STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055105	A. Building B. Wing	09/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Royal Vista Care Center	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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45099 Based an interview and record review, the facility failed to ensure the resident's environment was free from accident hazards for one (1) of two (2) sampled resident (Resident 1) by failing to ensure the resident head did not get injured while using the Hoyer lift (a patient lift used by caregivers to safely transfer patients) during transfer. This deficient practice resulted to a 1.5 cm laceration (deep cut or skin tear in the skin) and a small bump to Resident 1's left front part of his head. Resident 1 was also sent to General Acute Care Hospital 1 (GACH 1) on 8/27/24 and was found to have a scalp cephalohematoma (accumulation of blood under the scalp) Findings: During a review of Resident 1's Admission Record indicated the resident was admitted to the facility on [DATE] with a diagnosis of dementia (loss of cognitive functioning such as thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities) and Alzheimer (a brain disorder that slowly destroys memory and thinking skills, and eventually, the ability to carry out the simplest tasks). During a review of Resident 1's Minimum Data Set (MDS, standardized assessment and care screening tool), dated 1/5/2024, indicated Resident 1 had severely impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 1 was dependent (helper does all the effort) with eating, oral, toileting and personal hygiene, shower, and upper/lower body dressing, and putting on/taking off footwear. (continued on next page)

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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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's Situation, Background, Assessment, and Recommendation (SBAR, a structured communication framework used to share information in a healthcare setting to communicate about a patient's condition) signed by LVN 1 and dated 8/27/24 timed at 2 PM, the SBAR/COC indicated at around 1:50 PM, LVN 1 was called regarding an incident pertaining to Resident 1. The report indicated, Resident 1 was on the Hoyer lift suspended next to the bed facing the television. The report also indicated that CNA 1 went to get the wheelchair that was few steps away and the other CNA was standing by the foot side of the resident when suddenly Resident 1 tilted backwards with his feet facing upwards and his head hit the Hoyer lift by accident. The document further indicated the treatment Nurse (TN) who assessed Resident 1 noted a shallow laceration on the left frontal lobe (forehead part) of the residents his head measuring 1.5 cm in length and noted a small bump with light discoloration. During a review of the Computed Tomography (CT, a diagnostic imaging procedure that uses a combination of X-rays and computer technology to produce images of the inside of the body) scan of the brain without contrast performed at GACH 1 on 8/27/24 indicated Resident 1 had a scalp cephalohematoma overlying the left frontal bone. During an interview on 9/23/24 at 11:17 AM, the Licensed Vocational Nurse 1 (LVN 1) stated she was in the charting room on 8/27/24 at around 2:17 PM when she was called to see Resident 1. LVN 1 also stated when he saw Resident 1, she noticed the resident had bleeding, a small bump, and a laceration on the resident's left forehead. During an interview on 9/23/24 at 2 PM, the Certified Nursing Assistant 1 (CNA 1) stated she heard a bang right when she turned to get Resident 1's wheelchair while the resident was up on the Hoyer lift sling (a hammock-style harness that cradles a patient and allows them to be lifted and moved to a new surface). CNA 1 also stated she and CNA 2 who was helping her did not see where Resident 1 got hit. During an interview on 9/23/24 at 3:45 PM, the Director of Nursing (DON) stated someone should have been supporting both ends of the Hoyer Lift sling to avoid accidents and to ensure safety of Resident 1 during transfer. The DON also stated CNA 1 and 2 should have cleared the area inside the room before doing the transfer from bed to chair. During an interview on 9/23/24 at 4:07 PM, the LVN 2 stated one person should have used appropriate technique to lift Resident 1 and supported the upper part and the lower part of Resident 1's body while in the Hoyer lift sling to prevent the resident from sustaining any injuries such as hitting body parts against the Hoyer lift. LVN 2 also stated if not properly supported Resident 1 could get hurt due to the resident's movement and jerking tendencies. During another interview on 9/23/24 at 4:21 PM, CNA 1 stated on 8/27/24 during transfer of Reisdent 1via Hoyer lift, she was on the resident's head part and CNA 2 was on the foot part, and was not holding the sling of the Hoyer lift because it tilts normally. CNA 1 also stated she then went to get the wheelchair which was in the room but not close by. During a review of the facilities Policy and Procedure titled, Safe Lifting and Movement of Residents, dated 2001, indicated to protect the safety and well-being of staff and residents, and to promote quality care, the facility uses appropriate techniques and devices to lift and move residents.