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	02/03/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow the facility's Policy and Procedure (P&P) for Administering Medications and Documentation of Medication Administration for three of five sampled residents (Resident 2, 3, and 4) by failing to:Administer ordered medications within one hour before or one hour after the physician's ordered time.Document medications after, and not prior to medication administration. This deficient practice resulted in the delay of medication administration for Resident 2, 3, and 4, and had the potential for residents' health to be compromised.Findings: During a review of Resident 4's admission Record (AR), the AR indicated Resident 1 was admitted to the facility on [DATE] with a diagnosis of Alcoholic Cirrhosis of liver (when alcohol scars the liver causing permanent damage) with Ascites (fluid buildup) and diabetes(the body has trouble controlling blood sugar levels). During a review of Resident 4's History and Physical (H&P) dated 5/12/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 4's Minimum Data Set (MDS - a resident assessment tool) dated 11/28/2025, the MDS indicated the resident was cognitively intact (alert, aware ,able to understand conversation and make decisions) dependent (meaning helper does all of the effort) for most Activities of daily living (ADLs) such as toileting hygiene, shower , baths, and lower body dressing. During a review of Resident 4's Medication Administration Audit Report for 2/3/26, the Report indicated the following medications were scheduled for 9 AM:Metolazone (medication used to treat high blood pressure [hypertension] and fluid retention [edema] caused by heart failure or kidney disease) Tablet 5 milligrams (mg a unit of measurement) were documented as administered at 9:40 AMFurosemide (medication used to treat edema caused by heart failure, liver disease, or kidney disorders, and to treat high blood pressure) tablet 40 mg was documented as administered at 9:38 AM.Gabapentin (medication for seizure [a sudden, temporary disruption of normal electrical activity in the brain, causing involuntary changes in movement, behavior, awareness, or sensation, ranging from brief staring spells to full body convulsions [[shaking, stiffening]]) and nerve pain medication used to manage postherpetic neuralgia [pain after shingles] and treat partial seizures 300 mg was documented as administered at 9:39 AM.Lactulose (synthetic sugar used to treat constipation by acting as an osmotic laxative and to reduce blood ammonia levels) 10mg /15ml was documented as administered at 9:40 AM. RifAXIMin (antibiotic) 550 mg was documented as administered at 9:41 AM. Midodrine (medications used to treat symptomatic orthostatic hypotension (sudden low blood pressure upon standing) by constricting blood vessels to raise blood pressure) 5mg was documented as administered at 9:40 AM. Spironolactone (used to treat high blood pressure)50mg was documented as administered at 9:41 AM. During a review of Resident 3's AR, the AR indicated the resident was admitted to the facility on [DATE], with a diagnosis of diabetes (high blood sugar) and heart disease (problem with the heart and how it functions) . During a review of Resident 3's MDS dated [DATE], the MDS indicated Resident 3's cognition (mental (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	processes) was intact, requiring maximal assistance (helper does more than half the effort) with upper and lower body dressing and toileting hygiene. During a review of Resident 3's Medication Administration Audit Report for 2/3/2026, the Report indicated the following medications were scheduled for 9 AM:Ferrous Sulfate (iron) 35mg was documented as administered at 9:31 AM.Diltiazem (used to treat high blood pressure) 60mg was documented as administered at 9:30 AM.Metoprolol (used to treat high blood pressure) 50mg was documented as administered at 9:31 AM.Hydralazine (used to treat high blood pressure) 25 mg was documented as administered at 9:31 AM. During a review of Resident 2's AR, the AR indicated the resident was admitted to the facility on [DATE], with a diagnosis of sequela of cerebral infarction (stroke caused by a blocked blood vessel). During a review of Resident 2's H&P dated 4/14/2025, the H&P indicated Resident 2 has the capacity to understand and make decisions. During a review of Resident MDS dated [DATE], the MDS indicated Resident 2's cognition was moderately impaired (with noticeable memory problems and a struggle to recall words) requiring only supervision for most ADLs. During a review of Resident 2's Medication Administration Audit Report for 2/3/2026, the Report indicated the following medications were scheduled for 9 AM:Amlodipine (used to treat high blood pressure) 5mg was documented as administered at 9:28 AM.Clopidogrel (antiplatelet medication used to prevent blood clots) 75 mg was documented as administered at 9:27 AM. During a concurrent observation and interview on 2/3/2026 at 10:26 AM with licensed vocational nurse (LVN) 2), LVN 2 was observed standing at the medication cart. LVN 2 stated morning medications that were due at 9 AM were not administered to Resident 2, 3, and 4 who were all in the same room. During an interview on 2/3/2026 at 10:56 AM with Resident 4, Resident 4 stated sometimes his medications were not administered on time, and that it depended on who the nurse was. Resident 4 stated medications were late especially during the night shift (11 PM to 7 AM shift). During an interview on 2/5/2026 at 11:47AM with LVN 2, LVN 2 stated the medication administration audit report was indicated by scheduled date which meant the time a resident's medication was to be given, and administration time, which meant the actual time the licensed nurses (LN) administered the medication to the residents. LVN 2 stated on 2/3/26 at 9 AM, LVN 2 was late to administer medications to Resident 2, 3, and 4. LVN 2 stated she had documented the medications for Residents 2, 3, and 4 prior to administering their medications. LVN 2 stated she had pre-signed the medication administration report (MAR) for Residents 2, 3, and 4 and that it was not the facility's practice to sign medications given prior to their administration. During an interview on 2/5/2026 at 12:14PM with registered nurse (RN) 2, RN 2 stated the standard for administering medications should be, pour, pass, and sign, meaning that the medication must be administered to the resident prior to documenting the medication. RN 2 stated mediations must be administered as ordered, which includes the specific time the medication was ordered. RN 2 stated LN had a timeframe for medication administration, which was one (1) hour before or 1 hour after the ordered time. During a review of the facility policy and procedure (P&P) titled, Administering Medication, revised April 2019, the P&P indicated to ensure that medications are administered according to the prescriber' s orders and within the required timeframe. Medications must be given within 1 hour of the scheduled time unless otherwise specified (such as before or after meals), ensuring the right time of administration to promote safety and therapeutic effectiveness. The P&P indicated the individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones. A review of the facility's P&P for Documentation of Medication Administration, revised, April 2007, the P&P indicated administration of medication must be documented immediately after (never) it is given.