STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055818	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Royal Gardens Healthcare	2339 W. Valley Blvd. Alhambra, CA 91803

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow the process of investigation and report of grievance (a complaint, either oral or written, expressing dissatisfaction with service delivery or the quality of care furnished, regardless of whether remedial action is requested) for one (1) of 15 sampled residents (Resident 8) as indicated in the facility's policy and procedure by failing to document steps taken during the investigation of grievance, summarize pertinent findings or conclusion and document the date the grievance investigation result (decision) was confirmed This deficient practice had the potential to result in miscommunication and inaccurate information of the investigations which did not meet the documentation requirements for Resident 8's grievance.Findings:During a review of Resident 8's admission Record, the admission Record indicated Resident 8 was admitted to the facility on [DATE] and re-admitted on [DATE], Resident 8's diagnoses included chronic kidney disease (CKD, is a condition in which the kidneys are damaged and cannot filter blood as well as they should), anxiety disorder (a disorder characterized by nervousness characterized by a state of excessive uneasiness and apprehension, typically with compulsive behavior [repetitive, persistent, and often uncontrollable actions that a person feels driven to perform] or panic attacks), and chronic obstructive pulmonary disease (COPD, is a chronic inflammatory lung disease that causes obstructed airflow from the lungs) During a review of Resident 8's Minimum Data Set (MDS, a resident assessment tool), dated [DATE], the MDS indicated Resident 8 had intact cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 8 needed substantial/ maximal assistance (helper does more than half the effort. helper lifts, holds trunk or limbs, and provides more than half the effort) in toileting hygiene, shower/bathe self, lower body dressing, putting on/ taking off footwear, lying to sitting on the side of the bed, and tub/shower transfer. During an interview on [DATE] at 3:31 PM with Social Services Director (SSD), the Complaint and Grievance Report (CGR) Form dated [DATE] was reviewed. The CGR Form indicated, during the evening shift (3PM-11PM) care on [DATE] by the unknown Certified Nurse Assistant (CNA), the Unknown CNA pulled sheet from under Resident 8 and threw the sheet on the floor during care. SSD stated, she received the grievance report late morning on [DATE]. SSD stated the incident happened on Sunday during the evening shift, the CNA removed the sheet underneath Resident 8, and the CNA threw it on floor. Resident 8 cannot recall the name of the CNA during the SSD interview and SSD endorsed the report to the Director of Staff Development (DSD). During a concurrent interview and record review on [DATE] at 1:59 PM with SSD, the facility's Complaint and Grievance Report (CGR) Form dated [DATE] was reviewed. There was information missing on the CGR Form:Steps taken to investigate grievanceSummary of pertinent findings or conclusionDate grievance decision was confirmedSSD stated the DSD or nursing department will be the one responsible for the follow-up and ensure the steps taken to investigate the grievance were documented (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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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	in the CGR. The SSD stated the investigation should have been done by the nursing DSD responsible for a follow-up investigation and the space for the steps taken to investigate grievance including the summary of pertinent findings was left blank which means it was not done. The CGR Form should have included the in-service topic discussed with CNA 3 and it should include a summary of investigation. SSD also stated she did not review the summary and investigation, she should have reviewed and followed up the investigation and completed the CGR Form with the missing information. SSD stated SSD should have completed and explained to Resident 8 the steps that have been taken to investigate the grievance filed. During an interview on [DATE] at 2:06 PM with SSD, SSD stated after conducting thorough investigation on [DATE] of the Grievance report, it was found that it was not CNA 3 who was the staff involved with Resident 8's grievance, it was CNA 2. The investigation and in service was inaccurate for the grievance report for the incident. During a concurrent interview and record review on [DATE] at 2:08 PM with the SSD, the facility's policy and procedure a (P&P) titled, Grievances/ Complaints, Recording and Investigating revised 5/2023, the P&P indicated, upon receiving a grievance and