

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055818	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/23/2026
NAME OF PROVIDER OR SUPPLIER Royal Gardens Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 2339 W. Valley Blvd. Alhambra, CA 91803	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 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** Based on observation, interview, and record review, the facility failed to maintain a safe, clean, comfortable sanitary and home-like environment for four (4) of 4 sampled residents (Resident 4,6,19 and 35) reviewed for environment, by failing to ensure:The air vent (openings in buildings for air passage, essential for ventilation, air circulation, and maintaining indoor air quality) including the surrounding frame located on top of Resident 4's head of the bed does not have dust build up.The bedside table of Resident 6 was not chipped off exposing the interior wood.The bed control for Residents 6 and 19 does not have crack and rough edges.The overhead light of Resident 19 was not cracked.The television (TV) of Resident 35 was functioning. These deficient practices caused an unsanitary and unsafe environment and had potential for Residents 4, 6, and 19 and staff to be placed at risk of injury. In addition, it a potential to negatively affect Resident 35's well-being and quality of life.Findings:1.During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was initially admitted to the facility on [DATE] with diagnosis which dementia (progressive brain disorder that slowly destroys memory and thinking skills), diabetes mellitus (a disorder in which the body does not produce enough or respond normally to insulin [a hormone released from the pancreas that controls the amount of glucose in the blood], causing blood sugar [glucose] levels to be abnormally high), and chronic obstructive pulmonary disease (COPD, disease that causes obstructed airflow from the lungs) During a review of Resident 4's Minimum Data Set (MDS, a resident assessment tool), dated 12/10/2025, the MDS indicated Resident 4's cognitive skills (processes of thinking and reasoning) for daily decision making was severely impaired (never/rarely made decisions). The MDS also indicated Resident 4 needed partial/moderate assistance on personal hygiene (the ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands (excluding baths, showers, and oral hygiene). During an observation on 1/20/2026 at 8:18 AM in Resident 4's room, Resident 4 was in bed, and above Resident 4's head of the bed, the air vent was visibly coated with dust including the surrounding frame. During a concurrent observation in Resident 2's room and interview on 01/21/2026 at 4:14 PM with the Director of Nursing (DON), the DON stated Resident 4's air vent was covered with dust buildup. The DON also stated Resident 4's air vent with dust buildup was not acceptable, it creates fire risk, and it was not good for resident's health. During an interview on 1/23/2026 at 7:50 AM, with the Maintenance Supervisor (MS), the MS stated cleaning of Resident 4's air vent was not cleaned. The MS also stated air vents should be cleaned on daily basis to ensure the air vent can properly filter the air, especially for residents on breathing treatments to ensure the residents receive clean fresh air. 2.During a review of Resident 6's admission Record, the admission Record indicated Resident 6 was originally admitted to the facility on [DATE] and was re admitted on [DATE], Resident 6's diagnoses included muscle weakness, acute kidney failure (the sudden, rapid loss of kidney function), and scoliosis (progressive, three-dimensional lateral curvature of the spine). During a review of Resident 6's MDS dated [DATE] the MDS indicated Resident 6 ?s cognitive daily decision making was intact. The MDS also indicated Resident 6 was Dependent (helper does all the effort. Residents does none of (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 055818	If continuation sheet Page 1 of 47

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the effort to complete the activity) on eating (the ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident), Shower/bathe self (the ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair), Roll left and right (the ability to roll from lying on back to left and right side, and return to lying on back on the bed). During an observation in Resident 6's room on 1/20/2026 at 8:41 AM, observed Resident 6's bedside table had area that was chipped off and with rough wood exposed. During a concurrent observation and interview on 1/21/2026 at 12:55 PM with the Director of Staff and Development (DSD), DSD stated Resident 6's bedside table was chipped off, with rough wood exposed, and this can cause skin tears to Resident 6 and staff. 3. During an observation on 1/20/2026 at 8:41 AM in Resident 6's room, Resident 6's bed control was observed to be visibly damaged, with chipped and cracked edges around the casing. During a concurrent observation and interview on 1/21/2026 at 12:56 PM in Resident 6's room with the DSD, Resident 6's bed control was broken and with rough edges. The DSD stated Resident 6's bed control was broken, chipped around the edges, and with rough edges that can cause skin tears to Resident 6 and staff. 4. During a review of Resident 19's admission Record, the admission Record indicated Resident 19 was admitted on [DATE] with diagnoses that included muscle weakness, diabetes mellitus, heart failure (a lifelong condition in which the heart muscle can't pump enough blood to meet the body's needs for blood and oxygen). During a review of Resident 19's MDS dated [DATE], the MDS indicated Resident 19's cognitive daily decision making was intact. The MDS also indicated Resident 19 was set up or clean-up assistance (helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity) with eating and supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with oral hygiene and personal hygiene. During concurrent observation and interview on 1/21/2026 at 12:58 PM with the DSD in Resident 19's room, Resident 19's bed control has a crack. The DSD stated Resident 19's bed control was cracked, with rough edges and was visibly dirty. During the same concurrent observation and interview on 1/21/2026 at 12:58 PM with the DSD in Resident 19's room, Resident 19's overhead light has cracks. DSD stated Resident 19's overhead light was cracked. DSD also stated cracks or damaged bed control, and overhead light is not acceptable, and it can cause accident, skin injury, and infection to Resident 19. 5. During a review of Resident 35's admission Record, the admission Record indicated Resident 35 was originally admitted to the facility on [DATE] and was re admitted on [DATE]. The admission record also indicated, Resident 35's diagnoses included diabetes mellitus, hemiplegia (complete paralysis, muscle stiffness, and inability to move one side of the body) and hemiparesis (complete paralysis, muscle stiffness, and inability to move one side of the body). During a review of Resident 35's MDS dated [DATE] the MDS indicated Resident 35's cognitive skills for daily decision making is moderately impaired. The MDS indicated, Resident 35 was assessed to need substantial/maximal assistance (helper does more than half the effort. helper lifts or holds trunks or limbs and provides more than half the effort) with eating and oral hygiene. During a review of Resident 35's care plan date initiated on 10/29/2025, the care plan indicated Resident 35 enjoy watching television (news, movies, game shows, music channel) and listening to music. During an interview on 1/20/2026 at 12:18 PM in Resident 35's room, Resident 35 stated the TV in her room was not working. Resident 35 also stated she likes watching TV. During a concurrent observation and interview on 1/21/2026 at 12:27 PM with the Registered Nurse Supervisor (RNS) 1 in Resident 35's room, RNS 1 attempted to turn on the TV and the TV did not turn on. RNS 1 stated the TV was not working and the TV should be working so Resident 35 could use it at any time and enjoy the activity that the resident likes to do. During a concurrent interview and record review on 1/23/2026 at 5:12 PM with the DSD, the facility's Policy and Procedures (P&P) titled Maintenance Services revised date 12/2009, was reviewed. The DSD stated the P&P indicated maintenance services are provided to support a safe, comfortable, and well-maintained environment for residents, staff, and visitors. The P&P also indicated the maintenance department supports the facility by (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	maintaining buildings, grounds, and equipment in safe and proper working condition. The P&P indicated maintenance services are provided in a manner that promotes resident safety, minimizes disruptions, and supports daily operations. The DSD stated the P&P was not followed.		

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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** Based on observation, interview, and record review, the facility failed to ensure five (5) of five sampled residents (Resident 2, 6, 35, 10, and 31) reviewed for pressure ulcer (PU- injury to skin and underlying tissue resulting from prolonged pressure on the skin) were provided necessary treatment and services to prevent formation of PU and/ or promote healing of PU in accordance with the facility's policy and procedure and physician's order by failing to: Ensure Resident 2's low air loss mattress (LALM-are designed to distribute the patient's body weight over a broad surface area and help prevent skin breakdown) was set according to the resident's weight. On 1/21/2026, Resident 2 was observed with the LALM set at 350 pounds (lbs.- unit of measurement).Ensure Resident 6's LALM was set according to the resident's weight. Resident 6 was observed with the LALM set in between 265 to 400 lbs. on 1/21/2026 8:12 AM.Completely assess and document Resident 35's sacrococcyx (bones at the very bottom of your spine, with the sacrum being a large, triangular bone connecting to the pelvis, and the coccyx [tailbone] being a smaller, fused bone just below it, providing attachment points for muscles and ligaments and acting as a shock absorber when sitting) Stage 3 (a severe, full-thickness wound extending through the skin to expose subcutaneous fat, appearing as a deep crater, often with slough or rolled edges) PU when the resident was readmitted to the facility on [DATE].Ensure Resident 10's LALM was set according to the resident's weight. On 1/20/2026, Resident 6 was observed with the LALM set at 300 lbs.Ensure Resident 31's LALM was set according to the residents' weight. On 1/20/2026, Resident 31 was observed with the LALM set at 320lbs. These deficient practices had the potential for Resident 6, 10 and 31 to develop new PU and the potential for Resident 2 and 35 to experience worsening of PU.Findings: 1.During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE], Resident 2's diagnoses included anemia (low red cells), muscle weakness, and spondylolisthesis (one of the small bones in the spine slips out of its normal position). During a review of Resident 2's Minimum Data Set (MDS, a resident assessment and tool) dated 12/26/2025 the MDS indicated Resident 2 's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making were intact. The MDS also indicated Substantial/maximal assistance (helper does more than half the effort. helper lifts or holds trunk or limbs and provides more than half the effort) on roll left and right (the ability to roll from lying on back to left and right side and return to lying on back on the bed), sit to lying (the ability to move from sitting on side of bed to lying flat on the bed). The MDS indicated Resident 2 was at risk of developing pressure ulcers/injuries. The MDS indicated Resident 2 has unhealed stage 2 ulcer (partial thickness of loss of dermis presenting as a shallow open ulcer with red or pink wound bed, without slough or bruising). The MDS also indicated skin and ulcer/ injury treatment included pressure reducing device for bed. During a record review of Resident 2's Braden Scale (an assessment tool used for predicting the risk for developing pressure sores) dated 9/24/2025, it indicated Resident 2' is at risk for developing PU. During a record review of Resident 2's Care Plan, date initiated 9/26/2025, revised on 12/11/2025, the Care Plan indicated Resident 2 has actual impairment to skin integrity at right inner buttock stage 2. The care plan also indicated LALM to bed and set at resident weight for firmness and alternating, float. The Care Plane also indicated to check mattress every shift for proper setting and function may adjust to resident comfort level. (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a record review of Resident 2's Order Summary Report dated 1/21/2026, the Order Summary Report indicated a physician's order dated 11/7/2025 for Low Air Mattress to bed. Set at resident weight for firmness and alternating, float. During observation on 1/21/2026 at 7:59 AM in Resident 2's room, Resident 2's LALM setting was set at 350 lbs. During a concurrent observation in Resident 2's room, interview and record review on 1/21/2026 at 3:22 PM with the Registered Nurse Supervisor (RNS 1), Resident 2's weight dated 1/5/2026 entered at 3:46 AM was reviewed. The record indicated Resident 2 weighed 141 lbs. RNS 1 stated the LALM setting was set at 350 lbs. but should have been set to 150 lbs. since Resident 2 weighed 141 lbs. on 1/5/2026. RNS 1 also stated, when the LALM was not in the correct setting, it defeats its purpose and can cause more harm to Resident 2 than prevent harm/ development of new PU and worsening of PU. During an interview on 1/21/2026 at 3:52 PM with the Director of Nursing (DON), the DON stated 350 lbs. setting for Resident 2 was too firm, and it can contribute to the worsening of PU. Resident 2's LALM setting should be set 150 lbs. 2. During a review of Resident 6's admission Record, the admission Record indicated Resident 6 was originally admitted to the facility on [DATE] and was re admitted on [DATE]. The admission record indicated Resident 6's diagnoses included muscle weakness, acute kidney failure (the sudden, rapid loss of kidney function), scoliosis (progressive, three-dimensional lateral curvature of the spine). During a record review of Resident 6's Braden Scale dated 1/2/2026 indicated Resident 6 is at risk for developing PU. During a review of Resident 6's MDS dated [DATE], the MDS indicated Resident 6 's cognitive daily decision making was intact. The MDS also indicated Resident 6 was dependent (helper does all the effort. Residents do 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) on roll left and right, lying to sitting on side of bed. The MDS indicated Resident 6 was at risk of developing PU. During a record review of Resident 6's Order Summary Report dated 1/22/2026, the Order Summary Report indicated a physician's order dated 12/17/2025 for Low Air Mattress to bed. Set at resident weight for firmness and alternating, float. During a record review of Resident 6's Care Plan, revised on 10/15/2025, the Care Plan indicated Resident 6 has potential to skin integrity/breakdown due to impaired mobility, incontinence (involuntary loss of urine or stool). The care plan interventions indicated LALM to bed and set at resident weight for firmness and alternating, float. The care plan also indicated to check mattress every shift for proper setting and function and provide LALM for skin maintenance. During observation on 1/21/2026 at 8:12 AM at Resident 6's room observe LALM setting was in-between 265 lbs. to 400 lbs. During concurrent observation on 1/21/2026 at 12:52 PM with License Vocational Nurse (LVN 1) at Resident 6's room, LVN 1 stated the LALM was set in between 265 lbs. to 400 lbs. (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 1/22/2026 at 2:50 PM with RNS 1, Resident 6's weight dated 1/16/2026 entered at 2:34 PM was reviewed. The record indicated Resident 6 weighed 207 lbs. on 1/16/2026. RNS 1 stated the LALM setting was set in between 265 lbs. to 400 lbs., and it should have been set between 180 lbs. to 265 lbs. since Resident 6 weight was 207 lbs. on 1/16/2026. 3. During a review of Resident 35's admission Record, the admission Record indicated Resident 35 was originally admitted to the facility on [DATE] and was re admitted on [DATE]. The admission record indicated Resident 35's diagnoses included diabetes mellitus (a disorder in which the body does not produce enough or respond normally to insulin [a hormone released from the pancreas that controls the amount of glucose in the blood], causing blood sugar [glucose] levels to be abnormally high) pressure ulcer of sacral region, stage 3 (full-thickness wound extending through the skin into the subcutaneous fat layer [deepest layer of your skin], often appearing as a deep, crater-like, and painful, open wound), hemiplegia (complete paralysis, muscle stiffness, and inability to move one side of the body) and hemiparesis (complete paralysis, muscle stiffness, and inability to move one side of the body). During a record review of Resident 35's Braden Scale dated 12/29/2025 indicated Resident 35 is at risk for developing PU. During a review of Resident 35's MDS dated [DATE], the MDS indicated Resident 35 's cognitive skills for daily decision making were moderately impaired. The MDS also indicated Resident 35 was dependent on roll left and right, sit to lying, lying to sitting on side of the bed. The MDS indicated Resident 35 was at risk of developing PU. The MDS indicated Resident 35 has one Stage 3 pressure ulcer (location not indicated). During a concurrent interview and record review on 1/23/2026 9:52 AM with the DON, Resident 35's medical record titled Admit/Readmit Data Collection and Baseline dated 12/29/2025 timed at 4:20 PM was reviewed. Resident 35's admission assessment indicated resident had a healing stage 3 pressure ulcer, it did not include documentation of the size of the pressure ulcer. The DON stated a complete description of the pressure ulcer should have been documented to establish accurate baseline including the size and whether there is drainage or foul odor. During a concurrent interview and record review on 1/23/2026 at 12:25 with the DON and MDS Nurse (MDSN), Resident 35's medical records dated 12/29/2025 to 1/12/2026 were reviewed. The DON stated Resident 35 was admitted at the facility on 12/29/2025 and the only wound assessment for Resident 35 following the admission assessment (12/29/2025) was completed by the Nurse Practitioner (NP) on 1/13/2026. The DON stated Resident 35's medical records did not have documented evidence of the weekly wound assessments or measurements that were completed for Resident 35. The DON also stated the licensed nurses need more education regarding the need for assessing the resident's wound condition on a weekly basis and that during wound assessment the measurement and description of the wound needs to be documented to know the improvement or decline of the wound. During a concurrent interview and record review on 1/23/2026 4:49 PM with LVN 1 of Resident 35's care plan, LVN 1 stated the care plan initiated on 1/19/2026 indicated Resident 35 has sacrococcyx, moisture-Associated Skin Damage (MASD- caused by prolonged exposure to a source of moisture such as urine, stool, sweat, wound drainage, saliva, or mucus). related to fragile skin, decrease mobility, and incontinence. LVN 1 stated the care plan intervention indicated documentation to include (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations. LVN 1 stated there was no documented evidence that an assessment or monitoring was done for Resident 35's wound on the sacrococcyx. During a concurrent interview and record review on 1/23/2026 4:52 PM with LVN 1, LVN 1 stated the LALM operational manual titled Brand 1 Alternating Pressure Low Air Loss Mattress Replacement System date revised 3/22/2021, it indicated to determine the patient's weight and set the control knob to that weight setting on the control unit. LVN 1 also stated the P&P and operational manual was not followed. During a review of facility's Policy and Procedures (P&P) titled Charting and Documentation date revised 7/2017, the P&P indicated all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The P&P indicated documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. 4. During a review of the admission Record indicated Resident 10 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that includes diabetes mellitus (high blood sugar), encounter for attention to gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), and lack of coordination. During a review of Resident 10's MDS, dated [DATE], indicated Resident 10 had severely impaired cognitive (thought process and ability to reason or make decisions) skills for daily decision making. The MDS indicated Resident 10 was dependent (helper does all the effort) from staff for eating, oral hygiene, toileting hygiene, shower, upper and lower body dressing, putting on/taking off footwear and personal hygiene. The MDS also indicated Resident 10 was dependent from staff from rolling left and right (the ability to roll from lying on back to left and right side, and return to lying on back on the bed), sit to lying (the ability to move from sitting on side of bed to lying flat on the bed), and lying to sitting on side of bed (the ability to move from lying on the back to sitting on the side of the bed and with no back support). During a review of Resident 10's Order Summary Report, dated 1/21/2026, indicated an order of low air loss mattress to bed and set at resident weight for firmness. The order summary report also indicated to check mattress for proper setting and function, every shift for skin management with order date of 10/27/2025. During an observation of Resident 10's low air loss mattress on 1/20/2026 at 9:27 AM, the mattress was set to 300 pounds lbs. During an observation of Resident 10's low air loss mattress on 1/21/2026 at 3:33 PM, the mattress was set to 350 lbs. During a concurrent record review and interview on 1/21/2026 at 4:37 PM with MDS nurse (MDSN), Resident 10's electronic medical records dated 10/27/2025 to 1/21/2026 were reviewed. MDSN stated Resident 10's latest weight on 1/5/2026 is 112 lbs. MDSN stated Resident 10's LALM is for skin maintenance, as ordered on 10/27/2025. MDSN stated, the facility staff set the LALM according with the resident's weight. MDSN also stated the licensed nurses must do their rounds when they come in and make sure the LAL mattress setting of the resident is set correctly according the (continued on next page)		

