Amended & accepted 10/28/11 J Hering, RN HFEN

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/27/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055818	A. BUILDING _____ B. WING _____	08/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL GARDEN EXTENDED CARE HOS	2339 W. VALLEY BLVD. ALHAMBRA, CA 91803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the Department of Public Health during a Recertification survey. Total resident population: 41 Total resident sample: 11 Highest Scope and Severity: G Representing the Department of Public Health: Surveyor 22458, RN-HFEN Surveyor 25487, RN-HFEN Surveyor 12007, REHS-HFE	F 000	This plan of correction constitutes our written credible allegation of compliance for the deficiencies noted. This facility will be in substantial compliance no later than 9/5/11. 2011 OCT -7 PM 4:58	
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure a resident was free of physical restraints for one of 11 sampled residents (8). Resident 8, who had a Lap Buddy restraint for her wheelchair, was observed in the dining room under direct supervision of staff with the Lap Buddy (foam restraint which is placed around a resident's midsection while up in the wheelchair to prevent the resident from standing). Findings:	F 221	F221 It is RGECH policy that all residents have the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the residents' medical symptoms. • On 8/6/11, the licensed nurse immediately removed the Lap Buddy restraint from Resident #8 when informed of the deficient practice, while the resident was being fed by a staff member. The Lap Buddy was reapplied after lunch. • On 8/6/11, the Director of Staff Development (DSD) checked all residents with restraints and no	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Charles Fenton for [illegible]	Administrator	10/7/2011

y deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ner safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days lowing 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 ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Charles Pemberton by [illegible] | TITLE: Administrator | (X5) DATE: 10/7/2011

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F 221	Continued From page 1 On 8/6/11 at 12:15 p.m., during a dining observation, Resident 8 was observed sitting in her wheelchair. A Lap Buddy restraint was observed on the wheelchair. The resident was being fed by a staff member. A review of Resident 8's admission sheet indicated the resident's diagnoses included dementia and chronic obstructive pulmonary disease. Review of the quarterly MDS (minimum data set/resident assessment tool) dated 5/24/11, indicated the resident was confused, was incontinent of bowel and bladder, and was completely dependent on staff for all of her daily living activities. Review of the physician orders indicated an order dated 10/1/10 for a Lap Buddy when up in chair for safety secondary to poor safety awareness. During an interview with LN 2 immediately following, he stated the resident did not require the Lap Buddy when under direct supervision.	F 221	other residents were found to be with a restraint during feeding. On 8/8/11 the DSD inserviced all C.N.A.s and by the D.O.N. to the licensed nursing staff on 8/10/11 and 8/12/11 to ensure the residents are not with restraints while supervised by a staff member. • On a daily basis, the licensed nursing staff will ensure that all residents with restraints are not restrained while being directly supervised by a staff member. • On a daily basis, the D.O.N./R.N. Supervisor will monitor through rounds that all residents are not restrained while being directly supervised by a staff member. Findings will be discussed during the Quarterly Quality Assurance and Assessment for compliance and corrective action, if needed.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.	F 279	F279 It is RGECH's policy to use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. • On 8/7/11 the treatment nurse reassessed resident #2 and a new	9/5/11

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F 279	Continued From page 2 The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that 1 of 11 sampled residents (2) had a care plan developed to address a Stage II pressure sore. For Resident 2, who was currently being treated for a Stage II pressure sore, no care plan addressing the wound was in evidence in the clinical record. This deficient practice created the potential for the wound to worsen and possibly become infected. Findings: Resident 2 was admitted to the facility on 5/29/10, with diagnoses that included degenerative joint disease, diabetes, and Alzheimer's disease with dementia. According to the Minimum Data Set (MDS, an assessment tool) dated June 23, 2011, Resident 2 had severely impaired cognitive skills, was totally dependent on staff assistance for all activities of daily living, was incontinent of bowel and bladder, and had bilateral range of motion limitation to both upper and lower extremities.	F 279	care plan was developed to reflect the pressure sore. • On 8/7/11 the D.O.N. checked all residents with pressure sores to ensure all residents have a care plan for each site and no other deficient practice was found. • On a weekly basis during the weekly wound meeting all pressure sores will be reviewed and checked to ensure all sites for each patient have a written care plan. • The D.O.N. will monitor weekly to ensure all pressure sores have a written care plan in the resident's chart during the weekly wound care meeting. All findings will be discussed during the Quarterly Quality Assurance Committee meeting on a quarterly basis for compliance and corrective action, if needed.	9/5/11

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F 279	Continued From page 3 During numerous observations from 6:30 p.m. on August 5 thru 4 p.m. on August 7, 2011, Resident 2 was seen lying in bed. During a wound treatment observation on August 7, 2011 at 8:25 a.m., the resident was observed to have a Stage II pressure sore on her right buttock cleft. The clinical record for Resident 2 was reviewed on August 7, 2011. A physician's order dated July 15, 2011, indicated to cleanse pressure sore to right medial buttock with normal saline, pat dry, apply hydrogel dressing and cover with a dry dressing daily for 30 days. However, no care plan addressing the pressure sore was in evidence in the clinical record. During an interview with the Treatment Nurse on August 7, 2011 at 10 a.m., she stated she was certain that she had written the care plan addressing the Stage II pressure sore, but could not locate it in the clinical record. The facility's undated policy and procedure titled "Resident Care Planning", indicated resident care planning included continual reassessment and updating, at least quarterly, and upon change of condition. And each diagnosis will be listed and updated as necessary.	F 279		
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309	F309 It is RGECH's policy that each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in	

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F 309	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, interviews and document review, the facility failed to ensure that six of 11 sampled residents received necessary care (8, 2, 3, 7, 1, 4,) and 3 randomly selected residents (12, 14, 15). For Resident 8 was not assigned a CNA for 2.5 shifts (8/3/11, 11 p.m. to 7 a.m., 8/6/11, 7 a.m. to 3 p.m., and 8/7/11, 7 a.m. to 11 a.m.) which had the potential to result in neglect of care for the resident. The facility failed to ensure RNA (restorative nurse aide) services were provided according to physician's orders for 6 residents who required splint/brace services (2, 3, 7, 12, 14, 15). For three sampled residents (2, 3, 7) and three random sampled residents (12, 14, 15), the facility failed to provide RNA splint/brace care per physician's orders, which resulted in creating the potential for new contractures and increased severity of present contractures for all the residents. The facility failed to ensure vasopressure leg wraps (anti-embolism devices) were applied as ordered by the physician, and a physician's order to stand the resident with a platform stand was carried out for one of 15 sampled residents (1). For Resident 1, the Skilled Nurse (SN) documented that the leg wraps were applied as ordered by the physician, however, the resident's wife had taken the leg wraps home with her and they were not seen in the resident's room during numerous observations during the survey. The physician's order to stand the resident with a platform stand was not initiated for 3 days after the order was received. These deficient practices resulted in creating the potential for the resident	F 309	accordance with the comprehensive assessment and plan of care. • On 8/7/11 the DSD reviewed the assignment sheet and noted that another C.N.A. was providing patient care to the resident although not assigned on the assignment sheet. The resident was found to have received all the care required. On 8/7/11 the RNA applied the knee brace to resident #2; the left ankle, left elbow and the left wrist splints to resident #3; the left hand, bilateral knee and ankle splints applied to resident #7; the left ankle and left hand splints to resident #12; the left knee and left elbow spints to resident #13; and the bilateral ankle extension dynaspints to resident #14. On 8/7/11 the charge nurse called the resident's wife to bring back the vasopressure machine with the leg wrap for resident #1. The DON advised the resident's not to bring the device home and explained the importance for the machine. The machine and leg wrap were returned the same day. • On 8/7/11, the DSD reviewed the assignment sheets against the daily roster and all other residents were	

