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	12/05/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44018 Based on observation, interviews, and record reviews, the facility staff failed to ensure resident would not wait for 32 minutes to receive his meal tray while other residents in the same table were eating for one (1) of 15 sampled residents (Residents 25). This deficient practice violated the rights of the resident to be treated with dignity or respect. Findings: During a review of Resident 25's Admission Records indicated Resident 25 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that includes dysphagia (difficulty swallowing foods or liquids) following cerebral infarction (stroke-damage to the tissues in the brain due to a loss of oxygen to the area) and type II diabetes mellitus (high blood sugar). During a review of Resident 25's Minimum Data Set (MDS- a federally mandated resident assessment tool) dated 10/13/2024, indicated Resident 25 was cognitively (relating to the process of acquiring knowledge and understanding) impaired. The MDS indicated Resident 25 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) for eating, toileting hygiene, and oral hygiene. During a review of Resident 25's History and Physical Examination (H&P) dated 7/17/2024, the H&P indicated Resident 25 was not competent to understand his medical condition. During a review of facility's undated Dining Hour (DH - the time of day when people eat their meals). The DH indicated lunch was served at 12:00 PM. During a dining observation on 12/2/2024 at 12:08 PM, Resident 25 was observed sitting in the dining room waiting for the resident's lunch tray while other residents were eating. During a concurrent dining observation on 12/2/2024 at 12:32 PM (24 minutes from when other residents were observed eating except for Resident 25), Activity Specialist 1 (AS 1) was observed bringing the lunch tray to Resident 25 and assisted Resident 25 with feeding. AS 1 confirmed she started feeding Resident 25 at 12:32 PM and the other residents started eating approximately 24 minutes ago. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview with AS 1 on 12/2/2024 at 1:10 PM, the AS 1 stated the meal carts arrived in the dining room at 12:00 PM, AS 1 stated she was not sure why staff did not give the lunch tray to Resident 25 or assisted Resident 25 to eat as soon as the meal carts arrived. During an interview with Resident 25 in his room on 12/2/2024 at 1:40 PM, Resident 25 stated on 12/2/2024 between 12 PM to 12:32 PM, the resident felt uncomfortable and disrespected after witnessing other residents were eating and the resident did not have his lunch tray. During an interview with Administrator (ADM) on 12/2/2024 at 1:48 PM, ADM stated there are three meal carts total and the first cart for meals arrives in the dining room at 12 PM. The ADM stated it was not acceptable for some residents to wait longer than 5 minutes before receiving their meals while other resident were eating. ADM stated it was important to always treat residents with respect to ensure they feel comfortable and respected while in the facility. A review of the facility policy and procedure titled Dignity revised dated February 2021, indicated staff shall provide with a dignified dining experience. The policy statement indicated that each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being and level of satisfaction with life, and feelings of self-worth and self-esteem.

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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** 45456 Based on observation, interview, and record review, the facility failed to ensure the call light (device used by residents to call staff) was within reach for three (3) of 15 sampled residents (Resident 1, 6, and 5) in accordance with the facility policy and procedure. This failure had the potential for Residents 1, 6, and 5 to not be able to call for assistance, which could result in untimely delivery of care and services. Findings: 1. During a review of Resident 1's Admission Record, the Admission Record indicated Resident 6 was admitted to the facility on [DATE] and re- admitted on [DATE] with diagnoses included cerebral infarction (refers to damage to tissues in the brain due to a loss of oxygen to the area) affecting left dominant side, muscle weakness, stage 3 pressure ulcer of sacral region (it is a triangular-shaped bone at the base of the spine just superior to the coccyx[tailbone]) and unspecified buttock. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), the MDS dated [DATE], indicated Resident 1 has moderately impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 1 was dependent with toileting hygiene, shower/bathe self, upper and lower body dressing, putting on/ taking off footwear, roll left and right, sit to lying, and lying to sitting on side of the bed. During a concurrent observation and interview with Resident 1 on 12/3/2024 at 9:25AM, Resident 1's soft touch call light was placed on the left upper side of the bed, which was not within Resident 1's reach. Resident 1 stated, I do not know where my call light is, I cannot find it. I use it when I need help. During a concurrent observation in Resident 1's room and interview with Certified Nurse Assistant 5 (CNA 5) on 12/5/2024 at 2:54 PM, Resident 1's soft touch call light was placed on top of the bed side table on the left side of the bed, which was not within Resident 1's reach. CNA 5 stated, Call light should be within resident's (Resident 1) reach. If the resident cannot reach her call light, the resident will not be able to call for help if she needs assistance. 2. During a review of Resident 6's Admission Record, the Admission Record indicated Resident 6 was admitted to the facility on [DATE] and re- admitted on [DATE]. During a review of Resident 6's History and Physical (H&P), dated 11/9/2024, with diagnoses which included hemiplegia (paralysis of one side of the body) and hemiparesis (weakness on one side of the body) from cerebral vascular accident (CVA, or stroke is an interruption in the flow of blood to cells in the brain) affecting right dominant side and bilateral above-knee amputation (AKA, a surgical procedure to remove a leg above the knee joint when a limb is severely damaged or diseased). (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 6's MDS, dated [DATE], indicated Resident 6 has severely impaired cognitive skills for daily decision making. The MDS indicated Resident 6 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) with eating, toileting hygiene, shower/bathe self, lower body dressing, putting on/ taking off footwear, roll left and right, sit to lying, lying to sitting on side of the bed, and chair/bed-to chair transfer. During an observation in Resident 6's room on 12/2/2024 at 10:16 AM, Resident 6 was observed in bed with an Alternating Air Pressure Pad (APP, designed with rows of lateral air cells, which can be inflated or deflated to alternate the pressure within the lying surface which are designed to optimize pressure redistribution to prevent and treat pressure ulcers) mattress. Resident 6 was observed to have right side weakness and contracted (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) right hand. Resident 6 's call light was placed next to the right arm. Resident 6 was not able to press his call light button. During a concurrent observation in Resident 6's room and interview with Licensed Vocational Nurse 3 (LVN 3) on 12/4/2024 at 2:25 PM, Resident 6 was observed in bed with the APP mattress and call light was placed on Resident 6's right arm. LVN 3 verified Resident 6's call light was on the right side. LVN 3 stated, Call light should be on the left hand because Resident 6 has right side weakness. Resident 6 cannot reach the call light with his left hand. Resident 6 will not be able to call for help if he needs assistance. 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 timely response to the resident's request and needs. Ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor. 49537 3. During a review of Resident 5's Admission Record, the Admission record indicated the facility admitted Resident 5 on 11/5/2024 with diagnoses that included but not limited to left hemiplegia (paralysis [the loss of muscle function] on one side of the body) and hemiparesis (weakness on one side of the body) following a stroke (occurs when blood flow to the brain is interrupted leading to damage or death of brain cells), bilateral above-the-knee amputation (surgical removal of more than one limb, either both lower extremity or both upper extremity), muscle wasting and atrophy (referring to the loss of muscle mass and strength, typically caused by a lack of physical activity, injury, malnutrition or certain medical conditions), and protein calorie malnutrition (nutritional status on which reduced availability of nutrients leads to changes in body composition and function). During a review of Resident 5's MDS dated [DATE], the MDS indicated Resident 5 had intact cognitive (mental processes that take place in the brain, including thinking, attention, language learning, memory, and perception) skills for daily decision making. The MDS also indicated Resident 5 was dependent (Helper does all the effort. Resident does none of the effort to complete activity or the assistance of two or more helpers is required for the resident to complete the activity) with eating, oral/toileting/personal hygiene, shower/bathing self, upper and lower body dressing, and putting on/taking off footwear. