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	04/16/2026

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to accommodate the needs of one (1) of one sampled resident's by failing to ensure the call light (patient-safety device, often a button on a cord, used in hospitals and nursing homes to enable patients to alert staff for assistance, thereby preventing falls and ensuring care) was within reach (arm's length or less than) of Resident 6 on 4/15/2026. This deficient practice has the potential to delay in the necessary care and services and/or needs not being met for Resident 6.Findings:During a review of Resident 6's admission Record, the admission Record indicated the resident was originally admitted on [DATE] and was readmitted on [DATE] with diagnoses that included muscle weakness, chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing) and depression (a serious, common mood disorder causing persistent sadness, loss of interest, and physical symptoms that impair daily life for over two weeks). During a review of Resident 6's Minimum Data Set (MDS - a resident assessment tool), dated 3/6/2026, the MDS indicated the resident was moderately impaired in cognitive skills for daily decision making. The MDS also indicated the resident required substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with eating, oral hygiene, upper body dressing and personal hygiene but was dependent (helper does all of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) with toileting hygiene, shower/bathe self, lower body dressing, and putting on/taking off footwear. During a concurrent observation and interview on 4/15/2026 at 2:53 PM in Resident 6's room, Resident 6 was observed lying in bed and the resident's call light was on the top right corner of the resident's bed. Resident 6 stated she is thirsty and needs to drink water. Resident 6 also stated the resident cannot reach for the call light to alert the facility staff that she (Resident 6) needs water. During a concurrent observation and interview on 4/15/2026 at 2:55 PM in Resident 6's room, Certified Nursing Assistant 2 (CNA 2) stated Resident 6's call light was placed on the top right corner of Resident 6's bed. CNA 2 stated the call light was not within the resident's reach but should be within the reach of the resident. CNA 2 also stated it is important to have the call light within the resident's reach so the resident can use it in case the resident needs to call the facility staff for assistance. During an interview on 4/16/2026 at 1:30 PM, the Director of Nursing (DON) stated the call light should always be within the resident's reach, so the resident can use it to call the facility when assistance is needed. During a review of the facility's Policy and Procedure (P&P) titled, Answering the Call Light, revised 9/2022, the P&P indicated to ensure that the call light is accessible to the resident when in bed, form the toilet, from the shower or bathing facility and from the floor.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop an individualized resident-centered are plan (a care plan that prioritizes the unique health needs and desired outcomes of the resident) with measurable objectives, timeframe, and interventions for one of two sample residents (Resident 8) to address the Resident 8's behavior of getting out of bed unassisted.This deficient practice has the potential to delay in the necessary care and services for Resident 8, which can potentially result in further falls, injury and harm.Findings:During a review of Resident 8's admission Record, the admission Record indicated the resident was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included difficultly in walking, Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), muscle weakness and dementia (a progressive state of decline in mental abilities).During a review of Resident 8's Fall Risk Evaluation, dated 12/27/2023, the evaluation indicated Resident 8 is at high risk for falls.During a review of Resident 8's Progress Notes, dated 12/10/2025 at 11:00 AM, the progress notes indicated the resident had an unwitnessed fall on 12/9/2025. The progress notes also indicated Resident 8 did not ask for assistance prior to mobility.During a review of Resident 8's Minimum Data Set (MDS - a resident assessment tool), dated 1/27/2026, the MDS indicated the resident is severely impaired in cognitive (the ability to understand and make decisions) skills for daily decision making. The MDS also indicated the resident required substantial/maximal assistance (helper does more than half the effort. Helper lifts or hold trunk or limbs and provides more than half the effort) with toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on/taking off footwear and personal hygiene but required partial/moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with eating and oral hygiene.During an interview on 4/15/2026 at 2:55 PM, Certified Nursing Assistant 2 (CNA 2) stated Resident 8 has a tendency to get up on her own and has been like that since the resident got admitted to the facility on [DATE].During an interview on 4/15/2026 at 3:28 PM, Licensed Vocational Nurse 1 (LVN 1) stated Resident 8 had a tendency to get up on her own without assistance since the resident was admitted at the