

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055105	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/05/2024
NAME OF PROVIDER OR SUPPLIER Royal Vista Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 909 W. Santa Anita Ave San Gabriel, CA 91776	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45523</p> <p>Based on observations, interview and record review, the facility failed to report the resident- to- resident altercation to the State Survey Agency (SSA), the state ombudsman (advocates for residents of nursing homes, board and care homes and assisted living facilities), and local law enforcement (Local PD) within two (2) hours after the allegation of physical abuse (intentional bodily injury to a person, for example slapping, pinching, choking, kicking, shoving) for one of three sample residents (Resident 1) in accordance with the facility's policy and procedure.</p> <p>This deficient practice had the potential to place Resident 1 for further abuse and placed other residents at risk for elder abuse.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included but not limited to bilateral primary osteoarthritis of knee (a degenerative joint disease that affects both knees, causing pain, stiffness, swelling, and decreased mobility), hypertensive heart disease with heart failure (heart problems that occur because of high blood pressure that is present over a long time).</p> <p>During a review of Resident 1's History and Physical (H&P) dated 5/09/2024 indicated Resident 1 has the capacity to understand and make decisions.</p> <p>During a review of the Resident 1's Minimum data Set (MDS-an assessment and care screening tool) dated 5/16/2024, indicated Resident 1's required substantial to maximal assistance (helper does more than half the effort to complete the activity) for toilet hygiene, shower, upper and lower dressing, and personal hygiene.</p> <p>During a review of Resident 1's Care Plan initiated 5/09/2024 indicated, Resident shall not be subject to abuse by anyone, including but not limited to facility staff, other residents, consultants or volunteer staff or other agencies, family member or legal guardian. The care plan interventions indicated, Inform resident and/or responsible party of the facility for reporting of abuse.</p> <p>During a review of Resident 1's Change of Condition (COC) dated 7/30/2024 at 9:10 AM indicated, Charge Nurse (CN) goes to room, resident voiced out roommate hit her left arm. Resident is awake and oriented and able to make needs known.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 2's Admission Record indicated the resident was originally admitted to the facility on [DATE] and re admitted on [DATE], with diagnoses that included but not limited to psychosis (a severe mental disorder in which thought and emotions are so impaired that contact is lost with external reality) and schizophrenia (a mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions).</p> <p>During a review of Resident 2's H&P dated 5/09/2024 indicated Resident 2 has the capacity to understand and make decisions.</p> <p>During a review of the Resident 2's MDS dated [DATE], indicated Resident 2's required partial to moderate assistance (helper does less than half the effort to complete the activity) for oral hygiene, shower, upper and lower dressing, and personal hygiene.</p> <p>During a review of Resident 2's COC dated 7/30/2024 at 9:00 AM indicated, roommate voiced out she hit my left arm.</p> <p>During an interview with the Director of Nursing (DON) on 8/05/2024 at 10:05 AM, the DON stated, I reported on Thursday 8/1/24, reported on the phone on 7/31/24. I left a message. I got a call back 8/1/24. I did not make a report to the Police department because I was waiting for advice. On 7/30/24 it was not reported.</p> <p>During a concurrent interview with the DON on 8/05/2024 at 10:11 AM, the DON stated an abuse incident should be reported within 72 hours, if it can be done in 24 hours that is the better practice.</p> <p>During an interview with Social Service Director (SSD) on 8/05/2024 at 10:15 AM, SSD stated, SSD considered the incident between Resident 1 and 2 to be a resident- to- resident abuse case even if it is just claimed by one of the residents and even if it was not witnessed it was an allegation abuse. SSD stated It needs to be reported within 2 hours to California Department Public Health (CDPH/SSA), Ombudsman and the Police Department. I would not wait 72 or even 24 hours to report it. The in services and facility policies say it needs to be reported within 2 hours. the documentation using the SOC 341 (abuse reporting form) must be followed up, but the incident must be reported.</p> <p>During an interview with Certified Nurse Assistant 1 (CNA1) on 8/05/2024 at 10:28 AM, CNA 1 stated, an abuse case must be reported immediately to the charge nurse or registered nurse (RN) supervisor, even if the incident was not witnessed. If a resident reports any type of abuse, we must take it seriously and report it right away. We have been taught its ok to report it within 2 hours not 72 hours. It isa not okay to not report it, even if it is unwitnessed.