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	12/30/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide the necessary care and services to ensure one of three sampled residents (Resident 3), who was unable to carry out activities of daily living (ADLs), was assessed and changed timely for wet and soiled incontinence brief (an undergarment used when one has no control bladder and bowel) as indicated in the resident's care plan. Resident 3 was observed with soiled incontinence brief with urine and feces at 2 PM, Certified nurse assistant (CNA) 1 explained Resident 3 was last checked for incontinence at 8 a.m. on 12/30/2025. This deficient practice resulted in Resident 3 developed skin irritation and had the potential for skin breakdown and urinary tract infection (an inflammation in the bladder/ urinary tract). During a review of Resident 3's admission Record (AR), the AR indicated that Resident 3 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including hemiplegia (complete paralysis or no movement of the limbs) and hemiparesis (partial weakness) following cerebral infarction (known as CVA/stroke- loss of blood flow to a part of the brain), metabolic encephalopathy (a disorder that affects brain function), and dementia (a progressive state of decline in mental abilities). During a review of Resident 3's Minimum Data Set (MDS a resident assessment tool) dated 11/12/2025, the MDS indicated that Resident 3 was severely cognitively (ability to reason) impaired (rarely/ never made decisions). The MDS also indicated that Resident 3 required substantial/maximal assistance on oral hygiene, toileting hygiene, and lower body dressing. The MDS indicated Resident 3 was incontinent (no control) of bladder and bowel. During a review of Resident 3's Care Plan revised 8/5/2025, the Care Plan indicated that Resident 3 had self-care performance deficits related to generalized weakness, cognitive impairment, physical limitations, and ROM (range of motion) limitations and was dependent on toileting. During a concurrent observation and an interview on 12/30/2025 at 2 PM, Resident 3 was observed resting in bed wearing an incontinent brief that was soaked. CNA 1 stated Resident 3 was incontinent and total care. CNA 1 stated the incontinent brief was very wet, with some feces. CNA 1 stated she was not sure when Resident 3 had bowel movement. CNA 1 stated the last time she changed Resident 3 was by 8 AM. CNA 1 stated she was supposed to check Resident 3 more often and provide incontinent care as needed. During a concurrent observation and an interview on 12/30/2025 at 2:10 PM with the Registered Nurse (RN) 2, RN 2 stated Resident 3 was dependent on nearly all ADLs including toilet hygiene. RN 2 stated Resident 3 had small size of blanchable redness (temporary skin discoloration) noted near left medial buttock and sacrococcyx (junction and related structures of the triangular bone at the spine's base and tailbone), could possibly resulted from the soiled incontinent brief with urine and feces. RN 2 stated Resident 3's incontinent brief should have been checked more often and assistance with toileting hygiene should not have been delayed. During an interview on 7/10/2025 at 11:05 AM with the Director of Nursing (DON), the DON stated incontinent and perineal care were important because soiled incontinent brief create a warm, moist environment that promotes bacteria growth. DON stated the assigned CNA for Resident 3 should have provided care timely or endorsed to another staff to check the resident. The DON also stated that not maintaining good toilet hygiene, the resident could be at risk for skin breakdown leading to inflammation, pain, discomfort, and UTI. During a review of the facility's Policy and Procedures (P&P) titled Activities of Daily Living (ADLs), revised 3/2018, the P&P indicated that residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. The P&P also indicated that appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with elimination (toileting).

