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	09/25/2024

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48143 Based on observation and interview, the facility failed to safeguard one of two sampled residents (Resident 1) personal privacy and confidentiality of the medical records. This failure had the potential to result in Resident 1's personal information and medical records disclosed without Resident 1's permission, this will compromise the security or privacy of Resident 1's protected health information. Findings: During a review of Resident 1's Admission Record indicated Resident 1 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included type 2 diabetes mellitus diabetic with chronic kidney disease (high blood sugar level in the blood stream lead to a gradual loss of kidney function over time), dependence on renal dialysis (a person requires technology to sustain their life due to kidney failure), and end stage renal disease (a permanent condition where the kidneys stop working, requiring dialysis or a kidney transplant to survive). During a review of Resident 1's History and Physical Examination (H&P), dated 11/4/2023, H&P indicated the resident has the capacity to understand his medical condition or his bill of rights (a patient's rights and responsibilities). During a review of Resident 1's Minimum Data Set (MDS- a comprehensive assessment and screening tool) dated 8/7/2024, the MDS indicated Resident 1 was not able to follow commands, his cognition skills (process of thinking and reasoning) was moderate impaired for decision making. Resident 1 required helper to do more than half of the effort for resident for the toilet, personal hygiene. The MDS also indicated Resident 1 required more than half of the effort for change of position and transfer. Resident 1 is moderate dependent (helper does more than half of the effort). (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

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	09/25/2024

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 2's Admission Record indicated Resident 2 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included hypertensive heart disease (a group of conditions that can occur when chronic high blood pressure damages the heart) with heart failure (the heart is unable to pump enough blood to meet the body's needs), hemiplegia (a severe or complete loss of strength or paralysis on one side of the body) and hemiparesis (a mild loss of strength in a leg, arm, or face) following cerebral infarction (a damage to tissues in the brain due to a loss of oxygen to the area) affecting right dominant side, acute respiratory failure with hypoxia (medical emergency that occurs when the lungs have difficulty exchanging oxygen and carbon dioxide with the blood, resulting in low oxygen levels in the body's tissues). During a review of Resident 2's H&P, dated 9/17/2024, H&P indicated the resident does not have the capacity to understand his medical condition or his bill of rights (a patient's rights and responsibilities). During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2 was not able to follow commands, his cognition skills was severely impaired for decision making. Resident 2 required helper to do all the effort for resident for the toilet, personal hygiene. The MDS also indicated Resident 2 required helper to do all the effort for change of position and transfer. Resident 2 is totally dependent. During a concurrent interview and record review of nursing progress notes on 9/25/2024 at 9:42 AM with Registered Nurse 1 (RN1), Resident 2's nursing progress note dated 9/24/2024 was reviewed. RN1 stated Resident 2 got sent out to the General Acute Care Hospital (GACH) for further evaluation and care treatment due to fever and low oxygen level in his blood stream. RN1 stated Resident 2 was transferred to the hospital by 911 (provides emergency services), City Fire Department (CFD) paramedic. The transfer of Resident 2 to GACH happened on 9/24/24 morning around 7:22 AM. RN1 stated it was the night shift nurse Licensed Vocational Nurse (LVN1) 1 that coordinated Resident 2's transfer to GACH on 9/24/24 and sent Resident 1's medical records (face sheet, H&P [history and physical assessment], medications list, POLST [physician orders for life-sustaining treatment, a medical order that helps residents with serious illness specify their preferences for end- of- life care], and physician's order of transfer) instead of Resident 2's medical records to GACH. RN1 stated this is a violation of the HIPPA (Health Insurance Portability and Accountability Act- a federal law that protects sensitive health information and provides rights to health plan participants) law by sending out other resident's medical information during hospital transfer. During a telephone interview on 9/25/2024 at 11:15 AM with CFD, CFD's fire fighter stated GACH's emergency room notified him on 9/24/24 near 8:20 AM that CFD paramedic sent Resident 2 to the hospital with another resident's medical records the medical records inside the dispatch package (contains medical records of the reisdent when sent out from one facility to another facility) from the facility was for Resident 1, they were not for Resident 2. During a telephone interview on 9/25/2024 at 11:50 AM with GACH's emergency room charge nurse (ERCN), ERCN stated she had received Resident 1's face sheet, H&P, medications list, POLST, and physician's order of transfer, and no paperwork/ medical records for Resident 2. ERCN stated, she needed to call the facility for verification of Resident 2's identity and she was talking to Registered Nurse 2 (RN2). ERCN stated, on 9/24/2024 she obtained fax of Resident 2's face sheet, H&P, medications list, POLST, and physician's order of transfer from Registered Nurse 2 (RN2) at the facility. ERCN stated the facility violated the HIPPA law on 2 separate incidents. (continued on next page)

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	09/25/2024

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/25/2024 at 12:31 PM with RN2, RN2 stated she confirmed with ERCN that Resident 1 got sent out to GACH with Resident 2's medical records. RN2 also stated, RN 2 faxed Resident 2's face sheet, H&P, medications list, POLST, and physician's order to SGVMC emergency room per ERCN's request on 9/24/2024. RN2 stated this is a breach of the of protected health information (PHI) by sending out Resident 1's protected health information to CFD paramedic ambulance without carefully review and verification of the resident's identity or it is for the correct resident. During a telephone interview on 9/25/2024 at 1:28 PM with LVN1, LVN1 stated, the Director of Nursing (DON) did call him and let him know that he sent out Resident 1's medical records for Resident 2's transfer to GACH on the morning of 9/24/2024. LVN1 stated this is a breach of HIPPA law for unauthorized release or disclosure of other resident's medical information to the CFD paramedic and GACH. During an interview on 9/25/2024 at 1:47 PM with the DON, the DON stated she was aware of LVN1 sent out Resident 1's medical record for Resident 2's transfer to GACH by CFD paramedic on 9/24/2024 morning. DON stated this is an unauthorized release or disclosure of Resident 1's medical records. DON stated this is a breach of the protected health information. During a review of the facility's policy and procedure (P&P) titled, Protected Health Information (PHI), Management and Protection of revised April 2014, the P&P indicated, it is the responsibility of all personnel who have access to resident and facility information to ensure that such information is managed and protected to prevent unauthorized release or disclosure. During a review of the facility's policy and procedure (P&P) titled Resident Right revised December 2016, the P&P indicated, the unauthorized release, access, or disclosure of resident information is prohibited. All release, access, or disclosure of resident information must be in accordance with current laws governing privacy of information issues. All inquiries concerning the release of resident information should be directed to the HIPAA Compliance Officer.