

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  12/18/2024
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 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48143</b></p> <p>Based on interview and record review the facility failed to provide care consistent with the professional standards of practice (the set of guidelines, principles, and expectations that govern the conduct and performance of nursing professionals) to prevent worsening of the pressure ulcer (PU, a localized area of skin damage caused by prolonged pressure on the skin) for one of two sampled residents (Residents 1) by failing to:</p> <ol style="list-style-type: none"> <li>1. Assess and document detailed observations in SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents) of Resident 1's change with skin condition and/ or wound condition on the resident's sacral area (lower back region specifically triangular- shaped bone called the sacrum) and/ or left buttocks on 10/17/2024, 10/24/2024, 11/14/2024 and 11/30/2024.</li> <li>2. Monitor Resident 1's change with wound condition on the resident's left buttock of foul odor noted on 11/25/2024 every shift from 11/25/2024 afternoon shift (3 PM to 11 PM) to 11/26/2024 night shift (11 PM to 7 AM) and the progression in size of the wound on 11/27/2024 every shift from 11/27/2024 night shift to 11/29/2024 night shift.</li> </ol> <p>These deficient practices resulted to Resident 1's worsening of the PU. Resident 1 developed fever on 12/1/2024 with a temperature of 100.4 degrees Fahrenheit (F - unit of measurement. Normal adult temperature is 97 F to 99 F) and was admitted to General Acute Care Hospital (GACH) with diagnoses of infected sacral decubitus ulcer (another term for PU), fever, and leukocytosis (a condition where there are more white blood cells [WBC, cells that help your body fight infection/ diseases and other foreign substances. It elevates when there is an infection] than normal in the body) from 12/1/2024 to 12/10/2024. Resident 1 also received broad-spectrum antibiotic (a type of antibiotic that can treat a wide range of bacteria) treatment and underwent excisional debridement (a surgical procedure that involves cutting away or removing damaged tissues from the skin or subcutaneous tissue [under the skin]) of sacral PU on 12/4/2024.</p> <p>Findings:  (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 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE] and re admitted on [DATE], with diagnoses that included chronic obstructive pulmonary disease (a condition caused by damage to the airways or other parts of the lung, that leads to inflammation and other problems that block airflow and make it hard to breathe), and type 2 diabetes mellitus without complications (a chronic condition that occurs when the body doesn't use insulin properly, resulting in high blood sugar).</p> <p>During a review of Resident 1's History and Physical (H&amp;P), dated 9/1/2024, the H&amp;P indicated Resident 1 has capacity to understand and make decisions.</p> <p>During a review of Resident 1's MDS dated [DATE], indicated Resident 1 was assessed to require substantial and maximum assistance, (helper does more than half the effort) with roll on the left and right, sit to lying, and personal hygiene. The MDS also indicated Resident 1 was assessed to be dependent (helper does all of the effort to complete the activity) on sit to stand, chair/bed-to-chair transfer and toilet hygiene. The MDS indicated Resident 1 was assessed to be at risk of developing pressure ulcer and the resident has one or more unhealed pressure ulcers/injuries (location not specified).</p> <p>During a review of the GACH records with an admitted [DATE] and discharge date of [DATE], the GACH records indicated Resident 1 was admitted with consultation to General Surgery (medical specialty that involves diagnosing and treating a wide range of diseases and conditions that require surgical intervention) and Infectious Disease (medical specialty that involves in preventing, diagnosing, and treating communicable diseases and/ or infectious disease). The GACH records also indicated Resident 1 received broad-spectrum antibiotic treatment. The GACH record further indicated, Resident 1 underwent excisional debridement on 12/4/2024 and discharged from GACH on 12/10/2024. The GACH records indicated discharge diagnoses which included the following:</p> <ul style="list-style-type: none"> <li>a) Infected sacral PU stage 4 (full thickness tissue loss with exposed bone, tendon, or muscle, dead tissue may be present on some parts of the wound bed, often includes undermining and tunneling)</li> <li>b) Fever</li> <li>c) Leukocytosis</li> </ul> <p>During a review of Resident 1's SBAR dated 11/25/2024 entered at 2:04 PM, Resident 1 noted with foul odor from wound during wound care (location not specified). The SBAR also indicated, Resident 1 appears slightly confused which is not usual for the resident.