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F 309	Continued From page 5 to suffer further strokes and debility and fail to reach his highest practical physical state of well-being; and the facility failed to ensure a physician's order to insert a rectal tube to expel gas and deflate the abdomen and to call and inform the physician of results for one sampled resident (4) was carried out and documented. For Resident 4, the physician's order was not carried out, and record review and staff interviews failed to provide a clear understanding of the resident's outcome, which resulted in the potential for the resident to fail to reach her highest practicable level of physical well-being. Findings: a. On 8/7/11 at 10:25 a.m., during an observation, Resident 8 was observed asleep in her wheelchair in the activities room. When the surveyor inquired as to whom the resident's CNA (certified nursing assistant) was, the CNAs each stated the resident was not assigned to them. At 10:35 a.m., during interview and review of the staffing assignment with the DSD (director of staff development) and LN 1, it was discovered that there was no assigned CNA for Resident 8 for that particular day on the 7-3 p.m. shift. A review of the previous day's assignment (8/6/11) also indicated the resident's room number had not been assigned to a CNA. A review of Resident 8's admission sheet disclosed the resident was an 87 year old female readmitted to the facility on 10/1/10 with diagnoses which included dementia, chronic obstructive pulmonary disease, and generalized weakness.	F 309	account for having an assigned C.N.A. On 8/8/11 the nursing staff was inserviced by the DON on ensuring that all residents in the facility are assigned a C.N.A. to be providing patient care. All residents with an order for splints were checked by the DSD to ensure all residents with a physicians order have the splints/braces applied as ordered and all other residents were found not to be affected with the deficient practice. On 8/7/11 the DSD reviewed all residents with DVT devices to ensure that the facility had the equipment in-house to be applied and no other deficiencies were noted. • A room change form was created to ensure that all departments including the nursing department will be made aware of any room changes of the patients. The charge nurse on a daily basis will notify the C.N.A. receiving the patient of the change. The charge on a daily basis will review the assignment sheet against the facility roster and make rounds to ensure all residents are accounted for to prevent recurrence. The RNA will be responsible for	

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F 309	Continued From page 6 The quarterly MDS (minimum data set) dated 5/24/11, revealed the resident was severely impaired in cognitive status with confusion, was incontinent of both bowel and bladder, and required extensive to total assistance with all of her daily living activities. The resident was unable to be interviewed due to her confusion. On 8/7/11 at 10:45 a.m., LN 1 and the DSD reviewed the assignment and stated the resident was transferred to her current room near the nurses station from a room located in the adjacent wing, due to the resident's attempts to get up from her wheelchair. A review of the staffing assignments for 8/6/11 and 8/7/11, 7 a.m. to 3 p.m. shift, indicated CNA 2 was assigned to the resident's previous room and bed. The resident's present room number was not on the assignment. CNA 2 stated he was unaware he was assigned to Resident 8, as his residents were in the adjacent hall, and Resident 8 was in the other hall. At 10:50 a.m. during an interview, the DSD indicated it was each charge nurse's responsibility to make the assignment for the incoming shift, so the 11 a.m. to 7 a.m. charge nurse had made the assignment for the 7 a.m. to 3 p.m. shift. When asked who was responsible for ensuring the accuracy of the assignments, the DSD stated it was the responsibility of the charge nurse. The DSD further stated she did not normally work on weekends.	F 309	applying the splints/braces on a daily basis and the license nurse will ensure that all residents with an order have the device applied during rounds. The RNA will be responsible for applying the vasopressure machine with the leg wrap following physician's order and report missing equipment immediately to the charge nurse. The charge nurse will ensure the vasopressure machine and the leg wraps are applied as ordered by the physician. • The D.O.N./R.N. Supervisor will monitor the C.N.A. assignments to ensure all patients are assigned a C.N.A. to receive patient care during daily rounds. The DON/RN Supervisor will monitor the application of all splints and braces are applied as ordered by the physician on a daily basis during rounds. The DON/RN Supervisor will monitor daily of the vasopressure machine and the leg wraps are applied as ordered by the physician.	9/5/11

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F 309	Continued From page 7 During an interview with the 7 a.m. to 3 p.m. charge nurse (LN-1) immediately following, she indicated it was the DSD's responsibility to check the schedule when she was working. During a second interview with the DSD at 11:05 a.m., she indicated she oversaw the CNAs, and checked the assignments "once in a while". However, as she was not usually there on the weekend it was the responsibility of the RN supervisor to check the assignment. The DSD further indicated she was busy making rounds of the facility the prior day, so did not have the opportunity to review the assignments, and she has told the CNAs they must check the assignment sheet and inform the charge nurse if a bed was empty. During an interview with the RN supervisor following the above interview, he indicated the DSD and charge nurse were primarily responsible for ensuring the assignment was correct. The RN supervisor then stated since the DSD was not usually present on the weekends, the charge nurse and RN supervisor checked the assignment, but he had not had an opportunity the previous day (8/6/11) to check the assignment. The RN supervisor was unable to state who had actually cared for the resident the prior day. A review of the staffing assignments with the RN supervisor for 8/3 11 p.m.-7 a.m. shift also indicated the resident's current bed had not been assigned. On 8/7/11 at 11:40 a.m. during an interview, CNA 4 stated that mistakes in the assignment have occurred, that a resident would not be assigned a CNA, or a resident may be assigned twice.	F 309		

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F 309	Continued From page 8	F 309		

During an interview with CNA 5 at 12:05 p.m., she indicated when she came on that morning at 7 a.m., she observed that Resident 8 was already dressed and up in her wheelchair in the hall outside the dining room. CNA 5 also indicated the assignment was made out incorrectly on very rare occasions.

On 8/7/11 at 12 p.m., an interview with CNA 3 revealed she was assigned to Resident 8's roommate that day, but did not see another CNA in the room that morning.

On 8/7/11 at 12:50 p.m., during a telephone interview with LN 2, she verified that she had made out the assignments for the 7 a.m. to 3 p.m. shift for 8/6/11 and 8/7/11. When informed that Resident 8's bed had not been assigned, LN 2 stated she made a mistake, and had the room numbers mixed up.

During an interview with the SSD (social service director) at 1:10 p.m., she indicated when there is a request from the nursing staff for a room change, she completes a room change form, and informs the resident, family members, kitchen staff, activities director, and medical record department. The medical record staff then makes a new census list with the current resident names and room numbers. The DSD then indicated she would give copies of the room change form to the kitchen staff, activities director, and medical records, but not to the nursing staff.

At 1:15 p.m., during an interview with the DON (director of nursing), she stated the room change

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F 309	Continued From page 9	F 309		

should be documented in the 24 hour communication book, which each charge nurse was supposed to review at the beginning of their shift. A review of the communication book with the DON indicated that on 8/3/11, Resident 8 had changed rooms.