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Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055818	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/23/2026
NAME OF PROVIDER OR SUPPLIER Royal Gardens Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 2339 W. Valley Blvd. Alhambra, CA 91803	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 1/22/2026 at 8:01 AM with LVN 2, Resident 31's Physician order dated 12/15/2026 was reviewed. LVN 2 stated the physician order indicated Low Air Mattress to bed and set at resident weight for firmness. LVN 2 stated, Resident 31's current weight is 172 lbs. and the LALM setting of Resident 31 should have been set to 170 up to 180 lbs. During a concurrent observation and interview on 1/22/2026 at 8:02 AM with LVN 2 inside Resident 31's room, Resident 31's LALM was set up on 190mmHg. LVN 2 stated LALM was set up on 190-200 mmHg, which was a bit high and too firm. LALM in a very high settings are going to be too firm for Resident 31 and place the resident at risk for skin breakdown During an interview on 1/22/2026 at 8:04 AM with LVN 2, LVN 2 stated If the LALM was set up on 320 mmHg, that was too high, too firm or too hard for Resident 31. Resident 31 had a history of pressure ulcer, and there is potential for Resident 31 to have a skin breakdown. During a review of facility's P&P titled Pressure Relieving Devices Policy undated, the P&P indicated to provide guidance on the proper selection, use, and monitoring of pressure relieving devices to prevent and manage pressure injuries in residents at risk. The P&P indicated Low-air-loss mattress reduces moisture and shear in high-risk residents. The P&P also indicated under usage and maintenance the devices must be properly set up and positioned according to manufacturer instructions.		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on interview and record review, the facility failed to ensure appropriate competencies and skills sets to provide nursing and related services were completed for five (5) of 5 sampled employees in accordance with facility's policy and procedures (P&P). This deficient practice has high potential to cause an increased risk for improper resident assessments, inadequate documentation, and could negatively impact the quality of care to the residents which could lead to hospitalization or death. Findings: 1. During a review of Certified Nurse Assistant 2 (CNA 2)'s skills check evaluation competency, dated 12/23/2025, indicated a blank box where initial skills check date was performed. The form indicated under instructions that the Director of Staff Development (DSD)/ Facility Approved Nursing Training Instructor/ Responsible Appropriate Designee - will complete Initial CNA skills check evaluation competency for all onboarding CNA employee participant following education training provided upon new hire orientation and onboarding process, annually, and as deemed necessary by the Director of Nursing (DON)/Administrator/Appropriate Designee. The form also indicated, the instructor will check the appropriate column (either U [unsatisfactory] or S [satisfactory]) with dates of observations in the spaces provided following review of each skill and only few check marks were seen in the form, with no documentation of dates when the tasks were evaluated. During a concurrent record review and interview on 1/23/2026 at 9:05 AM with Director of Staff Development (DSD), CNA 2's employee file (personal records) was reviewed. DSD stated the employee file indicated CNA 2 was hired on 12/23/2025. DSD stated she conducted CNA 2's skills check evaluation competency on 12/23/2025. DSD explained that CNA 2 was able to perform all tasks in the checklist, that is why DSD checked off the first box of satisfactory and drew a line down to indicate that all the tasks down the list are satisfactory. DSD stated the last page (page 3) of the skills check evaluation competency, the box for CNA 2's signature and date signed was blank. DSD stated the skills check evaluation competency for CNA 2 is incomplete because there are no dates documented when the tasks were completed/ skills were evaluated, and no documentation on the comments section of which type of evaluation was used to evaluate specific tasks. DSD stated she completed the skills evaluation for CNA 2 by actual observation of the skills to residents on 12/23/2025. DSD refused to answer how she evaluated CNA 2 for the choking and Heimlich maneuver (first-aid procedure for dislodging an obstructions from a person's airway/ windpipe in which a sudden strong pressure is applied on the abdomen, between the navel and the rib cage) tasks. 2. During a review of CNA 3's skills check evaluation competency, dated 1/7/2026, indicated a blank box where initial skills check date was performed. The form indicated under instructions that the DSD/ Facility Approved Nursing Training Instructor/ Responsible Appropriate Designee - will complete initial CNA skills check evaluation competency for all onboarding CNA employee participant following education training provided upon new hire orientation and onboarding process, annually, and as deemed necessary by the DON/Administrator/Appropriate Designee. The form also indicated, the instructor will check the appropriate column (either U or S) with dates of observations in the spaces provided following review of each skill and only few check marks were seen in the form, with no documentation of dates when the tasks were evaluated. During a concurrent record review and interview on 1/23/2026 at 9:15 AM with DSD, CNA 3's employee file (personal records) was reviewed. DSD stated the employee file indicated CNA 3 was hired on 1/6/2026. DSD stated she conducted CNA 3's skills check evaluation competency on 1/7/2026. DSD stated CNA 3 was able to perform all tasks properly, that is why she thinks CNA 3 is competent to do her (CNA 3) job. DSD stated she was trying to do short-cut with filling in the forms, so she only wrote S in the first box of the satisfactory column and drew line all the way down the check list. DSD stated the skills check evaluation competency for CNA 3 is incomplete because there are no dates documented when the tasks were completed, and no documentation on the comments section of which type of evaluation was used to evaluate specific (continued on next page)		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and day 2 training acknowledgement review checklist, conducted by DSD, indicated new hire employee will review checklist below to ensure review of all subjects listed as it pertains to employment procedures in facility, employee will initial column for competence. The checklist consisted of one page and did not include the other 2 pages and did not indicate date of review. The checklist indicated one check mark and a line drawn down then list and no RN 4's initial to acknowledge the training was provided upon second day orientation. During a review of RNS 4's Licensed Nurse Skills Evaluation/Orientation Checklist, it indicated RNS 4's date of hire was 9/8/2025. The checklist instructions to place S (satisfactory) or U (Unsatisfactory) with dates of observations on the space provided. The checklist is to be completed on orientation, annually and as deemed necessary by the DON/Administrator. During a review of RNS 4's Skills checklist-Licensed Nurse Medication Administration, dated 9/8/2025, indicated skill proficiencies will be evaluated by describing the procedure and/or return demonstration. The skills checklist indicated 22 check marks under the column met out of the 29 skills for evaluation. The form did not indicate description of how the 22 skills were evaluated. The DON's name and signature was indicated on the last page, RN4's signature and date were left blank, and the DSD's signature and date was also left blank. During a review of RNS 4's medication pass evaluation form, dated 11/4/2025, indicated evaluator gave RNS 4 a handout, and the following were not marked as correct and reviewed with RNS 4:Identifies residents by wristband or current photograph.Always provides privacy for all procedures except oral administration.Residents are assessed for pain during med pass.Uses proper injection administration, technique and appropriate site.Uses proper ophthalmic medication administration technique.Uses proper nasal administration techniquesThe form did not indicate that RNS 4 is ready to work at bedside. During an interview on 1/23/2026 at 7:45 PM with Administrator (ADM), the ADM stated she did not know why the employee files were incomplete. ADM stated the employee files should always be accessible for review and if specific training is not in the file, it means it was not done. ADM stated the DON and DSD are the one who is conducting the orientations to nurses, they should be more organized and have a process to ensure that employee files and competency skills check are complete and up to date. During a review of facility assessment, reviewed with Quality Assurance and Performance Improvement (QAPI takes a systematic, interdisciplinary, comprehensive, and data-driven approach to maintaining and improving safety and quality in nursing homes while involving residents and families in practical and creative problem solving) on 11/26/2025, and updated on 1/16/2026, indicated staff training/education and competencies includes CNA/ skills competency checks annually or as needed, RN/LVN license competency testing annually or as needed. During a review of facility's P&P titled Personnel Records, revised in January 2008, indicated the facility maintains certain records for each employee which are directly related to his/her employment. The P&P also indicated personnel records may be retained at the facility under supervision of facility appointed designee per Administrator and the records must contain, as each may apply, the following date:Orientation and training program recordsPerformance evaluation		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 six (6) sampled residents (Resident 10 and 17) observed for medication administration as indicated on the facility policy and physician's order when: Resident 17's medications were not administered within 60 minutes of scheduled time of 9 AM on 1/22/2026. Resident 10's medications were not administered within 60 minutes of scheduled time of 9 AM on 1/22/2026. This deficient practice had the potential to prevent Residents 10 and 17 from obtaining the therapeutic level of their medications (a range in the blood that is medically effective but not dangerous), which could lead to complications and negatively impacting the residents' overall well-being. Cross reference: F759 Findings: 1. During a review of the admission Record, the admission Record indicated Resident 17 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 17's diagnoses included were benign prostatic hyperplasia (BPH, health issue with urination, problems like a weak stream, difficulty starting to pee, and frequent urination), dementia (a progressive state of decline in mental abilities), and hypertensive heart disease (long-term high blood pressure) with heart failure (the heart cannot pump). During a review of Resident 17's Minimum Data Set (MDS - a resident assessment tool) dated 7/12/2025, the MDS indicated Resident 17 had modified independence (some difficulty in new situations only) with cognitive (thought process and ability to reason or make decisions) skills for daily decision making. The MDS indicated Resident 10 was dependent (helper does all the effort) on staff for toileting hygiene, shower, upper and lower body dressing, and putting on/taking off footwear. The MDS indicated Resident 10 required substantial/maximal assistance (helper does more than half the effort) from staff with eating, shower and personal hygiene. During a review of Resident 17's Order Summary Report, dated 1/21/2026, the Order Summary Report indicated the following orders: Ascorbic acid (vitamin C, essential, water-soluble nutrient found in fruits and vegetables that the human body cannot produce on its own) oral tablet, give 1 tablet by mouth two times a day for supplement, ordered on 12/11/2025. Bethanechol chloride (used to treat urinary retention) oral tablet 10 milligrams (mg, unit of measurement), give 1 tablet by mouth three times a day for urine retention, ordered on 12/11/2025. Carbidopa-Levodopa (medication used to treat Parkinson's disease [a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements] symptoms like tremors, stiffness, and slowness) oral tablet 25-100 mg, give 1 tablet by mouth one time a day for Parkinson's disease, ordered on 12/11/2025. Docusate sodium oral tablet 100 mg, give 1 tablet by mouth two times a day for bowel management, hold for loose stools, ordered on 1/21/2026. Escitalopram oxalate (medication used to treat depression) oral tablet 10 mg, give 1 tablet by mouth one time a day for depression manifested by verbalization of sadness, ordered on 12/11/2025. Lactobacillus oral tablet, give 1 capsule by mouth, once a day for probiotic (bacteria and yeasts, that provide health benefits when consumed), ordered on 1/21/2026. Furosemide (medication used treat fluid retention) oral tablet 40 mg, give 1 tablet by mouth two times a day for congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), hold if systolic blood pressure (SBP, the top/higher number in a reading, representing the pressure when your heart beats and pumps blood out) is less than 110 or heart rate of less than 60, ordered on 12/11/2025. During a medication administration observation on 1/22/2026 at 11:03 AM, with LVN 2, LVN 2 prepared and administered the following six (6) medications to Resident 17: Ascorbic acid oral tablet, 1 tablet. Bethanechol chloride oral tablet 10 mg, 1 tablet. Carbidopa-Levodopa oral tablet 25-100 mg, 1 tablet. Docusate sodium oral tablet 100 mg, 1 tablet. Escitalopram oxalate oral tablet 10 mg, 1 tablet. Lactobacillus