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	04/29/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure standard infection prevention control practices (a set of practices that prevent or stop the spread of infections and or diseases in the healthcare setting) were followed for two (2) of three (3) sampled residents (Residents 1 and 3) with suspected (believed to have due to signs and symptoms and/ or exposure to confirmed) and confirmed (a doctor had officially identified) cases of scabies (is a highly contagious skin infestation caused by tiny, burrowing mites) in accordance with the facility's policy and procedure by failing to:1. Perform contact tracing (method used to slow the spread of infectious diseases by identifying, notifying, and advising people who have been exposed to an infected person) on caregivers, and staff with direct contact with Resident 1 for six (6) weeks before 4/8/2026 and with Residents 3 within for 6 weeks before 3/6/2026. 2. Perform surveillance monitoring (an ongoing systematic tracking of infections to detect, stop, and prevent the spread of the disease) and screening of all residents and staff (unknown number of staff) with direct contact with Residents 1 and 3 for new signs of scabies mites' infestation (severe large-scale invasion of pests) within 6 weeks after the last suspected case on 4/8/2026. 3. Provide treatment for scabies on Resident 3 as soon the facility was made aware of Reisdent 3's scabies diagnosis. No treatment done from 3/7/2026 to 3/15/2026 (total of 9 days).4. Placed Resident 3 on contact isolation precautions (infection-control measures designed to prevent the spread of harmful germs transmitted by direct skin-to-skin contact or indirect contact with a patient's contaminated environment) from 3/6/2026 to 3/16/2026. These deficient practices had the potential to spread scabies infestation to residents, staff, and visitors in the facility. Findings:1. 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 lack of coordination, difficulty in walking and metabolic encephalopathy (a brain disease, disorder, or damage that affects brain function). During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 2/13/2026, the MDS indicated Resident 1 had moderate impairment in cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 1 required substantial/maximal assistance (helper does more than half the effort) with toileting, hygiene and shower. It also indicated the resident required partial/moderate assistance (helper does less than half the effort) with oral and personal hygiene, upper and lower body dressing, and putting on/taking off footwear. The MDS further indicated Resident 1 required setup assistance (helper sets up; resident completes activity) with eating. During a review of Resident 1's Dermatology (the branch of medicine focused on the health of the skin, hair, and nails) report dated 4/8/2026, the dermatology report indicated a diagnosis of suspected scabies at the resident's neck, trunk, back, and extremities. During a concurrent interview and record review on 4/28/2026 at 1:56 PM, Resident 1's Nurse' Progress Notes dated 4/8/2026 at 9:52 AM was reviewed. Wound Care Treatment Nurse 1 (TN 1) stated Resident 1's nurses progress notes indicated that Resident 1 was sent to the resident's dermatology appointment using the facility van accompanied by a CNA. TN 1 also stated Resident 1 returned to the facility from the dermatology appointment with a diagnosis of suspected scabies on the resident's neck, trunk, back, and (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	extremities. 2. During a review of Resident 3'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 severe protein calorie malnutrition (a condition that occurs when a person's body doesn't get the right amount of nutrients it needs to function properly) and adult failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity). During a review of Resident 3's biopsy (a medical procedure that remove a small sample of tissue, cells, or fluid from the body to be examined under a microscope by a pathologist) report with a biopsy date of 2/27/2026 and a report date of 3/6/2026, the biopsy report on left upper chest skin site indicated a diagnosis of Arthropod assault reaction (an inflammatory skin reaction caused by bug bites or stings, such as from insects, spiders, ticks, or mites). The biopsy results also indicated Sarcoptes scabiei body parts (microscopic, eight-legged itch mites and their remains like legs, eggs, or poop have been found) are present in the stratum corneum (outer layer of the skin). During a review of Resident 3's nurses progress notes dated 3/6/2026 at 10:24 AM, the nurses progress notes indicated the staff was told by the dermatologist office that Resident 3's skin biopsy result was scabies. During a review of Resident 3's MDS dated [DATE], the MDS indicated Resident 3 had intact cognitive skills for daily decision making. The MDS also indicated Resident 3 was dependent (helper does all the effort) with toileting hygiene, shower, lower body dressing, putting on and taking off footwear. The MDS also stated Resident 3 required substantial/maximal assistance with oral and personal hygiene, and upper body dressing. During a concurrent observation and interview on 4/28/2026 at 2:32 PM, Resident 3 was in her room sitting on the wheelchair with Family 1 (FAM 1). FAM 1 stated Resident 3 went to see a dermatologist due to the rashes on the resident's body somewhere around late February or early March 2026 with the use of transport van. FAM 1 also stated he was notified by facility staff (unable to recall who) first week of March 2026 of the resident's scabies diagnosis. During a concurrent interview and record review on 4/28/2026 at 3 PM, Resident 3's skin biopsy report with a biopsy date of 2/27/2026 and report date of 3/5/2026was reviewed. Infection Prevention Nurse (IPN) stated Resident 3's medical records indicated the resident had confirmed scabies diagnosis based on the left upper chest skin biopsy on 3/6/2026 but the IP was not notified by the licensed staff who received the result from the dermatologist office. IPN also stated if she (IPN) only found out Resident 3 had a positive scabies result