STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055899	A. Building B. Wing	04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Royal Palms Post Acute	630 W. Broadway Glendale, CA 91204

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 0604

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 48854

Based on interviews and record reviews, the facility failed to ensure one of two residents (Resident 1) was free from physical restraint (any device attached or adjacent to the body that cannot be easily removed and restricts freedom of movement) when Certified Nursing Assistant 1 (CNA 1) tied the resident with a bed sheet to the waist and around the wheelchair on 4/11/24. According to CNA 1, she tied down the resident down in the wheelchair with a bed sheet to prevent the resident from getting up while she was attending to another resident (Resident 2)

This deficient practice resulted in Resident 1's rights being violated, and held against her will. As a result of being tied down, Resident 1 expressed verbalization of feeling hopeless, humiliated, upset, cried, verbalized being treated like a kid, scared of CNA 1, and felt that day like a nightmare. Resident 1 verbalized that she felt helpless and overpowered . and that CNA 1 took her freedom away.

On 4/16/2024 at 5:12 PM, while onsite at the facility, the California Department of Public Health (CDPH) identified an Immediate Jeopardy situation (IJ, a situation in which the provider's noncompliance with one or more requirements of participation has caused or is likely to cause serious injury, harm, impairment, or death of a resident) regarding the inappropriate use of physical restraint. The survey team notified the Director of Nursing (DON) and the Administrator (ADM) of an IJ situation due to the facility's failure to ensure Resident 1 was free from physical restraints imposed for discipline or staff convenience when CNA 1 tied Resident 1 to the wheelchair with a bedsheet, to restrict Resident 1's freedom of movement after finding Resident 1 playing with water in the toilet bowl and prevent the resident from falling, on 4/11/2024 during the 3 PM to 11 PM shift.

On 4/17/2024 at 6:01 PM, the IJ was removed while onsite at the facility, in the presence of the ADM and the DON, after the facility submitted an acceptable IJ Removal Plan (a plan that identifies all actions the facility will take to immediately address the noncompliance that has resulted in the IJ situation) and the surveyor verified/confirmed onsite the facility's implementation of the IJ Removal Plan and the IJ situation was no longer present.

The IJ Removal Plan dated 4/16/2024, included the following:

1. CNA 1 was suspended from employment on 4/12/2024 and upon facility's investigation CNA 1 was terminated from the facility on 4/16/2024.

(continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055899	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2024
NAME OF PROVIDER OR SUPPLIER: Royal Palms Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE: 630 W. Broadway, Glendale, CA 91204	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. Resident 1 was assessed by the DON on 4/12/2024. There are no visible injuries noted on Resident 1. 3. Resident 1 was monitored by the DON initially and the Licensed Vocational Nurses (LVNs) every shift for 72 hours for negative psychosocial impact starting 4/12/2024. 4. Social Services Director (SSD 1) conducted an evaluation of Resident 1 for emotional distress on 4/12/2024, 4/15/2024 and 4/16/2024 and will continue daily visits for two weeks. Licensed nurses monitored Resident 1 every shift on 4/13/24 and 4 14/2024 to ensure the resident's psychosocial well-being. The facility's Interdisciplinary Team (IDT; team of professionals with a common goal) met with Resident 1 on 4/12/2024. 5. Resident 1 was seen by the primary care physician on 4/15/2024 and recommended Psychology (the scientific study of the human mind and its functions, especially those affecting behavior) and Psychiatry (the branch of medicine concerned with the study, diagnosis, and treatment of mental illness) consult. 6. Resident 1 was referred to and seen by the psychologist on 4/16/2024 via telehealth (facetime) in the resident's room and will be visited weekly. The Psychologist will follow up with a resident in-person visit on 4/18/2024, to continue to monitor and notify, will be seen via telehealth (facetime) as needed. 7. Resident 1 was referred to and seen by the psychiatrist on 4/16/2024 via telehealth (facetime) in the resident's room with recommendation to monitor for any changes and continue current medication regimen. 8. Residents who were assigned to CNA 1 were interviewed by the Assistant DON on 4/15/2024. There are no other residents identified to be affected by the same deficient practice. 9. Immediate in-service was provided to facility staff; CNA, Licensed Vocational Nurses, Registered Nurse (RN) Supervisor, Rehabilitation Department staff, housekeeping staff, Activity staff, Maintenance staff, Kitchen staff and laundry staff that started on 4/15/2024 and will continue until 100 % achieved (estimated completion: 4/17/2024) regarding the following: - Resident's rights to be free from physical restraint. - Policy and Procedure on the use of restraint - Policy and Procedure on Identifying Involuntary Seclusion and Unauthorized Restraint - Abuse Reporting (Timely reporting of abuse-2-hour reporting) - Any staff that has not undergone the above training will not be put in the facility's schedule. - The Director of Staff Development (DSD) rechecked professional licenses and certificate for current staff such as CNAs, Licensed staff and therapists on 4/17/2024 for any disciplinary action related to abuse. Any staff member with disciplinary action against their professional license will be subject for investigation by the ADM. (continued on next page)

