

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

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 02/12/2026
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)		
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure three (3) of five sampled residents (Resident 7, 2 and 68) reviewed for unnecessary (any drug when used without adequate monitoring, and without adequate indication for use) psychotropic drugs (any medication capable of affecting the mind, emotions, and behavior) were free from unnecessary psychotropic drugs as indicated in the facility's policy and procedure by failing to:1.Monitor and document the specific target behaviors of striking out and grabbing staff for the use of olanzapine (Zyprexa- an antipsychotic medication used to treat schizophrenia [a mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness and social interactions) and bipolar disorder [a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration]) for Resident 7.This deficient practice had the potential to result in inaccurate evaluation in the effectiveness and/or ineffectiveness of the Resident 7's olanzapine medication and adjust the medication as necessary. 2. Ensure the specific number of Resident 2's bipolar disorder episodes manifested by changes in mood from happy to anger were monitored and documented in the resident's Medication Administration Record (MAR- is a report detailing the drugs administered to a resident by a healthcare professional at a treatment facility) for the use of Divalproex (also known as Depakote, a prescription medication used to treat manic episodes [a period of abnormally elevated, extreme changes in mood, behavior, activity and energy level] associated with bipolar disorder)), as indicated in the physician's order.This deficient practice resulted in inadequate monitoring of Resident 2's mood changing episodes with the potential to result in inaccurate evaluations in the effectiveness of Resident 2's Divalproex and the risk of receiving an unnecessary medication.3.Ensure Resident 68's specific behavior was monitored for the use of quetiapine fumarate (Seroquel, antipsychotic medication that treats several kinds of mental health conditions including schizophrenia [a serious mental illness that affects how a person thinks, feels, and behaves] and bipolar disorder) were documented on the MAR.This deficient practice had the potential to result to have inaccurate re-evaluation of Resident 68's need for psychotropic medications, which may lead to an overall negative impact on the resident's physical, mental, and psychosocial well-being.Findings: 1.During a review of Resident 7's admission Record, the admission Record indicated Resident 7 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included lobar pneumonia (a severe bacterial infection and inflammation of one or more lobes of the lung) , depression (a serious, common illness characterized by a persistent, intense, and long-lasting low mood, loss of interest in activities, and decreased energy), and dementia (a brain disorder that results in memory loss, poor judgment and confusion). During a review of Resident 7's Minimum Data Set (MDS- a resident assessment tool), dated 12/15/2025, the MDS indicated Resident 7 was assessed having severely impaired (never/rarely made decisions) cognitive (mental action or process of acquiring knowledge and understanding) skills (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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 2/11/2026 at 3:58 PM with MDS 1, Resident 68's Order Summary dated 2/11/2026 was reviewed. The PO indicated the following: 1. Monitor behavior episodes of: psychosis manifested by aggressive behavior and tally with hashmarks for each episode on the MAR every shift for Quetiapine ordered on 12/30/2025. 2. Monitor behavior episodes of: mood disorder manifested by aggressive towards others by hitting and tally with hashmarks for each episode on the MAR every shift for Depakote ordered pm 12/30/2025. MDS 1 stated the PO for behavior monitoring was incomplete because there was no specific aggressive behavior to monitor such as Resident 68 was hitting himself or the staff, yelling, verbal, or physical aggression for the use of Quetiapine. MDS 1 also stated monitoring aggressive behavior orders were almost the same for both quetiapine and Depakote medications. MDS 1 also stated each medication should have a different and specific behavior that needs to be monitored and documented so the staff can check if which medication was effective for Resident 68. During a concurrent interview and record review on 2/11/2026 at 4:19 PM with MDS 1, Resident 68's Care Plan (CP) for behavior problem dated 10/22/2025 was reviewed. TH CP intervention indicated to monitor/document observed behavior and attempted interventions in resident record. MDS 1 stated the CP intervention was not specific, incomplete and not person centered. MDS 1 stated the care plan should include interventions for behavior monitoring specifically for Resident 68's antipsychotic drug use, and also to check the effectiveness of the medications. During a concurrent interview and record review on 2/11/2026 AT 4:21 PM with MDS 1, the facility's P&P titled, Antipsychotic Medication Use, dated 5/2025 was reviewed. The P&P indicated, the nursing staff shall monitor for and report any of the following side effects and adverse consequences of antipsychotic medications to the attending physician. MDS 1 stated the P&P was missing the monitoring of the specific behavior of the resident using the anti-psychotic medication, it should be included the policy, and not only the adverse and side effects of medications.		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a Level 1 Preadmission Screening and Resident Review (PASRR, initial screening for all applicants to Medicaid-certified nursing facilities [meets federal and state standards for care and is approved to receive payment from Medicaid {a government health insurance program that provides free or low-cost coverage to eligible low-income individuals and families} for services provided to eligible residents] for possible serious mental disorder [MD, a health condition characterized by clinically significant alterations in thinking, mood, or behavior associated with distress and/or impaired functioning], intellectual disability [ID, a condition characterized by significantly subaverage intellectual functioning and substantial limitations in adaptive behavior] or a related condition, which is completed prior to admission to a nursing facility) was completed and was accurate for two (2) of two (2) sampled residents (Resident 38 and 68) reviewed for PASRR, in accordance with the facility's policy. This deficient practice had the potential to result in inappropriate placement of Resident 38 and 68 and had the potential for not receiving the necessary and appropriate level of treatment and evaluation in the facility. Findings: 1. During a review of Resident 38's admission Record, the admission Record indicated Resident 38 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) and unspecified intellectual disabilities. During a review of Resident 38's Minimum Data Set (MDS- a resident assessment tool), dated 1/13/2026, the MDS indicated Resident 38 had an intact cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 38 was dependent (helper does all the effort) with oral, toileting, and personal hygiene, shower, upper and lower body dressing, and putting on/taking off footwear. The MDS further indicated Resident 38 was independent (resident completes the activity by themselves with no assistance from helper) with eating. During a review of Resident 38's Medical Records, Residents 38's medical records did not indicate there was a PASARR 1 screening on 8/8/2025 re-admission. During a concurrent interview and record review on 2/10/2026 at 3:58 PM, the Director of Nursing (DON) stated PASARR 1 screening should have been completed when Resident 38 was readmitted back on 8/8/2025 to ensure the resident will be provided with the right care and the right kind of treatment and was appropriately placed. During a review of the facility's policy and procedure (P&P) titled, Preadmission Screening and Resident Review Reports (PASRR), updated on 1/2025, the P&P indicated that the facility must ensure PASARR screening requirements which included pre-admission completion of PASARR process was completed prior to any admission, regardless of the payer source (Medicaid, Medicare, or private pay). 2. During a review of Resident 68's admission Record, the admission Record indicated Resident 68 was admitted to the facility on [DATE] and re-admitted on [DATE]. The admission record indicated Resident 68's diagnoses included Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), psychosis (a mental disorder characterized by a disconnection from reality) and dementia (a progressive state of decline in mental abilities) (continued on next page)		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 68's MDS, dated [DATE], the MDS indicated Resident 68 had severely impaired cognitive skills for daily decision making. The MDS indicated Resident 68 was dependent on toileting hygiene, shower/ bathe self, upper and lower body dressing, putting on/taking off footwear, tub/ shower transfer, walk 10, 50 and 150 feet During a review of Resident 68's PASARR dated 10/3/2025, the PASARR indicated Level 1 was negative. The PASARR indicated Resident 68 was not diagnosed with serious mental illness and was not taking any psychotropic (any medication capable of affecting the mind, emotions, and behavior) medications. During a review of Resident 68's Order Summary (OS) dated 2/11/2026. The OS indicated Resident 68 was prescribed on 10/3/2025, Quetiapine (antipsychotic medication that treats several kinds of mental health conditions including schizophrenia [a serious mental illness that affects how a person thinks, feels, and behaves] and bipolar disorder [a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration]) 25milligram (MG, unit of mass) by mouth at bedtime for psychosis manifested by aggressive behavior. During a concurrent interview and record review on 2/10/2026 at 12:19 PM with DON, the PASRR dated 10/3/2025 was reviewed. The DON stated PASARR indicated Resident 68 was not diagnosed with serious mental illness and was not taking any psychotropic medications. The DON stated Resident 68's latest PASARR was dated 10/3/2025 from General Acute Hospital (GACH). The DON stated PASARR was incorrectly filled out because it should have indicated that Resident 68 had a diagnosis of psychosis and was taking Quetiapine. During an interview on 2/11/2026 at 12:22 PM with the DON, the DON stated if the PASRR was incorrectly done, the facility will not be able to provide the right level of care that Resident 68 possibly need. During review of the facility's P&P titled, PASARR Compliance Policy, updated on 1/2025, the P&P indicated, 1. Preadmission Screening (PAS) Requirements Admissions from Hospitals: The facility must only accept residents from General Acute Care Hospitals (GACH) if the PASRR Level I Screening has been completed and verified via the online system. 2. Level I Screening Process Negative Results: If the screening is negative, the PAS RR process is complete, and the individual may be admitted (pending other medical requirements). 3. Resident Review (RR) for Current Residents Significant Change in Status: Staff must initiate a new Level I Screening as a Resident Review whenever a current resident experiences a significant change in their physical or mental condition. Indicators for RR: This includes new symptoms of SMI or ID/DD, or a change in physical health that could alter the need for specialized mental. health services.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure two (2) of 2 sampled residents (Resident 3 and 38) reviewed for Activities of Daily Living (ADL - activities such as bathing, dressing and toileting a person performs daily) were provided care and services to maintain good grooming and personal hygiene by failing to: 1. Ensure Resident 38's nails were trimmed and not long and jagged (an uneven, rough, or broken free-edge fingernails). This deficient practice resulted in multiple scattered reddened scratch marks on Resident 38's right arm. 2. Ensure shower was provided for Resident 3 in accordance with residents' shower requests. This deficient practice had the potential to result in a negative impact on Resident 3's quality of life and self-esteem. Findings: 1. During a review of Resident 38's admission Record, the admission Record indicated Resident 38 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included dementia (a progressive state of decline in mental abilities), muscle disorders, and lack of coordination. During a review of Resident 38's Minimum Data Set (MDS- a resident assessment tool), dated 1/13/2026, the MDS indicated Resident 38 had an intact cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 38 was dependent (helper does all the effort) with oral, toileting, and personal hygiene, shower, upper and lower body dressing, and putting on/taking off footwear. The MDS further indicated Resident 38 was independent (resident completes the activity by themselves with no assistance from helper) with eating. During a concurrent observation and interview on 2/9/2026 at 10:42 AM, Resident 38 was observed in the hallway sitting in a wheelchair with multiple scattered reddened scratch marks on the right forearm and long, untrimmed, jagged nails on both hands. Resident 38 stated that he scratched his arm with his nails. During an interview on 2/11/2026 at 9:50 AM, the Assistant Director of Nursing (ADON) stated Resident 38's nails should be trimmed by the Certified Nursing Assistants (CNAs) or charge nurses to prevent the injuries from the resident scratching himself. During an interview on 2/12/2026 at 2:33 PM, CNA 3 stated CNAs and Restorative Nursing Assistants (RNAs) are assigned to do nail trimming for the residents. CNA 3 also stated long nails could easily get dirty and could break the residents' skin and if the nails are dirty, it could potentially cause infection. CNA 3 further stated Resident 38 could bleed if he scratches his skin too much. During an interview on 2/12/2026 at 2:37 PM, Registered Nurse 1 (RN 1) stated residents sometimes scratch themselves and if they have long and jagged nails, the residents could break their skin, injure themselves and potentially bleed, especially if they take blood thinners (medications that help prevent dangerous blood clots from forming). During an interview on 2/12/2026 at 2:59 PM, CNA 4 stated the CNA assigned to the resident should cut the nails if they are long to prevent the residents' from injuring themselves. During a review of the facility's Policy and Procedure (P&P) titled, Resident Nail Care, dated 6/2025, the P&P indicated that the facility shall ensure that the residents receive appropriate fingernail and (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	toenail care as part of routine personal hygiene. During a review of the facility's P&P titled, Activities of Daily Living (ADL), Supporting, dated 7/2025, the P&P indicated that appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with hygiene (bathing, dressing, grooming, and oral care). 2. During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was admitted to the facility on [DATE] and re-admitted on [DATE]. The admission record indicated Resident 3's diagnoses included spinal stenosis (happens when the space inside the backbone is too small) lumbar (lower back bone) region, peripheral vascular disease (reduced circulation of blood to arms or legs due to a narrowed or blocked blood vessel), and diabetes mellitus (DM, is a metabolic disease, involving inappropriately elevated blood glucose levels) 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 indicated Resident 3 needed substantial/ maximal assistance (helper does more than half the effort. helper lifts, holds trunks or limbs, and provides more than half the effort) in shower/ bathe self, putting on and taking off footwear and walk 50 feet. Resident 3 also needed partial/ moderate assistance (helper does less than half the effort, helper lifts, holds, or supports trunk or limbs but provides less than half the effort) in lower body dressing, personal hygiene, roll left and right, sit to lying, lying-to-sitting on the side of the bed, sit-to stand, and chair/ bed-to-chair transfer, toilet transfer, tub/ shower transfer and walk 10 feet. During an observation in Resident 3's room and interview on 2/9/2026 at 8:24 AM, Resident 3 was observed awake and lying in bed. Resident 3 stated that he has been trying to request a shower for two weeks, on both the morning and evening shifts, but his request has not been granted. Resident 3 stated that, according to the staff, they cannot give him a shower because they are only allowed to give showers at certain times. Resident 3 stated, They give me a bed bath every two days, but this does not work for my hair. I want to wash my hair. It makes me feel uncomfortable. It is different when you take a shower&mdash;I feel fresher, and it makes me feel better. During a concurrent interview and record review on 2/11/2026 at 8:48 AM with the ADON, Resident 3's current Care Plan (CP) was reviewed. The ADON stated there was no CP formulated for Resident 3's ADLs, which would include shower and/or bed bath. The ADON stated since there was no CP, there were no interventions, which means the facility staff did not address Resident 3's ADL needs. During a concurrent interview and record review on 2/11/2026 at 12:01 PM with the ADON, Resident 3's Shower and Bathing Flow Sheet (SBFS) dated 1/13/2026 to 2/9/2026 was reviewed. The ADON stated there was no documentation whether a shower or bed bath was provided to Resident 3 on 1/13/2026, 1/21/2026, 1/27/2026 to 1/31/2026, 2/4/2026 to 2/6/2026, 2/8/2026, and 2/9/2026. The ADON stated since there was no documentation, it means Resident 3 was not provided with a shower or bed bath on the said dates. During a concurrent interview and record review on 2/11/2026 at 12:30 PM with Director of Staff Development (DSD), the CNA Shower Review Form (CSRF) dated 1/27/2026 to 2/9/2026 was reviewed. The DSD stated there was no documentation on 1/27/2026, 1/31/2026, 2/3/2026, 2/5/2026, and 2/9/2026 indicating whether Resident 3 received a shower or a bed bath. The DSD stated if Resident 3 refused a shower, the staff should have documented the refusal, endorsed it to (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 02/12/2026
NAME OF PROVIDER OR SUPPLIER Royal Vista Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 909 W. Santa Anita Ave San Gabriel, CA 91776	
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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the charge nurse, and charted it in the nurses' progress notes. During an interview on 2/11/2026 at 12:31 PM with DSD, the DSD stated if a resident is unable to shower for several days, it can make the resident feel depressed. The DSD stated if a resident requests a shower, the CNA should provide it on any shift. The DSD stated Resident 3 has the right to shower in the morning or at any time he requests. The DSD added, It is part of the residents' rights. The resident (Resident 3) has the right to take a shower whenever he requests one. During a review of the facility's P&P titled, Activities of Daily Living (ADL), Supporting, dated 7/2025, the P&P indicated that appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with hygiene (bathing, dressing, grooming, and oral care).		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure three (3) of four (4) sampled residents (Resident 2, 3, and 42) reviewed for pressure ulcer (injury to skin and underlying tissue resulting from prolonged pressure on the skin) were provided necessary treatment and services in accordance with the facility's policy and procedure (P&P) and physician's order by failing to ensure:1. Resident 2's low air loss mattress (LALM, designed to distribute the resident's body weight over a broad surface area and help prevent skin breakdown) and use of heel and elbow protectors (specialized cushioned sleeves or pads designed to reduce pressure, friction, and shear on bony prominences to prevent skin breakdown, pressure ulcers, and abrasions) were implemented as ordered and as indicated in the resident's care plan (a document that outlines the facility's plan to provide personalized care to a resident based on the resident's needs).2. Resident 3's LALM was set according to the residents' weight. Resident 3, who weighed 199 pounds (lbs, unit of measurement for weight), was observed with the LALM weight setting at 270 lbs.3. Resident 42's LALM was set up according to the resident's weight. Resident 42, who weighed 140 lbs, was observed with the LALM weight setting at 240 lbs.This deficient practice placed Resident 2 at risk for deterioration of pressure ulcer and Residents and 42 to develop a pressure ulcer.Findings: 1. During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression [mood disorder that causes a persistent feeling of sadness and loss of interest in life] to elevated periods of emotional highs), and depression. During a review of Resident 2's Admission/readmission Data Collection, dated 1/8/2026, the Admission/readmission Data Collection indicated Resident 2 had right heel and left heel non blanchable (refers to an area on the skin that remains red and does not turn white when pressed) redness and a sacrococcyx (the area where the sacrum [base of the spine] connects with the coccyx [tailbone]) stage three (3) pressure ulcer (injury that extends through the skin into deeper tissue and fat). During a review of Resident 2's Order Summary Report, the Order Summary Report indicated Resident 2 may have LALM every day for wound management, ordered 1/9/2026. During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool), dated 1/14/2026, the MDS indicated Resident 2 had severely impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 2 needed partial/moderate assistance (helper does less than half the effort) for eating, oral and personal hygiene, and dependent (helper does all the effort) with toileting, self-showering/bathing and lower body dressing. The MDS also indicated Resident 2 had two (2) stage one pressure ulcers (intact skin that is discolored and does not turn white [blanch] when pressed) and one stage 3 pressure ulcer with treatments of a pressure reducing device for bed and pressure ulcer/injury care. During a review of Resident 2's Weekly Pressure Ulcer Records, dated 2/6/2026, the Weekly Pressure Ulcer Records indicated that Resident 2 had stage 3 pressure sores on the sacrum and on the left and right heels, with LALM identified as the pressure relieving intervention. (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 2's Left Heel Non Blanchable Redness care plan, initiated 1/9/2026, the care plan indicated the staff interventions included were to provide pressure reduction mattress and heel/elbow protectors. During a review of Resident 2's Right Heel Non Blanchable Redness care plan, initiated 1/9/2026, the care plan indicated the staff interventions included were to provide pressure reduction mattress and heel/elbow protectors. During a review of Resident 2's Sacro-coccyx Pressure Injury Stage 3 care plan, initiated 1/9/2026, the care plan indicated the staff interventions included were to provide pressure reduction mattress and heel/elbow protectors. During an observation on 2/10/2026 at 8:18 AM at Resident 2's bedside, Resident 2 was observed lying in bed with a low air loss pump at the foot of the bed, powered off. During a concurrent observation and interview on 2/10/2026 at 12:30 PM with Licensed Vocational Nurse 3 (LVN 3) at Resident 2's bedside, Resident 2's bed was observed without a LALM. A low air loss pump that was powered off was observed at the foot of Resident 2's bed. LVN 3 stated the current mattress on Resident 2's bed was a regular mattress, not a LALM and the last time he saw Resident 3 with a LALM on her bed was on 2/7/2026. LVN 3 stated per the MD order, Resident 2 should have a LALM and all nurses should be checking to make sure it is on and working. LVN 3 further stated he did not and should have checked to ensure Resident 2 had a LALM and/or that the pump was powered on during his shift. LVN 3 stated it was important for Resident 2 to have a LALM to help with wound healing. During an interview and record review on 2/10/2026 at 12:52 PM with the Assistant Director of Nursing (ADON), Resident 2's medical record was reviewed. Resident 2's medical record failed to indicate any documentation of why Resident 2's LALM was not implemented as ordered. The ADON stated nursing staff should be inspecting the LALM to ensure it is working properly and implemented as ordered. The ADON stated the staff should document reasons if LALM was not implemented such as resident's refusal or LALM malfunctions. The ADON also stated it was important to implement the LALM to prevent worsening of resident's pressure wounds or development of new pressure wounds. During a concurrent observation, interview and record review on 2/10/2026 at 1:38 PM with the Treatment Nurse 1 (TN 1) at Resident 2's bedside, Resident 2 was observed sitting in her wheelchair without any heel or elbow protectors on. TN 1 stated Resident 2 did not and should be using elbow and heel protectors. TN 1 stated heel and elbow protectors are nursing interventions and should be implemented unless Resident 2 refused. Resident 2's medical record was reviewed and failed to indicate any documentation of Resident 2 refusing heel and/or elbow protectors. TN 1 stated it was important for staff to implement the use of heel and elbow protectors and the LALM to help with Resident 2's wound healing. 2. During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was admitted to the facility on [DATE] and re-admitted on [DATE]. The admission record indicated Resident 3's diagnoses included spinal stenosis (happens when the space inside the backbone is too small) lumbar (lower back bone) region, peripheral vascular disease (reduced circulation of blood to arms or legs due to a narrowed or blocked blood vessel), and diabetes mellitus (DM, is a metabolic disease, involving inappropriately elevated blood glucose levels) (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 indicated Resident 3 needed partial/ moderate assistance for lower body dressing, personal hygiene, roll left and right, sit to lying, lying-to-sitting on the side of the bed, sit-to stand, and chair/ bed-to-chair transfer, toilet transfer, tub/ shower transfer and walk 10 feet. The MDS also indicated Resident 3 was at risk for pressure ulcers and was using pressure relieving devices for bed. During a review of Resident 3's Braden Scale Assessment (BSA, tool use to check a resident's risk for developing pressure sores), dated 11/26/2025, indicated Resident 3 was at high risk for developing pressure ulcers. During an observation and interview on 2/9/2026 at 8:33 AM in Resident 3's room, Resident 3 was observed awake and lying on a LALM which was set at 270 lbs. Resident 3 stated he was using the LALM because he used to have a pressure ulcer on his right buttock which was resolved for few months now. Resident 3 stated his estimated weight was 197 lbs. During a concurrent observation and interview on 2/10/2026 at 12 PM with the Assistant Director of Nursing (ADON) in Resident 3's room, Resident 3 was observed awake and lying on a LALM. ADON stated Resident 3's LALM was set at 210 lbs. The ADON stated the LALM should be set based on Resident's weight of 197 lbs. During a concurrent interview and record review on 2/10/2026 at 12: 03 PM with ADON, Resident 3's physician's order, dated 9/29/2025, and weight for the month of December 2025 were reviewed. The physician's order indicated LALM skin management per resident request every shift. Resident 3's weight on 12/1/5/2025 indicated 199 lbs. The ADON added that if the LALM setting was too high, it would be too firm and could cause skin breakdown because it would place pressure on Resident 3's pressure points, such as the hips and sacral area, causing him to lie on bony prominences. The ADON also stated that staff should check the LALM every shift to ensure it is set up correctly. During a concurrent interview and record review on 2/10/2026 at 12: 15 PM with the Director of Nursing (DON), Resident 3's care plan for skin management, dated 12/4/2025, was reviewed. The DON stated Resident 3's care plan did not and should have included the use of LALM to ensure that it was properly implemented. 3. During a review of Resident 42's admission Record, the admission Record indication Resident 42 was admitted to the facility on [DATE] with diagnoses that included epilepsy (brain activity that causes sudden, uncontrolled electrical disturbance in the brain and sometimes loss of awareness), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and mental disorder (a significant long-lasting disturbance in thinking, emotion, mood or behavior that impair daily functioning). During a review of Resident 42's MDS, dated [DATE], the MDS indicated Resident 42 was assessed to have moderately impaired cognitive skills for daily decision making. The MDS indicated Resident 42 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) with eating, oral/toileting hygiene, shower/bathe self, upper/lower body dressing, personal hygiene, roll left and right, sit to lying, and chair/bed-to-chair transfer. The MDS also indicated Resident 42 was at risk for developing pressure ulcers/injuries. During a review of Resident 42's Order Summary Report, dated 2/11/2026, the Order Summary Report (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indicated Resident 42 may have low air loss mattress for wound management every shift, with a start date of 2/10/2026. During a review of Resident 42's Braden Scale, dated 12/9/2025, the Braden Scale indicated Resident 42 had a score of 11 which indicated Resident 42 was at high risk for developing pressure injuries. During a review of Resident 42's Weight and Vitals Summary from 2/1/2026 to 2/28/2026, the Weight and Vitals Summary indicated Resident 42 weighed 140 lbs. on 2/6/2026. During an observation in Resident 42's room on 2/9/2026, at 10:52 AM, Resident 42 was observed in bed with the LALM mattress setting at 240 lbs. During an interview, on 2/10/2026, at 1:11 PM, with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated Resident 42 had sensitive skin and a history of pressure ulcers and skin breakdown. CNA 1 stated Resident 42's LALM was to prevent her from developing pressure ulcers. CNA 1 stated licensed nurses were responsible for adjusting Resident 42's LALM setting. CNA 1 stated she did not know what Resident 42's LALM setting was supposed to be. During an interview on 2/10/2026, at 1:04 PM, with Treatment Nurse 1 (TN 1), TN 1 stated Resident 42 used a LALM for wound prevention and management because Resident 42 had a history of pressure ulcers and skin breakdown. TN 1 stated the LALM setting should be based on Resident 42's weight. TN stated if Resident 42's weight was 140 lbs. then her LALM setting should have been set to 120 lbs. TN stated it was the responsibility of licensed nurses to make sure Resident 42's LALM was in the correct setting every shift. TN stated it was important for the LALM to be in the proper setting to get the benefits of wound prevention and management. During an interview, on 2/11/2026, at 3:34 PM, with the ADON, the ADON stated Resident 42 required maximum assistance with turning and positioning in bed. The ADON stated Resident 42 had a history of pressure ulcers and was ordered to use a LALM for wound management. The ADON stated Resident 42's LALM was used to prevent pressure points while Resident 42 was in bed. The ADON stated Resident 42's LALM setting at 240 lbs. was wrong. The ADON stated Resident 42's LALM setting should have been set according to Resident 42's weight of 140 lbs. The ADON stated it was the responsibility of the TN and licensed nurses to check the setting of the LALMs during their rounds. The ADON stated the facility's P&P should indicate the setting the residents' LALM needed to follow. During a review of the facility's P&P, titled, Low Air Loss Support Surface Policy, revised 7/2025, the P&P indicated the following: The facility will establish clinical and documentation standards for the use of Low Air Loss LAL support surfaces to prevent and treat pressure injuries in accordance with CMS (Centers for Medicare & Medicaid Services), Medicare (health insurance program for people age [AGE] or older), Medi-Cal (California's free or low-cost health care program), and California SNF (skilled nursing facility) requirements. Under Nursing responsibilities: to ensure proper mattress setup and function During a review of the Operation Manual for the Protekt Aire 4000DX/4600DX/5000DX pump, the Operation Manual indicated, under Weight/Pressure set up, the Users can adjust air mattress to a desired firmness according to a patient's weight or the suggestion from a health care professional.