oral tablet, 1 capsule. During an interview on 1/22/2026 at 11:26 AM, LVN 2 stated that he administered Resident 17's medications, (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	which were scheduled for 9 AM, late-after the one-hour window-because he was busy with another resident.2. During a review of the admission Record, the admission Record indicated Resident 10 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 10's diagnoses included diabetes mellitus (high blood sugar), encounter for attention to gastrostomy (G-tube, a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), and lack of coordination.During a review of Resident 10's (MDS - a resident assessment tool) dated 1/2/2026, the MDS indicated Resident 10 had severely impaired cognitive skills for daily decision making. The MDS indicated Resident 10 was dependent on staff for eating, oral hygiene, toileting hygiene, shower, upper and lower body dressing, putting on/taking off footwear and personal hygiene.During a review of Resident 10's Order Summary Report, dated 1/21/2026, the Order Summary Report indicated the following orders:Ativan (medication used as a powerful sedative and calming agent) oral tablet 0.5 mg, give 1 tablet via G-Tube every 12 hours for unspecified anxiety (a natural human feeling of fear, dread, or intense worry) disorder manifested by constantly yelling for no apparent reason, ordered on 10/3/2025.Baclofen (medication used as muscle relaxant) oral solution 5 mg/5ml, given 5 ml via G-tube one time a day for muscle relaxants, ordered on 1/19/2025.Benzotropine mesylate (medication used to treat movement disorders and muscle spasms) oral tablet 0.5 mg, give 1 tablet via G-Tube every 12 hours for extrapyramidal (Involuntary or uncontrollable muscle movements and body stiffness) and movement disorder, ordered on 10/3/2025.Escitalopram oxalate oral solution 5 mg/5ml, give 10 ml via G-Tube one time a day for depression manifested by constant crying for no apparent reason, ordered on 10/3/2025.Esomeprazole magnesium (medication that works by reducing the amount of acid produced in the stomach) oral packet 40 mg, give 1 packet via -tube, two times a day for Gastroesophageal Reflux Disease (GERD, a chronic condition where stomach acid frequently flows back up). Mix contents of 1packet with 15 ml of water and leave 2-3 minutes to thicken. Stir and administer within 30 minutes of mixing, ordered on 10/3/2025.Senna (plan-based medicine to treat constipation) oral tablet 8.6 mg, give 1 tablet via G-Tube two times a day for bowel management, hold for loose stool, ordered on 10/3/2025Zyprexa (olanzapine, medication used to treat serious mental health conditions) oral tablet 2.5 mg. Give 1 tablet via G-Tube two times a day for schizophrenia (a mental illness that is characterized by disturbances in thought) manifested by striking out at staff during activities of daily living. Ordered on 10/3/2025.During a medication administration observation on 1/22/2026 at 12:44 PM, RNS 4 prepared and administered the following six (7) medications to Resident 10:Ativan oral tablet 0.5 mg, 1 tablet.Baclofen oral solution 5 mg/5ml, 5 ml.Benzotropine mesylate oral tablet 0.5 mg, 1 tablet.Escitalopram oxalate oral solution 5 mg/5ml, 10 ml liquid solution.Esomeprazole magnesium oral packet 40 mg, 1 packet.Senna oral tablet 8.6 mg, 1 tablet.Zyprexa (olanzapine) oral tablet 2.5 mg, 1 tablet.During an interview on 1/23/2026 at 11:27 AM, RNS 3 stated failing to administer medication to a resident as ordered by the physician can lead to medical complications, possibly resulting in hospitalization. RNS 3 stated the facility's morning medication administration time is scheduled for 9 AM, and medications may be administered one hour before or after 9 AM. RNS 3 further stated if medications are administered late or early, the licensed nurse must notify the physician and document the reason for the delay in the resident's progress notesDuring an interview on 1/23/2026 at 12:11 PM, LVN2 stated on 1/22/2026, Resident 17's 9 AM medications were administered outside the one-hour window. LVN 2 stated when administering medications to his assigned residents, he takes time to check their vital signs, such as blood pressure, and pays attention to residents who want to speak with him. LVN 2 stated he should have delegated the administration of medications for other residents who had not received their 9 AM doses to another licensed nurse in the facility, such as the RN Supervisor, Director of Staff Development, Infection Preventionist Nurse, MDS Nurse, or Director of Nursing (DON). LVN 2 stated it is important to administer medications on time and as ordered by the physician to ensure efficacy and avoid possible adverse reactions or side effects that the resident may experience.During an interview on 1/23/2026 at 7 PM, the DON stated not following a physician's (continued on next page)		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to monitor the use of insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) and anticoagulant therapy (a medical treatment using drugs called blood thinners to prevent or treat dangerous blood clots [thrombi] by slowing the blood's clotting process, stopping existing clots from growing, and preventing new ones from forming) for two (2) of 15 sampled residents (Residents 1, and 32) as indicated on the residents' care plan by failing to monitor: 1. Resident 1 for signs and symptoms of hypoglycemia (an abnormally low level of sugar [glucose] in the blood) and hyperglycemia (a condition where the blood glucose [sugar] levels are abnormally high), while on Insulin Lispro (Humalog, a fast-acting insulin) from 12/21/2025 to 1/23/2026. 2. a. Resident 32 for signs and symptoms of hypoglycemia and hyperglycemia while on Insulin Lispro from 11/18/2025 up to 11/23/2026. 2. b. Resident 32 for signs and symptoms of bleeding from the use of Enoxaparin Sodium Injection (Lovenox, is an anticoagulant, also known as a blood thinner, that slows the body's normal clotting process and reducing risk of deep vein thrombosis [DVT, a condition in which harmful blood clots form in the blood vessels of the legs]) from 11/18/2025 to 1/23/2026. This deficient practice had the potential for Residents 2 and 32 to experience episodes of hypoglycemia, hyperglycemia, and bleeding without proper monitoring while on insulin, which may result in harm, hospitalization, and death. Findings: 1. During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] and re-admitted on [DATE]. Resident 1's diagnoses included type 2 diabetes (a disorder characterized by difficulty in blood sugar control and poor wound healing), right leg cellulitis (a bacterial infection that enters the skin and tissue through a wound), lumbar spine spondylosis (a common condition that refers to age related wear and tear affecting the discs and joints of the lower back over time), and lymphedema (swelling that occurs when the lymphatic system [part of the body's immune and drainage network] cannot properly remove excess fluid, causing it to accumulate in tissues leading to persistent swelling, often in the arms or legs). During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 12/29/2025, the MDS indicated Resident 1 had intact cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 1 needed setup or clean-up assistance (Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity) in eating and oral hygiene. The MDS also indicated Resident 1 needed supervision or touching assistance (helper provides verbal cues and/or touching/ steadying and/or contact guard assistance as resident completes activity) toileting hygiene, shower/ bathe self, upper body dressing, roll left and right, sit to lying, lying to sitting on side of bed, sit to stand, and chair/ bed-to-chair transfer, toilet transfer, tub / shower transfer, walk 10, 50, and 150 feet. During a concurrent interview and record review on 01/23/2026 8:10 AM with MDS Nurse (MDSN), Resident 1's Physician Orders (PO) dated 12/21/2025 was reviewed. The PO indicated Humalog Injection Solution 100 units per milliliter (ML, measure of volume) Inject subcutaneous (SQ, a shot that delivers medicine into the fatty tissue layer just under the skin, above the muscle, using a short, small needle for slow, steady absorption) three times a day for DM II. Inject per sliding scale (method of adjusting medication doses, most commonly insulin, based on the resident's blood glucose level [amount of sugar present in the blood at a given time]): If below 80= If conscious give four (4) ounces (oz, unit of weight) of juice. If unconscious, Give Glucagon (a hormone that raises blood sugar) 1 milligram (mg, a unit of weight/mass) intramuscular injection (IM, is the injection of a medication into a muscle); Notify Physician if 81 to 150 = 0; 151 to 200 = 2 units; 201 to 250 = 4 units; 251 to 300 = 6 units; 301 to 350 = 8 units; 351 to 400 = 10 units call MD IF Blood Sugar was greater than (>) 400 MDSN stated Resident 1 did not have an order to monitor for signs and symptoms (s/s) of hypoglycemia and hyperglycemia while using insulin; therefore, there (continued on next page)		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was no documented evidence that Resident 1 was monitored for these symptoms. MDSN stated if it was not documented, then it was not done. MDSN stated it was important for Resident 1 to be monitored for the s/s of hypoglycemia and hyperglycemia because the worst possible outcome during an episode of hypoglycemia is a diabetic coma (a medical emergency caused by a blood sugar level that was too low or too high). MDSN added, if Resident 1 exhibits symptoms of hyperglycemia, the most serious consequence could be metabolic acidosis (a condition in which there is too much acid in the body fluids), and the resident might need to be transferred to the hospital. During a concurrent interview and record review on 1/23/2026 at 8:15 AM with MDSN, Resident 1's Care Plan (CP) for diabetes mellitus dated 1/9/2026 was reviewed. The CP indicated Resident 1 had diabetes mellitus and was at risk for hypoglycemia or hyperglycemia reaction. MDSN state the CP interventions should have included monitoring Resident 1 for s/s of hypoglycemia or hyperglycemia. During an interview on 1/23/2026 at 4:57 PM with Pharmacist 2, Pharmacist 2 stated that licensed facility staff should know the s/s of hypoglycemia and hyperglycemia when residents are using insulin. They should document monitoring for these s/s in the residents' records. Pharmacist 2 stated this should be included in the resident's care plan, documented in the progress notes, and the physician should always be notified according to the physician's order. 2. During a review of Resident 32's admission Record, the admission Record indicated Resident 32 was admitted to the facility on [DATE] and re-admitted on [DATE]. Resident 32's diagnoses included DM II, bilateral knee osteoarthritis (a type of arthritis that happens when cartilage in the joints wears down), obesity (a condition marked by excess accumulation of body fat), and hypertension (high blood pressure). During a review of Resident 32's MDS, dated [DATE], the MDS indicated Resident 32's cognitive skills for daily decision making were intact. The MDS indicated Resident 32 needed substantial/ maximal assistance (helper does more than half the effort. helper lifts, holds trunk or limbs, and provides more than half the effort) 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 bed, sit to stand, and chair/ bed-to-chair transfer, toilet transfer, and walk 10 feet. The MDS also indicated Resident 32 received 2 insulin injections during the last 7 days. a. During a concurrent interview and record review on 1/23/2026 at 8:51 AM with MDSN, Resident 32's PO, dated 11/18/2025, was reviewed. The PO indicated, Insulin Lispro Injection Solution 100 units per ML, inject subcutaneously before meals and at bedtime for DM II. Inject as per sliding scale:If 0 to 80 =If conscious, give 4 oz of juice. If unconscious, give Glucagon 1mg IM times 1. Notify Physician.81 to 149 = 0;150 to 199 = 1 unit;200 to 249 = 2 units;250 to 299 = 3 units;300 to 349 = 4 units;350 to 400 = 5 unitsMDSN stated Resident 32 did not have an order to monitor for s/s of hypoglycemia and hyperglycemia while using insulin; therefore, there was no documented evidence that Resident 32 was monitored for these symptoms. MDSN stated if it was not documented, then it was not done. During a concurrent interview and record review on 1/23/2026 at 8:53 AM with MDSN, Resident 32's CP for diabetes mellitus dated, 2/2/2025 was reviewed. The CP indicated Resident 32 was at risk for hypoglycemia or hyperglycemia.The CP interventions indicated the following: Monitor/document/report as needed (PRN) signs and symptoms of hyperglycemia: increase thirst, headaches, trouble concentrating, blurred vision, frequent urination, fatigue, and weight loss. Monitor/document/report PRN signs and symptoms of hypoglycemia: sweating, tremor, increased heart rate (tachycardia), pallor (skin paleness), nervousness, confusion, slurred speech, lack of coordination, staggering gait.MDSN stated Resident 32's CP interventions for monitoring hypoglycemia and hyperglycemia were not followed and implemented because there was no documentation that the staff monitored Resident 32. During a concurrent interview and record review on 1/23/2026 8:55 AM with MDSN, Resident 32's Nurses' Progress Notes (NPN), dated 11/18/2025 to 11/30/2025 were reviewed. MDSN stated that there was no documentation indicating the licensed nurses monitored Resident 32 for hypoglycemia and hyperglycemia. MDSN added the licensed staff did not properly monitor Resident 32. During a concurrent interview and record review on 01/23/2026 at 9:00 AM with MDSN, Resident 32's Nurses' Progress Notes (NPN), dated 1/1/2026 to 1/23/2026, (continued on next page)		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	were reviewed. MDSN