facility on 2/14/2026.During an interview on 4/16/2026 at 9:54 AM, Registered Nurse 3 (RN 3) stated Resident 8 would fall because the resident would try to get up on her own without assistance or calling for help. RN 3 also stated most of the time Resident 8 would get up without assistance because the resident needs a adult brief/ diaper change.During an interview on 4/16/2026 at 1:30 PM, Resident 8's Care Plans, dated 9/2/2023 to 2/25/2026, were reviewed. The Director of Nursing (DON) stated there is no care plan addressing Resident 8 getting up on her own and there should be a care plan to address Resident 8 getting up on her own. The DON also stated there is no revision of care plan after Resident 8's fall on 9/27 and there should be a revision every time there is a change in condition.During a review of the facility's P&P titled, Comprehensive Person-Centered Care Plans, dated 3/2022, the P&P indicated the interdisciplinary teams (IDT -a group of professionals from diverse fields working collaboratively, rather than in isolation, to achieve shared goals or comprehensive care for residents) in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. The P&P also indicated the care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The P&P indicated the comprehensive, person-centered care plan describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide treatment and care in accordance with the professional standards of practice for two (2) of 2 sampled residents (Resident 4 and 7) by failing to:Continue and provide wound care treatment per physician (MD) orders for Resident 4.Ensure Resident 7 was seen by a pain specialist (a doctor who has specialized fellowship training in evaluating, diagnosing, and treating acute, chronic, or cancer-related pain) from 1/16/2026 to 4/16/2026 in accordance with the MD order. Thess failures resulted in Resident 4 not receiving wound care treatment for the resident's cervical spine (the uppermost segment of the spinal column) wound for 10 days (2/8/2026 to 2/16/2026 and 2/18/2026) and had the potential to result in Resident 4's cervical spine wound worsening in condition. These failures may result in Resident 7's unmanaged pain and affect the resident's physical well-being and could negatively affect the resident's quality of life. Findings: 1.During a review of Resident 4's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE] and readmitted [DATE] with diagnoses of osteomyelitis (a serious infection within the bone, usually caused by bacteria, that can cause pain, fever and swelling) of vertebra (the individual, interlocking bones that stack together to form the spine) and intraspinal (within the spinal column) abscess (a localized, swollen, and painful collection of pus [dead tissue, bacteria and white blood cells] that form within tissues or organs) and granuloma (a small nodule or bump). During a review of Resident 4'S Minimum Data Set (MDS – a resident assessment tool), dated 3/5/2026, the MDS indicated the resident was severely impaired (never/rarely made decision) with cognitive (ability to think, remember, and reason) skills for daily decision making. It indicated Resident 4 was dependent (helper does all of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) with chair/bed-to-chair transfers and going from sitting to standing. The MDS also indicated Resident 4 needed substantial/maximal assistance (helper does more than half the effort) with going from lying down to sitting on the side of the bed, rolling left and right in bed and putting on/taking off footwear. In addition, it indicated Resident 4 needed partial/moderate assistance (helper does less than half the effort with personal hygiene and lower body dressing (the ability to dress and undress below the waist and needed setup or clean-up assistance (helper set ups or cleans up; resident completes activity) with eating. During a concurrent interview and record review on 4/16/2026 at 12:55 PM with the Director of Nursing (DON), Resident 4's Wound Assessment documentation dated 2/10/2026 and Treatment Administration Record (TAR) dated February 2026 were reviewed. Resident 4's Wound Assessment documentation indicated a treatment order for Resident 4's cervical spine wound of a topical (something applied to a specific body part) application of Dakin's solution (a highly diluted medical-grade bleach solution used as a topical antiseptic to clean and disinfect infected wounds, burns and ulcers) and Betadine (a widely used antiseptic brand containing povidone-iodine that kills germs [bacteria, viruses and fungi] to prevent infection in minor cuts, scrapes and burns) and to cover with a calcium alginate (a highly absorbent, biodegradable [materials that can naturally break down into harmless components] wound dressing made from brown seaweed, designed for moderately to heavily draining wounds) dressing with a daily treatment frequency. Resident 4's TAR indicated no documented administration of treatment for Resident 4's cervical spine wound for 10 days (2/8/2026 to 2/16/2026 and 2/18/2026). The DON stated there is no documentation that Resident 4 received any wound care treatment for the resident's cervical spine wound for 10 days (2/8/2026 to 2/16/2026 and 2/18/2026) and stated treatment should have