

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055541	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/10/2025
NAME OF PROVIDER OR SUPPLIER  Royal Terrace Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE  1340 Highland Ave. Duarte, CA 91010	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689  Level of Harm - 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.  (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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview and record review, the facility failed to ensure one of two sampled residents (Resident 1), received interventions for the risk of elopement (a resident leaves the premises or a safe area without the facility's knowledge) when Resident 1 expressed to RN 1 that Resident 1 wanted to leave the facility. This failure resulted in Resident 1 leaving the facility unsupervised on 9/7/2025 and had the potential for Resident 1 to be injured. Findings:During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted Resident 1 on 5/21/2025 with diagnoses including cirrhosis of liver (chronic liver damage), chronic congestive heart failure (a condition in which the heart cannot pump enough blood to all parts of the body), and hepatic encephalopathy (brain disease that alters brain function or structure). During a review of Resident 1's History and Physical (H&amp;P), dated 5/23/2025, the H&amp;P indicated Resident 1 had the capacity to understand and make own medical decisions. During a review of Resident 1's Progress Notes (PN), dated 9/9/2025, The PN indicated that RN 1 documented the following on 9/7/2025 at 10:20 AM: Activity staff was looking for resident (Resident 1), resident (Resident 1) was not in his room, staff immediately started looking for resident (Resident 1) every where in side and outside the facility, resident was no where to be found, drove around the community looking for him. Per staff resident (Resident 1) was last seen around 9:45am. Around 7:20 am resident (Resident 1) verbalized wanting to leave the facility . Resident (Resident 1) was asked where are you going? Resident (Resident 1) unable to provide us with an address stated going to a friend house. During a telephone interview on 9/9/2025, at 1:33 PM with RN 1, RN 1 stated RN 1 was the supervisor on 9/7/2025 when Resident 1 left the facility. RN 1 stated Resident 1 came to the nurses' station around 9:00 AM on 9/7/2025 and told RN 1 that Resident 1 wanted to leave the facility and go home. RN 1 stated RN 1 explained to Resident 1 the risks of leaving against medical advice (AMA) and RN 1 did notify Resident 1's doctor that Resident 1 wanted to leave. RN 1 stated that at 10:20 AM, the facility discovered Resident 1 was missing from the facility. RN 1 stated Resident 1 did not notify anyone that he was leaving the facility. During a concurrent interview and record review on 9/9/2025 at 3:16 PM with the Director of Nursing (DON), Resident 1's Wander/Elopement Risk Evaluation (EE), dated 5/21/2025 was reviewed. The EE indicated, the EE would be completed by a member of the interdisciplinary team (IDT, a group of health care professionals with various areas of expertise who work together toward the goals of the resident) upon admission, quarterly and with a significant change. The EE indicated that one of the questions used to determine if Resident 1was at risk for eloping was, Verbalization of leaving the facility? This question was checked no. The EE indicated Resident 1 was not an elopement risk on 5/21/2025. The DON stated if Resident 1 verbalized he wanted to leave the facility at any point, Resident 1 would be considered an elopement risk. The DON stated if Resident 1 said Resident 1 wanted to leave the facility, then facility staff (in general) should fill out another EE. The DON stated RN 1 did not complete an EE on 9/7/2025, after Resident 1 told RN 1 that Resident 1 wanted to leave the facility and go home. The DON stated Resident 1 would be considered an elopement risk after expressing Resident 1 wanted to leave the facility. The DON stated the facility staff (in general) should monitor Resident 1 closely and make sure Resident 1 was not packing his belongings to leave the facility. During a review of the facility's policy and procedure (P&amp;P) titled, Elopement &amp; Wandering, undated, the P&amp;P indicated, A Wander/Elopement assessment will be completed on all residents upon admission to the facility. The elopement risk is assessed quarterly or as needed with change of condition.</p>		