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide adequate supervision and a hazard free, safe and secure environment for three (3) of three sampled residents' (Resident 1, 2, and 3) at risks of falling by failing to: 1.Ensure that Resident 1 with unsteady gait was monitored and not left unsupervised while in the bathroom. 2. Ensure that Resident 2's bed was kept in lowest position for risks for fall. 3. Ensure Resident 3's call light was always within reach and was monitored by other staff while Certified Nursing Assistant (CNA) 1 was on break. As a result, Resident 1 sustained a four (4) centimeter (cm- a unit of measurement of length) hematoma (blood in the tissues) on right forehead, transferred to GACH 1 and was diagnosed with left non-traumatic intracranial hemorrhage (ICH- brain bleeding) due to a fall on 10/29/2025. These deficient practices also had potential to place Residents 2 and 3 at risk for falls that could result in serious injuries. 1. During a review of Resident 1's admission Record (AR) the AR indicated that Resident 1 was originally admitted to the facility on [DATE] and recently readmitted on [DATE] with diagnoses including metabolic encephalopathy (a disorder that affects brain function), hemiplegia (complete paralysis) and hemiparesis (partial weakness) following cerebral infarction (known as CVA/stroke- loss of blood flow to a part of the brain). During a review of Resident 1's Minimal Data Set (MDS- a federally mandated resident assessment tool) dated 11/11/2025, the MDS indicated that Resident 1 was moderately cognitively impaired (decisions poor, supervision required). The MDS also indicated that Resident 1 required substantial/maximal assistance (helper does more than half the effort) on toileting hygiene, and partial/moderate assistance (helper does less than half the effort) on sit to stand and chair/bed-to-chair transfer. A review of the Care Plan dated 2/4/2025 indicated Resident 1 had a decline in activities of daily living (ADL) and functional mobility and was at risk for falls and further decline due to right hemiplegia, gait and imbalance. The intervention indicated the facility will provide safe and secure environment. During a review of Resident 1's Nursing Progress Notes (NPN) dated 10/29/2025, the NPN indicated Resident 1 was found on floor at 10 AM on 10/29/2025 and reported to the staff that he fell and hit his right forehead on the right wheelchair and noted a large bump on right side of head. A review of the GACH record indicated Resident 1 was admitted to the ER on [DATE] after a fall hitting the right side of the head with development of hematoma measuring (4) centimeter (cm- a unit of measurement of length). The record indicated the resident had history of stroke, use clopidogrel, and with chronic cognitive issues, which limit his ability to provide a full history. A CT (computed tomography- a diagnostic imaging test) result showed intraparenchymal bleed. During a concurrent interview and record review on 12/30/2025 at 12:20 PM with the Registered Nurse (RN 1), Resident 1's clinical records were reviewed. RN 1 stated Resident 1 fell during her shift on 10/29/2025 after using bathroom when she left Resident 1 alone in the bathroom and stepped out of the bathroom to look for a certified nurse assistant (CNA). RN 1 stated Resident 1's Care Plan interventions for fall precautions included to frequently provide visual checks to Resident 1 to ensure safety because Resident 1 would not use call light for assistance to get up. 2.During a review of Resident 2's AR, the AR indicated that Resident 2 was originally admitted to the facility on [DATE] and recently readmitted on [DATE] with diagnoses including hemiplegia and hemiparesis following cerebral infarction, and respiratory failure (a condition where there's not enough oxygen or too much carbon dioxide in the body). During a review of Resident 2's MDS dated [DATE], the MDS indicated that Resident 2 required substantial/maximal assistance (helper does more than half the effort) on rolling left and right, sit to lying, and lying to sitting on side of bed. During a review of Resident 2's Fall Risk Evaluation (FRE) dated 11/25/2025, the FRE indicated the category as high risk. During a review of Resident 2's Care Plan High risk for fall revised 12/1/2025, the care plan indicated the interventions were to anticipate and meet the resident's needs and be sure the resident's call light in within reach and encourage the resident to use it for assistance as needed. The care plan did not indicate other preventative measures related to bed position. During a review of Resident 2's NPN dated from 10/31/2025 to 12/26/2025, the NPN indicated to ensure that Resident 2's bed was kept at lowest position. During an observation and concurrent interview on 12/30/2025 at 11:15 AM with the treatment nurse (TXN 1), Resident 2's bed was in high position. TXN 1 stated Resident 2 had a star sign at door which means Resident 2 was at high risk for fall, and his bed was supposed to be kept in the lowest position. Resident 2 stated he was not made aware that leaving bed in high position can put him at risk for falling with major injury. Resident 2 stated he was not reminded by staff to keep his bed in lowest position. 3 During a review of Resident 3's AR