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 45099 Based on observation, interview, and record review, the facility failed to ensure safe provision of pharmaceutical services by failing to store unused insulin (used to help manage blood sugar levels on adults with diabetes [high blood sugar level]) injectable medications in the refrigerator and dispose of expired medications from two (2) of 2 sampled medication carts (Medication Cart one [1] and 3). These deficient practices had the potential for adverse reactions if these improperly stored medications were administered to the residents. Findings: During a concurrent observation and interview with Licensed Vocational 3 (LVN 3) on 9/23/24 at 2:25 PM, Medication Cart 1 was noted to have the following items: 1) 3 unopened Novolin R insulin (a short-acting insulin that starts to work in about 30 minutes and lasts for several hours to help lower blood sugar levels in the blood) Flex Pen injection 100 units labeled with name of 3 different residents. 2) 1 unopened Basaglar Insulin (a long-acting insulin that is slowly absorbed after being administered and maintains its effects over a long period of time to control high blood sugar in adults and children with type 1 diabetes and adults with type 2 diabetes) Flex Pen injection 100 units. 3) 1 Novolin R insulin Flex Pen injection with an open date of 8/17/24 and not labeled with expiry date or discard date. LVN 3 stated the Novolin R insulin should have been discarded on 9/14/24 which is twenty-eight (28) days from opened date since it could adversely affect the resident receiving the insulin and would not be as effective once expired. LVN 3 also stated the 3 unopened Novolin R insulin and 1 unopened Basaglar insulin injections must be refrigerated until opened. LVN 3 further stated the LVNs were responsible in checking the medication carts to ensure there is no expired medications and insulin injections are stored in the refrigerator until opened. During a concurrent observation and interview on 9/23/24 at 2:56 PM, the Medication Cart 3 was noted to have the following items: 1) 1 Aspart (rapid-acting insulin that starts working quickly to control blood sugar levels) Flex Pen insulin Flex Pen injection with an open date of 8/18/24 and not labeled with expiry or discard date. 2) 3 bubble packs (a card that packages doses of medication within small, clear, or light- resistant, amber-colored plastic bubbles) containing Catapres (medication used to treat high blood pressure) 0.1 milligrams (mg, unit dose) tablets with expiration dates of 9/5/24. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3) 1 bubble pack containing Zofran (medication used to prevent nausea and vomiting) 4 mg tablets with an expiration date of 9/5/24. LVN 1 stated the Aspart insulin injection should have been discarded on 9/15/24 which is 28 days from opening. LVN 1 also stated the medication would not be effective and would be unsafe for the residents because it could possibly cause a reaction if the medication administered was expired. During an interview on 9/23/24 at 3:45 PM, the Director of Nursing (DON) stated the efficacy of the insulin would not be maintained and possible side effects can happen to the residents if it was not stored properly in the correct temperature. The DON also stated the storage and administration of the medication is being compromised when the medication was not stored properly and when medication is expired. During an interview on 9/23/24 at 4:13 PM, the Director of Nursing (DON) stated the LVNs at start of shift, should look at all the medications in their carts to make sure that they do not have expired medications. The DON also stated, if the licensed staff were keeping the expired medications in the cart, they violated the facility's policy that no expired medications should be in the cart. The DON further stated, if expired medications get accidentally administered to the residents, there would be a possibility of complications. A review of the facility's policy and procedure titled, Storage of Medications, revised April 2007, indicated, the facility shall store all drugs and biologicals in a safe, secure, and orderly manner. The policy also indicated that the facility shall not use outdated drugs or biologicals and such drugs shall be returned to the dispensing pharmacy or destroyed. The policy further indicated, medications requiring refrigeration must be stored in a refrigerator located in the drug room at the nurses' station or other secured location.