POC Reviewed and Accepted

HFEN #43185, 3/30/22

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/17/2022 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:		A BUILDING			(XS) DATE SURVEY COMPLETED	
	055105 B. WING					28/2022		
NAME OF PROVIDER OR SUPPLIER ROYAL VISTA CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 809 W. SANTA ANITA AVE SAN GABRIEL, CA 91776					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ix	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	CH CORRECTIVE ACTION SHOULD BE S-REFERENCED TO THE APPROPRIATE		
F 761 SS=D	complaint Investigation standard survey. Complaint Number: C. Representing the Dep Evaluator Nurse #431. The inspection was lin complaint investigated the findings of a full in Two deficiencies were number CA00769749. Label/Store Drugs and CFR(s): 483.45(g)(h)(\$483.45(g) Labeling of Drugs and biologicals tabeled in accordance professional principles appropriate accessory instructions, and the eapplicable. \$483.45(h) Storage of \$483.45(h)(1) In accordance professional principles appropriate accessory instructions, and the eapplicable. \$483.45(h)(1) In accordance professional principles appropriate accessory instructions, and the eapplicable.	the findings of the tof Public Health for a noduring an abbreviated A00769749 artment: Health Facilities 85 nited to the specific of and does not represent spection of the facility. I written for complaint of Biologicals 1)(2) If Drugs and Biologicals used in the facility must be with currently accepted and cautionary expiration date when I Drugs and Biologicals of the facility must be with currently accepted and cautionary expiration date when		761	This Plan of Correction constitution written allegation of compliance for deficiencies cited. Submission of this of Correction is not an admission of This Plan of Correction is submit meet requirements established by Staffederal Law. Infection Prevention & Control: Corrective action(s) for those resident have been affected by the practice: 1. On January 21, 2022, Lie Vocational Nurse 1 (LVN 1) immediated took out the mediation from the bed Resident 1 after it was noted.	or the s Plan guilt. The sensed diately side of The sed by to all s were 2022. S, will sultants		
					<u> </u>			

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 80 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.

Administrator

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES TATEMENT OF DEPOSITORS

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(C2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
055105		B. WING		C		
NAME OF PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	01/28/2022	
				09 W. SANTA ANITA AVE		
ROYAL VI	STA CARE CENTER		s	an Gabriel, CA 91776		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 761	Continued From page 1		F 761			
	storage of controlled of the Comprehensive E Control Act of 1976 at abuse, except when the package drug distribution of the readily detected. This REQUIREMENT by: Based on observation review, the facility fall one of one sampled in facility's policy. This deficient practice in tampering of Residents.	drugs listed in Schedule II of brug Abuse Prevention and and other drugs subject to the facility uses single unit tion systems in which the simal and a missing dose can is not met as evidenced in, interview, and record ed to store medication for esident (Resident 1) per in the potential to result ent 1's medication and other consuming unattended		medication administration practices of licensed nurses to ensure that the compolicies and procedures are being followed for at least one month. During A Rounds, Department Managers will enthat medications are not left at bed Results of the monitoring will forwarded to the Quality Assurance.	nitor f the pany wed ngel sure side. be	
	Findings:					
	indicated the resident (loss of memory, lang other thinking abilities interfere with daily life (persistent feelings of interest), psychosis (characterized by a dishypertensive chronic pressure caused by the vessels that carry blo ischemic attack (TIA, symptoms similar to the cerebral infarction (of to part of the brain is	sconnection from reality), kidney disease (high blood he narrowing of blood od to the kidneys), transient				
		was asleep in bed and				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPFLIER/CLIA IDENTIFICATION NUMBER:		OC) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		05610 5	B. WING			C 01/28/2022		
NAME OF PROVIDER OR SUPPLIER				s	TREET ADDRESS, CITY, STATE, ZIP CODE	U1/2	28/2022	
ROYAL VISTA CARE CENTER					09 W. SANTA ANITA AVE AN GABRIEL, CA 91776			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			×		(EACH CORRECTIVE ACTION SHOULD BE ROSS-REFERENCED TO THE APPROPRIATE		
F 761	Continued From page	2	F	761				
		n a medication cup, and 1 on Resident 1's bedside						
	11:00 am, Resident 1	ith Resident 1 on 1/20/22 at stated he did not know on his bedside table were				•		
	with Licensed Vocation 1/20/22 at 11:10 am, know that Resident 1 LVN 1 stated it was not be leave medications at the policy indicated for until the resident swatchat staff should waite medications to Residence (packaging in well as the policy indicated and pack (packaging in well as the packaging in well as the packagin	observation and interview onal Nurse 1 (LVN 1) on LVN 1 stated she did not did not take his medication. ot the facility's policy to the bedside. LVN 1 stated or staff to observe and wait allowed his medications and ed. LVN 1 compared the ent 1's medication blister hich medications were riboard backing and clear er the counter medication. e 3 tablets were Amlodipine					·	
	besylate (high blood tablet, Metropolol Su- medication) Extender Plavix (blood thinner, stroke, and heart atta	e 3 tables were Armodiphie pressure medication) 10 mg ccinate (high blood pressure d Release 25 mg tablet, medication to prevent ck) 75 mg tablet, and Fish a triglyceride) 1000 mg						
	stated that Resident medication, did not h self-administer, and o self-administer asses	on 1/20/22 at 11:29 am, he 1 did not self-administer ave an order to did not have a medication asment.						
İ	A review of Resident	1's Physician Orders,			<u> </u>		1	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

