POC a cepted 4/5/17 #36289 #FGN 12:28:20 p.m. 03-21-2017 9/14

PRINTED: 03/20/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICALD SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (XZ) MURITIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 555348 B. WING 03/21/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3565 E: IMPERIAL HWY. **ROYAL OAKS CARE CENTER** LYNWOOD, CA 90262 SUMMARY STATEMENT OF DEFICIENCIES (X4) (D PREPIX PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) EAT TAG CROSS-REFERENCED TO THE APPROPRIATE OATE DEFICIENCY F 000 **INITIAL COMMENTS** F 000 The following reflects the findings of the Department of Public Health during the investigation of one complaint. Complaint number: CA00522199- Substantiated Representing the Department HFEN #36289 The inspection was limited to the specific complaint investigated and does not represent 5 the findings of a full inspection of the facility. One deficiency was written as a result of complaint number CA00522199. င္ပ F 252 483.10(e)(2)(i)(1)(i)(ii) F 252 SAFE/CLEAN/COMFORTABLE/HOMELIKE SS=E **ENVIRONMENT** (e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. §483.10(I) Safe environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide-(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE (20) DATE 31 SAMINIZATION

Any deficiency statement ending with an exterisk (7) denotes a deficiency which the institution may be excused from correcting providing it is determined that other sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclossible 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 disclossible 14 days following the date these documents are made systable to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2667(02-69) Previous Versions Obsolute

Event ID: SV:XC11

Feelity ID; CA940000078

If continuation sheet Page 1 of 6

DEPARTMENT OF HEALTH AND HUMAN SERVICES

12:28:59 p.m. 03-21-2017

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· CENTE	RS FOR MEDICARE	E & MEDICAID SERVICES			OMB NO	<u>. 0938-0391</u>		
	OF DEFICIENCIES OF CORRECTION	(X1) FROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		555348	B. WING_			C 21/2017		
	PROVIDER OR SUPPLIER DAKS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP 3565 E. IMPERIAL HWY. LYNWOOD, CA 90262	CODE	<u> </u>		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUSY BE PRÉCEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO	n should be	COMPLETION DATE		
F 252	Inspected at least inecessary. The po- check the wallpaper	age 2 dent rooms so each room is monthly and repaired as licy and procedure indicated to er, paint, door jams, and door damage and tears.	F 25	The facility also hired a licen inspect the roof on 3/23/17 to repairs needed to avoid future damage.  Monitoring of corrective ac	further assess leaks and ceiling	3/23/1		
•	2/7/17, indicated the On 2/13/17, at 2:26 initial observation to accompanied by the	elident Council Minutes," dated to "ceilings were dripping."  5 p.m., during an interview and our of Station 1 of the facility, the licensed vocational nurse ing rooms were observed with		Maintenance Director and ho Director will make rounds an with Administrator if any leal of resident ceilings are obsert Administrator and all departn also make weekly facility rou ensure no brown stains on the	d communicate es or discolorations ed.  tent managers shall ands in order to ceilings or leaks	3/31/17 F/118/2		
	paint was peeling, cracked holes that deformity:  1. There were brobubbles that forme	k discoloration in the ceiling, and plastered surfaces had formed a cone-shaped own stains, cracks, and d in the ceiling of room 5. The positioned sideways against		are present. Findings will be a Assurance committee.	eported to Quality			
	the wall. In another were brown stains celling.  2. The ceiling in f	area of the ceiling in room 5, and chipped paint on the Room 6 had black spots and subbles formed. The ceiling's	•			•		
	3. The ceiling in F bubbles formed on was chipped, and a head of the resider when it rained, the from where the ceil	Room 7had brown stains with the ceiling. The ceiling's paint a hole was observed near the at's bed. Resident 6 stated rain water sometimes drips ling hole was located and that, and through the ceiling about	·					
	4 The ceiling in S	Coom 8 had a light known etain						

FORM CMS-2567 (02-98) Previous Versions Obsoleto Event ID; SWKC11

Fedity ID: CA940000078

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

12:28:41 p.m.