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 12/2/2024 at 10 AM, in Resident 5's room, Resident 5 was observed lying in bed covered in blanket. Resident 5's call light was observed on the floor, out of reach of the resident. Resident 5 stated he cannot move his fingers so he cannot push the call button. Resident 5 stated he would call for help by yelling for a staff to come to his room. Resident 5's roommate stated he would push his call light when Resident 5 would start yelling for help since Resident 5 cannot move his fingers to push the call light himself. During a concurrent observation and interview on 12/5/2024 at 9:30 AM, in Resident 5's room with Licensed Vocational Nurses 3 and 4 (LVN 3 and LVN 4), call pad observed under Resident 5's right hand. LVN 4 stated call light button was changed to call pad that Resident 5 can use effectively. LVN 4 stated call button was not appropriate as Resident 5 cannot move his fingers or resident yells for help, which was not okay since the noise would also disturb and affect the other residents especially his roommate. During a review of the facility's P&P titled, Answering the Call Light, revised September 2022, the P&P indicated to ensure the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor. During a review of the facility's P&P titled, Quality of Life - Accommodation of Needs, revised August 2009, the P&P indicated the facility's environment and staff behaviors are directed toward assisting the resident in maintaining and/or achieving independent functioning, dignity, and well-being. P&P further stated, the resident's individual needs and preferences, including the need for adaptive devices and modifications to the physical environment, shall be evaluated upon admission and reviewed on an ongoing basis.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49537 Based on observation, interview, and record review, the facility failed to maintain a safe, clean, comfortable, and home like environment for six sampled residents (Residents 8, 194, 36, 18, 28, and 19) of 11 residents when facility failed to: 1. Maintain comfortable and safe temperature levels for Resident 8. 2. Maintain a working television for Resident 194. 3. Maintain a comfortable noise level for Resident 36. 4. Maintain a clean and sanitary environment by ensuring Resident 18's floor was not soiled and room did not smell like urine. 5. Maintain a clean and sanitary environment for Resident 28 by ensuring room did not smell like urine. 6. Ensure Resident 19's room did not have a chipping wall trim/molding. These deficient practices had the potential for Residents 8, 194, 36, 18, 28, and 19 to feel discomfort/sustain injury and had the potential to negatively affect the residents' well-being and quality of life. Findings: 1. During a review of Resident 8's Admission Record (front page of the chart that contains a summary of basic information about the resident), the Admission Record indicated the facility initially admitted the resident on 6/19/2020 and readmitted on [DATE] with diagnoses that included but not limited to hemiplegia (refers to paralysis [loss of the ability to move] on one side of the body after a stroke (a loss of blood flow to part of the brain, which damages brain tissue) and hemiparesis (condition that causes partial paralysis or weakness on one side of the body) affecting the left side, gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for residents with swallowing problems), and dysphagia (difficulty swallowing). During a review of Resident 8's Minimum Data Set (MDS - a resident assessment tool), dated 9/26/2024, the MDS indicated Resident 8's had severe cognitive (relating to mental processes involving knowing, learning, and understanding things) skills for daily decision making. The MDS also indicated Resident 8 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 and personal hygiene and was dependent (helper does all 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, shower/bathing, upper and lower body dressing and putting on/off footwear. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 12/4/2024 at 8:29 AM, in Resident 8's room with Licensed Vocational Nurse 1 (LVN 1), the room was observed to be warm. Maintenance Supervisor 1 (MS 1) checked the room temperature, which showed 83 and adjusted the thermostat (a device that automatically regulates temperature or that activates a device when the temperature reaches a certain point). During an interview on 12/4/2024 at 8:40 AM, with MS 1, MS 1 stated the room temperature was 83 degrees F. MS 1 stated the room was too hot and had adjusted the thermostat. MS 1 stated it was important to keep the room temperatures within range of 71 degrees to 81 degrees F as residents will get very warm or very cold and cause discomfort to them. 2. During a review of Resident 194's Admission Record, the Admission Record indicated the facility admitted the resident on 11/12/2024 with diagnoses that included but not limited to multiple fractures (break in the bone, either partial or complete, and can occur in any bone in the body) of the ribs (flat bones that form part of the rib cage to help protect internal organs such as the lungs and heart)-left and right side, chronic pain syndrome (major medical condition that involves persistent pain that lasts for months or years), uncomplicated opioid dependence (a physical change that occurs when someone takes opioids over a long period of time, causing their body to rely on the substance to avoid withdrawal), and hypertension (high blood pressure). During a review of Resident 194's MDS, dated [DATE], the MDS indicated Resident 194 had intact cognitive skills for daily decision making. The MDS also indicated Resident 194 required substantial/maximal assistance with lower body dressing and putting on/taking off footwear, 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). The MDS also indicated Resident 194 required set up or clean-up assistance (Helper sets up or cleans up, resident completes activity). During a concurrent observation with LVN 1 and interview with Resident 194 on 12/5/2024 at 9:34 AM, in Resident 194's room, Resident 194 was observed sitting in her bedside chair by the window. Resident 194 stated, My television (TV) is falling apart. It's not working, it's getting me frustrated, the TV is hazy/ pixelated. LVN 1 stated the resident's television should be fixed since it made the resident feel frustrated. 3. During a review of Resident 36's Admission Record, the Admission Record indicated the facility initially admitted the resident on 7/25/2024 and readmitted on [DATE] with diagnoses that included but not limited to cellulitis of the left lower limb (a bacterial infection[invasion and growth of germs in the body] of the skin and underlying tissues in the lower leg, congestive heart failure (chronic condition where the heart muscle weakens and cannot pump blood effectively leading to buildup of fluid in the lungs, legs and other parts of the body), and hypertension. During a review of Resident 36's MDS, dated [DATE], the MDS indicated Resident 36 had intact cognitive skills for daily decision making. The MDS also indicated Resident 36 required partial/moderate assistance with toileting and personal hygiene, shower/bathing, lower body dressing and putting on/taking off footwear, required supervision or touching assistance (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. The MDS also indicated Resident 36 required set up or clean up assistance with oral hygiene and was independent with eating. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 12/2/2024 at 9:58 AM, in Resident 36's room, Resident 36 was observed lying in bed, awake and covering both ears. Observed Resident 136's roommate next to his bed was moaning and groaning loudly and intermittently screaming. Resident 36 stated he was not able to sleep for two to three days when his roommate was having these episodes. Resident 36 stated episodes happen during the day and night. During an interview on 12/3/2024 at 2:45 PM with LVN 4, LVN 4 stated Resident 136 always complained about his roommates. LVN 4 stated she could hear Resident 36's roommate yelling from outside the room and stated if she was one of the residents in the room, she would not be able to sleep or rest if the someone was moaning, groaning, and yelling loudly. LVN 4 stated it is not acceptable as it would affect the other residents' rest and sleep. During a review of the facility's Policy and Procedure (P&P) titled, Homelike Environment, revised February 2021, the P&P indicated residents are provided with a safe, clean, comfortable, and homelike environment. The facility staff and management maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting and include comfortable and safe temperatures (71 degrees to 81 degrees F) and comfortable sound levels. 