STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055041	A. BUILDING _____ B. WING _____	**08/10/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ROYAL CARE SKILLED NURSING CTR	**2725 PACIFIC AVENUE LONG BEACH, CA 90806**

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	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement safety measures as per its policy and procedure, which included sensor mats, floor pads, non-skid mats and other equipment to prevent falls and injury for one of three sampled residents (Resident 1). Resident 1, who had a high risk for falls with a history of falls and an impulsive behavior of ambulating without assistance, was not provided with adequate supervision and assistance devices to prevent further falls. This deficient practice resulted in Resident 1 falling three (3) times within six days, and the last fall required a transfer to the GACH. Resident 1's condition was so severe the resident had to be transferred from GACH 1 to GACH 2 and an admission into the intensive care unit ((ICU) a higher level of care), with a [MEDICAL CONDITION] (deep cut), traumatic subdural hematoma (a collection of blood outside the brain), and a left rib fractures ((bones on both sides of the chest) broken bone) with a [MEDICAL CONDITION] contusion (a bruise on the lung). Findings: A review of Resident 1's Admission Face Sheet indicated Resident 1 was admitted to the facility on [DATE] and last readmitted on [DATE]. Resident 1's [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set (MDS), a resident assessment and care screening tool, dated 2/27/2020 indicated Resident 1 had no cognitive impairment (thought process). The MDS, under Section G110, Resident 1 was assessed requiring a one-person physical assist during bed mobility, toilet use, transferring, locomotion on and off the unit, personal hygiene and dressing. The MDS indicated Resident 1 required an extensive assistance with walking in room and corridor, as well as eating. According to the MDS, Resident 1 used a walker and wheelchair for mobility and was assessed as having an abnormal gait (manner of walking) and mobility. A review of Resident 1's Initial Fall Risk Screen, dated 2/21/2020 indicated Resident 1 had a score of 36 (total score of 25 to 44 indicated moderate risk for falls). According to the Initial Fall Risk Screen, Resident 1 had an impaired gait and required the use of an assistive device, such as a wheelchair. A review of Resident 1's care plan, initiated on 2/24/2020, identified a problem for risk for falls and injuries. The goal indicated Resident 1 would have decreased risk of falls and/or injuries for 90 days. The staff's interventions included to keep the call light in reach and keep the environment clutter free. A review of a Situation, Background, Assessment and Recommendation ((SBAR) an internal communication form), dated 3/7/2020 and timed at 9:45 a.m. indicated a fall report for Resident 1. The SBAR indicated Resident 1 was found by an unspecified staff member sitting on the floor near the bathroom in the room. The SBAR indicated a bed alarm was in place for Resident 1 and the bed was in the lowest position. Neurological checks (an examination of the motor responses to determine [MEDICAL CONDITION] or impairment) done and safety protocol in place. Will continue to monitor the resident's (Resident 1) whereabouts at all times. A review of Resident 1's plan of care (2/24/2020) for falls and injury indicated it was not revised nor updated after the resident fell to prevent Resident 1 from further falls. A review of an SBAR, dated 3/9/2020 and timed at 4:02 p.m., indicated Resident 1 had a second fall. The SBAR indicated Resident 1 was found on the floor lying on his left side with no injury noted. According to the SBAR, Resident 1 was able to move the upper and lower extremities. Resident 1 was observed with a bump and bruising to left side of the head. The SBAR indicated a skull x-ray was ordered and done without indication of the results. A review of a SBAR written by Licensed Vocational Nurse 1 (LVN 1), dated 3/13/2020 and timed at 10:35 a.m. indicated a Fall report incident. The SBAR indicated Resident 1 was found on the floor, with a laceration (deep cut) on the forehead. The SBAR indicated a possible contributing factor to Resident 1's falls was Resident 1 did not ask for help or the used the call light. A review of Resident 1's GACH 1 Emergency Department (ED) report, dated 3/13/2020 and timed at 11:40 a.m. indicated Resident 1 arrived to the ED with a 4 centimeters ((4 cm) unit of measurement) in size right eyebrow laceration after a fall with a pressure gauze dressing in place. A review of GACH 1's ED report, dated 3/13/2020 and timed at 12 