</p> <p>During a review of Resident 1's care plan for Active Infection Wound on Coccyx (the small, triangular bone at the end of the spine) initiated on 11/25/2024, indicated Resident 1 has pressure ulcer(s): Stage 2 (it means the skin is broken, but the damage has not reached the underlying tissues like fat, muscle, or bone), on 11/25/2024-Left buttock Unstageable (the wound's depth and extent of tissue damage cannot be determined because the wound bed is obscured by dead tissue) -New treatment order/Antibiotic Therapy. The care plan also indicated the goal is to ensure pressure ulcer will exhibit signs of healing and be free from signed and symptoms (S/S) of infection (redness, inflammation, warmth, odor free, drainage) for 90 days. The care plan also indicated intervention is to monitor for sign and symptoms of infection (i.e. fever).</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 1's SBAR dated 11/27/2024 entered at 3:48 PM, the SBAR indicated progression (increased) in size of the PU and provided treatment on the left buttock unstageable PU.</p> <p>During an interview on 12/17/2024 at 10:35 AM with Resident 1's family (Family 1), Resident 1's son stated the Certified Nursing Assistant (CNAs) did not change Resident 1's diaper on time, and the urine in the wet diaper made the resident's wound worst and got infected. Family 1 stated his mom's diapers were wet for most of time every time 342ewFamily 1 visits Resident 1. Resident 1's son stated he understood that Resident 1 refused diaper change at times, but why CNAs not tried to talk to Resident 1 and convinced the resident with the importance of diaper change.</p> <p>During a review of Resident 1's SBAR dated 12/1/2024, SBAR indicated Resident 1's temperature was 100.4 Fahrenheit. The SBAR also indicated the resident's wound got worse, resident had loss of appetite and the son at bedside and requested to send resident to the GACH's emergency room (ER). The SBAR indicated Resident 1's primary physician gave an order to send Resident 1 to GACH.</p> <p>During a concurrent interview and record review with Wound Treatment Nurse (WTN) on 12/16/2024 at 1:45 PM, Resident 1's Weekly Wound Communication log (WCL) dated 10/17/2024 to 11/30/2024 were reviewed, indicated the following:</p> <ul style="list-style-type: none"> <li>a. On 10/17/2024, Resident 1's sacrococcyx [refers to the joint between the sacrum (the triangular bone at the base of the spine) and the coccyx] has developed moisture-associated skin damage [MASD- is a range of skin conditions that occur when the skin is repeatedly exposed to moisture].</li> <li>b. On 10/24/2024, indicated Resident's 1 left buttock has worsen from MASD to pressure ulcer stage 2.</li> <li>c. On 11/14/2024, indicated Resident's 1 left buttock has pressure ulcer stage 2 progressed to unstageable.</li> <li>d. On 11/30/2024 indicated Resident's 1 left buttock has pressure ulcer stage progressed from unstageable to stage 4.</li> </ul> <p>WTN 1 stated there was no SBAR/ change of condition (COC) documentation has been established for the above wound status changes noted on 10/17/2024, 10/24/2024, 11/14/2024 and 11/30/2024. WTN 1 stated there was no documented evidence in Resident 1's medical record that Interdisciplinary Team (IDT- group of healthcare professionals from diverse fields who work in a coordinated manner toward a common goal for the resident) was informed of the worsening of Resident 1's wound on sacrococcyx and/ or left buttocks. The IDT review and revisions of care plan/ treatment can promote a more comprehensive wound treatment, and this can prevent Resident 1's wound getting worse, and to prevent infection of the wound.</p> <p>During an interview on 12/16/2024 at 4:00 PM with the MDSN, MDSN stated she only do quarterly assessment on Resident 1 including resident's skin assessment and condition. MDSN stated there were no other assessment and documentation using SBAR done by the licensed nurses regarding Residents 1's changes with the skin and/ or wound condition on 10/17/2024, 10/24/2024, 11/14/2024 and 11/30/2024. MDSN stated licensed nurses or treatment nurses should have assessed the resident and completed the SBAR.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 12/18/2024 at 7:45 AM with the Registered Nurse Supervisor (RNS), RNS stated there were no COC/ SBAR done for Resident 1's changes with skin and wound condition on 10/17/2024, 10/24/2024, 11/14/2024 and 11/30/2024. RNS stated not completing the SBAR can affect the resident care, residents may not get the right care and it can cause skin condition getting worse due to no communications between the respective divisions (nursing, physician and/ or dietitian). RNS also stated, since there were no SBAR done for the change in Resident 1's skin condition on 10/17/2024, 10/24/2024, 11/14/2024 and 11/30/2024, no monitoring of the resident's wound was done every shift for 72 hours which can lead to worsening of the wound.