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services including procedures to ensure the accurate acquiring, administering of drugs and biologicals to meet the needs for four (4) of four sampled residents (Residents 38, 2, 82, and 67) reviewed and observed for medication administration, in accordance with the facility's policy and procedure (P&P) by failing to: Correctly administer Combivent Respimat (medication used to treat and prevent tightening of the airway in adults) for Resident 38 as indicated in the package insert (a document included in the package of a medication that provides information about the medication and its use) This deficient practice had the potential for Resident 38 to experience shortness of breath and difficulty breathing. 2a. Administer 16 medications within 60 minutes of scheduled time of 9 AM for Resident 2. This deficient practice had the potential for a decline in Resident 2's overall health status and decrease the therapeutic levels for Resident 2's 16 medications which could cause Resident 2's mood, pain, blood pressure, heart rhythm, diabetes mellitus (DM- is a metabolic disease, involving inappropriately elevated blood glucose levels) symptoms to worsen or not be properly managed. 2b. Ensure the delayed or extended-release (designed to release active ingredients slowly into the bloodstream over an extended period, providing a steady, consistent dose rather than an immediate spike and drop) formulation of divalproex (medication used to treat bipolar disorder [bpd-mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration]), metoprolol (medication used to lower high blood pressure) and aspirin (a medication used as prophylaxis [action to prevent disease] for cerebrovascular accident [CVA or stroke- a medical emergency where blood flow to a part of the brain is interrupted or reduced, depriving brain tissue of oxygen and nutrients]) were not crushed, compromising the slow release of the medication for Resident 2. This deficient practice had the potential for harm to Resident 2 due to the potential side effects from medication administered not according to its extended-release or delayed release formulation. 3. Ensure Licensed Vocational Nurse 2 (LVN 2) used two (2) resident identifiers (unique, person-specific data points used to accurately identify, locate, or verify the identity of a resident such as in a long-term care facility. These identifiers are crucial for patient safety, typically requiring at least two unique identifiers such as full name, date of birth, or medical record number to distinguish the residents) prior administering medication to Resident 82 on 2/11/2026. This deficient practice had the potential to result in ineffectively managing Residents 82 medical condition and placing the resident for medication errors (any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of a healthcare professional, patient, or consumer) and compromised resident safety. 4. Failed to ensure Licensed Vocational Nurse 6 (LVN 6) prepared the correct medication of Vitamin C ascorbic acid 500 milligrams (mg- metric unit of measurement, used for medication dosage and/or amount) for Resident 67 during medication administration. On 2/11/2026, LVN 6 prepared Rena Vite (a medication with a combination of B vitamins used to treat or prevent vitamin deficiency) to administer to Resident 67 instead of the resident's Vitamin C. This failure had the potential for Resident 67 to receive double dose of Rena Vite and a missed prescribed dose of Vitamin C. Findings: 1. During a review of Resident 38's admission Record, the admission Record indicated Resident 38 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included metabolic encephalopathy (problem in the brain caused by a chemical imbalance in the blood), chronic obstructive pulmonary disease (COPD- a condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body), and essential hypertension (high blood pressure). (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 38's Minimum Data Set (MDS- a resident assessment tool), dated 1/13/2026, the MDS indicated Resident 38 was assessed having intact memory and cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 38 was independent (resident completes the activity by himself) with eating. The MDS indicated Resident 38 was dependent (helper does all of the effort) with oral hygiene, upper/lower body dressing, personal dressing, sit to lying, sit- to- stand, and tub/shower transfer. During a review of Resident 38's Order Summary Report, dated 2/11/2026, the Order Summary Report indicated a physician order for Combivent Respimat Inhalation Aerosol Solution 20-100 micrograms (mcg- unit of measurement), 1 inhalation, inhale orally two times a day for prevention related to COPD, ordered on 8/9/2025. During a review of Resident 38's Medication Administration Record (MAR), from 2/1/2026 to 2/28/2026, the MAR indicated Resident 38 was scheduled to receive Combivent Respimat Inhalation Aerosol Solution 20-100 mcg at 5 PM. During a review of the Combivent Respimat Inhalation Aerosol Solution's package insert (a document included in the package of a medication that provides information about that drug and its use, and how to administer the drug) for Combivent Respimat, the medication package insert, indicated the following instructions for use: Breathe out slowly and fully. Close your lips around the mouthpiece without covering the air vents. Point the inhaler to the back of your throat. While taking a slow, deep breath through your mouth, press the dose-release button (a grey button located on the side of the inhaler that releases a soft mist or puff of medication) and continue to breathe in. Hold your breath for 10 seconds or for as long as comfortable. During an observation of the medication pass on 2/10/2026, at 4:33 PM, Licensed Vocational Nurse 4 (LVN 4), LVN 4 placed Resident 38's Combivent inhaler in Resident 38's mouth. LVN 4 held the Combivent inhaler in Resident 38's mouth and pressed the dose-release button on Resident 38's inhaler. LVN 4 instructed Resident 38 to take a deep breath and counted to five while Resident 38 inhaled and exhaled five times. LVN 4 did not instruct Resident 38 to hold his breath after inhaling the medication. During an interview, on 2/10/2026, at 4:35 PM, with LVN 4, LVN 4 stated Resident 38's was ordered for one (1) inhalation of Combivent to help Resident 38 breathe better. LVN 4 stated Resident 38 took five breaths while she held the inhaler into Resident 38's mouth. LVN 4 stated Resident 38 did not receive his Combivent medication correctly per the Combivent package insert. During an interview, on 2/11/2026, at 3:54 PM, with the Assistant Director of Nursing (ADON), ADON stated Resident 38's Combivent was for the resident's COPD and was ordered to open Resident 38's airway and help him breathe. ADON stated Resident 38 should have been instructed by LVN 4 to hold his (Resident 38) breath for at least 5 seconds after inhaling the Combivent medication. ADON stated (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	it was important that Resident 38 held his breath after the resident inhaled his Combivent to receive the full effect of the medication. ADON also stated LVN 4 did not administer Resident 38's medication correctly. and that not administering Resident 38's Combivent correctly could cause Resident 38 to go into respiratory distress and can lead to hospitalization. 2a. During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE]. The admission record indicated Resident 2's diagnoses included encephalopathy, DM, and dementia (a progressive state of decline in mental abilities). During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 3 had severely impaired cognitive skills for daily decision making. The MDS indicated Resident 2 was dependent on toileting, hygiene, shower/ bathe self, lower body dressing, taking off footwear, sit-to stand, and chair/ bed-to-chair transfer, toilet transfer, tub/ shower transfer, car transfer, walk 10, 50 and 150 feet. During a review of Resident 2's Order Summary Report, dated 2/10/2026, the Order Summary Report indicated a physician order for the following 16 medications: Divalproex sodium oral tablet delayed release 250 milligrams (mg- unit of measurement) give 1 tablet by mouth two times a day for mood stabilizer/bpd manifested by (m/b) changes in mood from happy to anger do not crush, ordered on 1/9/2026. Gabapentin (medication used to treat nerve pain) oral capsule 300 mg give 1 capsule by mouth three times a day for nerve pain, ordered on 1/8/2026. Aspirin EC oral tablet delayed release 81 mg give 1 tablet by mouth one time a day for deep vein thrombosis (DVT- a condition where a blood clot forms in a deep vein) prophylaxis (ppx- action to prevent disease) do not crush, ordered on 1/8/2026. Eliquis (medication used to reduce the risk of stroke and blood clots) oral tablet 2.5 mg give 1 tablet by mouth two times a day for DVT ppx, ordered on 1/8/2026. Acetaminophen (medication used to treat mild to moderate pain), oral tablet 500 mg give 2 tablets by mouth one time a day for mild pain (1-3)/pain management, ordered on 1/14/2026. Hydralazine HCl (medication used to treat moderate to severe hypertension and heart failure) oral tablet 10 mg give 1 tablet by mouth four times a day for hypertension hold if SBP less than 110, HR less than 60, ordered on 1/8/2026. Losartan potassium (medication used to lower high blood pressure) oral tablet 50 mg give 2 tablets by mouth one time a day for hypertension hold if SBP less than 110, HR less than 60, ordered on 1/8/2026. Metformin HCl (medication used to control high blood sugar levels) oral tablet 500 mg give 2 tablets by mouth two times a day for DM management give with food, ordered on 2/4/2026. Pacerone (medication used to maintain normal heart rhythm) oral tablet 200 mg give 1 tablet by mouth two times a day for arrhythmia (irregular or abnormal heartbeat), ordered on 1/8/2026. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Sertraline HCl (medication used to treat depression) oral tablet 100 mg give 1 tablet by mouth one time a day for depression m/b verbalized sadness/withdraw from activities, ordered on 1/9/2026. Vitamin C (vitamin for immune [resistance to an infection] function), oral tablet give 500 mg by mouth one time a day to support wound healing of stage 3 pressure injury, ordered on 1/12/2026. Zetia (medication that lowers the bad cholesterol [a waxy, fat-like substance found in the cells of the body]), oral tablet 10 mg give 1 tablet by mouth one time a day for hyperlipidemia (a condition in which there are high levels of fat particles in the blood), ordered on 1/8/2026. Zinc sulfate (vitamin for immune function), oral tablet and give 50 mg by mouth one time a day to support wound healing of stage 3 pressure injury, ordered on 1/12/2026. Metoprolol succinate ER oral tablet extended release 24- hour 50 mg give 1 tablet by mouth every 12 hours for hypertension, ordered on 1/15/2026. Multivitamin-minerals oral tablet and give 1 tablet by mouth one time a day to support wound healing of stage 3 pressure ulcer injury (a deep wound where the skin is broken and fat is visible), ordered on 1/12/2026. Amlodipine besylate (medication used to lower high blood pressure) oral tablet 5 mg give 1 tablet by mouth two times a day for hypertension, ordered on 1/8/2026. During a review of Resident 2's MAR, from 2/1/2026 to 2/28/2026, the MAR indicated Resident 2 was scheduled to receive the following 16 medications at 9 AM: Divalproex sodium oral tablet delayed release 250 mg Gabapentin oral capsule 300 mg Aspirin Enteric- Coated (Aspirin EC) oral tablet delayed release 81 mg Eliquis oral tablet 2.5 mg Acetaminophen oral tablet 500 mg Hydralazine HCl oral tablet 10 mg Losartan potassium oral tablet 50 mg Metformin HCl oral tablet 500 mg Pacerone oral tablet 200 mg Sertraline HCl oral tablet 100 mg Vitamin C oral tablet Zetia oral tablet 10 mg (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Zinc sulfate oral tablet Metoprolol succinate ER oral tablet extended release 24- hour 50 mg Multivitamin-minerals oral 1 tablet Amlodipine besylate oral tablet 5 mg During an observation of the medication pass, on 2/11/2026, from 10:02 AM to 10:10 AM, LVN 3 administered the following 16 medications to Resident 2: Hydralazine HCl oral tablet 10 mg, 1 tablet by mouth Metformin HCl oral tablet 500 mg, 2 tablets by mouth Multivitamin-minerals oral tablet, 1 tablet by mouth Eliquis oral tablet 2.5 mg, 1 tablet by mouth Zinc sulfate oral tablet, 50 mg by mouth Losartan potassium oral tablet 50 mg, 2 tablets by mouth Sertraline HCl oral tablet 100 mg, 1 tablet by mouth Metoprolol succinate ER oral tablet extended release 24- hour 50 mg, 1 tablet by mouth Gabapentin oral capsule 300 mg, 1capsule by mouth Zetia oral tablet 10 mg, 1 tablet by mouth Vitamin C oral tablet, 500 mg by mouth Acetaminophen oral tablet 500 mg, 2 tablets by mouth Amlodipine besylate oral tablet 5 mg, 1 tablet by mouth Aspirin EC oral tablet delayed release 81 mg, 1 tablet by mouth Divalproex sodium oral tablet delayed release 250 mg, 1 tablet by mouth Pacerone oral tablet 200 mg, 1 tablet by mouth During an interview, on 2/12/2026, at 1:40 PM, with LVN 3, LVN 3 stated Resident 2's 9 AM medications were allowed to be given as early as 8 AM but no later than 9:59 AM. LVN 3 stated Resident 2's 16 medications: hydralazine HCl, metformin HCl, multivitamin-minerals, Eliquis, zinc sulfate, losartan potassium, sertraline HCl, metoprolol succinate ER, gabapentin, Zetia, vitamin C, acetaminophen, amlodipine besylate, aspirin EC, divalproex sodium, and Pacerone that were scheduled to be given at 9 AM, were administered to the resident after 10 AM. LVN 3 stated Resident (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2's medications were given late because the resident had a lot of medications scheduled for 9 AM. LVN 3 also stated Resident 2's late medication administration was caused by the need to replace the blood pressure cuff (the device wrapped around the arm to measure blood pressure) and check Resident 2's blood sugar before medication pass. LVN 3 stated it was important for Resident 2 to receive her hydralazine, losartan potassium, metoprolol succinate, and amlodipine besylate medications on time because Resident 2's systolic blood pressure (SBP- pressure in the arteries when the heart contracts and pumps ran in the high 150s and the resident needed her medications to maintain her blood pressure in the normal range. During the same interview, on 2/12/2026, at 1:40 PM, LVN 3 stated it was important for Resident 2 to receive her metformin on time because the resident had DM and needed her metformin to maintain her blood sugar in the normal range. LVN 3 stated not giving Resident 2 her metformin on time could cause her to have symptoms of hyperglycemia (which the level of glucose in the blood is higher than normal) like shaking and sweating. LVN 3 stated not giving Resident 2's medications on time could cause her to display side effects like unstable mood, pain, irregular heartbeat, and placed Resident 2 at risk for developing a DVT. LVN 3 stated it was important to administer medications as scheduled to prevent giving the medications too close together which could cause the residents to receive too much medication and drug interactions (a change in the way a medication works in the body caused by the presence of another substance, such as other drugs). During an interview, on 2/12/2026, at 4:10 PM with ADON, ADON stated medications can be administered 1 hour before and 1 hour after the scheduled administration time. ADON stated 9 AM medications were considered late if administered after 10 AM. ADON stated it was important to give medications on time to ensure the proper timing was given in between the medications or the next dose of the same medication. ADON also stated, not administering medications on time can affect the therapeutic levels (medication concentration in the blood, maximizing the effectiveness while minimizing the side effects) of the medications. ADON stated LVN 3 should have given Resident 2's 9 AM medications as ordered because they were significant medications (medications that pose a high risk of causing substantial patient harm, injury, or death if misused, dosed incorrectly, or administered not as ordered by the physician). ADON stated Resident 2 can experience symptoms such as hypertension, high blood sugar, depression, depression, blood clots, pain, and abnormal heartbeat if the therapeutic levels of her medications were low. ADON stated LVN 3 did not follow the policy for medication administration. During a review of the facility's policy and procedure (P&P), titled, Administering Medications, revised 9/2025, the P&P indicated the following: Medications are administered in a safe and timely manner, and as prescribed. Medications are administered in accordance with prescriber orders, including any required time frame. Medications administration times are determined by resident need and benefit, not staff convenience. Factors that are considered include: enhancing optimal therapeutic effect of the medication. Medications are administered within 1 hour of their prescribed time, unless otherwise specified. 2.b) During a review of Resident 2's Order Summary Report dated 2/11/2026, the order summary report indicated: (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	divalproex sodium 250 mg delayed release oral tablet **DO NOT CRUSH. Give 1 tablet by mouth twice a day for mood stabilizer, bipolar disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration) manifested by changes in mood from happy to anger. aspirin 81 mg oral tablet EC delayed release *** DO NOT CRUSH. Give 1 tablet by mouth one time a day for deep vein thrombosis (DVT, a blood clot in a vein located deep within your body, usually in your leg) prophylaxis. metoprolol tartrate 50 mg oral tablet Extended Release ***DO NOT CRUSH. Give 1 tablet every 12 hours for hypertension. Hold if systolic blood pressure (SBP) less than (<)110, heart rate (HR) <60 with food. During an observation on 2/11/2026 at 9:52 AM with LVN 3, LVN 3 crushed all the 9 AM medications for Resident 2. During an interview on 2/12/2026 at 1:40 PM with LVN 3, LVN 3 stated there were three medications for Resident 2 that indicated do not crush on the label. LVN 3 stated he did not know that those 3 medications (divalproex, aspirin and metoprolol) cannot be crushed. LVN 3 stated, LVN 3 crushed the medications and did not inform the Registered Nurse Supervisor (RNS), the facility's pharmacy or Resident 2's doctor. During an interview on 2/12/2026 at 2:04 PM with LVN 3, LVN 3 stated when medications indicate delayed release it means once it was swallowed, it was slowly dissolved and absorbed in the body. LVN 3 also stated if the delayed release medications were crushed, it affects the slow effect of the medication and it becomes rapid release which can affect Resident 2's mood, which could result to depressive symptoms, affect the resident's the blood pressure, blood consistency and Resident 2 can become unstable. LVN 3 stated Resident 2's physician's order for divalproex, aspirin and metoprolol were not followed. During an interview on 2/12/2026 at 4:10 PM with the DON, the DON stated when medications have an instruction of do not crush, the medications will not be absorbed properly. The DON stated the licensed nurses need to call the doctor or pharmacy to change the form, or if not able to, call the doctor to change the medications. The DON stated if a medication is labeled as delayed release, it means that once it is swallowed, it dissolves slowly in the body. If it is crushed, it disrupts the delayed or slow-release mechanism, causing the medication to be released too quickly. This can affect the resident's depression treatment and lead to instability. During review of the facility's P&P titled, Administering Medications updated on 9/2025, the P&P indicated, medications are administered in a safe and timely manner, and as prescribed. The P&P also indicated, medications are administered in accordance with prescriber orders, including any required time frame. 3) During a review of Resident 82's admission Record, the admission Record indicated Resident 82 was admitted to the facility on [DATE]. The admission record indicated Resident 82's diagnoses included spinal stenosis (happens when the space inside the backbone is too small) lumbar (lower (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	back bone) region, acute respiratory failure (occurs when you do not have enough oxygen in your blood) with hypoxia (a dangerous condition that happens when your body doesn't get enough oxygen) and hypertension(high blood pressure) During a review of Resident 82's MDS, dated [DATE], the MDS indicated Resident 82 had moderately impaired cognitive skills for daily decision making. The MDS indicated Resident 82 was dependent (helper does all of the effort, resident does not effort to complete the activity) in toileting hygiene, shower/ bathe self, putting on / taking off footwear, sit-to stand, and chair/ bed-to-chair transfer, toilet transfer, and tub/ shower transfer. During a review of Resident 82's electronic Medication Administration Record (MAR, is a report detailing the drugs administered to a resident by a healthcare professional at a treatment facility) for the month of February 2026. The MAR indicated the following medications were administered at 5:00PM: Atorvastatin 20 MG for hyperlipidemia (a condition characterized by abnormally high levels of lipids [fats] in the blood). Bethanechol 25 MG for urinary retention (a condition in which you cannot empty all the urine from your bladder). Calcium & Phosphorus with Vitamin D (supplement). Docusate Sodium 250 MG for bowel management. Meclizine 25 MG for nausea and vomiting. During an observation on 2/10/2026 4:33 PM with LVN 2 by the door of Resident 82's room, Resident 82 was sitting on her wheelchair. LVN 3 handed the medicine cup containing all five (5) medications (Atorvastatin, Bethanechol, Calcium Phosphorous with Vitamin D, docusate sodium and meclizine to Resident 82. LVN 3 did not verify Resident 82's identity by asking the resident's full name, date of birth , or medical record number before giving the medication. Resident 82 was not properly informed of the 5 medications being administered to the resident before Resident 82 took the medications with a cup of water. During an interview on 2/10/2026 at 4:35 PM with LVN 2 stated she only used one (1) identifier only the resident's MAR. LVN 2 stated she did not verify Resident 82's identity by asking the resident for at least two identifiers such as the resident's name, date of birth or medical record number before administering the medications because LVN 2 knew the resident already. LVN 2 stated she also did not look at Resident 82's armband (patient identification wristband- a secure, durable, and typically waterproof band worn around the wrist or ankle by individuals admitted to nursing homes, or long-term care facilities. It functions as a critical safety device that links a person to their medical records, ensuring accurate identification to reduce medical errors) to verify Resident 2's identity. LVN 2 stated she should have used two (2) patient identifiers such as checking the armband and asking the resident's name because it was part of the five (5) rights of medication administration. During an interview on 2/12/2026 At 2:38 PM with Infection Preventionist Nurse (IPN), IPN stated the licensed nurse needed to verify two (2) resident identifiers by asking the resident's name and verifying the armband and then explain each medication to the resident so that the resident know (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	what medications the resident was taking. IPN also stated f the licensed nurse did not inform the resident, they were not educating and getting consent from the Resident. During review of the facility's P&P titled, Administering Medications updated on 9/2025, the P&P indicated, the individual administering medications verifies the resident's identity before giving the resident his/her medications. The P&P also indicated methods of identifying the residents include: a. checking identification band b. checking photographs attached to medical record; and c. if necessary, verifying resident identification with other facility personnel. 4. During a review of Resident 67's admission Record, the admission Record indicated Resident 67 was admitted to the facility on [DATE] with diagnoses that included anemia (a condition where the body does not have enough healthy red blood cells), adult failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity) and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident MDS, dated [DATE], the MDS indicated Resident 67 had severely impaired cognitive skills (ability to understand and make decisions) for daily decision making. The MDS also indicated Resident 67 was dependent on oral, toileting and personal hygiene, shower/bathing self, dressing and was set up or clean up assistance (helper sets up or cleans up; resident completes activity) with eating. During a review of Resident 67's Order Summary Report, dated 2/11/2026, the Order Summary Report indicated Vitamin C oral tablet 500 mg, give one (1) tablet by mouth one time a day for supplement. It also indicated an order for [NAME] Vita Rx oral table, give one tablet by mouth one time a day. During a concurrent record review, observation of medication pass (process of administering scheduled/ prescribed medications to residents), on 2/11/2026 at 8:11 AM with Licensed Vocational Nurse 6 (LVN 6), Resident 67's MAR, dated 2/1/2026 through 2/28/2026, was reviewed. The MAR indicated to administer [NAME]-Vite Rx oral table 1 m, to give 1 tablet by mouth one time a day for supplement at 9 AM and Vitamin C oral tablet 500 mg, give 1 tablet by mouth one time a day for supplement at 9 AM. LVN 6 was observed grabbing a bubble pack (a card that packages doses of medication within small, clear, or light-resistant amber-colored plastic bubbles, separated by dose) labeled Rena Vite 1 mg, removed 1 tablet and placed it into a medication cup labeled Rena Vite. LVN 6 was then observed, reading the MAR for Vitamin C, grabbing a bubble pack labeled Rena Vite 1 mg for a second time, removed 1 tablet and placed it into a medication cup labeled Vitamin C. During the same observation of medication pass and interview on 2/11/2026 at 8:11 AM with LVN 6, LVN 6 stated she put the Rena Vite in the cup labeled Vitamin C, but it was the wrong medication prepared. LVN 6 stated she should have checked the medication bubble pack more than once to ensure the prepared medication was Vitamin C and not Rena Vite, because Rena Vite had already been prepared for Resident 67. LVN 6 stated it was important to follow the facility policy and ensure that the right medication is prepared to prevent administering extra or double dose if Rena Vite and/or administering the wrong medication to the residents. LVN 6 added, if the wrong medication is administered to residents, they would not receive their medications as ordered and needed. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy titled Administering Medications, dated 9/2025, the policy indicated medications are administered in a safe manner, as prescribed and the nurse administering the medication will check the label three (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure its medication error rate was less than five (5) percent (%). 18 medication errors (the observed or identified preparation or administration of medication or biologicals which is not in accordance with the prescriber's order/manufacture's specifications/accepted professional standards and principles) out of 36 opportunities (observed administered medications) for error which yielded a facility medication error rate of 50% for four (4) of 4 sampled residents (Residents 38, 2, 82, and 67) observed for medication administration (med pass). Licensed Vocational Nurse 4 (LVN 4) failed to correctly administer Combivent Respimat (medication used to treat and prevent tightening of the airway in adults) for Resident 38 as indicated in the package insert (a document included in the package of a medication that provides information about the medication and its use). 2a. LVN 3 failed to administer 16 medications within 60 minutes of scheduled time of 9 AM to Resident 2. 2b. LVN 3 failed to ensure three medications were not crushed and administered to Resident 2.3. LVN 6 failed to administer Vitamin C ascorbic acid 500 milligrams (mg- metric unit of measurement, used for medication dosage and/or amount) to Resident 67 on 2/11/2026. These deficient practices had the potential to result in harm to Residents 38, 2, and 67 by not administering medications as prescribed by the physician in order to meet their individual medication needs. Findings: 1. During a review of Resident 38's admission Record, the admission Record indicated Resident 38 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included metabolic encephalopathy (problem in the brain caused by a chemical imbalance in the blood), chronic obstructive pulmonary disease (COPD- a condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body), and essential hypertension (high blood pressure). During a review of Resident 38's Minimum Data Set (MDS- a resident assessment tool), dated 1/13/2026, the MDS indicated Resident 38 was assessed having intact memory and cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 38 was independent (resident completes the activity by himself) with eating. The MDS indicated Resident 38 was dependent (helper does all of the effort) with oral hygiene, upper/lower body dressing, personal dressing, sit to lying, sit to stand, and tub/shower transfer. During a review of Resident 38's Order Summary Report, dated 2/11/2026, the Order Summary Report indicated a physician order for Combivent Respimat Inhalation Aerosol Solution 20-100 micrograms (mcg- unit of measurement), 1 inhalation, inhale orally two times a day for prevention related to COPD, ordered on 8/9/2025. During a review of Resident 38's Medication Administration Record (MAR), from 2/1/2026 to 2/28/2026, the MAR indicated Resident 38 was scheduled to receive Combivent Respimat Inhalation Aerosol Solution 20-100 mcg at 5 PM. During a review of the package insert (the paper inside a medication box) for Combivent Respimat, the package insert, under instructions for use, indicated to do following: Breathe out slowly and fully Close your lips around the mouthpiece without covering the air vents (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Point the inhaler to the back of your throat While taking a slow, deep breath through your mouth, press the dose-release button (a grey button located on the side of the inhaler that releases a soft mist or puff of medication) and continue to breathe in Hold your breath for 10 seconds or for as long as comfortable During an observation of the medication pass on 2/10/2026, at 4:33 PM, LVN 4, LVN 4 placed Resident 38's Combivent inhaler in Resident 38's mouth. LVN 4 held the inhaler in Resident 38's mouth and pressed the dose-release button on Resident 38's inhaler. LVN 4 instructed Resident 38 to take a deep breath and counted to five (5) while Resident 38 inhaled and exhaled five times. LVN 4 did not instruct Resident 38 to hold his breath after inhaling the medication. During an interview, on 2/10/2026, at 4:35 PM, with LVN 4, LVN 4 stated Resident 38's was ordered for one (1) inhalation of Combivent to help Resident 38 breathe better. LVN 4 stated Resident 38 take took 5 breaths while she held the inhaler to Resident 38's mouth. LVN 4 stated Resident 38 did not receive his Combivent medication correctly. During an interview, on 2/11/2026, at 3:54 PM, with the Assistant Director of Nursing (ADON), the ADON stated Resident 38's Combivent was for his COPD and was ordered to open Resident 38's airway and help him breathe. The ADON stated Resident 38 should have been instructed by LVN 4 to hold his breath for at least 5 seconds after inhaling his Combivent medication. The ADON stated it was important that Resident 38 held his breath after he inhaled his Combivent to receive the full effect of the medication. The ADON stated LVN 4 did not administer Resident 38's medication correctly. The ADON stated not administering Resident 38's Combivent correctly could cause Resident 38 to go into respiratory distress and can lead to hospitalization. 2a. During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE]. The admission record indicated Resident 2's diagnoses included encephalopathy, DM, and dementia (a progressive state of decline in mental abilities) During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 3 had severely impaired cognitive skills for daily decision making. The MDS indicated Resident 2 was dependent in toileting hygiene, shower/ bathe self, lower body dressing, putting on / taking off footwear, sit-to stand, and chair/ bed-to-chair transfer, toilet transfer, tub/ shower transfer, car transfer, walk 10, 50 and 150 feet. During a review of Resident 2's Order Summary Report, dated 2/10/2026, the Order Summary Report indicated a physician order for the following medications: Divalproex sodium (medication used to treat bipolar disorder [bpd]-mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration) oral tablet delayed release 250 milligrams (mg- unit of measurement) give 1 tablet by mouth two times a day for mood stabilizer/bpd manifested by (m/b) changes in mood from happy to anger do not crush, ordered on 1/9/2026. Gabapentin (medication used to treat nerve pain) oral capsule 300 mg give 1 capsule by mouth three times a day for nerve pain, ordered on 1/8/2026. (continued on next page)		