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F 0604

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

10. Department Managers will conduct room rounds in the morning for safety and observation of any physical restraints and will conduct interview with current residents who are alert and interviewable, for five days a week starting 4/17/2024. LVNs and RN supervisors will monitor residents every shift to ensure restraints are not being used.

11. During weekends, the Administrator/DON will assign room rounds to RN Supervisors and Manager of the day (MOD) regarding the inappropriate use of physical restraints.

12. For non-interviewable residents, LVNs and RN supervisors will monitor residents every shift to ensure physical restraints are not being used in the facility.

13. Any negative findings during room rounds and monitoring will be reported immediately to the ADM/DON and will conduct investigation appropriately and report to appropriate agencies (local police, ombudsman, CDPH licensing).

14. The Department Manager as part of room rounds will conduct safety and observation of any physical restraints and will conduct interview with current residents who are alert and interviewable five days a week in the morning.

15. Any findings of the use of physical restraints during daily rounds will be reported to CEO/Quality Assurance and Performance Improvement (QAPI) Committee for additional recommendations.

16. The QAPI Committee should evaluate weekly the implementation of the plan of correction (room rounds, daily safety observation of the residents), monitor for effectiveness and revise plan as necessary for continuous improvement until the resolution is achieved.

Findings:

A review of Resident 1's Admission Record indicated the resident was admitted to the facility on [DATE], with diagnoses that included pneumonia (infection of one or two lungs), anxiety (feeling of fear, dread, and uneasiness), depression (mood disorder that causes a persistent feeling of sadness) and bipolar disorder (mental illness that causes unusual shifts in mood from extreme happiness to extreme sadness and vice-versa)

A review of Resident 1's History and Physical dated 3/22/2024, indicated the resident did not have the capacity to make decisions.

