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	10/02/2024

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48395 Based on interview and record review the facility failed to provide treatment and care in accordance with the professional standards of practice for ne (1) of two (2) sampled residents (Resident 1) by: 1. Failing to record Resident 1's bowel movement (BM) pattern each day on 7/9/24-7/11/24, 7/15/24-7/16/24 and 7/19/24-7/22/24 as indicated in the resident's care plan for constipation (a condition where it's difficult or infrequent to have a BM usually resulting in hard, dry stools). 2. Failing to monitor/document/report to physician (MD) as needed for complications related to constipation when the resident did not have documented evidence of BM from 7/5/2024 to 7/23/2024 (19 days). This failure resulted to Resident 1 being transferred to the General Acute Care Hospital (GACH) on 8/2/2024 due to persistence of abdominal bulge in the resident's right lower quadrant (area) of abdomen. Resident 1 was found to have severe fecal impaction (a serious condition that occurs when a large, hard, dry stool mass blocks the rectum or colon, making it difficult or impossible to pass stool) which needed to be manually evacuated by the gastrointestinal (GI; relating to the stomach and intestines) MD and was hospitalized from 8/2/2024 to 8/15/2024. Findings: During a review of Resident 1's Admission Record, Admission Record indicated the resident was initially admitted to the facility on [DATE] and readmitted [DATE] with diagnoses of intestinal obstruction (a blockage that prevents food, liquid, gas, and stool from moving through the intestine normally) and dementia (a chronic condition that describes a gradual decline in cognitive [ability to think, remember, and reason] abilities that interferes with daily life). During a review of Resident 1's History and Physical Examination (H&P), dated 8/16/2024, H&P indicated the resident does not have the capacity to understand and make decisions. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 1's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 8/18/2024, MDS indicated the resident was severely impaired (difficulty with or unable to make decisions, learn, remember things) with cognitive skills for daily decision making. Resident 1 was dependent (helper does all of the effort; Resident does none of the effort to complete the activity) with tub/shower transfers (the ability to get in and out of a tub/shower), going from lying down to sitting on the side of the bed, rolling left and right in bed, upper and lower body dressing (the ability to dress above and below the waist, including fasteners) and personal hygiene and needed substantial/maximal assistance (helper does more than half the effort) with eating. During a review of Resident 1's Constipation Care Plan initiated on 5/18/2020 (did not indicate reviewed or revise date), the Constipation Care Plan indicated Resident 1 was at risk for constipation with a goal of Resident 1 having a regular bowel movement as evidenced by soft/formed bowel movements at least once every three (3) days for 3 months. The care plan also indicated interventions including to monitor/document/report to physician (MD) as needed for complications relation to constipation and to record bowel movement pattern each day and to describe amount, color, and consistency. During an interview on 10/2/2024 at 10:21 AM with Certified Nurse Assistant (CNA) 1, CNA 1 stated, every day when she starts her shift, she assesses her residents which includes assessing and monitoring if a resident has had a BM. CNA 1 stated whether or not a resident has had BM needs to be reported and documented in the computer and is important because if it is not checked or monitored the resident might need to be transferred to the hospital for constipation and build up. During a review of Resident 1's Documentation Survey Report dated July 2024, the Documentation Survey Report indicated under Check and Change - Bowel on 7/9/2024-7/11/2024, 7/15/2024-7/16/2024 and 7/19/2024-7/22/2024 Resident 1 was D for dry and did not indicate that the resident was changed or if the resident had a BM. During a concurrent interview and record review on 10/2/2024 at 12:30 PM with Licensed Vocational Nurse (LVN), Resident 1's Documentation Survey Report dated July 2024 was reviewed. Resident 1's Documentation Survey Report indicated under Check and Change, no documented BM for Resident 1 from 7/5/2024-7/23/2024. LVN stated no documented BM for Resident 1 from 7/5/2024-7/23/2024 is unacceptable, and that normally if the resident has not had a BM for 3 days, they would provide the resident with as needed (PRN) medications such as a suppository (a solid, cone-shaped or round object that contains medication and is inserted into ta body cavity or passage to deliver the medication) or enema (a procedure that involves injecting a liquid into the rectum to clear out waste matter or stool) and if neither of those work then they would notify the MD. LVN also stated monitoring the BM for Resident 1 is important to prevent her from becoming constipated or having a bowel obstruction (a partial or complete blockage in the small or large intestine that prevents food, liquid, gas, and stool from passing through normally). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 10/2/2024 at 1:30 PM with Director of Staff Development (DSD), Resident 1's Documentation Survey Report dated July 2024 was reviewed. Resident 1's Documentation Survey Report indicated under Check and Change - Bowel, no documented BM for Resident 1 from 7/5/2024-7/23/2024. DSD stated Resident 1 having no documented BM from 7/5/2024-7/23/2024 should have been addressed and that interventions should have been implemented since the record showed Resident 1 did not have BM for 19 days. DSD stated the documentation indicating a D for dry instead of indicating whether the resident was changed or had a BM is improper documentation. DSD also stated a change in condition should have been done for something out of the resident's ordinary baseline and not monitoring Resident 1's BM placed the resident's wellbeing at risk and can cause resident's discomfort and irritability which could lead to vomiting and other problems. During a concurrent interview and record review on 10/2/2024 at 2:40 PM with the Director of Nursing (DON), Resident 1's Documentation Survey Report dated July 2024 was reviewed. Resident 1's Documentation Survey Report indicated under Check and Change - Bowel no documented BM for Resident 1 from 7/5/2024-7/23/2024. The DON stated there was no documented BM since 7/5/2024 for Resident 1 until 7/23/2024. The DON stated it could be improper documentation but if Resident 1 did not have a BM within 2-3 days, then the resident would need to be assessed to see what is going on and if the reisdent truly did not have a BM for that many days then it could lead to constipation and eventually a bowel obstruction which would require medical intervention. During the same interview with the DON on 10/2/2024 at 2:40 PM, the DON stated the resident not having a BM for 19 days is unacceptable and that the staff would need to look at her clinical diagnosis to see why it might be happening and that constant communication amongst staff is integral for the consistency of the care plan and if it is a significant change for the resident, the MD would need to be notified to see if there is or no improvement to the resident's condition so that changes to the resident's current interventions could be made. The DON further stated that from 7/27/2024-8/1/2024 there was no progress note documentation regarding Resident 1's bulge on the resident's right lower quadrant whether it was improving or not. During an interview on 10/2/2024 at 3:14 PM with CNA 2, CNA 2 stated when she comes in for her shift, she checks on all her residents and she will document under the bowel check and change task in the resident's electronic medical record (EMR; a digital version of a patient's medical history) if they were clean, had a BM or if they were dry. CNA 2 also stated for her documentation on Resident 1's Documentation Survey Report dated July 2024 under Check and Change - Bowel on 7/5/2024, 7/6/2024, 7/7/2024, 7/8/2024, 7/12/2024, 7/13/2024, 7/14/2024, 7/17/2024 and 7/18/2024, if she put 0 it means the reisdent did not have a BM for her. CNA 2 also stated that before charting, she also double checks with the LVN charge nurse for the resident to ask if they had assisted the resident with going to the restroom and if they say no, it means the resident did not have a BM. CNA 2 further stated that after day 2 of the resident not having a BM, she would report it to the LVN charge nurse. During a review of Resident 1's Change in Condition Form dated 7/23/2024, the Change in Condition Form indicated when the Certified Nursing Assistant (CNA) was providing care to the resident, Resident 1 was assessed with a bulge on the right side of her abdomen and when it was palpated (a physical examination technique that involves feeling the body with the hands or fingers to examine its parts) the surface of the bulge was hard and firm to touch and it was located below the right rib that extended almost above the right pubis (a bone in the hip that forms the front and lower part of each side of the pelvis). Resident 1 complained of pain when the bulge was palpated (touched). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 1's Radiology Report of the Abdomen dated 7/23/2024, the Radiology Report indicated Resident 1 had a large amount of stool in the rectosigmoid region (the terminal portion of the large intestine before reaching the rectum). During a review of Resident 1's Nurses Progress Note dated 7/24/2024 at 4:37 AM, the Nurses Progress Note indicated Resident 1 was being monitored for bulge/hard mass on right side of abdomen. The notes indicated an ultrasound was ordered with a result showing a large amount of stool in the rectosigmoid region. During a review of Resident 1's Nurses Progress Note dated 7/25/2024 at 1:08 AM, the Nurses Progress Note indicated Resident 1 still had a bulge on the abdomen but had gotten smaller. During a review of Resident 1's Nurses Progress Note dated 7/25/2024 at 9:37 PM, the Nurses Progress Note indicated Resident 1 still had a bulge on the right side of her abdomen that was hard to touch and was still constipated. The note also indicated, the resident was on a bowel management program and given a suppository on 7/25/2024 which resulted in the resident having a small BM. During a review of Resident 1's Nurses Progress Note dated 7/26/2024 at 4:14 AM, the Nurses Progress Note indicated that Resident 1 continued to have a bulge on the right side of her abdomen which was getting smaller and that the resident had a BM on the night shift. During a review of Resident 1's Progress Note dated 8/2/2024 at 8:06 PM, the Progress Note indicated Resident 1 needed to be transferred to GACH for further evaluation due to still having a bulging mass on the right lower quadrant (RLQ) of her abdomen. During a review of Resident 1's GACH Consult Note dated 8/2/2024, the GACH Consult Note indicated that Resident 1 was found to have a very rigid abdomen and CT Scan (a diagnostic imaging procedure that uses X-rays and a computer to create detailed pictures of the inside of the body) revealed severe fecal impaction which was evacuated by the GI MD. During a review of the facility's policy and procedure (P&P) titled Bowel (Lower Gastrointestinal Tract) Disorders - Clinical Protocol revised September 2017, the P&P indicated under Monitoring and Follow-Up, The staff and physician will monitor the individual's response to interventions and overall progress; for example, overall degree of comfort or distress, frequency and consistency of bowel movements, and the frequency, severity, and duration of abdominal pain, etc.