03-21-2017

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PRINTED: 03/20/2017 FORM APPROVED

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES		• •	FORM APPI		
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(XX) MULL A. BUILD	LTIPLE CONSTRUCTION BING	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED			
•		556348	B. WING		C		
NAME OF	PROVIDER OR SUPPLIER		<del>'</del>	STREET ADDRESS, CITY, STATE, ZIP CODE	03/21/20	017	
ROYAL	OAKS CARE CENTER	•		3565 E IMPERIAL HWY. LYNWOOD, CA 90262			
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFII TAG		M D OF	COMPLETION DATE	
F 252	Continued From page	ge 1	F2	950			
		does not pose a safety risk.					
	(ii) The facility shall the protection of the	exercise reasonable care for resident's property from loss	·	This plan of correction constitutes the credible allegation of compliance for deficiency noted.	r the		
	or theft. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain a safe, comfortable, and sanitary environment, by ensuring that the ceiling plaster surface was not leaking water or, damaged, or forming brown and black stained discoloration in the resident's rooms (5, 6, 7, 8, 9, 10, 11, 12, 15, and 17). Seven out of seven sampled residents verbalized that the			Royal Oaks Care Center makes its be operate in full compliance with both State law. Nothing included in this P Correction is an admission otherwise	Federal und lan of Royal		
				Oaks Care Center has submitted this Correction in order to comply with it obligation and does not waive any of the merits or form any allegations co	s regulatory		
				herein.  For the residents identified			
	celling in their room	leaked water.		Facility room rounds were made and rooms (5,6,7,8,9,10,11,12,15,17) ceil repaired to ensure ceiling plaster surf	ings were 2/2	1/17	
İ	spread disease-caus on the floor that may	tices had the potential to sing organisms, and wetness compromise the health, of the residents, staff, and		longer leaking water and does not have black stained discolorations, peeling blistering.	ve brown or		
	visitors.	or me residents' statt' and		For all residents			
	Findings:  A review of the facility's undated policy and procedure titled, "Interior Maintenance: Painting,"			Facility rounds were made and reside ceilings were repaired to ensure ceiling surface is no longer leaking water and have brown or black stained discolors	eg plaster I does not	3(3)(7	
· ·	indicated ceilings, wa should be inspected	ancr Maintenance: Painting," alls, doors, and doorframes for chipping and blistering, edure indicated each room		pecling or blixtering.  Measures to easure compliance			
	should be inspected	at least monthly.	•	DSD inserviced all department heads		31	
11	procedure titled, "Inte	y's undated policy and erior Maintenance: Resident		in regards to informing the maintenan supervisor of any physical plum/envin concerns, which includes any repairs i	ce onmental		
	interior surfaces and provide a safe, clean environment for resid	t," indicated to maintain all fixtures in good repair, to , and comfortable lents and employees. The indicated to rotate weekly		Administrator inserviced Maintenance supervisor on 3/30/17 on reporting any stains on the resident rooms ecilings, physical plant/environmental concerns should also be reported to the Administration of the Administration	y leaks or Any other or repairs	0/17	
	7(02-99) Provious Versions O		·F	, soon as possible.	vation sheet Page	2 of B	

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**DEPARTMENT OF HEALTH AND HUMAN SERVICES** 

12:29:17 p.m.

03-21-2017

12/14

PRINTED: 03/20/2017 FORM APPROVED

		(X1) PROVIDER/SUPPLIER/CLIA		_	<u>. 0938-0391</u>				
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		Y BRITT		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		B. WING	·		**************************************	C /21/2017			
NAME OF PROVIDER OR SUPPLIER ROYAL OAKS CARE CENTER				39	TREET ADDRESS, CITY, STATE, ZIP CODE 565 E. IMPERIAL HWY. YNWOOD, CA 80262	1 400			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DÉFICIENCIES (EACH DEFICIENCY MUST BE PRICEDED BY FULL, REGULATORY OR LSC (DENTIFYING INFORMATION)		(D PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	EACTION SHOULD BE			
	with bubbles formed 5. The ceiling in R spots, bubbles, and size of a nickel in the observed with black stated that the ceiling left side of the resid Bed B's privacy curt black and brown state the plastered surfactone-shaped deform dripping brown, wate There was no reside the observation. Rewas a resident who members would post against the wall to p directly on the reside leak in the ceiling by ago. Resident 2 stated she had beer the facility and the coroblem. Resident 2 the facility would fix the 6. The ceiling in Rebrown stains and bustated the facility pawhen it rains, but rejections.	SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL, REGULATORY OR LSC (DENTIFYING INFORMATION)  Intinued From page 3 In bubbles formed on the ceiling.  The ceiling in Room 9 had a large brown to, bubbles, and a hole, approximately the roof a nickel in the ceiling. The ceiling was erved with black colored stains. Resident 1 and that the ceiling leaked rain water near the side of the resident's bed (close to Bed A and It is privacy curtains). The evaluator observed it and brown stains on the ceiling near Bed-B. Plastered surface formed a large pointed e-shaped deformed structure that was ping brown water on the bed at the time of observation. Resident 2 stated when there is a resident who occupied Bed-B; staff inbers would position the bed sideways inst the wall to prevent water from dripping city on the resident. Resident 2 stated the in the ceiling by Bed-B occurred three weeks. Resident 2 stated the facility kept patching ceiling, but water still leaked out, Resident 2 and she had been a resident for two years at facility and the ceilings had been an ongoing slam. Resident 2 stated she would like to see facility in better condition, and was hoping the lity would fix the roofing.  The ceiling in Room 10 near Bed-B had on stains and bubbles on the ceiling and wall in it rains, but repair was only a temporarily 1. Room 10 near Bed-C had brown spots in		252	COLI RELIGITY				
	7. The ceiling in Robrown stains on the leak first started as a	com 11 near Bed-B had ceiling. Resident 5 stated the a small hole. Resident 5 ad the hole, but when the			·				

