

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 04/08/2025
NAME OF PROVIDER OR SUPPLIER Royal Palms Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47882</p> <p>Based on interview, and record review, the facility failed to implement the facility's Infection Prevention and Control Program (IPCP) for 27 of 129 residents (Residents 1 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, and 30) when:</p> <ol style="list-style-type: none"> 1. The facility failed to initiate surveillance tracking and interventions for the 26 affected residents when the Local Health Officer's Public Health Nurse (PHN 1) informed the facility's Director of Nursing (DON) on 3/27/2025 that Resident 1 tested positive for Carbapenem-Resistant Acinetobacter baumannii (CRAB) Tier 2 (an antibiotic resistant, communicable rare disease) right leg wound. 2. The facility failed to notify Resident 1's Primary Medical Doctor (PMD) 1 that Resident 1 had a positive right leg wound culture (CRAB) Tier 2. 3. The facility failed to notify and coordinate with the attending physicians of Residents 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, and 30 that PHN 1 recommended to conduct rectal swab screening for CRAB due to potential exposure to Resident 1. 4. Report to the California Department of Public Health (CDPH) Licensing and Certification District Office since CRAB TIER 2 is considered an unusual disease occurrence. <p>These deficient practices had a) the potential spread of CRAB in the facility, b) resulted in Resident 1 not getting appropriate treatment and recommendations from his PMD, and c) resulted in Residents 5 to 30 not getting appropriate treatment and recommendations from their PMD's, which can negatively affect facility's Resident's quality of life</p> <p>Findings:</p> <p>During a review of Resident 1's General Acute Care Hospital (GACH) 1's document for microbiology culture results, (undated), the culture result indicated Resident 1 was admitted at GACH 1 on 2/16/2025 and discharged on [DATE]. The document indicated leg wound was cultured on 2/17/2025, with final report on 2/21/2025 indicating CRAB complex - multidrug resistant organism. (Culture results sent to LA county public health for further studies).</p> <p>During a review of Resident 1's right leg wound culture (specimen received from GACH 1 collected on 2/17/2025 for further studies) results from the Local Health Department's Laboratory document, dated 3/15/2025, the document indicated Resident 1's right leg wound culture result showed CRAB Tier 2.</p> <p>(continued on next page)</p>

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: 055899	If continuation sheet Page 1 of 5

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 1's Admission Record (AR), the AR indicated Resident 1 latest readmission to the facility was on 3/20/2025, with diagnoses that included sepsis (a life-threatening medical emergency where the body's response to an infection damages its own tissues and organs), anemia (a problem of not having enough healthy red blood cells or hemoglobin to carry oxygen to the body's tissues), chronic kidney disease (a disease characterized by progressive damage and loss of function in the kidneys), gastroesophageal reflux disease (GERD) (a condition in which stomach acid repeatedly flows back up into the tube connecting the mouth and stomach), and cellulitis of the right lower limb (a bacterial infection of the skin and tissue just below the skin on the right leg).</p> <p>During a review of Resident 1's History and Physical Examination (H&P), dated 3/21/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions for healthcare purposes, able to identify needs in management of activities of daily living, and to make needs known.</p> <p>During a review of Resident 1's Minimum Data Set (MDS) -a resident assessment tool dated 3/24/2025, the MDS indicated Resident 1 cognitive status (ability to think, remember and reason) was intact. The MDS indicated Resident 1 required supervision or touching assistance (Helper provides verbal cues and or touching steadying) with eating, required partial/moderate assistance (helper does less than half the effort) with oral hygiene, dependent with toileting and bathing. The MDS indicated Resident 1 was at risk in developing pressure ulcers/injuries.</p> <p>During a review of an email communication dated 3/27/2025, from the Local Health Officer PHN 1 to the facility indicated PHN 1 informed the DON that Resident 1's right leg wound culture tested positive (GACH 1) for a rare and emerging multi-drug-resistant organism named CRAB Tier 2. PHN 1's email also indicated recommendations that included for the facility to:</p> <ol style="list-style-type: none"> 1. Determine if any exposure have occurred, and screen exposed patients. 