

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 11/15/2024
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)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40913</p> <p>B. During a review of Resident 23's AR, the AR indicated, Resident 23 was admitted to the facility on [DATE] with multiple diagnoses including shortness of breath, anxiety disorder (a mental health disorder of persistent and excessive feelings of worry or fear that interferes with daily activities), and fever, unspecified.</p> <p>During a review of Resident 23's H&P, dated 9/11/2024, the H&P indicated, Resident 23 had the capacity to understand and/or sign any form.</p> <p>During a review of Resident 23's MDS, dated [DATE], the MDS indicated, Resident 23's cognition (ability to think and process information) status was moderately impaired. The MDS indicated, Resident 23 did not receive the influenza vaccine in the facility.</p> <p>During a concurrent review of the activities CP with the Activities Staff (AS) on 11/14/2024 at 2:46 PM, the AS stated there was no activities CP developed for Resident 23. The AS stated the activities CP would guide the AS on what activities should be provided to Resident 23.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, revised March 2022, the P&P 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 P&P indicated assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. The P&P indicated, the comprehensive, person-centered care plan was developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission.</p> <p>42307</p> <p>Based on observation, interview, and record review, the facility failed to ensure comprehensive person-centered care plans (CP, provides direction on the type of nursing care an individual needs that includes goals of treatment, specific nursing interventions [actions, treatments, procedures, or activities designed to meet an objective], and an evaluation plan) was developed and implemented for two of two sampled resident (Resident 6 and Resident 23) in accordance with the facility's policy and procedure (P&P), titled, Care Plans, Comprehensive Person-Centered.</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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>This failure had the potential to result in Resident 6 and Resident 23 not to receive the necessary care and services in accordance with their specific needs and had the potential to cause Resident 6 pain and further complications.</p> <p>Cross Reference F684</p> <p>Findings:</p> <p>A. During a review of Resident 6's Admission Record (AR), the AR indicated, Resident 6 was admitted to the facility on [DATE] with multiple diagnoses including displaced intertrochanteric fracture of left femur (a type of broken hip in the [femur] thigh bone), subsequent encounter for closed fracture with routine healing, essential primary hypertension (high blood pressure) and pain, unspecified.</p> <p>During a review of Resident 6's History and Physical (H&P), dated 9/25/2024, the H&P indicated, Resident 6 had trace edema (swelling caused by too much fluid trapped in the body's tissues) in the ankles. The H&P indicated, Resident 6 had the capacity to understand and/or sign any form.</p> <p>During a review of Resident 6's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 9/27/2024, the MDS indicated, Resident 6's cognition (ability to think and process information) status was severely impaired. The MDS indicated, Resident 6 had impairment on one side in the lower extremity (hip, knees, ankle, foot) and was dependent to requiring setup or clean-up assistance (helper sets up or cleans up) with Activities of Daily Living (ADL, term used in healthcare that refers to self-care activities).</p> <p>During a review of Resident 6's Order Summary Report (OSR), dated active as of 11/15/2024, the OSR indicated, a physician order dated 10/11/2024 to apply elastic stocking (TED Hose, a compressive stocking applied to the legs to help prevent swelling) to BLE (bilateral [both] lower extremities [legs]) one time a day for compression (thigh high) apply to BLE in the AM [morning] and remove at HS [before bedtime] and remove per schedule.</p> <p>During a concurrent observation and interview on 11/12/2024 at 10:20 AM with Resident 6 inside Resident 6's room, Resident 6 was awake and alert, had regular socks on, and was sitting up in the wheelchair. Resident 6's both legs were swollen and dependent (hanging down, below the mean level of the body).</p> <p>During a concurrent observation and interview on 11/13/2024 at 1:14 PM with Licensed Vocational Nurse (LVN) 3, inside Resident 6's room, Resident 6 was sitting up in the wheelchair with both legs swollen and dependent. LVN 3 stated, Resident 6 was at the facility for left lower extremity swelling and Resident 6 was at risk for developing edema because of the surgery. LVN 3 stated, Resident 6 was not care planned and there should be a care plan that addressed Resident 6's edema. LVN 3 stated, a CP basically tells us [nursing staff] for what we should be doing for Resident 6's care including Resident 6's problem (edema). LVN 3 stated, all licensed nurses were responsible for creating a CP as soon as residents (in general) were admitted to the facility. LVN 3 stated, a CP was important, so staff knew how to address Resident 6's edema.</p> <p>During an interview on 11/15/2024 at 1:36 PM with the Director of Nursing (DON), the DON stated, a CP was a plan of care that included the problem, goal, and interventions, and a CP should have been created to address Resident 6's edema.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>40913</p> <p>Based on observation, interview, and record review, the facility failed to ensure grooming was provided to one of two sampled resident (Resident 18) who had dark brown substance under three fingernails of the left hand.</p> <p>This deficient practice had the potential to affect Resident 18's wellbeing and the potential to contaminate Resident 18's environment.</p> <p>Findings:</p> <p>During a review of Resident 18's Admission Record, the Admission Record indicated the facility admitted the resident on 6/19/2021, with diagnoses that included anxiety (emotion characterized by an unpleasant state of inner turmoil,) osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage.)</p> <p>During a review of Resident 18's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 8/15/2024, the MDS indicated Resident 18's cognitive (ability to understand and process information) skills for daily decision making were severely impaired. The MDS indicated Resident 18 sometimes understood verbal content and rarely was able to express ideas and wants. The MDS indicated Resident 18 was dependent with all activities of daily living.</p> <p>During an observation on 11/12/2024 at 10:01 AM, Resident 18 had dark brown substance under 3 fingernails of the left hand.</p> <p>During a concurrent observation and interview on 11/14/2024 at 09:30 AM, Resident 18 had dark brown substance under Resident 18's left three fingernails. Certified Nursing Assistant 1 (CNA 1) stated the dark brown substance under the fingernails could be because Resident 18 scratched staff.</p> <p>During an interview on 11/15/2024 at 03:30 PM, the Director of Staff Development (DSD) stated daily activities of daily living (ADL, term used in healthcare that refers to self-care activities) care included providing showers or bed baths, incontinent care, nail care, shaving and oral care.</p> <p>During a review of the facility's Policy and Procedure (P&P) titled Activities of Daily Living, Supporting dated March 2018, the P&P indicated residents who were unable to carry out activities of daily living independently would receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene.</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide activities to meet all resident's needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40913</p> <p>Based on observation, interview and record review, the facility failed to ensure activities were provided to one of three residents (Resident 23).</p> <p>This deficient practice had the potential to affect Resident 23's emotional and psychosocial wellbeing.</p> <p>Findings:</p> <p>During a review of Resident 23's Admission Record (AR), the AR indicated, Resident 23 was admitted to the facility on [DATE] with multiple diagnoses including shortness of breath, anxiety disorder (a mental health disorder of persistent and excessive feelings of worry or fear that interferes with daily activities), and psychosis not due to a substance or known physiological condition (a severe mental condition in which thought and emotions are so affected that contact with reality is lost).