been done on those days (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	per the wound physician's order on a daily basis which could have resulted in Resident 4's cervical spine wound getting worse. During a concurrent interview and record review on 4/16/2026 at 3:13 PM with Licensed Vocational Nurse 1 (LVN 1), Resident 4's Wound Assessment documentation dated 2/10/2026 and TAR dated February 2026 were reviewed. According to Resident 4's TAR and Wound Assessment documentation, LVN 1 stated there's no documented administration of treatment for Resident 4's cervical spine wound because the last physician (MD) treatment orders stopped on 2/7/2026 and no new orders were input per the wound MD's order as indicated in the Wound Assessment documentation. LVN 1 further stated Resident 4's cervical spine wound treatment orders should have been followed up and input into the system so that there was no delay in care or treatment of the wound. During a concurrent interview and record review on 4/16/2026 at 3:27 PM with the DON, Resident 4's Wound Assessment documentation dated 2/10/2026 and TAR dated February 2026 were reviewed. The DON stated according to Resident 4's TAR and Wound Assessment documentation, there were no new orders input for Resident 4's cervical spine wound treatment from 2/8/2025 to 2/17/2025 and the resident did not receive wound care treatment for 10 days (2/8/2026 to 2/16/2026 and 2/18/2026) which could have potentially made the condition of his cervical spine wound worse. During a review of the facility's policy and procedure (P&P) titled, Pressure Ulcers/Skin Breakdown – Clinical Protocol, revised April 2018, the P&P indicated the physician will order pertinent wound treatments, and application of topical agents. During a review of the facility's P&P titled, Wound Care Treatment Policy & Procedure, revised 2/2/2026, the P&P indicated, It is the policy of this facility to ensure all wound care treatments are performed using aseptic technique, proper hand hygiene, and in accordance with physician orders, to promote healing and prevent infection. The P&P also indicated: Preparation Verify physician's order for wound care treatment Application of Treatment Apply medications/treatments as ordered Responsibilities Licensed Nurse: Perform and document wound care, report changes Treatment Nurse/DON: Monitor compliance and outcomes Infection Preventionist: Audit adherence to infection control practices During a review of the facility's P&P titled, Treatment Administration Policy, revised 2/2/2026, the P&P indicated, The facility ensures that all treatments are administered safely, accurately, and in accordance with physician orders, professional standards of practice, and regulatory requirements. Treatments are performed by qualified personnel and documented timely and completely to reflect the care provided. The P&P also indicated treatments shall be administered as ordered. 2. During a review of Resident 7's admission Record, the admission Record indicated the resident was originally admitted to the facility on [DATE] and was readmitted on [DATE] with the following but not limited to diagnoses of fibromyalgia (a chronic disorder characterized by widespread (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	musculoskeletal pain, fatigue, sleep disturbances, and cognitive issues), muscle weakness, and osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage). During a review of Resident 7's MDS, dated [DATE], the MDS indicated, the resident is moderately impaired in cognitive skills for daily decision making. The MDS also indicated the resident required supervision/touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently) with toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, and putting on/taking off footwear. The MDS indicated Resident 7 occasionally have pain which has occasionally limited the resident's day to day activities. The MDS also indicated the resident's had moderate pain within the last 5 days of the assessment. During a review of Resident 7's Physician Orders, dated 1/16/2026, the Physician Orders indicated the following but not limited to: May refer to Pain Specialist Aspirin (Nonsteroidal anti-inflammatory drug [NSAID] used to reduce pain) Oral Tablet 325 milligrams (mg – unit of measure) Give 2 tablet by mouth every 6 hours as needed for breakthrough pain Oxycodone (opioid analgesic to treat moderate to severe pain) 5 mg 1 tab by mouth every 6 hours as needed for moderate to severe pain (4-10/10) every 6 hours as needed. Ibuprofen (NSAID, to treat mild pain) Oral Tablet 400 mg Give 1 tablet by mouth every 6 hours as needed for mild pain (1-3/10) scale During an interview on 4/15/2026 at 1:55 PM in Resident 7's room, Resident 7 stated he has told Social Services Director (SSD) and Licensed Vocational Nurse (LVN) 1 regarding his pain. Resident 7 also stated the facility will give him Aspirin for breakthrough pain, but he will still be in pain. Resident 7 stated LVN 1 would tell him that he would have to wait until his next scheduled pain medication which is the Oxycodone. During an interview on 4/15/2026 at 2:16 PM, Certified Nursing Assistant 2 (CNA 2) stated Resident 7 would be in pain (unable to recall exact dates and times), but when CNA 2 report to