</p> <p>During an interview on 12/18/2024 at 3:35 PM with the Director of Nursing (DON), the DON stated SBAR form should have been completed for Resident 1 when there is a change in the resident's wound condition, including PU on the left buttock, it can be bad and good change of condition to make sure proper treatment and care are provided. The DON stated license nurses were supposed to do the SBAR when Resident 1's wound progresses/ had changes on 10/17/2024, 10/24/2024, 11/14/2024 and 11/30/2024. The DON stated COC is connected to the notification, of all the IDT divisions and disciplines, WCD, dietitian and primary care doctor in that way they can put recommendations to ensure better wound healing. In addition, it is important to monitor the resident's change in condition/ wound condition every shift after the COC was noted. The DON stated, there was no documented evidence Resident 1's wound was monitored every shift if the condition got better or worst on 10/17/2024, 10/24/2024, 11/14/2024 and 11/30/2024. The DON also stated, there was SBAR done for Resident 1's changes with the wound condition on the left buttock on 11/25/2024 and on 11/27/2024, however there was no documented evidence that the licensed nurses monitored Resident 1's wound condition every shift for the foul smell coming from the resident's wound noted on 11/25/2024 from 11/25/2024 (afternoon shift) to 11/26/2024 (night shift) and for increase in size of the wound on the left buttock noted on 11/27/2024 from 11/27/2024 (night shift) to 11/29/2024 (night shift). The DON stated MASD wound to PU2 to unstageable to PU4 were considered significant changes, and licenses nurses were supposed to completed SBAR form to indicate if the primary physician was called, and if there were any new orders and/ or treatment.</p> <p>During a concurrent interview and record review on 12/18/2024 at 8:15 AM with WTN, Resident 1's Nurses Progress Notes dated from 10/16/2024 to 11/30/2024 was reviewed. The progress notes indicated the following:</p> <p>a. On 10/16/2024, indicated spoke to son regarding sacrococcyx recurrent moisture associate skin damage. The WTN nurse stated, he entered the note and that Resident 1 had MASD on sacrococcyx and there was no documented evidence in the resident's medical records that licensed nurse assessed and documented the change in resident's skin condition in the SBAR.</p> <p>b. On 10/24/2024, indicated left buttock PU 2 measurements 8 cm x 6 cm x 0.1 cm noted by WCD and WCD reassessed sacrococcyx MASD and the wound was assessed to be Stage 2 on left buttocks on 10/24/2024. The WTN nurse stated, he noted the Resident 1's stage 2 PU on left buttocks and there was no documented evidence in the resident's medical records that licensed nurse assessed and documented in the SBAR the change in resident's skin condition. In addition, the WTN stated, there was no documented evidence that the change in skin condition was monitored within 72 hours every shift whether it was improving or not.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>c. On 11/14/2024, indicated resident was seen by WCD, left buttock unstageable PU measurement noted .5 cm x 4 cm x UTD cm 100 % esc. tissue noted, continue treatment to left buttock pressure injury 2. The WTN nurse stated, there was no documented evidence in the resident's medical records that licensed nurse assessed and documented in the SBAR the change in resident's skin condition on 11/14/2024. In addition, the WTN stated, there was no documented evidence that the change in skin condition was monitored within 72 hours every shift whether it was improving or not.</p> <p>d. On 11/30/2024, indicated resident was seen by WCD, left buttock PU stage 4 measurement noted 6 cm x 5 cm x 3 cm 100 % esc. tissue noted, continue treatment to left buttock pressure injury 2. The WTN nurse also stated, there was no documented evidence in the resident's medical records. The WTN nurse stated, there was no documented evidence in the resident's medical records that licensed nurse assessed and documented in the SBAR the change in resident's skin condition on 11/30/2024. In addition, the WTN stated, there was no documented evidence that the change in skin condition was monitored within 72 hours every shift whether it was improving or not.</p> <p>During a review of the facility's Policy and Procedure titled Change in a Resident's Condition or Status , revised February 2021, indicated,our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc).</p> <p>c The nurse will notify the resident's attending physician or physician on call when there has been a refusal of treatment or medications two (2) or more consecutive times and a significant change of condition is a major decline or improvement in the resident's status that requires interdisciplinary review and/or revision to the care plan; and</p> <p>c Prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including (for example) information prompted by the Interact SBAR Communication Form.</p> <p>c The nurse will record in the resident's medical record information relative to changes in the resident's medical condition or status.</p> <p>During a review of the facility's Policy and Procedure titled Pressure Ulcers/Skin Breakdown - Clinical Protocol , revised March 2014, indicated, the nurse shall describe and document/report the following: Full assessment of pressure sore (same as PU) including location, stage, length, width and depth, presence of exudates or necrotic tissue.</p> <p>During a review of the facility's Policy and Procedure titled, Prevention of Pressure Injuries, revised April 2020, indicated that the purpose of the policy was to provide information regarding identification of pressure injury (PU) risk factors and interventions for specific risk factors. The policy also indicated to review the resident's care plan and identify the risk factors as well as the interventions designed to reduce or eliminate those considered modifiable.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45099</p> <p>Based on interview and record review, the facility failed to ensure licensed nurses document accurate information of Resident 1's skin condition and wound care treatment in the resident's Skilled Nursing Assessment form on 9/11/2024 and 10/25/2024 and in the Weekly Summary form on 9/18/2024, 10/11/2024, and 10/18/2024.</p> <p>This deficient practice had the potential to result in miscommunication, improper delivery of care and delayed communication of the progression of Resident 1's pressure ulcer.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record, the Admission Record indicated the resident was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included chronic kidney disease (a condition in which the kidneys are damaged and cannot filter blood as well as they should) and lack of coordination.</p> <p>During a review of Resident 1's Minimum Data Set (MDS, a federally mandated assessment tool), dated 11/1/2024, the MDS indicated Resident 1 had moderately 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) on toileting, shower, lower body dressing, and putting on and taking off footwear. The MDS further indicated Resident 1 required substantial assistance (helper does more than half the effort) with upper body dressing and personal hygiene and supervision (helper provides verbal cues) with oral hygiene. The MDS also indicated Resident 1 was at risk for developing pressure ulcers (shallow sore that looks like a blister or abrasion with visible damage to the deeper layers of the skin) with 1 stage 2 pressure ulcer which was not present on admission.</p> <p>During a review of Resident 1's medical records titled, Admission/Readmission Data Collection, dated 9/3/2024, the Admission/Readmission Data Collection indicated Resident 1 had redness on the coccyx (tail bone).</p> <p>During a review of the Resident 1's Treatment Administration Record (TAR) for the month of 9/2024, the TAR indicated a wound treatment for sacrococcyx (pertains to both large triangular shaped bone in the lower spine that forms part of the pelvis and the tailbone) using collagen powder (a wound dressing that can be used to treat a variety of wounds) and calcium alginate (a light, nonwoven fabrics derived from algae or seaweed) which started 9/4/2024 to 9/30/2024.</p> <p>During a review of Resident 1's Skilled Nurses Notes dated 9/11/2024, the Skilled Nurses Notes did not indicate that the resident had a treatment order for the Moisture Associated Skin Damage (MASD, a spectrum of injury characterized by the inflammation and a breakdown of the outer layer of the skin resulting from prolonged exposure to various sources of moisture and potential irritants such as urine and stools) on the sacrococcyx area.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the licensed nurses Weekly Summary of Resident 1's skin condition signed on 9/18/2024, the Weekly Summary indicated Resident 1 had no current treatments for the MASD on his sacrococcyx.</p> <p>During a review of the Resident 1's TAR for the month of 10/2024, the TAR indicated a wound treatment for the resident's MASD on sacrococcyx using collagen powder and calcium alginate from 10/1/2024 to 10/17/2024.</p> <p>During a review of the licensed nurses Weekly Summary of Resident 1's skin conditions signed on 10/11/2024, the Weekly Summary indicated Resident 1 had no current treatment on the resident's MASD on the sacrococcyx.