</p> <p>During a review of Resident 23's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 9/16/2024, the MDS indicated, Resident 23's cognition (ability to think and process information) status was moderately impaired. The MDS indicated, Resident 23 usually understood verbal content and usually was able to express ideas and wants. The MDS indicated Resident 23 required moderate assistance (helper does less than half the effort) with toileting hygiene, and bed mobility. The MDS indicated Resident 23 considered the following activity preferences as highly important: listening to music, go outside to get fresh air, participate in religious services or practices.</p> <p>During multiple observations from 11/12/2024 to 11/14/2024, Resident 13 was observed lying in bed.</p> <p>During an observation on 11/12/2024 at 9:33 AM, Resident 23 was asleep, lying in bed with the head of the bed up 45 degrees, daily chronicle was on top of the table, TV was on.</p> <p>During an observation on 11/13/2024 at 11:29 AM, Resident 23 was lying in bed.</p> <p>During an observation on 11/13/2024 at 1:35 PM, Resident 23 awake, was lying in bed, and watching TV.</p> <p>During an observation on 11/14/24 at 9:19 AM to 9:21 AM Resident Assistant 1 (RA 1) was passing out daily chronicles to 4 residents (unidentified). RA 1 left the chronicles on top of resident table and in 3 minutes completed room visits for 4 residents. RA 1 stated RA 1 was doing room visits by handing out chronicles and turned-on TVs if the residents wanted to watch TV.</p> <p>During a review of Resident 23's Activity Assessment with the Activities Staff (AS) AS stated the assessment indicated Resident 23 considered the following activity preference as highly important: listen to music, to go outside to get fresh air, and participating in religious services or practices.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 23's Activity Program Attendance (APA) 11/1/2024 to 11/12/2024 and a concurrent interview with the Activity Staff (AS). The APA indicated there were no activities provided to Resident 23 from 11/1/2024 to 11/9/2024. The AS stated Activities needed to be provided at least three times a week. The AS stated when the Activities Director was working, the AS was responsible for visiting residents who did not attend group activities. The AS stated the AS was responsible for group activities while the Activities Director was off work. The AS stated, RA 1 was assisting with room visits such as passing out chronicles and providing social interaction. The AS stated when activities were not provided for an extended period [of time], Resident 23 could feel bored and unengaged.</p> <p>During a review of the Policies and Procedures (P&P) titled New Activity Program Introduction dated 8/6/2003, the P&P indicated it was the policy of the facility to ask residents what they enjoyed participating in and for the new activity program to reflect resident interest.</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42307</p> <p>Based on observation, interview and record review, the facility failed to ensure one of one sampled resident (Resident 6) received treatment and care in accordance with the physician's order by failing to ensure Resident 6's edema (swelling caused by too much fluid trapped in the body's tissues) was cared for adequately.</p> <p>This deficient practice had the potential to result in Resident 6's edema not improving and had the potential to cause pain and further complications to Resident 6.</p> <p>Cross Reference F656</p> <p>Findings:</p> <p>During a review of Resident 6's Admission Record (AR), the AR indicated, Resident 6 was admitted to the facility on [DATE] with multiple diagnoses including displaced intertrochanteric fracture of left femur (a type of broken hip in the [femur] thigh bone), subsequent encounter for closed fracture with routine healing, essential primary hypertension (high blood pressure) and pain, unspecified.</p> <p>During a review of Resident 6's History and Physical (H&P), dated 9/25/2024, the H&P indicated, Resident 6 had trace edema (swelling caused by too much fluid trapped in the body's tissues) in the ankles. The H&P indicated, Resident 6 had the capacity to understand and/or sign any form.</p> <p>During a review of Resident 6's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 9/27/2024, the MDS indicated, Resident 6's cognition (ability to think and process information) status was severely impaired. The MDS indicated, Resident 6 had impairment on one side in the lower extremity (hip, knees, ankle, foot) and was dependent to requiring setup or clean-up assistance (helper sets up or cleans up) with Activities of Daily Living (ADL, term used in healthcare that refers to self-care activities).</p> <p>During a review of Resident 6's Order Summary Report (OSR), dated active as of 11/15/2024, the OSR indicated, a physician order dated 10/11/2024 to apply elastic stocking (TED Hose, a compressive stocking applied to the legs to help prevent swelling) to BLE (bilateral [both] lower extremities [legs]) one time a day for compression (thigh high) apply to BLE in the AM [morning] and remove at HS [before bedtime] and remove per schedule.</p> <p>During a concurrent observation and interview on 11/12/2024 at 10:20 AM with Resident 6 inside Resident 6's room, Resident 6 was awake and alert, had regular socks on, and was sitting up in the wheelchair. Resident 6's both legs were swollen and dependent (hanging down, below the mean level of the body). Resident 6 stated, Resident 6 broke her left femur. Resident 6 stated, the facility had not talked to Resident 6 about Resident 6's swollen legs and Resident 6 had to ask staff to place Resident 6's legs up on pillows when Resident 6 was in bed.</p> <p>During an observation on 11/13/2024 at 8:59 AM inside Resident 6's room, Physical Therapist (unnamed) was working with Resident 6. Resident 6 had regular socks on.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview on 11/13/2024 at 1:14 PM with Licensed Vocational Nurse (LVN) 3, inside Resident 6's room, Resident 6 was sitting up in the wheelchair with both legs swollen and dependent. LVN 3 stated, Resident 6 was at the facility for left lower extremity swelling and Resident 6 was at risk for developing edema because of the surgery. LVN 3 measured Resident 6's edema and Resident 6 had pitting edema of 2+ (determined by applying pressure on the affected area and then measuring the depth of the pit, or depression, and how long it lasts, also known as a rebound time). LVN 3 stated, Resident 6 should have Resident 6's legs elevated and the physician's order for Resident 6 to have elastic stockings on was not followed.</p> <p>During an interview on 11/15/2024 at 1:36 PM with the Director of Nursing (DON), the DON stated, one of the interventions for edema was to elevate the [Resident 6's] extremities and follow the physician's orders.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Applying Anti-Emboli Stockings (TED Hose), revision date October 2020, the P&P indicated, the purpose of the P&P procedure was to improve venous return to the heart, to improve arterial circulation to the feet, to minimize edema to the legs and feet.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<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** 50016</p> <p>Based on observation, interview, and record review, the facility failed to ensure floor mats were in place for one of one sampled resident (Resident 8), who was identified as high risk for falls and as indicated in Resident 8's physician's order, Plan of Care (CP) for at risk for falls, and the facility's policy and procedure (P&P) titled Falls and Fall Risk, Managing.</p> <p>This deficient practice had the potential to result in falls and serious injuries leading to fractures (break in the bone) and bleeding to Resident 8.</p> <p>Findings:</p> <p>During a review of Resident 8's Admission Record (AR), the AR indicated the facility admitted Resident 8 on 3/14/2024, and readmitted on [DATE], with diagnoses including malignant neoplasm of ascending colon (a cancerous growth in the colon [large intestine or large bowel]), difficulty walking, and muscle weakness.