the licensed nurses, the licensed nurses would say it is not time for the resident's pain medication yet. During an interview on 4/16/2026 at 1:48 PM, SSD stated she did not follow up with Resident 7's physician's order for a pain specialist and the appointment was not arranged but SSD should have followed up with Resident 7's physician order for a pain specialist. SSD also stated it is important to follow the physician's order for Resident 7 to see a pain specialist to ensure the resident's pain is managed and the resident is comfortable while in the facility. During an interview on 4/16/2026 at 2:20 PM, LVN 1 stated he did not follow up with Resident 7's physician's order for the resident to see a pain specialist but it should have been followed up and implemented. LVN 1 also stated May see a pain specialist means if the resident is having unmanaged pain by the current pain medications, then the resident can see a pain specialist. LVN 1 stated according to the physician's order, Resident 7 can see a pain specialist and the facility needs to ensure the resident's pain is managed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/16/2025 at 2:30 PM, the Director of Nursing (DON) stated Resident 7's physician's order of May see a pain specialist means if the resident is having unmanaged pain, then the resident needs to see the pain specialist. The DON also stated Resident 7 should have been seen by a pain specialist and it should have been followed up but it was not followed up and it was not done. During a review of the facility's Policy and Procedure (P&P) titled, Pain Management, dated 5/3/2023, the P&P indicated acceptable (tolerable) pain control is defined by the resident and to accurately assess and achieve pain control. During a review of the facility's P&P titled, Appointments, revised 2/2/2026, the P&P indicated the facility will help residents contact specialty providers as needed, based on health recommendations. The P&P also indicated nursing staff informs unit clerk or designee about the appointment order and appointments based on medical necessity.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide pharmaceutical services to meet the needs of two (2) of two sampled residents (Resident 1 and 2) by failing to ensure:a. Resident 1's wrist band (a secure identification bracelet worn by residents to link them to their medical records and alert staff to specific care needs, risks, or safety protocols) was checked prior to medication administration. b. Resident 1's medication Eliquis (blood thinner) was refilled and available. c. Registered Nurse (RN) 2 explained the seven (7) medications that were administered to Resident 1. 2. Director of Staff Development (DSD) accurately reconciled Resident 2's psychotropic (a mind-altering substance that affects mood, thoughts, feelings, perception, or behavior) medication upon admission to the facility.These deficient practices had the potential to result in medication errors (any preventable event that may cause or lead to inappropriate medication use or patient harm) and/or ineffectively managing residents' medical condition, which could result to harm, hospitalization and/or death.Findings: 1. During a review of Resident 1's admission Record, the admission Record indicated the resident was originally admitted to the facility on [DATE] and was readmitted on [DATE] with the following but not limited to diagnoses of atrial fibrillation (a common, often irregular, and rapid heart rate causing the heart's upper chambers [atria] to quiver chaotically instead of beating effectively. It increases blood clot, stroke, and heart failure risks), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness on one side of the body caused by brain or spinal cord damage, most commonly from stroke, tumor, or trauma) following cerebral infraction (stroke caused by blood clot blockage in brain blood vessels reducing blood flow to the brain). During a review of Resident 1's Minimum Data Set (MDS – a resident assessment tool), dated 3/18/2026, the MDS indicated the resident was moderately impaired in cognitive (the ability to understand and make decisions) skills for daily decision making. The MDS also indicated Resident 1 required partial to moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with shower/bathe self and putting on/taking off footwear but required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently) with oral hygiene, toileting hygiene, upper body dressing, lower body dressing and personal hygiene. During a review of Resident 1's Physician Orders, dated 1/6/2026, the order indicated the following but not limited to: Amlodipine Besylate (blood pressure medication) tablet 5 milligrams (mg – unit of measure) to give 1 tablet by mouth one time a day for hypertension (elevated blood pressure) and hold if systolic blood pressure (measures the maximum pressure in your arteries when the heart beats) is less than 110 (millimeter per mercury- unit of measurement) mmHg. Eliquis oral tablet 2.5 mg to give 1 tablet by mouth two times a day for deep vein thrombosis (DVT - a serious condition where a blood clot forms in a deep vein, usually the leg, causing swelling, pain, warmth, and redness) prophylaxis. Lactulose encephalopathy oral solution (laxative to