

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555503	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/10/2024
NAME OF PROVIDER OR SUPPLIER Royal Oaks Manor-Bradbury Oaks		STREET ADDRESS, CITY, STATE, ZIP CODE 1763 Royal Oaks Drive 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 (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689 Level of Harm - Actual harm Residents Affected - Few	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36924</p> <p>Based on observation, interview, and record review, the facility failed to provide care and services to prevent a fall for one of three sampled residents (Resident 1) by failing to:</p> <ol style="list-style-type: none"> 1. Ensure Certified Nursing Assistant 1 (CNA 1) provided two-person physical assistance (help from two persons) to transfer (moving a resident from one place to another) Resident 1 from the toilet to the wheelchair when CNA 1 used the Sara lift (mechanical lift, a device used by staff to transfer residents from one location to another e.g., a bed to a chair). 2. Ensure CNA 1 followed the facility's Policy and Procedures (P&P) titled, Lifting Machine, Using a Mechanical, and Fall & Fall Risk, Managing. <p>As a result, on 4/23/2024, at 3 p.m., Resident 1 fell forward from the Sara lift. Resident 1 experienced 7 out of 10 pain (on a pain scale from 0 to 10, 0 means no pain and 10 means the worst possible pain felt, severe/intense pain) on Resident 1's left shoulder. The X-ray (imaging study that takes pictures of bones and soft tissues) results indicated Resident 1 had a fracture in the neck of the humerus (long bone that runs from the shoulder and shoulder blade to the elbow), and Resident 1 was transferred to the General Acute Care Hospital 1's (GACH 1's) Emergency Department (ED).</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record (AR), the AR indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including seizures (sudden, uncontrolled electrical disturbance in the brain which can cause changes in behavior, movements, feelings, and consciousness), and chronic (long-standing) atrial fibrillation (irregular rapid heart rate).</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: 555503
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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 1's care plan (CP) titled, Falls, dated 8/15/2022, the CP indicated Resident 1 had risk factors that required monitoring and intervention to reduce the potential for self-injury associated with possible occurrence of falls. The CP indicated to consider Resident 1's medical conditions including, sensory alterations (sensory impairment, sensory overload, and sensory deprivation), balance, gait (walk), assistive devices, cognition (ability to understand and process information), mood/behavior, safety awareness, compliance, medications, and restrictions. The CP indicated Resident 1's risk factors included decreased functional mobility, wheelchair-bound, impaired ability to balance self with transfers, and needed assistance to maintain posture and safety. The CP indicated Resident 1 required extensive assistance [from staff] with bed mobility and transfers. The CP interventions indicated to observe Resident 1 for unsteady/unsafe transfers or positioning ability and to provide balance support and physical assistance to Resident 1 as needed.</p> <p>During a review of Resident 1's Fall Risk Assessment (FRA) dated, 10/3/2023, timed at 7:01 p.m., the FRA indicated Resident 1 was chair bound and required assistance with toileting. The FRA indicated Resident 1 required assistance (person, furniture/walls, or device) when Resident 1 stood on both feet.</p> <p>During a review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 2/1/2024, indicated Resident 1's cognition was severely impaired. The MDS indicated Resident 1 was dependent (helper [staff] does all the effort and the resident does none of the effort to complete the activity, or the assistance of two or more helpers was required for the resident to complete the activity) on staff for transfers from chair/chair-to-bed and toilet transfers.</p> <p>During a review of Resident 1's Interdisciplinary (related to more than one branch of knowledge) Notes-Change in Condition Evaluation (COC, a sudden clinically important deviation from a resident's baseline in physical, cognitive, behavioral, or functional domains), dated 4/23/2024, timed at 5:47 p.m., the COC indicated on 4/23/2024, at 3 p.m., while Resident 1 was being transferred from the toilet to the chair using the Sara lift Resident 1's knees buckled (lost the ability to support the weight and gave out), and Resident 1 was supporting herself [by grabbing the] Sara lift's handlebars. The COC indicated Resident 1 was in stable condition and was conversing with staff. The COC indicated Resident 1 was brought back to the nurse's station by staff (unidentified), and Resident 1 verbalized Resident 1 had 7 out of 10 pain on Resident 1's left shoulder.