On 8/7/11 at 2:45 p.m., during a telephone interview, CNA 6 verified she had taken care of Resident 8's roommate the prior day, and had not noticed another CNA, then stated she really had not paid attention. CNA 6 further stated Resident 8 usually stayed in the dining/activities room all morning, and the 11 p.m. to 7 a.m. shift got the resident up and dressed due to the resident's attempts to get out of bed unassisted. CNA 6 also indicated that there had been several occasions when a resident was not assigned to a CNA, or was assigned to two different CNAs.

A review of the Nursing Assistant Daily Flow Sheet for the 8/6/11 7 a.m. to 3 p.m. shift indicated no charting was done for that particular shift.

b. 1. Resident 2 was admitted to the facility on 5/29/10, with diagnoses that included degenerative joint disease, diabetes, and Alzheimer's disease with dementia. According to the Minimum Data Set (MD'S, an assessment tool) dated June 23, 2011, Resident 2 had severely impaired cognitive skills, was totally dependent on staff assistance for all activities of daily living, was incontinent of bowel and bladder, and had bilateral range of motion limitation to both upper and lower extremities.

During numerous observations on August 5,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055818	A. BUILDING _____ B. WING _____	08/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL GARDEN EXTENDED CARE HOS	2339 W. VALLEY BLVD. ALHAMBRA, CA 91803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 10 2011, from 6:30 p.m. through 4 p.m. on August 7, 2011; no knee braces were seen on Resident 2. The clinical record for Resident 2 was reviewed on August 6, 2011. The physician's orders recapitulation dated 8/01/11 to 9/15/11 included orders for the RNA (restorative nurse aide) to place splints to both knees for 1-6 hours on Monday-Wednesday-Friday-Saturday-Sunday as tolerated by the resident. The physician order was initiated on 11/18/10. The Joint Mobility Assessments dated 12/07/10, 3/23/11, and 6/23/11 indicated Resident 2 was tolerating application of splints/braces well and no adjustments were needed. A care plan titled "Limitation in Joint Mobility" dated 6/23/11, indicated to position a pillow between the resident's legs to prevent further contractors (such an intervention would not prevent contractor development/worsening). The care plan did not include the knee splints as an intervention. The RNA flow sheets for the month of August 2011, indicated Resident 2 "refused" application of the knee splints on 8/01, 03, 05, 06/11. 2. Resident 3 was admitted to the facility on 9/21/05, with diagnoses that included degenerative joint disease, diabetes, and dementia. According to the Minimum Data Set (MD'S, an assessment tool) dated 6/09/2011, Resident 3 had severely impaired cognitive skills, was totally dependent on staff assistance for all activities of daily living, was incontinent of bowel and bladder, and had bilateral range of motion limitation to both upper and lower extremities. During numerous observations on August 5,	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055818	A. BUILDING _____ B. WING _____	08/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL GARDEN EXTENDED CARE HOS	2339 W. VALLEY BLVD. ALHAMBRA, CA 91803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 11 2011, from 6:30 p.m. through 4 p.m. on August 7, 2011, no ankle, elbow or wrist splints were seen on Resident 3.	F 309		

The clinical record for Resident 3 was reviewed on August 6, 2011. The physician's orders recapitulation dated 8/01/11 to 9/15/11, included orders for the RNA (restorative nurse aide) to place splints to the resident's left ankle, left elbow, and left wrist for 1-6 hours daily as tolerated by the resident. The physician order was initiated on 1/24/11. The Joint Mobility Assessments dated 3/09/11 and 6/09/11, indicated Resident 3 was tolerating application of the splints well and no adjustments were needed. The RNA flowsheets dated August 2011, indicated Resident 3 "refused" application of the splints to left ankle, left elbow and wrist on 8/1/11 to 6/11.

3. Resident 7 was admitted to the facility on 5/23/08, with diagnoses that included stroke, Parkinson's disease, and dementia. According to the Minimum Data Set (MDS, an assessment tool) dated 6/09/2011, Resident 7 had severely impaired cognitive skills, was totally dependent on staff assistance for all activities of daily living, was incontinent of bowel and bladder, and had bilateral range of motion limitation to both upper and lower extremities.

During numerous observations on August 5, 2011, from 6:30 p.m. thru 4 p.m. on August 7, 2011, no left hand and bilateral knee and ankle splints were seen on Resident 7.

The clinical record for Resident 7 was reviewed on August 6, 2011. The physician's orders

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055818	A. BUILDING _____ B. WING _____	08/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL GARDEN EXTENDED CARE HOS	2339 W. VALLEY BLVD. ALHAMBRA, CA 91803

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F 309	Continued From page 12 recapitulation dated 8/01/11 to 9/15/11 included orders for the RNA (restorative nurse aide) to place splints on the resident's left hand, both knees and both ankles for 1-6 hours daily as tolerated by the resident. The order was initiated 10/17/10. Joint Mobility Assessments dated 12/06/10, 3/10/11, and 6/09/11 indicated Resident 7 was tolerating application of the splints well and no adjustments were needed. RNA flowsheets dated August 2011 indicated Patient 7 "refused" application of the splints on 8/1-6/11. 4. Resident 12 was admitted to the facility on 7/07/06, with diagnoses that included stroke with paralysis, diabetes, and osteoporosis. According to the Minimum Data Set (MDS, an assessment tool) dated 6/01/2011, Resident 12 had moderately impaired cognitive skills, required extensive staff assistance for all activities of daily living except eating, and had range of motion limitation to both upper and lower extremities on one side. During numerous observations on August 5, 2011, from 6:30 p.m. through 4 p.m. on August 7, 2011, no left arm and left hand splints were seen on Resident 12. The clinical record for Resident 12 was reviewed on August 6, 2011. The physician's orders recapitulation dated 8/01/11 to 9/15/11 included orders for the RNA (restorative nurse aide) to place splints on the resident's left arm and left hand for 1-4 hours daily as tolerated by the resident. The physician order was initiated on 2/22/11. The Joint Mobility Assessments dated 3/01/11 and 6/11/11, indicated Resident 12 was tolerating application of the splints well and no	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055818	A. BUILDING _____ B. WING _____	08/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL GARDEN EXTENDED CARE HOS	2339 W. VALLEY BLVD. ALHAMBRA, CA 91803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 13 adjustments were needed. The RNA flowsheets dated August 2011, indicated Patient 12 "refused" application of the splints on 8/1/11 to 6/11.	F 309		

5. Resident 13 was admitted to the facility on 5/26/10, with diagnoses that included stroke with Alzheimer's disease with dementia, degenerative joint disease, osteoarthritis, and osteoporosis. According to the Minimum Data Set (MDS, an assessment tool) dated 6/08/2011, Resident 13 had severely impaired cognitive skills, required extensive staff assistance for all activities of daily living, and had range of motion limitation to both upper and lower extremities.

During numerous observations on August 5, 2011, from 6:30 p.m. through 4 p.m. on August 7, 2011, left knee and left elbow splints were not seen on Resident 13.

The clinical record for Resident 13 was reviewed on August 6, 2011. A Documentation Record and Profile form dated 7/24/11, indicated to apply splint to left knee and left elbow 1-4 hours daily 7 days a week as tolerated. The RNA initials indicated the splints were applied on 7/ 25 to 7/27/11 and refused on 7/28/11. No further documentation regarding the splints was in evidence in the clinical record and no narrative explanation was provided by the RNA for stopping the treatment.