treat constipation [digestive issue characterized (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	by infrequent bowel movements (usually fewer than three per week), difficulty passing stool, or hard, dry, and lumpy stools]) 10 grams (gm – unit of measure)/15 milliliters (ml – unit of measure) to give 30 ml by mouth one time a day for bowel management hold for loose stool Oyster shell calcium + D (supplement) oral tablet 500 mg/5 micrograms (mcg – unit of measure). Prednisone (treat inflammation, allergic reactions and autoimmune diseases) oral tablet 5 mg to give 1 tablet by mouth one time a day for chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing) exacerbation. Metoprolol tartrate (treat blood pressure, chest pain and heart failure) tablet to give 12.5 mg by mouth two times a day. During a review of Resident 1's Physician Orders, dated 1/09/2026, the order indicated to give Famotidine (reduces stomach acid) oral tablet 40 mg, 1 tablet by mouth two times a day for gastroesophageal reflux disease (GERD- a chronic condition where stomach acid frequently flows back into the esophagus, causing persistent heartburn, chest pain, and swallowing issues). During a review of Resident 1's Physician Orders, dated 1/21/2026, the order indicated to give ferrous sulfate oral solution (Iron supplement) 220 mg/5 milliliters, give 5 ml by mouth one time a day for anemia During an interview on 4/15/2026 at 8:07AM, Resident 1's medication administration records (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 04/2026, was reviewed. The MAR indicated the following medications were refused by the resident: Amlodipine Ferrous Sulfate Lactulose Encephalopathy Oyster Shell Calcium + D Prednisone Eliquis Famotidine Metoprolol tartrate During an interview on 4/15/2026 at 8:07 AM, Resident 1 stated he refused his medications today (4/15/2026) because RN 2 did not explain the 7 medications that RN 2 is giving to Resident 1. During a medication administration observation on 4/16/2026 at 8:38 AM, Registered Nurse 2 (RN 2) was observed preparing Resident 1's medications. RN 2 stated they are out of Resident 1's Eliquis (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and would need to send a request to the pharmacy to refill it. During a medication administration observation on 4/16/2026 at 8:45 AM, RN 2 was observed giving 7 medications to Resident 1 without checking the resident's wrist band or the resident's photograph attached in the resident's medical record to confirm the resident's identity. RN 2 did not explain the types of medication and indication of the 7 medications that the resident is receiving. During an interview on 4/16/2026 at 9 AM, RN 2 stated she did not explain the medications to Resident 1, but she should have explained what medication's indication to the resident before giving the medication to the resident. RN 2 also stated she did not check Resident 1's wrist band to confirm the resident's identity if it is the correct resident before giving the medication. During an interview on 4/16/2026 at 11:10AM, RN 2 stated she did not administer Eliquis to Resident 1 because the medication was not available and the facility did not refill Resident 1's Eliquis medication on time. RN 2 also stated, for Eliquis medication, refills should be done when there are 3 to 2 pills left in the bubble packet (a secure, organized packaging system where pills are sealed)to ensure the facility gets it on time before the resident ran out of the medication stock. During an interview on 4/16/2026 at 1:30 PM, the Director of Nursing (DON) stated during medication administration the licensed nurses should explain what medications including the indication that the licensed nurses are administering to the resident. The DON also stated it is the resident's right to know what medications and the indication of the medication the resident is getting. The DON stated resident identifiers such as the wrist band need to be checked to verify is the correct resident and the medication refills should be done in a timely manner to ensure the resident takes their medication as physician ordered. During a review of the facility's Policy and Procedure (P&P) titled Administering Medications, revised 4/2019, the P&P indicated medications are administered in accordance with prescriber's orders, including any required time frame. The P&P also indicated the individual administering medications verifies the resident's identity before giving the resident his/her medications and methods of identifying the resident include checking identification band (wrist band), checking photograph attached to medical record, and if necessary to verify resident identification with other facility personnel. During a review of the facility's P&P titled Resident Rights Policy and Procedure, revised 10/2025, the P&P indicated residents have the right to be fully informed of their medical condition, treatment options, and changes in care. 2. During a review of Resident 2's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE] with diagnoses of unspecified psychosis (a mental health symptom – not a disease itself – characterized by a loss of contact with reality) not due to a substance or known physiological (refers to the normal, healthy functions and processes of a living body or its parts) condition and schizoaffective disorder (a chronic mental health condition combining symptoms of schizophrenia [a chronic severe brain disorder that cause people to interpret reality abnormally] with a major mood disorder [a serious mental health condition characterized by intense, long-lasting emotional disturbances such as deep depression or extreme mania – that interfere with daily functioning)] . During a review of Resident 2's MDS, dated [DATE], the MDS indicated the resident was severely (continued on next page)

