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 04/09/2026
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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure one of three sampled residents (Resident 2) were free from physical abuse (the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish), when Resident 1 allegedly pushed a laundry cart to Resident 2. This deficient practice had the potential to negatively affect Resident 2's comfort and psychosocial (having to do with the mental, emotional, social, and spiritual effects of a disease) well-being which can lead to hospitalization and/or death. Findings:During a review of Resident 1's admission Record, indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), depression (serious medical illness causing persistent sadness, low mood, and loss of interest in activities) and anxiety (a feeling of fear, dread, and uneasiness, often accompanied by physical symptoms like rapid heart rate, sweating, or tension). During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 3/29/2026, the MDS indicated Resident 1's cognitive (ability to think and reason) skills for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated Resident 1 was independent (resident completes the activity) with upper and lower body dressing. The MDS indicated Resident 1 required setup or clean-up assistance (helper sets up or cleans up) with eating, oral hygiene, putting on/taking off footwear and personal hygiene. The MDS indicated Resident 1 required supervision or touching assistance (helper provides verbal cues; resident completes activity) with toileting hygiene and shower/bath. The MDS indicated Resident 1 was independent with lying to sitting on side of bed, sit to stand, walk 10 feet (unit of measurement), and walk 50 feet with two turns. During a review of Resident 1's Change in Condition (COC) Evaluation, dated 3/29/2026, timed 1:25 PM, documented by Licensed Vocational Nurse 1 (LVN 1), indicated a situation of alleged physical altercation (physical contact or force and may include bullying, fighting, or violence) towards another resident (no specific resident indicated).). The COC Evaluation indicated Resident 1 has physical and verbal aggression. The COC Evaluation indicated Resident 1 was yelling profanities towards others and shoving objects at other residents (no specific resident indicated). During a review of Resident 2's admission Record, indicated Resident 2 was admitted to the facility on [DATE], readmitted om 12/24/2025, with diagnoses that included abnormal posture, lack of coordination and heart failure (condition where the heart muscle cannot pump enough blood to meet the body's needs for oxygen and nutrients). During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2's cognitive skills for daily decision making was moderately impaired (decisions poor; cues/supervision required). The MDS indicated Resident 2 required setup or clean-up assistance with eating. The MDS indicated Resident 2 required supervision or touching assistance with oral hygiene. The MDS indicated Resident 2 required partial/moderate assistance (helper does less than half the effort) with upper body dressing and personal hygiene. The MDS indicated Resident 2 was dependent (helper does all the effort) with toileting hygiene, shower, lower body dressing and putting on/taking off footwear. The MDS indicated Resident 2 uses wheelchair. During a review of Resident 2's COC Evaluation, dated 3/29/2026, timed (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1:25 PM, documented by Registered Nurse 1 (RN1), indicated a situation of alleged physical aggression (intentional behavior designed to cause bodily harm or damage) received from another resident (no specific resident indicated). During a review of the facility's interview record, dated 3/29/2026, indicated Visitor 1 stated Visitor 1 came to visit a resident in room [ROOM NUMBER]. It also indicated Visitor 1 stated we heard some yelling close to the room, so I peeked out to check and one of the resident (Resident 1) was screaming at another resident (Resident 2) who was in his (Resident 2) wheelchair. Resident 1 pushed a laundry basket hitting the other resident (Resident 2), and he (Resident 2) yelled ouch. The lady (Resident 1) was walking towards the shower after and was cursing at the other man (Resident 2). During an interview on 3/8/2026 at 2:35 PM with Certified Nurse Assistant (CNA) 1, CNA 1 stated Resident 1 has been rude and verbally aggressive to staff. CNA 1 stated Resident 1 had episode of throwing things on the floor inside the room. CNA 1 stated Resident 1 can be really aggressive and unsafe to other residents. During an interview on 4/8/2026 at 4 PM, with admission Director (AD), she stated that on 3/29/2026, she was walking with Resident 1 to the shower room. AD stated Resident 1 got upset about how the facility's shower looks like. AD stated she had to leave Resident 1 at the hallway briefly to get more towels, and the incident between Resident 1 and Resident 2 happened in the same hallway where she is heading to get more towels. Visitor 1 called AD, and as AD turned her back to check the 2 residents, Resident 2 who was sitting in the wheelchair, located in the middle of the hallway, was observed with laundry cart behind the wheelchair and heard Resident 1 shouting at Resident 2 in the hallway. AD stated laundry cart is usually placed at the side of the hallway and never placed in the middle of the hallway. AD stated Visitor 1 told her that Resident 1 pushed the laundry cart to Resident 2. During an interview on 4/8/2026 at 4:18 PM with Licensed Vocational Nurse (LVN) 1, LVN 1 stated on 3/29/2026, around 1:25 PM, LVN 1 heard Resident 2 saying ouch, and Resident 1 saying you fucking pigs, I hate this place, in the hallway. LVN 1 stated Visitor 1 told him (LVN 1) that Resident 1 pushed laundry cart to Resident 2. During a concurrent interview and record review with the Director of Nursing (DON) on 4/9/2026 at 4:50 PM, Resident 1's medical records (including physician's order, Medication Administration Record [MAR], treatment Administration Record [TAR] and progress notes) dated 3/26/2026 to 3/29/2026 were reviewed. Resident 1's medical records did not indicate an order to monitor Resident 1's aggressive behavior of throwing things at other people. The DON stated Resident 1 already manifested aggressive behavior of throwing things to other people on the resident's second day in the facility and the resident's aggressive behavior was not monitored by the facility staff, and it should have been included in the resident's behavior monitoring. The DON also stated the facility failed to prevent Resident 1 pushing the laundry cart to hit Resident 2. During a review of the facility's Policy and Procedure (P&P), titled Abuse and Neglect (the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress) -Clinical Protocol, revised in March 2018, the P&P indicated he facility management and staff will institute measures to address the needs of residents and minimize the possibility of abuse and neglect.