6. Resident 14 was admitted to the facility on 8/11/09 with diagnoses that included stroke with diabetes, dementia, and osteoporosis. According to the Minimum Data Set (MDS, an assessment tool) dated 5/19/2011, Resident 14 had severely impaired cognitive skills, required extensive staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055818	A. BUILDING _____ B. WING _____	08/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL GARDEN EXTENDED CARE HOS	2339 W. VALLEY BLVD. ALHAMBRA, CA 91803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 14 assistance for all activities of daily living, and had range of motion limitation to both upper extremities and a lower extremity on one side. During numerous observations on August 5, 2011, from 6:30 p.m. through 4 p.m. on August 7, 2011, bilateral ankle extension dynasplints were not seen on Resident 14. The clinical record for Resident 14 was reviewed on August 6, 2011. The physician's orders recapitulation dated 8/01/11 to 9/15/11, included physician orders for the RNA (restorative nurse aide) to place dynasplints on the resident's left and right ankles for 1-6 hours as tolerated by the resident 5 days a week. The physician order was initiated on 1/21/11. The Joint Mobility Assessments dated 2/19/11 and 5/19/11, indicated Resident 14 was tolerating application of the splints well and no adjustments were needed. The RNA flowsheets dated August 2011 indicated Patient 14 "refused" application of the splints on 8/1/11 to 6/11. During an interview with the RNA on August 7, 2011 at 8:40 a.m., he stated that he had not been applying any splints/braces to any of the patients for "about 2 weeks". The RNA stated that the Physical Therapist (PT) visited the facility about 2 weeks ago and instructed the RNA not to apply any of the splints/braces to any of the residents because they were all the wrong size. The PT re-assessed all the residents for new devices/apparatus. The RNA stated he was instructed by the PT to document that each of the residents "refused" application of the splints/braces. The RNA further stated that all the splints/braces for all the residents were the wrong	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055818	A. BUILDING _____ B. WING _____	08/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL GARDEN EXTENDED CARE HOS	2339 W. VALLEY BLVD. ALHAMBRA, CA 91803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 15 size. The RNA stated that the PT visited the facility when he had a resident to see. During an interview with the DON (Director of Nurses) on 8/07/11 at 10:45 a.m., she stated that the PT and the orthotics specialist visited the facility on 8/02/11, and stated that they had reassessed all the residents with splints/braces and decided that all the devices needed to be replaced. The DON stated the PT did not explain why he had decided to reassess all the residents' splints/braces and why they all needed to be replaced. The DON stated she was unaware that the PT had instructed the RNA to document that the residents refused the service. Both the DON and the RNA denied that they had called the PT to come out to the facility regarding this matter. The facility's policy and procedure guiding RNA services was requested but was not provided by the facility. c. Resident 1 was admitted to the facility on April 1, 2011, with diagnoses that included quadriplegia, paraplegia, diabetes, and high blood pressure. According to an MDS (Minimum Data Set, an assessment tool) dated July 13, 2011, Resident 1 was alert and oriented, non-ambulatory and totally dependent on staff assistance for all activities of daily living. A physician's order dated April 1, 2011 indicated vasopressure machine to bilateral lower legs for DVT maintenance, monitor each shift. During observations on the initial tour of the facility on August 5, 2011 at 6:30 p.m. and from 8:30 a.m. to 6:30 p.m. on August 6, 2011, Resident 1's vasopressure wraps were not applied and were not found anywhere in his room.	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055818	A. BUILDING _____ B. WING _____	08/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL GARDEN EXTENDED CARE HOS	2339 W. VALLEY BLVD. ALHAMBRA, CA 91803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 16 During an interview with the Charge Nurse on August 6, 2011 at 2:30 p.m., she stated that the RNA (restorative nurse aide) was responsible for applying the leg wraps. However, during an interview at the same time, the RNA stated he did not have anything to do with the leg wraps, that they were the responsibility of the treatment nurse. The RNA then stated that Resident 1's wife had taken the leg wraps home and he had not seen them for about a month. During an interview with Resident 1 on August 6, 2011 at 2:50 p.m., he stated that his wife had taken the wraps home a month ago. Resident 1 further stated that the wraps were hot and very uncomfortable for him. The clinical record for Resident 1 was reviewed on August 6, 2011. A Treatment Record and Profile dated August 2011, was initialed by the 3 p.m.-11 p.m. Treatment Nurse on August 5, 2011, and by the 11 p.m.-7 a.m. Treatment Nurse on August 6, 2011 indicating the wraps had been applied as ordered. The 7 a.m.- 3 p.m. Treatment Nurse on August 6, 2011, initialed the Treatment Record and documented that the resident refused placement of the wraps three times. Yet the wraps were not available to be applied during these three shifts. d. Resident 4 was admitted to the facility on July 6, 2006, with diagnoses that included stroke with right sided weakness, dementia, seizure disorder, and high blood pressure. According to the Minimum Data Set (MDS, an assessment tool) dated July 7, 2011, Resident 4 had long and short term memory problems, severely impaired cognitive skills for daily decision-making, was incontinent of bowel and bladder, and was totally	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055818	A. BUILDING _____ B. WING _____	08/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL GARDEN EXTENDED CARE HOS	2339 W. VALLEY BLVD. ALHAMBRA, CA 91803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 17 dependent on staff assistance for all activities of daily living. During the initial tour of the facility on August 5, 2011 at 6:30 p.m., Resident 4 was observed lying in bed. During the course of the survey the resident was observed sitting up in a geri- chair. The clinical record for Resident 4 was reviewed on August 6, 2011. A physician's order dated July 27, 2011 indicated: "May insert rectal tube to see if gas will pass and abdomen deflates-call and let me know (30 minutes) PRN (as needed)." The Licensed Nurse Progress Notes contained no entries on that date to indicate a possible concern that the resident's abdomen was distended and why the physician's order was given. A Treatment Record and Profile form dated July 27, 2011, indicated the rectal tube treatment was PRN, and also indicated that the treatment was to be done on July 27, 2011. However, no documentation was in evidence in the clinical record to indicate that Resident 4's abdomen was distended, if she was having discomfort/pain, why the order was given and why the treatment was not carried out as ordered by the physician. During an interview with the Charge Nurse on August 7, 2011 at 2 p.m., he stated that the treatment was not carried out per the physician's order. The Charge Nurse could not provide any further explanations.	F 309		
F 314 SS=E	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a	F 314	F314 It is RGECH's policy to ensure that a resident who enters the facility without pressure sores does not develop pressures sores unless the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055818	A. BUILDING _____ B. WING _____	08/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL GARDEN EXTENDED CARE HOS	2339 W. VALLEY BLVD. ALHAMBRA, CA 91803