</p> <p>During a review of the Wound Care Doctor's communication log dated 10/17/2024, the wound care doctor's communication log indicated Resident 1 had MASD on the sacrococcyx. The log also indicated under new treatment order of using MediHoney (a medical- grade honey dressing that can be used to treat a variety of wounds) and calcium alginate for the sacrococcyx wound.</p> <p>During a review of the Resident 1's TAR for the month of 10/2024, the TAR indicated a wound treatment for the resident's sacrococcyx using MediHoney and calcium alginate on 10/18/2024 to 10/24/2024.</p> <p>During a review of the licensed nurses Weekly Summary of Resident 1's skin conditions signed on 10/18/2024, the Weekly Summary indicated Resident 1 did not have a current treatment for MASD on the sacrococcyx.</p> <p>During a review of the Wound Care Doctor's communication log dated 10/24/2024, the wound care doctor's communication log indicated Resident 1 had Stage 2 pressure ulcer (shallow sore that looks like a blister or abrasion with visible damage to the deeper layers of the skin) on the left buttock.</p> <p>During a review of the Resident 1's TAR for the month of 10/2024, the TAR indicated a wound treatment for the resident's left buttock Stage 2 pressure ulcer using MediHoney and calcium alginate on 10/25/2024 to 10/31/2024.</p> <p>During a review of Resident 1's unsigned Skilled Nurses Notes dated 10/25/2024, the Skilled Nurses Notes did not indicate that the resident had a new skin problem of Stage 2 pressure ulcer on left buttock. The Skilled Nurses Notes also indicated Resident 1 had an intact general skin condition, did not indicate the resident have treatment orders for Stage 2 pressure ulcer on the left buttock.</p> <p>During a concurrent interview and record review on 12/18/2024 at 3:13 PM, the Minimum Data Set (MDS) Nurse confirmed Resident 1's Admission/Readmission Data Collection dated 9/3/2024 indicated resident had redness on the coccyx (last bone/ bottom of the spine) area. The MDS nurse stated Resident 1's redness on the coccyx area is the same as MASD. The MDS nurse confirmed Resident 1 had an order for collagen powder and calcium alginate treatment for the redness on the coccyx from 9/4/2024 until 10/18/2024 then changed to MediHoney and calcium alginate on 10/18/2024 after MASD progressed.</p> <p>During an interview on 12/18/2024 at 3:38 PM, the DON stated the licensed nurses should be doing and documenting complete and accurate weekly skin assessment for the residents to catch any possible skin issues and prevent progression of wound if not identified and/ or monitored.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 12/18/2024 at 6:18 PM, the DON stated, the skin assessments documented by the licensed nurses in the Skilled Nursing Assessment on 9/11/24 and 10/25/2024 and in the Weekly Summary form on 9/18/2024, 10/11/2024 and 10/18/2024, were not consistent with what skin condition/ wound Resident 1 had in accordance with the Wound Care Doctor's communication log and TAR.</p> <p>During an interview with the Administrator (ADM) on 12/18/2024 at 6:27 PM, the ADM stated the licensed nurses' documentation on the Weekly Summary form dated 9/18/2024, 10/11/2024 and 10/18/2024, and Skilled Nurses' Assessment on 9/11/2024 and 10/25/2024 were inaccurate representation of Resident 1's condition at that time. The ADM also stated the nurses probably did not take time to look and assess Resident 1's skin and/ or wound on the back that is why it did not reflect the actual Resident 1's skin condition and wound treatment.</p> <p>During an interview on 12/18/2024 at 6:40 PM, the Wound Care Doctor stated Sacro-coccyx and left buttock pressure ulcer was one and the same. The Wound Care Doctor stated he re-classified the sacrococcyx MASD to left buttock stage 2 pressure ulcer after he re-evaluated Resident 1 on 10/24/2024.</p> <p>During a review of the facility's policy titled, Pressure Ulcers/Skin Breakdown - Clinical Protocol, on assessment and recognition revised March 2014, indicated, the nurse shall describe and document/report full assessment of pressure sore (pressure ulcer) including location, stage, length, width, and depth (distance from the top or surface to the bottom of something), presence of exudates (fluid that leaks out of blood vessels into nearby tissues) or necrotic tissue (Exudate may ooze from cuts or from areas of infection or inflammation). The policy also included that the nurse shall describe and document current treatments.</p> <p>During a review of the facility's policy titled, Charting and Documentation, revised July 2017, indicated, all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. The policy also indicated that documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.</p>		