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	01/29/2025

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 - 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** 48903 Based on interview and record review, the facility failed to ensure one (1) of two (2) sampled residents (Resident 1) who was assessed as a high risk for falls and with diagnoses of dementia (a progressive state of decline in mental abilities), cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area), lack of coordination and repeated falls was free from falls and injury. On 1/18/2025, the Director of Activities (DOA) wheeled Resident 1 outside of the activity room to take care of other residents and left Resident 1 unattended while sitting in a wheelchair (WC) at the hallway (outside the activity room). This deficient practice resulted in Resident 1 fell in the hallway outside the activity room on 1/18/2025 around 11:13 AM. Resident 1 sustained redness on the right side of resident's forehead. On 1/24/2025 (6 days after the fall), Resident 1 complained of pain on the resident's right ribs (slender curved bones protecting the lungs). Resident 1 underwent a Xray (a quick, painless test that captures images of the inside of the body) on 1/25/2025 and the result showed that Resident 1 had a fracture (a break in a bone) on the resident's eighth (8th) and ninth (9th) ribs. Findings: During a review of Resident 1's Admission Record, it indicated the resident was admitted to the facility on [DATE] with diagnoses that included: dementia, cerebral infarction, lack of coordination and repeated falls. During a review of Resident 1's Admission Fall Risk Assessment (AFRA) dated 1/17/2025, it indicated, Resident 1 is chair bound (unable to walk and dependent on a chair/ wheelchair to move around) and has a high risk for potential falls. During a review of Resident 1's Care Plan (CP) dated 1/17/2025, the CP indicated Resident 1 was at risk for falls due to history of falls. The CP did not indicate interventions such as facility staff actions or strategies to prevent resident from falling while the resident is in the wheelchair, such as monitoring and/ or supervising the reisdent while in wheelchair. During a review of Resident 1's Change of Condition (CoC) dated 1/18/2025 at 11:13 AM, it indicated Resident 1 fell outside the activity room while trying to turn his WC and the resident's right hand slipped causing the resident to fall on the floor. The COC also indicated the resident was observed having redness to the right side of the forehead. (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 - Actual harm Residents Affected - Few	During a review of Resident 1's CoC dated 1/24/2025 at 7:44 PM, COC indicated the resident has hemiparesis (weakness to one side of body) and complained of pain on the right side of his ribs. During a review of Resident 1's physician's order, dated 1/24/2025, it indicated Resident 1 may have Xray of the right ribs due to pain. During a review of Resident 1's Radiology Report (Xray of ribs) dated 1/25/2025, it indicated Resident 1 had right 8th and 9th rib fractures. During a review of Resident 1's CoC dated 1/25/2025 at 11:09 PM, it indicated the resident's Xray result indicated the resident sustained fractures to the 8th and 9th rib and Tylenol (acetaminophen - medicine for mild pain) and ice were ordered for pain. During a review of Resident 1's Medication Administration Record (MAR) dated 1/1/2025 to 1/31/2025, it indicated Resident 1 received acetaminophen on 1/18/2025 at 11:28 AM for a pain (location of pain not indicated) level of two (2) out of 10 (mild pain). The MAR also indicated Resident 1 received acetaminophen on 1/26/2025 at 5:56 AM for a pain (location of pain not indicated) level of four (4) out of 10 (moderate pain). During an interview on 1/29/2025 at 8:04 AM with the DOA, DOA stated on 1/18/2025, DOA wheeled Resident 1 outside of the activity room and left Resident 1 at the hallway unattended to take care of other residents that were inside of the activity room. DOA also stated, DOA heard a sound coming from the hallway outside of the activity room and turned finding Resident 1 on the floor. DOA stated, Resident 1 is at high risk for falling and that means the resident must be constantly monitored, and the resident needs someone with him at all times especially when the resident is in the wheelchair. DOA stated on 1/18/2025, DOA did not tell another staff member to watch Resident 1 while DOA attends to other residents. DOA stated, Resident 1 should not have been left unattended by facility staff on 1/18/2025 and the fall could have been prevented. During an interview on 1/29/2025 at 8:26 AM with Certified Nursing Assistant (CNA) 1, CNA 1 stated on 1/18/2025, CNA 1 saw Resident 1 being wheeled out of the activity room by the DOA and left unattended in the hallway outside of the activity room. CNA 1 also stated, CNA 1 walked past Resident 1, then heard a thump, turned around and saw Resident 1 on the floor of the hallway outside of the activity room. During an interview on 1/29/2025 at 10:24 AM with RN 1, RN 1 stated Resident 1 is confused, has right sided weakness and is unable to use the WC by himself. RN 1 stated, on 1/18/2025 RN 1 was called to assess Resident 1 after the resident fell in the hallway outside of the activity room and saw redness on Resident 1's forehead. RN 1 also stated, Resident 1 had multiple falls before being admitted at the facility and was assessed to be at high risk for falling. RN 1 stated Resident 1 needs to always be monitored/ supervised because the resident is at risk for falling. RN 1 stated, Resident 1's fall and injury could have been prevented if the resident was monitored/ supervised by facility staff last 1/18/2025 while in the activity room. During a record review on 1/29/2025 at 11:46 AM with the Director of Nursing (DON), the facility's P&P titled, Fall Risk Assessment updated 1/27/2025 was reviewed. The P&P indicated: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	1. The nursing staff, in conjunction with others will seek to identify and document resident risk factors for falls and establish a resident centered falls prevention plan based on relevant assessment information. 2. Upon admission the nursing staff and physician will review a resident's record for a history of falls, especially falls in the last 90 days and recurrent or periodic bouts of falling over time.