45456 4. During a review of Resident 18's Admission Record, the Admission Record indicated Resident 18 was admitted to the facility on [DATE] with diagnoses included dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), adult failure to thrive (FTT, a syndrome of weight loss, decreased appetite and poor nutrition, and inactivity) and muscle wasting/ atrophy (decrease in size and wasting of muscle tissue) During a review of Resident 18's MDS, dated [DATE], indicated Resident 18 had moderately impaired cognitive skills for daily decision making. The MDS indicated Resident 18 needs partial/ moderate assistance (helper does less than half the effort, helper lifts, hold, or supports trunk or limbs but provides less than half the effort) in toileting hygiene, shower/bathe self, upper body dressing, putting on/ taking off footwear, roll left and right, sit to lying, lying to sitting on side of the bed, sit to stand, chair/bed-to chair transfer, toilet transfer and walk 10 feet. The MDS indicated Resident 18 was frequently incontinent in bowel and bladder. During an observation in front of Resident 18's room on 12/4/2024 at 9:47 AM, the hallway in front of Resident 18's room had a strong odor of urine. Resident 18's room has an air purifier inside the room and has a strong smell of urine. During an observation and interview with Certified Nursing Assistant 1 (CNA 1) on 12/4/2024 at 10:20 AM, CNA 1, The hallway has urine smell. I am not sure when did they put the air purifiers in the hallway. Resident 18's room has a strong urine odor because Resident 18 has urinary incontinence. During a concurrent observation and interview with Housekeeper 1(HKS 1) on 12/4/2024 at 10:24 AM, HSK 1 went inside Resident 18's Room and check Resident 18's bedroom area. HSK 1 stated Resident 18 has urine on the floor. HSK 1 stated, Resident 18 urinated on the floor next to his bed. HSK 1 stated Resident 18 is incontinent and usually urinates on the floor. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. During a review of Resident 28's Admission Record, the Admission Record indicated Resident 28 was admitted to the facility on [DATE] with diagnoses included End-stage renal disease (ESRD, irreversible decline in a person's own kidney function), hemiplegia (paralysis of one side of the body) and hemiparesis (weakness on one side of the body) cerebral infarction (refers to damage to tissues in the brain due to a loss of oxygen to the area) affecting left non- dominant side. During a review of Resident 28's MDS, dated [DATE], indicated Resident 28 had moderately impaired cognitive skills for daily decision making. The MDS indicated Resident 28 needs 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, roll left and right, sit to lying, lying to sitting on side of the bed, sit to stand, chair/bed-to chair transfer, and walk 10 feet. During observation and interview of Resident 28 on 12/5/2024 at 8:37 AM, Resident 28's room had a strong smell of urine. Resident 28 was laying on his bed, acknowledged the strong smell of urine and had a sad facial expression. During a concurrent observation and interview with CNA 6 on 12/5/2024 at 8:42 AM, CNA 6 verified Resident 28's room smelled like urine. CNA 6 stated, the room smells like urine because of Resident 28's roommate (Resident 18). CNA6 stated Resident 18 would frequently urinate on the bathroom or on the floor. During an interview with the MDS Nurse (MDSN) on 12/5/2024 at 2:22 PM, MDSN stated Resident 28's room has and should not have a strong urine smell to not affect the resident's wellbeing. During an interview with the MDSN on, 12/5/2024 at 2:25 PM, MDSN stated, It is important to keep the room clean and sanitary for Resident 18 and 28 because it might affect their well-being. During a review of the facility's Policy and Procedure (P&P) titled, Homelike Environment, revised 2/2021, the P&P indicated the facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflects a personalized, homelike setting. The characteristics include a) clean, sanitary, and orderly environment. f) pleasant, neutral scents. 44018 6. During a review of Resident 19's Admission Record, the Admission Record indicated Resident 19 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses including hyperlipidemia (a condition in which there are high levels of fat particles (lipids) in the blood) and seizure (uncontrolled jerking, loss of consciousness, blank stares caused by abnormal electrical activity in the brain). During a review of the Minimum Data Set (MDS-a federally mandated resident assessment tool), dated 10/18/2024, indicated Resident 19 had severely impaired cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 19 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) from staff for personal hygiene, toilet hygiene, and oral hygiene. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview with Resident 19 in Resident 19's room, on 12/2/2024 at 3:32 PM, Resident 19's wall trim/molding, measuring approximately six (6) inches above the level of the resident's head was observed with a piece of wood chipping off the wall trim. Resident 19 expressed disapproval of the piece of wood chipping off the wall trim. During a concurrent observation and interview with Registered Nurse Supervisor 1 (RNS 1) in Resident 19's room on 12/2/2024 at 4:12 PM, RNS 1 stated she would inform the Maintenance Supervisor 1 (MS 1) to repair the wall trim. RNS 1 stated Resident 19 could bump his head to the broken wall trim and could get injured. During a concurrent observation and interview with MS 1 in Resident 19's room, on 12/2/2024 at 4:40 PM, the MS 1 stated the cracked wall trim was a potential hazard and stated he would fix it right away to prevent potential accidents. During an interview with Director of Nursing (DON), on 12/3/2024 at 8:20 AM, DON stated broken wall trim should be immediately repaired. DON stated if MS 1 could not repair immediately, he should post a warning sign near the broken wall trim to prevent potential accidents to residents. DON also stated, It is the facility's responsibility to provide a safe, comfortable, and homelike environment to residents. During a review of the facility's policy and procedure (P&P) titled, Maintenance Service, revised date December 2009, the P&P indicated it is the policy of the facility to maintain the building in good repair and free from hazards. During a review of the P&P titled, Home like Environment, revised date February 2021, the P&P indicated it is the policy of the facility to provide residents with safe, clean, comfortable, and homelike environment and encouraged to use their personal belongings to the extent possible.

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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** 45456 Based on observation, interview, and record review, the facility failed to develop a comprehensive person-centered care plan for one (1) of 15 sampled residents (Resident 22) for the use of antibiotic (medicines that fight bacterial infections) and anticoagulants (substance that is used to prevent and treat blood clots in blood vessels and the heart) per facility's Comprehensive Person-Centered Care Plan policy and procedure. This deficient practice had the potential for Resident 22 to not receive specific interventions to prevent decline in the resident's functional ability, not being monitored for resident's therapeutic treatment, and also may result in injury/harm and/or worsening of the resident's condition. Findings: During a review of Resident 22's Admission Record, the Admission Record indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included osteomyelitis (inflammation or swelling that occurs in the bone) of lumbar vertebrae (are the five bones in the lower back that make up the lumbar spine), congestive heart failure (also called heart failure, is a serious condition in which the heart doesn't pump blood as efficiently as it should) and hypertension (high blood pressure). During a review of Resident 22's Minimum Data Set (MDS, a resident assessment tool) dated 11/8/2024, the MDS indicated Resident 22 had intact cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 22 was partial/ moderate assistance (helper does less than half the effort, helper lifts, hold, or supports trunk or limbs but provides less than half the effort) with oral hygiene, toileting hygiene, shower/bathe self, upper and lower body dressing, putting on and taking off footwear, personal hygiene, roll left and right, sit to lying, lying to sitting on side of the bed, sit to stand, chair/bed -to chair transfer, and walk 10 feet. During a review of Resident 22's order summary report dated 11/4/2024, indicated: 1. Ceftriaxone (is a third-generation cephalosporin antibiotic used for the treatment of a few bacterial infections) sodium injection solution reconstituted 2 grams (gm, unit of measurement). Use 2 grams intravenously (refers to a way of giving a drug or other substance through a needle or tube inserted into a vein) one time a day for osteomyelitis until 12/11/2024. 2. Eliquis (a prescription medicine used to treat blood clots in the veins of the legs [deep vein thrombosis {DVT, is a blood clot that forms in a deep vein, usually in the leg or pelvis, but can also occur in the arm}] or lungs [pulmonary embolism {PE, occurs when a blood clot gets stuck in an artery in the lung, blocking blood flow to part of the lung}], and reduce the risk of them occurring again) oral tablet 5 mg. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview with MDS Nurse (MDSN) and record review on 12/5/2024 at1:35 PM, Resident 22's care plans dated 11/4/2024 to 12/5/2024 were reviewed. The care plan did not indicate Resident 22 has a care plan for antibiotic therapy (Ceftriaxone use). MDSN stated, intravenous antibiotic care plan should have been done during admission because Resident 22 came in with antibiotic therapy. During a concurrent interview with MDSN and record review on 12/5/2024 at 1:45 PM, Resident 22's care plans dated 11/4/2024 to 12/5/2024 were reviewed. There was no care plan for Resident 22's anticoagulant therapy (Eliquis). MDSN stated, There was no care plan for resident's (Resident 22) anticoagulant use - Eliquis. We should have a care plan to monitor bleeding. If we do not have a care plan on anticoagulant, it means we are not monitoring if resident has bleeding. During an interview with the Director of Nursing (DON) on 12/5/2024 at 3:48 PM, the DON stated, Care plans should be done by the admitting nurse right away. The comprehensive care plan will be completed by the Registered Nurse/Quality Assurance Nurse. The DON also stated, if there was no care plan for Resident 22's antibiotic and Eliquis use, it means we are not monitoring if the treatment is effective.The DON added it also meant we are not monitoring for possible side effects of the medications or treatment. During a review of undated facility's policies and procedures (P&P) titled, Care Plan, Comprehensive Person-Centered, revised 3/2022, the P&P indicated the comprehensive, person-centered care plan is developed within seven (7) days of the completion of the requires MDS Assessment (Admission, Annual, or Significant Change in Status), and no more than 21 days after admission. The care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and relevant clinical decision making.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45456 Based on observation, interview, and record review, the facility failed to implement treatment for the prevention of pressure ulcer (painful wound caused as a result of pressure or friction) by failing to ensure that the low air loss mattress (LAL, mattress used for residents who are at risk for developing sores or already have pressure ulcer designed to circulate a constant flow of air for the management of pressure sores) was on the correct settings for three (3) of 3 sampled residents (Residents 30, 6, and 1), in accordance with the facility's policy and procedure (P&P) titled, Pressure Injury,. This deficient practice had the potential for Resident 30 and 6 to develop a pressure ulcer and place Resident 1 to have worsening stage 3 pressure ulcer (full-thickness skin loss in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole [rolled wound edges] are often present). Findings: 1. During a review of Resident 30's Admission Record indicated Resident 30 was admitted to the facility on [DATE] and re- admitted on [DATE]. During a review of Resident 30's History and Physical (H&P) dated 4/3/2024 with diagnoses included Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), muscle wasting/ atrophy (decrease in size and wasting of muscle tissue) and stage 4 pressure ulcer of the sacral region (it is a triangular-shaped bone at the base of the spine just superior to the coccyx [tailbone]). During a review of Resident 30's Minimum Data Set (MDS, a resident assessment tool) dated 10/9/2024, indicated Resident 30 has intact cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 30 needs 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, sit to lying, lying to sitting on side of the bed, sit to stand, chair/bed-to chair transfer, toilet transfer and walk 10 feet. During a review of Resident 30's Physician's Order dated 9/12/2024, indicated LAL therapy bed for treatment and management of pressure ulcer ever shift check for functionality and correct weight setting. During a review of Resident 30's Braden Scale (is a standardized, evidence-based assessment tool commonly used in health care to assess and document a client's risk for developing pressure injuries), dated 9/12/2024, indicated Resident 30 has total score of 15, which indicated Resident 30 was at risk for skin breakdown. During an observation in Resident 30's room on, 12/2/2024 at 10 AM, Resident 30 was observed in bed with the LAL set more than 350 millimeters of mercury (mmHg, unit of pressure) and set up on the maximum firmness. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation in Resident 30's room on,12/3/2024 at 9:07AM, Resident 30 was observed in bed with the LAL was set above 350 mmHg on the maximum firmness. During a concurrent observation in Resident 30's room and interview with Licensed Vocational Nurse 3 (LVN 3) on 12/4/2024 at 2:11 PM, Resident 30 was observed in bed with the LAL was set more than 350 mmHg. LVN 3 stated, LAL was set on the maximum setting. LAL was set on the incorrect setting. LAL will not be effective for Resident 30's wound management. During a concurrent interview with LVN 4 and record review of Resident 30's weight record on 12/4/2024 at 2:14 PM, LVN 4 Resident 30's weight was 220 pounds (lbs., unit of measurement). LVN 4 stated LAL should be set on 210 mmHg because LAL should be set up based on Resident's weight. During a concurrent interview with LVN 4 and record review of Resident 30's Physician's order on, 12/4/2024 at 2:18 PM, Physician's order dated 9/12/2024. LVN 4 stated, Physician's order indicated LAL is for wound healing and skin maintenance. Resident 30 was using LAL as maintenance order for his coccyx wound that was resolved. LVN 4 stated Resident 30 has no pressure ulcer, and the resident's LAL was set incorrectly, places the reisdent to develop pressure ulcers because the LAL was set up too firm or not in accordance with the manufacturer's guideline. 2. During a review of Resident 6's Admission Record indicated Resident 6 was admitted to the facility on [DATE] and re- admitted on [DATE]. During a review of Resident 6's H&P dated 11/9/2024 with diagnoses included hemiplegia (paralysis of one side of the body) and hemiparesis (weakness on one side of the body) from cerebral vascular accident (CVA, or stroke is an interruption in the flow of blood to cells in the brain) affecting right dominant side and bilateral (both right and left) above-knee amputation (AKA, a surgical procedure to remove a leg above the knee joint when a limb is severely damaged or diseased). During a review of Resident 6's Braden Scale dated 11/8/2024, indicated Resident 6 has total score of 13, which indicated Resident 6 was moderately at risk for skin breakdown. During a review of Resident 6's Physician's Order dated 11/8/2024, indicated Monitor Alternating Air Pressure Pad (APP, are designed with rows of lateral air cells, which can be inflated or deflated to alternate the pressure within the lying surface which are designed to optimize pressure redistribution to prevent and treat pressure ulcers) mattress for wound healing and skin maintenance every shift. During a review of Resident 6's MDS dated [DATE], indicated Resident 6 has severely impaired cognitive skills for daily decision making. The MDS indicated Resident 6 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) in eating, toileting hygiene, shower/bathe self, lower body dressing, putting on/ taking off footwear, roll left and right, sit to lying, lying to sitting on side of the bed, and chair/bed-to chair transfer. During a review of Resident 6's monthly weights dated 11/27/2024 indicated Resident 6 weighed 163 lbs. During an observation in Resident 6's room on 12/2/2024 at 10:16 AM, Resident 6 was observed in bed with the APP mattress was set up on number 5, the maximum firmness. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation in Resident 6's room on, 12/3/2024 at 9:15 AM, Resident 6 was observed in bed with the APP mattress was set up on number 5, the maximum firmness. During a concurrent observation in Resident 6's room and interview with LVN 3 on, 12/4/2024 at 2:20 PM, Resident 6 was observed in bed with the APP mattress was set on the maximum setting which is number 5. LVN 3 stated, APP mattress was set on the hardest setting. It is not ideal to set the APP mattress on the maximum setting because it can cause pressure injury to Resident 6. Resident 6 had a history of pressure injury. During an interview with LVN 3 on 12/4/2024 at 2:22 PM, LVN 3 stated, the facility should check the resident's weight before the facility set up the APP mattress because the APP should be set up based on the resident's weight. 3. During a review of Resident 1's Admission Record indicated Resident 6 was admitted to the facility on [DATE] and re- admitted on [DATE] with diagnoses included cerebral infarction (refers to damage to tissues in the brain due to a loss of oxygen to the area) affecting left dominant side, muscle weakness, Stage 3 Pressure Ulcer of sacral region (it is a triangular-shaped bone at the base of the spine just superior to the coccyx[tailbone]), and unspecified buttock. During a review of Resident 1's Physician's Order dated 9/22/2024, indicated: 1. LAL mattress for wound healing and skin maintenance every dayshift. 