</p> <p>During a review of Resident 8's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 10/15/2024, the MDS indicated Resident 8's cognition (ability to understand and process information) was intact. The MDS indicated Resident 8 required setup or clean-up assistance (helper sets up or cleans up and resident completes activity; helper assists only prior to or following the activity) with activities of daily living (ADL, term used in healthcare that refers to self-care activities) and supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity; assistance may be provided throughout the activity or intermittently) with mobility.</p> <p>During an observation on 11/12/2024 at 09:15 AM, Resident 8 was in Resident 8's room and was sitting on Resident 8's wheelchair. There were no floor mats in Resident 8's room.</p> <p>During an interview on 11/13/2024 at 1:35 PM, with Certified Nursing Assistant (CNA) 3, CNA 3 stated Resident 8 was at high risk for falls. CNA 3 stated interventions in Resident 8's plan of care (CP) for falls included floor mats to ensuring Resident 8's safety. CNA 3 stated Resident 8 should have had floor mats in place.</p> <p>During an interview on 11/14/2024 at 1:31 PM, with the DON, the DON stated staff should be following physician orders regarding medical equipment such as safety [floor] mats. The DON stated this ensured Resident 8's safety and the potential to reduce fall-related trauma if Resident 8 got up from bed, lost balance, and fell to the floor.</p> <p>During a review of Resident 8's admission Fall Risk Assessment, dated 7/9/2024, the assessment indicated Resident 8 was a high risk for falls.</p> <p>During a review of Resident 8's Order Summary Report (OSR), dated active as of 11/13/2024, the report included a physician's order, dated 10/11/2024, that indicated to keep Resident 8's bed low with floor mats every shift.</p> <p>(continued on next page)</p>

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40913</p> <p>Based on observation, interview, and record review, the facility failed to use appropriate alternatives prior to the use of bedrails for two of two sampled residents (Resident 12 and Resident 23.)</p> <p>This deficient practice had the potential to result in accidents for Resident 12 and Resident 23 due to the use of bedrails.</p> <p>Findings:</p> <p>A. During a review of Resident 12's Admission Record (AR), the AR indicated the facility admitted Resident 12 on 5/10/2024, with diagnoses that included dementia (a progressive state of decline in mental abilities,) muscle weakness, and difficulty with walking.</p> <p>During a review of Resident 12's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 8/15/2024, the MDS indicated Resident 3 was unable to express ideas and wants and was unable to understand verbal content.</p> <p>During an observation on 11/12/2024 at 10:35 AM, Resident 12 was asleep in bed, lying on her back. A quarter siderails was up on both sides of the bed.</p> <p>B. During a review of Resident 23's AR, the AR indicated Resident 23 was admitted to the facility on [DATE] with multiple diagnoses including shortness of breath, anxiety disorder (a mental health disorder of persistent and excessive feelings of worry or fear that interferes with daily activities), and psychosis not due to a substance or known physiological condition (a severe mental condition in which thought and emotions are so affected that contact with reality is lost).</p> <p>During a review of Resident 23's MDS, dated [DATE], the MDS indicated, Resident 23's cognition (ability to think and process information) status was moderately impaired. The MDS indicated, Resident 23 usually understood verbal content and usually was able to express ideas and wants. The MDS indicated Resident 23 required moderate assistance (helper does less than half the effort) with toileting hygiene, and bed mobility. The MDS indicated Resident 23 considered the following activity preferences as highly important: listening to music, go outside to get fresh air, participate in religious services or practices.</p> <p>During an observation on 11/12/2024 at 9:33 AM, Resident 23 was asleep in bed, the upper side rails were up on both sides of the bed.</p> <p>(continued on next page)</p>		

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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)		
<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent review of Resident 12 and Resident 23's Siderail Evaluations and interview on 11/14/2024 at 4:19 PM, the Siderail Evaluation forms indicated alternatives to attempt prior to the use of siderails was the use of a low bed. The Minimum Data Set Nurse (MDS Nurse) stated there was no clear documentation how the use of a low bed was not effective for Resident 12 and Resident 23, and there were no other alternatives attempted prior to the use of siderails. The MDS Nurse stated siderails were potential hazards especially for residents who had dementia because it could put residents (in general) at risk for entrapment. The MDS Nurse stated other alternatives included the use of pillows, foam bumpers or bolsters.</p> <p>During a review of the facility's undated Policy and Procedure (P&P) titled Bed Safety and Bedrails the P&P indicated the use of bed rails or side rails (including temporarily raising the side rails for episodic use during care) is prohibited unless the criteria for use of bed rails have been met, including attempts to use alternatives, interdisciplinary evaluation, resident assessment, and informed consent. The P&P indicated prior to the installation or use of a side or bed rail, alternatives to the use of side or bed rails are attempted. Alternatives may include: roll guards; foam bumpers; lowering the bed; and/or use of concave mattresses to reduce rolling off the bed. The P&P indicated if attempted alternatives do not adequately meet the resident's needs the resident may be evaluated for the use of bed rails. This interdisciplinary evaluation includes: an evaluation of the alternatives to bed rails that were attempted and how these alternatives failed to meet the resident's needs; the resident's risk associated with the use of bed rails; input from the resident and/or representative; and consultation with the attending physician.</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>40913</p> <p>Based on observation, interview and record review, the facility failed to follow Pharmacist's recommendation to perform a gradual dose reduction (GDR, the stepwise tapering [to reduce dose over time] of a dose to determine if symptoms, conditions, or risks can be managed by use of a lower dose or determination of whether the dose or medication can be discontinued) for Seroquel, an antipsychotic medication (main class of drugs used to treat people that have mental disorders like schizophrenia [mental disorder characterized by loss of contact with the environment]), for one of one sampled resident (Resident 12).</p> <p>This deficient practice had the potential to result in unnecessary use of Seroquel and could potentially lead lethargy and adverse side effects (unwanted, undesired effect of a medication) to Resident 12.</p> <p>Findings:</p> <p>During a review of Resident 12's Admission Record, the Admission Record indicated the facility admitted the resident on 5/10/2024, with diagnoses that included dementia (a progressive state of decline in mental abilities,) muscle weakness, and difficulty in walking.</p> <p>During a review of Resident 12's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 8/15/2024, the MDS indicated Resident 3's cognitive (ability to understand and process information) for daily decision making were severely impaired. The MDS indicated Resident 3 was unable to express ideas and wants and unable to understand verbal content.</p> <p>During multiple observations on the following dates and times, Resident 12 was asleep in bed.</p> <p>On 11/12/2024 at 10:35 AM, Resident 12 was asleep in bed. Resident 12's roommate stated I don't think you will get any response from Resident 12.</p> <p>On 11/13/2024 at 11:22 AM, Resident 12 was asleep in bed.</p> <p>On 11/13/2024 at 1:15 PM, Resident 12 was asleep in bed.</p> <p>On 11/13/2024 at 3:05 PM, Resident 12 was asleep in bed.</p> <p>During an observation on 11/15/2024 at 8:39 AM, the Treatment Nurse (TN) checked and repositioned Resident 12, Resident 12 was calm and cooperative. The TN stated Resident 12 was always compliant with turning and repositioning, Resident 12 was nice, and cooperative and was never combative.</p> <p>During an interview on 11/15/2024 at 11:17 AM, with Restorative Nurse Assistant 1 (RNA 1) stated when RNA 1 got Resident 12 up on the chair, Resident 12 slept. RNA 1 stated Resident 12 slept all the time.