	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
34		056531	B. WING	<u> </u>	10/0	: <u>2/2</u> 017
AME OF	PROVIDER OR SUPPLIER		· s	TREET ADDRESS, CITY, STATE, ZIP CODE		20017
ROYALV	VOOD CARE CENTER		E .	2520 MAPLE AVENUE ORRANCE, CA 90505	4.0	
(X4) ID PŘEFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INPORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDENCY)	DBE	(X5) COMPLET DATE
F 000	INITIAL COMMENT	rs	. F000	This Plan of Correction constitute facility's credible allegation		
** **	The following refle Department of Pub	cts the findings of the		compliance.	, 5.	. ,
ò	investigation of a C Abbreviated Survey	ompiaint during an	4			
		CA00542672- Substantlated.	,			
		epartment of Public Health:				
	Surveyor ID: 19152	KN, HFEN				
	Complaint investiga	limited to the specific ted and does not represent inspection of the facility.		What corrective action will be accomplished for the patient		
	One deficiency was CA00542672.	written for Complaint		identified to have been affect the deficient practice.	ed by	,
428 SS=D	483.45(c)(1)(3)-(5) I REPORT IRREGUL	ORUG REGIMEN REVIEW, AR, ACT ON	F 428	The Director of Nurses (DON) of In-service Training to the Licen		
0	c) Drug Regimen Ro	weive		Nurses on July 18, 2017 on Wh	nat To	,
.	(1) The drug regime reviewed at least on	n of each resident must be ce a month by a !lcensed		Do on Pharmacy Recommenda Reports.	ation	
İ	pharmacist.			On September 28, 2017, the M Director was informed on the	edical	, e
	brain activities asso	rug is any drug that affects ciated with mental processes	.	Pharmacy Recommendations a	and	
	limited to, drugs in the	e drugs include, but are not ne following categories:		the need to document resident- specific rationale in the medica	- 1	*
	(i) Anti-psychotic; (ii) Anti-depressant;	, ,		record if there is to be no chang		
	(iii) Anti-anxiety; and (iv) Hypnotic.	V		the medication.		e - 10
ATORY	DIRECTOR'S OR PROMOS	EVEUPPLIER REPRESENTATIVE'S SIGN	ATURE .	A. TITLE	(%0	) DATE
-6-1		><		m may be excused from correcting providing	10/1	2/1

FORM CMS-2567(02-99) Previous Versions Obsolete

Even( IO: KNZ311

Facility ID: CA910000071

If continuation sheet Page 1 of 4



DECENTED OF THE PROPERTY OF TH

		I AND HUMAN SERVICES E & MEDICAID SERVICES		•	FOR	M APPROVE
STATEMEN	T-OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:	(X2) MUL A BUILD	LTIPLE CONSTRUCTION 21NG	(X3) DA	O. 0938-039* TE SURVEY MPLETED
		055531	B. WING		10	C 0/02/2017
	PROVIDER OR SUPPLIER FOOD CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CO 22520 MAPLE AVENUE	ODE	//UZZV ( /
				TORRANCE, CA 90505		
(X4) (D PREFIX TAG	(each deficiency	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING BUFORMATION)	PREFIX TAG		RECTION SHOULD BE VPPROPRIATE	(X5) COMPLETION DATE
	(4) The pharmacist to the attending phy facility's medical dir and these reports in and these reports in the drug that meets the (d) of this section fo (ii) Any irregularities during this review m separata, written repatending physician director and director and director minimum, the reside and the Irregularity to (iii) The attending president's medical reirregularity has been action has been take be no change in the physician should do the resident's medic for the resident's medic frames for the different physician should do the resident's medic frames for the different physician should do the resident's medic frames for the different physician should do the resident's medic frames for the different physician should and procedures for the different physician should do the resident's medic frames for the different physician should do the physician should be physician should be physician should do the resident's medical frames for the different physician should be physicia	must report any irregularities sician and the ector and director of nursing, nust be acted upon.  Ide, but are not limited to, any criteria set forth in paragraph of an unnecessary drug.  Incted by the pharmacist sust be documented on a cort that is sent to the and the facility's madical of nursing and lists, at a ent's name, the relevant drug, the pharmacist identified.  Invision must document in the ecord that the identified or reviewed and what, if any, and to address it. If there is to medication, the attending nument his or her rationale in all record.  Idevelop and maintain policies the monthly drug regimental record.  In the process and the take when he or she with that requires urgent action.	F4	How other residents hat potential to be affected same deficient practice identified, and what con action will be taken.  The DON, RN Supervisor and the Health Information Designee (HID) reviewed medical records of the rewith Pharmacy Recommendation of the Review (MRR) from June September 2017. No other Pharmacy Consultant's (I recommendations found responded to by the atter Physician. Some resident already been discharged facility.  What systemic changes put into place to ensure deficient practice does	by the be rective r (RNS), on all sidents endations Regimen e 2017 thruer chC) not ading is have from the ethat the	
1	to protect the resider This REQUIREMENT  by: Based on interview a facility's nursing and ensure a clinical ratio	nt. It is not met as evidenced and record review the administrative staff failed to male for Sucralfate lon used to treat stomach		The PhC comes monthly MRR on all residents. Re recommendations are wit given to the DON and Hill	to do ports and tten and	•

