| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055818 | A. Building<br>B. Wing | 08/21/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Royal Gardens Healthcare | 2339 W. Valley Blvd.<br>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) |
|---|---|
| F 0627<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge.<br><br>(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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| F 0627<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the discharge needs for one (1) of two (2) sampled residents (Resident 1) were identified by failing to ensure an oxygen concentrator (a medical device that concentrates environmental air and delivers it in the form of supplemental oxygen), portable oxygen, and nebulizer (a device for breathing mist treatment) were provided and ready for use upon resident's discharge to a Recuperative Care Center (a short-term residential care for residents who no longer require hospitalization but still need to heal from an injury or illness). This deficient practice had the potential to result in an unsafe discharge for Resident 1 due to lack of an oxygen concentrator until 8/11/2025 (four days after discharge) and not receiving respiratory treatment due to the absence of a nebulizer from 8/7/2025 to 8/20/2025, which could lead to Resident 1 suffering from respiratory complications and hospitalization. Findings: During a record review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] with the diagnoses including but not limited to acute respiratory failure (an inability to maintain adequate oxygenation for tissues or adequate removal of carbon dioxide from tissues) with hypoxia (lack of oxygen in the tissues to sustain bodily function), dependence on supplemental oxygen, and chronic obstructive pulmonary disease (COPD, disease that causes obstructed airflow from the lungs) with acute exacerbation (sudden worsening of symptoms of the disease). During a record review of Resident 1's Care Plan, dated 6/24/2025, the care plan indicated Resident 1 had oxygen therapy related to diagnosis of COPD, hypoxic respiratory failure, and hypertensive (high blood pressure) heart disease. The staff interventions were to ensure oxygen was delivered via nasal prongs (plastic tubes inserted into the nostrils to provide a measured increased supply of oxygen) at 2 liters (L, unit of volume)/minute continuously. During a record review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 7/1/2025, the MDS indicated the resident's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making were intact. The MDS indicated Resident 1 required setup or clean-up assistance (helper sets up or cleans up; resident completes activity) for eating, oral hygiene, rolling, left and right, and sitting to lying. The MDS also indicated Resident 1 received oxygen therapy. During a record review of Resident 1's Physician Order Summary Report, the Physician Order Summary indicated as follows:- On 6/24/2025, oxygen at 2 liters via nasal cannula (NC, device used to deliver supplemental oxygen placed directly on a resident's nostrils) continuous. - On 6/25/2025, Budesonide Suspension (a drug that reduces inflammation in the lungs which helps to keep the airways open and improve airflow) 0.5 milligrams (mg, unit of measurement/2 milliliters (ml, unit of volume): 1 dose inhale orally every 12 hours for COPD. - On 8/7/2025, the report indicated discharge to Recuperative Care with current medications, home health for Registered Nurse (RN) medication management, and durable medical equipment (DME, refers to medical devices prescribed by healthcare providers for long-term or everyday use in the home) portable oxygen tank as needed. During a record review of Resident 1's Care Plan, dated 8/7/2025, the Care Plan indicated Resident 1 wished to discharge to a lower level of care. The staff interventions were to make arrangements with the required community resources to support independence post-discharge. During a record review of Resident 1's Nursing Note, dated 8/7/2025, the note indicated Resident 1 was discharged with a portable oxygen tank. During an interview on 8/20/2025 at 11:08 AM with Recuperative Care Clinical Director (RCCD), RCCD stated Resident 1 did not have all the appropriate DME when Resident 1 was discharged from the facility and admitted to Recuperative Care on 8/7/2025. RCCD stated Resident 1 should come to Recuperative Care with all DME needed upon arriving at Recuperative Care. RCCD stated Resident 1 needed and did not have an oxygen concentrator, oxygen tank, and nebulizer upon admission to Recuperative Care. RCCD stated Resident 1 was sent to Recuperative Care with an almost empty oxygen tank. RCCD stated the facility did not provide a safe discharge for Resident 1. RCCD stated Resident 1 was discharged to Recuperative Care on 8/7/2025 and the DME was delivered on 8/11/2025 (four days after being discharged ). RCCD stated Resident 1 had also still not received her nebulizer equipment for nebulizer treatment since being admitted to Recuperative Care (13 days). During an interview on 8/20/2025 at 11:24 AM with Resident 1, Resident 1 stated Resident 1 was not provided with a nebulizer when she was discharged from the facility. Resident 1 stated she had not