A review of Resident 1's Minimum Data Set (MDS, a comprehensive standardized assessment and screening tool) with assessment reference date of 3/28/2024, indicated the resident had severe cognitive (thought process) impairment. The MDS indicated Resident 1 was independent (able to complete task by themselves) in walking, with the use of a walker. The MDS indicated Resident 1 required maximal assistance (helper does more than half the effort) on tasks such as lower body dressing, bathing, and toileting, moderate assistance (helper does less than half the effort) on tasks such as upper body dressing, and supervision on tasks such as sit to stand and bed mobility. The MDS indicated Resident 1 did not have physical restraints used during the MDS assessment reference date.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of Resident 1's Fall Risk Evaluation, dated 3/22/2024, indicated Resident 1 was assessed at high risk for falls. The Fall Risk Evaluation indicated Resident 1 had no falls for the past 90 days. A review of Resident 1's care plan dated 3/23/2024, indicated the resident was high risk for falls related to confusion, balance problems, and cognitive impairment. The care plan interventions included anticipating/meeting the resident's needs, providing the resident with a safe environment, and reevaluating the use of adaptive equipment and devices to ensure the appropriateness on the use of least restrictive device or restraints. A review Resident 1's Progress Notes New, dated 4/12/24, timed at 9:30 AM, indicated a Nursing Progress Note authored by the DON, that the DON received a report from the Director of Rehabilitation (DOR) regarding an alleged incident of abuse; Resident [1] was tied with white single sheet around the waist in the wheelchair on 4/11/2024 during 3 to 11 shift . The progress notes indicated CNA 1 admitted tying Resident 1 in the wheelchair to prevent the resident from falling while CNA 1 was attending to other residents. The progress notes indicated the DON reached out to Speech Therapist (ST) 1 who saw Resident 1 in the resident's room on 4/11/2024. The progress notes indicated Resident 1 informed ST 1 that there was a sheet around Resident 1's waist and ST 1 immediately informed the charge nurse (LVN 1). The progress notes indicated Resident 1 was slightly upset/frustrated about the incident . and stated that someone tied her with a bed sheet around her waist in the wheelchair . A review of a facility record titled Care Plan Conference Summary dated 4/12/2024, authored by SSD 1, indicated that Resident 1 stated that the evening shift CNA tied her with a bedsheet around her waist while sitting in the wheelchair. The record indicated Resident 1 stated that she could not get up and became frustrated and informed ST 1 that she was tied to the wheelchair. A review of Resident 1's Psychosocial/Social Note, dated 4/16/2024, and timed at 6:36 PM, authored by SSD 1, indicated Resident 1 stated the incident made her feel helpless, and was asking for help when two people walked by. The Psychosocial/Social Note indicated Resident 1 felt overpowered by the CNA who seemed not seeing her even though she was there. During an interview on 4/12/2024 at 2:42 PM, Resident 1 stated she remembered being tied up yesterday (4/11/2024) with a staff that works at the facility. Resident 1 stated when the new nurse (CNA 1) came in the nurse tied Resident 1 using a bed sheet around the waist to the wheelchair for hours. Resident 1 stated she kept screaming while she was tied up. Resident 1 stated while she was screaming She heard two people walking by and nothing happened. Resident 1 stated being tied up upset her that she cried, felt humiliated, and being tied up made her feel like a person that got caught in a nightmare. Resident 1 further stated that being tied up made her feel like a kid who had no control and that her life was over because someone had the power to make her a bad person. Resident 1 stated she could not remove the bedsheet. Resident 1 stated she would feel scared if she ever sees CNA 1 again. Resident 1 stated CNA1 took her freedom away. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Royal Palms Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE: 630 W. Broadway Glendale, CA 91204	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 4/12/2024 at 4:22 PM with CNA 1, CNA 1 stated she was assigned to Resident 1 and Resident 2 in the same room, on 4/11/2024 for the 3 PM to 11 PM shift. CNA 1 stated when she was doing her initial rounds for her assigned residents when Resident 2 asked for assistance go to the bathroom. CNA 1 stated she was helping Resident 2 in the bathroom when Resident 1 started getting up from the bed. CNA 1 stated she did not call other staff for help because when she looked outside of Resident 1's room, there was no other staff available in the hallway. CNA 1 stated she put Resident 1 in the wheelchair and tied her to the wheelchair using a bed sheet. CNA 1 stated she tied Resident 1 to prevent the resident from falling because Resident 1 kept trying to get up. CNA 1 stated she started her initial rounds within 30 minutes of her arrival into the facility during the 3 PM to 11 PM shift. CNA 1 stated she finished the evening shift and had Resident 1 in her assignment throughout the shift, on 4/11/2024. CNA 1 stated that she informed LVN 2 on 4/11/2024, that she tied Resident 1 to the wheelchair. During an interview on 4/12/2024 at 4:36 PM with ST 1, ST 1 stated he went to Resident 1's room at around 5:45 PM to 6 PM and when he opened the door, he heard a resident yelling for help. ST 1 stated when Resident 1 saw ST 1, Resident 1 called ST 1 by his first name, asking for help to get her out. ST 1 stated he walked closer to Resident 1's bedside and he saw that Resident 1 was sitting on a wheelchair with a bed sheet wrapped around the waist and the wheelchair. ST 1 stated Resident 1 had a bedside table in front of her. ST 1 stated that during that same time, CNA 1 was inside the room, feeding another resident (Resident 3). ST 1 stated he reported what he saw to LVN 1 and the DOR. During an interview on 4/12/2024 at 4:13 PM with the DOR, the DOR stated she received a text message from ST 1 on 4/11/2024 at around 6 PM, stating that a resident was tied to the wheelchair. The DOR stated the text message also indicated that ST 1 informed a nurse about the incident. During an interview on 4/12/2024 at 5:33 PM with LVN 1, LVN 1 stated ST 1 reported to her that there was something blocking Resident 1. LVN 1 stated she started to walk towards Resident 1's room, but as she got closer to the room, she saw the resident walking outside of the room with LVN 2 and CNA 1. LVN 1 further stated she did not approach the resident or staff. During an interview on 4/12/2024 at 6 PM with LVN 2, LVN 2 stated CNA 1 did not inform him on 4/11/2024 that she tied Resident 1 to the wheelchair. LVN 2 stated he was not aware that CNA 1 tied Resident 1 with a bedsheet to the wheelchair on 4/11/2024. During an interview on 4/16/2024 at 3:19 PM, with Resident 2 (Resident 1's roommate) and Resident 2's family member (Family 1), Family 1 stated she talked to Resident 2 on 4/11/2024, on the phone but there was a lot of noise during that time, and she could not make sense of what Resident 2 was telling her. Family 1 stated so she told Resident 2 to stop talking about it. Family 1 stated that when she was at the facility, she had seen Resident 1 attempts to get up from bed frequently. During the interview, Resident 2 stated she was in the room with Resident 1, on the evening of 4/11/2024 but did not see Resident 1 being tied up in the wheelchair. However, Resident 2 stated that she heard Resident 1 screaming for help and swearing at the nurse (CNA 1) that evening. Resident 2 stated Resident 1 was screaming for a long time. A review of Resident 2's Admission Record indicated Resident 2 was admitted to the facility on [DATE], with diagnoses that included weakness, hypertension (consistent high blood pressure), and lack of coordination. (continued on next page)

