STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055899	A. BUILDING _____ B. WING _____	**05/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ROYAL PALMS POST ACUTE	**630 W. BROADWAY GLENDALE, CA 91204**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0698 **Level of harm -** Actual harm **Residents Affected -** Few	**Past noncompliance - remedy proposed** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record and review and interview, the facility failed to ensure that one of six sampled residents (Resident 1), who was receiving [MEDICAL TREATMENT] (a procedure to remove fluids and toxins from the blood), received care and services according to Resident 1's plan of care and facility's policy and procedure. Resident 1's [MEDICAL TREATMENT] on the left upper arm (LUA)was not assessed and had no assessment documentation for bleeding, drainage, bleeding, redness, swelling, pain, bruit (swishing sounds heard with a stethoscope), thrill (vibration felt through palpation), and dressing site on admission and after [MEDICAL TREATMENT] treatment that started at 6:47 p.m. for three hours on [DATE] and between 5:45 a.m. and 9:10 a.m., on [DATE]. This deficient practice resulted in Resident 1 bleeding profusely (large amount) from her arteriovenous fistula (AV, an abnormal connection between an artery and a vein) on the LUA on [DATE] at 9:15 a.m. The facility staff found Resident 1 unresponsive (not replying or reacting to someone's question, request, demand) in her room. Cardiopulmonary resuscitation (CPR, an emergency procedure to attempt to revive a person in [MEDICAL CONDITION]) was initiated, and 911 (medical telephone emergency) was called. The paramedics were at the resident bedside at 9:27 a.m. The heart monitor indicated no heartbeat, and Resident 1 was pronounced dead in the facility on [DATE] at 9:47 a.m. Findings: A review of Resident 1's Admission Record indicated the facility admitted the resident on [DATE] and readmitted her on [DATE] (Monday) with [DIAGNOSES REDACTED]. A review of Resident 1's care plan initiated on [DATE], titled Resident Needs [MEDICAL TREATMENT], related to renal (kidney) failure indicated Resident 1 received [MEDICAL TREATMENT] treatment at 2:00 p.m. every Monday, Wednesday and Friday. The care plan interventions indicated the staff would monitor/document/report as necessary (prn) including changes in level of consciousness or bleeding. A review of Resident 1's Minimum Data Set (MDS - standardized assessment and care-planning tool) dated [DATE] indicated Resident 1 had severe cognition (ability to think and process information) impairment, cued to recall a piece of furniture, and dependent/required full staff support for bed mobility, transfers, toileting, and personal hygiene. Resident 1 did not walk and used a wheelchair for mobility. A review of Resident 1's physician's orders [REDACTED]. A review of Resident 1's Progress Notes dated [DATE] and timed 8:21 p.m. indicated the facility admitted Resident 1 from a general acute care hospital (GACH 1). There was no documentation Resident 1's AV fistula on the LUA was assessed upon admission for bleeding, drainage, bleeding, redness, swelling, pain, bruit, thrill, and dressing site. A review of Resident 1's GACH 1 medical record for [MEDICAL TREATMENT] indicated Resident 1's [MEDICAL TREATMENT] treatment was started on [DATE] at 6:47 p.m. for a duration of three hours. A review of the facility's Nurse's [MEDICAL TREATMENT] Communication Record indicated Pre-[MEDICAL TREATMENT] Assessment and Facility's Post [MEDICAL TREATMENT] Check to be completed by the facility's licensed nurse and to check access site for bleeding, drainage, redness, swelling, pain, bruit, thrill, and dressing site. A review of Resident 1's medical records indicated no documentation for a Nurse's [MEDICAL TREATMENT] Communication Record for post [MEDICAL TREATMENT] check that included assessment to check Resident 1's AV fistula for bleeding, redness, swelling pain, bruit, thrill, and dressing site after admission on [DATE] at 8:21 p.m. A review of Resident 1's Progress Notes dated [DATE] timed 5:04 a.m. completed by Licensed Vocational Nurse 2 (LVN 2) indicated Resident 1 was sleeping, easily arousable to tactile (touch) and verbal stimuli (stimulation). Resident 1 was not in distress or discomfort. Resident 1's AV fistula on the LUA was intact with bruit and thrill. No signs and symptoms of infection or active bleeding, temperature (T) 98.1, pulse (HR, heart rate) 76, respiration (RR) 18 and blood pressure (BP) ,[DATE]. A review of Resident 1's VCSL-SBAR/COC record, dated [DATE] and timed 10:44 a.m. completed by Registered Nurse 2 (RN 2) indicated Resident 1 