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F 314	Continued From page 18 resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that 1 of 11 sampled residents (2) received the necessary treatment and services to prevent development of and promote healing of pressure sores. For Resident 2, who was currently being treated for a Stage II pressure sore, facility staff placed excessive amounts of cloth diapers and cloth pads between the resident and the alternating pressure mattress (APP). This deficient practice defeated the purpose of the APP mattress and created the potential for worsening of the wound and development of additional pressure sores. Findings: Resident 2 was admitted to the facility on 5/29/10 with diagnoses that included degenerative joint disease, diabetes, and Alzheimer's disease with dementia. According to the Minimum Data Set (MDS, an assessment tool) dated June 23, 2011, Resident 2 had severely impaired cognitive skills, was totally dependent on staff assistance for all activities of daily living, was incontinent of bowel and bladder, and had bilateral range of motion	F 314	individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. • On 8/7/11 the cloth diapers and pads were immediately removed from resident #2 and a new diaper and pad were replaced on the patient to ensure only one diaper and one pad was used for the patient. • On 8/7/11 the DSD checked all other patients to ensure only one diaper and/or one pad was used for each patient requiring them and no other residents were found with the deficient practice. • The licensed nursing staff will check each resident during their shift to ensure only one diaper and/or one pad is appropriately applied on a daily basis. • On a daily basis the D.O.N./R.N. Supervisor will randomly check residents to monitor only one diaper and/or one pad is used appropriately and is necessary for that particular resident. All findings will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055818	A. BUILDING _____ B. WING _____	08/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL GARDEN EXTENDED CARE HOS	2339 W. VALLEY BLVD. ALHAMBRA, CA 91803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 19 limitation to both upper and lower extremities. During numerous observations on August 5, 2011, from 6:30 p.m. through 4 p.m. on August 7, 2011, Resident 2 was seen lying in bed on an APP mattress. During a wound treatment observation on August 7, 2011 at 8:25 a.m., the resident was observed to have a Stage II pressure sore on her right buttock cleft. After wound care was completed, CNA 5 (Certified Nurse Aide 5) was observed as she applied 2 cloth diapers to the resident and placed 2 thick cloth pads under the resident. During an interview with CNA 5 at the same time, she stated that sometimes she applied 3 cloth diapers to Resident 2 because she had frequent diarrhea. The facility undated policy and procedure titled "Pressure Reducing/Relieving Devices to the Bed", indicated dynamic air mattress systems (APP and Low Air Loss Therapy) require "limited" linen protocols. The policy provided no further guidance to explain "limited linen protocols" regarding APP mattress therapy.	F 314	discussed during the Quarterly Quality Assurance and Assessment meeting for compliance and corrective action, if needed.	9/5/11
F 325 SS=G	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.	F 325	F325 It is the RGECH's policy to ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and receives a therapeutic diet when there is a nutritional problem.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055818	A. BUILDING _____ B. WING _____	08/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL GARDEN EXTENDED CARE HOS	2339 W. VALLEY BLVD. ALHAMBRA, CA 91803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 20	F 325	• On August 6, 2011, the D.O.N. immediately checked patient #6 physician's order to verify the correct infusion rate that was ordered and the infusion rate was immediately adjusted to 60cc/hour. On August 6, 2011 the Registered Dietician, via phone call, reassessed resident #6's nutritional needs and caloric requirements and recommended to continue current plan of care and to monitor weight. The D.O.N. updated the resident #6's plan of care to ensure all interventions and implementations are accurate and effective following physician orders to ensure compliance. • On August 6, 2011, the D.O.N. reviewed all residents' monthly weights and there were no significant weight loss noted. On August 6, 2011 the D.O.N. reviewed all tube feeders for the appropriate flow rate and all residents were in compliance. On August 7, 2011 an in-service was given by the D.O.N. to all licensed nurses on the policy and procedures on enteral administration with regards to the guidelines, the appropriate flow rate	

This REQUIREMENT is not met as evidenced by:
Based on observations, clinical record review, review of facility policy and procedure and staff interviews, the facility failed to ensure that one sampled resident (Resident #6) maintained his body weight. The facility also failed to properly assess the nutritional needs and identified problems. In addition, they failed to follow the physician ' s tube feeding order. These failures resulted in a severe weight loss of 14.5 pounds or 11% of his body weight.

Findings:

1. A review of Resident 6's clinical record conducted on 8/6/11, indicated that the resident was initially admitted to the SNF facility on 2/14/11, and readmitted on 7/28/11, with diagnoses which included history of stroke with right sided weakness, insertion of gastrostomy tube, dysphasia (difficulty swallowing), diabetes mellitus, congestive heart failure, anemia, cerebrovascular accident with right-sided hemiparesis, malignant connective tissue neoplasm of the abdomen and dementia.

The Quarterly MDS (Minimum Data Set, a resident assessment tool) dated 7/23/11, indicated that the resident's cognitive status was severely impaired (unable to make decisions for himself), and was totally dependent on staff for all daily living needs. The resident was aphasic (unable to speak due to stroke) but was alert.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055818	A. BUILDING _____ B. WING _____	08/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL GARDEN EXTENDED CARE HOS	2338 W. VALLEY BLVD. ALHAMBRA, CA 91803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 21 Resident 6 was 5' 4" and 132 lbs on admission. His physician ordered diet was a pureed NAS (no added salt). The nutritional assessment form also indicated the resident had a tendency to hold his food in his mouth. There were no recommendations or interventions made for this identified problem or evaluation of the resident ' s nutritional needs. A review of the Monthly Record of Vital Signs and Weights indicated the following: Date Weight 2/14/11 132 lb. (Admission) 3/3/11 132 lb, 4/2/11 126.5 lb (loss of 5.5 lb in one month) 5/12/11 124 lb (loss of 2.5 lb) 6/8/11 121.5 lb (loss of 2.5 lb) 7/12/11 117.5 lb (loss of 4 lb) The RD assessment did not include the estimated calories and the protein required to meet the resident's needs. There was a physician order dated March 26, 2011, for a pureed NAS (no added salt) NCS (no concentrated sweets) diet with extra sauce/gravy to moisten food, The resident's weight on 4/2/11 was 126.5 lb. This is a loss of 5.5 lb or 4.1% in one month). A care plan was developed on 4/21/11. Documentation indicated that the physician was aware of the weight loss and no new orders were given. The care plan approaches included to monitor intake, record and report intake that fell	F 325	with the correct labeling of the formula to be hung, the method of the feeding pump, and the appropriate water flushing. • A new system was introduced and implemented for those patients with a weight loss will be noted by the D.O.N. and a weekly weight x4 will be initiated. These residents will be discussed during the weekly weight variance committee for further intervention and monitoring. The D.O.N., Director of Staff Development., Social Service Designee and the Dietary Supervisor will be involved in the committee. All interventions will be discussed with the Registered Dietician for the further recommendations and interventions for nutritional and caloric requirements. All residents with significant or non-significant weight loss, will be weighed weekly x4 and will be monitored during the weekly Weight Variance committee meeting until the resident's weight is stable. A new form and log was created to include residents with specific weight problems with weight loss and weight gain. This form is intended as a communication	

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	055818	A. BUILDING _____ B. WING _____	08/07/2011