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Aspirin EC (a medication used as prophylaxis [action to prevent disease] for cerebrovascular accident [CVA or stroke- a medical emergency where blood flow to a part of the brain is interrupted or reduced, depriving brain tissue of oxygen and nutrients]) oral tablet delayed release 81 mg give 1 tablet by mouth one time a day for deep vein thrombosis (DVT- a condition where a blood clot forms in a deep vein) prophylaxis (ppx- action to prevent disease) do not crush, ordered on 1/8/2026. Eliquis (medication used to reduce the risk of stroke and blood clots) oral tablet 2.5 mg give 1 tablet by mouth two times a day for DVT ppx, ordered on 1/8/2026. Acetaminophen (medication used to treat mild to moderate pain) oral tablet 500 mg give 2 tablets by mouth one time a day for mild pain (1-3)/pain management, ordered on 1/14/2026. Hydralazine Hydrochloride (medication used to treat moderate to severe hypertension and heart failure), oral tablet 10 mg give 1 tablet by mouth four times a day for hypertension hold if SBP less than 110, HR less than 60, ordered on 1/8/2026. Losartan potassium oral tablet 50 mg give 2 tablets by mouth one time a day for hypertension hold if SBP less than 110, HR less than 60, ordered on 1/8/2026. Metformin Hydrochloride (medication used to control high blood sugar levels) oral tablet 500 mg give 2 tablets by mouth two times a day for DM management give with food, ordered on 2/4/2026. Pacerone (medication used to maintain normal heart rhythm) oral tablet 200 mg give 1 tablet by mouth two times a day for arrhythmia (irregular or abnormal heartbeat), ordered on 1/8/2026. Sertraline Hydrochloride (medication used to treat depression) oral tablet 100 mg give 1 tablet by mouth one time a day for depression m/b verbalized sadness/withdraw from activities, ordered on 1/9/2026. Vitamin C (vitamin for immune [resistance to an infection] function) oral tablet give 500 mg by mouth one time a day to support wound healing of stage 3 pressure injury, ordered on 1/12/2026. Zetia (medication that lowers the bad cholesterol [a waxy, fat-like substance found in the cells of the body) oral tablet 10 mg give 1 tablet by mouth one time a day for hyperlipidemia (a condition in which there are high levels of fat particles in the blood), ordered on 1/8/2026. Zinc sulfate oral tablet give 50 mg by mouth one time a day to support wound healing of stage 3 pressure injury, ordered on 1/12/2026. Metoprolol succinate ER (medication used to lower high blood pressure) oral tablet extended release 24-hour 50 mg give 1 tablet by mouth every 12 hours for hypertension hold if SBP less than 110, HR less than 60 with food, ordered on 1/15/2026. Multivitamin-minerals oral tablet give 1 tablet by mouth one time a day to support wound healing of stage 3 pressure ulcer injury (a deep wound where the skin is broken and fat is visible), ordered on 1/12/2026. Amlodipine besylate (medication used to lower high blood pressure) oral tablet 5 mg give 1 tablet by mouth two times a day for hypertension hold if systolic blood pressure (SBP- pressure in the arteries (continued on next page)		

