

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 12/23/2025
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 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge.</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

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<p>F 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that one of one sampled resident (Resident 1), who was assessed as self-responsible and capable of making decisions was accurately documented in the medical record. Resident 1's discharge to the facility was incorrectly recorded as leaving against medical advice (AMA- defined as those residents who chose to leave before the treating physician determined it was medically safe or appropriate), on 12/22/2025. Resident 1's records did not indicate the basis of the discharge, in accordance with the facility's policy and procedure (P&P) titled Transfer of Discharge Documentation and Transfer or Discharge, preparing a Resident for. This failure resulted in violating Resident 1's rights and was involuntarily discharged from the facility on 12/22/2025. Resident 1 had been reported missing on 12/20/2025 after failing to arrive for a scheduled dialysis appointment on 12/20/2025. On 12/31/2025, Resident 1 was found by a security guard from a local hotel and took Resident 1 back to the facility on the same date. The facility arranged for Resident 1 to be transferred to the general acute care hospital (GACH) on 12/31/2025 where resident 1 received hemodialysis treatments and readmitted back to the facility on 1/3/2026. Findings: During a review of Resident 1's admission Record (AR) , the AR indicated the facility originally admitted Resident 1 on 12/19/2024 with diagnoses that included end stage renal disease (kidneys have permanently lost nearly all of their ability to function), diabetes (high blood sugar), dementia and dependence on renal dialysis (a life-sustaining treatment that artificially filters waste products and excess fluid from the blood when the kidneys fail). During a review of Resident 1's History and Physical (H&P) dated 3/12/2025, the H&P indicated Resident 1 has the capacity to understand and make decisions. During a review of Resident 1's Order Summary Review, the report indicated the following physician orders: Dated 04/11/2025, the order indicated Resident 1 Dialysis scheduled every Tuesdays and Saturdays at 1:30 PM to 5:30 PM via a regular transportation. Dated 07/23/2025, the order indicated Resident 1 may go out on pass with a family member for therapeutic purposes, not to exceed 4 hours. Further review of the resident's records that included progress notes, care plans, IDT notes, did not indicate the reason why Resident 1's out on pass order was limited to 4 hours only and if the facility had discussed the plan/OOP order with a family member or emergency contact. During a review of Resident 1's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 12/09/2025, the MDS indicated Resident 1 was cognitively intact (alert, oriented, and able to think, remember and communicate clearly) with functional limitations that requires the use of walker for ambulation. During a review of Resident 1's progress note dated 12/20/2025 at 12:50 PM, the note indicated that facility staff witnessed Resident 1 getting into the transportation van to go to the dialysis center. During a review of Resident 1's progress note dated 12/20/2025 at 3:27 PM, the note indicated that the facility received a call from staff at the dialysis center on 12/20/2025 at 2:15 PM indicating that Resident 1 did not arrive for his dialysis treatment that day. The note indicated that RN 1 called the transportation company and relayed that dialysis center staff reported Resident 1 had not arrived for his dialysis appointment. The note further indicated that the transportation company informed RN 1 that the driver had dropped off Resident 1 at the dialysis center on 12/20/2025, about an hour prior to the phone call. During a review of Resident 1's progress note dated 12/20/2025 at 11:20 PM, the note indicated that the staff from 3-11 PM shift reported Resident 1 did not return to the facility and staff were unable to contact the resident by phone. The note further indicated that the local police department was contacted at this time, and a missing person report was filed for Resident 1. During a review of Resident 1's progress notes dated 12/21/2025 at 8:12 AM, the note indicated Resident 1 was still missing and no updates from the police department. During a review of Resident 1's progress note titled Discharge Summary, dated 12/22/2025 at 2:55 PM, the record indicated that Resident 1 had been missing from the facility since 12/20/2025. The record indicated that the local police department and Resident 1's emergency contact were notified. The note also indicated that staff tried to reach out to Resident 1 but Resident 1 did not answer his cell phone. The note further indicated that Resident 1 was alert and oriented to person, place, time, and situation and was deemed to have left the facility against medical advice (AMA) as of 12/22/2025. During a review of Resident 1's GACH 1 records titled History of Present Illness dated 12/31/25 timed at 10:47 PM, the GACH record indicated Resident 1 was admitted to the GACH for missed hemodialysis treatments and received catch up hemodialysis at the GACH. The GACH record further indicated Resident 1 received 5 units of insulin intravenously (IV) and corrected hyperkalemia of 5.7 (normal levels at 3.6 to 5.2 millimoles per liter) upon</p>