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 12's Order Summary Report (OSR), active as of 11/15/2024, the report indicated a physician's order for Seroquel 25 MG (milligram, unit of measurement), to take one tablet by mouth at bedtime for Psychosis (a collection of symptoms that affect the mind, where there has been some loss of contact with reality) manifested by pulling staff member's hair.</p> <p>During a review of Resident 12's Medication Regimen Review (MRR), recommendations created between 9/1/2024 to 9/17/2024 and a concurrent interview with the Infection Prevention Nurse (IPN). The MRR indicated a recommendation to evaluate Resident 12's current dose and consider a dose reduction, the MRR indicated Resident 12 had been taking Seroquel 25 mg since 6/17/2024 and had dementia. The MRR's physician/prescriber response was blank and had no documentation from the physician. The IPN stated the Director of Nursing was responsible for following up on the recommendations indicated on the MRR but the IPN stated the IPN could not see any documentation that the physician was notified of the recommendation or the physician's response to the recommendation.</p> <p>During a review of Resident 12's care plan for behavior related to psychosis, date initiated 10/8/2024, the care plan indicated the last GDR was on 6/17/2024, Seroquel was decreased from 37.5 mg to 25 mg. The care plan indicated to observe closely for side effects of antipsychotic medication including lethargy.</p> <p>During a review of the facility's Policy and Procedure (P&P) titled Psychotropic Medication Use dated July 2022, the P&P indicated residents on psychotropic medications receive gradual dose reductions (coupled with non pharmacological interventions), unless clinically contraindicated, in an effort to discontinue these medications.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40913</p> <p>42307</p> <p>Based on observation, interview, and record review, the facility failed to ensure one of two sampled residents' (Resident 20) medication, Potassium Chloride (a mineral supplement used to treat or prevent low amounts of potassium in the blood to maintain the health of your kidneys, heart, muscles, and nervous system) ER (Extended Release, designed to release the medication at delayed or slower rates) was administered correctly as indicated in the facility's policy and procedure (P&P) titled, Administering Medications.</p> <p>This failure had the potential for Resident 20 to develop gastric (of the stomach) upset and irritation and possibly lead to further harm and discomfort to Resident 20.</p> <p>Findings:</p> <p>During a review of Resident 20's Admission Record (AR), the AR indicated, Resident 20 was originally admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including anemia (blood disorder that occurs when your body doesn't produce enough healthy red blood cells, or when the red blood cells aren't functioning properly), unspecified, essential (primary) hypertension (low blood pressure) and gastro-esophageal reflux disease (GERD, a common condition, digestive disorder that occurs when acidic stomach juices, or food and fluids back up from the stomach into the esophagus [muscular tube through which food passes from the throat to the stomach]) without esophagitis (inflammation of the esophagus).</p> <p>During a review of Resident 20's History and Physical (H&P), dated 8/28/2024, the H&P indicated, Resident 20 was alert and oriented x 3 (awake and oriented to person, place, and time).</p> <p>During a review of Resident 20's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 10/24/2024, the MDS indicated, Resident 20's cognition (ability to think and process information) status was intact. The MDS indicated, Resident 20 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity).</p> <p>During a review of the facility's Consultant Pharmacist's Medication Regimen Review (MRR), dated 10/1/2024 -10/15/2024, the MRR indicated, a recommendation for the potassium supplement to be best administered with food or after meals and with a full glass (4 to 8ozs [ounce, unit of weight) of water or fruit juice to minimize the possibility of GI (gastrointestinal, refers collectively to the organs of the body that play a part in food digestion) upset and irritation.</p> <p>During a review of Resident 20's Order Summary Report (OSR), dated active as of 11/15/2024, the OSR included an order dated 8/31/2024 with a start date of 10/1/2024 for Potassium Chloride ER Tablet Extended Release 10 MEQ (milliequivalent, unit of measure), give 1 tablet by mouth one time a day and taken with food or after meals with a full glass of water [4 to 8 oz] or fruit juice.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Royal Oaks Manor-Bradbury Oaks		STREET ADDRESS, CITY, STATE, ZIP CODE 1763 Royal Oaks Drive Duarte, CA 91010	

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 20's Medication Administration Record (MAR), dated 11/1/2024 - 11/30/2024, the MAR indicated one 10 MEQ Potassium Chloride ER Tablet was administered one time a day at 9 a.m. to Resident 20 from 11/1/2024 to 11/14/2024.</p> <p>During a concurrent observation and interview on 11/14/2024 at 8:19 AM with Licensed Vocational Nurse (LVN) 1 during medication administration, Resident 20 was lying in bed, watching tv, and a breakfast tray (appeared untouched) was on top of Resident 20's beside table. Resident 20 stated Resident 20 had not eaten breakfast. LVN 1 did not provide instructions to Resident 20 about when Potassium Chloride ER tablet was best taken and LVN 1 administered Resident 20's 9 a.m. medication tablets in a single medicine cup including Potassium Chloride ER. LVN 1 stated, Potassium Chloride ER was to be administered with food and LVN 1 should have waited to give Resident 20's Potassium Chloride ER medication until Resident 20 ate [because Potassium Chloride], could irritate [Resident 20's] stomach.</p> <p>During an interview on 11/15/2024 at 4:14 PM with the Director of Nursing (DON), the DON stated, medications should be administered correctly and followed as ordered [by the physician], to make sure the correct way, for the effectiveness of the medication.</p> <p>During a review of the facility's P&P titled, Administering Medications, revised April 2019, the P&P indicated, medications are administered in a safe and timely manner, and as prescribed. The P&P indicated, medications are administered in accordance with prescriber orders, including any required time frame.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42307</p> <p>Based on observation, interview, and record review, the facility failed to ensure the drugs and biologicals used in the facility were stored properly in one of two sampled medication carts (Med Cart 2).</p> <p>This failure had the potential to impact the effectiveness of the medications located in Med Cart 2 and decrease the efficacy (the ability to produce a desired or intended result) of the drugs. The failure had the potential to compromise the health and safety of Resident 33 and the residents who received medication from Med Cart 2 due to administration of the drugs.</p> <p>Findings:</p> <p>During a review of Resident 33's Admission Record (AR), the AR indicated, Resident 33 was originally admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including type 2 diabetes mellitus (adult onset high blood sugar) with diabetic polyneuropathy (when multiple peripheral [relating to the edge of something] nerves become damaged), chronic obstructive pulmonary disease (COPD, a group of [long standing] lung diseases that block airflow and make it difficult to breathe), unspecified and unspecified dementia (a general term to describe a group of symptoms related to loss of memory, judgment, language, complex motor skills, and other intellectual function), unspecified severity, with other behavioral disturbance.</p> <p>During a review of Resident 33's History and Physical (H&P), dated 6/20/2024, the H&P indicated, Resident 33 did not have the capacity to understand and/or sign any form due to dementia.</p> <p>During a review of Resident 33's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 9/16/2024, the MDS indicated, Resident 33's cognitive (ability to think and process information) skills for daily decision making were moderately impaired (decisions poor; cues/supervision required). The MDS indicated, Resident 33 was taking hypoglycemic (including insulin [controls or lowers levels of blood sugar]) medication.</p> <p>During a review of Resident 33's Order Summary Report (OSR), dated active as of 11/15/2024, the OSR indicated a physician's order dated 6/16/2024 for Insulin Aspart (rapid-acting insulin taken before meals that works quickly to prevent blood sugar from getting too high after carbohydrates intake) injection and an order dated 10/6/2024 for One Touch Ultra 2 (a brand name) test strips for blood glucose (blood sugar) monitoring TID (three times a day).