F 781 Continued From page 3 indicated the resident had medication orders for Amlodipine Besylate 10 mg tablet daily for hypertension, Metropoid Succinate Extended-Release tablet daily for hypertension, Plavix 75 mg tablet daily for hepertension, and Fish Oil 1000 mg capsule daily for high triglyceride. A review of the facility's policy, titled "Storage of Medications," dated April 2017, indicated that the facility shall store all drugs in a safe and secure manner. F 880 SS=E F 781 F 7	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A BUILDING			COMPLETED	
ROYAL VISTA CARE GENTER SUMMARY STATEMENT OF DEPICIENCIES SAN GABRIEL, CA 91776 PREPIX CACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 781 Continued From page 3 Indicated the resident had medication orders for Amiodipine Besylate 10 mg tablet daily for hypertension, Metropotol Succinate Extended-Release tablet daily for hypertension, Plavix 75 mg tablet daily for hypertension, Plavix 75 mg tablet daily for hypertension, Plavix 75 mg tablet daily for hypertension, and Fish Oil 1000 mg capsule daily for high triglyceride. A review of the facility's policy, titled "Storage of Medications," dated April 2017, indicated that the facility shall store all drugs in a safe and secure manner. Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) \$483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases are infections.			055105	B. WING			_	
FREFX TAG (EACH DEFICIENCY WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 781 Continued From page 3 indicated the resident had medication orders for Amiodipine Besylate 10 mg tablet delily for hypertension, Metropotot Succinate Extended-Release tablet delily for hypertension, Plavix 75 mg tablet delily for hypertension, Metropotot Succinate Extended-Release tablet delily for hypertension, Plavix 76 mg tablet delily for high trighyceride. A review of the facility's policy, titled "Storage of Medications," dated April 2017, indicated that the facility shall store all drugs in a safe and secure manner. F 880 SS=E F 880 SS=E F 880 SS=E F 880 SS=E F 880 SS=E F 880 CFR(s): 483.80(a)(1)(2)(4)(e)(f) This Plan of Correction constitutes a written allegation of compliance for the deficiencies cited. Submission of this Plan of Correction is not an admission of guilt. This Plan of Correction is submitted to meet requirements established by State and Federal Law.					90	9 W. SANTA ANITA AVE		
indicated the resident had medication orders for Amiodipine Besylate 10 mg tablet delily for hypertension, Metropolol Succinate Extended-Release tablet delily for hypertension, Plavix 75 mg tablet delily for deep vein thrombosis prophylads (blood clot prevention), and Fish Oil 1000 mg capsule delily for high triglyceride. A review of the facility's policy, titled "Storage of Medications," dated April 2017, indicated that the facility shall store all drugs in a safe and secure manner. F 880 Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) \$483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			ĸ	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION DATE
§483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; Infection Prevention & Control: Corrective action(s) for those residents that have been affected by the practice: 1. On January 21, 2022, the Infection Preventionist Nurse (IPN) started N-95 fit testing for all current staff who are not up to date with their tests. The facility developed N-95 Respirator Testing Policy and Procedure in accordance with Department of Public Health and Cal-OSHA guidelines. 2. No residents were affected by the deficient practice:	F 880	indicated the resident Amlodipine Besylate hypertension, Metropi Extended-Release tal Plavix 75 mg tablet di prophylaxis (blood cid 1000 mg capsule dail) A review of the facility Medications, "dated A facility shall store all dimanner. Infection Prevention & CFR(s): 483.80(a)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)	thad medication orders for 10 mg tablet daily for clot Succinate of the taily for hypertension, aily for deep vein thrombosis at prevention), and Fish Oil y for high triglyceride. It's policy, titled "Storage of the pril 2017, indicated that the irugs in a safe and secure it control (2)(4)(e)(f) Introl blish and maintain an and control program a safe, sanitary and tent and to help prevent the hismission of communicable ins. Interpretation and control blish an infection prevention (IPCP) that must include, at wing elements: In for preventing, identifying, and controlling infections is eases for all residents, ors, and other individuals der a contractual upon the facility assessment to §483.70(e) and following			written allegation of compliance for deficiencies cited. Submission of this of Correction is not an admission of This Plan of Correction is submittee meet requirements established by State Federal Law. Infection Prevention & Control: Corrective action(s) for those residents have been affected by the practice: 1. On January 21, 2022, the Inferpreventionist Nurse (IPN) started N-9 testing for all current staff who are not to date with their tests. The fact developed N-95 Respirator Testing Poand Procedure in accordance Department of Public Health and OSHA guidelines.	the Plan guilt. d to and that that the tup cility olicy with Cal-	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIE/CLIA IDENTIFICATION NUMBER:	A. BUILDI			COMPLETED C		
		055105	B. WING			1	: :8/2022	
NAME OF PROVIDER OR SUPPLIER ROYAL VISTA CARE CENTER				90	treet address, city. State, zip code 09 w. Santa anita ave An Gabriel, ca 91776			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION)			×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ON SHOULD BE HEAPPROPRIATE		
F 880	§483.80(a)(2) Written procedures for the procedure of surveil possible communicable communicable disease reported; (iii) When and to whore communicable disease reported; (iii) Standard and trant to be followed to prev (iv) When and how is cresident; including but (A) The type and durate depending upon the involved, and (B) A requirement that least restrictive possic circumstances. (v) The circumstance must prohibit employed is contact with residents contact will transmit to (vi) The hand hygiene by staff involved in displaying the procedure of the corrective actions take \$483.80(a) (b) Linens. Personnel must hand	standards, policies, and ogram, which must include, lance designed to identify ble diseases or can spread to other in possible incidents of se or infections should be esmission-based precautions ent spread of infections; lation should be used for a truct limited to: atton of the isolation, infectious agent or organism at the isolation should be the ble for the resident under the sunder which the facility ses with a communicable on their food, if direct the disease; and a procedures to be followed rect resident contact. Sem for recording incidents acility's IPCP and the ten by the facility. Ille, store, process, and it to prevent the spread of	F	880	3. A fit testing log will be maintaine updated by the IPN indicating the dathe most recent N-95 fit testing of all to ensure that all current staff are tupon hire and annually thereafter. monthly basis, the IPN will refer to the to identify staff who are due for fit test. 4. The Administrator and/or Direct Nursing (DON) will randomly checkfit testing log to ensure complicate Results of the monitoring will forwarded to the Quality Assurant Performance Improvement (Committee for further review. Completion date: March 14, 2022.	tes of staff ested On a se log ting. or of k the ance. be		