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	when the heart contracts and pumps blood out) less than 110, heart rate (HR) less than 60, ordered on 1/8/2026. During a review of Resident 2's MAR, from 2/1/2026 to 2/28/2026, the MAR indicated Resident 2 was scheduled to receive the following medications at 9 AM: Divalproex sodium oral tablet delayed release 250 mg Gabapentin oral capsule 300 mg Aspirin EC oral tablet delayed release 81 mg Eliquis oral tablet 2.5 mg Acetaminophen oral tablet 500 mg Hydralazine HCl oral tablet 10 mg Losartan potassium oral tablet 50 mg Metformin HCl oral tablet 500 mg Pacerone oral tablet 200 mg Sertraline HCl oral tablet 100 mg Vitamin C oral tablet give 500 mg Zetia oral tablet 10 mg Zinc sulfate oral tablet Metoprolol succinate ER oral tablet extended release 24 hour 50 mg Multivitamin-minerals oral 1 tablet Amlodipine besylate oral tablet 5 mg During an observation of the medication pass, on 2/11/2026, from 10:02 AM to 10:10 AM, LVN 3 administered the following medications to Resident 2: Hydralazine HCl oral tablet 10 mg, 1 tablet by mouth Metformin HCl oral tablet 500 mg, 2 tablets by mouth Multivitamin-minerals oral tablet, 1 tablet by mouth Eliquis oral tablet 2.5 mg, 1 tablet by mouth (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Zinc sulfate oral tablet, 50 mg by mouth Losartan potassium oral tablet 50 mg, 2 tablets by mouth Sertraline HCl oral tablet 100 mg, 1 tablet by mouth Metoprolol succinate ER oral tablet extended release 24 hour 50 mg, 1 tablet by mouth Gabapentin oral capsule 300 mg, 1capsule by mouth Zetia oral tablet 10 mg, 1 tablet by mouth Vitamin C oral tablet, 500 mg by mouth Acetaminophen oral tablet 500 mg, 2 tablets by mouth Amlodipine besylate oral tablet 5 mg, 1 tablet by mouth Aspirin EC oral tablet delayed release 81 mg, 1 tablet by mouth Divalproex sodium oral tablet delayed release 250 mg, 1 tablet by mouth Pacerone oral tablet 200 mg, 1 tablet by mouth During an interview, on 2/12/2026, at 1:40 PM, with LVN 3, LVN 3 stated Resident 2's 9 AM medications were allowed to be given as early as 8 AM but no later than 9:59 AM. LVN 3 stated the Resident 2's hydralazine HCl, metformin HCl, multivitamin-minerals, Eliquis, zinc sulfate, losartan potassium, sertraline HCl, metoprolol succinate ER, gabapentin, Zetia, vitamin C, acetaminophen, amlodipine besylate, Aspirin EC, divalproex sodium, and Pacerone were administered after 10 AM. LVN 3 stated Resident 2's medications were given late because she had a lot of medications scheduled for 9 AM. LVN 3 also stated Resident 2's late medication administration was caused by the need to replace the blood pressure cuff (the device wrapped around the arm to measure blood pressure) and check Resident 2's blood sugar before medication pass. LVN 3 stated it was important for Resident 2 to receive her hydralazine, losartan potassium, metoprolol succinate, and amlodipine besylate medications on time to because Resident 2's SBP ran in the high 150s and needed her medications to maintain her blood pressure in the normal range. LVN 3 stated it was important for Resident 2 to receive her metformin on time because she had DM and needed her metformin to maintain her blood sugar in the normal range. LVN 3 stated not giving Resident 2 her metformin on time could cause her to have symptoms of hyperglycemia like shaking and sweating. LVN 3 stated not giving Resident 2's medications on time could cause her to display side effects like unstable mood, pain, irregular heartbeat, and placed Resident 2 at risk for developing a DVT. LVN 3 stated it was important to administer medications as scheduled to prevent giving them too close together which could cause the residents to receive too much medication. During an interview, on 2/12/2026, at 4:10 PM, with the ADON, the ADON stated medications can be administered 1 hour before and 1 hour after the scheduled administration time. The ADON stated 9 AM medications were considered late if administered after 10 AM. The ADON stated it was important to give medications on time to ensure the right time space was given in between the medications. The ADON also stated not administering medications on time can affect the therapeutic levels (medication (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	concentration in the blood) of the medications. The ADON stated LVN 3 should have given Resident 2's 9 AM medications as ordered because they were significant medications. The ADON stated Resident 2 can experience symptoms such as hypertension, high blood sugar, depression, blood clots, pain, and abnormal heartbeat if the therapeutic levels of her medications were low. The ADON stated LVN 3 did not follow the policy for medication administration. 2.b) During a review of Resident 2's Order Summary Report dated 2/11/2026, the order summary report indicated: divalproex sodium 250 mg delayed release oral tablet **DO NOT CRUSH. Give 1 tablet by mouth twice a day for mood stabilizer, bipolar disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration) manifested by changes in mood from happy to anger. aspirin 81 mg oral tablet EC delayed release *** DO NOT CRUSH. Give 1 tablet by mouth one time a day for deep vein thrombosis (DVT, a blood clot in a vein located deep within your body, usually in your leg) prophylaxis. metoprolol tartrate 50 mg oral tablet Extended Release ***DO NOT CRUSH. Give 1 tablet every 12 hours for hypertension. Hold if systolic blood pressure (SBP) less than (<)110, heart rate (HR) <60 with food. During an interview on 2/12/2026 at 1:40 PM with LVN 3, LVN 3 stated there were three medications for Resident 2 that indicated do not crush on the label. LVN 3 stated he did not know that those 3 medications (divalproex, aspirin and metoprolol) cannot be crushed. LVN 3 stated, LVN 3 crushed the medications and did not inform the Registered Nurse Supervisor (RNS), the facility's pharmacy or Resident 2's doctor. During an interview on 2/12/2026 at 2:04 PM with LVN 3, LVN 3 stated when medications indicate delayed release it means once it was swallowed, it was slowly dissolved and absorbed in the body. LVN 3 also stated if the delayed release medications were crushed, it affects the slow effect of the medication and it becomes rapid release which can affect Resident 2's mood, which could result to depressive symptoms, affect the resident's the blood pressure, blood consistency and Resident 2 can become unstable. LVN 3 stated Resident 2's physician's order for divalproex, aspirin and metoprolol were not followed. During an interview on 2/12/2026 at 4:10 PM with the DON, the DON stated when medications have an instruction of do not crush, the medications will not be absorbed properly. The DON stated the licensed nurses need to call the doctor or pharmacy to change the form, or if not able to, call the doctor to change the medications. The DON stated if a medication is labeled as delayed~release, it means that once it is swallowed, it dissolves slowly in the body. If it is crushed, it disrupts the delayed or slow-release mechanism, causing the medication to be released too quickly. This can affect the resident's depression treatment and lead to instability. 3. During a review of Resident 67's admission Record, the admission Record indicated Resident 67 was admitted to the facility on [DATE] with diagnoses that included anemia (a condition where the (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	body does not have enough healthy red blood cells), adult failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity) and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident MDS, dated [DATE], the MDS indicated Resident 67 had severely impaired cognitive skills (ability to understand and make decisions) for daily decision making. The MDS also indicated Resident 67 was dependent on oral, toileting and personal hygiene, shower/bathing self, dressing and was set up or clean up assistance (helper sets up or cleans up; resident completes activity) with eating. During a review of Resident 67's Order Summary Report, dated 2/11/2026, the Order Summary Report indicated Vitamin C oral tablet 500 mg, give one (1) tablet by mouth one time a day for supplement. It also indicated an order for [NAME] Vita Rx oral table, give one tablet by mouth one time a day. During a concurrent record review, observation of medication pass (process of administering scheduled/ prescribed medications to residents), on 2/11/2026 at 8:11 AM with Licensed Vocational Nurse 6 (LVN 6), Resident 67's MAR, dated 2/1/2026 through 2/28/2026, was reviewed. The MAR indicated to administer [NAME]-Vite Rx oral table 1 m, to give 1 tablet by mouth one time a day for supplement at 9 AM and Vitamin C oral tablet 500 mg, give 1 tablet by mouth one time a day for supplement at 9 AM. LVN 6 was observed grabbing a bubble pack (a card that packages doses of medication within small, clear, or light-resistant amber-colored plastic bubbles, separated by dose) labeled Rena Vite 1 mg, removed 1 tablet and placed it into a medication cup labeled Rena Vite. LVN 6 was then observed, reading the MAR for Vitamin C, grabbing a bubble pack labeled Rena Vite 1 mg for a second time, removed 1 tablet and placed it into a medication cup labeled Vitamin C. During the same observation of medication pass and interview on 2/11/2026 at 8:11 AM with LVN 6, LVN 6 stated she put the Rena Vite in the cup labeled Vitamin C, but it was the wrong medication prepared. LVN 6 stated she should have checked the medication bubble pack more than once to ensure the prepared medication was Vitamin C and not Rena Vite, because Rena Vite had already been prepared for Resident 67. LVN 6 stated it was important to follow the facility policy and ensure that the right medication is prepared to prevent administering extra or double dose if Rena Vite and/or administering the wrong medication to the residents. LVN 6 added, if the wrong medication is administered to residents, they would not receive their medications as ordered and needed. During a review of the facility's Policy and Procedure (P&P) titled, Administering Medications, dated 9/2025, the P&P indicated medications are administered in a safe manner, as prescribed and the nurse administering the medication will check the label three (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.		

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure two (2) of four sampled residents (Residents 38 and Resident 2) were free from significant medication errors (error which causes the resident discomfort or jeopardizes his or her health and safety) by failing to: Correctly administer Combivent Respimat (medication used to treat and prevent tightening of the airway in adults) for Resident 38 as indicated in the package insert (a document included in the package of a medication that provides information about the medication and its use) This deficient practice had the potential for Resident 38 to experience shortness of breath and difficulty breathing. 2. Ensure the extended-release formulation of divalproex, metoprolol, and Aspirin were not crushed, compromising the slow release of the medications for Resident 2. This deficient practice had the potential for harm to Resident 2 due to the potential side effects from medications administered not according to its extended-release formulation. Findings: During a review of Resident 38's admission Record, the admission Record indicated Resident 38 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included metabolic encephalopathy (problem in the brain caused by a chemical imbalance in the blood), chronic obstructive pulmonary disease (COPD- a condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body), and essential hypertension (high blood pressure). During a review of Resident 38's Minimum Data Set (MDS- a resident assessment tool), dated 1/13/2026, the MDS indicated Resident 38 was assessed having intact memory and cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 38 was independent (resident completes the activity by himself) with eating. The MDS indicated Resident 38 was dependent (helper does all of the effort) with oral hygiene, upper/lower body dressing, personal dressing, sit to lying, sit to stand, and tub/shower transfer. During a review of Resident 38's Order Summary Report, dated 2/11/2026, the Order Summary Report indicated a physician order for Combivent Respimat Inhalation Aerosol Solution 20-100 micrograms (mcg- unit of measurement), 1 inhalation, inhale orally two times a day for prevention related to COPD, ordered on 8/9/2025. During a review of Resident 38's Medication Administration Record (MAR), from 2/1/2026 to 2/28/2026, the MAR indicated Resident 38 was scheduled to receive Combivent Respimat Inhalation Aerosol Solution 20-100 mcg at 5 PM. During a review of the package insert (the paper inside a medication box) for Combivent Respimat, the package insert, under instructions for use, indicated to do following: Breathe out slowly and fully Close your lips around the mouthpiece without covering the air vents Point the inhaler to the back of your throat While taking a slow, deep breath through your mouth, press the dose-release button (a grey button located on the side of the inhaler that releases a soft mist or puff of medication) and continue to (continued on next page)		

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	breathe in Hold your breath for 10 seconds or for as long as comfortable During an observation of the medication pass on 2/10/2026, at 4:33 PM, Licensed Vocational Nurse 4 (LVN 4), LVN 4 placed Resident 38's Combivent inhaler in Resident 38's mouth. LVN 4 held the inhaler in Resident 38's mouth and pressed the dose-release button on Resident 38's inhaler. LVN 4 instructed Resident 38 to take a deep breath and counted to five while Resident 38 inhaled and exhaled five times. LVN 4 did not instruct Resident 38 to hold his breath after inhaling the medication. During an interview, on 2/10/2026, at 4:35 PM, with LVN 4, LVN 4 stated Resident 38's was ordered for one (1) inhalation of Combivent to help Resident 38 breathe better. LVN 4 stated Resident 38 take took five breaths while she held the inhaler to Resident 38's mouth. LVN 4 stated Resident 38 did not receive his Combivent medication correctly. During an interview, on 2/11/2026, at 3:54 PM, with the Assistant Director of Nursing (ADON), the ADON stated Resident 38's Combivent was for his COPD and was ordered to open Resident 38's airway and help him breathe. The ADON stated Resident 38 should have been instructed by LVN 4 to hold his breath for at least 5 seconds after inhaling his Combivent medication. The ADON stated it was important that Resident 38 held his breath after he inhaled his Combivent to receive the full effect of the medication. The ADON stated LVN 4 did not administer Resident 38's medication correctly. The ADON stated not administering Resident 38's Combivent correctly could cause Resident 38 to go into respiratory distress and can lead to hospitalization. 2. During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE]. The admission record indicated Resident 2's diagnoses included encephalopathy, DM, and dementia (a progressive state of decline in mental abilities) During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 3 had severely impaired cognitive skills for daily decision making. The MDS indicated Resident 2 was dependent in toileting hygiene, shower/ bathe self, lower body dressing, putting on / taking off footwear, sit-to stand, and chair/ bed-to-chair transfer, toilet transfer, tub/ shower transfer, car transfer, walk 10, 50 and 150 feet. During a review of Resident 2's Order Summary Report dated 2/11/2026, the order summary report indicated: divalproex sodium 250 mg delayed release oral tablet **DO NOT CRUSH. Give 1 tablet by mouth twice a day for mood stabilizer, bipolar disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration) manifested by changes in mood from happy to anger. 2. aspirin 81 mg oral tablet EC delayed release *** DO NOT CRUSH. Give 1 tablet by mouth one time a day for deep vein thrombosis (DVT, a blood clot in a vein located deep within your body, usually in your leg) prophylaxis. 3. metoprolol tartrate 50 mg oral tablet Extended Release ***DO NOT CRUSH. (continued on next page)		

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give 1 tablet every 12 hours for hypertension. Hold if systolic blood pressure (SBP) less than (<)110, heart rate (HR) <60 with food. During an interview on 2/12/2026 at 1:40 PM with LVN 3, LVN 3 stated there were three medications for Resident 2 that indicated do not crush on the label. LVN 3 stated he did not know that those 3 medications (divalproex, aspirin and metoprolol) cannot be crushed. LVN 3 stated, LVN 3 crushed the medications and did not inform the Registered Nurse Supervisor (RNS), the facility's pharmacy or Resident 2's doctor. During an interview on 2/12/2026 at 2:04 PM with LVN 3, LVN 3 stated when medications indicate delayed release it means once it was swallowed, it was slowly dissolved and absorbed in the body. LVN 3 also stated if the delayed release medications were crushed, it affects the slow effect of the medication and it becomes rapid release which can affect Resident 2's mood, which could result to depressive symptoms, affect the resident's the blood pressure, blood consistency and Resident 2 can become unstable. LVN 3 stated Resident 2's physician's order for divalproex, aspirin and metoprolol were not followed. During an interview on 2/12/2026 at 4:10 PM with the DON, the DON stated when medications have an instruction of do not crush, the medications will not be absorbed properly. The DON stated the licensed nurses need to call the doctor or pharmacy to change the form, or if not able to, call the doctor to change the medications. The DON stated if a medication is labeled as delayed release, it means that once it is swallowed, it dissolves slowly in the body. If it is crushed, it disrupts the delayed or slow-release mechanism, causing the medication to be released too quickly. This can affect the resident's depression treatment and lead to instability. During a review of the facility's policy and procedure (P&P), titled, Administering Medications, revised 9/2025, the P&P indicated the following: Medications are administered in a safe and timely manner, and as prescribed. Medications are administered in accordance with prescriber orders, including any required time frame.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and review, the facility failed to label and store drugs in locked compartments as indicated in the facility's Policy and Procedure (P&P) by failing to ensure: One unopened insulin (a hormone that works by lowering levels of sugar in the blood) pen was stored inside the refrigerator instead of inside Medication Cart 1 (MC 1) per manufacturer's guidelines. This deficient practice had the potential for loss of efficacy of the insulin medication. 2. One opened Ipratropium-Albuterol Solution (a medication that treats shortness of breath by opening the air passages in the lungs) foil packet, with an open date of 2/1/2026 and expired 7 days after opening, was removed from MC 1 as indicated in the facility's policy and procedure (P&P). 3. One opened Ipratropium-Albuterol Solution foil packet, which expires 7 days after opening, was labeled with the opened date and was removed from MC 1 as indicated in the facility's P&P. 4. One opened Albuterol Sulfate inhalation solution (medication used to treat shortness of breath) foil packet, with an opened date of 1/27/2026, which expired two weeks after opening, was removed from MC 1 as indicated in the facility's P&P. These deficient practices had the potential for loss of efficacy of the medications and unintentional medication administration of expired medications, which could potentially cause harm to the residents. 5. Expired syringes, needles and alcohol prepping pads were kept inside the medication storage room. This deficient practice had the potential for residents to have an adverse reaction in the event that the expired syringes, needles and alcohol prepping pads were used for the residents. Findings: 1. During the concurrent medication inspection and interview on 2/12/2026, at 11:38 AM, of MC 1, with Licensed Vocational Nurse 5 (LVN 5), one unopened Humalog insulin pen was observed in the top left drawer of MC 1. The insulin pen was placed in an individual clear plastic bag with a blue sticker that indicated, Refrigerate Until Opened. LVN 5 stated the insulin pen label indicated a sent date of 2/11/2026 and was most likely delivered by the pharmacy late in the evening of 2/11/2026 or early morning on 2/12/2026. LVN 5 stated the insulin pen was new and unused and should have been refrigerated after it was delivered. LVN 5 stated unused insulin can become ineffective which could cause the residents' blood sugar level to remain high or out of range if it is not stored in the refrigerator. to 4. During the same concurrent medication inspection and interview on 2/12/2026, at 12:09 PM, of MC 1, with LVN 5, the following medications were observed in the bottom right drawer of MC 1: One box of Ipratropium-Albuterol solution which contained an open foil packet with four plastic ampules of Ipratropium-Albuterol solution inside. The foil packet had a yellow date opened sticker on the back which was dated 2/1/2026. The label on the Ipratropium-Albuterol Solution box indicated an expiration date of 7 days after the open date. One box of Ipratropium-Albuterol solution that contained an open foil packet with four plastic ampules of Ipratropium-Albuterol solution inside. The foil packet had a yellow date opened sticker on the back which was not dated. One box of Albuterol Sulfate solution which contained an open foil packet of four plastic ampules of Albuterol Sulfate solution inside. The foil packet had a white date opened sticker on the back which was dated 1/27/2026. The label on the Albuterol Sulfate box indicated an expiration date of 2 weeks after the foil was opened. (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LVN 5 stated the Albuterol Sulfate foil packet with an opened date of 1/27/2026 expired and should have been discarded on 2/9/2026. LVN 5 stated the Ipratropium-Albuterol foil packet with an opened date of 2/1/2026 expired and should have been discarded on 2/8/2026. LVN 5 stated expired medications should not be stored in the medication cart and should be discarded in the medication storage room. LVN 5 stated it was important to date the foil packets with the opened date so facility staff know when the ampules will expire. LVN 5 stated the Ipratropium and Albuterol medications were ordered as needed for shortness of breath and could be ineffective and cause an undesired effect on the residents who are experiencing symptoms. LVN 5 stated medications carts were checked every shift by the licensed nurse assigned to the medication cart. LVN 5 stated it was the responsibility of the licensed nurses assigned to give medications to check and make sure the medications in the medication carts were not expired and were labeled with the opened dates. During an interview, on 2/12/2026, at 4:23 PM, with the Assistant Director of Nursing (ADON), the ADON stated new and unused insulin should always be stored in the refrigerator. The ADON stated it was the responsibility of the licensed staff receiving the insulin to place the insulin in the refrigerator. The ADON stated expired medications should immediately be discarded and not kept in the medication carts. The ADON stated administering expired medications could affect the efficacy of the medications and will not be effective. The ADON stated it was important to date the medications once they are opened and to follow the expiration dates on the medication boxes. During a review of the facility's P&P titled, Administering Medications, revised 9/2025, the P&P indicated, When opening a multi-dose container, the date opened is recorded on the container. During a review of the facility's P&P, titled, Medication Storage/Labeling, dated 7/2025, the P&P indicated the following: The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. Medications requiring refrigeration are stored in a refrigerator located in the medication room at the nurses' station or other secured location. If the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items. The medication label includes, at a minimum: expiration date, when applicable and appropriate instructions and precautions. During a review of the facility's P&P, titled, Insulin Management and Administration, dated 7/2025, the policy indicated, Unopened insulin shall be refrigerated between 36 Fahrenheit (F- unit of measurement for temperature) and 46 F. 2. During a concurrent observation and interview on 2/12/2026 at 11:55 AM with the Assistant Director of Nursing (ADON) in the Medication Storage Room, one opened 3 milliliter (ML, measure of volume) syringe with capped needle was found in a box of sealed syringes. ADON stated this is not safe to have an opened syringe, because the staff can get injured. During a concurrent observation and interview on 2/12/2026 at 12:02 PM with ADON in the Medication Storage Room, there were 33 safety needles found with expiration date of 12/20/2025. ADON stated (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the syringes were expired for two (2) months. The needles might be dull or can cause possible reactions to the residents. Sterility was questionable because it was beyond expiration date. During a concurrent observation and interview on 2/12/2026 at 12:15 PM with ADON in the Medication Storage Room, one bag of alcohol prepping pads (10 pieces) was found with expiration date of 10/2023. ADON stated the alcohol pads will not be effective anymore, it will not be able to clean the injection site because they were expired. During a concurrent observation and interview on 2/12/2026 at 12:20 PM with ADON in the Medication Storage Room, there were 5-gallon size bags of expired needles and syringes with expiration dates of 7/31/2025 and 6/28/2025. ADON stated the staff were supposed to be cleaning the medication storage room and also should be checking the expiration dates before using the supply. Using expired supplies can possibly injure the residents or can cause infection because the staff does not know if they were still good to use. During a review of facility's P&P titled, Medication Storage/ Labeling, dated 7/2025, the P&P indicated the facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls. Medication Storage 2.The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure proper food handling practices and maintain the food service area in a clean and sanitary manner in accordance with the facility's policies and procedures (P&P) by failing to ensure:1. All personnels in the kitchen wore hair and or beard nets.2. Multiple food items were stored in a manner that prevents foodborne illness (illness that comes from eating contaminated food) for residents.3. Staff personal items were not placed inside the kitchen refrigerator. 4. Kitchen staff did not touch the rim of multiple glasses of water with bare hands during tray line preparation. These deficient practices have the potential to result in foodborne illness in a population of 80 residents who consume the food prepared by the facility every day.Findings:1. During an observation on 2/9/2026 at 7:35 AM, [NAME] 1 (CK 1) was observed without a hair net and was wearing a hat while his hair on the back of his head was exposed. During a concurrent observation and interview on 2/9/2026 at 8:11 AM, the Dietary Service Supervisor (DSS) was seen without a beard net, exposing his facial hair. DSS stated hair and beard nets should be used inside the kitchen to keep hair out of the food and prevent food contamination. During a tray line (behind the scenes check on how the facility kitchen staff prepare meal trays) observation on 2/11/2026 at 12:08 PM, Dietary Service Aid 1 (DSA 1) was seen without a hair net and was wearing a hat with his hair exposed at the back of his head while preparing rice soups for the residents. During an interview on 2/11/2026 at 3:18 PM, DSA 1 stated hair nets are used to prevent the hair from falling on the residents' food and contaminate the food. DSA 1 also stated he thought wearing only a hat without a hair net was acceptable. During a review of the facility's Policy and Procedure (P&P) titled, Hair Net, dated on 7/2025, the P&P indicated that the facility would enforce strict hair restraint standards to prevent food contamination. The P&P also indicated that all food service personnel, including cooks, dietary aides, and dishwashers must wear effective hair restraints when preparing, handling, or serving non prepackaged food or clean utensils. The P&P further indicated that staff with beards or mustaches that are not closely cropped and neatly trimmed must wear a beard net or restraint. The P&P also indicated that restraints must be put on before entering the kitchen area and the dietary manager or designee would perform daily sanitation inspection to ensure all staff adhere to proper attire and hair restraint standards. 2. During an observation on 2/9/2026 at 7:40 AM, a beef patty box was observed inside refrigerator #2 without a use by date on the box. During an observation on 2/9/2026 at 7:48 AM in freezer #2, the following items were found:A large metal tray of green gelatin with mandarin oranges unlabeled with preparation date and use by dateA large metal tray of plain green gelatin unlabeled with preparation date and use by dateExpired container of pumpkin soup prepared on 11/15/2025 with use by date of 12/15/2025Expired chorizos inside a large clear container with preparation date of 1/1/2026 and use by date of 2/1/2026 During an observation on 2/9/2026 at 7:53 AM in refrigerator #1, a clear container with 10 cucumbers with use by date of 2/3/2026 During an observation on 2/9/2026 at 7:58 AM in freezer #1, the following items were found:A bowl of uncovered ice cream undatedThree gallons of vanilla ice cream - unlabeled and no use by dateOpened box of dinner rolls unlabeledOpened bags of French fries (2 bags) unlabeledUnknown food item inside the plastic bag with use by date of 8/5/2025 During an observation on 2/9/2026 at 8 AM in refrigerator #3, the following items were found:Six pieces of Vanilla Greek Yogurts 32 ounce (oz) unlabeled1 gallon of an open container of milk (2) without an open date and use by dateOpened silk almond milk 32 fluid oz (2) with no open date and use by dateA clear pitcher of cranberry juice with use by date of 2/5/2026A clear pitcher of thickened water with use by date of 2/5/2026Chocolate flavored syrup (24 oz) with use by date of 12/2025Opened thick and easy hydrolyte thickened water 46 fluid oz (2) with no open date and use by date During a concurrent observation and interview on 2/9/2026 at 8:06 AM, CK 1 stated the facility had multiple expired and unlabeled food items inside refrigerators and freezers. CK 1 stated that expired food items should (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	have been discarded and not used to prevent the residents from potentially getting sick. During a concurrent interview on 2/9/2026 at 8:11 AM, the DSS stated food items should be labeled to keep track of when the food items would expire. The DSS also stated residents could get food borne illness (an illness caused by eating or drinking contaminated, spoiled food/drinks leading to symptoms of nausea, vomiting, and stomach cramps) if expired items are consumed. During a review of the P&P titled, Food Labeling and Storage, dated 10/2024, the P&P indicated that all food items removed from the original packaging or prepared in-house must be labeled with the common name of the food and the date of preparation/opening. The P&P also indicated on use-by dates that perishable, ready to eat foods must be marked with a discard date not to exceed 7 days from the date of opening or preparation. The P&P further indicated on resident-specific food that any personal food brought in by family must be labeled with the residents' name, date received, and discard date. 3. During an observation on 2/9/2026 at 7:53 AM in refrigerator #1, a bag of strawberries belonging to CK 1 were found inside the refrigerator. During an interview on 2/9/2026 at 8:11 AM, the DSS) stated staff personal items should not be stored inside the kitchen refrigerator to avoid cross contamination. 4. During a tray line observation on 2/11/2026 at 11:12 AM, DSA 2 prepared multiple batches of water in small cups and grabbed each around the mouthpiece without gloves while placing plastic cover on each of the cups. During an interview on 2/12/206 at 10:28 AM, DSA 3 stated it was important to wear gloves when filling up water cups and to keep everything clean for the residents. During a review of the P&P titled, Food Handling and Safety, dated 10/2024, the P&P indicated that the facility ensures resident safety through strict temperature control, sanitation, and adherence to physician-ordered diets.		