was found unresponsive in her room, Life saving measures initiated, and unable to appreciate the resident's vital signs on [DATE]. The record indicated that at 9:15 a.m. Resident 1 was found bleeding profusely from the AV fistula on the LUA, pressure applied, and tourniquet applied above AV fistula site. At 9:20 a.m., Resident 1's oxygen saturation (a measurement of your blood oxygen) was at 82 percent (%) reference range (95% to 100%). Oxygen was administered at 15 liters per minute (LPM) via a non-rebreather mask and cardiopulmonary resuscitation (CPR, an emergency procedure that combines chest compressions and ventilation to manually preserve intact brain function until further measures are taken to restore spontaneous blood circulation and breathing in a person who is in [MEDICAL CONDITION]) was initiated. Resident 1 was still bleeding from AV fistula site on the LUA. At 9:22 a.m., the paramedics arrived at the bedside. At 9:30 a.m., an intravenous (IV, into vein) was started at Resident 1's right lower leg and normal saline solution was administered. At 9:47 a.m., Resident 1 was in asystole (no heartbeat), on cardiac (heart) monitor and Resident 1 was pronounced dead by 9:47 a.m. A review of emergency response service (EMS, a system that provides emergency medical care) 911 run sheet dated [DATE] indicated Resident 1 was last seen normal by staff at 8:00 a.m. The run sheet indicated at 9:15 a.m., the resident was found unresponsive by staff with profuse (excessive) bleeding from [MEDICAL TREATMENT] fistula. The run sheet indicated Resident 1 pulled the fistula out and lost a, large amount of blood and that the area appeared to have been cleaned with ammonia (colorless gas with a characteristic pungent smell). Resident 1 did not have blood pressure or pulse (heart rate) from 9:27 a.m. to 9:45 a.m. During a telephone interview, on [DATE] at 7:54 a.m., the Occupational Therapist (OT) stated, on [DATE] at around 9:00 a.m., she observed Resident 1 in bed and thought the resident was sound asleep. However, the OT stated she noticed the resident's top blanket stained with blood, pulled back the blanket and saw a pool of blood on the resident's left trunk and the bottom sheet soaked with blood. The OT stated Resident 1 looked pale, like white color, and felt warm to touch. The OT stated she immediately called for help. During a telephone interview on [DATE] at 8:06 a.m., Certified Nurse Assistant 1 (CNA 1) stated on [DATE], he reported to work at 7:00 a.m. CNA1 stated at 8:00 a.m., he made rounds by walking in and out of the residents' rooms on assigned residents including Resident 1. CNA 1 stated at 8:55 a.m., he took his break and returned at 9:15 a.m. CNA 1 stated at 9:20 a.m., a therapist (did not know the name) came from Resident 1's room and stated the resident was bleeding. CNA 1 stated Resident 1's left side soaked in blood from under the arm to the waist line. CNA 1 stated he called LVN 1, called code blue (emergency response), brought oxygen, and started performing cardiopulmonary resuscitation. CNA 1 stated another CNA, LVN 1 and himself were the only staff in the room performing CPR on Resident 1. CNA 1 did not state Resident 1 received oxygen during CPR after asked multiple times or the AV fistula ruptured (break open). During a telephone interview on [DATE] at 8:21 a.m., LVN 1 stated she reported to work at 8:15 a.m., Because I was late. LVN 1 stated LVN 2 handed over that the facility admitted Resident 1 after [MEDICAL TREATMENT] treatment on [DATE] at 8:21 p.m., LVN 1 stated she did not assess Resident 1's [MEDICAL TREATMENT] during rounds and before medication administration. LVN 1 stated she started medication pass at 8:25 a.m. after making rounds. LVN 1 stated the OT alerted her that Resident 1's LUA was bleeding. LVN 1 stated Resident 1 had significant amount of blood on the bed and gown. LVN 1 stated she applied pressure to Resident 1's LUA. LVN 1 stated Resident 1 had a low oxygen saturation (amount of oxygen in the blood) 87 %. LVN 1 stated she called for help and one of the nurses applied pressure to Resident 1's LUA and relieved each other with the chest compressions. LVN 1 did not mention Resident 1's AV fistula ruptured. During an interview on [DATE] at 7:32 p.m., the Director of Nurses (DON) stated the Occupational Therapist (OT) found Resident 1 unresponsive and bleeding. The DON stated the licensed nurses must check Resident 1's LUA [MEDICAL TREATMENT] for thrill and bruit, signs of infection, pain, [MEDICAL CONDITION] (swelling) and or