</p> <p>During a review of Resident 1's stat (immediately, without delay) Radiology 1 (a branch of medicine that uses imaging technology to diagnose and treat disease) X-ray Report, dated 4/23/2024, at 7:02 p.m., the X-ray report indicated Resident 1 had an acute (sudden) fracture involving the left humerus.</p> <p>During a review of the Interdisciplinary Notes dated 4/24/2024, at 7:50 a.m., the notes indicated Resident 1 woke up at around 3:10 a.m., complained of 8 out of 10 pain on Resident 1's left shoulder, and requested for pain medication. The notes indicated Resident 1 stated Resident 1 could not fall asleep due to the pain on the left shoulder. The notes indicated Resident 1 had bruising on the left wrist, and Resident 1 did not want anyone [staff] to move or change her. The notes indicated Resident 1 needed assistance from two CNAs (any two CNAs) for bed repositioning.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the Interdisciplinary Notes, dated 4/24/2024, timed at 11:48 a.m., the notes indicated Medical Doctor (MD) 1 was notified Resident 1 continued to have extreme pain and an inquiry to send Resident 1 to GACH's ED for further evaluation. The notes indicated MD 1 requested a call to MD 2 (orthopedic physician, a branch of medicine that focuses on the correction of deformities of bones and muscles) to see (check) Resident 1 on 4/24/24 and to change pain medication (Norco 325 milligram (mg), pain medication for moderate to severe pain) administration to every 4 hours as needed. The notes indicated MD 2 was unable to see Resident 1, and at 11 a.m., the ambulance arrived at the facility to transfer Resident 1 to GACH 1 due to Resident 1's fracture on the left upper extremity (arm).</p> <p>During a review of Resident 1's Orthopedic Group Report (OGR), encounter date 4/26/2024, the report indicated Resident 1 presented with a complaint of left shoulder pain and indicated Resident 1 stated Resident 1 was in the bathroom and fell forward onto Resident 1's left shoulder. The report indicated Resident 1 was diagnosed with a fracture in the neck of the left humerus. The report indicated Resident 1's left humerus fracture was a surgical neck fracture and typically would require surgery, however, due to Resident 1's relative lack of function, her age, her mentation (the process of using your mind to consider something carefully), Resident 1's family members and Resident 1 refused surgery.</p> <p>During a concurrent observation and interview on 5/9/2024, at 2 p.m., Resident 1 was wearing a black sling (a device used to support and keep still [immobilize] an injured part of the body) on Resident 1's left arm and Resident 1 had facial grimacing when being moved by staff. Resident 1 stated the girl (unidentified staff) did something that caused me to slip and fall. Resident 1 stated due to the fall, Resident 1 developed a fear of the machine (Sara lift). Resident 1 stated after the fall, Resident 1 experienced bad pain (unrated) on the left shoulder. Resident 1 stated after Resident 1 fell, Resident 1 went to the dining-activity room to play a game of volleyball but Resident 1 could not play due to the pain. Resident 1 stated Resident 1's current pain level was a 6 out of 10 pain and Resident 1 asked LVN 2 for pain medication.</p> <p>During an interview on 5/9/2024, at 3 p.m., CNA 2 stated CNA 2 had worked at the facility for [AGE] years. CNA 2 stated CNA 2 had, in the past, used the [NAME] mechanical lift to take Resident 1 to the bathroom. CNA 2 stated CNA 2 and all new CNAs received training on how to use the Sara lift. CNA 2 stated the Sara lift was always used with two staff and the staff would push the lift to the bathroom while Resident 1 stood on the lift's foot support. CNA 2 stated, [usual facility practice included] one CNA was positioned in the front of the lift and another CNA was positioned behind the resident.