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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 follow the standard infection prevention control practices (a set of practices that prevent or stop the spread of infections and or diseases in the healthcare setting) in accordance with the facility's policy and procedure when: 1.a Licensed Vocational Nurse 2 (LVN 2) failed to change gloves and perform hand hygiene during medication administration to Resident 2.1.b LVN 3 failed to sanitize medication tray (equipment includes durable plastic, divided trays designed to organize, transport, and dispensing pills and syringes in clinical or home settings) after putting in the dirty lancet (a small, disposable, double-edged needle or blade used to prick the skin-usually on the finger-to obtain a tiny blood sample for checking blood sugar levels) and failed to perform hand hygiene in between tasks during medication administration to Resident 2.2. The facility failed to ensure the facility linens (bed sheets, pillowcases and blankets) were washed and dried at the appropriate temperatures and time lengths, as indicated in the facility's policies. These deficient practices have potential to contaminate clean items and can place the residents at risk for infection. Findings: 1.a During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE] with the diagnoses that included encephalopathy (a disturbance of brain function), diabetes mellitus (DM, is a metabolic disease, involving inappropriately elevated blood glucose levels) and dementia (a progressive state of decline in mental abilities). During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool), dated 1/14/2026, the MDS indicated Resident 3 had severely impaired cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 2 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) in toileting hygiene, shower/ bathe self, lower body dressing, putting on / taking off footwear, sit-to stand, and chair/ bed-to-chair transfer, toilet transfer, tub/ shower transfer, car transfer, walk 10, 50 and 150 feet. During an observation on 2/10/2026 at 4:24 PM with LVN 2 in the hallway near the nurse station, Resident 2 was sitting in the wheelchair facing the nurse station. LVN 2 was wearing a glove while placing the medications into Resident 2's mouth when one (1) medication fell and rolled onto the floor. LVN 2 picked up the medication tablet from the floor and discarded the medication in the biohazard container. LVN 2 then dispensed another medication from medication cart into the medicine cup without changing her (LVN 2) disposable gloves, picked up the medication from the medicine cup and put the medication inside Resident 2's mouth. During an interview on 2/10/2026 at 4:27 PM with LVN 2, LVN 2 stated she picked up the medication on the floor, wasted it, and replaced it with a new one. LVN 2 stated she forgot to change her gloves, and it is considered dirty. LVN 2 stated she should have removed the dirty gloves, performed hand hygiene before putting on a new pair of gloves and before administering the new medication because Resident 2 might get an infection. During an interview on 2/12/2026 at 2:30 PM with Infection Preventionist Nurse (IPN), IPN stated when LVN 2 picked up medication from the floor, LVN 2 should have changed her (LVN 2) gloves, and perform hand hygiene before getting/ preparing the new medication for Resident 2. IPN also stated if LVN 2 did not change her (LVN 2) gloves and put the medication inside Resident 2's mouth, then Resident 2 could get sick from the bacteria on the floor. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1.b During an observation on 2/11/2026 at 9:32 AM with LVN 3 inside Resident 2's room, LVN 3 checked Resident 2's blood sugar and discarded the dirty lancet inside the medication tray. LVN 3 then used the same medication tray to store the medicine cups without sanitizing the medication tray during medication preparation. During an observation on 2/11/2026 at 9:34 AM with LVN 3 in the hallway, LVN 3 picked up medication cup on floor with his bare hands and threw it away in the trashcan. LVN 3 then started to prepare Resident 2's medication without performing hand hygiene. During an interview on 2/12/2026 at 2:20 PM with LVN 3, LVN 3 stated he did put the dirty/ used lancet in the medication tray and did not sanitize the medication tray after LVN 3 checked Resident 2's blood sugar. LVN 3 did not clean the medication tray before putting the medicine cups with Resident 2's medications. LVN 3 stated they should clean the medication tray because it was dirty and for infection control. During an interview on 2/12/2026 at 2:45 PM with IPN, IPN stated LVN 3 should have disinfected the medication tray before putting in the medicine cups with Resident 2's medications. LVN 3 should have done hand hygiene after picking up anything on the floor and before preparing the medication of the resident because Resident 2 can get exposed to bacteria. During review of the facility's policy and procedure (P&P) titled, Hand washing/ Hand Hygiene updated on 1/2025, the P&P indicated, this facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections. The P&P also indicated all personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors. The P&P indicated hand hygiene is indicated after contact with blood, body fluids, or contaminated surfaces. During review of the facility's P&P titled, Administering Medications updated on 9/2025, the P&P indicated, medications are administered in a safe and timely manner, and as prescribed. The P&P also indicated under implementation, staff will follow established facility infection control procedures (e.g., handwashing, and gloves, etc.) for the administration of medications, as applicable. 2. During a concurrent observation and interview on 2/11/2026 at 12:58 PM with the Maintenance Director (MTD) and Laundry Staff (LS) 1, in the facility's laundry room, a poster titled Brand 1- Wash Formula Chart, was observed. The poster indicated the following linen types and formula/card numbers: Whites number 1 Heavy whites number 2 Colors number three (3), no bleach Heavy colors number four (4), no bleach Rags and mops number five (5) Rewash number six (6) (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LS 1 stated he used this poster when loading linens into the washer machines to know which cycle to select. MTD stated the formula/card number means the cycle number on the washer machine and the poster is used by laundry staff to determine the appropriate cycle number based off linen types indicated on the chart. During a concurrent observation and interview on 2/11/2026 at 1:02 PM with the MTD and LS 1 in the facility's laundry room, LS 1 was observed loading Washer Machine 1 with colored linen, set on cycle 3 and then started. LS 1 was then observed loading Washer Machine 2 with white linens, set on cycle 1 and then started the washer cycle. LS 1 was unable to state the water temperatures for the washer cycles 1 and 3. MTD was unable to state the set temperatures for cycles 1 and 3 and further stated the cycle temperatures were already programmed in the washer machines settings. During a concurrent interview and record review on 2/12/2026 at 12:22 PM with the MTD, the facility's document titled Automated Laundry Systems, undated, was reviewed. The document indicated the recommended washer machine temperatures of 120 to 140 degrees Fahrenheit (F) for cycles 1 and 2 and 85 to 105 degrees F for wash cycles 3 through 6. The document also indicated a Brand 2 recommended temperatures of 120 to 140 degrees F for white and heavy soiled colorfast items, 85 to 105 degrees F most loads and 65 to 75 degrees F for very bright colored linens with light soil only and water below 65 degrees is not recommended for washing. The MTD stated Brand 2 is the supplier of the washer machine and the recommended temperatures on this document are the temperatures that were set for cycle number for the facility Washer Machines 1 and 2. During a concurrent interview and record review on 2/12/2026 at 12:30 PM with the MTD, the facility's policy titled Washer and Dryer, dated 1/2025, was reviewed. The policy indicated the purpose of the policy for laundry is to align with federal standards and linens should be exposed to water at a minimum of 160 degrees F for at least 24 minutes during the wash cycle to ensure disinfection with the standard hot water method. The MTD stated the facility washer machines use standard hot water method and per facility policy, the washer cycles 1 through 6 do not meet the minimum temperature requirement of 160 degrees F. MTD added the washer machine temperatures should follow the current facility policy for Washer and Dryer to make sure linens are cleaned and disinfected. During a continuous concurrent observation and interview on 2/11/2026 from 1:05 PM to 1:50 PM with LS 1, MTD and the Maintenance Supervisor (MS), in the facility's laundry area, LS 1 was observed loading the Dryer 1 with white linen and Dryer 2 with colored linen, then started the drying cycle for Dryers 1 and 2. LS 1 stated Dryer 1 contained sheets and pillowcases and Dryer 2 contained blankets. LS 1 stated he monitors the dryer temperatures by a gauge located outside of the drying machines to make sure the temperature reached 180 degrees F. During the same observation and interview on 2/11/2026 from 1:05 PM to 1:50 PM with LS 1, the MTD and MS, in the facility's laundry area, Dryer 1's load cycle was observed running at a temperature of 160 degrees F from 1:34 PM to 1:41 PM (7 minutes) and Dryer 2's load cycle ran at a temperature of 150 degrees F from 1:31 PM to 1:43 PM (12 minutes). LS 1 was observed removing the linens from Dryers 1 and 2 into a large bin. LS 1 stated he was going to start folding the linens that LS 1 got from Dryers 1 and 2. During a concurrent interview and record review on 2/11/2026 at 1:52 PM with MTD, the facility's document titled Brand 1- Laundry Drying Procedures, (undated), was reviewed. The Laundry Drying Procedures indicated for sheets and pillowcases to be dried at 160 to 170 degrees F for 12 to 15 (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	minutes and blankets were to be dried at 150 to 170 degrees for 25 to 30 minutes. The MTD stated per facility protocol, staff need to follow the drying times and temperature range indicated in the Laundry Drying Procedures. MTD also stated the linens that were dried in Dryers 1 and 2 did not run at the appropriate temperatures for the full indicated time frame and LS 1 should have let it complete the required amount of time before removing the linens from Dryers 1 and 2. MTD further stated it was important to follow the drying times and dry time temperature ranges for health reasons, to prevent mold and bacteria accumulation on the linen and to make sure it is dried and disinfected properly for the residents. During an interview on 2/11/2026 at 3:02 PM with the Infection Preventionist Nurse (IPN), the IPN stated it was important for the facility's linen to be washed and dried at appropriate temperatures and time lengths to ensure whatever bacteria is present is killed and the linen will be sanitized and bacteria free. During a review of the facility's policy titled Policies and Practices & Infection Control, revised 10/2018, the policy indicated the intention to maintain a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections.		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure two (2) of five (5) sampled residents (Residents 72 and 4), in the infection control care area, were provided education or a Vaccine Information Statements (VIS- information sheets produced by the Center of Disease Control and Prevention [CDC] that explain both the benefits and risks of a vaccine [medications used to prevent diseases usually given by injection or by mouth] to vaccine recipients) for influenza (the flu- a contagious respiratory virus) and pneumococcal (a serious, often fatal infection caused by Streptococcus pneumoniae bacteria) vaccinations per facility policy. This failure had the potential for Residents 72 and 4 (or their responsible party [RP]) to accept or decline the influenza and/or pneumococcal vaccinations without the proper understanding of risks and benefits to make an informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered). Findings: 1. During a review of Resident 72's admission Record, the admission Record indicated Resident 72 was originally admitted to the facility on [DATE] with diagnoses that included fusion of the spine (a surgical procedure that permanently connects two or more vertebrae [a small bone in the spine] in the spine), chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing), and difficulty in walking. During a review of Resident 72's Minimum Data Set (MDS - a resident assessment tool), dated 11/18/2025, the MDS indicated Resident 72 has intact cognitive skills (ability to understand and make decisions) for daily decision making. The MDS also indicated Resident 72 was assessed to need set up or clean-up assistance (helper sets up or cleans up; resident completes activity) with eating and oral hygiene and supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) and with toileting and personal hygiene and showering/bathing self. During a review of Resident 72's physical medical charts dated from 8/1/2025 to 2/11/2026, the medical chart did not indicate documentation that Resident 72 was provided education or a VIS form regarding the influenza vaccine. During an interview on 2/11/2026 at 10:32 AM with the Infection Preventionist Nurse (IPN), IPN stated the facility protocol is to provide the residents and/or RP with VIS forms to educate the residents or the resident's RP on the risks and benefits and then let them decide if they consent to or will decline the offered influenza and pneumococcal vaccinations. IPN also stated per facility protocol, once the VIS form is provided, it would be documented in the resident's electronic medical chart under the immunizations section or documented in a progress note. During a concurrent interview and record review on 2/11/2026 at 10:39 AM with the IPN, Resident 72's electronic medical record, from 8/1/2025 to 2/11/2026 and Resident 72's Vaccine Consent Form, dated 10/1/2026, were reviewed. The electronic medical chart and the Vaccine Consent Form both did not indicate Resident 72 was provided with education or VIS form for influenza vaccine, prior to obtaining the consent for the flu and pneumococcal vaccine. IPN stated there was no documentation in the medical record or on the consent to ensure Resident 72 was provided education or a VIS form for the influenza vaccination and there should be documentation that it was provided, so it was not done. 2. During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was readmitted to the facility on [DATE] with diagnoses that included acute (sudden) and chronic (long lasting) respiratory failure (condition in which not enough oxygen passes from the lungs into the blood), COPD and depression (mood disorder that causes a persistent feeling of sadness and loss of interest in life). During a review of Resident 4's MDS, dated [DATE], the MDS indicated Resident 4 had severely impaired cognitive skills for daily decision making. The MDS also indicated Resident 4 was dependent (helper does all the effort) with toileting hygiene, shower/bathing self, partial/moderate assistance (helper does less than half the effort) with oral and personal hygiene and supervision or touching assistance with eating. During a review of Resident 4's physical medical charts dated from 7/4/2025 (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Royal Vista Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 909 W. Santa Anita Ave San Gabriel, CA 91776	
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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to 2/11/2026, the medical chart did not indicate documentation that Resident 4's RP was provided education or a VIS form regarding the influenza and pneumococcal vaccines. During a concurrent interview and record review on 2/11/2026 at 10:48 AM with IPN, Resident 4's electronic medical record, from 7/4/2025 to 2/11/2026 and Resident 4's Vaccine Consent Form, (undated), were reviewed. The electronic medical record and the Vaccine Consent Form both did not indicate Resident 4 and/or the RP were provided a VIS form for the influenza and pneumococcal vaccines. IPN stated there is no documentation in Resident 4's medical record or the consent form regarding any provided education or VIS forms for the pneumococcal and flu vaccine and there should be documentation if provided. During an interview on 2/11/2026 at 10:59 AM with IPN, IPN stated it was important to ensure residents and/or the RP are provided education and the VIS forms regarding offered vaccines (influenza and pneumococcal) to ensure family/residents are educated for their own understanding of what they are receiving, to know the side effects, and to help with their (the resident or RP) decision to consent or decline the vaccine. The IPN also stated that without ensuring the residents/family are provided education and the VIS forms, the facility cannot ensure family/residents are fully informed of the offered vaccinations. During a review of the facility's policy and procedure (P&P) titled Influenza Vaccination Program, dated 2/2026, the P&P indicated the purpose of the vaccination program is to prevent transmission of disease within the facility and to provide qualified residents the opportunity to receive the influenza vaccine while at the facility. The P&P also indicated the influenza vaccine will be offered October through March and for staff to provide the Resident with the appropriate Vaccine Information Sheet before obtaining a consent from the resident or representative. During a review of the facility's P&P titled Pneumococcal Vaccination Program, dated 2/2026, the P&P indicated the purpose of the vaccination program is to prevent transmission of disease within the facility and to provide qualified residents the opportunity to receive the pneumococcal vaccine while at the facility and for staff to provide the Resident with the appropriate Vaccine Information Sheet before obtaining a consent from the resident or representative. During a review of the facility P&P titled Vaccination Program, (undated), the P&P indicated the policy purpose of recognizing the major impact and mortality of both influenza, pneumococcal and Covid- 19 disease (a highly contagious respiratory illness caused by the SARS-CoV-2 virus) on the elderly and other individuals at risk and the effectiveness of vaccines for reducing health care costs and in preventing illness, hospitalization, and death. The P&P also indicated to provide the resident (RP) with a VIS prior to the consenting and/or administering of the influenza, pneumococcal and/or Covid vaccinations.		