received her breathing treatment twice a day through a nebulizer since 8/6/2025. Resident 1 stated she was only given a half full portable oxygen tank and was rushed to be discharged from the facility on 8/7/2025 |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain complete medical records for two (2) of 2 sampled residents (Residents 1 and 2) in accordance with the facility's policy. This deficient practice had the potential for Residents 1 and 2 not to receive the discharge information necessary for the residents' continuity of care in the community.Findings: 1. During a record review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] with the diagnoses including but not limited to acute respiratory failure (an inability to maintain adequate oxygenation for tissues or adequate removal of carbon dioxide from tissues) with hypoxia (lack of oxygen in the tissues to sustain bodily function), acute ischemic heart disease (heart damage caused by narrowed heart arteries), and chronic obstructive pulmonary disease (COPD, disease that causes obstructed airflow from the lungs) with acute exacerbation (sudden worsening of symptoms of the disease). During a record review of Resident 1's Physician Order Summary Report, dated 8/7/2025, the report indicated discharge to Recuperative Care (a short-term residential care for residents who no longer require hospitalization but still need to heal from an injury or illness) with current medications, home health (medical services and skilled care provided in a resident's home to help recover from an illness or injury, manage chronic conditions, or age in place) for Registered Nurse (RN) medication management. During a record review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 7/1/2025, the MDS indicated the resident's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making were intact. The MDS indicated Resident 1 required setup or clean-up assistance (helper sets up or cleans up; resident completes activity) for eating, oral hygiene, rolling, left and right, and sitting to lying. During a record review of Resident 1's Care Plan, dated 8/7/2025, the Care Plan indicated Resident 1 wished to discharge to a lower level of care. The staff interventions were to encourage the resident to discuss feelings and concerns with impending discharge; monitor for and address episodes of anxiety, fear, and distress; and evaluate the resident's motivation to return to the community. During a record review of Resident 1's Notice of Transfer/Discharge form, dated 8/7/2025, the bottom left corner of form indicated for the resident's signature. There was no signature signed by Resident 1 on the form when Resident 1 was discharged . The Notice of Transfer/Discharge form indicated the discharge location, reason for transfer or discharge, and the right to appeal the transfer or discharge. 2. During a record review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE] with the diagnoses including but not limited to traumatic subdural hemorrhage (collection of blood that occurs between the outer layer of the brain and the inner layers) without loss of consciousness, non-ST elevation myocardial infarction (NSTEMI, a type of heart attack that occurs when the heart muscle does not receive enough oxygen, leading to damage), and type 2 diabetes mellitus (a disease that occurs when there is a problem in the way the body regulates and uses sugar as fuel). During a record review of Resident 2's MDS, dated [DATE], the MDS indicated the resident's cognitive skills for daily decision making were moderately impaired. The MDS indicated Resident 2 required substantial/maximal assistance (helper does more than half the effort) for toileting hygiene, shower/bathing, lower body dressing, rolling left and right, and sitting to lying. During a record review of Resident 2's Physician Order Summary Report, dated 8/7/2025, the report indicated the last covered day of skilled services on 8/8/2025 and discharge home on 8/9/2025. During a record review of Resident 2's Notice of Transfer/Discharge form, dated 8/9/2025, the bottom left corner of form indicated for the resident's signature. There was no signature signed by Resident 2 on the form when Resident 2 was discharged . During a concurrent interview and record review on 8/18/2025 at 3:30 PM with the Director of Nursing (DON) of Resident 1's Notice of Transfer/Discharge, the DON stated staff usually signed the form, but Registered Nurse 1 (RN 1) forgot to have the resident sign the form. The DON stated the Notice of Transfer/Discharge was the only document residents signed when they were discharged . During an interview on 8/18/2025 at 4:50 PM with RN 2, RN 2 stated the Notice of Transfer/Discharge was signed by RN 1 and this meant that the resident was notified about the details of the Notice of Transfer/Discharge and information such as the discharge location, their belongings, and medications. RN 2 stated the Notice of Transfer/Discharge should be signed by the resident or responsible party.During a concurrent record review of Resident 1 and Resident 2's Notice of Transfer/Discharge forms and interview with the DON on 8/18/2025 at 5:03 PM, the DON stated both forms did not have the residents' signatures. The DON stated the forms should be signed by the |