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	05/13/2024

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 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** 48854 Based on interview and record review, the facility failed to respond to the grievance (an official statement of a complaint over something believed to be wrong or unfair) for one of three residents (Resident 2) when Resident 2 verbalized to facility staff of wanting to file a grievance. This failure resulted in Resident 2's grievance not being addressed. Findings: A review of Resident 2's Admission Record indicated the resident was originally admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses that included diabetes mellitus type 2 (DM, a chronic disease that result in high blood sugar levels in the blood) and ileus (a condition in which the bowel does not work correctly and cannot push food and waste out of the body). A review of Resident 2's History and Physical (H&P), dated 3/16/2024, indicated Resident 2 did not have the capacity to understand or make needs known. The H&P indicated Resident 2 had a very distended abdomen and still had bloating at the time of assessment. A review of Resident 2's Minimum Data Set (MDS, a comprehensive standardized assessment and screening tool), dated 3/1/2024, indicated Resident 2 had intact cognition. The MDS also indicated Resident 2 was dependent (helper does all of the effort and resident does none of the effort to complete the activity) on activities such as eating, oral hygiene, toileting, bathing, dressing, and personal hygiene. The MDS also indicated Resident 2 was dependent on functional abilities such as bed mobility, sitting to standing, and chair-to-chair or bed-to-chair transfers (the ability to transfer from a bed to a chair. The MDS also indicated Resident 2 was not able to perform walking of 10 feet or more. A review of Resident 2's Order Summary Report, dated 5/13/2024, indicated an order for Fleet Enema [a bottle with a small plastic nozzle containing a liquid solution that is directly inserted into a resident's rectum to help in defecating] Rectal Enema 7-19 gm/118mL [gm/mL, grams per milliliter, a unit of measurement] (Sodium Phosphatase) Insert 1 rectally [via the rectum] as needed for constipation [difficulty in defecating] once daily. (continued on next page)