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure two (2) of five (5) sampled residents (Residents 72 and 4), in the infection control care area, were provided education or a Vaccine Information Statements (VIS- information sheets produced by the Center of Disease Control and Prevention [CDC] that explain both the benefits and risks of a vaccine [medications used to prevent diseases usually given by injection or by mouth] to vaccine recipients) for the Covid-19 (a highly contagious respiratory illness caused by the SARS-CoV-2 virus) vaccine per the facility's policy and procedure. This failure had the potential for Residents 72 and 4 (or their responsible party [RP]) to accept or decline the Covid-19 vaccine without the proper understanding of risks and benefits to make an informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered). Findings: 1. During a review of Resident 72's admission Record, the admission Record indicated Resident 72 was originally admitted to the facility on [DATE] with diagnoses that included fusion of the spine (a surgical procedure that permanently connects two or more vertebrae [a small bone in the spine] in the spine), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), and difficulty in walking. During a review of Resident 72's Minimum Data Set (MDS - a resident assessment tool), dated 11/18/2025, the MDS indicated Resident 72 has intact cognitive skills (ability to understand and make decisions) for daily decision making. The MDS also indicated Resident 72 was assessed to need set up or clean-up assistance (helper sets up or cleans up; resident completes activity) with eating and oral hygiene and supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) and with toileting and personal hygiene and showering/bathing self. During a review of Resident 72's physical medical charts dated from 8/1/2025 to 2/11/2026, the medical chart did not indicate documentation that Resident 72 was provided education or a VIS form regarding the Covid-19 vaccine. During an interview on 2/11/2026 at 10:32 AM with the Infection Preventionist Nurse (IPN), the IPN stated the facility protocol is to provide the residents and/or RP with VIS forms to educate them on the risks and benefits and then let them decide if they consent to or will decline the offered Covid vaccinations. The IPN also stated per facility protocol, once the VIS form is provided, it would be documented in the resident's electronic medical chart under the immunizations section or documented in a progress note. During a concurrent interview and record review on 2/11/2026 at 10:39 AM with the IPN, Resident 72's electronic medical record, from 8/1/2025 to 2/11/2026 and Resident 72's Vaccine Consent Form, dated 10/1/2026, were reviewed. The electronic medical chart and the Vaccine Consent Form both did not indicate Resident 72 was provided with education or VIS form for Covid-19 vaccine. IPN stated there was no documentation in the medical record or on the consent to ensure Resident 72 was provided education or a VIS form for the Covid-19 vaccination and there should be documentation if it was provided. 2. During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was readmitted to the facility on [DATE] with diagnoses that included acute (sudden) and chronic (long lasting) respiratory failure (condition in which not enough oxygen passes from the lungs into the blood), COPD and depression (mood disorder that causes a persistent feeling of sadness and loss of interest in life). During a review of Resident 4's MDS, dated [DATE], the MDS indicated Resident 4 had severely impaired cognitive skills for daily decision making. The MDS also indicated Resident 4 was dependent (helper does all the effort) with toileting hygiene, shower/bathing self, partial/moderate assistance (helper does less than half the effort) with oral and personal hygiene and supervision or touching assistance with eating. During a review of Resident 4's physical medical charts dated from 7/4/2025 to (continued on next page)		

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2/11/2026, the medical chart did not indicate documentation that Resident 4's RP was provided education or a VIS form regarding the Covid-19 vaccine. During a concurrent interview and record review on 2/11/2026 at 10:48 AM with IPN, Resident 4's electronic medical record, from 7/4/2025 to 2/11/2026 and Resident 4's Vaccine Consent Form, (undated), were reviewed. The electronic medical record and the Vaccine Consent Form both did not indicate Resident 4 and/or the RP were provided a VIS form for the covid vaccine. IPN stated there is no documentation in Resident 4's medical record or the consent form regarding any provided education or VIS forms for the Covid-19 vaccine and there should be documentation if provided. During an interview on 2/11/2026 at 10:59 AM with IPN, IPN stated it was important to ensure residents and/or the RP are provided education and the VIS forms regarding offered vaccines (including Covid-19) to ensure family/residents are educated for their own understanding of what they are receiving, to know the side effects, and to help with their (the resident or RP) decision to consent or decline the vaccine. The IPN also stated that without ensuring the residents/family are provided education and the VIS forms, the facility cannot ensure family/residents are fully informed of the offered vaccinations. During a review of the facility's policy and procedure (P&P) titled Covid Vaccination Program, dated 2/2026, the P&P indicated the purpose of the vaccination program is to prevent transmission of disease within the facility and to provide qualified residents the opportunity to receive the Covid vaccine while at the facility. The P&P also indicated for staff to provide the Resident with the appropriate Vaccine Information Sheet before obtaining a consent from the resident or representative. During a review of the facility P&P titled Vaccination Program, (undated), the P&P indicated the policy purpose of recognizing the major impact and mortality of both influenza, pneumococcal and Covid disease on the elderly and other individuals at risk and the effectiveness of vaccines for reducing health care costs and in preventing illness, hospitalization, and death. The P&P also indicated to provide the resident (RP) with a VIS prior to the consenting and/or administering of the influenza, pneumococcal and/or Covid vaccinations.		

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents' medical records were updated to show documentation that advance directives (a legal document indicating resident preference on end-of-life treatment decisions) were discussed upon admission and written information were provided for one (1) of two (2) sampled residents and/or responsible party (Resident 78), in the advance directive care area. This deficient practice violated Resident's 78 and/or the responsible party's (RP) right to be fully informed of the option to formulate their advanced directives and had the potential to cause conflict with the residents' wishes regarding health care. Findings: During a review of Resident 78's admission Record, the admission Record indicated Resident 78 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included wedge compression fracture (an injury of the spine where the front part of a vertebra [a small bone in the spine] collapses, creating a wedge-shaped bone) of first lumbar (lower part of the back) vertebra, spinal stenosis (a narrowing of the spaces within your spine) and hepatomegaly (an abnormally enlarged liver). The admission Record also indicated a blank entry for an advance directive. During a review of Resident 78's Minimum Data Set (MDS - a resident assessment tool) dated 1/27/2026, the MDS indicated Resident 78 had severely impaired cognitive skills (ability to understand and make decisions) for daily decision making. The MDS indicated Resident 78 was dependent (helper does all of the effort) with toileting, shower/bathing self and dressing, partial/moderate assistance (helper does less than half the effort) with eating, oral and personal hygiene. During a review of Resident 78's Social Services Assessments, dated 1/22/2026 and 2/6/2026, the Social Services Assessments failed to indicate if Resident 78 had an advance directive and/or if any written information was provided to Resident 78 or Resident 78's RP. During a review of Resident 78's physical medical charts dated from 2/4/2026 to 2/10/2026, the medical chart did not indicate an advance directive acknowledgment form or documentation that Resident 78 and the resident's RP were informed and provided written material regarding formulating an advance directive. During an interview on 2/10/2026 at 11:04 AM with the Director of Social Services 1 (DSS 1), the DSS 1 stated per facility's policy, facility staff will complete an advance directive acknowledgment form for all residents within 72 hours of admission either from the resident or with verbal consent from the resident's responsible party. DSS 1 stated it was important to inquire with the resident/ resident's if the resident has any advance directive prior to or upon admission and that family or representative complete the advance directive acknowledgment so that residents know they have the option to appoint someone to speak on behalf of them for their medical decisions when they do not have the capacity to do it themselves. During a concurrent interview and record review on 2/10/2026 at 2:15 PM with the Director of Social Services 2 (DSS 2), Resident 78's physical medical charts dated from 2/4/2026 to 2/10/2026 were reviewed. Resident 78's medical chart did not have a completed advance directive acknowledgement form. DSS 2 stated Resident 78's medical chart did not have an advance directive or an advance directive acknowledgment form in the chart and there should be one completed. DSS 2 also stated per the facility policy, the advance directive acknowledgment is usually completed as soon as the resident is admitted and that the social services director or designee inquires of the resident, the resident's family members and/or the resident's legal representative, about the existence of any written advance directives. During a concurrent interview and record review on 2/10/2026 at 2:32 PM with the DSS 2, DSS 2 provided an Advance Directive Acknowledgement, dated 1/21/2026 for Resident 78. The Advance Directive Acknowledgement did not indicate if Resident 78 had an advance directive or if Resident 78's RP wanted more information regarding formulating an advance directive. DSS 2 stated the Advance Directive Acknowledgement was not in Resident 78's current medical chart because it was from a previous admission and that the form was incomplete and it should have (continued on next page)		

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated if there was an advance directive for Resident 78 or if information was wanted or not. DSS 2 further stated when Resident 78 was readmitted to the facility on [DATE], a new advance directive acknowledgement form should have been completed since it was a new admission. DSS 2 stated it was critical to have a completed advance acknowledgment form because those include a residents' or RP's wishes in the event of emergency and those wishes needed to be respected and followed. During a review of the facility's policy and procedure (P&P) titled Advance Directives, updated 10/2024, the P&P indicated the resident has the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment, and advance directives are honored in accordance with state law and facility policy. The P&P also indicated the following: Prior to or upon admission of a resident, the social services director or designee inquires of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives. The resident or representative is provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so. Written information about the right to accept or refuse medical or surgical treatment, and the right to formulate an advance directive is provided in a manner that is easily understood by the resident or representative. If the resident is incapacitated and unable to receive information about his or her right to formulate an advance directive, the information may be provided to the residents' legal representative. Information about whether or not the resident has executed an advance directive is displayed prominently in the medical record in a section of the record that is retrievable by any staff.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide a safe, comfortable wheelchair for one (1) of two (2) sampled residents (Residents 38) reviewed for environmental concerns by failing to ensure the resident's wheelchair's left armrest pad was free from peeling and cracks and the wheelchair had a right padded armrest. This deficient practice had the potential to affect Resident 38's safety and comfort when sitting in the wheelchair. Findings: During a review of Resident 38's admission Record, the admission Record indicated Resident 38 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included difficulty in walking and lack of coordination. During a review of Resident 38's Minimum Data Set (MDS- a resident assessment tool), dated 1/13/2026, the MDS indicated Resident 38 had an intact cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 38 was dependent (helper does all the effort) with oral, toileting, and personal hygiene, shower, upper and lower body dressing, and putting on/taking off footwear. The MDS further indicated Resident 38 used manual wheelchair as mobility device. During a concurrent observation and interview on 2/10/2026 at 8:34 AM, Resident 38 was observed sitting in a wheelchair that was missing the right armrest pad, exposing the metal frame, and had a left armrest pad with peeling and cracked leather covering. Resident 38 stated he could not place his right arm on the exposed metal part of the wheelchair because it was hard and uncomfortable. Resident 38 further stated the cracks and peeling on the left armrest pad scratched his left arm. During an interview on 2/10/2026 at 3:10 PM, Licensed Vocational Nurse 6 (LVN 6) stated cracked and worn-out wheelchairs could cause discomfort and could potentially cause irritation to Resident 38's skin. During an interview on 2/11/2026 at 9:43 AM, the Assistant Director of Nursing (ADON) stated the residents' wheelchairs should be in good condition without tears and peeling to prevent injuries to the residents' skin. The ADON stated that Resident 38's wheelchair should have armrests to ensure the resident can sit comfortably and to prevent the resident's right arm from dangling at the side. During an interview on 2/12/2026 at 9:06AM, the Maintenance Director (MTD) stated the wheelchair arm rest is there for arm support and for the residents' comfort. MTD also stated Resident 38's wheelchair left arm rest should have been replaced to prevent discomfort and should have been provided with a right arm rest to have proper support for his right arm. During a review of the facility's policy and procedure (P&P) titled, Maintenance Services, updated on 1/1/2026, the P&P indicated maintenance services shall be provided to all areas of the building, grounds, and equipment. The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times.		

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to monitor signs and symptoms of hypoglycemia (an abnormally low level of sugar [glucose] in the blood) and hyperglycemia (a condition where the blood glucose [sugar] levels are abnormally high) from 5/3/2025 up to 2/11/2026 for one (1) of 18 sampled residents (Residents 3) on Insulin aspart (Novolog, is a rapid-acting, man-made version of human insulin), as indicated on the care plan (CP). This deficient practice had the potential for Residents 3 not to receive treatment in the event of a hypoglycemic and hyperglycemic episode, which could lead to complications, harm, hospitalization, or death. Findings: During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was admitted to the facility on [DATE] and re-admitted on [DATE]. The admission record indicated Resident 3's diagnoses included spinal stenosis (happens when the space inside the backbone is too small) lumbar (lower back bone) region, peripheral vascular disease (reduced circulation of blood to arms or legs due to a narrowed or blocked blood vessel), and diabetes mellitus (DM, is a metabolic disease, involving inappropriately elevated blood glucose levels) During a review of Resident 3's Minimum Data Set (MDS, a resident assessment tool), dated 11/26/2025, the MDS indicated Resident 3 had intact cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 3 needed partial/ moderate assistance (helper does less than half the effort, helper lifts, holds, or supports trunk or limbs but provides less than half the effort) in lower body dressing, personal hygiene, roll left and right, sit to lying, lying-to-sitting on the side of the bed, sit-to stand, and chair/ bed-to-chair transfer, toilet transfer, tub/ shower transfer and walk 10 feet. The MDS also indicated Resident 3 received seven (7) insulin injections. During an interview on 2/9/2026 at 8:41 AM with Resident 3, Resident 3 stated, My eyes get blurry when my blood sugar is high, and I do not feel good. During a concurrent interview and record review on 2/11/2026 at 8:26 AM with the Assistant Director of Nursing (ADON), Resident 3's Physician's Orders (PO), dated 5/23/2025, was reviewed. The ADON stated Resident 3's PO indicated Insulin Aspart Subcutaneous (SQ, a shot that delivers medicine into the fatty tissue layer just under the skin, above the muscle, using a short, small needle for slow, steady absorption) Solution Pen-injector 100 units per milliliter (ML, measure of volume) Inject as per sliding scale: if 0 - 150 = 0; 151 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; If Blood Sugar was greater than (>) 400, SQ inject 10 units insulin and report to MD, subcutaneously before meals and at bedtime for DM. The ADON stated Resident 3 did not have an order to monitor for signs and symptoms (s/s) of hypoglycemia and hyperglycemia while using insulin. The ADON stated there should have been monitoring orders so it can be ensured that the licensed nurses would assess Resident 3 for the s/s of hypoglycemia and hyperglycemia. During a concurrent interview and record review on 2/11/2026 at 8:28 AM with the ADON, Resident 3's Care Plan (CP) for diabetes mellitus, dated 10/8/2025, was reviewed. The CP indicated Resident 3 was at risk for hypoglycemia or hyperglycemia. The CP interventions indicated the following: Monitor/document/report as needed (PRN) s/s of hyperglycemia: increase thirst, headaches, trouble concentrating, blurred vision, frequent urination, fatigue, and weight loss. Monitor/document/report PRN signs and symptoms of hypoglycemia: sweating, tremor, increased heart rate (tachycardia), pallor (skin paleness), nervousness, confusion, slurred speech, lack of coordination, staggering gait. MDSN stated Resident 3's CP interventions for monitoring hypoglycemia and hyperglycemia were not followed or implemented because there was no documentation indicating that staff had monitored Resident 3. During a concurrent interview and record review on 2/11/2026 at 8:30 AM with the ADON, Resident 3's Medication Administration Record (MAR, a report detailing the drugs administered to a resident by a healthcare professional at a treatment facility) for the month of February 2026 was reviewed. The MAR indicated from 2/1/2026 to 2/10/2026, Resident 3 had received insulin before (continued on next page)		

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	meals and at bedtime. The ADON stated the staff should have monitored Resident 3 for the s/s of hypoglycemia and hyperglycemia. The ADON stated the staff should have documented whether Resident 3 exhibited s/s of hypoglycemia (such as sweating, tremors, increased heart rate [tachycardia], pallor, nervousness, confusion, slurred speech, lack of coordination, or a staggering gait) or not. The ADON also stated it was important for the licensed staff to monitor so Resident 3's physician could be notified, and additional orders could be obtained if Resident 3 becomes hypo or hyperglycemic. During a concurrent interview and record review on 2/11/2026 at 8:34 PM with ADON, the Nurses' Progress Notes (NPN) dated 1/12/2026 to 2/11/2026 were reviewed. The NPN did not indicate any documentation for monitoring Resident 3 for hypoglycemia and hyperglycemia. ADON stated there was no documentation for monitoring resident 3 for s/s of hypoglycemia and hyperglycemia. The NPN indicates the licensed staff do not check Resident 3 after giving him insulin. Resident 3's blood sugar was always high so the resident can undergo diabetic ketoacidosis (DKA, is a life-threatening, emergency complication of diabetes caused by a severe lack of insulin) or diabetic coma (a medical emergency caused by a blood sugar level that was too low or too high). During a concurrent interview and record review with the ADON on 2/11/2026 at 8:34 PM, the Nurses' Progress Notes (NPN), dated 1/12/2026 to 2/11/2026, were reviewed. The NPN did not include any documentation indicating that Resident 3 was monitored for hypoglycemia or hyperglycemia. During review of the facility's policy and procedure (P&P) titled, Hypoglycemia Management Policy, dated on 5/2025, the P&P indicated to establish standardized procedures for the prevention, identification, treatment, documentation, and monitoring of hypoglycemia in the skilled nursing facility setting. All hypoglycemia events shall be documented and trended. Documentation: Blood glucose values, symptoms, interventions, and resident response shall be documented. Provider notifications and treatment changes shall be recorded. Recurrent episodes shall be addressed in the care plan. During review of the facility's P&P titled, Hyperglycemia Management Policy dated on 6/2025, the P&P indicated, to establish standardized procedures for assessment, monitoring, treatment, documentation, and prevention of hyperglycemia in the skilled nursing facility setting. All hyperglycemia events shall be documented and trended. Documentation: Blood glucose values, interventions, and resident response shall be documented. Provider notifications and medication changes shall be recorded. Care plan updates shall reflect recurrent hyperglycemia. During review of the facility's P&P titled, Policy on Diabetes Mellitus Management dated on 7/2025, the P&P indicated, to establish standards for assessment, monitoring, treatment, and education related to Diabetes Mellitus in the skilled nursing facility setting. Assessment and Care Planning Care plans shall address blood glucose monitoring, nutrition, medications, and recognition of hypo- and hyperglycemia. Care plans shall be reviewed and updated with any significant change in condition. Hypoglycemia and Hyperglycemia Management Staff shall be trained to recognize signs and symptoms of hypoglycemia and hyperglycemia. Documentation Blood glucose values, interventions, and resident response shall be documented. Medication administration and monitoring shall be recorded in the medical record. Physician notifications and treatment changes shall be documented.		

