STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555503	A. BUILDING _____ B. WING _____	**05/08/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ROYAL OAKS MANOR-BRADBURY OAKS	**1763 ROYAL OAKS DRIVE DUARTE, CA 91010**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure to notify a resident's physician for one of two sampled residents (Resident 1) when there was a change in condition. Resident 1 readmitted from the general acute care hospital (GACH) to the facility with wet lung secretions, pale, clammy, and [MEDICAL CONDITION] (swelling). The facility did not transfer Resident 1 back to the GACH for four hours. This deficient practice resulted in a delay in receiving medical services and had the potential for the resident to further decline in health. Findings: A review of Resident 1's Detailed Summary (a record of admission) indicated the resident admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set (MDS), a standardized assessment and care-screening tool, dated 1/15/2020, indicated the resident had severe impairment in cognitive skills. According to the MDS, Resident 1 required extensive assistance (resident involved in activity, staff provided weight-bearing support) from staff for transferring, dressing, and toileting. During an interview, on 5/7/2020 at 12:40 p.m., the Director of Nurses (DON) stated Resident 1 arrived to the facility at 4:19 p.m. on 2/13/2020. The DON stated that when Resident 1 arrived, the resident had decreased pulse (heart rate), [MEDICAL CONDITION], and wet lung sounds (normal lung sounds is clear). The DON stated Resident 1's physician should have been notified right away about the wet lung sounds and [MEDICAL CONDITION] because it was considered a change of condition (COC) for the resident. The DON stated there is no documentation indicating the facility staff notified Resident 1's physician about the COC. The DON stated if the nurses feel like the resident was in distress they should call the physician right away and if they do not get a response from the physician right away, the facility staff would call the Medical Director next. During an interview, on 5/7/2020 at 2:18 p.m., a Licensed Vocational Nurse 1 (LVN 1) stated when she arrived at the start of her shift Resident 1 was already at the facility. LVN 1 stated Resident 1 was exhibiting labored breathing, had congestion and needed suctioning. LVN 1 stated Resident 1 told her that he did not feel good. A review of Resident 1's Vital Stats for the period 2/13/2020 thru 5/8/2020, indicated on 2/13/20 at 3:23 p.m., Resident 1's vital signs are as follows: temperature 98.4 degrees Fahrenheit (F), Pulse (heart rate) 104, Respirations (breathing rate per minute) 22, and Oxygen saturation (O2 sat, a measurement of O2 level in the blood) 96 percent (%) (normal 95 to 100%) on room air. A review of Resident 1's Interdisciplinary Notes (Nursing) dated 2/13/2020 at 4:25 p.m., indicated Resident 1 admitted to the facility with lungs wet with secretions, pale and clammy, plus three (+3, moderate to severe) [MEDICAL CONDITION] to bilateral lower extremities (both lower legs), and had a weak grip strength. A review of Resident 1's Interdisciplinary Notes (Nursing) dated 2/13/2020 at 11:52 p.m., indicated Resident 1 had labored breathing, heavy secretions, pale skin, and discomfort. Vital signs were heart rate 123 (normal 80 to 100), blood pressure (BP) 140/80 (normal less than 120/80 and above 90/60), O2 sat 88 %, and temperature 101.9 (normal range 97 to 99). Resident 1 was suctioned with 360 milliliters (ml) output of light yellow secretions. Resident 1 received 2 liters (L) O2 via nasal cannula (a tubing used to deliver supplemental O2 through the nares) and Tylenol (a medication used to treat pain and elevated temperatures). The note indicated the nurse rechecked Resident 1's vital signs and indicated the following: BP 153/86, temperature 100.0, O2 sat 96% and heart rate 107. The note indicated the nurse paged and notified Resident 1's physician about Resident 1's change in condition. The noted indicated the family wanted Resident 1 to go back to the GACH. The facility staff called 911 and Resident 1 transferred back to the GACH. A review of Resident 1's monthly physician's orders [REDACTED]. A review of the facility's, Daily Log Notes, dated 2/13/2020, indicated at 8 p.m. the staff called 911. Resident 1 and the emergency ambulance transported Resident 1 back to the GACH. A review of the facility's policy and procedure titled, Change of Condition, dated on 11/2017, indicated the nurse would notify the resident's Attending Physician or the physician on call when there has been a significant change in the resident's physical/emotional/mental condition.
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to document on the Medication Administration Record (MAR) after [MEDICATION NAME] (Tylenol, a medication to treat pain and high temperatures) was administered for one of two sampled residents (Resident 1). This deficient practice had the potential for medication error and/or the resident not receiving care services needed. Findings: A review of Resident 1's Detailed Summary (a record of admission) indicated the resident admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set (MDS), a standardized assessment and care-screening tool, dated 1/15/2020, indicated the resident had moderate impairment in cognitive skills. According to the MDS, Resident 1 required extensive assistance (resident involved in activity, staff provided weight-bearing support) from staff for transferring, dressing, and toileting. In a record review of Resident 1's Order Summary Report dated 2/13/2020 indicated to administer [MEDICATION NAME] 650 milligrams (mg)/ 20.3 milliliters (ml) via gastrostomy ((GT) a surgical opening through the abdomen into the stomach used for feeding and medications) as needed (PRN) for pain. A review of Resident 1's Interdisciplinary Notes (Nursing) dated 2/13/2020 at 11:52 p.m., indicated Resident 1 had labored breathing, heavy secretions, pale skin, and discomfort. Vital signs were heart rate 123 (normal 80 to 100), blood pressure (BP) 140/80 (normal less than 120/80 and above 90/60), oxygen saturation (O2 sat, a measurement of O2 in the blood) 88 percent (normal 95 to 100%), and temperature was 101.9 (normal range 97 to 99). Resident 1 was suctioned with 360 milliliters (ml) output of light yellow secretions. Resident 1 received 2 liters (L) O2 via nasal cannula (a tubing used to deliver supplemental O2 through the nares) and Tylenol. The note indicated the nurse rechecked Resident 1's vital signs and indicated the following: BP 153/86, temperature 100.0, O2 sat 96% and heart rate 107. The note indicated the nurse paged and notified Resident 1's physician about Resident 1's change in condition. The noted indicated the family wanted Resident 1 to go back to the GACH. The facility staff called 911 and Resident 1 transferred back to the GACH. During a telephone interview and record review, on 5/8/2020 at 11:15 a.m., the Director of Nurses (DON) stated Resident 1's Interdisciplinary Notes (Nursing) on 2/13/2020 at 11:52 p.m. indicated a Licensed Vocational Nurse 1 (LVN 1) administered Tylenol to Resident 1 for discomfort. The DON stated she was unable to find documentation on Resident 1's MAR. The DON stated LVN 1 should have documented on the MAR after administration. A review of the facility's policy and procedure titled, Documentation of Medication Administration, dated 11/1/19 indicated a nurse or a Certificated Medication Aid (where applicable) shall document all medications administered to each resident on the resident's MAR.

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.