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	02/06/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48661 Based on interview and record review the facility failed to notify the resident ' s representative (RR) a change of condition for one (1) of three (3) sampled residents (Resident 1) by failing to notify the RR Resident 1 ' s diabetic ulcer by not implementing the facility ' s policy & procedure (P&P) titled, change in a Resident ' s Condition or Status, revised May 2017. The P&P statement indicated Our facility shall promptly notify the resident, his or her attending physician, and representative (sponsor) of changes in the resident ' s medical/mental condition and/or status (e.g. changes in level of care). This deficient practice had violated the RR ' s right to be informed of Resident 1 ' s change of medical condition that led to RR not able to request medical treatment and care for Resident 1, to prevent further worsening of the condition that can potentially lead to serious condition such as amputation. Findings: During a review of Resident 1 ' s Admission Record (AR), the AR indicated the facility admitted the resident on 6/1/2017 and readmitted on [DATE], with diagnoses including encephalopathy (a disease, disorder, or damage that affects the brain ' s structure or function), quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury), and type two (2) diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 1 ' s History and Physical (H&P) dated 9/19/2024, the H&P indicated Resident 1 had severe cognitive impairment (problems with a person ' s ability to think, learn, remember, use judgement, and make decisions). During a review of Resident 1 ' s Nursing Progress Notes dated 9/19/2024 at 6:24 PM, the Nursing Progress Note indicated the resident was readmitted from the General Acute Care Hospital (GACH) and reoriented to his room and roommates. The Nursing Progress Note indicated the Resident ' s Representative (RR) was informed of the facility ' s policy and care. The Nursing Progress Note did not indicate the RR was notified or informed of any diabetic ulcer (a sore or open wound that develops on the foot of a person with diabetes). (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s Admission Data Collection dated 9/19/2024 at 6:36 PM, the Admission Data Collection indicated the resident had a left lateral malleolus (the prominent bone on the outside of the ankle) diabetic ulcer, 100% purple, no drainage, non-foul odor, surrounding tissue was fragile, scarred, and discolored. The Admission Data Collection indicated the RR was informed of the admission to the facility and telephone consent was provided by the RR for all documents that required a signature. The Admission Data Collection did not indicate the RR was informed of the resident ' s diabetic ulcer. During a review of Resident 1 ' s physician ' s order dated 9/20/2025, the physician ' s order indicated treatment - left lateral malleolus diabetic ulcer, cleanse with normal saline (NS), pat dry, paint with betadine and leave open to air, every day shift for four (4) weeks. During a review of Resident 1 ' s Weekly Wound Note dated 9/26/2024 at 4:01 PM, the Weekly Wound Note indicated the resident had a left lateral malleolus diabetic wound, no exudate (fluid that leaks from blood vessels into nearby tissues), non-foul odor, 100% eschar (dead tissue that forms over healthy skin and then, over time, falls off (sheds), surrounding skin was fragile and discolored, with interventions of off-loading (the practice of reducing pressure on a wound to help it heal) and repositioning. The Weekly Wound Note indicated updates to family but did not indicate what information was updated to the family. During a review of Resident 1's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 10/15/2024, the MDS indicated the resident had moderate cognitive impairment (a person was experiencing noticeable and significant difficulties with thinking, learning, remembering, and other cognitive skills that impact their daily life). The MDS indicated the resident had a diabetic foot ulcer and was receiving treatments for pressure ulcer/injury care, applications ointment/medications, and application of dressings to feet. During a review of Resident 1 ' s Change of Condition (COC) dated 1/17/2025 at 1:59 PM, the COC indicated the residents left lateral leg diabetic ulcer was non healing and increasing in size. The COC indicated the RR and physician was notified and ordered for the resident to discharge to the GACH. During a review of Resident 1 ' s Nursing Progress Note dated 1/17/2025 at 2 PM, the Nursing Progress Note indicated the RR was provided an update of the resident ' s wound conditions. The Nursing Progress Note indicated the resident ' s wound was not healing and responding to treatment and the facility would be sending the Resident 1 to the GACH for further evaluation and management. During an interview on 2/5/2025 at 12:05 PM, the RR stated the facility never informed her about the resident ' s diabetic ulcer. The RR stated she found out about the wound on the day the resident transferred to the GACH for further evaluation and management of the wound. The RR stated she was in contact with the facility but was shocked to hear of the diabetic ulcer because the wound was never brought up in any meetings. During an interview on 2/6/2025 at 4 PM, the Social Services Director (SSD) stated she was responsible to coordinate interdisciplinary team (IDT) meetings with the RR to discuss the whole care provided to the resident including wound care. The SSD stated she was unaware the resident ' s wound worsened and was unable to find an IDT with the RR present regarding discussion of the resident ' s wounds. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/6/2025 at 5 PM, the SSD stated there also was no documentation in the progress notes the family was notified of the diabetic ulcer. The SSD stated there should have been documentation of what was discussed with the family. The SSD stated there should have been documentation if the RR was not reachable as well, to show proof the facility was reaching out to the RR. The SSD stated if there was no proof to show the facility was informing the RR of the resident ' s care, the family could think the facility did not care for the resident. During a review of the facility ' s policy and procedure (P&P) titled Change in a Resident ' s Condition or Status, revised May 2017, indicated the facility shall promptly notify the resident, his or her attending physician, and representation of changes in the resident ' s medical/mental condition and/or status. The P&P also indicated the nurse will notify the resident ' s representative when there was a significant change in the resident ' s physical, mental, or psychosocial status.