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident must receive and the facility must provide necessary behavioral health care and services.</p> <p>(continued on next page)</p>

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record review, the facility failed to develop and implement resident centered care plan interventions and interdisciplinary team involvement for one of two sampled residents (Resident 1), who had a behavior and history of leaving the facility without permission and failing to return from out on pass, in accordance with the physician's order. The facility did not initiate behavioral interventions, or document strategies to address repeated non-compliance and unsafe behaviors of leaving facility without permission. Resident 1 left the facility without permission on 12/16/25 with no documented evidence of Resident 1's status when he came back to the facility. Resident 1 left the facility after being dropped off to the Dialysis center on 12/20/25 and did not come back to the facility until 12/31/25. Resident 1 was transferred to a general acute care hospital (GACH) for evaluation on 12/31/25 and readmitted back to the facility on 1/3/26 and received dialysis treatments at the GACH. These deficient practices had the potential to result in increased risk of elopement, medical emergencies while unsupervised, delayed medically necessary treatments and appointments having the potential to compromise the resident's safety, health, and wellbeing. Cross referenced to F627Findings: During a review of Resident 1's admission Record (AR) , the AR indicated the facility originally admitted Resident 1 on 12/19/2024 with diagnoses that included end stage renal disease (kidneys have permanently lost nearly all of their ability to function), diabetes (high blood sugar), dementia, and dependence on renal dialysis (a life-sustaining treatment that artificially filters waste products and excess fluid from the blood when the kidneys fail). During a review of Resident 1's History and Physical (H&P) dated 3/12/2025, the H&P indicated Resident 1 has the capacity to understand and make decisions. During a review of Resident 1's Order Summary Review, the report indicated the following physician orders: Dated 04/11/2025, the order indicated Resident 1 Dialysis scheduled every Tuesdays and Saturdays at 1:30 PM to 5:30 PM via a regular transportation. Dated 07/23/2025, the order indicated Resident 1 may go out on pass with a family member for therapeutic purposes, not to exceed 4 hours. Further review of the resident's records that included progress notes, care plans, IDT notes, did not indicate the reason why Resident 1's out on pass order was limited to 4 hours only and if the facility had discussed the plan/OOP order with a family member or emergency contact. During a review of Resident 1's physician order dated 11/18/25 indicating for Resident 1 to have a psychiatric (psych) evaluation. The resident's records did not indicate the reason for the psych order. Further review of Resident 1's records for November and December 2025 did not indicate documented evidence that the psych eval order was initiated or scheduled after the order was placed on 11/18/25. During a review of Resident 1's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 12/09/2025, the MDS indicated Resident 1 was cognitively intact (alert, oriented, and able to think, remember and communicate clearly) with functional limitations that requires the use of walker for ambulation. During a review of Resident 1's progress notes dated 12/16/2025 documented at 3:51 PM, the note indicated Resident 1 missed dialysis at this day, 12/16/2025 and dialysis treatment was rescheduled for 12/18/2025. The note did not indicate the reason why Resident 1 missed his dialysis appointment and the resident's whereabouts. The note did not indicate the physician was made aware. The progress notes did not indicate the date, time, and status of Resident 1 when he came back to the facility after leaving the facility without permission on 12/16/2025. During a review of Resident 1's progress note dated 12/20/2025 at 12:50 PM, the note indicated that facility staff witnessed Resident 1 getting into the transportation van to go to the dialysis center. During a review of Resident 1's progress note dated 12/20/2025 at 3:27 PM, the note indicated that the facility received a call from staff at the dialysis center on 12/20/2025 at 2:15 PM indicating that Resident 1 did not arrive for his dialysis treatment that day. The note indicated that RN 1 called the transportation company and relayed that dialysis center staff reported Resident 1 had not arrived for his dialysis appointment. The note further indicated that the transportation company informed RN 1 that the driver had dropped off Resident 1 at the dialysis center on 12/20/2025, about an hour prior to the phone call. The note also indicated that the driver recalled Resident 1 had asked to be picked up from the dialysis center at 4:45 PM. During a review of Resident 1's progress note dated 12/20/2025 at 11:20 PM, the note indicated that the staff from 3-11 PM shift reported Resident 1 did not return to the facility and staff were unable to contact the resident by phone. The note further indicated that the local police department was contacted at this time, and a missing person report was filed for Resident 1. During a review of Resident 1's progress notes dated 12/21/2025 at 8:12 AM the note</p>		