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	055818	A. Building B. Wing	04/16/2026

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Royal Gardens Healthcare	2339 W. Valley Blvd. Alhambra, CA 91803

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	impaired (never/rarely made decision) with cognitive skills for daily decision making. The MDS indicated Resident 2 needed setup or clean-up assistance (helper sets up or cleans up, resident completes activity) with putting on/taking off footwear, personal hygiene and eating. It also indicated, Resident 2 was also independent with walking 50 feet with two turns, chair/bed-to-chair transfers, going from sitting to standing and upper and lower body dressing (the ability to dress and undress above and below the waist). During a review of Resident 2's General Acute Care Hospital (GACH) Discharge Medication Reconciliation documentation dated 3/26/2026, Resident 2's GACH Discharge Medication Reconciliation documentation indicated under All Active Home Medications at time of Discharge Reconciliation on 3/24/2026, an order for risperidone (a prescription antipsychotic medication used to treat schizophrenia, bipolar disorder [a chronic mental health condition characterized by intense, extreme mood swings that interfere with daily life], and irritability associated with autism [a lifelong developmental difference that affects how a person perceives the world, communicates and interacts with others]) 3 mg (milligrams – a unit of measurement) oral tablet give 1 tablet orally 2 times a day. During a review of Resident 2's Order Summary Report dated 3/26/2026, Resident 2's Order Summary Report indicated an order that was input on 3/26/2026 (input by DSD) for risperidone oral table 3 mg, give 3 tablets by mouth two times a day for schizophrenia.During a review of Resident 2's Physician Order Note dated 3/26/2026, Resident 2's Physician Order Note indicated the risperidone order that was input on 3/26/2026 for Resident 2 by DSD was outside of the recommended dose or frequency further indicating the dosing regimen of 3 tablets 2 times per day exceeds the usual dose regimen of 0.02 tablet daily to 0.67 tablet 6 times per day.During an interview on 4/15/2026 at 2:57 PM with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated when a resident is admitted to the facility, the resident's admission packet needs to be reviewed which includes information on what medications the resident needs to continue. LVN 1 stated the resident's primary physician (MD) is then notified of the resident's arrival to the facility and to ask MD if the resident's current or active medications are okay to be continued or not and once approval is received from the MD, the licensed nurse in charge of the resident's admission will start inputting the medication orders for the resident. LVN 1 also stated if ever he would see an alert on the system about a resident's medication order that was input into the system, he would double check the order and alert the Registered Nurse Supervisor to ask if they would be able to double check because often times it was transcribed incorrectly. LVN 1 further stated it is important to double check, reconcile and transcribe a resident's medication orders accurately because of human error and to double check if something was missed by the licensed nurse in charge of the resident's admission. During an interview on 4/16/2026 at 12:35 PM with DSD, DSD stated the process for admitting a resident to the facility, the licensed nurse would get report from GACH and inform the MD that the resident was admitted to the facility, will do medication reconciliation, and the MD will give orders to continue medication orders from GACH unless the MD wants to change something on the resident's medication list. DSD stated when DSD admitted Resident 2 on 3/29/2026, she (DSD) was tired and had transcribed Resident 2's risperidone order in error and instead of putting in the order for 1 tablet twice a day, she put it in for 3 tablets twice a day. DSD stated she did not notice the system had alerted that the dose was above the recommended dose and stated if she had seen the alert, she would have gone back to look through Resident 2's GACH Discharge Medication Reconciliation to double check to see if she reconciled or input the order correctly. DSD further stated there should have been a double checked by another staff member after DSD had input the orders. During a concurrent interview and record review on 4/16/2026 at 12:55 PM with the Director of Nursing/Infection Preventionist (DON/IP), the facility's policy and procedure (P&P) titled, Reconciliation of Medications on Admission, revised July 2017 and Charting and