2. Use the Local Health Department's Multidrug Resistant Organism (MDRO) Screening Guidance for Tier 2 CRAB as indicated in the email notification. 3. Screen exposed contacts (residents/staff) and perform surveillance (tracking) for any potential transmission. 4. Report to the California Department of Public Health (CDPH) Licensing and Certification District Office since CRAB TIER 2 is considered an unusual disease occurrence. <p>During a review of the facility's document list titled Rectal Swab Screening for CRAB dated 4/8/2025, due to possible exposure from Resident 1, the list indicated 26 residents residing at the facility (23 tested , 3 refused), were included in the list for CRAB screening test (tested Residents 5, 6, 7, 8, 9, 10, 11,12,13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30. The list indicated Residents 9, 10, and 14 refused the rectal swab screening.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 4/8/2025 at 9:00 AM with the DON, the DON stated, Resident 1 was a very fragile resident. The DON stated Resident 1 was originally admitted to the facility on [DATE] and was hospitalized to GACH 1 on 2/16/2025. The DON stated Resident 1 was readmitted back to the facility from GACH 1 on 2/24/2025 and was sent to the GACH again on 3/13/2025 and readmitted back to the facility on [DATE]. The DON stated Resident 1 was transferred again to a GACH on 4/6/2025, for persistent vomiting. The DON stated, Resident 1 was still residing at the facility on 3/27/2025 when PHN 1 called and informed the facility and send an email notification that Resident 1 had a positive culture of CRAB TIER 2, from Resident 1's right leg wound. The DON stated, on 3/27/2025 PHN 1 emailed her (DON) the local health department's recommendations to contain any potential spread of CRAB TIER 2 within the facility.</p> <p>During a concurrent interview with the DON and record review of the Local Health Officer PHN 1's email communication dated 3/27/2025, to the DON, on 4/8/2025, at 10:10 AM, the DON stated, she did not initiated any of PHN 1's recommendations from the local health department on 3/27/25, except to complete an in service to the facility staff on 3/28/2025. The DON stated, she did not initiate, and did not have any documentation that surveillance tracking was initiated on 3/27/2025 or 3/28/2025 after receiving the email notification and recommendations from PHN 1 regarding facility's exposure to CRAB Tier 2. The DON stated the screening for possible exposed residents was initiated on 4/7/2025 (11 days after receiving PHN 1 CRAB Tier 2 notification exposure). The DON stated, she did not report the unusual occurrence to CDPH within 24 hours (3/28/25) after learning the unusual occurrence of a potential CRAB outbreak from PHN 1 on 3/27/2025. He DON stated Resident 1 was positive for CRAB Tier 2 on his right leg wound according to PHN 1. The DON stated, she was covering for the facility's infection preventionist (IP) on 3/27/2025 and did not get a permanent IP until 4/2/2025. The DON stated she was too busy to follow up on PHN 1's notification of a potential CRAB outbreak, failed to notify CDPH within 24 hours and implement the facility's IPCP by following PHN 1's recommendations, including initiating appropriate surveillance tracking of residents and/or staff that may have been exposed from Resident 1</p> <p>During an interview on 4/8/2025 at 10:40 AM with facility's IP, the IP stated, he was in-serviced by PHN 2 on 4/4/2025, and the local health officer sent the facility the rectal swabs and highlighted the facility map that showed those residents' rooms, who were possibly exposed from Resident 1's CRAB Tier 2. The IP stated the rectal swab screening test was done on 4/7/2025 after receiving the swabs. The IP stated he started being the facility's designated IP on 4/2/2025, so he did not have an answer as to why the facility did not initiate any surveillance tracking of possible exposed residents to CRAB Tier 2 on 3/27/2025.</p> <p>During a concurrent interview and record review, on 4/8/2025, at 11 AM, with Medical Record Director (MRD) and the DON, Resident 1's electronic health record (EHR) until 4/6/2025 was reviewed. Resident 1's EHR did not have any documented evidence of Resident 1 having tested positive of CRAB Tier 2 on his right leg according to PHN 1 notification on 3/27/25. The EHR did not have documentation of a Change of Condition (COC), including notification to Resident 1's attending physician. The DON stated, Resident 1's attending physician was not made aware of Resident 1 positive CRAB Tier 2, and the COC form was not initiated. The DON stated Resident 1's records did not indicate any evidence of having CRAB Tier 2 on the right leg wound, the DON stated documentation was missed.