2. Monitor LAL Mattress for any leakage and adjust static button according to Resident's weight every shift. During a review of Resident 1's MDS dated [DATE], indicated Resident 1 has moderately impaired cognitive skills for daily decision making. The MDS indicated Resident 1 was dependent in toileting hygiene, shower/bathe self, upper and lower body dressing, putting on/ taking off footwear, roll left and right, sit to lying, and lying to sitting on side of the bed. MDS indicated Resident 1 had three pressure injuries. During a review of Resident 1's Braden Scale dated 10/14/2024, indicated Resident 1 has total score of 13, which indicates Resident 1 was moderately at risk for skin breakdown. During a review of Resident 1's monthly weights dated 11/4/2024 indicated Resident 1 weighed is 203 lbs. During an observation in Resident 1's room on, 12/2/2024 at 10:45AM, Resident 1 was observed in bed with the LAL set on 250 mmHg. During an interview with Resident 1 on, 12/3/2024 at 9:25AM, Resident 1 stated, the mattress was hard yesterday. It hurts my back. I weighed 220 lbs. During an interview with LVN 3 on 12/4/2024 at 2:30 PM, LVN 3 stated, We are using the LAL as preventative measure for Resident 1's wound. If LAL mattress was set up on the highest setting, it can bring Resident 1's pressure ulcer back or LAL mattress can cause a new pressure injury to the resident. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's P&P titled, Pressure Injury, dated 2/29/2024, indicated to assess and implement interventions as appropriate to reduce the likelihood of development of pressure injuries and that a Resident who has a pressure injury receives appropriate care and services to promote healing and to prevent additional pressure injuries. A review of the undated Operation Manual titled, Operation Manual for Brand 1 3000/3500/36003600AB, indicated in the operating instructions determine the resident's weight and set the control knob to that weight setting on the control unit.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. 45456 Based on observation, interview, and record review, the facility failed to ensure the Daily Posted Nurse Staffing (Nurse Staffing Information) for 11/29/2024, 11/30/2024, and 12/1/2024 were posted in accordance with the facility's policy and procedure titled, Posting Direct Care Daily Staffing Numbers. This deficient practice had the potential for residents and visitors not to be accurately informed of the census and staffing for the facility. Findings: During an observation at the Nursing Station 2 on 12/2/2024 at 8:02 AM, there were Census and Direct Care Service Hours Per Patient Day (DHPPD, refers to the actual hours of work performed per patient day by a direct caregiver) forms dated 11/28/2024 and 11/29/2024 in staffing posting area. During a concurrent observation and interview with the Assistant Administrator (AADM) on 12/3/2024 at 5PM, AADM stated the DHPPD posted only included projected hours for 11/29/24. There was no DHPPD posting for 11/29/2024 to reflect the actual hours for licensed and unlicensed nursing staff directly responsible for resident care. AADM stated the DHPPD was not posted on 11/30/2024 and 12/1/2024. During an interview with Administrator (ADM) on 12/3/2024 at 5:01 PM, ADM stated the purpose of staffing posting was to ensure the nursing hours per patient day (NHPPD) were met. During an interview with Director of Nursing (DON) on 12/3/2024 at 5:02 PM, the DON stated, the purpose of posting the DHPPD was to inform residents, family, and also staff that the facility have enough number of staff to take care of the residents. During an interview with AADM on 12/03/2024 at 5:03 PM, AADM stated, The staff posting should be discussed with the residents to inform them that we have enough staff. it should also be discussed with the resident during the resident council meeting. During an interview with DON on 12/3/2024 at 5:25 PM, DON stated, the Nursing staff in charge should have completed and posted the DHPPD for the weekend (11/30/24 and 12/1/2024). During a review of the facility's policy and procedure (P&P) titled, Posting Direct Care Daily Staffing Numbers, revised on 8/2022, P&P indicated the facility will post on a daily basis for each shift nurse staffing data, including the number of nursing personnel responsible for providing direct care to residents. Within two (2) hours of the beginning of each shift, the charge nurse or designee computes the number of direct care staff and completes the Nurse Staffing Information Form. The charge nurse completed the form and posts the staffing information in the locations(s) designated by the administrator. The previous shift's forms shall be maintained with the current shift form for a total of 24 hours of staffing information in a single location. Once a form is removed, it is forwarded to the office of the director of nursing services (DNS) and filed as a permanent record. Records of staffing information for each shift will be kept for a minimum of eighteen (18) months or as required by state law.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45456 Based on interview, and record review, the facility failed to ensure one (1) of five (5) sampled residents (Resident 11) was free from unnecessary psychotropic drug (any medication capable of affecting the mind, emotions, and behavior) use as indicated in the facility's policy and procedure by failing to provide documented evidence that Resident 11's behavior was monitored for the use of: 1. Abilify (an antipsychotic medicine used to treat the symptoms of schizophrenia and bipolar disorder [a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration]) 2. Depakote (also used to treat acute manic or mixed episodes associated with bipolar disorder with or without psychotic features). This deficient practice had the potential to result to inaccurate re-evaluation of Resident 11's need for psychotropic medications, which may lead to an overall negative impact on the resident's physical, mental, and psychosocial well-being. Findings: During a review of Resident 11's Admission Record, the Admission Record indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included dementia (a mental disorder in which a person loses the ability to think, remember, learn, make decisions, and solve problems), schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves) and hypertension (high blood pressure). During a review of Resident 11's Minimum Data Set (MDS, a resident assessment tool), dated 10/16/2024, the MDS indicated Resident 11 had severely impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 11 needed substantial/ maximal assistance (helper does more than half the effort/helper lifts, holds trunk or limbs, and provides more than half the effort) with shower/bathing, bed mobility, transfer, and walking 10 feet. Resident 11 needed partial/ moderate assistance (helper does less than half the effort, helper lifts, hold, or supports trunk or limbs but provides less than half the effort) with oral hygiene, toileting hygiene, upper and lower body dressing, putting on and taking off footwear, and personal hygiene. The MDS indicated Resident 11 did not have any mood or behavior indicators. During a review of Resident 11's Order Summary Report, dated 8/13/2024, the order summary report indicated: 1. Abilify oral tablet 10 milligrams (mg, unit of measurement). Give 1 tablet by mouth one time a day for schizophrenia manifested by verbal outburst. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Depakote Oral Tablet delayed release 500 mg (Divalproex Sodium) Give 1 tablet by mouth two times a day for bipolar disorder manifested by from quiet to verbal outburst. During a concurrent interview with Minimum Data Set Nurse (MDSN) and record review of Resident 11's order summary on, 12/5/2024 at 1:52 PM, MDSN stated there were no physician's orders for behavior monitoring specifically for the use of Abilify and Depakote. MDSN stated, We do not have but we should have orders to monitor the manifested behavior for Abilify and Depakote. During a concurrent interview with MDSN and record review of Resident 11's Care Plans on, 12/5/2024 at 1:54 PM, MDSN stated manifested behavior for Abilify and Depakote use were not addressed in the care plan. During a concurrent record review of Resident 11's Medication Administration Record (MAR) with MDSN on 12/05/24 at 1:58 PM, the MAR indicated Resident 11's Behavior monitoring for use of Antipsychotic. It indicated to document number of episodes of target behavior, intervention attempted, and effectiveness with target behavior from quiet to verbal outburst, including interventions and effectiveness. The MAR was blank from 11/1/2024 to 11/30/2024. MDSN stated the blank MAR meant Resident 11's behavior for the use of Abilify and Depakote were not monitored. MDSN added, We do not have behavior monitoring orders for using Abilify and Depakote. It means the staff were not monitoring Resident 11's behavior for the use of both medications. During a review of undated facility's policy and procedure (P&P) titled, Psychopharmacological, the P&P indicated the licensed nurse or designee will document any known targeted behaviors and potential interventions. The care plan will include the resident's focus and target behaviors for the medication. Licensed nurses and additional staff will monitor and document any targeted behaviors that occur.