Documentation, revised July 2017 were reviewed. The Reconciliation of Medication on Admission, P&P indicated, The purpose of this procedure is to ensure medication safety by accurately accounting for the resident's medications, routes and dosages upon admission or readmission to the facility and to review the list (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	carefully to determine if there are discrepancies/conflicts. The P&P also indicated, medication reconciliation reduces medication errors and enhances resident safety by ensuring that the medications the resident needs and has been taking continue to be administered without interruption, in the correct dosages and routes, during the admission/transfer process. The Charting and Documentation, P&P indicated, Documentation in the medical record will be objective (not opinionated or speculative), complete and accurate. The DON/IP stated she agreed with the policy and that the medication reconciliation for Resident 2's risperidone on 3/29/2026 was not accurate. The DON/IP also stated after admission orders are input into the system, it is the DON's job to double check and review the next day that the resident's medications were input correctly. The DON/IP further stated it is important that a resident's medications are reconciled accurately to ensure the medications are continued for the resident in the correct dose, route, time and indication.During the same interview on 4/16/2026 at 12:55 PM with the DON/IP, the DON/IP stated because Resident 2's risperidone order was input incorrectly as 3 tablets instead of 1 tablet, the pharmacy would not dispense the medication which is why it was not delivered to the facility and was not given to the resident from 3/27/2026 to 3/29/2026 (3 days). The DON/IP further stated because Resident 2 was not able to take her (Resident 2) risperidone, not taking it could have further aggravated the resident's condition.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow their infection control policy and procedure for two (2) of three (3) sampled residents (Residents 1 and 3) by:1. Not ensuring Registered Nurse 1 (RN 1) changed gloves and performed hand hygiene (washing hands with either an alcohol based hand sanitizer or washing hands) when going from dirty to clean task during wound care treatment for Resident 3 and did not perform hand hygiene after doffing (taking off) personal protective equipment (PPE; clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) after leaving the Resident 3's room.2. Failing to disinfect blood pressure cuff (a medical device, consisting of an inflatable rubber bladder within a sleeve, used to measure blood pressure) before using it on Resident 1.These failures had the potential to result in infection to Resident 3's wound and the spread of infection to other residents in the facility. During a review of Resident 3's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE] and readmitted [DATE] with diagnoses of pressure ulcer (localized damage to the skin and/or underlying tissue usually over a bony prominence) of sacral region (a large, triangular-shaped bone located at the very base of the spine, situated between the lumbar spine [lower back] and coccyx [tailbone]) stage 4 (most severe type of pressure ulcer characterized by full-thickness skin loss that exposes underlying muscle, tendon or bone) and local infection of the skin and subcutaneous tissue (the deepest layer of the skin located directly beneath the dermis [the thick, inner layer of skin located between the outer epidermis and deeper subcutaneous tissue]). During a review of Resident 3'S Minimum Data Set (MDS – a resident assessment tool), dated 1/17/2026, the MDS indicated the resident was moderately impaired with cognitive (ability to think, remember, and reason) skills for daily decision making. It indicated, Resident 3 was dependent (helper does all of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) with chair/bed-to-chair transfers, going from lying to sitting on side of the bed, going from sitting to lying down, putting on/taking off footwear, lower body dressing (the ability to dress and undress below the waist) and showering and bathing himself The MDS also indicated Resident 3 needed also needed substantial/maximal assistance (helper does more than half the effort) with personal hygiene and needed partial/moderate assistance (helper does less than half the effort) with rolling left and right in bed, upper body dressing (the ability to dress and undress above [NAME] waist) and needed setup or clean-up assistance (helper sets up or cleans up, resident completes activity) with eating. It further indicated Resident 3 had one stage 3 pressure ulcer that was present upon admission. During a review of Resident 3's Order Summary Report dated 4/16/2026, Resident 3's Order Summary Report indicated an order initiated on 4/13/2026 to apply santyl collagenase ointment (prescription medication used to clean wounds by removing dead, damaged skin [necrotic tissue]) to sacrum stage 4 topically (to a specific surface or spot on the body) and then apply collagen powder (medical-grade, protein-based dressing derived from natural sources that is applied to open, chronic [long-term] or hard-to-heal wounds to jump-start the