STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055541	A. Building B. Wing	10/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Royal Terrace Healthcare	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 - Some	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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the environment remained as free of accident hazards possible and residents received adequate supervision for two of three sampled residents (Residents 2 and 3) when:a. Resident 2's bed sensor pad alarm (an assistive electronic device that makes alerts/sounds to warn caregivers when the resident tries to get up from the bed) did not sound when Resident 2 got up from Resident 2's bed unassisted by staff and walked to the bathroom.b. The facility's licensed nursing staff (in general) failed to conduct a fall risk assessment (an evaluation to determine a resident's likelihood of falling) or inaccurately assessed Resident 3 as low risk for fall following Resident 3's falls on 5/31/2025, 8/4/2025, and 10/4/2025. c. The facility's Interdisciplinary Team (IDT, a group of health care professionals who work together toward the goals of the resident) failed to conduct a comprehensive root cause analysis (systematic process to identify the underlying reasons a fall occurred, which can then be used to prevent future incidents) of Resident 3's falls on 5/31/2025, 8/4/2025, and 10/4/2025 and update Resident 3's care plan interventions to prevent Resident 3 from falling again.These failures had the potential for Resident 2 to sustain injury and/or harm due to falling while in care of the facility. In addition, these violations resulted in Resident 3 falling on 5/31/2025, 8/4/2025, and 10/4/2025 and sustained lacerations (a pattern of injury in which skin and underlying tissues are cut or torn) to the head on 5/31/2025 and 8/4/2025. Findings: a. During a review of Resident 2's admission Record (AR), the AR indicated the facility admitted Resident 2 on 4/4/2025 with diagnoses including transient cerebral ischemic attack (TIA, a temporary interruption of blood flow to the brain), dysphagia (difficulty swallowing foods or liquids), and dementia (a group of thinking and social symptoms that interferes with daily functioning). During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool) dated 10/12/2025, the MDS indicated Resident 1 had moderately impaired cognition (ability to make daily decisions). The MDS indicated Resident 1 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity; assistance may be provided throughout the activity or intermediately) from staff for toileting, personal hygiene, and dressing. The MDS indicated Resident 2 required supervision or touching assistance from staff for walking. During a review of Resident 2's Order Summary Report (OSR) dated 10/27/2025, the OSR indicated a physician order dated 9/15/2025 for nursing staff to apply bed sensor pad alarm to Resident 2 every shift for safety due to history of falls and to monitor placement every shift. During an observation on 10/27/2025 at 11:22 AM, in Resident 2's room, Resident 2 got up from Resident 2's bed and walked alone while using a front wheel walker (FWW, a device used to assist individuals with balance and mobility problems). Resident 2 walked to the restroom on the other side of the room from Resident 2's bed. Staff (in general) did not come to Resident 2's room. The sensor alarm for Resident 2 did not sound. Resident 2 shut the bathroom door behind her. During a follow-up interview on 10/27/2025 at 11:41 AM with Resident 2, Resident 2 stated Resident 2 had fallen multiple times at the facility. Resident 2 stated Resident 2 gets dizzy due to chemotherapy (a drug-based medical treatment that uses powerful chemicals to kill or slow the growth of cancer cells). Resident 2 stated Resident 2 was not supposed to walk by herself to the bathroom. Resident 2 stated Resident 2 had walked by herself earlier (when surveyor observed) without assistance from staff (in general) because staff did not always come right away when Resident 2 needed to use the toilet. b. During a review of Resident 3's AR, the AR indicated the facility admitted Resident 3 on 1/22/2025 and readmitted on [DATE] with diagnoses including encounter for surgical aftercare following surgery on the digestive system, metabolic encephalopathy (brain disease that alters brain function or structure), and seizures (a sudden, uncontrolled electrical disturbance in the brain). During a review of Resident 3's MDS dated [DATE], the MDS indicated Resident 3 was severely impaired in cognitive skills. The MDS indicated Resident 3 required supervision or touching assistance from staff for personal hygiene, bathing and dressing. The MDS indicated Resident 3 required supervision or touching assistance from staff for walking. During a review of Resident 3's General Acute Care Hospital 1 (GACH 1) Emergency Trauma Documentation (ETD) dated 5/31/2025, the ETD indicated Resident 3 presented to GACH 1 Emergency department (ED) on 5/31/2025 with chief complaint of a fall. The ETD indicated Resident 3 hit Resident 3's head when Resident 3 fell in the facility. The ETD indicated Resident 3 had a 3-centimeter (cm-unit of measurement) scalp laceration. The ETD indicated the physician repaired Resident 3's laceration with three staples (specialized staples that are used instead of sutures to mend skin wounds)