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	10/08/2024

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48395 Based on observation, interview and record review, the facility failed to create a resident- centered care plan for one (1) of three (3) sampled residents (Resident 1) with interventions to prevent future fall (to drop suddenly or collapse) after the resident's fall incidents on 5/22/2024, 7/26/2024 and 9/27/2024. This failure resulted in Resident 1 had another fall on 7/26/2024 and 9/27/2024 and place resident at risk for another incident of fall. Findings: During a review of Resident 1's Admission Record, Admission Record indicated the resident was initially admitted to the facility on [DATE] with diagnoses of Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills, and eventually, the ability to carry out the simplest tasks) and muscle wasting and atrophy (decrease in size or wasting away of a body part or tissue). During a review of Resident 1's History and Physical Examination (H&P), dated 2/2/2024, H&P indicated the resident does not have the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 8/8/2024, MDS indicated the resident had severe impairment (difficulty with or unable to make decision, learn, remember things) with cognitive (ability to think, remember, and reason) skills for daily decision making. Resident 1 needed supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with walking 150, 50 and 10 feet and transfers (how resident moves to and from bed, chair, wheelchair, standing position), needed substantial/maximal assistance (helper does more than half the effort) with personal hygiene and dressing (how a resident puts on, fastens and takes off all items of clothing) and was independent with eating. During a review of Resident 1's Change in Condition Form dated 5/22/2024, the Change in Condition Form indicated Resident 1 was found (specific time not indicated) sitting on the floor next to her bed and according to Resident 1, the resident was trying to go to the bathroom by herself when she lost balance and fell . (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 1's Change in Condition Form dated 7/26/2024, the Change in Condition Form indicated Resident 1 was last seen by staff at 12:15 PM sitting in bed eating lunch and then at 1:30 PM it was reported by Resident 1's roommate's family member that Resident 1 had a fall as the reisdent attempted to get up out of bed and fell to the floor. During a review of Resident 1's Change in Condition Form dated 9/27/2024, the Change in Condition Form indicated Resident 1 had an unwitnessed fall and was found lying on the floor near the bed around 3:30 AM. During an interview on 10/8/2024 at 10:30 AM with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated Resident 1 is a fall risk and that she does get up on her own to use the restroom which is why it is important to make sure that the resident's call light (a device that allows patients in hospitals and nursing homes to communicate with healthcare staff for assistance) is near her so she can easily call facility staff for assistance, ensure the resident's bed is in the lowest position and that the resident needs frequent visual checks from the staff every 15 to 20 minutes. LVN 1 also stated, although the resident is aware how to use her call light, the resident must constantly be reminded to use it. During a concurrent interview and record review on 10/8/2024 at 11:01 AM with Minimum Data Set Nurse (MDSN), Resident 1's Fall Risk Care Plan dated 9/27/2024 was reviewed. Resident 1's Fall Risk Care Plan indicated interventions that were last updated on 2/28/2022. MDSN stated, Resident 1's last fall was on 9/27/2024 and that although her Fall Risk Care Plan was updated to reflect the fall on 9/27/2024, the interventions were not created to Resident 1's needs to prevent another fall. MDSN stated the purpose of a care plan was to make sure interventions are in place for a specific resident problem and stated, after Resident 1's fall incident on 9/27/2024, the care plan should have been reviewed and revised/ created a new one to reflect interventions that such as frequent visual checks indicating how often resident should be checked. During an interview on 10/8/2024 at 11:09 AM with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated, Resident 1 is a fall risk and that since the resident likes to stay in bed most of the time, when the resident tries to get up, she gets dizzy. During an interview on 10/8/2024 at 11:13 AM with the Director of Nursing (DON), the DON stated for fall risk residents, the facility needs to assess the care plans if they are specific to the needs of the resident and to make sure the CNAs and licensed staff are aware of the problem such as the fall and interventions to prevent another fall. The DON also stated they put an emphasis on those residents who have a history of falls. The DON stated, after a fall incident, the resident's care plan should be created for the actual fall and that the interventions should be specific to the resident's need and in addition the facility staff needed to check if the interventions are effective or not effective and to also make sure the nurses are following through with the interventions. During a concurrent interview and record review on 10/8/2024 at 2:03 PM with the DON, Resident 1's Fall Risk Care Plan dated 9/27/2024 was reviewed. Resident 1's Fall Risk Care Plan indicated the interventions were last updated on 2/8/2022. The DON stated Resident 1's Fall Risk Care Plan interventions should have been reviewed and should have included new interventions to prevent another fall after 9/27/2024. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 10/8/2024 at 2:05 PM with DON, the following Resident 1's Fall Risk care plans were reviewed: a. Care plan dated 8/25/2024, indicated interventions for Resident 1's call light to be within reach and to encourage to use it for assistance as needed and to respond promptly to all requests for assistance. b. Care plan dated 5/22/2024 did not indicate any intervention for resident to be on a toileting schedule. c. 7/26/2024 indicated to keep call light within reach and answered promptly and to encourage resident to call for assistance as needed. The DON stated, Resident 1 rarely used her call light, and that Resident 1 always wants to do things herself. The DON also stated, the DON the intervention to remind Resident 1 to call for help was appropriate but stated, the interventions needed to be reviewed and discussed to see what is working and what is not since the resident had three (3) falls. The DON also stated because on 5/22/2024 Resident 1 fell attempting to go to the bathroom, an intervention that addressed putting the resident on a toileting schedule should have been included in Resident 1's care plan initiated on 5/22/2024. The DON stated interventions need to be personalized to the resident because everyone has different needs and mental diagnosis. During a concurrent interview and record review on 10/8/2024 at 2:50 PM with the DON, Resident 1's Fall Risk Care Plans dated 5/22/2024 and 7/26/2024 were reviewed. Resident 1's Fall Risk Care Plan dated 5/22/2024 indicated an intervention for resident to have frequent visual checks and Resident 1's Fall Risk Care Plan dated 7/26/2024 did not indicate any intervention for a more specific time frame for resident's visual checks. The DON stated for best practice, frequent visual checks for residents who are fall risks should be done every hour or as needed depending on the clinical condition of the resident. The DON stated she does agree with the facility staff stating that visual checks for Resident 1 need to be around every 20 minutes and stated a specific time frame should have been included in Resident 1's 7/26/2024 Care Plan for fall, so that the interventions would be more personalized to the resident. The DON further stated Resident 1's noncompliance of using the call light when calling for assistance before getting up in bed should have been addressed in the resident's care plan as well. During a review of the facility's policy and procedure (P&P) titled Safety and Supervision of Residents revised July 2017, the P&P indicated under Individualized, Resident-Centered Approach to Safety: The care team shall targe interventions to reduce individual risks related to hazards in the environment including adequate supervision and assistive devices. Monitoring the effectiveness of interventions shall include the following: o Ensuring that interventions are implemented correctly and consistently; o Evaluating the effectiveness of interventions; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	o Modifying or replacing interventions as needed; and o Evaluating the effectiveness of new or revised interventions. Systems Approach to Safety o Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs and identified hazards in the environment. During a review of the facility's P&P titled Falls - Clinical Protocol revised March 2018, the P&P indicated under treatment/management, Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address the risks of clinically significant consequences of falling. The P&P also indicated under monitoring and follow-up: The staff and physician will monitor and document the individuals response to interventions intended to reduce falling or the consequences of falling If the individual continues to fall, the staff and physician will re-evaluate the situation and reconsider possible reasons for the resident's falling (instead of, or in addition to those that have already been identified) and also reconsider the current interventions. During a review of the facility's P&P titled Falls and Fall Risk, Managing revised March 2018, the P&P indicated: Resident-Centered Approaches to Managing Falls and Fall Risk o If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. o In conjunction with the attending physician, staff will identify and implement relevant interventions (e.g. hip padding or treatment of osteoporosis, as applicable) to [NAME] to minimize serious consequences of falling. Monitoring Subsequent Falls and Fall Risk o The staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling. o If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. As needed, the attending physician will help the staff reconsider possible causes that may not previously have been identified. During a review of the facility's P&P titled Care Plans, Comprehensive Person-Centered revised December 2018, the P&P indicated: The comprehensive, person-centered care plan will: (continued on next page)

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