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F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of Resident 2's MDS dated [DATE], indicated Resident 2 has intact cognition. The MDS indicated Resident 2 has adequate (no difficulty) hearing without the use of a hearing aid. On 4/16/2024 at 6:14 PM, during another interview with Resident 1, in the presence of SSD 1, five days after Resident 1 was tied up in the wheelchair on 4/11/2024, Resident 1 stated she remembered being tied to the wheelchair with a bedsheet by a staff. Resident 1 stated her trauma does not go away. Resident 1 stated that she cried and was upset. Resident 1 stated she remembered calling for help because she heard two people passing by and they did not stop. During an interview on 4/12/2024 at 8:24 PM, with the DON, the DON stated CNA 1 tied Resident 1 to the wheelchair with the bed sheet and it was a form of physical restraint. The DON stated other non-restrictive alternatives must be unsuccessful before physical restraints may be used and there must be a physician's order, proper monitoring, consent, and evaluation prior to the use of restraints. The DON stated Resident 1 could suffer from emotional trauma and physical injuries affecting the resident's quality of life with the improper use of restraints. During an interview on 4/15/24 at 3:10 PM, with the ADM, the ADM stated the improper use of restraints on Resident 1 with or without consent, could be classified as a form of physical, emotional, and psychological abuse. The ADM stated there was no reason for CNA 1 to tie down Resident 1. A review of the facility's policy and procedure titled, Identifying Involuntary Seclusion and Unauthorized Restraint, revised in September 2022, indicated Risk of falling is not considered a medical symptom or self-injurious behavior that warrants the use of restraints. The policy and procedure indicated Restraints that are used as a last resort to protect the safety of the resident and others must be accompanied by an order from the practitioner and documentation reflecting the circumstances that led up to the decision to restrain the resident. A review of the facility's policy and procedure titled Resident Rights, (undated), indicated it is the resident's right to be free from corporal punishment or involuntary seclusion, and physical restraints.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 48854 Based on interview and record review, the facility failed to ensure that all allegations of abuse are reported immediately but no later than two hours if the alleged violation involves abuse, to the local, state, and federal agencies, in accordance with the facility ' s policy and procedure on Abuse Investigation and Reporting for one of two sampled residents (Resident 1). Speech Therapist (ST) 1 found Resident 1 tied by a whitesheet around the wheelchair by Certified Nursing Assistant (CNA) 1 on 4/11/24 at 6 PM. The facility abuse coordinator was made aware of the incident on 4/12/24 at 9 AM and the facility reported to the California Department of Public Health (CDPH) on 4/12/24 at 11:41 AM (18 hours). This deficient practice put Resident 1 the potential to suffer further abuse, including other residents assigned to CNA 1. Findings: A review of Resident 1 ' s Admission Record indicated the resident was admitted to the facility on [DATE], with diagnoses that included pneumonia (an infection of one or both lungs), anxiety (feeling of fear, dread, and uneasiness), depression (mood disorder that causes a persistent feeling of sadness) and bipolar disorder (mental illness that causes unusual shifts in mood from extreme happiness to extreme sadness and vice-versa). A review of Resident 1 ' s History and Physical (H&P), dated 3/22/2024, indicated the resident did not have the capacity to make decisions. A review of Resident 1 ' s Minimum Data Set (MDS, a comprehensive standardized assessment and screening tool), dated 3/28/24, indicated the resident has severe cognitive (thought process) impairment. The MDS indicated the resident was independent (able to complete task by themselves) in walking with the use of a walker. The MDS indicated the resident required maximal assistance (helper does more than half the effort) on tasks such as lower body