stated that there was no documentation showing staff monitored Resident 32 for s/s of hypoglycemia and hyperglycemia. MDSN also stated that if there was no documentation of monitoring for these s/s, staff were not aware of the residents' condition and would not be able to provide quality care. During an interview on 1/23/2026 at 4:52 PM with Pharmacist 1, Pharmacist 1 stated that the facility usually has a protocol when a resident is taking insulin which is to monitor for s/s of hypoglycemia and hyperglycemia. During a review of the facility's undated policy and procedure (P&P) titled, Diabetes Clinical Protocol, the P&P indicated, the staff and provider will monitor for and manage hypoglycemia appropriately. Monitoring is included as part of the plan of care. The staff and provider will monitor for and manage hyperglycemia appropriately. Monitoring is included as part of the plan of care. b. During a concurrent interview and record review on 1/23/2026 at 8:51 AM with MDSN, Resident 32's PO, dated 11/18/2025, was reviewed. The PO indicated Enoxaparin Sodium Solution 40 mg/ 0.4 ml. Inject 40 mg subcutaneously one time a day for blood clotting prevention. MDSN stated Resident 32 did not and should have had an order to monitor bleeding, for bruises, and hematoma (a localized collection of blood outside of the blood vessels) because the resident was prone to it due to use of Lovenox. During a concurrent interview and record review on 1/23/2026 at 9:09 AM with MDSN, Resident 32's CP on Anticoagulant therapy dated 11/19/2025 was reviewed. The CP Interventions indicated the following: Administer anticoagulant medications as ordered by physicians. Monitor for side effects and effectiveness every shift. Monitor/document/report PRN adverse reactions of Anticoagulant therapy: blood tinged or red blood in urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy, bruising, blurred vision, shortness of breath, loss of appetite, sudden changes in mental status, significant or sudden changes in vital signs. MDSN stated Resident 32's CP interventions were not followed and implemented because there was no documented evidence in Resident 32's chart. During a concurrent interview and record review on 1/23/2026 at 9:11AM with MDSN, Resident 32's NPN, dated 11/18/2025 to 11/30/2025 was reviewed. MDSN stated there was no documentation that Resident 32 was monitored for signs and symptoms of bleeding in the nurses' progress notes. During a concurrent interview and record review on 1/23/2026 at 9:20AM with MDSN, Resident 32's NPN, dated 1/1/2026 to 1/23/2026 was reviewed. MDSN stated there was no documentation that Resident 32 was monitored for signs and symptoms of bleeding which means the licensed staff were not checking Resident 32 while on anticoagulant therapy. During an interview on 1/23/2026 at 4:57 PM with Pharmacist 2, Pharmacist 2 stated when a resident is on anticoagulant therapy, the licensed staff should monitor the resident for bleeding. Pharmacist 2 stated the licensed staff should document in the resident's chart the specific symptoms of bleeding being monitored like nosebleeds, gum bleeding, and signs of internal bleeding such as dark stools or reddish- colored urine).		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure its medication error rate was less than five (5) percent (%). 13 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 35 total opportunities (observed administered medications) for error, to yield an overall medication error rate of 37.14 % for two (2) of six (6) sampled residents (Resident 10 and Resident 17) observed for medication administration. Licensed Vocational Nurse 2 (LVN 2) failed to administer Resident 17's medications, and Registered Nurse Supervisor 4 (RNS4) failed to administer Resident 10's medication within 60 minutes of the scheduled time of 9 AM on 1/22/2026. This deficient practice had the potential to result in Resident 17 and Resident 10 experiencing adverse medication effects (unwanted, uncomfortable, or dangerous effects that a medication may have), negatively impacting their health and well-being. Findings: 1. During a review of the admission Record, the admission Record indicated Resident 17 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 17's diagnoses included were benign prostatic hyperplasia (BPH, health issue with urination, problems like a weak stream, difficulty starting to pee, and frequent urination), dementia (a progressive state of decline in mental abilities), and hypertensive heart disease (long-term high blood pressure) with heart failure (the heart can't pump). During a review of Resident 17's Minimum Data Set (MDS - a resident assessment tool) dated 7/12/2025, the MDS indicated Resident 17 had modified independence (some difficulty in new situations only) with cognitive (thought process and ability to reason or make decisions) skills for daily decision making. The MDS indicated Resident 10 was dependent (helper does all the effort) on staff for toileting hygiene, shower, upper and lower body dressing, and putting on/taking off footwear. The MDS indicated Resident 10 required substantial/maximal assistance (helper does more than half the effort) from staff with eating, shower and personal hygiene. During a review of Resident 17's Order Summary Report, dated 1/21/2026, the Order Summary Report indicated the following orders: Ascorbic acid (vitamin C, essential, water-soluble nutrient found in fruits and vegetables that the human body cannot produce on its own) oral tablet, give 1 tablet by mouth two times a day for supplement, ordered on 12/11/2025. Bethanechol chloride (used to treat urinary retention) oral tablet 10 milligrams (mg, unit of measurement), give 1 tablet by mouth three times a day for urine retention, ordered on 12/11/2025. Carbidopa-Levodopa (medication used to treat Parkinson's disease [a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements] symptoms like tremors, stiffness, and slowness) oral tablet 25-100 mg, give 1 tablet by mouth one time a day for Parkinson's disease, ordered on 12/11/2025. Docusate sodium oral tablet 100 mg, give 1 tablet by mouth two times a day for bowel management, hold for loose stools, ordered on 1/21/2026. Escitalopram oxalate (medication used to treat depression) oral tablet 10 mg, give 1 tablet by mouth one time a day for depression manifested by verbalization of sadness, ordered on 12/11/2025. Lactobacillus oral tablet, give 1 capsule by mouth, once a day for probiotic (bacteria and yeasts, that provide health benefits when consumed), ordered on 1/21/2026. Furosemide (medication used treat fluid retention) oral tablet 40 mg, give 1 tablet by mouth two times a day for congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), hold if systolic blood pressure (SBP, the top/higher number in a reading, representing the pressure when your heart beats and pumps blood out) is less than 110 or heart rate of less than 60, ordered on 12/11/2025. During a medication administration observation on 1/22/2026 at 11:03 AM, with LVN 2, LVN 2 prepared and administered the following six (6) medications to Resident 17: Ascorbic acid oral tablet, 1 tablet. Bethanechol chloride oral tablet 10 mg, 1 tablet. Carbidopa-Levodopa oral tablet 25-100 mg, 1 tablet. Docusate sodium oral tablet 100 mg, 1 tablet. Escitalopram oxalate oral tablet 10 mg, 1 tablet. Lactobacillus (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	oral tablet, 1 capsule. During an interview on 1/22/2026 at 11:26 AM, LVN 2 stated that he administered Resident 17's medications, which were scheduled for 9 AM, late-after the one-hour window-because he was busy with another resident. 2. During a review of the admission Record, the admission Record indicated Resident 10 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 10's diagnoses included diabetes mellitus (high blood sugar), encounter for attention to gastrostomy (G-tube, a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), and lack of coordination. During a review of Resident 10's (MDS - a resident assessment tool) dated 1/2/2026, the MDS indicated Resident 10 had severely impaired cognitive skills for daily decision making. The MDS indicated Resident 10 was dependent on staff for eating, oral hygiene, toileting hygiene, shower, upper and lower body dressing, putting on/taking off footwear and personal hygiene. During a review of Resident 10's Order Summary Report, dated 1/21/2026, the Order Summary Report indicated the following orders: Ativan (medication used as a powerful sedative and calming agent) oral tablet 0.5 mg, give 1 tablet via G-Tube every 12 hours for unspecified anxiety (a natural human feeling of fear, dread, or intense worry) disorder manifested by constantly yelling for no apparent reason, ordered on 10/3/2025. Baclofen (medication used as muscle relaxant) oral solution 5 mg/5ml, given 5 ml via G-tube one time a day for muscle relaxants, ordered on 1/19/2025. Benztropine mesylate (medication used to treat movement disorders and muscle spasms) oral tablet 0.5 mg, give 1 tablet via G-Tube every 12 hours for extrapyramidal (Involuntary or uncontrollable muscle movements and body stiffness) and movement disorder, ordered on 10/3/2025. Escitalopram oxalate oral solution 5 mg/5ml, give 10 ml via G-Tube one time a day for depression manifested by constant crying for no apparent reason, ordered on 10/3/2025. Esomeprazole magnesium (medication that works by reducing the amount of acid produced in the stomach) oral packet 40 mg, give 1 packet via -tube, two times a day for Gastroesophageal Reflux Disease (GERD, a chronic condition where stomach acid frequently flows back up). Mix contents of 1 packet with 15 ml of water and leave 2-3 minutes to thicken. Stir and administer within 30 minutes of mixing, ordered on 10/3/2025. Senna (plan-based medicine to treat constipation) oral tablet 8.6 mg, give 1 tablet via G-Tube two times a day for bowel management, hold for loose stool, ordered on 10/3/2025. Zyprexa (olanzapine, medication used to treat serious mental health conditions) oral tablet 2.5 mg. Give 1 tablet via G-Tube two times a day for schizophrenia (a mental illness that is characterized by disturbances in thought) manifested by striking out at staff during activities of daily living. Ordered on 10/3/2025. During a medication administration observation on 1/22/2026 at 12:44 PM, RNS 4 prepared and administered the following six (7) medications to Resident 10: Ativan oral tablet 0.5 mg, 1 tablet. Baclofen oral solution 5 mg/5ml, 5 ml. Benztropine mesylate oral tablet 0.5 mg, 1 tablet. Escitalopram oxalate oral solution 5 mg/5ml, 10 ml liquid solution. Esomeprazole magnesium oral packet 40 mg, 1 packet. Senna oral tablet 8.6 mg, 1 tablet. Zyprexa (olanzapine) oral tablet 2.5 mg. 1 tablet. During an interview on 1/23/2026 at 11:27 AM, RNS 3 stated failing to administer medication to a resident as ordered by the physician can lead to medical complications, possibly resulting in hospitalization. RNS 3 stated the facility's morning medication administration time is scheduled for 9 AM, and medications may be administered one hour before or after 9 AM. RNS 3 further stated if medications are administered late or early, the licensed nurse must notify the physician and document the reason for the delay in the resident's progress notes. During an interview on 1/23/2026 at 12:11 PM, LVN2 stated on 1/22/2026, Resident 17's 9 AM medications were administered outside the one-hour window. LVN 2 stated when administering medications to his assigned residents, he takes time to check their vital signs, such as blood pressure, and pays attention to residents who want to speak with him. LVN 2 stated he should have delegated the administration of medications for other residents who had not received their 9 AM doses to another licensed nurse in the facility, such as the RN Supervisor, Director of Staff Development, Infection Preventionist Nurse, MDS Nurse, or Director of Nursing (DON). LVN 2 stated it is important to administer medications on time and as ordered by the physician to ensure efficacy and (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	avoid possible adverse reactions or side effects that the resident may experience. During an interview on 1/23/2026 at 7 PM, the DON stated not following a physician's order constitutes a medication error. The DON confirmed that LVN 2 administered Resident 17's 9 AM medications late on 1/22/2026 and that RNS 4 also administered Resident 10's 9 AM medications late on the same day. The DON stated medications may be administered one hour before or after the scheduled time but should not exceed that window, as doing so is considered a medication error. The DON added when LVN 2 and RNS 4 were having difficulty administering medications within the allotted time, they should have asked for assistance so another licensed nurse could help. The DON stated, If medications are not administered on time, for example, anti-anxiety medications, it can affect the mood and behavior of residents, which can impact their activities of daily living (ADLs). The DON also added failing to administer medication as ordered by the physician can lead to medical complications, possibly resulting in hospitalization. During a review of facility's Policy and Procedure (P&P) titled, Administering Medications, revised in April 2019, the P&P indicated medications are administered in a safe and timely manner, and as prescribed. It indicated medications are administered in accordance with prescriber orders, including any required time frame. The P&P indicated medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders) or ordered by the physician. The P&P also indicated medication administration times are determined by resident need and benefit, not staff convenience. Factors that are considered included: Enhancing optimal therapeutic effect of the medication. Preventing potential medication or food interactions.		