</p> <p>During an interview with CN 1 on 8/05/2024 at 10:32AM, CN1 stated, I was there on the day of the incident (Resident 1 and 2) I did the COC. I was at the nursing station. I hear loud voices. I went to the residents' room. CN1 stated she saw Resident who pointed to her left arm, and then pointed at Resident 2. CN1 also stated, Resident 1 said Resident 2 hit her. CN1 stated, I reported it to the DON. It happened 7/30/24 around 8:40 AM.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview with CN1 on 8/05/2024 at 10:47 AM, CN1 stated any type of abuse needs to be reported within 2 hours from the incident or from when the allegation was made. CN1 stated Waiting 72 hours is not okay. What if something else happened? It could have been worse. This is the reason I reported it to the DON right away. I follow the chain the of command; we can also call CDPH. I believe there is a list of protocols to do inside a binder at the nurse's station, but we normally follow chain of command.</p> <p>During a concurrent interview with the DON on 8/05/2024 at 11:02 AM, the DON defined abuse when a patient or resident rights or safety is compromised. The DON stated, there is different types of abuse, physical, emotional (attempts to frighten, control, or isolate), social (behavior that aims to cut a person off from your family, friends, or community), financial (a common tactic used by abusers to gain power and control), we are mindful of their (resident's) rights. The DON confirmed that hitting is considered abuse and stated, It is physical abuse, but then it is not physical injury, if you have to really investigate, if it was fabricated or something that has been evident.</p> <p>During an interview and record review with the facility Administrator (Admin) on 8/05/2024 at 11:13 AM, Admin stated, According to the facility policy, any alleged or witnessed abuse should be reported within 2 hours. Admin stated the definition of abuse is any act against a patient that would result in harm. Admin stated, it is considered abuse or not by the comment the resident made, it would warrant an investigation. Admin also stated, I cannot remember the resident stated she was hit. It would still be an alleged abuse.</p> <p>During an observation and interview with Resident 1 on 8/05/2024 at 11:56 AM, Resident 1 was sitting up at the side of her bed and stated, This month the other patient (Resident 2) has mental issues in the morning, she, the other patient punched me, (observed Resident 1 to close her hand and ball up into a fist to show how she was hit) on the left arm, tengtong (pain, ache, hurt), it hurt.</p> <p>During concurrent interview and record review with the DON on 8/05/2024 at 12:44 PM, the DON stated, a thorough investigation should have been done within 2 hours, in the facility policy it does say 2 hours, one thing that we were not aware of was that it should be within 2 hours. A resident can be affected by not following the policy. The DON also stated she did not know what form to complete to report the abuse and confirmed a SOC 341 (a form to report Suspected Abuse of Dependent Adults and Elders) was not completed.</p> <p>During a review of the facility's policy revised 4/2010, titled Reporting Abuse to Facility Management indicated, It is the responsibility of our employees, facility consultants, attending Physicians, family members, visitors etc., to promptly report any incident or suspected incident of neglect or resident abuse, including injuries of unknown source, and theft or misappropriation of resident property to facility management.</p> <p>During a review of the facility's policy revised 11/2010, titled Reporting Abuse to State Agencies and Other Entities/Individuals indicated, All suspected violations and all substantiated incidents of abuse will be immediately reported to appropriate state agencies and other entities or individuals as may be required by law.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1. Should a suspected violation or substantiated incident of mistreatment (a behavior shows disrespect for the dignity of others), neglect (to give little attention or respect to) injuries of an unknown source, or abuse (including resident to resident abuse) be reported, the facility Administrator, or his/her designee, will promptly notify the following persons or agencies (verbally and written) of such incident:</p> <ul style="list-style-type: none"> a. The State licensing/certification agency responsible for surveying/licensing the facility b. The local/State Ombudsman e. Law enforcement officials <p>2. Verbal/written notices to agencies will be made within Two (2) hours of the occurrence of such incident and such notice may be submitted via special carrier, facsimile (fax), electronic mail (email), or by telephone.</p> <p>9. Any violation of this policy may result in disciplinary action.</p> <p>During a review of the facility's policy revised 9/2022, titled Resident to Resident Altercation indicated, If two residents are involved in an altercation, staff: report incidents, findings and corrective measure to appropriate agencies as outlined in Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigating.</p>		