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49537 Based on observation, interview, and record review, the facility failed to ensure its medication error rate was less than five (5) percent (%). There were 3 medication errors (the observed or identified preparation or administration of medications or biologicals which is not in accordance with the prescriber's order/manufacturer's specifications/accepted professional standards and principles) out of 29 opportunities (observed administered medications) for error which yielded a facility medication error rate of 10.34% for one (1) of 5 sampled residents (Resident 29) observed during medication administration (med pass): Licensed Vocational Nurse 2 (LVN 2) failed to administer multivitamin (a pill containing a combination of vitamins), vitamin C (a nutrient your body needs to form blood vessels, cartilage, muscle and collagen in bones), and vitamin D3 (group of vitamins fond in the liver and fish oils, essential for the absorption of calcium and the prevention of rickets in children and osteomalacia in adults) within 1 hour of prescribed time for Resident 29. This deficient practice had the potential to result in harm to Resident 29 by not administering medications as prescribed by the physician. Findings: During a review of Resident 29's Admission Record, the Admission Record indicated the facility initially admitted the resident on 2/26/2024 and readmitted on [DATE] with diagnoses that included but not limited to mild protein calorie malnutrition (a condition that occurs when the body doesn't receive enough protein and calories), metabolic encephalopathy (a group of neurological disorders [range of medical conditions that impact the brain, spinal cord, and nerves] that occur when brain function is impaired due to a chemical imbalance in the blood), and type two (2) diabetes mellitus (adult onset diabetes, a common form of diabetes that occurs when the body doesn't respond properly to insulin). During a review of Resident 29's Minimum Data Set (MDS-a resident assessment tool) dated 11/7/2024, the MDS indicated the resident has severe impairment with cognitive (relating to mental processes involving knowing, learning, and understanding things) skills for daily decision making. Resident 29 required partial/moderate assistance (helper does less than half the effort) with shower/bathing self, required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with oral, toileting, personal hygiene upper and lower body dressing and putting on /taking off footwear. Resident 29 required set up or clean up assistance (helper sets up or cleans up, resident completes activity) with eating. During a concurrent med pass observation and interview on 12/4/2024 at 10:34 AM in Resident 29's room with LVN 2, resident was seated on the side of her bed and waiting for her medications to be given. LVN 2 administered Resident 29's medications which were Multivitamins, Vitamin C, and Vitamin D3. LVN stated the medications were supposed to be administered at 9 AM and it was past the time frame that it should be given since it was already 10:34 AM. (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

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/5/2024 at 3:45 PM with the Director of Nurses (DON), the DON stated medications should be given within 1 hour of the prescribed time, if not given within the time frame, the residents could potentially have adverse effects. During a review of the facility's Policy and Procedure (P&P) titled, Administering Medications, revised April 2019, indicated: 1. Medications are administered in a safe and timely manner, and as prescribed. 2. Medications are administered in accordance with prescriber orders, including any required time frame. 3. Medications are administered within 1 hour of their prescribed time, unless otherwise specified.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 45456 Based on observation, interview, and record review, the facility failed to ensure safe provision of pharmaceutical services as indicated in the facility policy by failing to ensure: 1. Medication storage freezer did not have an ice built up. 2. Medication storage room counters were free of dust. 3. Medications were stored under proper temperature control. This deficient practice had the potential for adverse reaction in the event that these medications, which were not stored under proper control temperature were administered to the residents and potential source of infection if cleanliness were not maintained. Findings: During a concurrent observation in the medication storage room and interview with the Director of Nursing (DON) on 12/5/2024 at 10:12 AM, the medication storage freezer had ice built up. The DON stated, We should not have ice built up in the refrigerator's freezer because we will not have an accurate temperature for the medications that were kept inside the refrigerator. During a concurrent observation in the medication storage room and interview with the DON on 12/5/2024 at 10:18 AM, the medication storage room counters and shelves were dusty. The DON stated, We should keep it all clean. Cleaning should be done every day or every other day. During a concurrent observation in the medication storage room and interview with DON on 12/5/2024 at 10:30 AM, the Medication Storage Room Temperature indicated 83 Fahrenheit (F). The following medications were labeled to store medications at 68 F-77 F. 1. One bottle of Valproic Acid (medicine to treat certain types of seizures [abnormal burst of electrical brain activity that causes a person to experience sudden change in behavior, movement, or consciousness]) 2. Two bottles of 0.9% Sodium Chloride Irrigation (solution that exerts a mechanical cleansing action for sterile irrigation of body cavities, tissues, or wounds) 3. One bottle of Lidocaine 2% viscous solution (local anesthetic used to treat pain of a sore or irritated moth and throat) The DON stated the medications will be discarded since they were not kept in the correct storage temperature. DON stated this will ensure the medications will not be administered to the residents, which could result in an adverse reaction. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of undated facility's Policy and Procedure (P&P) titled, Medication Labeling and Storage, the P&P indicated the facility stores all medication and biologicals in locked compartments under proper temperature, humidity, and light controls. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44018 Based on observation, interview and record review, the facility failed to ensure foods are handled, prepared, stored and distributed in a manner that prevents foodborne illness (infections or irritations of the gastrointestinal tract [a series of hollow organs joined in a long, twisting tube from the mouth to the anus] caused by food or beverages that contain harmful bacteria, parasites, viruses, or chemicals) by failing to ensure foods are labeled with date opened, use by date and/ or expiration date. These deficient practices had the potential to result in food contamination and/or foodborne illness for the residents in the facility. Findings: During an observation in the kitchen on [DATE] at 7:50 AM, the following were observed in the presence of the Dietary Supervisor (DS), 1. One (1) opened container of butter - not labeled with use by date. 2. One (1) gallon of chocolate syrup bottle - not labeled with use by date. 3. One (1) bag of potatoes hash brown - not labeled with use by date. 4. 20 tomatoes in the plastic bin - not labeled with use by date. During an interview with the DS on [DATE] at 8:26 AM, the DS stated some of the opened food items such as the butter, chocolate syrup, bag of potatoes and tomatoes in the plastic bin were not labeled with use by date. The DS stated it was important for the food items to be labeled with use by date so the facility staff knows until when we can use or serve the food item and when to discard it. DS also stated because if the food or food item was used passed/ after the use by date, residents could get stomach illness. During an observation in the dry storage room on [DATE] at 8:48 AM, the following items were observed in the presence of the DS: 1. Two (2) single packets of No Bake Custard in the plastic bin - not labeled with use by date and no expiration date. 2. Five (5) bags of biscuit Gravy Mix in the plastic bin - not labeled with used by date and no expiration date. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with DS on [DATE] at 9:06 AM, the DS was unable to state the expiration date or use by date of the No Bake Custard and the biscuits Gravy Mix. DS stated The DS could not tell the expiration date because the original boxes that indicated the expiration date were discarded. The DS stated, The facility could serve the expired food to the residents and the residents could get sick. During an interview with the Director of Nursing (DON) on [DATE] at 2:12 PM, the DON stated the kitchen staff were supposed to label the food items with the date when they opened, prepared the food in the kitchen and the use by date. The DON also stated residents could get sick since food items had to be consumed at a certain time and not after the expiration date or use by date. During an interview with Registered Dietary (RD) on [DATE] at 3:05 PM, RD stated all opened food items should be labeled with open date and use by date to ensure that the facility preserved the quality of the food and to avoid any foodborne illness by serving expired food to the resident. A review of the facility policies and procedures titled, Food Receiving and Storage, revised date [DATE], indicated the following: a. Dry Food Storage - dry foods that are stored in bins are removed from original packaging, labeled, and dated (use by date). b. Refrigerated/Frozen storage - refrigerated food are labeled, dated, and monitored so they are used by their use-by date, froze, or discarded.