FORM CMS-2557(02-99) Province Versions Obsolete

Event ID: 5WKC11

FecDity ID: CA940000076

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

12:29:36 p.m.

03-21-2017

13/14 PRINTED: 03/20/2017 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938									. 0938-039 <sup>-</sup>	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  658348		(XX) MULTIPLE CONSTRUCTION A. BUILDING					(X3) DATE SURVEY COMPLETED			
		B. WING		<u> </u>	· · · · · · · · · · · · · · · · · · ·			C		
NAME OF	PROVIDER CR SUPPLIER		` 1	ST	REETADDRESS	CITY, STATE.	ZIP COSE	1 03	21/2017	
ROYAL OAKS CARE CENTER			j	35	65 E. IMPERIAL NWOOD, CA	. HWY.			•	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFI TAG	- 1	(EACH CO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			COMPLETION (X5)	
F 252	hole. Resident 5 standard might collapse.  8. The ceiling in R brown stain and but ceiling. Resident 4 s	i, the ceiling formed a larger sted she was afraid the ceiling com 12 near Bed-C had obles that formed on the stated there was some leaking.	F 2	52			•			
	9. The ceiling in R brown stain in the cobrown stain with but 10. The ceiling in R crack on the celling, brown stains on the Friday and Saturday	cek.  com 15 near Bed-B had elling. Room 15, Bed C, had a obles formed on the ceiling.  com 17 near Bed-B had a Room 17 close to Bed-A had ceiling. Resident 3 stated last t, the facility patched the ter was leaking into the room							•	
	During an interview maintenance supervise 18 had a leakage in ago, and was current MS stated the reside mainly affected by the lifthere was only a supersident's room, the	on 2/13/17 at 3:20 p.m., the isor (MS), stated that Room the ceiling almost one month thy repairing the damages. ent's rooms in Station 1 were the damages. MS stated even mall leak from in the facility would move the er room to prevent injuries	•	-		·			•	
-	administrator (ADMil place a bucket on Ro temporarily catch the	on 2/13/17 at 3:38 p.m., the N) stated his plan was to com 9 close to Bed-B to water that was leaking from the no residents in the room.			•			,		
<u> </u>	During an interview o Resident 7 stated sh	in 2/13/17, at 4:15 p.m., e used to reside in Room 7,								

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12:29:54 p.m. 03-21-2017

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CENTERS FOR MEDICARE & I STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	()(2) MULTIPE A. BUILDING	E CONSTRUCTION	0	FORM APPROVE OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
Marin of Pro-	555348	B. WING		C 03/21/2017		
NAME OF PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE,	ZIP CODE		10112011
ROYAL OAKS CARE CENTER			585 E. IMPERIAL HWY. YNWOOD, CA 90262	•	•	•
PREFIX (EACH DEFICIENCY MUI	ENT OF BEFICIENCIES . ST BE PRECEDED BY FULL BENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE A) CROSS-REFERENCED TO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		
Resident 7 stated, "I wa fail." Resident 7 stated Room 7, the staff would against the wall, so that directly on the resident.  During an interview and facility's "Daily Rounds "Maintenance Supervise Inspection Report," 2/13 stated that the environn resident's rooms should designated forms. Miss February 2017, he forgo inspection of the facility inspection Report." Miss reports should be subm	her current room on use the ceiling paint was and had black molds, as afraid the ceiling would that when she was in a move her bed to the side the water would not fall record review of the inspection Report and or's Daily Rounds 17, at 5:30 p.m., the MS mental rounds of the be documented on the stated for January and at to document his on the "Daily Rounds stated the inspection litted to the administrator tated he was also not able this environmental.					
	· .				•	