complaint report, the Social Services Director or designee will begin an exploration into the allegations/concerns. SSD stated she could have provided better interviews with Resident 8 and follow up the department responsible for investigating and summary. The Corrective action, my follow- through interview thoroughly and, if she did her follow up interview with Resident 8, she would have captured the grabbing and reported it properly. SSD has to do her own interview as a grievance officer. During a concurrent interview and record review on [DATE] 11:20 AM with the Director of Nursing (DON), the CGR dated [DATE] was reviewed. The CGR Form were missing information on the steps taken to investigate the grievance and summary of pertinent findings or conclusion. The DON stated the space for the steps taken to investigate grievance including the summary of pertinent findings were blank and there was no document attached. The DON stated the investigation report should be attached to the CGR if it was done and if the space for the steps taken to investigate grievance including the summary of pertinent findings was not filled out and there was no attachment, it means it was not done. During a concurrent interview and record review on [DATE] at 11:23 AM with the DON, the facility's policy and procedure (P&P) titled, Grievance revised 7/2017 was reviewed, the P&P indicated, the investigation and report will include, as applicable:a) The date and time of the alleged incident.b) The circumstances surrounding the alleged incident.c) The location of the alleged incident.d) The names of any witnesses and their accounts of the alleged incident.h) Recommendations for corrective action if not already remedied.The DON stated they did not follow the policy because the staff did not fill in the information needed for the CGR form, there was no proof that it was investigated such as letters A to D, and H in the list per the facility's P&P and no information of pertinent findings to draw conclusion. During a concurrent interview and record review on [DATE] at 12:28 PM with DSD, the CGR Form dated [DATE] was reviewed. DSD stated the nursing department was responsible for follow up interview with the resident, and staff involved in the grievance filed and ensured the steps taken to investigate the grievance were documented in the CGRThe DSD stated the space for the steps taken to investigate grievance including the summary of pertinent findings was not filled out and there was no attachment, it means it was not done and the CGR Form for Resident 1 was incomplete they were missing information for the investigation and summary. During a concurrent interview and record review on [DATE] at 12:34 AM with, the facility's policy and procedure (P&P) titled, Grievance revised 7/2017 was reviewed. DSD stated she did not follow the policy because the investigation report that she did for the CGR Form was incomplete, she was missing the names of staff being interviewed, name of the resident involved, time of interviewer, date, names of involved person and name of the (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interviewer.

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement the facility's abuse (the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish) policy regarding investigating an allegation of verbal abuse (the use of oral, written, or gestured communication, or sounds, to residents within hearing distance, regardless of age, ability to comprehend, or disability) for one (1) of two (2) sampled residents (Resident 8) reviewed for abuse.This deficient practice had the potential to compromise or impede the protection of Resident 8, which could affect resident's emotional and mental wellbeing. Cross reference with F610. Findings:During a review of Resident 8's admission Record, the admission Record indicated Resident 8 was admitted to the facility on [DATE] and re-admitted on [DATE]. Resident 8's diagnoses included chronic kidney disease (CKD, a condition in which the kidneys are damaged and cannot filter blood as well as they should), anxiety disorder (mental health condition marked by persistent, excessive worry, fear, or nervousness that interferes with daily life), and chronic obstructive pulmonary disease (COPD, a chronic inflammatory lung disease that causes obstructed airflow from the lungs). During a review of Resident 8's Minimum Data Set (MDS, a resident assessment tool), dated 1/12/2026, the MDS indicated Resident 8 had intact cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 8 needed substantial/ maximal assistance (helper does more than half the effort. helper lifts, holds trunk or limbs, and provides more than half the effort) in toileting hygiene, shower/bathe self, lower body dressing, putting on/ taking off footwear, lying to sitting on the side of the bed, and tub/shower transfer. During