		ID HUMAN SERVICES				FORM	0: 03/17/2022 MAPPROVED	
STATEMENT C	F DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	O(2) MUI	TIPL	LE CONSTRUCTION	OMB NO), 0938-0391 SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILD	A. BUILDING			LETED	
		055105	B. WNG			C 01/28/2022		
NAME OF PROVIDER OR SUPPLIER				Т	STREET ADDRESS, CITY, STATE, ZIP CODE	017.	ZW SV SK	
BOWN MOTE AS DE APRITED					909 W. SANTA ANITA AVE			
ROYAL VISTA CARE CENTER					SAN GABRIEL, CA 91776			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(XS) COMPLETION DATE	
F 880	•	o 5 ct an annual review of its r program, as necessary.	F	880	0			
		is not met as evidenced						
	Based on interview a	nd record review, the facility						
		terventions to prevent and						
	-	COVID-19 (Coronavirus, a ess caused by a virus and			1 .			
		person) in accordance with						
		idelines, and California						
	Division of Occupation		1					
	•	to ensure 64 of 79 staff conducted to verify that a						
		fortable and provides the	1					
	•	cted protection) initially and						
		irators (protective device						
	designed to achieve a very efficient filtration	a very close facial fit and						
	very enicient muauon	of all bottle particles).						
	This deficient practice COVID-19 to resident	had the potential to spread s, staff, and visitors.						
	Findings:							
		ith the facility's Administrator	}]	
		5:08 pm, the facility did not						
	have a N95 fit testing	policy in place.						
	During a concurrent is	nterview and record review						
		ventionist Nurse (IPN) on						
	1/20/22 at 7:13 pm, th	ne IPN stated that of the 79	1		}]	
		s, 59 staff were fit tested in						
		e missed and not fit tested			1			
		N was not aware that N95 fit e annually because the	1		[
		policy in place. The IPN						
	stated fit testing is Im	portant to ensure proper fit			1]	
	and reduce risk of CC	VID-19 transmission in the			1			