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F 325	Continued From page 22 below 70%. On 5/12/11, the resident weighed 124 lbs, He had further lost 2.5 lbs in a month, a total of 8 lbs since admission or 6% of his total weight. This was a significant weight loss. A quarterly assessment dated 5/25/11, documented by the DSS, indicated that the resident's weight was 124 lb, which reflected a difference of eight lb for that quarter. The DSS recommended the same diet as ordered in March and plan to continue to monitor the resident. There was no evidence of an RD assessment for May 2011, for the resident. There were no new interventions. The resident's weight on 6/8/11, was 121.5 lbs. Resident 6 had lost an additional 2.5 lbs in one month, and a total loss of 10.5 lbs since admission. This is a severe weight loss of 7.9% in three months. A review of the CNA logs for June 2011, indicated that the resident's meal intake was between 60-80% consumed. The facility failed to follow Resident 6's care plan. The care plan intervention dated 4/12/11, indicated to report if intake fell below 70%. The care plan approaches included to monitor intake, record and report intake that fell below 70%. There was no documented evidence that the facility reported when intake fell below 70%. There was physician's orders dated 7/8/11, for Megace (an appetite stimulant) 400 mg (milligrams) orally every day. The IDT meeting dated 7/8/11, indicated there	F 325	between the Registered Dietician, Dietary Supervisor and the D.O.N. The Registered Dietician referral form will be initiated by the D.O.N. to alert the Registered Dietician of residents who needs immediate intervention. The Registered Dietician will exit with the Dietary Supervisor and the D.O.N. to very all recommendations. • The D.O.N./D.S.D./RN Supervisor will monitor daily that all enterals hung are on the appropriate flow rate and the formula label is properly dated with the appropriate flow rate and signed by the Licensed Nurse. The D.O.N. will monitor weekly during the weekly Weight Variance committee meeting to ensure compliance. All findings will be discussed during the Quarterly Quality Assurance and Assessment committee meeting for compliance and corrective action, if needed.	9/5/11

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F 325	Continued From page 23 was a care plan meeting with the resident's family member on the issue of weight loss. A recommendation was made for the resident to have a registered dietitian (RD) assessment, and to monitor weight status. There was a physician order dated 7/8/11, indicating the resident was to have weekly weights for four weeks, Glucerna 1.5 calories per milliliters (a nutritional supplement) one eight ounce can, b.i.d. (twice daily) between meals. This order for weekly weight was not carried out. The RD made a entry on the nutritional progress notes of 7/12/11, recommending to change the resident's diet to a large portion fortified pureed NAS (no added salt) NCS (no concentrated sweets) diet with extra sauce/gravy. There was a physician order dated July 13, 2011, for a large portion fortified pureed NAS (no added salt) NCS (no concentrated sweets) diet with extra sauce/gravy. On 7/12/11, the resident weighed 117.5 lbs. This was an additional 4.5 lb weight loss for the month; 14.5 lbs since admission or 11% total weight loss in four months. This is considered a severe weight loss. The review of RD progress notes dated 7/20/11 revealed to conduct a calorie count for three days, and to obtain laboratory tests (sodium, potassium, BUN-blood urea nitrogen, H&H-hematocrit and hemoglobin) for evaluation. (laboratory tests are used to determine the resident's nutritional status). The physician order of 7/21/11, indicated the	F 325		

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F 325	Continued From page 24 resident was to have a calorie count for three days and to have laboratory tests of sodium, potassium, glucose, BUN, hemoglobin and hematocrit. The facility initiated the calorie count and did the laboratory tests as the physician ordered. There was no evidence that interventions such as Megace, Glucerna, weekly weight monitoring, or laboratory tests (sodium, potassium, BUN-blood urea nitrogen, H&H-hematocrit and hemoglobin) had been provided to the resident in July 2011. On 8/6/11 at 4:40 p.m., during an interview and record review, the DSS confirmed the resident was not placed on a nutritional supplement until July 2011. The DSS stated she thought she spoke with the RD in June 2011, and stated ... "I don't know what happened." The DSS also indicated she was unable to recall if weekly weights were carried out. On 8/6/11 at 5 p.m., during an interview and review of the clinical record, the director of nurses (DON) was unable to locate any documented evidence that the physician had been notified on 4/2/11 of the resident's 5.5 pound weight loss. (there was indication earlier that the MD was notified) The DON could not explain why weekly weights were not done for Resident 6 in spite of having already experienced a weight loss of approximately 11% over a four month period. During an interview with CNA 2 on 8/7/11 at 3:15 p.m., she indicated that the resident's appetite had declined 1-2 months prior to his admission to the general acute care hospital on July 23, 2011.	F 325		

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F 325	Continued From page 25	F 325		

During an interview with CNA 3 on 8/7/11 at 3:50 p.m. she stated that the resident's appetite started to decline in May. The facility did not implement any interventions for weight loss until 7/8/11.

There was no evidence to indicate the CNA 2 or 3 had reported the resident's decline in meal intake percentage to the licensed nurse.

A review of the facility's undated policy titled "Follow-up on Significant Weight Loss ...stipulated the DSS would ... note resident's weight loss ... for the R.D. to assess on the next visit. There was no evidence in the clinical record that this policy was followed.

The licensed personnel progress notes of 7/23/11, indicated that Resident 6 was to be transferred to an acute care hospital for further evaluation and the resident was difficult to arouse.

The physician orders indicated the that resident was readmitted to the SNF from an acute care hospital on 7/28/11, with a gastrostomy tube feeding (GTF) with a physician order of Glucerna 1.2 calories per milliliter formula, 40 milliliters (ml) every hour (hr) until 8 p.m., and to increase the GTF to 10 ml every 12 hours until goal of 60 ml/hr is reached. Then maintain 60 ml /hr of Glucerna. Resident 6 was not receiving anything by mouth.

The care plan approach for having a GT dated 7/28/11, indicated that the resident would have the tube feeding as ordered.

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F 325	Continued From page 26	F 325		

As indicated by the physician's order, on 7/29/11, at 8 a.m. the GTF rate was to be increased from 40 ml per hour to 50 ml per hour, and on 7/29/11, at 8 p.m. the GTF rate was to be increased from 50 ml/hr to 60 ml/hr.

On 8/5/11 at 6:30 p.m., and 8/6/11 at 8:15 a.m., Resident 6 was observed lying in bed. A tube feeding formula was infusing via a gastrostomy tube at a rate of 40 ml per hour via an enteral feeding pump.

On 8/6/11, a review conducted of Resident 6's clinical record indicated that the resident had been readmitted to the SNF from the general acute care hospital on 7/28/11, and a gastrostomy tube had been inserted into the resident's stomach for nutritional purposes during the resident's hospital stay.

On 8/6/11 at 2:15 p.m., during observation and interview, the 7 a.m. to 3 p.m. charge nurse stated she had noted the physician admitting orders on 7/28/11, and the tube feeding rate should be 60 ml per hour. After the surveyor asked about the resident's GTF, the charge nurse increased the GTF rate from 40 ml to 60 ml per hour.

The resident had already experienced a recent severe weight loss of more than 10% over a four month period from 3/3/11, when the resident weighed 132 lb, to 7/8/11, when the resident weighed 117.5 lb.