</p> <p>During a review of Resident 33's Medication Administration Record (MAR), dated 11/1/2024 - 11/30/2024, the MAR, indicated, Resident 33 was administered (given) Insulin Aspart on 11/3/2024, 11/4/2024, 11/10/2024, 11/11/2024, 11/13/2024 and on 11/14/2024.</p> <p>During a concurrent observation and interview on 11/14/2024 at 2:06 PM with Licensed Vocation Nurse (LVN) 1 during medication storage and labeling task, Med Cart 2 was observed to have the following:</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1. An opened/used Magnesium Citrate (a mineral supplement, house supply once opened only good for one year), 400 mg (milligrams, a unit of measurement) 60 tablet bottle, marked with an opened date of 4/3/2023 and with a manufacturer's expiration date of 09/2025.</p> <p>2. An opened/used PreserVision Eye Vitamin & Mineral (a supplement, house supply once opened only good for one year), bottle, marked with an opened date of 9/21/2023 and with a manufacturer's expiration date of 2025/06.</p> <p>3. 2 unopened Insulin Aspart 100 unit/ml injection Flexpen (a pen prefilled with insulin) inside a ziploc bag with a yellow-colored sticker indicating REFRIGERATE for Resident 33.</p> <p>4. 2 opened/used containers of test strips for glucometer (a small, portable medical device that lets you check your blood glucose [sugar] level) True Metrix Pro, (brand name) and a Glucose Control solution with no opened dates labeled.</p> <p>5. An opened/used container of OneTouch Ultra, (brand name) test strips for blood glucose testing with no open date. The container had manufacturer's instructions to Discard 6 months after opening.</p> <p>LVN 1 stated, it was important to label drugs and biological with the opened date because everything had an expiration date. LVN 1 stated, LVN 1 did not know how long the 2 insulin flexpens had been inside Med Cart 2. LVN 1 stated, the insulin flexpens should have been stored in the refrigerator to keep the insulin from becoming ineffective and could potentially give Resident 33 faulty insulin [administration]. LVN 1 stated, staff would not know when to discard (medications and biologicals) if there was no opened date label.</p> <p>During an interview on 11/15/2024 at 1:36 PM with the Director of Nursing (DON), the DON stated, it was important to store medications properly for the effectivity of the medication so the medication is potent (strong effect) and not ruin the ingredients of the medication.</p> <p>During a review of the facility's policy and procedure (P&P) titled, House Supplied (Floor Stock) Medications, dated 2007, the P&P indicated, floor stock [house supply] medications kept in the original manufacturer's container must have expiration date and lot numbers clearly visible. Unless otherwise specified, the expiration date was limited to the expiration date on the original container or one year's time from date of opening, whichever comes first.</p> <p>During a review of the facility's P&P titled, Obtaining a Fingerstick Glucose Level, revised October 2011, the P&P indicated, if using the blood glucose monitoring system (blood glucose meter with test strips), use test strips before their expiration date.</p> <p>During a review of the facility's P&P titled, Labeling of Medication Containers, revised April 2019, the P&P indicated, all medications maintained in the facility were properly labeled in accordance with current state and federal guidelines and regulations.</p> <p>During a review of the facility's P&P titled, Medication Labeling and Storage, revision date February 2023, the P&P indicated, medications requiring refrigeration were stored in a refrigerator located in the medication room at the nurses' station or other secured location</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40913</p> <p>Based on interview and record review, the facility failed to ensure accuracy of medical records for one of one sampled resident (Resident 23) by failing to:</p> <p>A. Ensure Resident 23's Medication Administration Record (MAR, a log initialed and/or signed by the nurse with the date and time each time a medication is administered to a resident) was complete when on 9/21/2024, 9/25/2024, and 9/28/2024, the facility's Controlled Drug Record for Hydrocodone-Acetaminophen (pain medication used to relieve moderate to severe pain, works in the brain to change how your body feels and responds to pain) 5-325 mg (milligram, unit of measurement) indicated Hydrocodone-Acetaminophen 5-325 mg was removed and Resident 23's MAR did not reflect administration of Hydrocodone-Acetaminophen 5-325 mg.</p> <p>B. Ensure Resident 23's change of condition for the development of a skin rash was documented in Resident 23's medical record.</p> <p>These deficient practices resulted in an inaccurate MAR and had the potential to result in a medication error for Resident 23. Additionally, there was a potential for Resident 23 not to receive the necessary care and treatment for Resident 23's skin rash.</p> <p>Findings:</p> <p>A. During a review of Resident 23's Admission Record (AR), the AR indicated, Resident 23 was admitted to the facility on [DATE] with multiple diagnoses including shortness of breath, anxiety disorder (a mental health disorder of persistent and excessive feelings of worry or fear that interferes with daily activities), and psychosis not due to a substance or known physiological condition (a severe mental condition in which thought and emotions are so affected that contact with reality is lost).</p> <p>During a review of Resident 23's History and Physical (H&P), dated 9/11/2024, the H&P indicated, Resident 23 had the capacity to understand and/or sign any form.</p> <p>During a review of Resident 23's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 9/16/2024, the MDS indicated, Resident 23's cognition (ability to think and process information) status was moderately impaired. The MDS indicated, Resident 23 usually understood verbal content and usually was able to express ideas and wants. The MDS indicated Resident 23 required moderate assistance (helper does less than half the effort) with toileting hygiene, and bed mobility.</p> <p>During a review of Resident 23's Controlled Drug Record for Hydrocodone-Acetaminophen 5-325 mg., dated 9/9/2024, the Controlled Drug Record indicated the medication was removed on the following dates:</p> <p>9/21/24 at 6 PM, 2 tablets were removed.</p> <p>9/22/24 at 9 PM , 2 tablets removed.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>9/23/24 at 2:15 AM, 2 tablets removed.</p> <p>9/23/24 at 7 PM, 2 tablets removed.</p> <p>9/24/24 at 11:42 AM, 2 tablets removed.</p> <p>9/25/24 at 6:15 PM, 2 tablets removed.</p> <p>9/28/24 at 11:20 AM, 2 tablets removed.</p> <p>9/29/24 at 10:30 AM, 2 tablets removed.</p> <p>During a review of Resident 23's Medication Record (MAR) dated September 2024, the MAR indicated one tablet of Hydrocodone-Acetaminophen 10 mg-325 mg. was administered for moderate to severe pain on the following dates, 9/22/2024, 9/23/2024, 9/24/2024, and on 9/29/2024. Resident 23's September 2024 MAR indicated there was one more order for Hydrocodone-Acetaminophen 5-325 mg tablet, two tablets taken by mouth every 4 hours by mouth as needed for pain. The MAR was blank and did not indicate administration of Hydrocodone-Acetaminophen 5-325 mg from 9/1/24 to 9/30/24.</p> <p>During a concurrent interview 11/15/2024 at 4:46 PM and review of the MAR dated September 2024, with the Director of Nursing (DON), the DON stated on 9/2024, the facility used a different computer system to document in the MAR and if there was a computer issue, the licensed nurses would document on the paper MAR. Reviewed the paper MAR with the DON, there was written documentation on 9/24/24 at 11:50 am and on 9/29/24 at 10:30 am.</p> <p>During a concurrent review of Resident 23's Controlled Drug Record for Hydrocodone-Acetaminophen 5-325 mg and concurrent interview on 11/15/2024 at 5:05 PM, the DON stated there were days hydrocodone-acetaminophen was removed and not documented in Resident 23's MAR, the dates were 9/21/24, 9/25/24, and on 9/28/24. The DON stated licensed nurses needed to document on the MAR when hydrocodone-acetaminophen was removed from the supply and administered to Resident 23.</p> <p>During a review of the facility's Policy and Procedure (P&P) titled Administering Medications dated April 2019, the P&P indicated the director of nursing services supervises and directs all personnel who administer medications and/or have related functions and medication errors are documented, reported, and reviewed by the QAPI committee to inform process changes and or the need for additional staff training. The P&P indicated the individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones and as required or indicated for a medication, the individual administering the medication records in the resident's medical record:</p> <p>a. the date and time the medication was administered;</p> <p>b. the dosage;</p> <p>c. the route of administration;</p> <p>d. the injection site (if applicable);</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Royal Oaks Manor-Bradbury Oaks		STREET ADDRESS, CITY, STATE, ZIP CODE 1763 Royal Oaks Drive Duarte, CA 91010	