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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** 48661 Based on interview and record review the facility failed to develop a person-centered care plan (a treatment plan that focuses on the needs and preferences of a patient or individual) for one (1) of three (3) sampled residents (Resident 1). Resident 1 did not have a resident specific care plan for Prevalon boots (a cushioned bottom that floats the heel off the surface of the mattress, helping to reduce pressure), and the care plan did not include interventions on how to maintain the Prevalon boots. These deficient practices were lack of individualized focused quality care that provided to Resident 1 and had the potential to lead to worsening or irreversible of condition. Findings: During a review of Resident 1 ' s Admission Record (AR), the AR indicated the facility admitted the resident on 6/1/2017 and readmitted on [DATE], with diagnoses including encephalopathy (a disease, disorder, or damage that affects the brain ' s structure or function), quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury), and type two (2) diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 1 ' s Care Plan titled Potential impairment to skin integrity of the bilateral heel related to poor mobility dated 2/23/2024, the Care Plan indicated an intervention to have bilateral Prevalon boots. The Care Plan did not include how to clean or maintain the boot. During a review of Resident 1 ' s History and Physical (H&P) dated 9/19/2024, the H&P indicated Resident 1 had severe cognitive impairment (problems with a person ' s ability to think, learn, remember, use judgement, and make decisions). During a review of Resident 1 ' s Admission Data Collection dated 9/19/2024 at 6:36 PM, the Admission Data Collection indicated the resident had bilateral Prevalon boots (a cushioned boot that helps prevent bedsores by keeping the heel elevated). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 10/15/2024, the MDS indicated the resident had moderate cognitive impairment (a person was experiencing noticeable and significant difficulties with thinking, learning, remembering, and other cognitive skills that impact their daily life). The MDS indicated the resident had a Stage 3 pressure ulcer (a deep, open wound that goes through the skin and into the underlying tissue, including the fatty layer beneath the skin (the hypodermis) present upon admission/reentry. The MDS indicated the resident had a diabetic foot ulcer and was receiving treatments for pressure ulcer/injury care, applications ointment/medications, and application of dressings to feet. During a review of Resident 1 ' s physician ' s order dated 9/20/2024, the physician ' s order indicated treatment - may have bilateral Prevalon boots every shift. The physician ' s order did not include how to clean or maintain the boot. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s Treatment Administration Record (TAR) dated 1/1/2025 to 1/31/2025, the TAR indicated a section to document the resident ' s bilateral Prevalon boots every shift. The TAR did not include how to clean or maintain the boot. During an interview on 2/5/2025 at 12:05 PM, the Resident ' s Representative (RR) stated the resident ' s boots were disgusting and had old blood and pus (a milky-like fluid that can form underneath your skin or ooze from wounds, among other places) stains. During an interview on 2/6/2025 at 10:47 AM, Certified Nursing Assistant (CNA) 1 stated Resident 1 had two Prevalon boots for each foot and there was no place to document when the Prevalon boots were washed/cleaned and was unsure how often the Prevalon boots should have been cleaned. CNA 1 stated there should have been documentation to make the staff more accountable. CNA 1 stated if the Prevalon boots were not properly maintained that could lead to other illnesses or infections for Resident 1. During an interview on 2/6/2025 at 12:16 PM, Licensed Vocational Nurse (LVN) 1 stated the resident should have had a care plan for the Prevalon boots and how to care for them. LVN 1 stated the Prevalon boots should have been cleaned and if there was not a care plan for the Prevalon boots the wound could get dirty and become infected or start another wound. During a concurrent interview and record review with the Treatment Nurse (TN) on 2/6/2025 at 12:47 PM. The facility ' s policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered revised December 2016 the P&P indicated the comprehensive, person-centered care plan would describe the services that were to be furnished to attain or maintain the resident ' s highest practicable physical, mental, and psychosocial well-being; incorporate identified problem areas; and incorporate risk factors associated with identified problems. The P&P indicated assessments of residents were ongoing, and care plans were revised as information about the residents and the resident ' s conditions change. The P&P indicated the interdisciplinary team would review and update the care plan when there had been a significant change in the resident ' s condition or when the desired outcome was not met. The TN stated there should have been a care plan for each individual care that was given to the resident including a care plan for the Prevalon boot. The TN stated if there was no documentation for the Prevalon boot, there would not be evidence anything was done including wearing or maintaining the boot. The TN stated the facility was not following the P&P and if the Prevalon boot was not washed properly, the Prevalon boot would not be clean and could cause an infection. During a concurrent interview and record review with the Director of Nursing (DON) on 2/6/2025 at 4:15 PM. The facility ' s policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered revised December 2016, the P&P indicated the comprehensive, person-centered care plan would describe the services that were to be furnished to attain or maintain the resident ' s highest practicable physical, mental, and psychosocial well-being; incorporate identified problem areas; and incorporate risk factors associated with identified problems. The P&P indicated assessments of residents were ongoing, and care plans were revised as information about the residents and the resident ' s conditions change. The P&P indicated the interdisciplinary team would review and update the care plan when there had been a significant change in the resident ' s condition or when the desired outcome was not met. The DON stated there was no specification or order on how to clean the Prevalon boot. The DON stated if the Prevalon boot was not cleaned that was an infection control issue and the resident could get an infection. The DON stated the facility was not following the P&P and the resident could have been at risk and the resident ' s existing conditions could have been affected.