an interview on 1/20/2026 at 9:26 AM with Resident 8, Resident 8 stated Certified Nursing Assistant 2 (CNA 2) who worked the 3PM to11 PM shift had a bad attitude and was pushy. Resident 8 stated two days ago, on Sunday night, CNA 2 yanked out the drawsheet (are small, durable sheets or absorbent pads placed crosswise over the middle of a resident's bed under a resident's hips and torso to assist with repositioning, transferring, and reducing friction on the skin) under her and threw it on the floor near the door. Resident 8 also stated CNA 2 pulled out her (Resident 8's) brief and grabbed Resident 8's arm and held it straight up while being changed. Resident 8 further stated CNA 2 was mean to Resident 8 and it made the resident cry. Resident 8 stated she informed the Social Services Director (SSD) about CNA 2's bad attitude on 1/19/2026. During an interview on 1/21/2026 at 12:58 PM with Resident 8, Resident 8 stated the incident happened Sunday (1/18/2026) night when CNA 2 grabbed her (Resident 8's) right arm so Resident 8 could not reach the adhesive tabs for her brief as Resident 8 likes to adjust and secure the brief adhesive tabs herself. Resident 8 stated CNA 2 told her to stop and held her arm straight up to prevent her from touching the adhesive tabs. Resident 8 described CNA 2 as rough and scary and that she did not like what CNA 2 did to her and it made Resident 8 cry. During a concurrent interview and record review on 1/21/2026 at 3:35 PM with SSD, the facility's Interview Record dated 1/20/2026 at 3:40 PM was reviewed. The Interview Record indicated Resident 8 recalled CNA during the 3PM-11PM shift and that the resident does not recall the date, and the day of the week that CNA (name not identified in the form) freaked out. The form also indicated Resident 8 requested to be changed and specified she asked CNA to return in 1 hour and CNA refused. The form indicated, when CNA went back to change Resident 8 the CNA roughly took drawsheet (sheet that is placed in such a way that it can be taken from under a patient for various purposes in the healthcare setting such as repositioning) from under Resident 8 and threw it on the floor near the door and when Resident 8 was trying to fasten tabs on her brief, CNA grabbed Resident 8's right arm. The form indicated Resident 8 stated (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA was mean. SSD stated according to the form CNA roughly pulled the drawsheet per Resident 8's interview. During a concurrent interview and record review on 1/21/2026 at 5:11 PM with Director of Health Information (DHI), the Investigation Report dated 1/20/2026 was reviewed. The investigation report was incomplete, and it is missing the name of investigator, name of all the staff being interviewed, name of the Resident that was involved in the allegation and the time the interview was conducted. DHI stated it was the Director of Staff Development (DSD) who provided the copy of the report to the DHI and the DHA knew that there were missing information. During a concurrent interview and record review on 1/21/2026 at 5:21 PM with Administrator (ADM), the Investigation Report dated 1/20/2026 was reviewed. ADM stated the formal investigation report submitted was incomplete and the phone interview conducted by the DSD between the two CNAs (CNA 2 and 3) were missing the CNAs signatures, there was no time indicated when the two CNAs were interviewed and there was no name of the Resident involved in the incident. The ADM stated the DSD concluded in the investigation that CNA 3 was the perpetrator instead of CNA 2. During a concurrent interview and record review on 1/23/2026 11:25 AM with Director of Nursing (DON), the investigation report dated 1/20/2026 was reviewed. The investigation report was incomplete. DSD stated the investigation report was incomplete and confusing, the report had no information if who did the investigation, who was the other CNA, who was the Resident involved and what time the investigation occurred. During a concurrent interview and record review on 1/23/2026 at 11:35 AM with DON, the facility's policy and procedure (P &P) titled, Abuse Investigation and Reporting revised 7/2017 was reviewed. The P&P indicated, the individual conducting the investigation will, as minimum:Review the completed documentation forms.Interview the Resident.Interview the staff members on all shifts who have contact with the Resident during the period of the alleged incident.Review all the events leading up to the alleged incident.The DON stated they did not follow the investigation process per the policy, the documentation interview is inaccurate and incomplete. During a concurrent interview and record review on 1/23/2026 at 12:48 PM with DSD, the undated CNA Statement Form was reviewed. CNA 2's Statement Form was incomplete. DSD stated CNA 2 statement form was missing the