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with CNA 1, on 5/10/2024, at 12:41 p.m., CNA 1 stated CNA 1 used the Sara lift more than ten times in the past (prior to the incident with Resident 1's fall on 4/23/24) including using the lift to assist Resident 1. CNA 1 stated, on 4/23/24, (did not remember exact time) CNA 1 came into Resident 1's room to assist Resident 1 to the bathroom located inside Resident 1's room. CNA 1 stated CNA 1 was assisting Resident 1 from the wheelchair to the bathroom and used the Sara lift by herself. CNA 1 stated when transferring Resident 1 from the wheelchair to the Sara lift, CNA 1 made sure Resident 1's wheelchair wheels were locked, Resident 1 was strapped to the Sara lift's belt, and clipped the Sara lift sling onto Resident 1. CNA 1 stated CNA 1 made sure Resident 1 was holding the handles on the Sara lift while Resident 1 stood (after being lifted) on the Sara lift's foot support (affixed to the Sara lift). CNA 1 stated CNA 1 pushed the button on the Sara lift and Resident 1 was lifted off the wheelchair to the Sara lift's foot support and CNA 1 [pushed the Sara lift] and took Resident 1 to the bathroom. CNA 1 stated CNA 1 lowered the Sara lift and Resident 1 sat comfortably on the toilet [Resident 1 remained strapped on the Sara lift]. CNA 1 stated CNA 1 stepped outside of the bathroom to provide privacy to Resident 1 and left the bathroom door open. CNA 1 stated Resident 1 made CNA 1 aware Resident 1 was ready. CNA 1 stated CNA 1 entered the bathroom, pushed the button on the Sara lift and lifted Resident 1 up while Resident 1 held onto the Sara lift bars. CNA 1 stated CNA 1 transferred Resident 1 from the toilet to the Sara lift by herself. CNA 1 stated CNA 1 noticed Resident 1's knees buckled (knee instability, when the knees bend and give out), and Resident 1 fell forward. CNA 1 stated CNA 1 and Resident 1 started yelling help. CNA 1 stated CNA 1 was the only staff present while CNA 1 assisted Resident 1 to the bathroom using the Sara lift. CNA 1 stated CNA 1 normally transferred residents (in general) and Resident 1 alone using the Sara lift. CNA 1 stated Sara lift transfers were always done by one staff, and this was how CNA 1 was taught. CNA 1 stated 'this was normal practice.</p> <p>During an interview, on 5/10/2024, at 2:57 p.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated LVN 1 worked at facility for a total of 5 years and stated the Sara lift was used when a resident (in general) had some movement and was able to stand up but did not have the balance or the strength to transfer out of the bed to the toilet. LVN 1 stated LVN 1 was taught to use the Sara lift with two staff for resident transfers and this was the facility's policy. LVN 1 stated it was not safe to use the Sara lift with one person because the resident's knees can fail (buckle) LVN 1 stated two staff positioned one on each side when using the Sara lift and one staff stood in front [of the lift] and the other staff stood behind the resident. LVN 1 stated using the Sara lift with two staff helped [staff] intervene if something happened to the resident. LVN 1 stated this was important [to follow] for the safety of the resident and for staff safety. LVN stated this prevented injuries for CNAs, and the residents. LVN 1 stated Resident 1 was able to follow directions but needed to have assistance from two staff because Resident 1 was very scared of the Sara lift. LVN 1 stated when Resident 1 was on the Sara lift, she would start shaking and stated hurry up. LVN 1 stated Resident 1 was on the heavy side (large frame), so it was hard to maneuver the Sara lift in a safe way and it was hard to maneuver the resident and the Sara lift with only one person (staff).</p> <p>During a phone interview, on 5/10/2024, at 4:51 p.m., with CNA 3, CNA 3 stated CNA 3 worked at the facility for 3.5 years. CNA 3 stated the Sara lift should be used with two staff.</p> <p>During an interview, on 5/10/2024, at 5:18 p.m., with the Director of Nursing (DON), the DON stated for safety [purposes] it was the policy of the facility to use the Sara lift with two staff. The DON stated using the Sara lift with two staff was important in case there was a malfunction or in the event the resident got spooked (frighten/scare) by the lift.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility's P&P titled, Lifting Machine, Using a Mechanical, revised in July 2017, the P&P indicated the purpose of this procedure is to establish principles of safe lifting using a mechanical lifting device and it is not a substitute for [the device's] manufacturer's training or instructions. The P&P indicated At least two nursing assistants are needed to safely move a resident with a mechanical lift.</p> <p>A review of the facility's P&P titled, Fall & Fall Risk, Managing, revised in March 2018, the P&P indicated Based on previous evaluations and current data [of the resident] the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling.</p>		