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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>e. any complaints or symptoms for which the drug was administered;</p> <p>f. any results achieved and when those results were observed; and</p> <p>g. the signature and title of the person administering the drug.</p> <p>During a review of the facility's P&P, titled Charting and Documentation, dated July 2017, the P&P indicated information documented in the resident medical record included, medications administered. The P&P indicated documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.</p> <p>B. During a review of Resident 23's AR), the AR indicated, Resident 23 was admitted to the facility on [DATE] with multiple diagnoses including shortness of breath, anxiety disorder (a mental health disorder of persistent and excessive feelings of worry or fear that interferes with daily activities), and psychosis not due to a substance or known physiological condition (a severe mental condition in which thought and emotions are so affected that contact with reality is lost).</p> <p>During a review of Resident 23's H&P), dated 9/11/2024, the H&P indicated, Resident 23 had the capacity to understand and/or sign any form.</p> <p>During a review of Resident 23's MDS, dated [DATE], the MDS indicated, Resident 23's cognition (ability to think and process information) status was moderately impaired. The MDS indicated, Resident 23 usually understood verbal content and usually was able to express ideas and wants. The MDS indicated Resident 23 required moderate assistance (helper does less than half the effort) with toileting hygiene, and bed mobility.</p> <p>During a concurrent observation and interview on 11/12/2024 at 9:45 AM, Resident 23 had a red scabbed rash on the right arm and elbow. Resident 23 stated the rash was itchy Resident 23 tried not to scratch the area.</p> <p>During a follow-up interview on 11/13/2024 at 2:30 PM, Resident 23 stated Resident 23 did not know how long Resident 23 had the rash and stated maybe since last week.</p> <p>During a review of Resident 23's medical record, there was no change of condition evaluation (COC, a for indicating a sudden clinically important deviation from a resident's baseline in physical, cognitive, behavioral, or functional domains) form.</p> <p>During a review of Resident 23's Long Term Evaluation Progress Notes dated 11/5/2024, 11/7/2024, 11/8/2024, the notes did not indicate Resident 23 had a skin rash or skin issues.</p> <p>During an interview on 11/14/2024 at 3:15 PM, the Treatment Nurse (TN) stated if a resident (in general) developed a new rash, the nurse needed to assess the rash and notify the physician. The nurse also needed to notify the Infection Prevention Nurse (IPN) since it was possible the rash could be infectious. The TN stated the rash was documented on the progress notes but the licensed nurse that discovered the rash needed to complete a COC form so staff would be able to monitor the rash, the area affected, and whether the rash had spread to other parts of the body. The TN stated the rash had spread from the elbow to the lower arm.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility's Policy and Procedure (P&P) Charting and Documentation dated July 2017, the P&P indicated all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record.</p> <p>42307</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50016</p> <p>Based on observation, interview, and record review, the facility failed to maintain its infection prevention and control program for four of seven sampled residents (Resident 2, 26, 41, and 40) by failing to:</p> <p>A. Ensure enhanced barrier precautions (EBP, an infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDROs, bacteria that have become resistant to certain antibiotics] in nursing homes) were followed and hand hygiene was performed when entering and exiting Room A.</p> <p>B. Ensure the toilet seat was clean in the shared restroom of Resident 2 and Resident 26.</p> <p>C. Ensure an open and unlabeled personal toiletry was not stored inside the shared restroom of Residents 41 and 40</p> <p>D. Ensure the clean linen was handled properly in the laundry room.</p> <p>These deficient practices had the potential to result in transmission of infectious microorganisms (an organism that can be seen only through a microscope) and cross contamination (process by which bacteria can be transferred from one area to another) among Residents 2, 26, 41 and 40 and throughout the facility and result in infections.</p> <p>Findings:</p> <p>A. During an observation on 11/12/2024 at 10:43 AM, Room A had signage indicating EBP located on the wall next to Room A's door. Maintenance Technician (MT) 1 and MT 2 entered Room A without personal protective equipment (PPE, clothing or equipment that protects workers from injury or illness in the workplace) or without performing hand hygiene. While inside of Room A, MT 1 adjusted Resident 41's bed, per family member's request. MT 1 touched Resident 41's bed and MT 1's shirt came into direct contact with the bed linens. MT 1 and MT 2 exited Room A without performing hand hygiene.</p> <p>During a joint interview on 11/12/2024 at 10:50 AM, with MT 1 and MT 2, MT 1 stated MT 1 should have gowned up properly prior to entering Room A which was on EBP. MT 1 stated this helped prevent contamination of clothing, gowns, and protected both healthcare workers from potential infections and residents (in general) from acquiring infections. MT 1 stated MT 1 forgot to perform hand hygiene before and after entering Room A. MT 1 stated hand hygiene reduced the risk of spreading harmful germs between patients and healthcare workers, prevented the transmission of infections, and protected the patient's health.</p> <p>During a joint interview on 11/12/2024 at 10:50 AM, with MT 2 and MT 1, MT 2 stated MT 2 forgot to gown up (to wear a gown) before entering Room A and forgot to perform hand hygiene before and after entering the room. MT 2 stated any break in infection control was a problem because this could directly lead to the transmission of infectious diseases between patients and healthcare workers.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 11/14/2024 at 4:30 PM, with the Infection Preventionist (IP), the IP stated hand hygiene should be performed before and after entering residents' rooms. The IP stated hand hygiene significantly reduced the risk of spreading harmful germs between patients and healthcare workers, effectively preventing the transmission of infections and other potentially dangerous microorganisms that could be easily transferred through contaminated hands. The IP stated staff expectations with residents on EBP was to properly gown up when staff performed high-contact resident care activities (any medical procedure or task that involved a healthcare worker having close, direct physical contact with a patient's body). The IP stated staff should gown up [to follow] EBP if their clothing was likely to come into direct contact with [resident] bed linens.</p> <p>During a review of the facility's P&P titled, Handwashing/Hand Hygiene revised dated 8/2019, the P&P indicated:</p> <ol style="list-style-type: none"> 1. The facility considers hand hygiene the primary means to prevent the spread of infections. 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. 3. Use an alcohol-based hand rub containing at least 62% alcohol; or alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: 4. After contact with objects (e.g. medical equipment) in the immediate vicinity of the resident. <p>During a review of the facility's P&P titled, Enhanced Barrier Precautions revised dated 3/2024, the P&P indicated enhanced barrier precautions are used as an infection prevention and control intervention to reduce the transmission of multi-drug resistant organisms (MDROs, [microorganisms that are resistant to one or more classes of antimicrobial agents like antibiotics and antifungals]) to residents.