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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. Based on observation, interview, and record review, the facility failed to ensure proper food handling and maintain the food service area in a clean and sanitary manner in accordance with the facility's policies and procedures (P&P) when: The can opener was chipped and soiled with food residue. The blender was chipped and inside the jar showed white to yellowish discoloration around the blade. The onion powder container lid was partially closed and did not have a label to indicate open and discard date. The stand mixer (used for mixing, whisking, and kneading ingredients) had peeling and chipped paint, with exposed metal on the adjustment handle. The coffee maker's spout (the part where the coffee flows out into the pot or cup) was cracked. These deficient practices have the potential to expose residents to pathogens (germs), placing them at risk for developing foodborne illness (food poisoning), which may cause symptoms such as upset stomach, stomach cramps, nausea, vomiting, diarrhea, and fever which could lead to serious medical complications and hospitalization. Findings: During an observation on 1/20/2026 at 7:40 AM in the facility's kitchen, the can opener was observed to be chipped and soiled with food residue. The blender was chipped and inside the jar showed white to yellowish discoloration around the blade. During an observation on 1/20/2026 at 7:41 AM in the facility's kitchen, the onion powder container lid was partially closed and did not have a label to indicate open and discard date. During an observation on 1/20/2026 at 7:42 AM in the facility's kitchen, the stand mixer had peeling and chipped paint, with exposed metal on the adjustment handle. The spout of the coffee maker was observed to be cracked. During an interview on 1/22/2026 at 1:19 PM with the Dietary Supervisor (DS), the DS stated that the coffee maker pot was cracked, the stand mixer paint was chipped and peeling, the onion powder lid was not properly closed and was not dated, and the can opener was chipped and had marinara sauce residue. The DS stated that all lids are supposed to be properly closed and dated with open and discard dates. The DS also stated that the can opener should be washed daily after use and that all equipment should be maintained in good condition to prevent food contamination, which could possibly cause illnesses such as diarrhea and stomach aches. During an interview on 1/23/2026 at 7:32 AM with the Cook, the [NAME] stated that the can opener should be cleaned after every use. The [NAME] stated that all opened food should be labeled, dated, and sealed properly. The [NAME] also stated that all equipment should be in good condition to prevent sickness. During a review of the facility's undated P&P titled, Food Storage, the P&P indicated that all opened and partially used foods shall be dated, labeled, and sealed before being returned to the storage area. During a review of the undated facility's P&P titled, Safety and Sanitation, the P&P indicated that Food and nutrition services employees shall perform job responsibilities in a safe and sanitary manner. The P&P also indicated that any equipment making unusual noises, giving off odd odors, or operating in an abnormal manner will be reported immediately. Equipment should be turned off, unplugged, and a do not use sign attached until it is evaluated, repaired, and found to be safe to use.		