dressing, bathing, and toileting, moderate assistance (helper does less than half the effort) on tasks such as upper body dressing, and supervision on tasks such as sit to stand and bed mobility. A review Resident 1 ' s Progress Notes New, dated 4/12/24, timed at 9:30 AM, indicated a Nursing Progress Note authored by the DON, that the DON received a report from the Director of Rehabilitation (DOR) regarding an alleged incident of abuse; Resident [1] was tied with white single sheet around the waist in the wheelchair on 4/11/2024 during 3 to 11 shift . The progress notes indicated CNA 1 admitted tying Resident 1 in the wheelchair to prevent the resident from falling while CNA 1 was attending to other residents. The progress notes indicated the DON reached out to Speech Therapist (ST) 1 who saw Resident 1 in the resident ' s room on 4/11/2024. The progress notes indicated Resident 1 informed ST 1 that there was a sheet around Resident 1 ' s waist and ST 1 immediately informed the charge nurse (LVN 1). The progress notes indicated Resident 1 was slightly upset/frustrated about the incident . and stated that someone tied her with a bed sheet around her waist in the wheelchair . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a facility record titled Care Plan Conference Summary dated 4/12/2024, authored by SSD 1, indicated that Resident 1 stated that the evening shift CNA tied her with a bedsheet around her waist while sitting in the wheelchair. The record indicated Resident 1 stated that she could not get up and became frustrated and informed ST 1 that she was tied to the wheelchair. During an interview on 4/12/2024 at 2:42 PM, Resident 1 stated she remembered being tied up yesterday (4/11/2024) with a staff that works at the facility. Resident 1 stated when the new nurse (CNA 1) came in the nurse tied Resident 1 using a bed sheet around the waist to the wheelchair for hours. Resident 1 stated she kept screaming while she was tied up. Resident 1 stated while she was screaming She heard two people walking by and nothing happened. Resident 1 stated being tied up upset her that she cried, felt humiliated, and being tied up made her feel like a person that got caught in a nightmare. Resident 1 further stated that being tied up made her feel like a kid who had no control and that her life was over because someone had the power to make her a bad person. Resident 1 stated she could not remove the bedsheet. Resident 1 stated she would feel scared if she ever sees CNA 1 again. Resident 1 stated CNA1 took her freedom away. During an interview on 4/16/2024 at 3:19 PM, with Resident 2 (Resident 1 ' s roommate) and Resident 2 ' s family member (Family 1), Family 1 stated that she talked to Resident 2 on 4/11/2024, on the phone but there was a lot of noise during that time, and she could not make sense of what Resident 2 was telling her. Family 1 stated so she told Resident 2 to stop talking about it. Family 1 stated that when she was at the facility, she had seen Resident 1 attempts to get up from bed frequently. During the interview, Resident 2 stated she was in the room with Resident 1, on the evening of 4/11/2024 but did not see Resident 1 being tied up in the wheelchair. However, Resident 2 stated that she heard Resident 1 screaming for help and swearing at the nurse (CNA 1) that evening. Resident 2 stated Resident 1 was screaming for a long time. During a follow up interview on 4/16/24 at 3:44 PM with ST, ST stated Resident 1 suffered a form of abuse when Resident 1 was tied to the wheelchair by CNA 1. ST stated he should have reported the incident to the abuse coordinator or to the state agency. ST stated he is a mandated reporter and there was no excuse for [him] to not report it. ST further stated cases of abuse should be reported immediately or within 2 hours to protect the affected resident and other residents from suffering abuse. During an interview on 4/12/2024 at 4:13 PM with the DOR, the DOR stated she received a text message from ST 1 at around 6 PM, stating that a resident was tied to the wheelchair. The DOR stated the text message also indicated that ST 1 informed a nurse about the incident. The DOR stated ST 1 did not mention talking to the facility ' s abuse coordinator. The DOR stated she did not report to the abuse coordinator what happened to Resident 1, until 4/12/2024 at around 9 AM. The DOR stated the incident is a case of abuse and should have been reported immediately or within 2 hours of finding out about the abuse. The DOR further stated if abuse allegations are not reported within 2 hours, the affected resident and other residents could suffer further abuse. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/12/2024 at 4:22 PM with CNA 1, CNA 1 stated she was assigned to Resident 1 and Resident 2 in the same room, on 4/11/2024 for the 3 PM to 11 PM shift. CNA 1 stated when she was doing her initial rounds for her assigned residents, Resident 2 asked for assistance go to the bathroom. CNA 1 stated she was helping Resident 2 in the bathroom when Resident 1 started getting up from the bed. CNA 1 stated she did not call other staff for help because when she looked outside the resident ' s room, no one was in the hallway. CNA 1 stated she put Resident 1 in the wheelchair and tied her to the wheelchair using a bed sheet. CNA 1 stated she tied Resident 1 to prevent the resident from falling because Resident 1 kept trying to get up. CNA 1 stated she started her initial rounds within 30 minutes of her arrival into the facility during the 3 PM to 11 PM shift. CNA 1 stated she finished the evening shift and had Resident 1 in her assignment throughout the shift, on 4/11/2024. CNA 1 stated that she informed LVN 2 on 4/11/2024, that she tied Resident 1 to the wheelchair. During an interview on 4/12/2024 at 4:36 PM with ST 1, ST 1 stated he went to Resident 1 ' s room at around 5:45 PM to 6 PM and when he opened the door, he heard a resident yelling for help. ST 1 stated when Resident 1 saw ST 1, Resident 1 called ST 1 by his first name, asking for help to get her out. ST 1 stated he walked closer to Resident 1 ' s bedside and he saw that Resident 1 was sitting on a wheelchair with a bed sheet wrapped around the waist and the wheelchair. ST 1 stated Resident 1 had a bedside table in front of her. ST 1 stated that during that same time, CNA 1 was inside the room, feeding another resident (Resident 3). ST 1 stated he reported what he saw to LVN 1 and the DOR (on 4/11/2024). During an interview on 4/12/2024 at 5:33 PM with LVN 1, LVN 1 stated ST 1 reported to her that there was something blocking Resident 1. LVN 1 stated when she went to see Resident 1. LVN 1 stated that when she was closed to Resident 1 ' s room, she saw Resident 1 was already walking outside of her room with CNA 1 and LVN 2, so LVN 1 did not bother to go closer to Resident 1. During an interview on 4/12/2024 at 6 PM with LVN 2, LVN 2 stated CNA 1 did not inform him on 4/11/2024 that she tied Resident 1 to the wheelchair. LVN 2 stated he did not report the incident to the abuse coordinator. During an interview on 4/12/2024 at 8:24 PM with the DON, the DON stated ST 1 should have reported the incident to the facility ' s abuse coordinator (Administrator). The DON stated CNA 1 should have been suspended and sent home immediately on 4/11/2024, until the investigation was finished to protect Resident 1 and other residents. The DON stated because the incident was not reported timely, Resident 1 could have suffered more psychological harm and other residents could have become victims of abuse. A review of the facility ' s Nursing Assignment dated 4/11/2024, for the 3 PM to 11 PM shift, indicated CNA 1 was assigned to 10 residents, including Resident 1 and Resident 2. A review of CNA 1 ' s timesheet for the week of 4/7/2024 to 4/13/2024 indicated CNA 1 indicated clocked out from the facility on 4/11/2024 at 11 PM. During an interview on 4/15/2024 at 3:10 PM, with the Administrator (ADM), the ADM stated the improper use of restraints on Resident 1 with or without consent, could be classified as a form of physical, emotional, and psychological abuse. The ADM stated he was notified of the incident on 4/12/2024 at 9 AM. The ADM stated ST 1 should have reported the incident to him on 4/11/2024 so that the facility could have acted sooner such as sending CNA 1 home and not let CNA 1 finish her shift. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055899	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Royal Palms Post Acute	630 W. Broadway Glendale, CA 91204