interview date, name of interviewer/ investigator, the staff phone number and signature of the staff. DSD stated, CNA 2 statement was not valid because it was incomplete. During a concurrent interview and record review on 1/23/2026 at 1:06 PM with DSD, the facility's P &P titled, Abuse Investigation and Reporting revised 7/2017. DSD stated the investigation process in the policy was not followed because the interviews and/ or investigation report were missing information such as the date and time, resident involve, staff involved, and the interviewer's name. DSD stated it is not considered a valid investigation report if it is of missing all the information needed pet the policy. During a review of the facility's policy and procedure (P&P) titled, Abuse Prevention Program revised 12/2016 was reviewed, the P&P indicated develop and implement policies and procedures to aid the facility in preventing abuse.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report an allegation of verbal abuse (the use of oral, written, or gestured communication, or sounds, to residents within hearing distance, regardless of age, ability to comprehend, or disability) for one (1) of two sampled residents (Resident 8) reviewed for abuse, within 2-hour timeframe to the State Survey Agency (SA, where state law provides for jurisdiction in long-term care facilities), the state ombudsman (advocates for residents of nursing homes, board and care homes and assisted living facilities), and local law enforcement. This deficient practice had the potential to compromise or impede the protection of Resident 8, which could affect resident's emotional and mental wellbeing. Findings:During a review of Resident 8's admission Record, the admission Record indicated Resident 8 was admitted to the facility on [DATE] and re-admitted on [DATE]. Resident 8's diagnoses included chronic kidney disease (CKD, a condition in which the kidneys are damaged and cannot filter blood as well as they should), anxiety disorder (mental health condition marked by persistent, excessive worry, fear, or nervousness that interferes with daily life), and chronic obstructive pulmonary disease (COPD, a chronic inflammatory lung disease that causes obstructed airflow from the lungs) During a review of Resident 8's Minimum Data Set (MDS, a resident assessment tool), dated 1/12/2026, the MDS indicated Resident 8 had intact cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 8 needed substantial/ maximal assistance (helper does more than half the effort. helper lifts, holds trunk or limbs, and provides more than half the effort) in toileting hygiene, shower/bathe self, lower body dressing, putting on/ taking off footwear, lying to sitting on the side of the bed, and tub/shower transfer. During an interview on 1/20/2026 at 9:26 AM with Resident 8,Resident 8 stated Certified Nursing Assistant 2 (CNA 2), who worked the 3 PM to 11 PM shift, had a bad attitude and was pushy. Resident 8 stated that two days ago, on Sunday night, CNA 2 yanked out the drawsheet (a small, durable sheet or absorbent pad placed crosswise over the middle of a resident's bed under the hips and torso to assist with repositioning, transferring, and reducing friction on the skin) from under her and threw it on the floor near the door. Resident 8 stated CNA 2 then pulled out her brief and grabbed her arm, holding it straight up while changing her. Resident 8 further stated that CNA 2 was mean and made her cry. Resident 8 stated she reported the incident to the Social Services Director (SSD) on 1/19/2026. During an interview on 1/20/2026 at 3:38 PM with SSD, SSD stated Resident 8 reported on 1/19/2026 that a CNA from the 3 PM to 11 PM shift had pulled the sheet from under Resident 8 and thrown the drawsheet onto the floor. During an interview on 1/21/2026 at 12:58 PM with Resident 8, Resident 8 stated police officers came to speak with her regarding the allegation of abuse. Resident 8 stated the incident occurred on Sunday night (1/18/2026). Resident 8 stated CNA 2 grabbed her right arm so she could not reach the adhesive tabs for her brief, as Resident 8 likes to adjust and secure the tabs herself. Resident 8 stated CNA 2 told her to stop and held her right arm straight up to prevent her from touching the tabs. Resident 8 described CNA 2 as rough and scary, stating CNA 2 made her cry and that she did not like what CNA 2 did to her. During a concurrent interview and record review on 1/21/2026 at 4:23 PM with Registered Nurse Supervisor 2 (RNS 2), the RN Statement/Witness Report (RSWR), dated 1/20/2026 was reviewed. The RSWR indicated on Sunday, 1/18/2026, RNS 2 was walking in the hallway when she heard Resident 8's voice coming from her room. RNS 2 entered the room and observed that both Resident 8 and CNA 2 were upset. Resident 8 informed RNS 2 that the drawsheet had been thrown on the floor. Resident 