DEPAR CENTE	TMENT OF HEALT RS FOR MEDICAR	HAND HUMAN SERVICES E&MEDICAID SERVICES	•		RINTED: 10/02/201 FORM APPROVE
STATEMEN	T OF DEFICIENCIES JF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	MB NO. 0938-039 (X3) DATE SURVEY COMPLETED
		055631	B. WING_		G
NAME OF	PROVIDER OR SUPPLIER		<del>'</del>	STREET ADDRESS, CITY, STATE, ZIP CODE	10/02/2017
ROYALV	VOOD CARE CENTE	R		22520 MAPLE AVENUE ( TORRANCE, CA 90505	
(X4) ID PREFIX TAG	i (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC (DENTEYING INFORMATION)	(II PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	DE CANAL
F 428	the facility's pharm recommendation was practice placed the	provided for Resident Awhen acist consultant's as declined. This deficient resident at risk for receiving	F 42	and distribute them to the RNS notify the Attending Physicians (MD). Any MD who does not	to
	unnecessary media Findings: A review of Reside	cation. ent A's Admission Records		and does not document the rationale in the medical record:	shall
·	indicated the reside facility on 4/8/17, w	ent was re-admitted to the ith a diagnosis of chronic licer (sore)without hemorrhage		be called by the RN to comply.  who has not responded timely a  who is not compliant to the  pharmacy recommendations sh  be reported to the Medical Direct	and all
	4/8/17, indicated to (medication used to excessive stomach Release 40 milligra	nt A's physician's order, dated administer Omeprazole o freat stomach ulcers and acid) Capsute Delayed ms (mg) two times a day for r without hemorrhage or		who shall then call and follow u Out of the Reports, a Monthly Pharmacy Recommendation Lo (MPRL) is created for each mor This contains the list of names of	p. g nth.
	A, dated 5/20/17, in Sucralfate tablet on	physician's order for Resident dicated to administer e gram (gm) before meals ulcer, take on empty stomach.		residents reviewed by the PhC has recommendation for the MI act on. The list also has a checi section to verify that MD provide resident-specific rationale	to coff
	report dated 6/02/1; received Sucralfate consider discontinui should not be used as it requires an aci activated. The Ame Gastroenterology fir the acute treatment	ity's Pharmacist Consultant /, indicated Resident A (Carafate) and Omeprazore, ing Sucraffate and Sucraffate with acid suppressive therapy, dic environment to be incan College of ids no tole for Sucraffate in of peptic utcer disease, r non-pregnant GERD		describing why or why not follow the PhC recommendation. The DON and or the RNS check off list. This will then be placed in a binder entitled Medication Regin Review for Record-Keeping.	the