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of CNA 1 ' s timesheet for the week of 4/7/24 to 4/13/24 indicated CNA 1 clocked into the facility on [DATE] at 3:22 PM. The timesheet also indicated CNA 1 finished her shift and clocked out of the facility on 4/11/24 at 11:00 PM. A review of the facility ' s policy and procedure (P&P) titled, Abuse Investigation and Reporting, revised 7/17, indicated all reports of abuse shall be promptly reported to local, state, and federal agencies. The P&P also indicated an alleged violation of abuse will be reported immediately, but no later than two hours if the alleged violation involves abuse.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055899	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48854 Based on interview and record review, the facility failed to follow its policy and procedure to ensure that only persons licensed or permitted by the state to prepare, administer, and document the administration of medications may administer medications for one of two sampled residents. Licensed Vocational Nurse (LVN) 2 delegated CNA 1 to administer medications (atorvastatin, melatonin, propranolol, senna, trazodone hydrochloride, and divalproex sodium) to Resident 1 on 4/11/2024. This deficient practice put Resident 1 at risk for harm due to lack of qualified staff ' s supervision of adverse reaction after medication administration. Findings: A review of Resident 1 ' s Admission Record indicated the resident was admitted to the facility on [DATE], with diagnoses that included pneumonia (an infection of one or both lungs), anxiety (feeling of fear, dread, and uneasiness), depression (mood disorder that causes a persistent feeling of sadness) and bipolar disorder (mental illness that causes unusual shifts in mood from extreme happiness to extreme sadness and vice-versa). A review of Resident 1 ' s History and Physical (H&P), dated 3/22/2024, indicated the resident did not have the capacity to make decisions. A review of Resident 1 ' s Minimum Data Set (MDS, a comprehensive standardized assessment and screening tool), dated 3/28/2024, indicated the resident has severe cognitive (thought process) impairment. The MDS indicated the resident was independent (able to complete task by themselves) in walking with the use of a walker. The MDS indicated the resident required maximal assistance (helper does more than half the effort) on tasks such as lower body dressing, bathing, and toileting, moderate assistance (helper does less than half the effort) on tasks such as upper body dressing, and supervision on tasks such as sit to stand and bed mobility. During an interview on 4/12/2024 at 5:53 PM with CNA 1, CNA 1 stated LVN 2 gave her a cup containing apple sauce mixed with Resident 1 ' s crushed medications and LVN 2 told her to give the medications to Resident 1. CNA 1 stated she did not know what medications were in the cup. CNA 1 further stated she was not trained to give medications and did not know why LVN 2 delegated to her to give Resident 1 ' s medications. During an interview on 4/12/24 at 6 PM with LVN 2, LVN 2 stated he instructed CNA 1 to give Resident 1 ' s medications on 4/11/2024. LVN 2 stated he handed CNA 1 a medication cup containing Resident 1 ' s crushed medications mixed with apple sauce. LVN 2 stated CNA 1 cannot give medications because CNAs were not trained to administer medications. LVN 2 stated the medications in the medication cup included the following: -Atorvastatin 20 milligrams (mg, a unit of measurement) 1 tablet by mouth at bedtime for hyperlipidemia (elevated cholesterol levels) (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Melatonin 5 mg 1 tabled by mouth at bedtime for supplement -Propranolol HCL 60 mg 1 tabled by mouth at bedtime for hypertension (constant elevated blood pressure) -Senna 8.6 mg 2 Tablets by mouth at bedtime for stool softener -Trazodone HCL 100 mg 1 Tabled by mouth at bedtime for depression -Divalproex Sodium 250 mg 1 Tabled by mouth two times a day for bipolar disorder During an interview on 4/12/2024 at 6:25 PM with CNA 2, CNA 2 stated CNAs are not trained to administer medications and should not administer medications to residents. During an interview on 4/12/2024 at 7:58 PM with LVN 1, LVN 1 stated having unlicensed staff such as CNAs administer medications instead of licensed nurses is not safe. LVN 1 stated CNAs are not trained to administer medications and lack the knowledge and training to give medications. LVN 2 also stated it is not within a CNA ' s scope of practice to administer medications. During an interview on 4/12/2024 at 8:01 PM with Registered Nurse 1, RN 1 stated CNAs should not administer medications to residents. RN 1 stated residents are put in danger because CNAs are not trained about the adverse effects of medications and what to do if such effects occur. During an interview on 4/12/2024 at 8:24 PM with the Director of Nursing (DON), the DON stated CNAs should not administer medications because they are not qualified. The DON stated if CNAs are made to administer medications, residents are at risk for harm because of lack of supervision of dangerous adverse effects of the medications. A review of the facility ' s document titled, Certified Nursing Assistant- Skills Check Evaluation Competency, signed by CNA 1 on 1/5/2024, did not include administration of medication as one of the skills CNA 1 was evaluated for competency. A review of the facility ' s job description for a Certified Nurse Assistant, updated on September 2020, did not indicate that CNAs are permitted to administer medications to residents. A review of the facility ' s job description for a Charge Nurse, revised 3/14, indicated one of the roles is to administer medications, treatments, and provide direct care to residents. The job description also indicated a charge nurse must have a current, active license as Registered Nurse or Licensed Vocational Nurse. A review of the facility ' s policy and procedure (P&P) titled, Administering Medications, revised April 2019, indicated only persons licensed or permitted by this state to prepare, administer, and document the administration of medications may do so.