8 remained upset even after RNS 2 placed another drawsheet under her because the previous drawsheet had been thrown on the floor. RNS (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2 stated that during the 3 PM to 11 PM shift on Sunday, she heard loud voices from Resident 8's room. Resident 8 stated that CNA 2 threw the drawsheet on the floor and became upset. Resident 8 likes to have two drawsheets and stated that she told CNA 2 what she wanted, but CNA 2 was not listening. Resident 8 refused further care from CNA 2, and her voice was shaky. RNS 2 stated that she got overwhelmed and busy with her shift and should have reported the incident to the Administrator or Director of Nursing (DON) because it was a possible allegation of abuse. RNS 2 stated she should have endorsed it to the other licensed nurse. During an interview on 1/21/2026 at 4:43 PM with CNA 2, CNA 2 stated Resident 8 requested two drawsheets because one of her drawsheets was dirty. CNA 2 stated that Resident 8 insisted on having two drawsheets. CNA 2 removed one drawsheet and left the room. CNA 2 stated RNS 2 was in the hallway and asked her to come into Resident 8's room. CNA 2 stated Resident 8 was yelling that CNA 2 was rough and rude to her and was upset with CNA 2. During an interview on 1/22/2026 at 2:11 PM with SSD, SSD stated that she should have conducted a thorough investigation of Resident 8's reported incident and could have reported it immediately. SSD stated it was important to report and notify the appropriate agencies to prevent further incidents of abuse and ensure Resident 8's safety. During a concurrent interview and record review on 1/23/2026 at 11:26 AM with the Director of Nursing (DON), the investigation report dated 1/20/2026 was reviewed. The report indicated CNA 3 stated Resident 8 told her that the CNA who took over her care last Sunday, 1/18/2026, after 7 PM was rude to her. The DON stated CNA 3 should have reported this to the DON, the charge nurse, or the Director of Staff Development (DSD) when Resident 8 reported that the staff was mean. The DON stated CNAs are mandated reporters and should have reported the allegation to the Administrator, DON, Director of Staff Development (DSD), and SSD within two hours During a concurrent interview and record review on 1/23/2026 at 11:50 AM with DON, the facility's policy and procedure (P &P) titled, Abuse Investigation and Reporting revised 7/2017 was reviewed. The P&P indicated, an alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than:Two (2) hours if the alleged violation involves abuse or has resulted in serious bodily injury.DON stated the staff should have called within 2 hours because of the allegation of abuse. Resident 8 mentioned to CNA 3 that the other staff was rude, which is possible verbal abuse. We should report immediately to prevent abuse to Resident 8, and we should make sure the residents are protected from abuse. During a review of the facility's policy and procedure (P&P) titled, Abuse Prevention Program revised 12/2016 was reviewed, The P&P indicated, Investigate and report any allegations of abuse within timeframe required by federal requirements.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide evidence that the alleged abuse (the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish) was thoroughly investigated for one (1) of two (2) sampled residents (Resident 8) reviewed for abuse, as indicated in the facility's policy and procedure. This deficient practice had the potential to compromise or impede the protection of Resident 8, which could affect resident's emotional and mental wellbeing. Cross Reference with F607.Findings:During a review of Resident 8's admission Record, the admission Record indicated Resident 8 was admitted to the facility on [DATE] and re-admitted on [DATE]. Resident 8's diagnoses included chronic kidney disease (CKD, a condition in which the kidneys are damaged and cannot filter blood as well as they should), anxiety disorder (mental health condition marked by persistent, excessive worry, fear, or nervousness that interferes with daily life), and chronic obstructive pulmonary disease (COPD, a chronic inflammatory lung disease that causes obstructed airflow from the lungs). During a review of Resident 8's Minimum Data Set (MDS, a resident assessment tool), dated 1/12/2026, the MDS indicated Resident 8 had intact cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 8 needed substantial/ maximal assistance (helper does more than half the effort. helper lifts, holds trunk or limbs, and provides more than half the effort) in toileting hygiene, shower/bathe self, lower body dressing, putting on/ taking off footwear, lying to sitting on the side of the bed, and tub/shower transfer. During an interview on 1/20/2026 at 9:26 AM with Resident 8, Resident 8 stated Certified Nursing Assistant 2 (CNA 