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

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

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/13/2024 at 11:15 PM with Resident 2, Resident 2 stated Licensed Vocational Nurse (LVN) 1 administered his enema in the presence of Certified Nursing Assistant (CNA) 1 about a week ago. Resident 2 stated he felt that LVN 1 did not do the procedure correctly, so he wanted to speak to a Registered Nurse (RN) 1 about it. Resident 2 stated he spoke to RN 1 about his grievance that night. Resident 2 stated RN 1 did not do anything and RN 1 did not come back after he spoke to RN 1. Resident 2 stated no one has spoken to him since the day he reported his grievance to RN 1. During a phone interview on 5/13/2024 at 12:06 PM with RN 1, RN 1 stated Resident 2 spoke to RN1 about Resident 2's grievance regarding LVN 1. RN 1 stated he spoke to LVN 1 and informed the facility's Assistant Director of Nursing (ADON) through text message on the night Resident 2 reported the grievance to LVN1. RN 1 stated he was not able to follow up with ADON regarding the grievance because he did not work the next day. During a phone interview on 5/13/2024 at 12:12 PM with CNA 1, CNA 1 stated he assisted LVN 1 when LVN 1 administered Resident 2's enema. CNA 1 stated Resident 1 was giving LVN 1 instructions on how to administer the enema. CNA 1 stated LVN 1 was following Resident 1's instructions. During a phone interview on 5/13/2024 at 12:21 PM with LVN 1, LVN 1 stated he administered Resident 2's enema. LVN 1 stated the resident was able to defecate (have a bowl movement) after LVN1 administered the enema. LVN 1 stated he told RN 1 regarding Resident 2's grievance. During an interview on 5/13/2024 at 1:10 PM with the ADON, the ADON stated he was notified by RN 1 on the night Resident 2 complained about LVN 1. ADON stated he received a text message from RN 1. The ADON stated he did not follow up on Resident 2's grievance. The ADON stated a grievance for Resident 1 should have been completed and addressed. During an interview on 5/13/2024 at 3:28 PM with the Director of Nursing (DON), the DON stated if a resident's grievances are not addressed, it could affect the psychosocial wellbeing of the resident. The DON stated the overall health of the resident could be affected. A review of the facility's Grievances/Complaint Log, for the months of 1/2024, 2/2024, 3/2024, 4/2024, and 5/2024, did not show documented evidence that Resident 2's grievance regarding LVN 1 was filed or addressed. A review of Resident 2's Progress Notes, for the date range of 3/1/2024 to 5/13/2024, did not show documented evidence that Resident 2's grievance was addressed. A review of the facility's Policy and Procedure (P&P) titled, Resident Rights, revised 2/2021, indicated a resident's rights includes the right to voice grievances to the facility. The P&P also indicated a resident's rights includes the right to have the facility respond to his or her grievances. A review of the facility's P&P titled, Grievances/Complains, Filing, revised 4/2017, indicated the following: a. Residents may file a grievance or complaint concerning care, treatment, behavior of other residents, staff members, theft of property, or any other concerns regarding his or her stay at the facility. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Residents have the right to voice or file grievances without discrimination or reprisal in any form, and without fear of discrimination or reprisal. c. Grievances and/or complaints may be submitted orally or in writing and may be filed anonymously. d. The administrator and staff will take immediate action to prevent further potential violations of resident rights while the alleged violation is being investigated.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48854 Based on interview and record review, the facility failed to monitor the behavior for one of three residents (Resident 1) for the use of Trileptal (medication for convulsions) Oral Tablet 150 mg for Resident 1's behavior of hitting staff and throwing objects. As a result of the failure, Resident 1's behavior was not monitored for effectiveness of the prescribed medication, placing Resident 1 at risk for an unnecessary medication. Findings: A review of Resident 1's Admission Record indicated Resident 1 was originally admitted to the facility on [DATE], readmitted on [DATE], with diagnoses that included schizophrenia (a severe mental condition in which thought, and emotions are so affected that contact is lost with external reality) 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 5/7/2024, indicated Resident 1 did not have the capacity to make decisions or make needs known. A review of Resident 1's Minimum Data Set (MDS, a comprehensive standardized assessment and screening tool), dated 3/3/2024, indicated Resident 1 had severe cognitive impairment. A review of Resident 1's Order Summary Report, dated 5/13/2024, indicated an order was started on 5/7/2024 for Trileptal (medication for convulsions) Oral Tablet 150 mg (milligrams, a unit of measurement) Give 1 tablet by mouth every 12 hours for poor impulse control [manifested by] getting agitated easily becoming physically aggressive hitting staff and throwing objects. During a review of Resident 1's Medical Administrator Record (MAR), from 5/1/2024 to 5/13/2024, Resident 1's MAR did not indicate that Resident 1's behavior for poor impulse control of getting agitated easily becoming physically aggressive hitting staff and throwing objects was being monitored. The MAR indicated Resident 1 was being given the Trileptal every day since it was ordered on 5/7/2024. A review of Resident 1's Progress Notes, for date range of 3/1/2024 to 5/13/2024, did not show documented evidence that Resident 1's behavior was being monitored. A review of Resident 1's Change in Condition Evaluation (CIC), dated 4/22/2024, timed at 4:30 PM, indicated Resident 1 attempted to leave the facility unassisted, spitting and throwing things at staff. A review of Resident 1's CIC, dated 4/12/2024, timed at 2:05 PM, indicated Resident 1 was biting himself and throwing stuff. A review of Resident 1's CIC, dated 4/7/2024, timed at 3:04 PM, indicated Resident 1 with aggressing behavior throwing things to staff and hitting the wall with his [hands]. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review 5/13/2024 at 3:28 with Assistant Director of Nursing. (ADON) Resident 1's MAR was reviewed. ADON stated there was no documented evidence that Resident 1's behavior was being monitored. ADON stated Trileptal was ordered for Resident 1's poor impulse control. ADON stated the behavior should be monitored to make sure the medication was effective. During an interview on 5/13/2024 at 3:28 PM with the Director of Nursing (DON), the DON stated medications administered to residents should be monitored for their effectiveness and for potential side effects. The DON stated Resident 1's behavior should be monitored to make sure the medication was effective. The DON stated if the medication's efficacy was not monitored, the resident's aggressive behavior could get worse. A review of the facility's policy and procedure (P&P) titled, Administering Medications, revised 4/2019, indicated the individual administering the medication records in the resident's medical record any results achieved and when those results were observed. A review of the facility's P&P titled, Medication Utilization and Prescribing- Clinical Protocol, revised 4/2018, indicated staff will evaluate the effectiveness and effects of the medications in a resident's regimen.