facility.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	QC) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
		055106	B. WING				28/2022 28/2022
NAME OF PROVIDER OR SUPPLIER ROYAL VISTA CARE CENTER				8	TREET ADDRESS, CITY. STATE, ZIP CODE 09 W. SANTA ANITA AVE AN GABRIEL, CA 91776		
(X4) (D PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DERCIENCY)		(KS) COMPLETION DATE
F 880	guideline, titled "Guid Managing COVID-19 updated on 1/2/22, in respiratory fit testing in Cal-OSHA. Retrieved http://publicheatth.lac healthfacilities/snf/pre A review of the facility Notification Letter from Health, dated 1/18/22 annual N95 respirators staff per Cal/OSHA. A review of the Cal-OCode of Regulations, Protection, updated 7 workplace where respirators are require employer shall establine respiratory program we procedures. The employers in the program the following procedures for select workplace, fit testing employees in the program of the p	Department of Public Health elines for Preventing and in Skilled Nursing Facilities," dicated annual N95 s required for all staff per from cunty.gov/acd/nccrona2019/vention/ 's COVID-19 Outbreak in local Department of Public indicated that initial and y fit testing is required for all SHA's Title 8, California Section 5144, Respiratory /14/21, indicated that in any pirators are necessary to the employee or whenever ed by the employer, the ish and implement a written with worksite specific cloyer shall include in the provisions, as applicable: ing respirators for use in the procedures, and training of per use of respirators and removing. Retrieved from	F	880			