</p> <p>42307</p> <p>B. During a review of Resident 2's Admission Record (AR), the AR indicated, Resident 2 was originally admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including other seizures (a sudden burst of electrical activity in the brain), chronic atrial fibrillation (long standing, rapid, irregular heart beat) and essential (primary) hypertension (high blood pressure).</p> <p>During a review of Resident 2's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 8/2/2024, the MDS indicated, Resident 2's cognition (ability to think and process information) status was severely impaired and used a wheelchair. The MDS indicated, Resident 2 was dependent (helper does all of the effort) with toileting.</p> <p>During a review of Resident 2's History and Physical (H&P), dated 9/20/2024, the H&P indicated, Resident 2 did not have the capacity to understand and/or sign any form.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 26's AR, the AR indicated, Resident 26 was admitted to the facility on [DATE] with multiple diagnoses including unspecified atrial fibrillation, essential (primary) hypertension and unspecified dementia (a general term to describe a group of symptoms related to loss of memory, judgment, language, complex motor skills, and other intellectual function), unspecified severity, without behavioral disturbance, psychotic (a mental disorder characterized by disconnection from reality) disturbance, mood disturbance, and anxiety (intense, excessive, and persistent worry and fear about everyday situations).</p> <p>During a review of Resident 26's History and Physical, dated 6/9/2024, the H&P indicated, Resident 26 did not have the capacity to understand and/or sign any form.</p> <p>During a review of Resident 26's MDS, dated [DATE], the MDS indicated, Resident 26's cognitive status was severely impaired and Resident 26 used the walker or wheelchair. The MDS indicated, Resident 26 required substantial/maximal assistance (helper does more than half the effort) with toileting.</p> <p>During a concurrent observation and interview on 11/12/2024 at 9:04 AM with Certified Nursing Assistant (CNA) 2 inside the shared restroom of Resident 2 and Resident 26, the toilet seat had a large brownish colored fecal (poop) smear. CNA 2 stated, the smear should not be there, not even at home because it was a health risk and cross contamination concern. CNA 2 stated, the toilet seat should have been cleaned.</p> <p>During an interview on 11/12/2024 at 9:12 AM with CNA 4, CNA 4 stated, staff needed to check, and the facility liked to clean up as much as possible and would call maintenance to sanitize Resident 2 and Resident 26's shared toilet seat for sanitary purposes.</p> <p>C. During a review of Resident 41's AR, the AR indicated, Resident 41 was admitted to the facility on [DATE] with multiple diagnoses including traumatic subdural hemorrhage (significant bleeding inside the skull) with loss of consciousness of unspecified duration, subsequent encounter, type 2 diabetes mellitus (adult-onset high blood sugar level)</p> <p>without complications, essential (primary) hypertension (low blood pressure).</p> <p>During a review of Resident 41's H&P, dated 8/28/2024, the H&P indicated, Resident 41 was minimally verbal and not able to follow commands.</p> <p>During a review of Resident 41's MDS, dated [DATE], the MDS indicated, Resident 41's cognitive (ability to think and process information) skills for daily decision making were severely impaired (never/rarely made decisions). The MDS indicated, Resident 41 was dependent for activities of daily living (ADL, term used in healthcare that refers to self-care activities).</p> <p>During a review of Resident 40's AR, the AR indicated, Resident 40 was admitted to the facility on [DATE] with multiple diagnoses including hypotension (low blood pressure), unspecified, down syndrome (a genetic chromosome 21 disorder causing developmental and intellectual delays) and cachexia (a general state of ill health involving great weight loss and muscle loss).</p> <p>During a review of Resident 40's H&P, dated 10/4/2024, the H&P indicated, Resident 40 did not have the capacity to understand and/or sign any form.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 40's MDS, dated [DATE], the MDS indicated, Resident 40's cognitive status was moderately impaired. The MDS indicated, Resident 40 was dependent to requiring substantial/maximal assistance with ADLs.</p> <p>During a concurrent observation and interview on 11/12/2024 at 10:48 AM with Licensed Vocational Nurse (LVN) 2, inside the shared restroom of Resident 41 and Resident 40, on top of the sink there was an unlabeled 33.8 fl. oz (fluid ounce, a unit of measurement) bottle of Tena (name brand) cleansing cream. LVN 2 stated, the cleansing cream was used to clean the private areas of the body. LVN 2 stated, the cleansing cream should have been labeled with a resident's name to avoid cross contamination.</p> <p>D. During a concurrent observation and interview on 11/15/2024 at 11:45 AM with the Housekeeping/Laundry Supervisor (HLS) and the Building and Grounds Director (BGD) inside the laundry room, Laundry Aide (LA) 1 and LA 2 were removing dried laundry from the dryers and putting the dried laundry into a hamper. LA 2 was grabbing dried linens from the hamper to be sorted out/folded and in the process while LA 2 was handling the linen, the bottom of the linen was touching and dragging on the floor. LA 1 stated, the linen should not be touching the floor since the floor was dirty, affects the patients and for infection control purposes.</p> <p>During an interview on 11/15/2024 at 1:22 PM with the Infection Preventionist (IP), the IP stated, the toilet seat should not be left with fecal smear absolutely not for infection control [purposes]. The IP stated, personal toiletry should be labeled with resident's name to prevent cross contamination.</p> <p>During a review of the facility's P&P titled, Departmental (Environmental Services) - Laundry and Linen, revised January 2014, the P&P indicated, clean linen will remain hygienically clean (free of pathogens in sufficient numbers to cause human illness) through measures designed to protect it from environmental contamination.</p> <p>During a review of the facility's P&P titled, Handling Clean Linen, revision date 11/14/23, the P&P indicated, after washing, cleaned/dried textiles, fabrics and clothing shall be pressed, folded and packaged for transport, distribution and storage by methods that ensure their cleanliness until used.</p>

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42307</p> <p>Based on interview and record review, the facility failed to ensure administration of the Influenza ([flu] a common, sometimes deadly infection of the nose, throat and lungs) vaccine (are injections [shots], liquids, pills, or nasal sprays you receive to protect you against harmful diseases, before you come into contact with them) for one of five sampled residents (Resident 23), who was eligible and consented to receive the flu vaccine.</p> <p>This deficient practice placed Resident 23 at greater risk for acquiring, transmitting, or experiencing complications from the flu and had the potential to result in a physical decline to Resident 23.</p> <p>Findings:</p> <p>During a review of Resident 23's Admission Record (AR), the AR indicated, Resident 23 was admitted to the facility on [DATE] with multiple diagnoses including shortness of breath, anxiety disorder (a mental health disorder of persistent and excessive feelings of worry or fear that interferes with daily activities), and fever, unspecified.</p> <p>During a review of Resident 23's History and Physical (H&P), dated 9/11/2024, the H&P indicated, Resident 23 had the capacity to understand and/or sign any form.</p> <p>During a review of Resident 23's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 9/16/2024, the MDS indicated, Resident 23's cognition (ability to think and process information) status was moderately impaired. The MDS indicated, Resident 23 did not receive the influenza vaccine in the facility.</p> <p>During a review of Resident 23's Order Summary Report (OSR), dated active as of 11/15/2024, the OSR included a physician's order, dated 9/27/2024, that indicated Resident 23 may receive the annual influenza vaccine.</p> <p>During a concurrent interview and record review on 11/15/2024 at 10:01 AM with the Infection Prevention Nurse (IPN), Resident 23's Resident Immunization Consent or Refusal Form (RICRF), and the facility's Resident Vaccination Log (RVL), were reviewed. The RICRF indicated, Resident 23 signed the consent to receive the flu vaccine on 9/9/2024. The RVL indicated, Resident 23 did not receive the flu vaccine. The IPN stated flu vaccine administration started in September. The IPN stated, Resident 23 should have received the flu vaccine to protect Resident 23 from getting the flu, from getting sick, and if Resident 23 got the flu, the flu would not be worse.</p> <p>During a review of the facility's policy and procedure (P&P), titled Vaccination of Residents, revised October 2019, the P&P indicated, all residents would be offered vaccines that aid in preventing infectious diseases unless the vaccine was medically contraindicated, or the resident had already been vaccinated. The P&P indicated, certain vaccines (e.g., influenza and pneumococcal vaccines) may be administered per the physician-approved facility protocol (standing orders) after the resident has been assessed by the physician for medical contraindications for each vaccine.</p> <p>(continued on next page)</p>		

