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	03/13/2025

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49537 Based on observation, interview and record review, the facility failed to ensure the facility exit doors and hallways were free from obstruction and clutter. This deficient practice had the potential to place residents and facility staff at risk for accidents, such as tripping and falling, and impede or hinder immediate evacuation from the facility in cases of emergency. Findings: During an observation of the facility on 3/13/2025 at 7:36 AM, one wheelchair was observed on the left side of the hallway and one wheelchair was observed on the right side of the hallway blocking the exit doors by rooms [ROOM NUMBERS]. During an observation of the facility on 3/13/2025 at 7:38 AM, one wheelchair was observed on the right side of the hallway blocking the exit doors by rooms [ROOM NUMBERS]. During an observation of the facility on 3/13/2025 at 7:40 AM, one wheelchair was observed on the left side of the wall and two soiled linen bins were observed on the right side of the wall blocking the exit doors by rooms [ROOM NUMBERS]. During an observation of the facility on 3/13/2025 at 7:42 AM, one wheelchair was observed placed on the left side of the wall and another wheelchair was placed on the right side of the wall in front of the exit doors. During an observation of the facility on 3/13/2025 at 7:44 AM, by the hallway before the back dining room, a bed was observed placed on the left side of the wall and a wheelchair, 2 drawer carts and a linen cart were observed placed on the right side of the wall blocking the exit doors. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 3/13/2025 at 7:52 AM with the Interim Director of Nursing (IDON), the five exit doors with wheelchairs, bed, soiled linen bins, drawer carts and equipment were observed. The IDON stated that any object placed near the exit doors should be three feet (ft-a unit of length, equal to 12 inches) away from the exit doors so they remain unobstructed. The IDON stated if the exit doors were obstructed, residents and staff could not safely exit the facility. The IDON stated that only one side of the hallway should be used to place wheelchairs, carts, bins or any equipment. During an interview on 3/13/2025 at 11:53 AM with Certified Nurse Assistant 1 (CNA 1), CNA 1 stated staff should not leave any wheelchairs or carts by the exit doors and carts and wheelchairs should only be placed on one side of the hallway. CNA 1 stated the importance of placing the carts and wheelchairs on one side and not blocking or placing them by the exit door was for safety in cases of emergencies evacuation. CNA 1 stated residents and staff could not get out of the facility if exit doors were blocked and would be trapped inside the building. CNA 1 stated if wheelchairs, carts or other equipment were placed on each side of the hallways the hallways, the residents could also trip then fall and hurt themselves. During an interview on 3/13/2025 at 12:36 PM with the Director of Staff Development (DSD), the DSD stated all facility staff were responsible in ensuring the hallways leading to the emergency exit doors were clear for the safety of the residents. The DSD stated wheelchairs or carts should be stored inside the residents ' rooms or placed on one side of the hallway. During a concurrent interview and record review on 3/13/2025 at 1:25 PM with the Administrator (ADM), the Policy and Procedure (P&P) titled Emergency Job Tasks - Fire, updated 11/2024, was reviewed. The P&P indicated all staff, and other employees were to ensure hallways and exits are free from obstruction, including medical equipment. The P&P also indicated that Maintenance Personnel were to ensure exits have three feet of space from the exit door and ensure fire doors remain closed with only one side free from obstruction to egress (action of going out of or leaving a place). The ADM also stated there were still no red tape on the exit doors. The ADM stated it was very important to have the hallways and the exit doors clear of any obstruction to allow safe and fast evacuation of residents and staff in cases of emergencies. The ADM further stated that it was very important to have the hallways free of clutter to prevent accidents, slipping and falling.