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 0698 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) bleeding, assess Resident 1 for signs and symptoms of distress, and document on the progress notes every shift. Concurrently, a review of the Nurses' Progress Notes dated [DATE] timed 5:04 a.m., indicated the resident's AV fistula had a bruit and thrill. The DON stated there was no further assessment of the resident's AV fistula and or resident assessment done/documented until [DATE] at 5:04 a.m. The DON stated four hours had passed before the facility's staff identified Resident 1 was bleeding from AV fistula site. During a telephone interview on [DATE] at 1:01 p.m., Registered Nurse 2 (RN 2) stated a staff from the rehabilitation department and another nurse informed her that there was an emergency due to Resident 1's bleeding. RN 2 stated she immediately went to the resident's bedside, the resident was unresponsive and was bleeding a lot from the LUA fistula. RN 2 stated LVN 1 applied pressure on Resident 1's LUA and another licensed nurse applied a tourniquet (any device for arresting bleeding by forcibly compressing a blood vessel, as a bandage tightened by twisting) above the fistula. RN 2 stated LVN 1 and a certified nurse assistant (CNA) started performing cardiopulmonary resuscitation. RN 2 stated Resident 1 did not have a blood pressure, heart rate, respiration rate, and temperature. A review of Resident 1's Certificate of Death, indicated the resident died on [DATE] at 9:15 a.m., and cause of death listed as: cardiopulmonary arrest (abrupt loss of heart function, breathing and consciousness), exsanguination (the action of draining a person, animal, or organ of blood) line to ruptured left arm [MEDICAL TREATMENT] graft, and acute (sudden) [MEDICAL CONDITION] infarction ([MEDICAL CONDITION]). The certificate of death indicated Resident 1 had left arm [MEDICAL TREATMENT] fistula placement on [DATE]. Resident 1's physician signed the certificate of death on [DATE]. During a telephone interview, on [DATE] at 8:25 a.m., the Responsible Party (RP) stated Resident 1 had the AV fistula created on [DATE]. RP stated the facility admitted Resident 1 on [DATE] at 8:00 p.m., and the dressing remained clean, dry and intact pressure dressing on the resident's LUA remained clean, when RP left the facility. RP stated RN 2 contacted her on [DATE] at 9:15 a.m. and stated Resident 1 had massive bleeding on the [MEDICAL TREATMENT]. During a telephone interview with Resident 1's Physician (Physician 2) on [DATE] at 4:09 p.m., the Physician 2 stated the facility either phoned him or sent him a text on [DATE] that indicated Resident 1 died . The Physician 2 stated the facility indicated the resident bled from [MEDICAL TREATMENT] site. The Physician 2 stated Resident 1 died from severe [MEDICAL CONDITION] due to severe bleeding. The Physician 2 stated he completed the resident's certificate of death. During a telephone interview on [DATE] at 3:51 p.m. the Assistant Director of Nurses (ADON) stated the facility uses the Nurse's [MEDICAL TREATMENT] Communication Record for Residents who are dialyzed at a contracted [MEDICAL TREATMENT] center. The ADON stated licensed nurses and CNAs check on all residents' [MEDICAL TREATMENT] and check on each resident to identify any needs and concerns at the beginning of each shift and every two hours. During a telephone interview and concurrent record review of the facility's Nursing [MEDICAL TREATMENT] Communication Record, on [DATE] at 10:19 a.m., the DON stated the Nursing [MEDICAL TREATMENT] Communication Record was completed after a resident return back from [MEDICAL TREATMENT]. The DON stated after the post [MEDICAL TREATMENT] check was completed, the [MEDICAL TREATMENT] was checked every shift. A review of the facility's policy and procedure, titled [MEDICAL TREATMENT] Access Care Steps in the Procedure Care of AVFs and AVGs revised date ,[DATE] indicated to check for signs of infection (warmth, redness, tenderness, or [MEDICAL CONDITION]) at the access site when performing routine care and at regular intervals. A review of the facility's End-State [MEDICAL CONDITION], Care of a Resident, revised date, ,[DATE], indicated education and training of staff include a type of assessment data that was to be gathered about the resident's condition on a daily or per shift basis. The education and training included recognizing and intervening in medical emergencies such as hemorrhage (bleeding). A review of the facility's policy and procedure, titled Routine Resident Checks revised ,[DATE] indicated the staff shall make routine resident checks to help maintain resident safety and well-being. Routine checks involve entering the resident's room to determine if the resident's needs are being met, and identify any change in the resident's condition.