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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** Based on observation, interview, and record review, the facility failed to ensure that the call light device (one of the major communication technologies that link nursing home staff to the needs of residents) was within reach (an arm's length) of one (1) of 15 sampled residents (Resident 4). This failure had the potential to cause a delay in care for Resident 4 and prevent the resident from receiving the necessary care and services, which could lead to illness or serious injury. Findings: During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was initially admitted to the facility on [DATE] with diagnosis of dementia (progressive brain disorder that slowly destroys memory and thinking skills), muscle weakness, and aphasia (an impairment of language, affecting the production or comprehension of speech and the ability to read or write). During a review of Resident 4's Minimum Data Set (MDS, a resident assessment tool), dated 12/10/2025, the MDS indicated Resident 4's cognitive skills (processes of thinking and reasoning) for daily decision making was severely impaired (never/rarely made decisions). The MDS also indicated Resident 4 was partial/moderate assistance (helper does less than half the effort) on personal hygiene (the ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands (excluding baths, showers, and oral hygiene). The MDS indicated Resident 4 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) on toileting hygiene (the ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement). During a review of Resident 4's care plan revised on 12/18/2025, the care plan indicated Resident 4 was at risk for fall related to confusion, history of fall, incontinence (involuntary loss of urine or stool), unaware of safety needs, poor vision. The care plan also indicated to ensure the resident's call light is within reach and encourage the resident to use it for assistance as needed. During a review of Resident 4's care plan initiated on 5/28/2025, it indicated Resident 4 cannot verbally communicate which makes having the call light at his (Resident 4) side very important as well as paying attention to his verbal cues. The care plan indicated the activities will trigger call light and alert nursing staff at Resident 4's request for medications and pain management. During an observation on 1/20/2026 at 2:24 PM in Resident 4's room, observed Resident 4 call light coiled on the right of the resident's bed rails (are adjustable metal or rigid plastic bars that attach to the bed. They are available in a variety of types, shapes, and sizes ranging from full to one-half, one-quarter, or one-eighth lengths) and hanging, the call was visibly out of Resident 4's reach. During a concurrent observation and interview on 1/22/2026 at 7:58 AM in Resident 4's room with the Certified Nursing Assistant (CNA1), observed Resident 4 looking for his call light. CNA 1 stated the call light was observed coiled at the resident's bed rails hanging down. CNA 1 stated the resident was looking for the call light and was unable to find and reach it. CNA 1 stated call lights should be easily accessible. During an interview on 1/23/2026 5:07 PM with the License Vocational Nurse (LVN 1), LVN 1 stated the call light should be answered as soon as possible and the call light should be placed within the resident's reach. LVN 1 stated the call light was the resident's way of communication, and to alert the facility staff when the resident needs assistance. LVN 1 stated Resident 4 can feel hopeless and that nobody cares for the resident, and that is why it is very important to ensure call light is within the resident's reach at all times. During a review of facility's Policy and Procedure (P&P) titled Answering the Call Light revised 9/ 2022, it indicated the purpose of policy and procedure is to ensure timely responses to the resident's requests and needs. The P&P also indicated 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.		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow the process of investigation and report of grievance (a complaint, either oral or written, expressing dissatisfaction with service delivery or the quality of care furnished, regardless of whether remedial action is requested) for one (1) of 15 sampled residents (Resident 8) as indicated in the facility's policy and procedure by failing to document steps taken during the investigation of grievance, summarize pertinent findings or conclusion and document the date the grievance investigation result (decision) was confirmed This deficient practice had the potential to result in miscommunication and inaccurate information of the investigations which did not meet the documentation requirements for Resident 8's grievance. Findings: During a review of Resident 8's admission Record, the admission Record indicated Resident 8 was admitted to the facility on [DATE] and re-admitted on [DATE], Resident 8's diagnoses included chronic kidney disease (CKD, is a condition in which the kidneys are damaged and cannot filter blood as well as they should), anxiety disorder (a disorder characterized by nervousness characterized by a state of excessive uneasiness and apprehension, typically with compulsive behavior [repetitive, persistent, and often uncontrollable actions that a person feels driven to perform] or panic attacks), and chronic obstructive pulmonary disease (COPD, is a chronic inflammatory lung disease that causes obstructed airflow from the lungs) During a review of Resident 8's Minimum Data Set (MDS, a resident assessment tool), dated [DATE], the MDS indicated Resident 8 had intact cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 8 needed substantial/ maximal assistance (helper does more than half the effort. helper lifts, holds trunk or limbs, and provides more than half the effort) in toileting hygiene, shower/bathe self, lower body dressing, putting on/ taking off footwear, lying to sitting on the side of the bed, and tub/shower transfer. During an interview on [DATE] at 3:31 PM with Social Services Director (SSD), the Complaint and Grievance Report (CGR) Form dated [DATE] was reviewed. The CGR Form indicated, during the evening shift (3PM-11PM) care on [DATE] by the unknown Certified Nurse Assistant (CNA), the Unknown CNA pulled sheet from under Resident 8 and threw the sheet on the floor during care. SSD stated, she received the grievance report late morning on [DATE]. SSD stated the incident happened on Sunday during the evening shift, the CNA removed the sheet underneath Resident 8, and the CNA threw it on floor. Resident 8 cannot recall the name of the CNA during the SSD interview and SSD endorsed the report to the Director of Staff Development (DSD). During a concurrent interview and record review on [DATE] at 1:59 PM with SSD, the facility's Complaint and Grievance Report (CGR) Form dated [DATE] was reviewed. There was information missing on the CGR Form: Steps taken to investigate grievance Summary of pertinent findings or conclusion Date grievance decision was confirmed SSD stated the DSD or nursing department will be the one responsible for the follow-up and ensure the steps taken to investigate the grievance were documented in the CGR. The SSD stated the investigation should have been done by the nursing DSD responsible for a follow-up investigation and the space for the steps taken to investigate grievance including the summary of pertinent findings was left blank which means it was not done. The CGR Form should have included the in-service topic discussed with CNA 3 and it should include a summary of investigation. SSD also stated she did not review the summary and investigation, she should have reviewed and followed up the investigation and completed the CGR Form with the missing information. SSD stated SSD should have completed and explained to Resident 8 the steps that have been taken to investigate the grievance filed. During an interview on [DATE] at 2:06 PM with SSD, SSD stated after conducting thorough investigation on [DATE] of the Grievance report, it was found that it was not CNA 3 who was the staff involved with Resident 8's grievance, it was CNA 2. The investigation and in service was inaccurate for the grievance report for the incident. (continued on next page)		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on [DATE] at 2:08 PM with the SSD, the facility's policy and procedure a (P&P) titled, Grievances/ Complaints, Recording and Investigating revised 5/2023, the P&P indicated, upon receiving a grievance and complaint report, the Social Services Director or designee will begin an exploration into the allegations/concerns. SSD stated she could have provided better interviews with Resident 8 and follow up the department responsible for investigating and summary. The Corrective action, my follow- through interview thoroughly and, if she did her follow up interview with Resident 8, she would have captured the grabbing and reported it properly. SSD has to do her own interview as a grievance officer. During a concurrent interview and record review on [DATE] 11:20 AM with the Director of Nursing (DON), the CGR dated [DATE] was reviewed. The CGR Form were missing information on the steps taken to investigate the grievance and summary of pertinent findings or conclusion. The DON stated the space for the steps taken to investigate grievance including the summary of pertinent findings were blank and there was no document attached. The DON stated the investigation report should be attached to the CGR if it was done and if the space for the steps taken to investigate grievance including the summary of pertinent findings was not filled out and there was no attachment, it means it was not done. During a concurrent interview and record review on [DATE] at 11:23 AM with the DON, the facility's policy and procedure (P&P) titled, Grievance revised 7/2017 was reviewed, the P&P indicated, the investigation and report will include, as applicable:a) The date and time of the alleged incident.b) The circumstances surrounding the alleged incident.c) The location of the alleged incident.d) The names of any witnesses and their accounts of the alleged incident.h) Recommendations for corrective action if not already remedied.The DON stated they did not follow the policy because the staff did not fill in the information needed for the CGR form, there was no proof that it was investigated such as letters A to D, and H in the list per the facility's P&P and no information of pertinent findings to draw conclusion. During a concurrent interview and record review on [DATE] at 12:28 PM with DSD, the CGR Form dated [DATE] was reviewed. DSD stated the nursing department was responsible for follow up interview with the resident, and staff involved in the grievance filed and ensured the steps taken to investigate the grievance were documented in the CGRThe DSD stated the space for the steps taken to investigate grievance including the summary of pertinent findings was not filled out and there was no attachment, it means it was not done and the CGR Form for Resident 1 was incomplete they were missing information for the investigation and summary. During a concurrent interview and record review on [DATE] at 12:34 AM with, the facility's policy and procedure (P&P) titled, Grievance revised 7/2017 was reviewed. DSD stated she did not follow the policy because the investigation report that she did for the CGR Form was incomplete, she was missing the names of staff being interviewed, name of the resident involved, time of interviewer, date, names of involved person and name of the interviewer.		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement the facility's abuse (the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish) policy regarding investigating an allegation of verbal abuse (the use of oral, written, or gestured communication, or sounds, to residents within hearing distance, regardless of age, ability to comprehend, or disability) for one (1) of two (2) sampled residents (Resident 8) reviewed for abuse. This deficient practice had the potential to compromise or impede the protection of Resident 8, which could affect resident's emotional and mental wellbeing. Cross reference with F610. Findings: During a review of Resident 8's admission Record, the admission Record indicated Resident 8 was admitted to the facility on [DATE] and re-admitted on [DATE]. Resident 8's diagnoses included chronic kidney disease (CKD, a condition in which the kidneys are damaged and cannot filter blood as well as they should), anxiety disorder (mental health condition marked by persistent, excessive worry, fear, or nervousness that interferes with daily life), and chronic obstructive pulmonary disease (COPD, a chronic inflammatory lung disease that causes obstructed airflow from the lungs). During a review of Resident 8's Minimum Data Set (MDS, a resident assessment tool), dated 1/12/2026, the MDS indicated Resident 8 had intact cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 8 needed substantial/ maximal assistance (helper does more than half the effort. helper lifts, holds trunk or limbs, and provides more than half the effort) in toileting hygiene, shower/bathe self, lower body dressing, putting on/ taking off footwear, lying to sitting on the side of the bed, and tub/shower transfer. During an interview on 1/20/2026 at 9:26 AM with Resident 8, Resident 8 stated Certified Nursing Assistant 2 (CNA 2) who worked the 3PM to 11 PM shift had a bad attitude and was pushy. Resident 8 stated two days ago, on Sunday night, CNA 2 yanked out the drawsheet (are small, durable sheets or absorbent pads placed crosswise over the middle of a resident's bed under a resident's hips and torso to assist with repositioning, transferring, and reducing friction on the skin) under her and threw it on the floor near the door. Resident 8 also stated CNA 2 pulled out her (Resident 8's) brief and grabbed Resident 8's arm and held it straight up while being changed. Resident 8 further stated CNA 2 was mean to Resident 8 and it made the resident cry. Resident 8 stated she informed the Social Services Director (SSD) about CNA 2's bad attitude on 1/19/2026. During an interview on 1/21/2026 at 12:58 PM with Resident 8, Resident 8 stated the incident happened Sunday (1/18/2026) night when CNA 2 grabbed her (Resident 8's) right arm so Resident 8 could not reach the adhesive tabs for her brief as Resident 8 likes to adjust and secure the brief adhesive tabs herself. Resident 8 stated CNA 2 told her to stop and held her arm straight up to prevent her from touching the adhesive tabs. Resident 8 described CNA 2 as rough and scary and that she did not like what CNA 2 did to her and it made Resident 8 cry. During a concurrent interview and record review on 1/21/2026 at 3:35 PM with SSD, the facility's Interview Record dated 1/20/2026 at 3:40 PM was reviewed. The Interview Record indicated Resident 8 recalled CNA during the 3PM-11PM shift and that the resident does not recall the date, and the day of the week that CNA (name not identified in the form) freaked out. The form also indicated Resident 8 requested to be changed and specified she asked CNA to return in 1 hour and CNA refused. The form indicated, when CNA went back to change Resident 8 the CNA roughly took drawsheet (sheet that is placed in such a way that it can be taken from under a patient for various purposes in the healthcare setting such as repositioning) from under Resident 8 and threw it on the floor near the door and when Resident 8 was trying to fasten tabs on her brief, CNA grabbed Resident 8's right arm. The form indicated Resident 8 stated CNA was mean. SSD stated according to the form CNA roughly pulled the drawsheet per Resident 8's interview. During a concurrent interview and record review on 1/21/2026 at 5:11 PM with Director of Health Information (DHI), the Investigation Report dated 1/20/2026 was reviewed. The investigation report was incomplete, and it (continued on next page)		