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 4/8/2025 at 11:30 AM with the DON, the DON stated, not following the Local Health Department's recommendations on 3/27/2025 such initiating surveillance and not notifying CDPH timely had the potential for CRAB TIER 2, a communicable rare disease to spread in the facility. The DON stated, not notifying Resident 1's attending physician, had resulted Resident 1 to not receive any type of treatment or recommendations from the physician about the disease.</p> <p>During an interview on 4/8/2025 at 12:45 PM with the IP, the IP stated, on 4/7/2025 he tested 23 residents out of 26 (three refused) residents for possible exposure to Resident 1's CRAB TIER 2 for CRAB Tier 2. The IP stated, the attending physicians of the 26 residents who were possibly exposed was not notified of the exposure and recommendations for rectal swabbing. The IP stated there was no documentation or notification, or COC form completed for all 26 residents exposed. The IP stated, the facility should have notified the attending physicians of the possible exposed residents for update, any type of treatment or recommendations. The IP stated, it would be hard to track residents who are being tested if it's not in the residents' medical records, and appropriate IPCP surveillance tracking log.</p> <p>During an interview on 4/8/2025 at 2:35 PM with PHN 1, PHN 1 stated, she spoke with the DON and sent her an email of her recommendations that contain recommendations to prevent potential spread of CRAB TIER 2. PHN 1 stated that the CRAB TIER 2, which Resident 1 had, was a rare communicable antibiotic-resistant disease that the local health department is tracking. PHN 1 stated, she was not aware the facility did not notify Resident 1's attending physician and CDPH timely. PHN 1 stated the facility should have notified the physicians and CDPH timely.</p> <p>During an interview on 4/8/2025 at 3:40 PM with the DON, the DON stated she was busy, and it was a difficult transition, not having an IP during that time when she was notified of Resident 1's positive CRAB Tier 2. The DON stated, all the physicians of the 26 exposed residents were not made aware of the rectal swab testing done on 4/7/2025. The DON stated, surveillance tracking of all potentially exposed residents or staff should have been done timely as per PHN 1's recommendation to ensure the disease does not spread in the facility.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Infection Prevention and Control Program (IPCP) dated 12/2024, the P&P indicated; a) the infection prevention and control program is established and maintained to provide a safe, sanitary and comfortable environment and to help the development and transmission of communicable diseases and infections, b) surveillance and data reporting is used to inform the committee of potential issues and trend, c) Process of surveillance (adherence to infection prevention and control practices) and outcome surveillance (incidence of prevalence of healthcare acquired infections) are used as measures of the IPCP effectiveness and d) surveillance tools are used for identifying the occurrence of infections, recording their number and frequency, detecting outbreaks and epidemics, monitoring adherence to infection prevention and control practices ,ands detecting unusual pathogens with infection and control implications.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Subject: Changes in Resident Condition , dated 11/3/2023, the P&P indicated; a) attending physician are notified when changes in condition or certain events occur, b) the facility must immediately consult with resident's physician when there is a significant physical or clinical condition, c) examples of clinical condition changes includes change in resident's baseline / onset of new concern and d) immediate notification to physician would include but not limited to critical lab values, and significant change in wound status.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility's policy and procedure (P&P) titled, Unusual Occurrence Reporting , dated 12/2007, the (P&P) indicated; a)as required by state or federal regulations the facility reports unusual occurrence or other reportable events which affect the health and safety, or welfare of the resident , employees or visitors, b) the facility will report to appropriate agencies an outbreak of any communicable diseases and c) unusual occurrences shall be reported via telephone to appropriate agencies as required by law and/or regulations within twenty-four hours (24) of such incident or as otherwise required by federal or state regulations.</p>		