p.m. indicated Resident 1 was transported immediately for a computed tomography ((CT Scan) an imagery that reveals anatomic details of internal organs that cannot be seen on conventional x-rays) of the head. The report dated 3/13/2020 and timed at 12:47 p.m. indicated the ED was contacted to transfer Resident 1 to GACH 2 for a higher level of care. GACH 1's ED documentation indicated the paramedics were at the bedside to transport Resident 1 via 911 to GACH 2 due to a brain bleed. Resident 1's Blood pressure was elevated at 149/129 (normal reference range (NRR) is 90/60-139/79). A review of GACH 2's ED report, dated 3/13/2020 and timed at 1:10 p.m. indicated Resident 1 arrived from GACH 1 with a [DIAGNOSES REDACTED]. GACH 2's ED report indicated Resident 1 had an altered level of consciousness ((ALOC) lack of responsiveness to stimuli) with a hematoma and laceration near the right eye. A review of GACH 2's ED report, dated 3/13/2020 and timed at 1:47 p.m. indicated Resident 1 sustained a confirmed holohemispheric subdural hematoma (a type of bleeding in which there is a collection of blood associated with a [MEDICAL CONDITION] gathers between the inner layers of the brain), left chest ecchymosis (bruising) with a left [MEDICAL CONDITION] contusion (a bruise on the left lung caused by chest trauma), left flank (side of the body between the ribs and the hip) ecchymosis (a hemorrhagic spot in the skin or mucous membrane, forming a flat, rounded or irregular, blue or purplish patch), a left nondisplaced fracture (broken bone) of the left seventh rib and with closure of the [MEDICAL CONDITION]. Resident 1 was admitted into the ICU. GACH 2's ED report indicated Resident 1's medical condition placed him at an increased risk of decompensation (showing signs of deterioration regarding daily functioning) and death. On 4/9/2020 at 7:42 a.m., during a telephone interview, Certified Nursing Assistant 1 (CNA 1) stated she was providing care for another resident and stated she was called by LVN 1 for an emergency to assist with Resident 1. CNA 1 stated she saw Resident 1 on the floor and LVN 2 was applying pressure to Resident 1's forehead. CNA 1 stated Resident 1 had a [MEDICAL CONDITION] after falling in his room. CNA 1 stated Resident 1 always tried to get out of his bed and wheelchair without assistance from the staff. On 4/9/2020 at 8:03 a.m., during a telephone interview, LVN 1 stated Resident 1 was offered his morning medications on 3/13/2020 but refused. LVN 1 stated about five minutes later Resident 1's roommate called the staff to report Resident 1 had fallen two times in the room. LVN 1 stated she heard Resident 1 fall again from the hallway and she responded right away. LVN 1 stated upon entering the room she observed Resident 1 on the floor laying on his side, with a laceration on his forehead above the right eyebrow. LVN 1 stated she called for help and the treatment nurse (LVN 2) responded. LVN 1 stated Resident 1 sustained a bleeding laceration and LVN 2 applied a gauze and an ice pack to the site. LVN 1 stated Resident 1's physician was called and gave an order to transfer the resident out to GACH 1. On 4/9/2020 at 8:22 a.m., during a telephone interview, LVN 2 stated Resident 1 sustained a laceration of the forehead after a fall but was stable. According to LVN 2, Resident 1 was at risk for falls due to a history of getting up from his wheelchair unassisted and unsupervised. LVN 2 stated an Interdisciplinary Team ((IDT) a group of healthcare providers from different fields who work together or toward the same goal to provide the best care or best outcome for a resident) Meeting was held with the Administrator (ADM) and staff regarding Resident 1's fall. According to LVN 2, the ADM was aware of Resident 1's fall because she documented about the fall on the facility's communication board. On 4/9/2020 at 8:39 a.m., during a telephone interview, the ADM stated he was made aware of Resident 1's fall with

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

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F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) laceration by the staff during the morning huddle (rounds). The ADM stated he was not aware of the extent of Resident 1's injuries, which included a rib fracture and subdural hematoma. A review of the facility's policy and procedure (P/P) titled, Fall Management, dated 8/2014, indicated the purpose of the P/P was to evaluate risk factors and provide interventions to minimize risk, injury and occurrences. The P/P indicated fall prevention may include but is not limited to alarms, sensor mats, transfer poles, floor pads, non-skid mats, handrails, grab bars, trapeze, adaptive equipment, transfer lifts etc.