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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** 44018 Based on observation, interview, and record review, the facility failed to ensure standard infection prevention control practices (a set of practices that prevent or stop the spread of infections and or diseases in the healthcare setting) were followed for four (4) out of fifteen sampled residents (Resident 8, 144, 44 and 22) in accordance with the facility's policy and procedure titled Infection Prevention and Control Program indicated an infection control prevention and control program (IPCP) when: 1. A urine-soaked diaper was seen sitting on top of paper towel dispenser in Room A 's communal bathroom. 2. Licensed Vocational Nurse (LVN) 1 did not use an isolation gown while administering medication via gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach, common for residents with swallowing problems) tube to Resident 8 who was on enhanced barrier precaution (EBP, an infection control practice that involves wearing gowns and gloves during high-contact activities with residents in nursing homes). 3. LVN 2 did not use an isolation gown while administering medication via gastrostomy tube to Resident 144 who was on EBP. These failures had the potential to spread of infection throughout the facility. 4. Resident 44's nebulizer mask (a device that fits over the nose and mouth to deliver medication in the form of a mist) was found on the floor. 5. Resident 22's bedside urinal bottle (a handheld bottle container used to collect urine) filled with urine was seen placed next to the resident's water pitcher. These deficient practices have a potential to contaminate clean items, spread of infection and can place the residents at risk for infection. Findings 1. During a concurrent observation and interview with the Infection Prevention Nurse (IPN 1) on 12/04/2024 at 4:04 PM, a urine-soaked diaper was seen sitting on top of the paper towel dispenser in the Room A's bathroom. IPN 1 stated the soiled diaper should be disposed in the separate plastic bag and tossed it in the trash bin. IPN 1 also stated residents may encounter the waste matter and get sick. During an interview with the Director of Nursing (DON) on 12/04/2024 at 4:23 PM, DON stated, used diaper should never be sitting on top of the paper towel dispenser. The DON further stated the residents could be at risk for infection and ended up in the hospital. 49537 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a review of Resident 8's Admission Record (front page of the chart that contains a summary of basic information about the resident), the Admission Record indicated the facility initially admitted the resident on 6/19/2020 and readmitted on [DATE] with diagnoses that included but not limited to hemiplegia (refers to paralysis [loss of the ability to move] on one side of the body after a stroke (a loss of blood flow to part of the brain, which damages brain tissue) and hemiparesis (condition that causes partial paralysis or weakness on one side of the body) affecting the left side, gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for residents with swallowing problems), and dysphagia (difficulty swallowing). During a review of Resident 8's Minimum Data Set (MDS - a resident assessment tool), dated 9/26/2024, the MDS indicated Resident 8's had severe cognitive (relating to mental processes involving knowing, learning, and understanding things) impairment. The MDS also indicated Resident 8 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 and personal hygiene and was dependent (helper does all 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, shower/bathing, upper and lower body dressing and putting on/off footwear. During a review of Resident 8's Order Summary dated 11/21/2024 indicated Enhanced barrier precautions - Staff to utilize gowns and gloves for high contact resident care activities every shift for G-Tube (GT - a surgically inserted tube that provides a way to deliver nutrition, fluids, and medications directly to the stomach). During a medication pass observation on 12/4/2024 at 8:29 AM, in Resident 8's room, LVN 1 was observed checking Resident 8's blood pressure (BP), and LVN 1 was not wearing gloves and gown. LVN 1 touched Resident 8's clothing, right hand, and arm to place the BP cuff. LVN 1's clothing was also in contact with Resident 8's bed linens. EBP signage and personal protective equipment (PPE-refers to protective clothing, helmets, gloves, face shields, facemasks to minimize exposure to a variety of hazards) were also observe posted outside Resident 8's room. During the same medication pass observation in Resident 8's room on 12/4/2024 at 8:29 AM, LVN 1 was observed checking placement and gastric residual volume (amount of liquid in the stomach- green color is often considered a significant finding, indicating presence of bile [fluid produced by the liver and stored in the gall bladder that helps digest food], clear color may indicate normal gastric contents, milky color can be seen with milk based feeds, and blood stained may indicate bleeding in the gastrointestinal system) of Resident 8's GT. LVN 1 observed fixing LVN 1's stethoscope (a medical instrument for detecting sounds produced in the body that are conveyed to the ears of the listener through rubber tubing connected with a piece placed upon the area to be examined) and touching her face mask after handling resident's GT and syringe. LVN 1 was observed opening the GT y-port adapter ([NAME] valve-a three way stop cock intended to be used in conjunction with gastric or feeding tubes designed to prevent accidental exposure of the healthcare worker to the patient's gastric fluids or secretions), while some clear, light yellow liquid spilled out and LVN 1 and liquid kept dripping out of the GT whenever LVN 1 turned the valve to open and close the GT port to give the medications. Resident 8 observed to be moving the resident's right arm and hand and coming in contact with LVN 1's arms. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During a review of Resident 144's Admission Record, the Admission Record indicated the facility initially admitted the resident on 9/8/2023 and readmitted on [DATE] with diagnoses that included but not limited to dementia (the loss of cognitive functioning-thinking, remembering, and reasoning to an extent that it interferes with a person's daily life and activities), gastrostomy, and dehydration (occurs when the body loses too much water and other fluids that it needs to work normally). During a review of Resident 144's MDS dated [DATE], the MDS indicated Resident 144 had severe cognitive impairment and was dependent with eating and personal hygiene. During a review of Resident 144's Order Summary dated 11/21/2024, the order summary indicated EBP-staff to utilize gowns and gloves for high contact resident care activities every shift for GT. During a concurrent medication pass observation and interview on 12/4/2025 at 9:57 AM in Resident 144's room, LVN 2 was observed not wearing isolation gown, and proceeded to check resident's GT placement and residual volume. LVN 2 observed giving medications. LVN 2 stated he did not wear an isolation gown. There was no EBP signage posted and PPE cart outside Resident 144's room. During a concurrent interview and record review on 12/5/2024 with the DON, the Policy and Procedure (P&P) titled Enhanced Barrier Precaution, revised March 2024 was reviewed. The DON stated, gown and gloves should be worn by staff when giving medications through the feeding tube or GT to prevent exposure to resident's gastric contents in case of spillage or splatter and prevent spread of germs from other residents to EBP residents. The P&P indicated that EBPs are utilized to reduce the transmission of multi-drug resistant organisms (MDROs) to residents. EBPs employ targeted gown and glove use in addition to standard precautions during high contact resident care activities. The P&P also indicated examples of high contact resident care activities requiring the use of gown and gloves include device care or use (central line, urinary catheter, feeding tube), staff are trained prior to caring for residents on EBPs. 45456 4. During a review of Resident 344's Admission Record, the Admission Record indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included acute respiratory failure (ARF, a serious condition that makes it difficult to breathe on your own), Coronavirus 2019 (COVID-19 -a highly contagious respiratory disease caused by the SARS-CoV-2 virus [SARS-CoV-2 is thought to spread from person to person through droplets released when an infected person coughs, sneezes, or talks]) and anxiety disorder (a disorder characterized by nervousness characterized by a state of excessive uneasiness and apprehension, typically with compulsive behavior or panic attacks). During a review of Resident 344's MDS dated [DATE], the MDS indicated Resident 344 had intact cognitive skills for daily decision making. The MDS also indicated Resident 344 was substantial/ maximal assistance with toileting hygiene, shower/bathe self, lower body dressing, putting on and taking off footwear, roll left and right, sit to stand, chair/bed -to chair transfer, toilet transfer, sit to lying, lying to sitting on side of the bed, chair/bed-to chair transfer and tub/shower transfer. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 344's order summary dated 11/19/2024 indicated Ipratropium -Albuterol Inhalation Solution (0.5-2.5 milligrams [mg, unit of measurement]/ milliliters[ml]) 3mg/ 3ml, albuterol and ipratropium (used to prevent wheezing, difficulty breathing, chest tightness, and coughing) give 1 dose inhale orally three times a day for history of ARF for 12 weeks end date: 2/12/2025. During an observation inside Resident 344's Room on 12/3/2024 at 4:20 PM, Resident 344's nebulizer mask was laying on the floor. The nebulizer machine was left turned on, and there was no medication inside the nebulizer's medicine cup connected to the nebulizer mask. During a concurrent observation with LVN 5 on, 12/3/2024 at 4:22 PM, LVN 5 saw Resident 344's nebulizer face mask on the floor, and stated, the nebulizer mask should not be touching the floor. We have to throw it right away. Resident 344 should not use it anymore because of infection control. 5. During a review of Resident 22's Admission Record, the Admission Record indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included osteomyelitis (inflammation or swelling that occurs in the bone) of lumbar vertebrae (are the five bones in the lower back that make up the lumbar spine), congestive heart failure (also called heart failure, is a serious condition in which the heart doesn't pump blood as efficiently as it should) and hypertension (high blood pressure). During a review of Resident 22's MDS dated [DATE], the MDS indicated Resident 22 had intact cognitive skills for daily decision making. The MDS also indicated Resident 22 was partial/ moderate assistance (helper does less than half the effort, helper lifts, hold, or supports trunk or limbs but provides less than half the effort) with oral hygiene, toileting hygiene, shower/bathe self, upper and lower body dressing, putting on and taking off footwear, personal hygiene, roll left and right, sit to lying, lying to sitting on side of the bed, sit to stand, chair/bed -to chair transfer, and walk 10 feet. During an observation inside Resident 22's room on, 12/2/2024 at 9:55 AM, Resident 22's bedside urinal bottle with 300 milliliters (ml, unit of measurement) of urine was placed next to the resident's water pitcher on top of the over bed table. During an observation inside Resident 22's room on 12/3/2024 at 11:45 AM, Resident 22's bedside urinal bottle filled with 300 ml of urine was placed on top of the resident's overbed table and next to the resident's water pitcher. During a concurrent observation with Registered Nurse Supervisor 1 (RNS 1) and interview with Resident 22 on 12/5/2024 at 9:28 AM, RNS 1 saw Resident 22's bedside urinal bottle filled with urine was placed on top of the bedside table next to resident's radio and unopened soda cans. During a concurrent observation and interview with RNS 1 on, 12/5/2024 at 9:29 AM, RNS 1 stated, bedside urinal bottle should not be placed next to the water pitcher on Resident 22's overbed table because of infection control. RNS 1 stated its the facility's policy to ensure to provide clean and sanitary environment to the residents to help prevent development and transmission of infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of undated facility's policies and procedures titled, Infection Prevention and Control Program indicated an infection control prevention and control program (IPCP) is established and maintained to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49537 Based on observation, interview and record review, the facility failed to provide the minimum of 80 square feet (sq.ft. - unit of measurement) per resident in multiple resident bedrooms for 12 of 17 residents' rooms (Rooms 101, 102, 104, 106, 109, 110, 111, 112, 114, 115, 116, and 117) in the facility. This deficient practice had the potential to affect the ability to provide a home like environment to the residents. Findings: During a tour of the facility on 12/2/24 at 11:00 AM, 12 of 17 residents' rooms did not meet the minimum 80 sq. ft. per resident in multiple resident bedrooms. These are Rooms 101, 102, 104, 106, 109, 110, 111, 112, 114, 115, 116, and 117. During a concurrent observation and interview on 12/2/2024 at 2:00 PM in room [ROOM NUMBER], a wheelchair folded in the left side corner of the room was observed while both residents are in their respective beds. The residents stated there was enough space for the staff to provide care and enough storage for their belongings. The resident using the wheelchair stated that he can maneuver his wheelchair in and out of the room without difficulty. During a concurrent observation and interview on 12/5/2024 at 9:30 AM in room [ROOM NUMBER], one resident was observed sitting on the edge of his bed waiting for his morning medications. Roommate was still in bed asleep. The resident in room [ROOM NUMBER] stated the space was adequate and he has a wheelchair and can move around in the room without any difficulty. Resident stated staff had enough space to move around while providing care. During a concurrent review of the facility's client accommodation analysis and interview with the Assistant Administrator (AADM) on 12/5/24 at 3:30 PM, the AADM stated the facility have 17 resident's rooms. The AADM stated 12 rooms did not meet the 80 square feet per resident in multiple resident bedrooms (Rooms 101, 102, 104, 106, 109, 110, 111, 112, 114, 115, 116, and 117). The AADM stated she will continue to request for room waiver because it did not affect the health and safety of the residents. The AADM stated there was enough space for the staff to provide care to the residents. During a review of the facility's room waiver letter, dated 12/02/2024, the room waiver indicated the following: Room # Beds Sq.Ft. Sq.Ft. per Bed 101 2 144.82 72.41 102 3 236.09 78.69 104 4 318.73 79.68 (continued on next page)

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	12/05/2024

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 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	106 4 299.25 74.81 109 4 302.70 75.67 110 2 150.2 75.12 111 2 150.2 75.12 112 2 150.2 75.12 114 2 154.4 77.22 115 2 153.84 76.92 116 2 145.20 72.60 117 2 145.20 72.60 During a review of the facility's room waiver letter, dated 12/02/2024, the room waiver indicated a request for the continued waiver for square footage per resident on the condition that there was ample room to accommodate wheelchairs and other medical equipment, as well as space for mobility and movement of ambulatory (able to walk around) residents. The room waiver also indicated the rooms had adequate space for nursing care, and the health and safety of residents occupying these rooms were not in jeopardy (dangerous situation). (Rooms 101, 102, 104, 106, 109, 110, 111, 112, 114, 115, 116, and 117) were in accordance with the special needs of the residents and did not have adverse effect on the residents' health and safety or impeded the ability of any residents in the rooms to attain his or her highest practical well-being. During observation of Rooms 101, 102, 104, 106, 109, 110, 111, 112, 114, 115, 116, and 117 from 12/02/2024 to 12/05/2024 at random times of the day, the following were observed: for rooms 101, 102, 104, 106, 109, 110, 111, 112, 114, 115, 116, and 117, there was adequate ventilation and lighting. The residents in the rooms had bathroom and toilet facilities. The residents had privacy curtains around their beds and there was adequate space for getting in and out of the resident's wheelchairs and residents were afforded sufficient freedom of movement in the rooms. The Department would be recommending the room waiver for Rooms 101, 102, 104, 106, 109, 110, 111, 112, 114, 115, 116, and 117.