from an RN last 3/6/2026, IPN could have started the contact tracing and surveillance. IPN added, Resident 3 did not receive the Permethrin 5% external cream (used to treat scabies by causing paralysis and death in parasites) from 3/6/2026 until 3/15/2026. During the same concurrent interview and record review on 4/28/2026 at 3 PM with IPN, Resident 3's Physicians order dated 3/6/2026 to 3/16/2026 were reviewed. The physicians order did not indicate to place resident on contact isolation from 3/6/2026 to 3/16/2026. It also indicated to place the resident on contact isolation on 3/17/2026. IPN stated Resident 3 was not placed on contact precaution from 3/6/2026 until 3/16/2026. During a concurrent interview and record review with Registered Nurse 1 (RN 1) RN 1 on 4/28/2026 at 4:25 PM, the facility's Policy and Procedure titled, Scabies Prevention and Control, dated 3/2026 was reviewed. The P&P indicated contact tracing should be done 6 weeks from the confirmed case or suspected case, screening of staff for symptoms, and surveillance monitoring within 6 weeks after the last suspected or confirmed case of scabies. RN 1 stated surveillance, screening and monitoring of residents should have been done 6 weeks after the last suspected or confirmed case of scabies which was 4/8/2026. RN 1 also stated staff that had direct contact with both suspected and confirmed cases of scabies contact tracing should have been done for Resident 1 for six (6) weeks before 4/8/2026 and with Residents 3 within for 6 weeks before 3/6/2026 for the safety of the residents and staff and as a precautionary measure. RN 1 also stated facility's Policy and Procedure (P&P) on scabies prevention and control was not followed for Residents 1 and 3. During a concurrent interview and record review with the IPN on 4/28/2026 at 4:35 PM, the facility's P&P titled, Scabies Prevention and Control, dated 3/2026 was reviewed. The IPN stated she did not (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	perform contact tracing, surveillance, and staff management as indicated in the facility's policy on scabies prevention and control for Resident 1 and 3. The IPN also stated she should have done 6 weeks ?of surveillance monitoring after the last case of scabies which was on 4/8/2026 and maintain a line list to see if the cases (suspected or confirmed) were going down and no additional residents or staff were being affected. IPN further stated contact tracing should be done to control transmission of scabies among residents, staff and visitors and to prevent outbreaks (sudden rise in the number of cases of a disease in a specific are, exceeding what is usually expected) from 6 weeks from when the suspected or confirmed case was known. IPN was unable to provide documentation of any surveillance, line list, screening of staff for symptoms, and contact tracing for Residents 1 and 2 based on the facility's policy. During an interview on 4/28/2026 at 4:48 PM, CNA 2 stated she took care of Resident 3 on 3/10/2026 and 3/11/2026 and was not notified by any of the licensed staff including IPN of the resident's scabies diagnosis. During an interview on 4/28/2026 at 4:52 PM, CNA 3 stated she had taken care of Resident 3 and helped CNA 2 provide care to Resident 3. CNA 3 also stated she was not informed by the IPN to monitor herself for any symptoms of scabies. During a review of the facility's Policy and Procedure (P&P) titled, Scabies Prevention and Control Policy, dated 3/2026, indicated its purpose was to prevent, identify, and control transmission of scabies among residents, staff, and visitors in accordance with California Department of Public Health (CDPH), Los Angeles County Department of Public Health (LACDPH), and Centers for Disease Control (CDC, a major agency in the United States federal government dedicated to protecting public health and safety to detect, prevent, and respond to health threats, and injuries, providing data and guidance to communities worldwide). The policy also indicated that the facility shall promptly identify, isolate, and treat suspected or confirmed scabies cases, prevent outbreaks, and report as required. The P&P further indicated that the facility would do the following including:1. Contact Tracing to include roommates, caregivers, and staff with direct contact within six (6) weeks. 2. Staff management which included screening staff for symptoms.3. Surveillance monitoring for 6 weeks after the last case and maintain line lists. During a review of the CDC's Public Health Strategies for Scabies Outbreaks in Institutional Settings, dated 12/18/2025, the strategies indicated suggestions for preventing, detecting, and responding to single or multiple cases of non-crusted scabies in an institution.1. Prevention- Early detection, treatment, and implementation of appropriate isolation and infection control practices are essential in preventing scabies outbreaks. Epidemiologic and clinical information about patients/residents with confirmed and suspected scabies should be collected and used for systematic review to facilitate early identification of and response to potential outbreaks.2. Surveillance - establish surveillance. Have an active program for early detection of infested patients/residents and staff. Maintain a high index of suspicion that scabies may be the cause of undiagnosed skin rash; evaluate and confirm suspected cases by obtaining skin scrapings. Screen all new patients/residents and staff for scabies.3. Control & Treatment - establish appropriate procedures for infection control and treatment. Maintain records with patient/resident name, age, sex, room number, roommate(s) name(s), skin scraping status and result(s), and name(s) of all staff who provided hands-on care to the patient/resident. Use epidemiological data about the distribution of confirmed cases by building, room, floor, wing, occupation (for staff), dates of admission, and onset of scabies-like condition to determine levels of risk for patients/residents and staff. Identify and treat all people (e.g., staff, relatives, patients/residents) having prolonged, direct skin-to-skin contact with an infected person before they were treated.https://www.cdc.gov/scabies/php/public-health-strategy/