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<p>F 0883</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 P&P titled Influenza, Prevention and Control of Seasonal, revised October 2019, the P&P indicated, the facility followed current guidelines and recommendations for the prevention and control of seasonal influenza.</p>

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42307</p> <p>B. During a review of Resident 39's AR, the AR indicated, Resident 39 was originally admitted to the facility on [DATE] with multiple diagnoses including anxiety disorder (a mental health disorder of persistent and excessive feelings of worry or fear that interferes with daily activities), encounter for attention to gastrostomy (a surgical procedure used to insert a tube often referred to as a G-tube through the abdomen and into the stomach for feeding and medications) and need for assistance with personal care.</p> <p>During a review of Resident 39's History and Physical, dated 10/16/2024, the H&P indicated, Resident 39 was in NAD (no acute distress) and was awake, alert, and oriented x 3 (to person, place, and time).</p> <p>During a review of Resident 39's MDS, dated [DATE], the MDS indicated, Resident 39's cognition (ability to think and process information) status was moderately impaired. The MDS indicated, Resident 39 was dependent (helper does all the effort, resident does none of the effort to complete the activity, or the assistance of two or more helpers is required for the resident to complete the activity) to requiring substantial/maximal assistance (helper does more than half of the effort) for all activities of daily living. The MDS indicated, Resident 39 had a feeding tube (e.g. nasogastric [a thin, soft tube that is inserted through the nose and into the stomach to deliver food, liquids, or medicine] or abdominal [PEG]).</p> <p>During a concurrent observation and interview on 11/12/2024 at 9:46 a.m. with the Director of Staff Development (DSD) inside Resident 39's room, Resident 39 was asleep in bed and the call light was not within sight. The DSD looked for Resident 39's call light and found the call light looped around Resident 39's G-tube feeding pump, located in the back and on the left side of Resident 39's head of bed. The DSD stated Resident 39's call light should be within Resident 39's reach so Resident 39 could call for help when needed.</p> <p>During an interview on 11/14/2024 at 9:31 a.m. with the Director of Nursing (DON), the DON stated it was important of course for the call light to always be within the reach of residents (in general) for residents to use and to call in case residents needed help and assistance. The DON stated the call light was part of communicating their [residents] needs.</p> <p>During a review of Resident 39's Care Plan (CP, provides direction on the type of nursing care an individual needs that include goals of treatment, specific nursing interventions [actions, treatments, procedures, or activities designed to meet an objective] and an evaluation plan), titled, Resident 39 uses quarter side rails to enhance functional independence & promote skin integrity, date initiated 10/28/2024, the CP indicated, one of the interventions was to place the call light cord within easy reach.</p> <p>50016</p> <p>Based on observation, interview, and record review, the facility failed to ensure call lights were within reach for two of two sampled residents (Resident 300 and 39) as indicated in the facility's policy and procedure (P&P) titled Answering Call Light.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Royal Oaks Manor-Bradbury Oaks		STREET ADDRESS, CITY, STATE, ZIP CODE 1763 Royal Oaks Drive Duarte, CA 91010	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>This deficient practice had the potential to result in a delay or the inability for Residents 300 and 39 to obtain necessary care and services.</p> <p>Findings:</p> <p>A. During a review of Resident 300's Admission Record (AR), the AR indicated the facility admitted Resident 300 on 11/6/2024, with diagnosis including, encephalopathy (a serious health problem that affects brain function or structure), muscle weakness, and cellulitis (a bacterial [living organism that can cause an infection] infection that affects the skin and tissues below).</p> <p>During a review of Resident 300's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 11/12/2024, the MDS indicated Resident 300 had severe cognitive (the ability to understand and process information) impairment. The MDS indicated Resident 300 required substantial/maximal assistance (helper does more than half the effort and helper lifts or holds trunk or limbs and provides more than half the effort) with activities of daily living (ADL, term used in healthcare that refers to self-care activities) and required substantial/maximal assistance (helper does all the effort) with mobility.</p> <p>During an observation on 11/12/2024 at 10:21 AM, Resident 300 was lying in bed and Resident 300's call light was observed hanging from the upper bed rail tucked between the wall and Resident 300's bed mattress.</p> <p>During an interview on 11/12/2024 at 10:21 AM, with Resident 300, Resident 300 stated that Resident 300 did not know where Resident 300's call light was located. Resident 300 stated Resident 300 was admitted to the facility about a week ago and Resident 300 was unaware of the facility's call light system and waited for staff to enter the room [to ask] for assistance.</p> <p>During an interview on 11/12/2024 at 10:49 AM, with Certified Nursing Assistant (CNA) 2, CNA 2 stated Resident 300's call light was not within Resident 300's reach and the call light should have been placed where it was easily accessible to Resident 300 in case Resident 300 required assistance. CNA 2 stated resident (in general) call lights must always be within reach [because] this allowed the residents to quickly request assistance and improved communication between patients and staff. CNA 2 stated this ensured patients connected with staff and [call lights within reach were] important for patient safety and satisfaction. CNA 2 stated residents should be educated and on the call light system upon admission and frequently reminded on the importance of using the call light system.</p> <p>During an interview on 11/14/2024 at 1:31 PM, with the DON, the DON stated call lights were important as they provided residents with a direct means to communicate their needs to staff. The DON stated call lights ensured patient safety and satisfaction. The DON stated residents should be educated on call lights because they served as a critical communication tool between patients and staff.</p> <p>During a review of the facility's P&P titled Answering Call Light, dated revised 9/2022, indicated that the facility will:</p> <ol style="list-style-type: none"> 1. Upon admission and periodically as needed, explain, and demonstrate use of the call light to the resident. 2. Ask the resident to return the demonstration. <p>(continued on next page)</p>		

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 11/15/2024
NAME OF PROVIDER OR SUPPLIER Royal Oaks Manor-Bradbury Oaks		STREET ADDRESS, CITY, STATE, ZIP CODE 1763 Royal Oaks Drive Duarte, CA 91010	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. Ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor.</p>