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

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

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

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

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

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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** Based on observation, interview and record review, the facility failed to implement a comprehensive resident-centered care plan (care plan, a formal process that correctly identifies existing needs and recognizes a resident's potential needs or risks to achieve healthcare outcomes) for one of 15 sampled residents (Resident 10) by failing to set Resident 10's Low Air Loss mattress (LAL mattress, designed to prevent and treat pressure injury/ ulcer [localized damage to the skin and underlying soft tissue caused by prolonged pressure]) according to the resident's weight. This deficient practice had the potential for Resident 10's skin to break down and develop skin impairment such as redness and pressure ulcer. Findings: During a review of the admission record indicated Resident 10 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including diabetes mellitus (high blood sugar), encounter for attention to gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), and lack of coordination. During a review of Resident 10's Minimum Data Set (MDS - a resident assessment tool) dated 1/2/2026, indicated Resident 10 had severely impaired cognitive (thought process and ability to reason or make decisions) skills for daily decision making. The MDS indicated Resident 10 was dependent (helper does all the effort) from staff for eating, oral hygiene, toileting hygiene, shower, upper and lower body dressing, putting on/taking off footwear and personal hygiene. The MDS also indicated Resident 10 was dependent from staff from rolling left and right (the ability to roll from lying on back to left and right side, and return to lying on back on the bed), sit to lying (the ability to move from sitting on side of bed to lying flat on the bed), and lying to sitting on side of bed (the ability to move from lying on the back to sitting on the side of the bed and with no back support). During a review of Resident 10's Order Summary Report, dated 1/21/2026, indicated an order of low air loss mattress to bed and set at resident weight for firmness. The order also indicated to check mattress for proper setting and function, every shift for skin management, ordered on 10/27/2025. During a review of Resident 10's Care Plan (CP), focusing on Resident 10's potential impairment to skin integrity related to existing diagnoses and risk factors, revised on 12/5/2025, indicated the following interventions: LAL mattress as ordered. LAL mattress to bed, set at resident weight for firmness and heck mattress for proper setting and function. During an observation of Resident 10's low air loss mattress on 1/20/2026 at 9:27 AM, indicated the LAL mattress was set to 300 pounds (lbs, unit of measurement). During an observation of Resident 10's low air loss mattress on 1/21/2026 at 3:33 PM, it indicated the LAL mattress was set to 350 Lbs. During a concurrent record review and interview on 1/21/2026 at 4:37 PM with MDS nurse (MDSN), Resident 10's electronic medical records dated from 10/27/2025 to 1/21/2026 were reviewed. MDSN stated Resident 10's latest weight on 1/5/2026 is 112 lbs. MDSN stated Resident 10's LAL mattress is for skin maintenance, as ordered on 10/27/2025 and we set the LAL mattress by the resident's weight. MDSN also stated the licensed nurses must do their rounds when they come in and make sure the resident's LAL mattress setting is set correctly. MDSN added it is important to follow the physician's order and the resident's care plan to prevent skin impairment to ensure LAL mattress is benefiting Resident 10 and will not cause new skin problems. MDSN stated if LAL mattress is not set correctly, the pressure might not be enough and can cause more harm to Resident 10 such as developing skin redness and skin breakdown that's potential for infection, especially Resident 10 is incontinent. MDSN stated Resident 10's LAL mattress care plan with intervention to set the LAL mattress according to Resident 10's weight was not implemented and should have been implemented to maintain Resident 10's skin integrity. During a concurrent observation and interview on 1/21/2026 at 4:42 PM with MDSN, Resident 10's LAL was observed. MDSN verified Resident 10's LAL mattress is currently set at 350. MDSN stated the settings were wrong and not set according to (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 10's weight which is 112 lbs. During an interview on 1/22/2026 at 8:33 AM with Treatment Nurse (TXN 1) 1, he stated using a LAL mattress was important for Resident 10 because the resident is not ambulatory. TXN 1 stated, it is to prevent skin impairment and t is important to follow resident's care plan because it is the planned care specific to the resident's need. TXN 1 stated not following the plan of care for Resident 10's LAL mattress to set the LAL mattress according to the resident's weight may cause skin impairment which will place Resident 10 in pain. During a review of facility's Policy and Procedure (P&P), titled Care Plans, Comprehensive Person-Centered, revised in March 2022, indicated comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical functional needs is developed and implemented for each resident.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide grooming services for one (1) of 1 sampled residents (Resident 4) reviewed for activities of daily living (ADL, activities related to personal care that include bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating), in accordance with the facility's policy and procedure (P&P) titled, Care of Fingernails/Toenails This deficient practice resulted in Resident 4's having unkempt and dirty fingernails, which could potentially lead to skin injury and infection. Findings: During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was initially admitted to the facility on [DATE]. Resident 4's diagnoses included dementia (progressive brain disorder that slowly destroys memory and thinking skills), diabetes mellitus (persistently high levels of sugar in the blood), and muscle weakness. During a review of Resident 4's Minimum Data Set (MDS, a resident assessment tool), dated 12/10/2025, the MDS indicated Resident 4's cognitive skills (processes of thinking and reasoning) for daily decision making was severely impaired (never/rarely made decisions). The MDS also indicated Resident 4 required partial/moderate assistance with personal hygiene (the ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands, and oral hygiene). During a review of Resident 4's Care Plan initiated on 7/28/2021, revised 9/20/2025, the care plan indicated Resident 4 was at risk for ADL self-care deficit related to overall condition. The care plan also indicated to check nail length and trim and clean on bath day and as necessary. During observation in Resident 4's room on 1/20/2026 at 8:18 AM, Resident 4's fingernails were observed to be dirty and crusted with gunk (dirt under the fingernails). During a concurrent observation in Resident 4's room and interview with the Director of Nursing (DON) on 1/21/2026 at 4:10 PM, Resident 4's fingernails were observed to be dirty and crusted with gunk. The DON stated Resident 4's nails need to be cleaned. During a concurrent observation in Resident 4's room and interview with Certified Nursing Assistant (CNA 1) on 1/22/2026 at 8:01 AM, CNA 1 stated Resident 4's nails were dirty, with dark-colored small particles under the fingernails. CNA 1 also stated Resident 4's nails were not smooth. CNA 1 stated the nails are supposed to be clean and smooth, as rough or dirty nails can potentially cause scratches or skin tears to Resident 4. During a review of facility's P&P titled, Care of Fingernails/Toenails, revised 2/2018, the P&P indicated the purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections. The P&P also indicated nail care includes daily cleaning and regular trimming. Proper nail care can aid in the prevention of skin problems around the nail bed. The P&P also indicated trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin.		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide activities to support resident's choice of activity for one of two sampled residents (Resident 10) reviewed for activities as indicated on the care plan. This deficient practice had the potential to negatively impact Resident 10's physical, cognitive, emotional health, and sense of belonging. Findings: During a review of the admission Record, the admission Record indicated Resident 10 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including diabetes mellitus (high blood sugar), encounter for attention to gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), and lack of coordination. During a review of Resident 10's Minimum Data Set (MDS - a resident assessment tool), dated 1/2/2026, the MDS indicated Resident 10 had severely impaired cognitive (thought process and ability to reason or make decisions) skills for daily decision making. The MDS indicated Resident 10 has impairment on bilateral upper and lower extremities. The MDS indicated Resident 10 was dependent (helper does all the effort) from staff for eating, oral hygiene, toileting hygiene, shower, upper and lower body dressing, putting on/taking off footwear and personal hygiene. The MDS also indicated Resident 10 was dependent from staff from rolling left and right (the ability to roll from lying on back to left and right side, and return to lying on back on the bed), sit to lying (the ability to move from sitting on side of bed to lying flat on the bed), and lying to sitting on side of bed (the ability to move from lying on the back to sitting on the side of the bed and with no back support). During a review of Resident 10's Care Plan (CP) focusing on activities, initiated on 11/14/2025, the CP indicated Resident 10 enjoys listening to the radio or watching television (TV). Resident 10 enjoys a sip of juice daily and socializing when she wants to. The CP goals indicated: Activity staff will make sure radio/tv is on in Resident 10's room. Offer juice daily. Activities staff will work with nursing to get Resident 10 to activity room at least once a week. The CP interventions initiated on 11/14/2025 indicated the following: Activities will be aware of resident's legs when kicking feet in her room/bed. Activities will offer something to drink for Resident 10 daily. Activities will turn radio or tv to desired station or channel of Resident 10. During a review of Resident 10's Medical Record titled, Activity Interview for Daily and Activity Preferences, with an effective date of 1/1/2026, the record indicated that Resident 10's previous work experience was as a musical artist and performer. It noted that Resident 10's daily pleasure is music, and playing the piano provides comfort and relaxation. The record also indicated that Resident 10 does not like books or magazines but her favorite TV shows and movies are westerns. It also indicated that it is very important for her to listen to music she enjoys, specifically classical music. It also indicated that keeping up with the news and being in a group of people is not very important to Resident 10. During an observation on 1/20/2026 at 2:32 PM in the facility's activity room, Resident 10 was observed sitting in a Geri chair (a specialized, mobile, reclining chair designed for individuals with limited mobility) without any activity. Other residents in the activity room were observed playing board games with each other. During an observation in Resident 10's room on 1/21/2026 at 3:35 PM, Resident 10 was observed lying in bed, awake, with the television turned off. During a concurrent record review and interview with the Activity Director (AD) on 1/23/2026 at 4:36 PM, Resident 10's medical records were reviewed. The AD stated Resident 10 was a music performer and enjoyed listening to classical music. The AD verified there was no documented evidence that activities such as listening to music were provided to Resident 10. The AD stated Resident 10 does not have, but should have, a radio at her bedside. The AD also stated she does not recall observing Resident 10 watching TV in her room. The AD stated that it is important to provide activities according to Resident 10's assessment to support quality of life and mental health, such as reducing feelings of sadness or depression. During an interview on 1/23/2026 at 5:58 PM with Director of Nursing (DON), the DON stated that it is important to provide activities appropriate to residents to (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	help bring back memories and support mental health and quality of life. During a review of facility's Policy and Procedures (P&P) titled, Activity Programs, revised in June 2018, the P&P indicated activity programs are designed to encourage maximum individual participation and are geared to the individual resident's needs. It also indicated all activities are documented in the resident's medical record.		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide appropriate treatments and services to increase, prevent, or maintain range of motion (ROM, full movement potential of a joint) for one (1) of 15 sampled residents (Resident10) as indicated on the facility's Assistive Devices and Equipment policy. This deficient practice placed Resident 10 at risk for developing contractures (condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints), which could result in pain and discomfort, joint deformities, immobility, and skin breakdown. Findings: During a review of the admission Record, the admission Record indicated Resident 10 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including diabetes mellitus (high blood sugar), encounter for attention to gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), and lack of coordination. During a review of Resident 10's Minimum Data Set (MDS - a resident assessment tool) dated 1/2/2026, the MDS indicated Resident 10 had severely impaired cognitive (thought process and ability to reason or make decisions) skills for daily decision making. The MDS indicated Resident 10 has impairment on bilateral upper and lower extremities. The MDS indicated Resident 10 was dependent (helper does all the effort) from staff for eating, oral hygiene, toileting hygiene, shower, upper and lower body dressing, putting on/taking off footwear and personal hygiene. The MDS also indicated Resident 10 was dependent from staff from rolling left and right (the ability to roll from lying on back to left and right side, and return to lying on back on the bed), sit to lying (the ability to move from sitting on side of bed to lying flat on the bed), and lying to sitting on side of bed (the ability to move from lying on the back to sitting on the side of the bed and with no back support). Resident 10 was assessed with bilateral upper and lower functional limitations in ROM. During a review of Resident 10's History and Physical (H&P), dated 10/4/2025, the H&P indicated Resident 10 has multiple medical issues including muscle weakness, muscle wasting (weakening, shrinking, and loss of muscle) and atrophy (the loss of muscle mass and strength, resulting in thinner, smaller muscles), abnormal posture (improper, rigid, or chronic misalignment of the body). During an observation on 1/20/2026 at 2:32 PM, in facility's activity room, Resident 10 was observed sitting in a Geri chair (a specialized, mobile, and reclining chair designed for individuals with limited mobility). During a concurrent record review and interview on 1/21/2026 at 3:50 PM with the MDS Nurse (MDSN), Resident 10's medical records were reviewed. The MDSN stated that Resident 10 has always used a Geri chair and not a wheelchair. The MDSN stated Resident 10 was using the Geri chair due to a diagnosis of abnormal posture. The MDSN verified that Resident 10 does not have an order for the use of a Geri chair. The MDSN stated before a resident can use a Geri chair, an assessment by the rehabilitation department should be conducted, and a recommendation for its use should be communicated to the nursing department. The MDSN further stated that once the recommendation from the rehabilitation department is received, the Director of Nursing (DON) will assess the resident using the Nursing-Physical Restraint/Assistive Device Evaluation in the resident's electronic medical record. The MDSN stated this assessment tool documents what type of device is needed for the resident's positioning and comfort. The MDSN stated there was no documented evidence that the rehabilitation department was consulted regarding Resident 10's abnormal posture. The MDSN also stated that Resident 10 does not have, but should have, a Nursing-Physical Restraint/Assistive Device Evaluation for the use of a Geri chair. During an interview on 1/23/2026 at 5:45 PM with the DON, she stated that the rehabilitation department should have communicated Resident 10's abnormal posture to the nursing department and indicated if they were recommending the use of a Geri chair. The DON stated it was important to address Resident 10's poor posture and obtain an order for a Geri chair to promote proper body alignment and positioning for (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	safety. The DON further stated Resident 10's mobility was not properly addressed since the rehabilitation department did not provide a recommendation for the use of a Geri chair to assist with Resident 10's abnormal posture. During a review of the facility's Policy and Procedure (P&P) titled, Assistive Devices and Equipment, dated 2001, the P&P indicated certain devices and equipment that assist with resident mobility, safety, and independence are provided for residents. These may include (but are not limited to) mobility devices (wheelchairs, walkers, and canes). P&P also indicated recommendations for the use of devices and equipment are based on a comprehensive assessment and documented in the resident's care plan.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide care and treatment for one (1) of two (2) sampled residents (Resident 8) reviewed for catheter (flexible tube inserted into the bladder to drain urine when a person cannot urinate naturally) by failing to monitor and empty the nephrostomy (a medical procedure in which a tube is inserted through the skin of the lower back into the kidney to drain urine when the normal flow is blocked) drainage tube in accordance with the physician's order, care plan, and the facility's Care of Nephrostomy Policy and Procedures (P&P). This deficient practice had the potential to result in Resident 8 experiencing pain, discomfort, and infection, as well as complications such as kidney damage (condition when kidneys cannot properly filter waste and excess fluids from the blood) due to urine backing up into the kidneys, which could negatively affect the resident's overall well-being. Findings: During a review of Resident 8's admission Record, the admission Record indicated Resident 8 was admitted to the facility on [DATE] and re-admitted on [DATE]. Resident 8's diagnoses included chronic kidney disease (CKD, a long-term condition where the kidneys gradually lose their ability to filter waste and excess fluids from the blood), anxiety disorder (mental health condition characterized by excessive, persistent, and often uncontrollable feelings of worry or fear that interfere with a person's daily activities), and chronic obstructive pulmonary disease (COPD, inflammatory lung disease that causes obstructed airflow from the lungs). During a review of Resident 8's Minimum Data Set (MDS, a resident assessment tool), dated 1/12/2026, the MDS indicated Resident 8 had intact cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 8 needed substantial/ maximal assistance (helper does more than half the effort. helper lifts, holds trunk or limbs, and provides more than half the effort) in toileting hygiene, shower/bathe self, lower body dressing, putting on/ taking off footwear, lying to sitting on the side of the bed, and tub/shower transfer. During a concurrent observation and interview on 1/22/2026 at 7:52 AM in Resident 8's room, Resident 8's nephrostomy tube dressing had greenish-brown drainage on the adhesive dressing. The site showed minimal redness, and there was a slight foul odor from the area. Resident 8's nephrostomy bag was positioned on the left side of the bed. Resident 8 stated that she always reminds the outgoing shift nurses to inform the incoming shift nurses to empty the bag at 1 AM, but this is often not done. Resident 8 stated the nephrostomy bag fills up quickly and takes only a minute to drain. Resident 8 added, If the nephrostomy bag fills up, it sometimes causes pain in my lower back because the urine backs up to my kidneys. Resident 8 added that this can lead to an infection and possibly result in the resident being transferred to the hospital. During a concurrent observation and interview on 1/22/2026 at 7:55 AM with Treatment Nurse 1 (TXN 1) in Resident 8's room, Resident 8's nephrostomy drain site had a greenish- brown drainage on the dressing and minimal redness at the site. TXN 1 stated the nephrostomy site dressing was dirty and had some hair on the adhesive dressing. TXN1 also stated that the nephrostomy site consistently had a greenish brown - drainage. During an interview and record review on 1/22/2026 at 11:12 AM with TXN 1, Resident 8's Physician orders dated 5/15/2025 and 10/30/2025 were reviewed. The orders indicated the following: Treatment: Left flank (the area on the side of the body between the ribs and the hip) nephrostomy site: cleanse with normal saline solution, pat dry, cover with dry dressing, cover with dry dressing every 7AM to 3PM (AM) shift. Left flank nephrostomy: Check for obstructive and reflux uropathy (kidney damage caused by the backward flow of urine from the bladder up into the ureters and kidneys) every shift Nephrostomy: Empty drainage bag every shift or before completely full. Monitor urine output for any change such as amber colored urine, foul urine odor, poor urine output, sediments every shift. TXN 1 stated the licensed nurses monitor Resident 8's nephrostomy site for any bleeding swelling and pain. TXN 1 stated Resident 8 had a nephrostomy treatment order daily. (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	TXN 1 stated they should empty the drainage bag every shift or as needed. During an interview and record review on 1/23/2026 at 11:02 AM with TXN 1, Resident 8's Treatment Administration Record (TAR), dated 1/4/2026 to 1/18/2026 was reviewed. The TAR indicated Left flank nephrostomy: Check for obstructive and reflux uropathy every shift. The TXN 1 stated the TAR did not have a licensed nurse signature on 1/4/2026, 1/8/2026 to 1/12/2026, 1/14/2026, and 1/18/2026 for the 3PM to 11PM shift. TXN 1 stated if the spaces were blank (not signed) in the TAR, it means, the licensed nurses did not check the resident's nephrostomy for obstructive and reflux uropathy. During an interview and record review on 1/23/2026 at 11:05 AM with TXN 1, Resident 8's TAR dated 1/4/2026 to 1/18/2026 was reviewed. The TAR indicated Nephrostomy: empty drainage bag every shift or before completely full. Monitor urine output for any change such as amber colored urine, foul urine odor, poor urine output, sediments every shift. The TXN 1 stated the TAR did not have a licensed nurse signature on 1/4/2026, 1/8/2026 to 1/12/2026, 1/14/2026 and 1/18/2026 in the 3PM to 11PM shift. TXN 1 stated the licensed nurses should have signed the TAR. TXN 1 stated if there were no documentation it means the licensed nurses did not empty the nephrostomy bag and monitor Resident 8's urine. During an interview and record review on 1/23/2026 at 11:09 AM with TXN 1, Resident 8's Care Plan (CP) for nephrostomy on Left flank related to diagnosis of obstructive and reflux uropathy revised on 11/14/2025 was reviewed. The CP interventions indicated the following: Check nephrostomy tube proper placement, patency Empty drainage bag every shift or before completely full. Monitor Urine Output for any changes such as amber color urine, foul urine odor, poor urine output, sediments. Monitor for urinary infection, foul smelling urine, sediments and address accordingly TXN 1 stated the licensed nurses did not implement Resident 8's care plan interventions. During a concurrent interview and record view on 1/23/2026 at 11:10 AM with TXN 1, the facility's policy and procedure (P&P) titled, Care of Nephrostomy Tube, revised 3/2018, was reviewed. The P&P indicated to check placement of the tubing and integrity of the tape during assessment. Empty drainage bag once per shift and as needed. TXN 1 stated the staff should look at Resident 8's nephrostomy site and document what they have monitored. TXN 1 stated the staff did not follow the facility's policy for the nephrostomy. During an interview on 1/23/2026 at 11:56 AM with the Director of Nursing (DON), the DON stated Resident 8's nephrostomy site had some hair on the dressing, the dressing was dirty, and there was slight redness at the site. The DON stated it is not normal to have drainage, and the site should be clean and free of redness. The DON further stated that if the nephrostomy site is dirty, it could cause infection at Resident 8's nephrostomy site. During a concurrent interview and record review on 1/23/2026 at 12 PM with the DON, Resident 8's TAR dated 1/4/2026 to 1/18/2026 was reviewed. The DON stated the blank spaces on the TAR meant the treatment as ordered were not done by the staff. The DON stated that the staff did not monitor Resident 8's nephrostomy for obstruction and kinks and the staff were not emptying the nephrostomy bag every shift. The DON stated if the staff did not monitor Resident 8's nephrostomy, it could get infected. During a concurrent interview and record review on 1/23/2026 at 12:04 PM with the DON, Resident 8's CP for nephrostomy on Left flank related to diagnosis of obstructive and reflux uropathy, revised on 11/14/2025, was reviewed. The DON stated Resident 8's care plan interventions were not implemented by the staff. During a concurrent interview and record view on 1/23/2026 at 12:05 PM with the DON, the facility's P&P titled, Care of Nephrostomy Tube, revised 3/2018, was reviewed. The P&P indicated, check placement of the tubing and integrity of the tape during assessment. Empty drainage bag once per shift and as needed. The DON stated the staff did not and should have followed their policy.		