TATEMENT NO PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DA	). 0938-039 TE SURVEY MPLETED
		QS6531	B. WING		1/1	C /02/2017
NAME OF F	PROVIDER OR SUPPLIER		<u>-                                    </u>	STREET ADDRESS, CITY, STATE, ZIP CO		in the second
ROYALW	OOD CARE CENTER			22620 MAPLE AVENUE TORRANCE, CA 90606	•	
(X4) ID PREFIX TAG	· (EACH DEFICIENC\	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	(D PREFI		RECTION SHOULD BE APPROPRIATE	COMPLETION DATE
F 428	in which the stomact leak backwards from esophagus (the tub stomach). This active causing heartburn a Sucralfate has not it preventing non ster gastric or duodenal to continue, it is recepted to continue, it is recepted to the prescriber document versus benefit, individual (b) the facility in ongoing monitoring adverse consequent the administration of medication by at least the administration of report further indicate the pharmaciet recepted to the	al Reflux Disease - a condition on contents (food or liquid) on the stomach into the efrom the mouth to the on can irritate the esophagus, and other symptoms). The en shown to be effective in coldal anti-inflammatory drug ulceration. If dual therapy is commended that (a) the nt an assessment of risk cating that it continues to be a servention for this individual: nterdisciplinary team ensures for effectiveness and potential sees; and (c) nursing separate of Sucralfate from all other ast two hours before and after of other medications. The sted the prescriber declined ommendation by documenting	F4		including sented N to the mance for further tions. The ist in s for done for hs until the deficient	
	indicated If the atter Practice Nurse (AP does not choose to recommendations.	orth," dated 12/12/16,  Inding physician/Advanced  N)/Physician's Assistant (PA)  follow the pharmacist  it is his/her responsibility to  al reason in the medical	•	HOVEHING! E, ECT.	· ·	

## Genesis

In-service/Training Sign-In Sheet

Royalwood Care Center Topic Marmany (manitant Presenter Baty Fe Cacdack Time(s) 2.30 pm Length of Presentation N-30 min Brief Description of Presentation Monthly Pl fleepmondations  Length of Presentation Nonthly Pleasant Authority  Length of Presentation Nonthly  Length of Presentation  Length of Presentation  Length of Presen
Time(s) 2:30 PM Length of Presentation N-30 mine Brief Description of Presentation Monthly PC Recommendations  Length of Presentation Notations  Length of Presentation N-30 mine  Length of Presentation Notations  Length of Presentation N-30 mine  Length of Presentation N-30 min
Brief Description of Presentation Monthly PC fleommendations  Le acted upon by the facility. GDRS and after flece  required MD's application will be followed by the printed Name / Title  Printed Name / Title  Signature  Signature  Shift  CANTIONCH UN  LUCIA TELENAND  AND CASIAND  LORENA PASCUAL RN  DESSICA CORROR  TO THE STATE OF THE SIGNAL RN  DESSICA CORROR  TO THE STATE OF THE
Printed Name / Title  Signature  Signature  Shift  SAMYTOMCH MIN  HUGA HELDAND  AND CASIAND  LORENA PASCUAL RN  DESSICA CORROL  ALCORROL
Printed Name / Title  Signature  Signature  Shift  SAMYTOMCH MIN  HUGA HELDAND  AND CASIAND  LORENA PASCUAL RN  DESSICA CORROL  ALCORROL
Printed Name / Title  Signature  Shift  SAMMTONICH WN  GRAND  AUGUSTENAND  JANE CASIAND  LORENA PASCUAL RN  JESSICA CORROL  3-11
CAMMITONICH WIN GRANDER 7-3  HUGA KERNANDER ALLERANDER, W 7-3  JANE CASIAND 3-11  LORENA PASCUAL RN SIMMUL 3-11  JESSICA CORROLL  3-11
Huga Hernandet, en Allerandez, nu 7-3  JANE CASIANU  LORENT PASCUAL RN Summer 3-11  JESSICA CORROL  3-11
LANE CASIAND  LORENA PASCUAL RN  DESSICA CORPOR  3-11
DESSICA CORPUS 3-11
JESSICA CORPUZ
Marlica Firming Lin 7-3