healing process) and calcium alginate (a highly absorbent, biodegradable [materials that can naturally break down into harmless components] wound dressing made from brown seaweed, designed for moderately to heavily draining wounds) and to cover with a dry dressing every day shift and to also change the dressing when soiled. During an observation on 4/15/2026 at 9:25 AM inside Resident 3's room, RN 1 was observed rendering a wound care treatment for Resident 3's sacrum stage 4 wound. RN 1 was observed to remove Resident 3's dirty dressing and cleaned the wound and did not perform hand hygiene or change her (RN 1) gloves before applying the treatment of santyl collagenase ointment, collagen powder, calcium alginate and covering Resident 3's wound with a dry dressing. During an observation (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Before moving from work on a soiled body site to a clean body site on the same resident. Immediately after glove removal. During a review of the facility's P&P titled, Wound Care Treatment Policy & Procedure, revised 2/2/2026, the P&P indicated, It is the policy of the facility to ensure all wound care treatments are performed using aseptic technique, proper hand hygiene, and in accordance with physician orders, to promote healing and prevent infection. The P&P also indicated its purpose, To provide a consistent, safe, and infection-controlled approach to wound care treatment. The P&P further indicated perform hand hygiene: After exposure to wound/drainage After removing gloves The P&P also indicated the steps for removal of old dressing are as follow: Don clean gloves Remove old dressing carefully Observe wound drainage, odor, color Discard dressing in appropriate waste Remove gloves and perform hand hygiene In addition, the P&P indicated during application of treatment: apply medications/treatments as ordered, use aseptic technique, avoid contamination of supplies, strict adherence to hand hygiene and to not cross-contaminate supplies between residents. 2. During a review of Resident 1's admission Record, the admission Record indicated the resident was originally admitted to the facility on [DATE] and was readmitted on [DATE] with the following but not limited to diagnoses of atrial fibrillation (a common, often irregular, and rapid heart rate causing the heart's upper chambers [atria] to quiver chaotically instead of beating effectively. It increases blood clot, stroke, and heart failure risks), Hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness on one side of the body caused by brain or spinal cord damage, most commonly from stroke, tumor, or trauma) following cerebral infraction (stroke caused by blood clot blockage in brain blood vessels reducing blood flow to the brain). During a review of Resident 1's MDS, dated [DATE], the MDS indicated the resident was moderately impaired in cognitive skills for daily decision making. The MDS also indicated Resident 1 required partial to moderate assistance c with shower/bathe self and putting on/taking off footwear but required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently) with oral hygiene, toileting hygiene, upper body dressing, lower body dressing and personal hygiene. During a review of Resident 5's admission Record, the admission Record indicated the resident was (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	originally admitted on [DATE] and was readmitted on [DATE] with the following but not limited to protein-calorie malnutrition, disorder of kidney (organ that helps filter waste from body) and ureter (urine passes from the kidney to the bladder), and dementia (a progressive state of decline in mental abilities) with anxiety (a feeling of fear, dread, and uneasiness, often characterized by future-oriented worry, apprehension, and physical symptoms like rapid heart rate, tension, and dizziness). During a review of Resident 5's MDS, dated [DATE], the MDS indicated the resident was severely impaired in cognitive skills for daily decision making. The MDS also indicated that the resident was dependent with shower/bathe self, upper body dressing, lower body dressing, putting on/taking off footwear, putting on/taking off footwear and personal hygiene. During an observation on 4/16/2026 at 8:32 AM, RN 2 was observed checking Resident 5's blood pressure and giving medications to Resident 5. During an observation on 4/16/2026 at 8:38 AM, RN 2 was observed checking Resident 1's blood pressure without disinfecting the blood pressure cuff after using it on Resident 5. During an interview on 4/16/2026 at 9 AM, RN 2 stated she did not disinfect the blood pressure cuff after using it on Resident 5 and prior to using it on Resident 1. RN 2 also stated it is for infection control reasons that is why the BP cuff should be disinfected in between resident use. During an interview on 4/16/2026 at 1:30 PM, Director of Nursing/ Infection Preventionist Nurse (DON/IP) stated, equipment should be disinfected before and after each resident to prevent the spread of infection. During a review of the facility's Policy and Procedure (P&P) titled, Cleaning and Disinfection of Resident-Care Items and Equipment, revised 9/2022, the P&P indicated reusable items are cleans and disinfected or sterilized between residents.