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that one (1) of one sampled resident (Resident 17) reviewed for nutrition, who required adaptive feeding equipment (modified utensils, accessories, glasses, and plates to help improve residents' comfort and independence), was provided with built-up utensils (specialized utensils with a built-up handle designed to assist residents with limited or weakened grasping strength) during meals, as indicated in the physician's order. This deficient practice placed Resident 17 at risk for further decline in physical functioning and a decrease in self-feeding ability. Findings: During a review of the admission Record, the admission Record indicated Resident 17 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 17's diagnoses included Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), dementia (a progressive state of decline in mental abilities), and hypertensive heart disease (long-term high blood pressure) with heart failure (the heart can't pump). During a review of Resident 17's Minimum Data Set (MDS - a resident assessment tool) dated 7/12/2025, the MDS indicated Resident 17 had modified independence (some difficulty in new situations only) in cognitive (thought process and ability to reason or make decisions) skills for daily decision making. The MDS indicated Resident 17 had impairment on bilateral lower extremities. The MDS indicated Resident 10 was dependent (helper does all the effort) on staff for toileting hygiene, showering, upper and lower body dressing, and putting on/taking off footwear. Resident 10 required substantial/maximal assistance (helper does more than half the effort) from staff with eating, showering, and personal hygiene. During a review of Resident 17's Order Summary Report, dated 1/21/2026, the Order Summary Report indicated an order on 12/12/2025 to provide built up utensils for meals to increase independence for self-feeding. During a review of Resident 17's Occupational Therapy Treatment Encounter Notes, dated 12/19/2025, documented by Certified Occupational Therapy Assistant 1 (COTA 1) indicated that Resident 17 preferred to use regular utensils despite education on utilizing built-up utensils. During an observation in Resident 17's room on 1/20/2026 at 12:23 PM, Resident 17 was observed sitting in bed and eating lunch with a regular spoon from the resident's lunch tray. During an observation in Resident 17's room on 1/21/2026 at 12:34 PM, Resident 17 was observed sitting in a wheelchair and eating lunch with a regular spoon from the resident's lunch tray. During a concurrent observation in Resident 17's room and interview with COTA 1 on 1/22/2026 at 12:22 PM, COTA 1 verified that Resident 17's lunch tray did not have built-up utensils. COTA 1 stated Resident 17 refused to use built-up utensils. During a concurrent observation in Resident 17's room and interview with Licensed Vocational Nurse 2 (LVN 2) on 1/23/2026 at 12:30 PM, Resident 17's lunch tray was observed to have two regular spoons. LVN 2 stated Resident 17 always had two regular spoons and had never been seen using a special spoon other than the regular spoon used by other residents. LVN 2 verified Resident 17 had an order to use built-up utensils since 12/12/2025. LVN 2 stated if the resident refused to use the built-up utensils, the order should have been discontinued. LVN 2 stated having an order for built up utensils is usually placed after the rehabilitation department assesses the resident's capability to eat. During an interview on 1/23/2026 at 1:04 PM, Registered Dietician (RD) stated she was at the facility on 1/19/2026 and saw Resident 17. RD stated the rehabilitation and nursing departments did not communicate Resident 17's refusal to use built-up utensils to her. RD stated Resident 17's order for built-up utensils was important for nutrition, promoting independence, and preventing weight loss. During an interview on 1/23/2026 at 7:28 PM, the Director of Nursing (DON) stated Resident 17's order for built-up utensils was not implemented during meals. The DON stated she was not aware that Resident 17 had refused to use built-up utensils and that they were not being provided on the meal tray due to the refusal. The DON stated the order for built-up utensils was an assistive device (continued on next page)		

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	intended to promote Resident 17's ability to self-feed and maintain independence. The DON stated that if Resident 17 refused to use the assistive device during meals, the rehabilitation department should have communicated this and re-evaluated whether the assistive device was still appropriate. During a review of facility's Policies and Procedure (P&P) titled, Assistance with Meals, revised in March 2022, the P&P indicated adaptive devices will be provided for residents who need or request them. Assistance will be provided to ensure residents can use and benefit from special eating equipment and utensils. Residents may choose not to use adaptive devices.		

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to ensure one (1) of two (2) dumpsters (a movable waste container) were closed and not overflowing, in accordance with the facility's Policy and Procedure (P&P) titled, Food Related Garbage and Refuse Disposal. This deficient practice had a potential to attract vermin (animals that are believed to be harmful, carry diseases such as rodents, parasitic worms, or insects), pests (any living thing that has a negative effect on humans), and wildlife (undomesticated animal species) which may cause disease and other health issues to residents residing in the facility, staff, and the community. Findings: During a concurrent observation of the kitchen dumpsters located at the back of the facility and interview on 1/22/2026 7:45 AM with the Dietary Supervisor (DS), 1 of the kitchen dumpsters was not covered/ sealed and trash was overflowing. DS confirmed 1 of the 2 kitchen dumpsters were left open and overflowing with trash. During an interview on 1/23/2026 at 7:32 AM with [NAME] 1, [NAME] 1 stated, the kitchen dumpsters are supposed to be closed/ sealed and not overflowing to prevent odor, and it can attract flies and rats. During a concurrent interview and record review on 1/23/2026 at 7:34 AM with DS, the facility's Policy and Procedure P&P titled Food Related Garbage and Refuse Disposal revised date 10/20217 was reviewed. DS stated the P&P under the policy interpretation and implementation indicated outside dumpsters provided by garbage pickup services will be kept closed and free of surrounding litter. DS stated the dumpster should be closed all the time, it may cause unpleasant odor and could attract insects. The DS also stated P&P to ensure the dumpster was kept closed was not followed.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain an accurate and complete record for two (2) of 15 sampled residents (Resident 8 and 17) as indicated in the facility's policy and procedure when.1.The facility failed to update Resident 8's Medication Administration Records (MAR, a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) and care plan to indicate the behavior monitoring is for the use of clonazepam (a long-acting benzodiazepine with intermediate onset commonly used to treat panic disorders, severe anxiety, and seizures) and not Xanax (Alprazolam, is used to relieve symptoms of anxiety, including anxiety caused by depression [a mood disorder that causes a persistent feeling of sadness and loss of interest] and treat panic disorder[sudden, intense feelings of fear that cause physical symptoms like racing heartrate, fast breathing and sweating])). 2.Resident 17's progress notes on 1/19/2026 to 1/23/2026 indicated the resident is being monitored for weight gain instead of weight loss. This deficient practice had the potential to result in miscommunication and improper delivery of care and inaccurate information of the care provided to Resident 8 and 17.Findings: 1. During a review of Resident 8's admission Record, the admission Record indicated Resident 8 was admitted to the facility on [DATE] and re-admitted on [DATE], Resident 8's diagnoses included chronic kidney disease (CKD, is a condition in which the kidneys are damaged and cannot filter blood as well as they should), anxiety disorder (a disorder characterized by nervousness characterized by a state of excessive uneasiness and apprehension, typically with compulsive behavior [repetitive, persistent, and often uncontrollable actions that a person feels driven to perform] or panic attacks), and chronic obstructive pulmonary disease (COPD, is a chronic inflammatory lung disease that causes obstructed airflow from the lungs) During a review of Resident 8's Minimum Data Set (MDS, a resident assessment tool), dated 1/12/2026, the MDS indicated Resident 8 had intact cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS also indicated Resident 8 needed substantial/ maximal assistance (helper does more than half the effort. helper lifts, holds trunk or limbs, and provides more than half the effort) in toileting hygiene, shower/bathe self, lower body dressing, putting on/ taking off footwear, lying to sitting on the side of the bed, and tub/shower transfer. During a review of Resident 8's Care Plan for anxiety manifested by constant thoughts of over concern of health issues revised on 8/6/2025. The Care plan intervention indicated to monitor behavior episodes of constant thoughts of over concern of health issues and document with tally marks/ hash mark for each episode in the MAR every shift for Xanax use. During a review of Resident 8's Physician's Orders dated 8/5/2025 was reviewed, the Physician's order indicated clonazepam tablet 0.5 milligram (mg, a unit of weight/mass, give 1 tablet by mouth in the morning for anxiety manifested by constant thoughts of over concern of health issues. During a record review of Resident 8's Physician Orders dated 11/22/2022 and 7/30/2025, the physician orders indicated, on 11/22/2025, to start Resident 8 on Xanax tablet 0.5 mg by mouth one time a day and it was discontinued on 7/30/2025. The physician order dated 11/22/2022 also indicated to monitor the resident for behavior episodes of constant thoughts of over concern of health issues and hashmark for each episode in the MAR every shift for Xanax use. (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and record review on 1/23/2026 at 8:30 AM with MDS Nurse (MDSN), MAR for the month of January 2026 was reviewed. The MAR indicated to monitor Resident 8 for behavior episodes of constant thoughts of over concern about health issues and hashmark for each episode in the MAR every shift for Xanax use. MDSN stated the staff were monitoring Resident 8 for behavior episodes for the use of clonazepam and not for Xanax since Xanax was discontinued on 7/30/2025 and was changed to clonazepam on 8/5/2025. MDSN stated the medication name in the MAR for the behavior monitoring was incorrect and it should have been changed to clonazepam instead of Xanax. MDSN added, the licensed nurse should have clarified the order with the doctor so it will reflect the correct medication name in the care plan and MAR. During a concurrent interview and record review on 1/23/2026 at 8:33 AM with MDSN, the facility's policy and procedure (P&P) titled, Charting and Documentation revised 7/2017, the P&P indicated, documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. The MDSN stated the staff documentation should be consistent and accurate. The medication name was inaccurate in the physician's order, care plan and MAR for the monitoring of the resident's behavior episodes of constant thoughts of over concern of health issues for Xanax use instead of clonazepam. MDSN stated the licensed nurse should have updated the medication name on the behavior monitoring order. 2. During a review of the admission Record, the admission Record indicated Resident 17 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), dementia (a progressive state of decline in mental abilities) and hypertensive heart disease (long-term high blood pressure) with heart failure (the heart can't pump). During a review of Resident 17's MDS dated [DATE], the MDS indicated Resident 17 had modified independence (some difficulty in new situations only) cognitive (thought process and ability to reason or make decisions) skills for daily decision making. The MDS indicated Resident 17 has impairment on bilateral lower extremities. The MDS indicated Resident 10 was dependent (helper does all the effort) from staff for toileting hygiene, shower, upper and lower body dressing, and putting on/taking off footwear. The MDS indicated Resident 10 required substantial/maximal assistance from staff with eating, shower and personal hygiene. During a review of Resident 17's Progress notes dated 1/19/2026, timed 11:17 AM, indicated Resident 17 has seven (7) pounds (lbs, unit of measurement) weight loss in one month. During a review of Resident 17's Progress notes dated 1/19/2026 at 11:13 PM to 1/23/2026 at 5:38 AM, the notes indicated Resident 17 is on monitoring for weight gain of 7 lbs in 30 days. During an interview on 1/23/2026 at 1:05 PM with Registered Dietician (RD), RD stated Resident 17 has a weight loss of 7 lbs, and the licensed nurses had to do change of condition monitoring since 1/19/2026. RD stated the licensed nurses should have documented that Resident 17 had a weight loss of 7 lbs. and not weight gain for the other staff to be aware of Resident 17's current condition. RD stated wrong documentation can lead to wrong treatment which might cause harm to Resident 17. During an interview on 1/23/2026 at 1:20 PM with Facility's Administrator (ADM), ADM stated she is aware of Resident 17's change of condition on 1/19/2026 regarding 7 lbs weight loss. ADM stated the licensed nurses documented weight gain on 1/19/2026 until today, 1/23/2026. ADM stated, wrong (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documentation can lead to wrong treatment and might cause harm to any residents. ADM also added that almost five consecutive days of wrong documentation is not acceptable, and it is wrong. During a review of facility's P&P titled Charting and Documentation, revised in July 2017, indicated any changes in the resident's medical or physical, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team (a collaborative group of professionals—including physicians, nurses, therapists, social workers, and dietitians) regarding the resident's condition and response to care.		

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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	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** Based on observation, interview and record review, the facility failed to provide a 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 care, safety, and a home-like environment for the residents. Findings:During a tour of the facility on 1/20/2026 at 10 :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 1/23/2026 at 8:30 AM in room [ROOM NUMBER], one resident (Resident 3) was observed sitting on the edge of his bed waiting for his morning medications, while his roommate was still in bed. Resident 3 stated that the space in the room was adequate and that he has a wheelchair, which allows him to move around without difficulty. Resident 3 also stated that staff have enough space to move around while providing care.During a concurrent review of the facility's client accommodation analysis and interview with the Administrator (ADM) on 1/23/2026 at 7:50 PM, the ADM stated the facility has 17 resident rooms. The ADM stated 12 of these rooms do not meet the requirement of 80 square feet per resident in multiple - resident bedrooms. The ADM stated that she will continue to request a room waiver because not meeting the required square footage does not affect the health and safety of the residents. The ADM also stated that there is enough space for staff to provide care to the residents.During a review of the facility's room waiver letter, dated 1/20/2026, the room waiver indicated the following:Room # Beds Sq.Ft. Sq.Ft. per Bed101 2 144.82 72.41102 3 236.09 78.70104 4 318.73 79.68106 4 299.25 74.81109 4 302.7 75.67110 2 150.25 75.12111 2 150.2 75.10112 2 150.2 75.10114 2 154.4 77.20115 2 153.84 76.92116 2 145.2 72.60117 2 145.2 72.60During a review of the facility's room waiver letter, dated 1/20/2026, the facility's room waiver indicated a request for the continued waiver for square footage per resident. It also indicated the rooms have adequate space for nursing care, and the health and safety of residents occupying these rooms are not in jeopardy (dangerous situation). These rooms are in accordance with the special needs of the residents, and do not have adverse effect on the residents' health and safety or impedes the ability of any residents in the rooms to attain his or her highest practical well-being.During the survey from 1/20/2026 to 1/23/2026, rooms 101, 102, 104, 106, 109, 110, 111, 112, 114, 115, 116, and 117 were observed with adequate ventilation and lighting. The residents in the rooms have bathroom and toilet facilities. The residents have privacy curtains around their beds, which assured privacy. There was adequate space for getting in and out of wheelchairs and residents were afforded sufficient freedom of movement in the rooms.The residents did not complain regarding the space in their room. There was enough space for the staff to provide care and enough storage for residents' belongings. Residents that are wheelchair bound were able to move in the room without difficulty.The Department would recommend the room waiver for Rooms 101, 102, 104, 106, 109,110, 111, 112, 114, 115, 116, and 117.		