The facility failed to follow the physician's order. There was a systemic failure by the facility staff

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F 325	Continued From page 27 that resulted in the severe weight loss. There were no interventions when problems of pocketing of food, or the initial weight loss was identified, there was no proper nutrition assessment completed, they failed to implement care plan strategies, and did not provide Resident 6 with adequate nutrition.	F 325		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure proper care was given for one of 11 sampled residents (5). 1. Resident 5's I.V. (intravenous) line had infiltrated (catheter became dislodged from the vein and I.V. fluid had infused into the surrounding soft tissue). This deficient practice had the potential to result in discomfort for the resident. 2. The I.V. solution bag was dated as being hung on 8/4/11 at 8:30 a.m., almost 36 hours prior,	F 328	F328 It is RGECH's policy to ensure that residents receive proper treatment and care for the following special services: Injections; parenteral and enter fluids; colostomy, ureterostomy, or ileostomy care; tracheostomy care; tracheal suctioning; respiratory care; foot care; and prostheses. • On 8/5/11 resident 5's IV line was immediately reassessed by the D.O.N. and the IV line was reinserted properly to correct the infiltration, the I.V. solution was immediately removed once noted and the oxygen concentrator was regulated to 2 liters/minute. • On 8/5/11 the D.O.N. reviewed all residents with IV and/or using a concentrator to ensure all residents have accurate IV insertion, IV solutions being hung with appropriate time limits and the	

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F 328	Continued From page 28 which had the potential to result in contamination. 3. The resident, who had an order for oxygen at two liters per minute, was receiving oxygen at ½ liter per minute, which had the potential to result in hypoxia (abnormally low level of oxygen in the blood). Findings: On 8/5/11 at 7 p.m. during the initial tour, Resident 5 was observed lying in bed. A family member at the bedside pointed out that the resident's gown and bed linens were wet, then pointed to the resident's right hand. A plastic I.V. catheter was observed lying on top of the hand, which was reddened and swollen. The resident was also receiving oxygen per nasal cannula at a flow rate of .5 liters per minute via an oxygen concentrator unit. A review of Resident 5's admission sheet disclosed the resident was a 102 year old female who was admitted to the facility on 7/23/11, and readmitted on 7/29/11 with diagnoses of ESBL (extended-spectrum class A beta-lactamases) of the urine, MRSA (methicillin-resistant staphylococcus aureus) of the nares, and a Stage III pressure ulcer of the coccyx. The resident had also been admitted to hospice care on 7/23/11, and was in contact isolation for the diagnoses of MRSA and ESBL infections. Review of the Nursing Admission Assessment dated 7/29/11, indicated the resident was confused and disoriented to person, time and place. The resident was incontinent of bowel and bladder, and was completely dependent on staff	F 328	oxygen concentrator is set at the appropriate rate. No other deficient practice was found. • The licensed nurses on a daily basis will check each resident with an IV for the appropriate insertion to prevent infiltration and to prevent contamination of the IV bag and to check for residents with an oxygen concentrator for the appropriate rate is set. • The D.O.N./R.N. Supervisor will monitor during daily rounds for proper IV insertion, to prevent contamination of the IV bag and for the appropriate rate for the oxygen concentrator. Findings will be discussed during the Quarterly Quality Assurance and Assessment meeting for compliance and corrective action, if needed.	9/5/11

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F 328	Continued From page 29 for all of her daily living needs. Review of the physician's orders indicated an order dated 7/23/11, for continuous oxygen at two liters per minute via nasal cannula. There was also an order dated 8/4/11, to insert a peripheral I.V. catheter and start infusion of Dextrose 5% in ½ normal saline solution one liter to infuse at rate of 20 ml (milliliters) per hour continuously for hydration until ST (speech therapy) evaluation was done, then call Hospice MD. A review of the care plan titled "I.V. Therapy Hydration & Medication", undated, stipulated to observe the site frequently for signs and symptoms of complications such as redness, swelling, pain, drainage, and leakage. During an interview with LN (licensed nurse) 1 on 8/5/11 at 7:20 p.m., she stated she monitored the resident's I.V. site every hour. When asked how long a bag of I.V. solution was allowed to hang, the licensed nurse stated it depended upon the ordered flow rate. When questioned regarding signs and symptoms of I.V. infiltration, LN 1 stated the resident's hand "was like that before." During an interview with the DON (director of nursing) on 8/5/11 at 8:05 p.m., she initially stated it depended on how much I.V. fluid had been ordered. She then indicated it was 48 hours, but she needed to check the facility's policy. On 8/6/11 at 9:15 a.m., Resident 5's family member stated the resident's right hand had not been swollen prior to insertion of the I.V. catheter. A review of the undated policy titled "Policies and	F 328		

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F 328	Continued From page 30 Procedures for I.V." indicated an intermittent I.V. therapy administration set is changed every 24 hours..... On 8/6/11 at 9:25 a.m., during interview and review of the physician's orders with the DON, the DON indicated the oxygen rate was supposed to be two liters per minute.	F 328		
F 371 SS=C	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that foods were stored, distributed and served under sanitary conditions. There were no labels and dates identifying left-over foods and thickened liquids (consistency) stored inside the kitchen reach-in refrigerator. There was rust on refrigerator shelves. Accumulation of dust particles were embedded in and around the refrigerator cooling system fan-guard. Ice cream was observed at 10 degrees Fahrenheit inside the kitchen ice cream freezer. This had the potential to result in improper sanitation and food handling practices that could lead to the outbreak of foodborne	F 371	F371 It is RGECH's policy to procure food from sources approved or considered satisfactory by Federal, State, or local authorities; and store, prepare, distribute and service food under sanitary conditions. • On 8/5/11, the food trays containing glasses of thickened soy-milk and thickened orange juice, regular milk, regular orange juice, apple juice and prune juices, low-fat milk, high protein nourishments and tortillas not properly labeled were immediately discarded. On 8/5/11 the fan guard in the refrigerator was thoroughly cleaned, the shelves in the reach-in refrigerator was cleaned, and the ice-cream in the freezer were discarded. Dietary supervisor checked the temperature	

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F 371	Continued From page 31 illness. Findings: On 8/5/11, at 6:30: p.m., during the initial tour of the facility's kitchen in the presence of the dietary supervisor, the following were observed: 1. There were no labels and date identified on the following food stored inside the kitchen reach-in refrigerator: (a). Food trays containing glasses of thickened soy-milk and thickened orange juice. Glasses of regular milk, orange, apple and prune juice were not labeled. The dietary supervisor in an interview was unable to identify the consistency of the thickened soy-milk and thickened orange juice. (b). There were no dates on left-over bags of tortillas, and glasses of low -fat milk. There was no label identifying a food tray containing glasses of high protein nourishment. 2. Accumulation of dust particles were embedded in and around the kitchen reach-in refrigerator cooling system fan-guard. 3. There was rust observed on shelves inside the large reach-in refrigerator located near the kitchen stove. 4. The temperature of vanilla ice-cream inside the ice-cream freezer was 10 degrees Fahrenheit. The thermometer was left inside a 4 oz cup ice cream for 30 minutes. The facility policy and procedures on food storage indicated that all food items that are out of the	F 371	of the freezer and reviewed the log and found the temperature of the freezer and refrigerator was maintained at the correct temperature. • On 8/6/11, the dietary checked all food stored in the refrigerator and all other food was properly labeled and stored at the appropriate temperature. Refrigerator and freezers were checked for any other cleanliness issues and none were found. On 8/6/11 the Dietary Supervisor inserviced the dietary staff on the proper procedures on labeling and storing of food in the refrigerator and freezer and to ensure the refrigerator and freezer are maintained in a clean manner and operating properly. • The dietary supervisor will ensure through weekly checking of the refrigerator and freezer for proper labeling and storage of food and the cleanliness of storage area. An on-going inservice will be given on a quarterly basis to dietary staff to ensure compliance. • The Registered Dietician and/or the administrator will monitor monthly through random checking of the	

