

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055818	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/08/2026
NAME OF PROVIDER OR SUPPLIER  Royal Gardens Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE  2339 W. Valley Blvd. Alhambra, CA 91803	

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)
<p>F 0691</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to provide necessary care and treatment for one (1) of two (2) sampled residents (Resident 1) with urostomy (a surgical procedure creating a permanent opening on the abdomen to divert urine out of the body), in accordance with the facility's urostomy and self-catheterization policy by failing to: Obtain physician order for self-catheterization (a safe, routine procedure used four to six times daily to drain urine from the bladder using a flexible tube). Assess and monitor Resident 1's capability to perform self-catheterization. Maintain a daily record of Resident 1's daily fluid intake and output per Facility's Policy and Procedures (P&amp;P). Inspect the condition of the skin around the stoma for any irritation or breakdown. Document Resident 1's time and frequency of catheterization. This deficient practice had the potential to result in complications of urostomy such as peristomal skin irritation (caused by leakage resulting in sore, red or inflamed skin), urinary tract infection, stoma leaks and long-term risk such as metabolic acidosis (too much acid in the blood). Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was initially admitted to the facility on [DATE], with diagnosis which included retention of urine, paraplegia (loss of movement and/or sensation, to some degree, of the legs), and lack of coordination. During a review of Resident 1's Admit/Readmit Data Collection and Baseline record dated 3/24/2026, the record indicated under skin condition assessment that Resident 1 has an opening on right lower abdomen for bladder movement, uses straight catheter for voiding. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 3/30/2026, the MDS indicated Resident 1's cognitive skills (processes of thinking and reasoning) for daily decision making was independent (decisions consistent/reasonable). The MDS indicated Resident 1 required setup or clean-up assistance (helper sets up or cleans up) with eating. 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) with oral hygiene. The MDS indicated Resident 1 required partial/moderate assistance (helper less than half the effort) with putting on/talking off footwear. Resident 1 was dependent on toileting hygiene, shower, upper and lower body dressing. The MDS also indicated Resident 1 has an appliance for ostomy (a surgically created opening, or stoma, on the abdomen that redirects bodily waste [stool or urine]) and was always incontinent for urinary continence. During a review of Resident 1's Order Summary Report, dated 4/7/2026, the Order Summary Report indicated a physician's order, dated 3/30/2026 to cleanse right lower abdomen urostomy site with normal saline, pat dry and leave open to air. During a concurrent observation in Resident 1's room and interview on 4/7/2026 at 10:30 AM, Resident 1 was observed lying in bed. Resident 1 stated that she takes care of her urostomy. Resident 1 refused to show her right lower quadrant stoma and stated does self-catheterization but did not provide details. Resident 1 stated that she would request some of the supplies like gauze from the staff, but she has her personal supplies for the most part. During an interview on 4/7/2026 at 1:18 PM with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated Resident 1 does self-catheterization. LVN 1 stated he never assisted or observed Resident 1 care for her urostomy. LVN 1 stated he was not aware of Resident (continued on next page)</p>

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 0691</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1's skin condition around the stoma. During a concurrent record review and interview on 4/7/2026 at 2:54 PM with Registered Nurse (RN 1), Resident 1's medical records were reviewed. RN 1 stated that Resident 1 did not have a urostomy care order since admission date of 3/24/2026 to 3/30/2026. RN 1 stated Resident 1's urostomy care was not done from 3/24/2026 to 3/30/2026. RN 1 stated Resident 1's does self-catheterization but was nt aware how often does Resident 1 performs it. RN 1 stated that there were no physician's orders, assessments and documented evidence that Resident 1 can safely do self-catheterization. RN 1 stated there were no records to indicate how many times Resident 1 does self-catheterization in a day. RN 1 also stated there were no records to indicate that Resident 1's urine output and its characteristics were assessed. RN 1 stated Resident 1's care plan for urostomy was only developed on 4/5/2026. RN 1 stated Resident 1's admission baseline care plan did not indicate how to care for Resident 1's urostomy. RN 1 stated there was no documented evidence that Resident 1's intake and output were monitored. During a concurrent record review and interview on 4/7/2026 at 3:25 PM with Infection Prevention Nurse (IPN), Resident 1 medical records were reviewed. IPN stated Resident 1 was not and should have been evaluated if she is able to perform self-catheterization. IPN stated knowing Resident 1s' capability and understanding of urostomy care upon admission was important to ensure that Resident 1 understands the procedure, and it could have been done by Resident 1's demonstration and verbal explanation of urostomy care. IPN verified that Resident 1 did not have an order for self-catheterization, and no care plan was developed as well. IPN stated it was important to have an order for urostomy care upon Resident 1's admission to the facility for all staff to safely provide the care needed. During a record review of the facility's undated Policy and Procedures (P&amp;P) titled Urostomy/Ureterostomy Care, the P&amp;P indicated that these procedures are to promote cleanliness and to protect peristomal skin from irritation, breakdown, and infection. It also indicated the following general guidelines:Determine if the resident is on intake or output before discarding urine.Check urine for unusual appearance and record findings.Maintain a daily record of residents' daily fluid intake and output, as indicated.Inspect the condition of the skin around the stoma for any irritation or breakdown. If present, notify the supervisor and physician immediately.A resident with established stoma may prefer to change their own ostomy pouch. Check the plan of care and follow the resident's stated preference. During a record review of the facility's undated P&amp;P titled Self-Catheterization, the P&amp;P indicated residents who are assessed and deemed capable may perform self-catheterization in accordance with physician orders. Nursing staff will provide education, supervision (as needed), and ongoing monitoring to ensure safety and compliance with infection control standards. The P&amp;P indicated to verify physician order for self-catheterization and document competency prior to initiation. The P&amp;P also indicated to document the following:Resident competencyFrequency and toleranceAny complicationsResident competencyFrequency and tolerance</p>		