

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

PRINTED: 03/17/2022
FORM APPROVED
OMB 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 C 01/28/2022
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 761	<p>Continued From page 1</p> <p>storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and record review, the facility failed to store medication for one of one sampled resident (Resident 1) per facility's policy.</p> <p>This deficient practice had the potential to result in tampering of Resident 1's medication and other residents taking and consuming unattended medication.</p> <p>Findings:</p> <p>A review of Resident 1's Admission Record, indicated the resident had a history of dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), major depressive disorder (persistent feelings of sadness and loss of interest), psychosis (a mental disorder characterized by a disconnection from reality), hypertensive chronic kidney disease (high blood pressure caused by the narrowing of blood vessels that carry blood to the kidneys), transient ischemic attack (TIA, temporary period of symptoms similar to those of a stroke) and cerebral infarction (occurs when the blood supply to part of the brain is interrupted or reduced).</p> <p>During an observation of Resident 1 on 1/20/22 at 10:57 am, Resident 1 was asleep in bed and</p>	F 761	<p>4. The Director of Nursing (DON) or designee will randomly monitor medication administration practices of the licensed nurses to ensure that the company policies and procedures are being followed for at least one month. During Angel Rounds, Department Managers will ensure that medications are not left at bedside. Results of the monitoring will be forwarded to the Quality Assurance & Performance Improvement (QAPI) Committee for further review.</p> <p>Completion date: April 29, 2022.</p>		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056105	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/28/2022
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 761	<p>Continued From page 2</p> <p>there were 3 tablets in a medication cup, and 1 capsule on a napkin on Resident 1's bedside table.</p> <p>During an interview with Resident 1 on 1/20/22 at 11:00 am, Resident 1 stated he did not know what the medications on his bedside table were for.</p> <p>During a concurrent observation and interview with Licensed Vocational Nurse 1 (LVN 1) on 1/20/22 at 11:10 am, LVN 1 stated she did not know that Resident 1 did not take his medication. LVN 1 stated it was not the facility's policy to leave medications at the bedside. LVN 1 stated the policy indicated for staff to observe and wait until the resident swallowed his medications and that staff should waited. LVN 1 compared the medications to Resident 1's medication blister pack (packaging in which medications were sealed between a cardboard backing and clear plastic cover) and over the counter medication. LVN 1 verified that the 3 tablets were Amlodipine besylate (high blood pressure medication) 10 mg tablet, Metoprolol Succinate (high blood pressure medication) Extended Release 25 mg tablet, Plavix (blood thinner, medication to prevent stroke, and heart attack) 75 mg tablet, and Fish Oil (used to treat high triglyceride) 1000 mg capsule.</p> <p>During an interview with the facility's MDS Coordinator (MDSC) on 1/20/22 at 11:29 am, he stated that Resident 1 did not self-administer medication, did not have an order to self-administer, and did not have a medication self-administer assessment.</p> <p>A review of Resident 1's Physician Orders,</p>	F 761			

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

PRINTED: 03/17/2022
FORM APPROVED
OMB 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 C 01/28/2022
NAME OF PROVIDER OR SUPPLIER ROYAL VISTA CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 909 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 761	Continued From page 3 indicated the resident had medication orders for Amlodipine Besylate 10 mg tablet daily for hypertension, Metoprolol Succinate Extended-Release tablet daily for hypertension, Plavix 75 mg tablet daily for deep vein thrombosis prophylaxis (blood clot prevention), 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 761			
F 880 SS=E	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. §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;	F 880	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. 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.		

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

PRINTED: 03/17/2022
FORM APPROVED
OMB 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 C 01/28/2022
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 880	<p>Continued From page 4</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review.</p>	F 880	<p>3. A fit testing log will be maintained and updated by the IPN indicating the dates of the most recent N-95 fit testing of all staff to ensure that all current staff are tested upon hire and annually thereafter. On a monthly basis, the IPN will refer to the log to identify staff who are due for fit testing.</p> <p>4. The Administrator and/or Director of Nursing (DON) will randomly check the fit testing log to ensure compliance. Results of the monitoring will be forwarded to the Quality Assurance & Performance Improvement (QAPI) Committee for further review.</p> <p>Completion date: March 14, 2022.</p>		

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

PRINTED: 03/17/2022
FORM APPROVED
OMB 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 C 01/28/2022
NAME OF PROVIDER OR SUPPLIER ROYAL VISTA CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 909 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 880	<p>Continued From page 5</p> <p>The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to implement interventions to prevent and control the spread of COVID-19 (Coronavirus, a severe respiratory illness caused by a virus and spread from person to person) in accordance with local Public Health guidelines, and California Division of Occupational Safety and Health (Cal-OSHA), by failing to ensure 64 of 79 staff were fit tested (a test conducted to verify that a respirator is both comfortable and provides the wearer with the expected protection) initially and annually for N95 respirators (protective device designed to achieve a very close facial fit and very efficient filtration of airborne particles).</p> <p>This deficient practice had the potential to spread COVID-19 to residents, staff, and visitors.</p> <p>Findings:</p> <p>During an interview with the facility's Administrator (ADM) on 1/20/22 at 5:08 pm, the facility did not have a N95 fit testing policy in place.</p> <p>During a concurrent interview and record review with the Infection Preventionist Nurse (IPN) on 1/20/22 at 7:13 pm, the IPN stated that of the 79 current staff members, 59 staff were fit tested in 2020, and 5 staff were missed and not fit tested by the facility. The IPN was not aware that N95 fit testing should be done annually because the facility did not have a policy in place. The IPN stated fit testing is important to ensure proper fit and reduce risk of COVID-19 transmission in the facility.</p>	F 880			

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

PRINTED: 03/17/2022
FORM APPROVED
OMB 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 C 01/28/2022
NAME OF PROVIDER OR SUPPLIER ROYAL VISTA CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 909 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 880	Continued From page 6 A review of the local Department of Public Health guideline, titled "Guidelines for Preventing and Managing COVID-19 in Skilled Nursing Facilities," updated on 1/2/22, indicated annual N95 respiratory fit testing is required for all staff per Cal-OSHA. Retrieved from http://publichealth.lacounty.gov/acd/ncorona2019/healthfacilities/snf/prevention/ A review of the facility's COVID-19 Outbreak Notification Letter from local Department of Public Health, dated 1/18/22, indicated that initial and annual N95 respiratory fit testing is required for all staff per Cal/OSHA. A review of the Cal-OSHA's Title 8, California Code of Regulations, Section 5144, Respiratory Protection, updated 7/14/21, indicated that in any workplace where respirators are necessary to protect the health of the employee or whenever respirators are required by the employer, the employer shall establish and implement a written respiratory program with worksite specific procedures. The employer shall include in the program the following provisions, as applicable: procedures for selecting respirators for use in the workplace, fit testing procedures, and training of employees in the proper use of respirators including putting on and removing. Retrieved from https://www.dir.ca.gov/title8/5144.html .	F 880			