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F 371	Continued From page 32 original container will be properly stored in the refrigerators and shall be covered, labeled and dated. Frozen food shall be stored at 0 degrees Fahrenheit.	F 371	refrigerator and freezer for continued compliance. Findings will be discussed during the Quarterly Quality Assurance and Assessment meeting for compliance and corrective action, if needed.	9/5/11
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441	F441 It is RGECH's policy to establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. • On 8/6/11 the medication nurse was counseled on hand washing protocols after pushing a resident's wheelchair, after obtaining blood pressure and after dropping medication bottles on the floor. C.N.A. 1 was counseled on 8/6/11 to not return linen to the clean linen cart after it has been removed from the cart. The linen returned was immediately removed from the clean linen cart and was inserted into the dirty linen barrel. • An inservice was given to the licensed nursing staff by the D.O.N. on 8/10/11 and 8/12/11 in regards to the proper hand washing	

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	055818	A. BUILDING _____ B. WING _____	08/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL GARDEN EXTENDED CARE HOS	2339 W. VALLEY BLVD. ALHAMBRA, CA 91803

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F 441	Continued From page 33 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure the residents' environment was free from contamination. 1. During the medication pass, the medication nurse failed to wash her hands after pushing a resident's wheelchair into the resident's room, after obtaining the resident's blood pressure, and after dropping a bottle of multivitamins on the floor. This deficient practice had the potential to result in contamination of the medication cart. 2. CNA (certified nursing assistant) 1 removed two clean towels from a resident's bedside and placed them back on the clean linen cart, which had the potential to result in contamination. Findings: 1. On 8/6/11 at 7:55 a.m., during observation of the morning medication pass, LN 1 pushed Resident 15's wheelchair from the hallway into the resident's room, then returned to the medication cart and began preparing the resident's medications without first washing or sanitizing her hands. After preparing the medications, LN 1 obtained the resident's blood pressure reading, then again returned to the medication cart, touching the cart, and bottles	F 441	protocols, specifically after touching potentially contaminated surfaces, and after obtaining blood pressure and medication bottles falling to the floor. An inservice was given to C.N.A. staff on 8/8/11 regarding the proper handling of linen outside of the clean linen cart and to prohibit the returning of linen back to the clean linen cart. • During daily rounds, the RN Supervisor will ensure the medication nurse is in compliance with all hand washing protocols. The licensed nursing staff will ensure the C.N.A. staff is following infection control protocols by ensuring any linen taken out of the clean linen cart is not being put back to the cart, instead to be put into the dirty linen barrel. A quarterly inservice will be given by the Director of Nurses and the DSD to the licensed nurses and the C.N.A. staff, respectively, regarding infection control protocols. • The D.O.N./R.N. Supervisor will monitor daily and the pharmacy consultant monthly during their visit to ensure infection control compliance is being met during	

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F 441	Continued From page 34 inside the cart, without washing her hands. While preparing Resident 7's medications, LN 1 accidentally dropped a bottle of multivitamins on the floor, picked up the bottle, then placed it back in the medication cart. She continued to prepare the resident's medications without washing or sanitizing her hands. On 8/7/11 at 11 a.m., LN 1 stated she should have washed her hands after direct contact with Resident 15, and immediately after picking up the bottle of multivitamins due to potential for contamination. 2. On 8/6/11 at 8:35 a.m. during observation of the medication pass for Resident 7, CNA 1 was observed removing two clean towels from the bedside table of Resident 7's roommate, then returning the towels to the clean linen cart in the hallway. During an interview with CNA 1 immediately following, she indicated she should not have returned the towels to the linen cart due to potential for contamination/infection control.	F 441	medication pass. The D.O.N./Licensed nursing staff will monitor daily for infection control compliance regarding the clean linen and the clean linen cart. All findings will be discussed during the Quarterly Quality Assurance and Assessment committee meeting for compliance and corrective action, if needed.	9/5/11
F 456 SS=B	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain essential mechanical laundry room equipment in a safe operating condition.	F 456	F456 It is RGECH's policy to maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. * On 8/8/11, the maintenance supervisor repaired the water leak from laundry washer #2.	

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F 456	Continued From page 35 There was water leaking from the laundry washer onto the floor. Findings: On 8/6/11, at 11:40 a.m., during the general observation of the facility's laundry room, in the presence of the maintenance supervisor, there was water leaking from the laundry washer #2 onto the floor. A cloth towel was observed being used to catch the water leaking from the washer. During an interview on the same date at 11:41 a.m., that maintenance supervisor stated he was not aware of the leaky washer.	F 456	• On 8/8/11, the maintenance supervisor inspected all washing machines and no other water leak was found. • The maintenance supervisor inserviced laundry staff on 8/10/11 to promptly report of any repair issues with the washers to the maintenance supervisor. A log was provided for any repairs to be resolved. • The administrator will monitor through auditing the repair log and interviewing the laundry staff monthly to ensure all repairs are completed timely. All findings will be discussed during the Quarterly Quality Assurance and Assessment committee meeting for compliance and corrective action, if needed.	9/5/11
F 458 SS=B	483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure that all bedrooms measured at least 80 square feet (sq. ft.) per resident in multiple resident bedrooms for 12 of 17 resident rooms. Findings: On 8/7/11, at 3:25 p.m., during the general observation of the physical environment of the facility in the presence of the maintenance supervisor noted that 12 of 17 resident rooms did	F 458	F458 It is RGECH's policy to have at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. • The facility submitted a room variance to the surveyor on 8/7/11 for rooms 101, 102, 104, 106, 109, 110, 111, 112, 114, 115, 116, and 117. All rooms had ample space for	

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F 458	Continued From page 36	F 458		

not measure 80 square feet per resident. On 8/7/11, the administrator submitted a room waiver request for the 12 resident rooms, which did not meet the minimum requirement. A review of the room waiver included the following information.

Room	No. of Beds	Square Feet
101	2	145
102	3	236
104	4	309
106	4	299
109	4	303
110	2	150
111	2	150
112	2	150
114	2	154
115	2	150
116	2	145
117	2	145

The minimum square footage for a 2-bed room is 160 sq. ft., a 3-bed room is 240 sq. ft., and a 4-bed room is 320 sq. ft.

The evaluator noted that the residents were able to move freely around in their rooms and there were sufficient spaces for resident care equipment. The rooms had adequate privacy curtain for each resident and the rooms had direct access to the corridor. The residents stated that they did not have any problems with their rooms.

residents to move around freely in the rooms and for resident care equipment. All the rooms had adequate privacy curtain for each resident and direct access to the corridor.

- On 8/7/11 the maintenance supervisor measured the remaining rooms and all those were found to be in compliance with appropriate square footage.
- The facility will continue to ensure the residents in the variance rooms to have ample space to move around freely and have sufficient space for resident care equipment.
- The administrator/assistant administrator will monitor monthly the rooms to ensure residents have ample space to be able to move around freely and for the resident care equipment. All findings will be discussed during the Quarterly Quality Assurance and Assessment meeting for compliance and corrective action, if needed.

9/5/11

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/13/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 000	INITIAL COMMENTS The following reflects the findings of the Department of Public Health during a Revisit Survey. Representing the Department of Public Health: 27785 28074 Total Resident Population: 39 Total Resident Sample Size: 8 No Deficiencies Noted	F 000		

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

Administrator 1-19-12

For 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.