2) who worked the 3PM to11 PM shift had a bad attitude and was pushy. Resident 8 stated two days ago, on Sunday night, CNA 2 yanked out the drawsheet (are small, durable sheets or absorbent pads placed crosswise over the middle of a resident's bed under a resident's hips and torso to assist with repositioning, transferring, and reducing friction on the skin) under her and threw it on the floor near the door. Resident 8 also stated CNA 2 pulled out her (Resident 8's) brief and grabbed Resident 8's arm and held it straight up while being changed. Resident 8 further stated CNA 2 was mean to Resident 8 and it made the resident cry. Resident 8 stated she informed the Social Services Director (SSD) about CNA 2's bad attitude on 1/19/2026. During an interview on 1/20/2026 at 3:38 PM with SSD, SSD stated on 1/19/2026, Resident 8 reported to SSD that a CAN from 3PM - 11PM shift pulled the drawsheet under Resident 8 and threw the draw sheet onto the floor. During a concurrent interview and record review on 1/21/2026 at 3:48 PM with Director of Staff Development (DSD), the Investigation Report dated 1/20/2026 was reviewed. The Investigation Report indicated CNA 3 stated Resident 8 told her that the CNA who took over the 3PM-11PM shift last 1/18/2026 was rude to Resident 8. The investigation report indicated CNA 2 stated she took over Resident 8 when CNA 3 left at 7PM last 1/18/2026. The investigation report also indicated when CNA 2 came back to Resident 8's room to change Resident 8, CNA 2 rolled up the drawsheet under the resident because it was dirty then pulled out the drawsheet under Resident 8 and Resident 8 grabbed it. The investigation report indicated, CNA 2 stated when Resident 8 unrolled the drawsheet, all the food crumbs fell back on Resident 8's bed, then CNA 2 took the drawsheet from Resident 8 and left the room to look for the nurse in charge. In addition, the investigation report indicated CNA 2 informed Registered Nurse Supervisor (RNS) 2 that Resident 8 stated CNA 2 was being rough. DSD stated, DSD did not interview Resident 8 after interviewing CNA 2 and 3 because the report was just pulling out of the drawsheet and putting it on the floor. During an interview on 1/22/2026 at 2:06 PM with SSD, SSD stated she should have done a thorough investigation of the reported incident of Resident 8 regarding CNA 2 after the DSD conducted the (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Royal Gardens Healthcare	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)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	investigation of the allegation of abuse. SSD also stated the investigation conclusion was not accurate for the incident; it was not CNA 3 that Resident 8 alleged of being rough, it was CNA 2. SSD stated she could have conducted better follow-up interviews for Resident 8 and staff involved, and she should have done an in-depth investigation. SSD stated if she did a thorough follow up interview, she could have identified the perpetrator right away. During a concurrent interview and record review on 1/23/2026 at 11:53 AM with DON, the facility's policy and procedure (P &P) titled, Abuse Investigation and Reporting revised 7/2017 was reviewed. The P&P indicated, all reports of resident abuse The DON stated the investigation conducted was inaccurate and confusing because of missing information. During a concurrent interview and record review on 1/23/2026 at 12:40 PM with DSD, the CNA (name not identified) statement dated 1/20/2026 was reviewed. The CNA statement indicated Resident 8 mentioned to CNA 2 that a CNA (unable to give a name) was mean to the resident. DSD stated CNA 3 statement was incomplete because it was missing the interviewer's name. DSD also stated CNA 3's statement was possible verbal abuse if Resident 8 mentioned that a CNA was mean to Resident. During a concurrent interview and record review on 1/23/2026 at 12:48 PM with DSD, the undated CNA (name not identified) statement form was reviewed. The CNA statement form was incomplete. DSD stated CNA 2 statement form was missing the interview date, name of interviewer/ investigator, the staff phone number and signature of the staff. DSD stated, CNA 2 statement was not valid because it was incomplete. During a concurrent interview and review on 1/23/2026 at 1:06 PM with DSD, the facility's P&P titled, Abuse Prevention Program revised 12/2016 was reviewed, The P&P indicated, upon conclusion of the investigation, the investigator will record the results of the investigation on approved documentation forms and provide the completed documentation to the Administrator. DSD stated the policy was not followed because the investigation was missing information - date and time, resident, staff involved, and name of the interviewer/ investigator. DSD stated it is not a valid investigation report because of the missing information.