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one of one sampled resident (Resident 72) from the vision/hearing care area, maintained a scheduled ophthalmology (the specialized field of medicine that focuses on the health of the eye appointment). This failure resulted in a delaying preoperative appointment with the potential risk for a delay in necessary treatment and evaluation including surgery. Findings: During a review of Resident 72's admission Record, the admission Record indicated Resident 72 was originally admitted to the facility on [DATE] with diagnoses that included fusion of the spine (a surgical procedure that permanently connects two or more vertebrae [a small bone in the spine] in the spine), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), and difficulty in walking. During a review of Resident 72's Ophthalmology Consultation, dated 10/7/2025, the Ophthalmology Consultation indicated complaints of cataract (the clouding of the eye's natural lens), eye pain and blurrier vision on the left eye. It also indicated, Resident 72 had history of cataract to the left and right eye with physician recommendations to refer Resident 72 to a cataract surgeon for surgery evaluation with the goal of treatment being a quality-of-life enhancement. During a review of Resident 72's Minimum Data Set (MDS - a resident assessment tool), dated 11/18/2025, the MDS indicated Resident 72 has intact cognitive skills for daily decision making. The MDS also indicated Resident 72 required setup or clean-up assistance (helper sets up or cleans up; resident completes activity) with eating and oral hygiene and supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with toileting and personal hygiene and showering/bathing self. During a review of Resident 72's Physician Orders, dated 12/5/2025, the Physician Orders indicated a preoperative ophthalmology appointment on 1/29/2026 at 8 AM. During an interview on 2/9/2026 at 10:30 AM with Resident 72, Resident 72 stated she is having trouble with her vision and had an ophthalmology appointment, sometime in 1/2026, to have surgery on her eye, but it was missed and it was an important appointment because They were going to measure my eyeballs and stuff. During a concurrent interview and record review on 2/12/2026 at 7:55 AM with Registered Nurse 2 (RN 2), Resident 72's medical chart dated from 1/14/2026 to 2/12/2026, was reviewed. The medical chart did not indicate the reason for Resident 72's missed ophthalmology appointment on 1/29/2026, if Resident 72 refused and/or that Resident 72's doctor was notified of the missed appointment. RN 2 stated there was no documentation including a progress note or MD notification regarding Resident 72's missed ophthalmology appointment on 1/29/2026. RN 2 added, the missed appointment and what was done after the appointment was missed should have been documented in Resident 72's records and it was not documented it was not done. RN 2 stated Resident 72's ophthalmology appointment was regarding a surgery the resident needs for both eyes. RN 2 stated it was important that Resident 72 made it to her scheduled appointments, and the doctor should have been made aware if the resident missed the appointment for the resident's safety and care and to be evaluated if the eye surgery can wait. During a review of the facility's policy and procedure (P&P) titled Ancillary Services, (undated) the P&P indicated the facility shall provide or arrange necessary ancillary services based on physician orders and resident needs. The P&P indicated ancillary services may include vision services, shall be coordinated with nursing and other disciplines to ensure continuity of care. During a review of the facility's policy titled Visually Impaired Resident, Care of, dated 10/2024, the policy indicated it was the facility's responsibility to assist the resident and representatives in locating available resources, scheduling appointments and arranging transportation to obtain needed services.		

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F 0689 Level of Harm - Minimal harm or potential for 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** Based on observation, interview and record review, the facility failed to ensure a fall risk identifier, frequent visual checks and caregiver education were implemented for one (1) of 1 sampled resident (Resident 78), for the accidents care area, as indicated in Resident 78's care plan (a document that outlines the facility's plan to provide personalized care to a resident based on the resident's needs) and the facility's policy and procedure. This failure had the potential for Resident 78 to experience preventable falls, injury or accident hazards. Findings: During a review of Resident 78's admission Record, the admission Record indicated Resident 78 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included wedge compression fracture (an injury of the spine where the front part of a vertebra [a small bone in the spine] collapses, creating a wedge-shaped bone) of first lumbar (lower part of the back) vertebra, spinal stenosis (a narrowing of the spaces within your spine), displaced fracture (a severe break where the bone snaps into two or more pieces and moves out of its normal alignment, creating a gap between the fragments) of the left ulna (a long bone in the forearm) and hepatomegaly (an abnormally enlarged liver). During a review of Resident 78's At Risk for Falls Related To: Confusion, Poor Safety Awareness, History of Falls care plan, dated 1/22/2026, the care plan indicated the staff intervention to review information on past falls and educate resident, family, caregiver as to cause of falls. During a review of Resident 78's Minimum Data Set (MDS - a resident assessment tool), dated 1/27/2026, the MDS indicated Resident 78 had severely impaired cognitive skills (ability to understand and make decisions) for daily decision making. The MDS indicated Resident 78 was dependent (helper does all of the effort) with toileting, shower/bathing self, dressing, walking and transfers, partial/moderate assistance (helper does less than half the effort) with eating, oral and personal hygiene. During a review of Resident 78's medical record, dated from 1/21/2026 through 2/12/2026, the medical record indicated Resident 78 had 2 falls while at the facility on 1/31/2026 and 2/4/2026. During a review of Resident 78's Fall Risk Assessment, dated 2/4/2026, the Fall Risk Assessment indicated the resident was assessed to be at high risk (a significantly increased likelihood of falling) for fall. During a review of Resident 78's At Risk for Injury Related to Recent Fall 2/4/2025 care plan, dated 2/5/2026, the care plan indicated the intervention of frequent visual checks. During an interview on 2/12/2026 at 10:10 AM with Licensed Vocational Nurse 5 (LVN 5), LVN 5 stated she was assigned to provide care to Resident 78 during the 7:00 AM to 3:00 PM shift and was unable to state the resident specific fall prevention intervention of frequent visual checks for Resident 78. LVN 5 stated she was not aware of Resident 78's full fall history and risk for fall because this was the first time she was working with Resident 78. During a concurrent observation and interview on 2/12/2026 at 10:10 AM with LVN 5 at Resident 78's room door, Resident 78's name plate (mounted signage outside of the door used for identifying the resident and their bed location) was observed with no fall risk identifier (a red star). LVN 5 stated red stars are placed next to the resident's name per facility protocol and to identify if residents have had recent falls. LVN 5 stated Resident 78's name plate did not have a red star but should have because Resident 78 had a recent fall and is at high risk for fall. LVN 5 further stated it was important to use the fall risk identifier and implement fall prevention measures to keep staff alert and ensure the patients are safe and their needs are met. During an interview on 2/12/2026 at 10:52 AM with Certified Nursing Assistant 6 (CNA 6), CNA 6 stated he was assigned to provide care to Resident 78 during the 7:00 AM to 3:00 PM shift and was not aware if Resident 78 had any history of falls and/or the cause of previous falls. CNA 6 further stated Resident 78 was not a high risk for falls because She does not have any red stars on the door. CNA 6 stated he provided rounding and visual checks on Resident 78 every 2 hours and would do it more often (did not specify how often) if the resident had the red start sign that resident is fall risk. During an interview on 2/12/2026 at 2:15 PM with the (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assistant Director of Nursing (ADON), ADON stated staff should be aware of their assigned residents' fall risks, history, and that fall prevention measures should be implemented to ensure everyone is aware of how to prevent another fall from occurring for the residents. ADON also stated, without staff implementing fall prevention measures and/or identifying the fall risk accurately for residents, there is no way to ensure the residents' safety. During a review of the facility's policy and procedure titled Falls and Fall Risk, Managing, updated 1/27/2025, the policy indicated:Staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling.The identification of residents at risk for falls will include:Yellow star located on the name plate outside of the Residents room, which identifies falls within the past 3 months.Red star located on the name plate outside of the Residents room, which identifies falls within the past 1 month.The staff will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one of 18 sampled residents (Resident 78) who was incontinent (loss of control) of bladder, was provided a bladder retraining and/or toileting program (helps manage incontinence [involuntary loss of urine or stool] by training the bladder to hold more urine and reducing the frequency of bathroom visits) in accordance with the resident care plan (a document that outlines the facility's plan to provide personalized care to a resident based on the resident's needs) and the facility's policy and procedure titled Bowel and Bladder Program. This deficient practice had potential to result in Resident 78's inability to regain control of bladder function, continued urinary incontinence, and development of urinary tract infection (UTI- an infection in any part of the urinary system, the kidneys, bladder or urethra), and/or another occurrence of fall. Findings: During a review of Resident 78's admission Record, the admission Record indicated Resident 78 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included wedge compression fracture (an injury of the spine where the front part of a vertebra [a small bone in the spine] collapses, creating a wedge-shaped bone) of first lumbar (lower part of the back) vertebra, spinal stenosis (a narrowing of the spaces within your spine), displaced fracture (a severe break where the bone snaps into two or more pieces and moves out of its normal alignment, creating a gap between the fragments) of the left ulna (a long bone in the forearm) and hepatomegaly (an abnormally enlarged liver). During a review of Resident 78's Minimum Data Set (MDS -resident assessment tool), dated 1/27/2026, the MDS indicated Resident 78 had severely impaired cognitive skills (ability to understand and make decisions) for daily decision making. The MDS indicated Resident 78 was dependent (helper does all of the effort) with toileting, shower/bathing self, dressing, walking and transfers, partial/moderate assistance (helper does less than half the effort) with eating, oral and personal hygiene. During a review of Resident 78's SBAR (situation, background, assessment, recommendation- a communication tool used by healthcare workers when there is a change of condition among the residents) / Change of Condition (COC), dated 1/31/2026, the SBAR/COC indicated Resident 78 had an unwitnessed fall after attempting to go to the bathroom. The SBAR/COC also indicated Resident 78 was incontinent (inability to control) with bladder and bowel. During a review of Resident 78's Actual Fall Related to Actual Fall Occurred on 1/31/2026 care plan, dated 2/2/2026, the care plan indicated the initiation of bladder training program for two (2) weeks then transition resident to scheduled toileting using bedside commode as tolerated. During an interview on 2/12/2026 at 9:41 AM with Resident 78, Resident 78 stated she wears A diaper and urinates inside of there, instead of going to the restroom. During an interview on 2/12/2026 at 10:10 AM with Licensed Vocational Nurse 5 (LVN 5), LVN 5 stated according to Resident 78's care plan for Actual Fall Related to Actual Fall Occurred on 1/31/2026, Resident 78 should currently be on a bladder training program, but LVN 5 has not implemented it for the resident because LVN 5 is not aware how to complete bladder training for Resident 78 because that is only done for residents with urinary catheters (a hollow tube inserted into the bladder to drain or collect urine), and Resident 78 does not currently have a catheter. During an interview on 2/12/2026 at 10:52 AM with Certified Nursing Assistant 6 (CNA 6), CNA 6 stated Resident 78 is incontinent, and incontinent briefs are currently being used for the resident. CNA 6 stated Resident 78 is not currently on a bladder training program. During an interview on 12/12/026 at 11:09 AM with the Minimum Data Set Coordinator (MDS 1), MDS 1 stated a bladder training program was initiated by MDS 1 for Resident 78 after the resident's fall on 1/31/2026 where the cause was related to Resident 78 trying to go to the restroom. MDS 1 stated, when a resident is on the bladder training program, certified nursing assistants (CNAs) are to check on the residents hourly to assess if the resident needs to use the restroom and document it in the resident's electronic medical records. MDS 1 stated this (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	intervention was necessary for Resident 78 so staff can assess when/ what time or the pattern the resident usually goes to the restroom and needs assistance, because Resident 78 is confused and may not be able to call the staff to ask for assistance. During a concurrent interview and record review on 2/12/2026 at 11:17 AM with LVN 5, Resident 78's paper and electronic medical charts, dated 2/5/2026 through 2/12/2026, were reviewed. The medical chart did not indicate any documentation of hourly or scheduled intervals of Resident 78 being offered toileting assistance, the initiation of a bladder training program or tolerance of a bladder training program. LVN 5 stated if the bladder training program was implemented, there would be documentation in the resident paper and electronic medical chart and there is none, so it was not done. LVN 5 stated it was important to implement the bladder training program for Resident 78 so staff can monitor when the resident need to use the restroom and to help prevent bladder infections and another occurrence of fall. During an interview on 2/12/2026 at 11:28 AM with the Medical Records Director (MRD), the MRD stated Resident 78 did not have any paper documentation regarding bowel and bladder training. During an interview on 2/12/2026 at 2:15 PM with the Assistant Director of Nursing (ADON), ADON stated per facility protocol, for bowel and bladder training program, the CNAs are to check the residents and offer to take the resident to the restroom hourly. ADON also stated it was important to ensure the bladder training program was implemented because it is the reason the resident fell previously and it will help prevent future falls. During a review of the facility's policy titled Bowel and Bladder Program, (undated), the policy indicated the purpose was to promote continence, dignity, skin integrity, and quality of life for residents. The policy also indicated the nursing staff and CNAs shall implement the program as outlined in the care plan, residents shall be offered toileting assistance at scheduled intervals and staff shall document bowel and bladder function, episodes of incontinence and response in the medical record and flow sheets as applicable.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to store the nebulizer (a small device that turns liquid medicine into a mist or fine spray) mask in a clean plastic bag when not in use for one (1) of 1 sampled resident (Resident 55) reviewed for respiratory care services, as indicated on the facility policy and procedure (P&P). This deficient practice had the potential to contaminate the nebulizer and place Resident 55 at risk for respiratory infection. Findings: During a review of Resident 55's admission Record, the admission Record indicated Resident 55 was admitted to the facility on [DATE] with diagnosis that included chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing). During a review of Resident 55's Minimum Data Set (MDS, a resident assessment tool), dated 11/17/2025, the MDS indicated Resident 55 had moderate impairment in cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 55 was dependent (helper does all the effort) with oral and personal, and toileting hygiene, shower, lower body dressing, and putting on/taking off footwear. The MDS further indicated Resident 55 required substantial/maximal assistance (helper does more than half the effort) with upper body dressing and required partial/moderate assistance (helper does less than half the effort) with eating. During a review of Resident 55's Order Summary Report, the Order Summary Report indicated an order for Albuterol Sulfate (a drug that relaxes and opens the airways, used to treat COPD) inhalation nebulization solution 1.25 milligrams (mg- metric unit of measurement, used for medication dosage and/or amount) per three (3) cubic centimeters (cc, unit of volume on liquids) to give 1 dose via nebulizer every four (4) hours as needed for shortness of breath (SOB, difficulty breathing)/wheezing (a high-pitched sound made when breathing is restricted/obstructed in the lungs). During a review of the medication administration records (MAR, a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), the MAR indicated Resident 55 was administered the Albuterol Sulfate Nebulization solution 1.25 mg per 3 cc on 2/1/2026, 2/4/2026, and 2/7/2026. During an observation in Resident 55's room on 2/9/2026 at 9:15 AM, Resident 55 was in bed sleeping. Resident 55's nebulizer mask was observed attached to an oxygen tubing connected to the nebulizer machine and placed inside the resident's bedside drawer. The nebulizer mask was not stored in a plastic bag. During an interview on 2/10/2026 at 2:14 PM, Licensed Vocational Nurse 6 (LVN 6) stated Resident 55 was receiving nebulizer treatment. LVN 6 also stated the resident's nebulizer mask should have been placed inside a labeled clean plastic bag to prevent contamination which could potentially cause respiratory infection. During an interview on 2/10/2026 at 2:46 PM, the Director of Nursing (DON) stated nebulizer masks should be placed in a clean plastic bag to prevent the mask from getting dirty and contaminated, which could prevent Resident 55 from getting respiratory infection. During a review of the facility's P&P titled, Nebulizer Treatment, dated 6/2025, the P&P indicated that the facility ensures the safe administration of nebulizer treatments while minimizing infection risk and ensuring optimal respiratory outcomes for the residents. The P&P indicated that the equipment shall be stored clean, dry, and labeled for resident specific use.		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to manage the pain timely and effectively for one of two sampled residents (Resident 4) reviewed for pain by not administering Cyclobenzaprine (is a medication used to treat muscle spasms) on 1/13/2026 and 1/20/2026 as indicated on the physician's order and facility policy. This deficient practice had the potential for unmanaged pain in Resident 4's left thigh which could negatively affect the resident's overall well-being and quality of life. Findings: During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was admitted to the facility on [DATE] and re-admitted on [DATE]. The admission record indicated Resident 4's diagnoses included chronic respiratory failure (a condition in which the blood does not have enough oxygen or has too much carbon dioxide) with hypoxia (low levels of oxygen in the body tissues), open reduction and internal fixation (ORIF, is surgery to repair broken bones) of the left hip fracture (a partial or complete break in the bone), gout (a painful form of arthritis), and osteoarthritis (a type of arthritis that happens when cartilage in the joints wears down) of the knee. During a review of Resident 4's Minimum Data Set (MDS, a resident assessment tool), dated 12/11/2025, the MDS indicated Resident 4 had severely impaired cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 4 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) in toileting hygiene, shower/ bathe self, chair/ bed-to-chair transfer, toilet transfer, tub/ shower transfer, walk 10, 50 and 150 feet. During a review of Resident 4's Physician's Orders (PO) dated 12/15/2025, the PO indicated Cyclobenzaprine Hydrochloride (HCl) tablet 5 milligrams (mg, units of measurement) Give 1 tablet by mouth two times a day for left thigh spasm/pain. During a concurrent record review and interview on 2/12/2026 at 4:34 PM with MDS Coordinator (MDS 1), Resident 4's Medication Administration Record (MAR, a report detailing the drugs administered to a resident by a healthcare professional at a treatment facility) for the month of January 2026 was reviewed. The MAR indicated Cyclobenzaprine was not administered to Resident 4 on the following dates: 1. On 1/13/2026 at 9 AM - HO (MAR Follow up codes indicating On Hold by Physician) 2. On 1/20/2026 at 9 AM - HO 3. On 1/20/2026 at 5 PM - HOMDS 1 stated Resident 4 did not receive Cyclobenzaprine since it was on hold by physician as indicated on the MAR. During a concurrent interview and record review on 2/11/2026 at 4:47 PM with MDS Coordinator (MDS 1), Resident 4's PO, dated 12/15/2025, was reviewed. The PO indicated Cyclobenzaprine HCl oral tablet 5 mg (Cyclobenzaprine HCl) Give 1 tablet by mouth two times a day for left thigh spasm/pain. MDS 1 stated there was no order to hold the medication (Cyclobenzaprine) on 1/13/2026 and 1/20/2026. MDS 1 stated we need to call the doctor if there was no available pain medication to ensure Resident 4 receives an alternative pain medication. During a review of Resident 4's Nurses' Progress Notes (NPN), dated 1/13/2026 and 1/20/2026, the NPN indicated the following: 1. On 1/13/2026 at 8:46 AM - No medication was on hand, reached out to pharmacy. 2. On 1/20/2026 at 8:48 AM - Waiting for pharmacy to deliver. 3. On 1/20/2026 at 5:19 PM - awaiting delivery, 2nd request done today. MDS 1 stated there was no documentation about the medication being given or what other interventions were provided to Resident 4 to address resident's left thigh pain/spasms. During a concurrent interview and review on 2/11/2026 at 4:57 PM with ADON, Resident 4's current Care Plans (CP) were reviewed. There was no care plan formulated for Resident 4's left thigh pain/spasm. MDS 1 stated Resident 4 did not and should have had a CP developed to address resident's left thigh pain/spasm. During an interview on 2/12/2026 at 12:08 PM with Licensed Vocational Nurse 5 (LVN 5), LVN 5 stated she was not able to administer Resident 4's pain medication (Cyclobenzaprine) last month (January) of 2026 because it was unavailable. LVN 5 stated she called the Pharmacy, and the medication was later delivered the day. LVN 5 stated she should have called and informed the doctor to avoid delay in caring for Resident 4. During an interview on 2/12/2026 at 2:59 PM with Resident 4, Resident 4 stated (continued on next page)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	he always has pain rated 7/10 in his left thigh. Resident 4 stated that the staff did not inform him that he had missed a dose of his pain medication.During review of the facility's Policies & Procedures (P&P) titled, Pain Management dated 6/2025, The P&P indicated, the facility is committed to assessing, treating, and reassessing pain using a comprehensive, interdisciplinary approach. Pain management interventions shall include pharmacologic and non-pharmacologic strategies, individualized to resident needs, and monitored for effectiveness and adverse effects.During a review of the facility's P&P titled, Administering Medications, dated 9/2025, the P&P indicated medications are administered in a safe manner, as prescribed.During review of the facility's P&P titled, Administering Medications dated on 9/2025, the P&P indicated, if a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication will chart time medication was administered,		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to monitor the fluid intake for one (1) of 1 sampled resident (Resident 92) reviewed for dialysis in accordance with the care plan and facility policy. This deficient practice had the potential to place the resident at risk for fluid overload (a condition where the body has too much fluid) or dehydration (condition that occurs when the loss of body fluids, mostly water, exceeds the amount that is taken in). Findings: During a review of Resident 92's admission Record, the admission Record indicated Resident 92 was admitted to the facility on [DATE] with diagnoses that included end stage renal disease (ESRD, irreversible kidney failure) and dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed). During a review of the Resident 92's Physician's Order, dated 2/4/2026 at 10:29 PM, the Physician's Order indicated 1500 cc/day fluid restriction broken down to Breakfast = 500 cc, Lunch = 500 cc, and Dinner = 500 cc. During a review of Resident 92's Care Plan initiated on 2/5/2026, the Care Plan indicated a focus on Resident 92's fluid restriction which included a breakdown of Breakfast = 500 cc, Lunch = 500 cc, and Dinner = 500 cc and an approach plan to monitor fluid intake and output (I&O, the measurement of all fluids entering and leaving a residents body over 24 hours). During an observation on 2/9/2026 at 9:41 AM, Resident 92 was awake and lying in bed. A pitcher that was half full of water (approximately 500 cc) was observed on Resident 92's bedside table. During a review of Resident 92's Minimum Data Set (MDS, a resident assessment tool), dated 2/10/2026, the MDS indicated Resident 92 had moderate impairment in cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 92 was dependent (helper does all the effort) with toileting, shower, lower body dressing, and putting on/taking off footwear. The MDS further indicated Resident 92 required substantial/maximal assistance (helper does more than half the effort) with upper body dressing and required partial/moderate assistance (helper does less than half the effort) with oral hygiene. The MDS also indicated Resident 92 required setup assistance (helper sets up; resident completes activity) with eating. During an interview on 2/10/2026 at 2:26 PM, Certified Nursing Assistant 5 (CNA 5) stated she had placed a full pitcher of water in Resident 92's room. CNA 5 stated she should not have provided Resident 92 with a full pitcher of water since the resident should not be drinking a lot of water. CNA 5 further stated she does not check or measure how much water Resident 92 drinks from the water pitcher. During a concurrent interview and record review on 2/10/2026 at 3:30 PM with MDS Coordinator (MDS 1), Resident 92's medical records were reviewed. MDS 1 stated Resident 92 was on 1500 cc fluid restriction according to the physician's order but there was no documentation of fluid intake monitoring in the MAR. MDS 1 added that there was no amounts of fluid intake documented by the CNAs on the task section of the resident's medical record since 2/5/2026. MDS 1 stated it was important to monitor and document Resident 92's fluid intake to ensure the physician's order for fluid restriction was followed to prevent the resident from developing fluid overload. During an interview on 2/10/2026 at 3:52 PM, the Assistant Director of Nursing (ADON) stated Resident 92's fluid intake should have been documented in the resident's MAR every shift to verify how much fluid the resident had taken. ADON also stated Resident 92 fluid intake should be monitored because the resident could either get too much fluid and develop fluid overload or not enough fluids which could get the resident dehydrated (losing too much water). During an interview on 2/11/2026 at 5 PM, the Director of Nursing (DON) stated the CNA should have asked Licensed Nursing staff if the resident was allowed fluids or not and should not keep water at bedside for residents on fluid restrictions to prevent going over the restricted amount. During a review of the facility's Policy and Procedure (P&P) titled, I&O Monitoring, dated 5/2025, the P&P indicated its purpose was to ensure early identification and prevention of dehydration, fluid overload, electrolyte imbalance, renal compromise, and other conditions requiring fluid balance management. The P&P also (continued on next page)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated that the I&O monitoring shall be initiated when clinically indicated, including but not limited to kidney disease. The P&P further indicated that I&O shall be performed only with a valid physicians' order or care plan direction, documentation shall be accurate and timely, and I&O data shall be reviewed each shift. During a review of the facility's P&P titled, Fluid Restriction, dated 6/2025, the P&P indicated to safely implement and monitor physician ordered fluid restrictions to maintain resident hydration, prevent fluid overload or dehydration. The P&P also indicated its purpose was to establish clear standards for the initiation, monitoring, documentation, and evaluation of fluid restriction orders to support resident safety and quality of care.		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on interview and record review, the facility failed to ensure appropriate competencies and skills sets to provide nursing and related services were completed for one (1) of four (4) sampled employees in accordance with the facility assessment when Licensed Vocational Nurse 3 (LVN3) did not have a medication administration competency completed upon hire. This deficient practice has the potential to cause improper medication administration causing medication errors which could result in resident harm. Findings:During a review of LVN 3's Application of Employment, dated 2/28/2025, the application indicated LVN 3 was hired on 3/10/2025.During a concurrent interview and record review on 2/12/2026 at 3:13 PM with ADON, the Employee Competency Folder for LVN 3 was reviewed. There was no documentation that the new hire competency pre-checklist skills form was completed for LVN 3. The ADON stated LVN 3 was hired on 3/10/2025 and the competency folder should have the competency pre- checklist form during the start of LVN 3's floor orientation. The ADON stated they should have kept all the competency documents in LVN 3's competency folder. The ADON stated if there was no record, it means it was not done.During an interview on 2/12/2026 at 3:19 PM with ADON, ADON stated LVN 3 did not have the opportunity to be followed by the facility's pharmacy consultant to be evaluated for the medication pass/administration because LVN 3 was sick on the days that he was supposed to be evaluated. The ADON stated that LVN 3 needs to complete the medication pass competency. During a concurrent interview and record review on 2/12/2026 at 4:35 PM with ADON, LVN3's Orientation Competency Checklist was reviewed. The ADON stated the basic medication administration was not and should have been included in the skills checklist to be able to ensure and verify that LVN 3 had done the medication administration competency.During a review of facility assessment tool dated 9/25/2024, and updated on 10/5/2025, the facility assessment tool indicated in,Part 2: Services and Care We Offer Based on our Residents' Needs, General Care: Medications, Awareness of any limitations of administering medications Administration of medications that residents need by route: oral, nasal, buccal, sublingual, topical, subcutaneous, rectal, intravenous (peripheral or central lines), intramuscular, inhaled (nebulizer, metered dose inhaler), vaginal, ophthalmic, etc.Staff training/education and competencies3.6 Describe the staff training/education and competencies that are necessary to provide the level and types of support and care needed for your resident population. Include staff certification requirements as applicable. Potential data sources include hiring, education, training, competency instruction, and testing policies.It may be helpful to review specific references in the regulation regarding the facility assessment (see Attachment 1).Review current regulations and list all staff training and competencies needed by type of staff, including managers, nursing, and other direct care staff, as well as individuals providing services under a contractual arrangement and volunteers. Consider if it would be helpful to indicate which competencies are reviewed at the time the staff member is hired, and cadence of subsequent reviews.Consider the following competencies (this is not an inclusive list): Medication administration -injectable, oral, subcutaneous, topical, intravenous, ophthalmic .		

