, Resident 1 walked around the facility and tried to leave.</p> <p>During an interview on 4/15/2024 at 2:36 p.m. with the Director of Nursing (DON), the DON stated on day Resident 1 fell (3/29/2024, unable to recall the time). Resident 1 was sitting down in the hallway with other residents. The DON stated a resident (unidentified) yelled out, she's running, and CNA 3 came around the nurse's station and saw Resident 1 running down the hall toward the front lobby and CNA 3 started running after Resident 1. The DON stated she saw the Administrator (ADM) got up, ran to the front lobby and she followed the ADM. The DON stated, she saw Resident 1 was on the floor of the front lobby, rolled on Resident 1's back. The DON stated interventions that were implemented for Resident 1 who was high fall risk included frequent rounds (visual checks). The DON stated frequent rounds meant monitoring Resident 1 more frequently than every two hours. The DON stated prior to Resident 1's fall on 3/29/2024, Resident 1 was taken outside for walks only when someone had time because this [activity] was not a regular part of Resident 1's care.</p> <p>During an interview on 4/15/2024 at 4:33 p.m. with the Social Services Director (SSD), the SSD stated the SSD had contacted Resident 1's family prior to Resident 1's fall (2/26/24) due to the SSD recognized Resident 1 made frequent elopement attempts and stated the facility was fearful Resident 1 might leave without staff noticing.</p> <p>During a concurrent interview and record review on 4/15/2024 at 4:50 p.m. with the DON, Resident 1's CP titled Cognitive Loss/Dementia, dated 3/8/2024 and CP titled Activities dated 3/25/24 were reviewed, the DON stated there were no documentations indicated Resident 1's CP interventions were implemented by facility's staff for these CPs.</p> <p>(continued on next page)</p> |  |  |

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| <p>F 0744</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>During a review of the facility's policy and procedure (P&amp;P) titled, Safety and Supervision of Residents, dated 7/2017 the P&amp;P indicated implementing interventions to reduce accident risks and hazards shall include ensuring that the interventions are implemented and documented.</p> <p>During a review of the facility's P&amp;P titled, Dementia - Clinical Protocol, dated 11/2018, the P&amp;P indicated the IDT will identify a resident-centered care plan to maximize remaining function and quality of life, direct care staff will support the resident in initiating and completing activities and tasks of daily living. The P&amp;P indicated the staff will monitor the individual with dementia for changes in condition and decline in function and will report these findings to the physician, the IDT will adjust interventions and the overall plan depending on the individual's responses to those interventions, progression of dementia. The P&amp;P indicated the IDT will identify and document the resident's condition and level of support needed during care planning and review changing needs as they arise.</p> |