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to promptly provide dental services for one (1) of 1 sampled resident (Resident 3) reviewed for dental care as indicated in the facility's policy and procedure. This deficient practice had the potential to result in Resident 3's inability to effectively chew food, weight loss, discomfort, and develop infection in the oral cavity. Findings: During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was admitted to the facility on [DATE] and re-admitted on [DATE]. The admission record indicated Resident 3's diagnoses included spinal stenosis (happens when the space inside the backbone is too small) lumbar (lower back bone) region, peripheral vascular disease (reduced circulation of blood to arms or legs due to a narrowed or blocked blood vessel), and diabetes mellitus (DM, is a metabolic disease, involving inappropriately elevated blood glucose levels) During a review of Resident 3's Minimum Data Set (MDS, a resident assessment tool), dated 11/26/2025, the MDS indicated Resident 3 had intact cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 3 needed partial/ moderate assistance (helper does less than half the effort, helper lifts, holds, or supports trunk or limbs but provides less than half the effort) in lower body dressing, personal hygiene, roll left and right, sit to lying, lying-to-sitting on the side of the bed, sit-to stand, and chair/ bed-to-chair transfer, toilet transfer, tub/ shower transfer and walk 10 feet. During a review of Resident 3's Physician's Orders (PO), dated 7/8/2025, the PO indicated Resident 3 may have dental consultations and treatment as indicated. During an observation and interview on 2/9/2026 at 8:38AM inside Resident 3's room, Resident 3 was observed awake and was lying in bed. Resident 3 stated the dentist came in to see him last year and took pictures but did not come back. Resident 3 told the dentist that he has broken teeth buried in his upper gums and food was getting stuck inside when he eats. Resident 3 stated it hurts him sometimes. Resident 3 was observed to have 2 to 3 teeth in the upper part and 6 to 8 teeth in lower part of his mouth. During a concurrent interview and record review on 2/10/2026 at 2:32 PM with Director of Social Services (DSS), the Dental Notes (DN) dated 10/22/2025 was reviewed. The DN indicated, tooth 8 X-rays (uses invisible electromagnetic energy beams to produce images of internal tissues, bones, and organs on film or digital media). DSS stated that Dentist also came to the facility on 11/2025 and 1/2026 but did not check Resident 3. DSS also stated she did not have documentation regarding the dental visits for Resident 3 on 10/22/2025. DSS stated she only documents when there were special procedures and referrals done for the residents. DSS stated the DN had incomplete documentation because it was missing the information about Resident 3's teeth concerns. During a concurrent interview and record review on 2/10/2026 at 2:39 PM with DSS, the Nurses' Progress Notes (NPN) dated 9/3/2025 to 11/2/2025 were reviewed. The NPN did not indicate any dental visits for Resident 3. DSS stated we should document dental visits because the notes will explain everything that had happened during the Resident's dental visit and we can follow up if there were concerns. During a concurrent interview and record review on 2/10/2026 at 2:39 PM with DSS, the Social Services Notes (SSN) dated 9/3/2025 to 11/2/2025 were reviewed. SSD Notes did not have a documentation regarding dental visits for Resident 3. DSS stated since there was no documentation regarding Resident 3's dental visits, the facility may not be able to do a follow up dental appointment because it is not known if there were concerns, especially since the dental report provided to the facility was incomplete. SSD stated the facility should have documented and assisted a dental follow-up visit for Resident 3 to avoid infection when food gets inside his teeth. During review of the facility's policy and procedure (P&P) titled, Availability of Services, Dental updated on 1/1/2026, the P&P indicated, Oral healthcare and dental services will be provided to each resident. 3. Social Service will be responsible for making necessary dental appointments. 4. All requests for routine and emergency dental services should be directed to social services to assure that (continued on next page)		

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	appointments can be made in a timely manner.5.Inquiries concerning the availability of dental services should be referred to social services or to the director of nursing.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to maintain accurate medical records for one of 18 sampled residents (Resident 2) in accordance with the facility's Policy and Procedure (P&P). This deficient practice had the potential to result in miscommunication, improper delivery of wound management and inaccurate information of the care provided, which could result in skin breakdown to Resident 2. Findings: During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), and depression (mood disorder that causes a persistent feeling of sadness and loss of interest in life). During a review of Resident 2's Order Summary Report, the Order Summary Report indicated Resident 2 may have a low air loss mattress (LALM, designed to distribute the resident's body weight over a broad surface area and help prevent skin breakdown) everyday/shift for wound management, ordered 1/9/2026. During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool), dated 1/14/2026, the MDS indicated Resident 2 had severely impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 2 needed partial/moderate assistance (helper does less than half the effort) for eating, oral and personal hygiene, and dependent (helper does all the effort) with toileting, self-showering/bathing and lower body dressing. The MDS also indicated Resident 2 had two (2) stage one pressure ulcers (intact skin that is discolored and does not turn white [blanch] when pressed) and one stage 3 pressure ulcer with treatments of a pressure reducing device for bed and pressure ulcer/injury care. During an observation on 2/10/2026 at 8:18 AM at Resident 2's bedside, Resident 2 was observed lying in bed with a low air loss pump at the foot of the bed, powered off. During a concurrent observation and interview on 2/10/2026 at 12:30 PM with Licensed Vocational Nurse 3 (LVN 3) at Resident 2's bedside, Resident 2's bed was observed without a LALM. A low air loss pump that was powered off was observed at the foot of Resident 2's bed. LVN 3 stated the current mattress on Resident 2's bed was a regular mattress, not a LALM and the last time he saw Resident 3 with a LALM on her bed was on 2/7/2026. LVN 3 stated per the MD order, Resident 2 should have a LALM and all nurses should be checking to make sure it is on and working. During a concurrent interview and record review on 2/10/2026 at 1:57 PM with the Treatment Nurse 2 (TN 2), Resident 2's Treatment Administration Record (TAR), dated 2/1/2026 through 2/28/2026, the TAR indicated a LALM was provided on 2/10/2026 to Resident 2. TN 2 stated she documented on the TAR that Resident 2 had a LALM but Resident 2 did not have a LALM so the documentation was not accurate. TN 2 stated it was important to document accurately so staff know what care or services were provided to the resident. TN 2 stated without accurate documentation, Resident 2 may not receive the LALM which could negatively affect how her wound progressed. During a review of the facility's policy titled, Skilled Nursing Facility Policy: Clinical Documentation and Charting (including TAR Charting - California, dated 1/1/2025, the policy indicated the facility maintains complete, accurate, timely, legible and authenticated health records for each resident and all documentation reflects assessments, orders, interventions, resident response and outcomes. The policy also indicated TAR documentation to be done after completing the treatment; never pre-chart.		

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement their protocol for Antibiotic Stewardship (the ongoing effort by a provider and clinical caregivers to optimize and minimize the use of antimicrobial medicines) for one (1) of two sampled residents (Resident 72), after being prescribed an antibiotic (drug used to prevent and treat bacterial infections) without meeting the criteria for cellulitis (bacterial skin infection that may appear as a red, swollen area, feeling hot and tender to the touch), soft tissue or wound infection. This deficient practice had the potential for Resident 72 to develop antibiotic resistance (when bacteria change so antibiotic medicines cannot kill them or stop their growth) from unnecessary or inappropriate antibiotic use. Findings: During a review of Resident 72's admission Record, the admission Record indicated Resident 72 was originally admitted to the facility on [DATE] with diagnoses that included fusion of the spine (a surgical procedure that permanently connects two or more vertebrae [a small bone in the spine] in the spine), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), and difficulty in walking. During a review of Resident 72's Minimum Data Set (MDS - a resident assessment tool), dated 11/18/2025, the MDS indicated Resident 72 with intact cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 72 was set up or clean-up assistance (helper sets up or cleans up; resident completes activity) with eating and oral hygiene and supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with toileting and personal hygiene and showering/bathing self. During a review of Resident 72's Weekly Non-Pressure Skin Condition Record, dated 12/4/2025, the Weekly Non-Pressure Skin Condition Record indicated Resident 72 had a non-pressure chronic ulcer (open wound) on the resident's right hip that was progressing positively with less drainage noted and a weekly debridement (a medical procedure to remove dead, damaged, or infected tissue from a wound to promote healing and prevent infection) was being completed and tolerated without complications. During a concurrent interview and record review on 2/11/2026 at 2:43 PM with the Infection Preventionist Nurse (IPN), Resident 72's Surveillance Data (ongoing, systematic collection, analysis, and interpretation of health-related information-such as infection rates, symptom tracking, and resident outcomes-to monitor trends, detect outbreaks early, and guide public health actions) Collection Form, dated 12/4/2025 was reviewed. The Surveillance Data Collection Form indicated Resident 72 met one criteria of the required four (at minimum) for the use of antibiotic for cellulitis, soft tissue or wound infection. The form did not have documented evidence that a wound culture (laboratory test that identifies bacteria, fungi, or viruses causing an infection in a wound) was collected and that the doctor was notified that criteria were not met for antibiotic use. The Surveillance Data Collection Form also indicated a treatment of Bactrim DS (a double-strength antibiotic used to treat bacterial infections) to start on 12/5/2025 for 10 days for delayed wound healing. IPN stated Resident 72 did not meet the criteria to qualify for the need of the Bactrim DS because only 1 of four (4) criteria were met and that IPN should have notified the doctor to inform but the doctor that Resident 72 did not meet the criteria for antibiotic use. During a continued concurrent interview and record review on 2/11/2026 around 2:50 PM with the IPN, Resident 72's Medication Administration Record (MAR), dated 12/1/2025 through 12/31/2025 was reviewed. The MAR indicated Resident 72 was administered Bactrim DS 1 tablet oral twice a day from 12/5/2025 to 12/15/2025. IPN stated Resident 72 completed the antibiotic treatment for 10 days. During a continued interview on 2/11/2026 around 3:00 PM, IPN stated per the facility protocol, McGreer criteria (standardized surveillance definitions used in long-term care facilities to consistently identify infections based on clinical signs, symptoms, and laboratory results) was used during antibiotic surveillance to ensure the antibiotics ordered are necessary, and when the criteria is not met, the (continued on next page)		

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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 02/12/2026
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)		
F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	doctor should be notified. IPN also stated it was important to follow the McGreer criteria and notify the doctor to prevent residents from having Multidrug-Resistant Organisms (MDROs- microorganisms [primarily bacteria] that have developed resistance to many antibiotics) and to ensure residents do not become antibiotic resistant, making any future infection harder to treat. During an interview on 2/12/2026 at 2:15 PM with the Assistant Director of Nursing (ADON), ADON stated it was important to ensure antibiotic stewardship is completed to ensure residents receiving antibiotics are necessary treatments, to prevent unnecessary medications usage and to prevent residents from experiencing unnecessary side effects from the antibiotics like diarrhea (frequent or uncontrollable bowel movements that may be soft, loose, or watery) and antibiotic resistance that could lead to other infections. During a review of the facility's policy titled Antibiotic Stewardship- Staff and Clinician Training and Roles, (undated), the policy indicated the Infection Preventionist will monitor individual resident antibiotic regimens, including reviewing clinical documentation supporting antibiotic orders and that staff will be educated about the facility's antibiotic stewardship program including appropriate prescribing, monitoring, and surveillance of antibiotic use and outcomes. During a review of the facility's policy titled Policy on Unnecessary Medications, dated 7/2025, the policy indicated:The policy purpose to prevent the use of unnecessary medications, including psychotropic drugs, antibiotics, and other medications without adequate clinical indication, and to ensure appropriate monitoring and gradual dose reduction when required.All medications shall be prescribed, administered, monitored, and reviewed in accordance with California law, federal Centers for Medicare & Medicaid Services (CMS) regulations, and accepted clinical standards to promote resident safety, quality of life, and optimal outcomes. Antibiotics shall be prescribed only when clinically indicated, diagnostic criteria and culture results shall support use when applicable and antibiotic use shall be monitored as part of the facility's stewardship program.The policy applied to all licensed nurses, physicians, nurse practitioners, physician assistants, consultant pharmacists, and all staff involved in medication administration, monitoring, and documentation.		

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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 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure 10 of 36 rooms (17, 42, 42, 44, 51, 52, 53, 54, 62, and 63) met the requirement of 80 square feet (sq. ft.) for each resident in multiple resident rooms. This deficient practice had the potential to affect the residents' personal space, decrease freedom of mobility and could compromise the provision of care. Findings: During observation of the facility and Resident's rooms from 2/9/2026 to 2/12/2026, Rooms 17, 42, 43, 44, 51, 52, 53, 54, 62, and 63 did not meet the minimum requirement of 80 sq. ft. per resident in multiple residents' rooms. During an interview on 02/11/2026, at 4:22 PM, with Resident 38, Resident 38 stated he was comfortable in his room. Resident 38 stated he had space for his belongings and his wheelchair. Resident 38 stated staff were able to move around his bed when they provided care. During a review of the facility's Client Accommodations Analysis form, dated 2/10/2026, the facility's Client Accommodations Analysis indicated the facility had several rooms that measured less than the required 80 sq. ft. per resident in multiple bedrooms. The following resident bedrooms were: room [ROOM NUMBER] (2 beds) and measured 153.28 sq. ft., to equal 76.64 sq. ft. per Resident room [ROOM NUMBER] (4 beds) and measured 319.88 sq. ft., to equal 79.97 sq. ft. per resident room [ROOM NUMBER] (4 beds) and measured 312.47 sq. ft., to equal 78.11 sq. ft. per resident room [ROOM NUMBER] (4 beds) and measured 313.99 sq. ft., to equal 78.5 sq. ft. per resident room [ROOM NUMBER] (4 beds) and measured 316.25 sq. ft., to equal 79.06 sq. ft. per resident room [ROOM NUMBER] (4 beds) and measured 311.46 sq. ft., to equal 77.86 sq. ft. per resident room [ROOM NUMBER] (4 beds) and measured 311.12 sq. ft., to equal 77.78 sq. ft. per resident room [ROOM NUMBER] (4 beds) and measured 319.88 sq. ft., to equal 79.97 sq. ft. per resident room [ROOM NUMBER] (4 beds) and measured 311.28 sq. ft., to equal 77.82 sq. ft. per resident room [ROOM NUMBER] (4 beds) and measured 314.65 sq. ft., to equal 78.66 sq. ft. per resident. During an observation from 2/9/2026 to 2/12/2026, of the facility and residents' room, the residents residing in the rooms (Rooms 17, 42, 43, 44, 51, 52, 53, 54, and 63) with an application for variance were observed to have enough space to move freely inside the rooms. Each Resident inside the affected rooms had beds and side tables with drawers. There was an adequate room for the operation and use of wheelchairs, walkers, or canes. The room variance did not affect the care and services provided to the residents when nursing staff were observed providing care to these residents. The Department is recommending approval of the room waiver request for 10 of 36 rooms (Rooms 17, 42, 43, 44, 51, 52, 53, 54, 62, and 63).		